The Postpartum Period and Its Impact on an Individuals Sexuality

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Postpartum sexuality refers to the sexual health and experiences of individuals following childbirth, including physical, emotional, and relational changes that may affect sexual desire, function, and satisfaction. Research on postpartum sexuality is limited, despite its importance for overall well-being. In addition to physical and psychological changes, postpartum sexuality is often shaped by an individual's location, cultural background, social norms, or religious beliefs. In many cases, traditional rituals outline the appropriate timing of sexual intercourse, sometimes disregarding the needs and readiness of the individual. Social media can serve as both a source of support and a reinforcement of harmful societal expectations. It can offer connection, community, and shared experiences, but it can also perpetuate unrealistic expectations and pressures related to sexual recovery and body image.

Understanding postpartum sexuality is crucial for individuals, couples, and healthcare providers or counsellors. As noted above, the postpartum period may significantly impact an individual's self-concept, as well as their emotional and physical well-being. Individuals may have shifts in their sexual desire, identity, and physical functioning, which can influence their interest or ability to connect with themselves or others. For couples, the postpartum period always brings many changes to their daily life, including a lack of sleep and increased responsibilities. These adjustments, sometimes combined with shifts in communication, often influence a couple’s relationship satisfaction and emotional closeness. Healthcare providers have an opportunity to offer individuals and couples the support and information they need to understand the impacts of birth and postpartum on the individual’s body and mind.

This paper uses the term “women”, reflecting most existing research. It is important to note that the term “women” does not represent all individuals who give birth, as some do not

identify as women. Furthermore, the term “breastfeeding” will also be used, and once again, it should also be noted that many individuals choose to use other terms that may be more queer and trans-inclusive or neutral. Terms such as chestfeeding, bodyfeeding, and nursing may be more appropriate and inclusive for some individuals. Therefore, it is important to note that not all terminology in this paper is inclusive and representative of all people who give birth and experience the postpartum period. In addition to a thorough discussion around the numerous dimensions of postpartum care, I will aim to highlight the limited research and common barriers for 2SLGBTQ+ families**.** For this paper, I will focus on the following research questions. How do biological, psychological, and relational factors impact an individual’s experience with postpartum sexuality? How can counsellors equipped with this knowledge anticipate postpartum challenges, validate and normalize experiences, support emotional processing, and encourage healthier relational dynamics around intimacy?

Structure

This literature review is organized into the following key sections: the biological and physiological factors, psychological and emotional factors, social and relational influences, and diverse experiences and influencing factors. I have outlined the relevant theories used to explore the factors influencing postpartum sexuality.

Personal and Academic Interest in the Topic

My interest in postpartum sexuality began during my time as a midwife, as I noticed a gap in knowledge due to the limited education we received in our training. This meant that, as clinicians, we were providing limited psychoeducation to our clients during pregnancy and into the postpartum period. I have had a personal curiosity and interest in postpartum sexuality, including mental health, relationships, and identity.

Sexuality is highly personal, yet often extremely influenced by society and culture. While it is much more common to see sex positive social media accounts, it remains an area that is often stigmatized or neglected within the healthcare system. This is particularly relevant during the perinatal period, where physical, mental, and life changes impact an individual's sexuality. Healthcare providers have an opportunity to provide psychoeducation and counselling to clients during this time. Through my exploration of the research, I aim to identify and support a more holistic and well-rounded understanding of postpartum sexuality that goes beyond the biomedical understanding. Along with the biopsychosocial approach, which includes the psychological, emotional, relational, and experiential aspects of sexuality. My goal is to highlight the existing gaps in the literature that critique the biomedical model, as it often focuses on the clinical issues, such as physical pain, hormonal changes, and the six-week postpartum checkup. Ideally, this process enables counsellors to recognize their own knowledge gaps and biases, and to reflect on how these may influence their practice. In Western, and many other cultures, there is an expectation that once an individual gives birth, their priority should be on caregiving, de-prioritizing their own sexual, physical, and emotional needs. These expectations often contribute to individuals feeling shame, guilt, or conflict when they desire intimacy or are experiencing relationship challenges. Sexuality is rarely discussed in the immediate postpartum period, leaving individuals feeling isolated and unsupported.

In our society, I have also noticed comments and jokes that portray the non-birthing partner as sexually deprived, rather than acknowledging this period as a time of transition and emphasizing the importance of supporting both individuals in rebuilding intimacy after a significant life change. This reinforces frustration, entitlement, and resentment towards the postpartum individuals, instead of recognizing it as a transition that both partners experience

together. These jokes often emphasize the prioritization of male sexual needs, a dismissal of the psychological, physical and emotional challenges individuals face in the postpartum period, as well as the gendered expectations of sexual obligation. These societal expectations often impact the birthing person's experience and pressure to return to being sexual when they're not ready. Alternatively, gendered stereotypes that suggest new parents shouldn't be sexual and should only focus on the baby may influence individuals to ignore their desires for intimacy.

The transition to becoming a parent often influences an individual's sexual identity as well as intimate relationships in the postpartum period. I believe that a better understanding of postpartum sexuality is vital for new parents, as well as healthcare providers and counsellors. Unfortunately, resources are often not inclusive, diverse, and informative for new parents and healthcare providers. My goal for this research is to support my practice in being person-centered, inclusive, culturally sensitive, and supportive to all postpartum individuals.

Throughout my studies, I have spent time understanding human sexuality, attachment theories, perinatal mental health, and postpartum changes. Factors such as gender diversity, sexual orientation, cultural background, and relationship dynamics will influence how an individual experiences their postpartum period as well as their sexuality. I hope to shed light on the experiences of those who identify within marginalized communities.

Literature Review

Postpartum sexuality is shaped by a complex interplay of biological, psychological, and relational influences. In the postpartum period, these factors can influence an individual's sexual well-being after childbirth. Understanding how these factors intersect offers counsellors an opportunity to better recognize clients' needs, anticipate challenges, and normalize their experiences. This review will examine the literature within these domains.

Conceptualizing Sexual Health in the Postpartum Period

To conceptualize postpartum sexuality, we must first define sexual health and sexuality, followed by definitions of the postpartum period and sexual dysfunction. The World Health Organization (WHO) defines sexual health as a state of physical, emotional, mental and social well-being concerning sexuality (WHO, 2006a). Sexual health is not simply the absence of disease, dysfunction, or infirmity, but a positive and respectful approach to sexuality and sexual relationships. This includes the potential for pleasurable and safe experiences free of coercion, discrimination, and violence. These rights ensure that individuals can express their sexuality and enjoy sexual health, without discrimination, so long as the rights of others are also upheld.

Sexuality is recognized as an essential part of human identity and includes sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. An individual may experience and express their sexuality through fantasies, desires, behaviours, practices, roles, and relationships. It is shaped by ongoing experiences and interactions with the world. Influencing factors include psychological, economic, cultural, historical, religious, legal, and spiritual dimensions, as well as broader political climates and societal norms.

The postpartum period encompasses the period from childbirth through the first 12 months (Zhang et al., 2021; McBride et al., 2016). This is a period of significant transition and challenges, which may lead sexual dysfunction, which, as defined by the DSM-V is “a clinically significant disturbance in a person’s ability to respond sexually or to experience sexual pleasure” (Zhang et al., 2021). Sexual dysfunction among postpartum individuals varies from 35.5% to over 80% (Smetanina et al., 2025; Gutzeit et al., 2020). It was noted that sexual pleasure and emotional satisfaction remained consistently lower even beyond 18 months postpartum (McDonald et al., 2017). This suggests that the biological, psychological, and social changes

following childbirth have far-reaching impacts and may continue to influence an individual's sexual health well beyond the traditionally defined postpartum period.

Biological and Physiological Factors

Biological and physiological changes after birth will significantly influence an individual's postpartum sexual experience. The hormonal shifts, physical recovery, and demands of infant feeding can all influence desire, comfort, energy, and sexual functioning.

Hormonal Changes

Many biological and physiological factors influence postpartum sexuality. In individuals who choose to breastfeed, there is a suppression of estrogen levels which can lead to vaginal dryness (Gutzeit et al., 2019; O'Malley et al., 2018). McBride et al. (2016) support this, while also adding that elevated prolactin and oxytocin levels are also seen in individuals who breastfeed and subsequently have been seen to harm one's desire. Ollivier et al. (2024) identify that for some women it is difficult to communicate with their partner about the changes and their concerns with lactation, specifically breast leakage. The participants describe the challenge of not wanting their partners to associate their breasts with feeding during sexual activities. This highlights the broader tension individuals face in balancing the dual roles of certain body parts in both caregiving and sexual contexts.

Smetanina et al. (2025) conducted a systematic review of publications that reported scores in sexuality using the Female Sexual Dysfunction Index (FSDI). They found that individuals experienced difficulties in their sexual lives during the postpartum period, irrespective of the feeding type. However, they noted that individuals who exclusively breastfed had lower desire scores, suggesting that they may be less likely to engage in sexual intercourse, particularly when experiencing vaginal dryness. Furthermore, orgasm scores were lower in

women who exclusively breastfed compared to those who supplemented breastfeeding with other feeding methods. The authors provided additional insight, explaining that elevated prolactin levels, resulting from breast stimulation, inhibit estrogen secretion, leading to vulvovaginal atrophy, dryness, and subsequent dyspareunia. There is an inherent challenge in providing information about the potential impacts of breastfeeding on sexual activity, dyspareunia and vaginal lubrication, while also supporting breastfeeding without discouraging it.

There are many benefits to breastfeeding, however, individuals must be informed on the impact that breastfeeding may have on their sexual interest and health. Healthcare providers should be providing information on the options for vaginal lubrication and other ways to manage the potential impacts of how they feed their baby (O'Malley et al., 2018; Pardell-Dominguez et al., 2021). Another key consideration is the experience of 2SLGBTQ+ families and the barriers and challenges they face in accessing lactation support (Chestynd, 2019). This includes considering the unique lactation experiences, including induced lactation, chestfeeding for transmasculine parents, and co-nursing. Lack of lactation support can contribute to worsening mental health conditions, impacting their postpartum health and sexuality.

Utilizing the Female Sexual Dysfunction Index (FSDI), Zhang et al. (2021) conducted a multicenter longitudinal study in southwest China to examine female sexual dysfunction throughout pregnancy and into the postpartum period. Their findings differed from other studies, as they reported no statistical differences between groups based on breastfeeding characteristics. This difference in outcomes across studies could be attributed to individual hormonal differences, as well as cultural and socioeconomic factors. The study offered a valuable cultural lens, describing Chinese sexual norms as being conservative and implicit. This can influence how women perceive, report, and experience sexual dysfunction. The longitudinal approach

aimed to identify how sexual function evolves across the perinatal period, rather than focusing solely on the postpartum period. The study concluded at six months postpartum, which is relatively early and may not fully reflect sexual functioning at 12 months.

Perineal Trauma and Healing

Findings indicate that individuals who had a more severe second-degree tear reported greater dyspareunia (Risløkken et al., 2025; O'Malley et al., 2018). Women who received an episiotomy at birth reported more dyspareunia at three and twelve months postpartum, compared to individuals who did not have an episiotomy. The severity of tears impacted their sexuality, and the time individuals took to resume intercourse (Risløkken et al., 2025). Individuals who had second-degree tears resumed intercourse approximately one month later than those with no tear or first-degree tear. Interestingly, the authors found individuals with 2C-tears reported the highest percentages of sex at twelve months postpartum, despite reporting the highest levels of dyspareunia.

This study (Risløkken et al., 2025) focused on individuals who either did not tear or had a first-degree, or second-degree tear. It did not include third- and fourth-degree tears, which are the most severe forms of perineal trauma and can have significant short-term and long-term consequences. While the authors briefly outlined the classification of third- and fourth-degree tears in their introduction, they chose to exclude them from their study. I presume this was to narrow their study and provide more precise insights into the outcomes associated with second-degree tears. Furthermore, third- and fourth-degree tears are less common, making it harder to gather a large enough sample for statistically significant results. Gommesen et al. (2019) included individuals with third- and fourth-degree tears and found a higher risk of dyspareunia associated with these more extensive tears. Interestingly, this study also examined pre-pregnancy

dyspareunia and found it to be associated with postpartum dyspareunia. However, the authors noted that the pre-pregnancy data were collected well into the postpartum period, which may have affected the accuracy of recall.

As many studies examining perineal trauma and dyspareunia do not include a pre-pregnancy baseline, there may be an overlooked proportion of individuals who had existing dyspareunia before delivery, potentially inflating the association with postpartum outcomes. Individuals who reported pre-pregnancy dyspareunia were seen to have several postpartum sexual health concerns at six and 12 months postpartum. This included dyspareunia, a lack of vaginal lubrication and a loss of interest in sex at six and 12 months.

Doke et al. (2021) propose that cesarean delivery inhibits perineum damage and consequently prevents postpartum dysfunction. This statement should be interpreted with caution, as many individuals experience failed instrumental deliveries before requiring a cesarean section, which can still cause perineal tissue damage (McBride et al., 2016). Furthermore, cesarean delivery does not eliminate pelvic floor concerns. Dyspareunia was reported more frequently in women who had a vaginal delivery compared to those who underwent cesarean delivery at both six weeks and three months postpartum. However, the primary risk factor for dyspareunia appeared to be perineal trauma rather than the mode of delivery. Similar to other studies, the authors noted that an episiotomy delayed the resumption of sex by one month, while individuals who had instrumental and spontaneous deliveries both resumed sex earlier. Their study found that women who had a vaginal delivery resumed sexual activity earlier than those who had a cesarean section.

Physical Fatigue and Sleep Deprivation

Fatigue has been reported as the most common health problem in the postpartum period (Bakker et al., 2014). Many factors contribute to fatigue, including poor sleep, nighttime feeding, being single, complications from birth, and mental health concerns. The authors also found that advanced maternal age and increased responsibilities both at home were found to predict higher fatigue at 12 weeks. There is limited research on the role of maternal age in postpartum adjustment, although it has been suggested that older first-time parents may face unique challenges related to lifestyle adjustment and loss of autonomy. This could be influenced by individuals being more established in their routines, including sleep habits and work-life structures. In comparison, younger parents may demonstrate greater flexibility in adapting to postpartum changes, including sleep deprivation and irregular sleep schedules. Future research could explore how age influences an individual's postpartum experience and adaptation.

Sexual activity often requires rest, energy, and interest. However, the demands of caring for a new infant and the irregular schedules of feeding and waking do not create an ideal environment for sexual activity. These new responsibilities placed on parents have been recognized as inhibitory to sexual intimacy (Pardell-Dominguez et al., 2021; Rahmani et al., 2023). They reported that when individuals feel rested, their energy levels increase, and their desire and ability to engage in sexual activity tend to return. However, this often requires support from partners and open communication from postpartum individuals. Interestingly, Rahmani et al. (2023) studied Iranian and Swedish participants in their study and found that participants from both countries either reported either no change or improvements in their sexual lives postpartum. While most research emphasizes negative outcomes, this study highlights a more neutral or even hopeful perspective on postpartum sexuality.

Psychological and Emotional Factors

Psychological factors are highly influential, as mood may shift in response to hormonal fluctuations, body image concerns, shifting identity, and birth trauma. An individual may develop significant mental health concerns throughout the postpartum period and require support in navigating these complex emotions.

Body Image and Self-Perception

An individual's self-concept, including how they perceive their body, greatly influences their sexuality. The postpartum period is a period of greater body dissatisfaction, with individuals reporting poor self-image and a dissatisfaction with their physical appearance during pregnancy and in the first year postpartum (Bader et al., 2024; Levy et al., 2020). Comparatively, they viewed larger breasts as positive and a sense of pride in the physical changes because this provided evidence of what their bodies achieved (Ollivier et al., 2024). Self-image is shaped by socially constructed ideals of sexual attractiveness, gender, and the conventional beliefs of femininity and sexuality (Pardell-Dominguez et al., 2021). Societal messaging often implies that women are valued based on their ability to appear young, sexually appealing, and for how quickly they “bounce back” after childbirth. While many are deeply impacted by dominant ideologies, some individuals hold a positive perspective on the changes their body goes through during the perinatal period. Levy et al. (2021) report that lower body satisfaction, along with increased anxiety and self-focus when the body is exposed during sex, is associated with lower sexual function. Therefore, our society's beliefs and pressures can greatly impact an individual's sexual health. O’Malley et al. (2015) found that a positive self-image improves sexual health and increases enjoyment with sex in the postpartum period.

Social media shapes self-perception and often worsens mental health. Social norms and media also influence an individual, as they create unrealistic expectations, shape what is

considered “normal”, and at times provide misinformation based on anecdotal advice. Social media can offer supportive spaces and reduce isolation, as individuals can talk openly about their concerns and experiences. Individuals in the postpartum period are subject to ads that depict negative changes associated with childbirth that promote genital cosmetic surgery procedures and other measures to improve their genitals or other parts of their body in the postpartum period. Cosmetic procedures such as vaginoplasty and labiaplasty are marketed as solutions to individuals who have been influenced by fear-based messaging suggesting that their genitals become “loose” or undesirable after childbirth.

Individuals are often conditioned to prefer a genital appearance that is tight and trim, with uniform labia. Zielinski et al. (2017) performed a cross-sectional study utilizing the Vaginal Changes Sexual and Body Esteem (VSBE) Scale for women post childbirth, to explore the associations between childbirth events and both physical and sexual self- esteem. Their study found that 84% of participants reported vaginal or rectal changes following childbirth; however, most also reported positive self-esteem - both physically and about their vaginal changes. Dominoni et al. (2023) also found similar results, indicating that the type of delivery does not significantly impact an individual’s perception of genitalia after childbirth. However, participants who had an episiotomy had lower VSBE scores (Zielinski et al., 2017).

This is not surprising as previous articles have shown that episiotomies can significantly impact an individual’s quality of life and sexual health. While the study notes that this finding contrasts with conventional understandings that episiotomies result in more aesthetically pleasing repair, it suggests a need to reconsider the assumption that aesthetic appearance and sexual well-being are inherently related. The study acknowledges that these findings are consistent with studies that found episiotomies are associated with lower sexual functioning post childbirth. A

limitation, however, is that the researchers did not know which participants were sexually active. This could skew the results as the questions were not as relevant to their current sexual life.

The study recognized that their use of the term “normal” potentially contributed to stigmatization and unclear conceptualization of what constitutes normal genitals. The majority of these papers do not include partner status or sexual orientation. These answers could skew the results as individuals who are not in a partnership may not be sexually active, making certain questions on sexual functioning, arousal, or satisfaction less applicable or harder to answer meaningfully. Same-sex relationships, individuals with non-penetrative partnerships, or non-binary identities may have sexual experiences that influence how they experience their genitals following childbirth. Individuals who are in a partnership, or who are not, may have different experiences towards their sexual and body self-esteem. Individuals may have higher VSBE scores based on the positive feedback they receive from their partner, while some may report lower scores if they have had a negative experience with their partner. Individuals without a partner might have more of an internal perception of genital changes with less external influence or pressure. Future studies that include partner status, sexual orientation, as well as cultural context, may improve their interpretability of findings and variability, creating a more robust study that include diverse participants and their experiences in the postpartum period.

Postpartum Depression and Anxiety

The postpartum period has a significant influence on an individual's mental health. Transitions such as the physical recovery, identity and lifestyle changes, isolation, and changes in relationship dynamics can contribute to an individual's psychological well-being. Approximately 85% of individuals report experiencing the “baby blues”, while around 20% meet the diagnostic criteria for postpartum depression (PPD).

While “baby blues” are often short-lived, depression can be long-lasting and contributes to challenges in sexual functioning. To assess postpartum depression, most studies and clinicians use the Edinburgh Postnatal Depression scale, as it has been specifically validated to assess for PPD. Antidepressants are often the first choice for individuals with postpartum depression, however, they have been suggested to lower sexual function (Kelley & Kingsberg, 2023). Almost 40% of postpartum individuals report challenges with sexual desire, arousal, and orgasm. These issues may contribute to low sexual desire and low rate of intercourse at eight to 12 weeks postpartum (De Judicibus & McCabe, 2022). The link between postpartum depression and challenges with sexual function is bidirectional, and the postpartum individuals’ and partners’ postpartum depressive symptoms are also positively related (Dawson, Strickland, and Rosen, 2022). These authors identify that individuals who are struggling with postpartum depression may often have thinking patterns that influence their ability to see positive feedback, while focusing on the more negative situations and factors. This could influence increased awareness of the challenges they may be experiencing physically, within their relationship, as well as changes to their sex life. Interestingly, Kelley & Kingsberg (2023) noted several studies that did not find a correlation between depression and sexual pain ratings. The authors suggest that when an individual has been found to have postpartum depression, they utilize this opportunity to incorporate questions regarding changes to the sexual relationship. This study was predominantly comprised of White, heterosexual, cisgender individuals who were of high socioeconomic status.

Throughout the literature, one consistent factor contributing to postpartum depression is poor partner support. Research indicated an association with postpartum depression at 12 to 15 months in individuals who reported low relationship quality and a decreased sex life. This was after accounting for earlier depression, during pregnancy or at six to eight months postpartum.

Birth Trauma and PTSD

Psychological birth trauma refers to the severe psychological harm caused by events occurring during labour and birth. Seen in roughly nine and 44% of births, it is common and can lead to post-traumatic stress and sometimes suicide. Desiree D. Rowe wrote an article, “Please Don’t Use the Restraints: Forgetting, Failure, and Childbirth”. Writing from a queer woman’s perspective, she wrote an article that proposed the queer potentiality of remembering birth trauma, instead of the conventional suggestion of people forgetting following childbirth. Queer people have more obstetrical and neonatal complications (Klittmark et al., 2024). Not surprisingly, they also have increased levels of severe fear of childbirth. In it, she referred to her own birth experience and described how her body was the victim of the “medical gaze”, a term introduced by philosopher Michel Foucault (Rowe, 2016). It refers to the dehumanizing medical separation of the individual’s body from the individual’s person or identity. This article explores what individuals often fear and experience in childbirth - a loss of autonomy, pressure to forget and move on, and an inability to simply do that. Birth trauma follows individuals for months and years after, impacting various aspects of their lives. Individuals with birth-related PTSD symptoms frequently experience difficulties with infant feeding and sleep, challenges in bonding with their infant, and strain within their relationship. They are also at a greater risk of ongoing mental health concerns. Birth trauma is likely to influence an individual’s sexuality as well, highlighting the importance of psychoeducation about its potential impacts.

Social and Relational Influences

Social and relational factors are highly influential and extend beyond romantic relationships but also cultural expectations, community norms, and access to resources. These factors all shape how individuals experience postpartum sexuality.

Partner Dynamics and Intimacy

Individuals undergo significant changes to their lives following childbirth. This transitional period can also put considerable strain on romantic relationships, as there is often increased demand, reprioritization of daily responsibilities and tasks, increased fatigue, and feelings of being overwhelmed in the postpartum period. Romantic relationships tend to be impacted the most in the first five months, and are most likely related to infants and their more frequent demands and nighttime waking.

Tavares et al. (2019) also suggest that vaginal dryness or dyspeuria may contribute to couples feeling overwhelmed and unable to cope. They noted that the more sexual desire fathers had for their partners, the more stressed the mothers felt. It's been found that during this period there tends to be a shift to more traditionally gendered division of tasks, resulting in women taking on more childcare and household responsibilities and men taking on more financial responsibilities (Cohen et al., 2019).

Individuals who take on responsibilities and roles that do not align with their preferred choice are more likely to experience a decline in mental health and increased PPD symptoms. Individuals who perceive the division of labour to be unfair or are dissatisfied were more likely to report less love and increased conflict with their partner. Emotional capital theory suggests that partners who are more sexually satisfied are better able to cope with the unique changes and responsibilities of new parenthood, as evidenced by their reported lower stress.

Khajehei (2015) also found an association between depression and relationship dissatisfaction, similar to the findings reported by Cohen et al. (2019). One limitation of the study was that it required access to a computer and an internet connection, which may have excluded individuals without a computer, potentially affecting the generalizability of the results.

Additionally, this study, like many others, utilized very heteronormative language, which may limit its inclusivity and relevance to diverse sexual and gender identities. Tavares et al. (2019) excluded a same sex couple from their study, due to the use of a statistical model that required distinguishable dyads. While it is methodologically justified, the reliance on models that require distinctions reinforces heteronormative frameworks and limits the generalizability of findings to same-sex or gender-diverse couples. Future studies would benefit from using models that allow the inclusion of indistinguishable dyads.

Therapists are encouraged to support couples in communicating and sharing their ideal roles and responsibilities in the postpartum period, as this can offer insight into how the division of tasks might be structured to reduce dissatisfaction and resentment (Cohen et al., 2019).

Cultural and Societal Expectations

Cultural and societal expectations can significantly influence an individual's sexuality and will impact the support they receive. In some cultures, sexual issues are believed to be a personal matter and should not involve individuals outside the couple. As discussed by Alnuaimi et al. (2020), women did not ask about sexuality as they were embarrassed to discuss sexual concerns with healthcare providers. This hesitation was attributed to Jordanian culture, which considers conversations about these topics as shameful and forbidden. Healthcare providers reported that due to cultural beliefs and values, women were less likely to refuse sexual advances from their husbands. They suggested that women resume sex to protect their marriage and avoid domestic violence indicating that women's sexual needs are not valued among the postpartum individuals. One healthcare provider suggested that religious leaders, such as an Imam, could be an appropriate person to advocate for women's rights regarding these sexual concerns. However, the Imam may continue to reinforce cultural beliefs and values, which may discount the desires

and needs of the clients. The healthcare providers believed that women had to wait 40 days before they resumed sexual activity due to their traditional and cultural beliefs. Unfortunately, without adequate discussion and recognition of the complexities of postpartum, individuals may receive this information and feel pressure to resume before feeling ready. This study included depictions of healthcare providers describing discomfort if women did not follow the traditional beliefs and wait until 40 days. Once again, this confirms a bias for a cultural timeline to resume sex, versus an individualized approach.

Healthcare and Provider Support

The majority of individuals receive healthcare from an obstetrician or midwife during their pregnancy and postpartum. McBride et al. (2016) note that only 15% of individuals report discussing sexual challenges with their healthcare providers. Ideally, sexual education and counselling begin before pregnancy and continue throughout and into the postpartum period. The goal would be to provide individuals and couples with information to better equip them during their postpartum period. It is important that women receive education throughout their lives, as this can empower them to feel autonomous and understand their options sexually.

Diverse Experiences and Influencing Factors

Similar to 2SLGBTQ+ individuals, people with disabilities are also often discriminated against. The prevalence of disability among individuals of childbearing age is between six and 10% (Hall et al., 2018). They are often undervalued and mistreated, and not considered within the context of pregnancy, birth, and postpartum (Devkota et al., 2019). This influences the support, education, and resources they receive, inherently influencing and limiting their sexual and reproductive rights. Furthermore, a higher prevalence of disability is seen within poor families in low-income countries. Unfortunately, due to cultural beliefs and values, individuals

with disabilities within these socioeconomic and cultural contexts are often prevented from marrying or having their sexual and reproductive rights respected. The participants within this study were pregnant and reported discrimination, exploitation, and abuse within their communities and their homes due to their disability. The study encourages more research as well as social policies that raise awareness about misconceptions about disability and childbirth.

Summary

This review highlights how postpartum sexuality is influenced by biological, psychological, and relational factors. Several hormonal changes begin in the postpartum period, and depending on the individual, can continue for a few years. Poor body image can negatively impact sexuality, as individuals report discomfort in their new body and a decreased desire (Pardell-Dominguez et al., 2021). Long-term sleep deprivation decreases an individual's mental health, contributes to relationship tension, and impacts their ability to cope with daily tasks and responsibilities. Individuals who receive well-rounded support often report increased desire for their partner, better mental health scores, and less pain (Levy et al., 2021).

Marginalized communities often receive discriminatory treatment within healthcare (Singer et al., 2019; Klittmark et al., 2024). Poor outcomes have significant consequences for their psychological and physical health, as well as their relationships. Healthcare providers are often insufficiently educated and inadequately prepared to care for clients who do not fit the cisgender and heterosexual norms, which places individuals receiving perinatal care at risk of unsafe or inequitable care. Clinic spaces, hospitals, and cisheteronormative behaviours and language often reinforce a system that questions the legitimacy of 2SLGBTQ+ families and increases their risk of harm. Healthcare providers should be required to undergo training, as

research demonstrates that education improves the quality of care received by people.

Implications for Counselling Psychology

Counsellors encounter postpartum clients facing interwoven biological, psychological, relational, and social changes. These factors directly affect sexuality, identity, and intimacy. Education on hormonal shifts and recovery, which affect libido and dyspareunia, will help normalize diverse experiences of desire, and validate struggles with intimacy. This can be done through a variety of modalities, such as handouts, group meetings, and social media, to reduce stigma and increase engagement.

Interpersonal psychotherapy (IPT) helps build healthy relationships and emotional processing by addressing common postpartum challenges such as interpersonal conflicts, grief and loss, and role transitions (Palmer Molina et al., 2024). Furthermore, it is recognized as an effective treatment for low-income and minoritized parents. This is particularly important for low-income and minority parents who often face additional systemic stressors. Study participants reported that therapist support in accessing resources and social services was highly valuable. Other discoveries suggest that IPT can be successful in a group setting for new parents, as it provides community and reduces stigmas within the community (Palmer Molina et al, 2024).

Cognitive behavioural therapy (CBT) can improve sexual functioning and self-efficacy after childbirth (Erfanifar et al., 2022). Following an eight-week program, sexual desire, arousal, and satisfaction improved. Physically, individuals also noted that CBT reduced anxiety and fear of intimacy, decreasing dyspareunia and vaginismus. This is significant as sexual self-efficacy and improved psychological health contribute to improved relationship satisfaction and sexual functioning. Throughout this study, participants learned mindfulness and stress coping strategies, highlighting another key part of the counselling process for postpartum individuals.

Sexual intimacy and satisfaction within a relationship are found to significantly influence marital quality. Banaei et al. (2017) indicate that sexual health education and postpartum counselling benefit marital satisfaction and reduce divorce rates. This education helps couples have a positive view of sexuality, shape realistic expectations, and work towards a healthier relationship with their partner. Banaei et al. (2017) identified a limitation within their study in that sexuality is a taboo subject in Iran, potentially reducing the number of people who would attend these sessions. In couple counselling, therapists can build confidential and trusting therapeutic relationships, which fosters trust, creating space to address taboo topics more openly.

Khajehei (2015) identifies the first five months as a pivotal time for counsellors to assess the quality of the relationships and support couples throughout this transitional period, including sexual identity and functioning. Early interventions and counselling support can improve the mental health of parents, as well as have secondary benefits for child mental health. Research indicates that children who grow up exposed to marital conflict are often at higher risk of emotional and behavioural problems (Tomfohr-Madsen et al., 2020). Programs that include counselling during pregnancy and the early postpartum support infants in having lower negative emotionality and fewer externalizing symptoms at 12 months of age and 24 months. These findings underscore that postpartum well-being, including sexual health, is not solely the responsibility of the birthing person; rather, positive relationships and perceived partner support contribute to improved outcomes for both parents and children. Counsellors can address this in sessions by providing psychoeducation on the role of healthy and positive co-parenting, relationship satisfaction, and the importance of acknowledging and supporting changes in the postpartum period.

Reproductive Justice

Reproductive justice is a foundational framework for understanding the rights of individuals (Grace et al., 2022). Within the postpartum period, sexuality and family planning are deeply tied to reproductive justice, particularly when considering whether an individual would like to have another baby. Fear of unintended pregnancy may rise, especially if their partner disregards their reproductive preferences or exerts control over contraception and reproductive choices. In such cases, sexual activity may feel unsafe or coerced, diminishing the individual's sexual autonomy and sense of safety.

This is in direct conflict with the WHO's definition of sexual health, as it requires the possibility of having pleasurable and safe sexual experiences, free of coercion and violence. Reproductive coercion (RC) is defined as a range of behaviours that restrict reproductive autonomy, including coercion to get pregnant, sabotaging contraception, and controlling the outcome of pregnancy (Grace et al., 2022). Marginalized populations are at higher risk of intimate partner violence (IPV), which is also associated with reproductive coercion (RC). Both RC and IPV are associated with poor health outcomes such as PTSD, depression, and decreased breastfeeding. These different situations highlight the need for counsellors to assess relational power dynamics and reproductive autonomy as part of postpartum care. Recognizing signs of RC and IPV is key, as there is often stigma and shame involved with both. Counsellors can work to create a space for open, nonjudgmental dialogue about sexuality, safety, and choice.

Birth Trauma

Childbirth is often characterized as a transformative experience; however, for a significant number of individuals, it can be the cause of extreme distress. Birth trauma can cause mental health challenges such as postpartum depression (PPD) and postpartum anxiety disorder (PAD) (Horstmann et al., 2024). It also influences relationships and delays bonding with their baby.

Posttraumatic stress disorder (PTSD) is another form of postpartum distress, and one in three individuals will report their birth as traumatic. Counsellors can be aware of antenatal risk factors such as mental health problems and fear of childbirth. Individuals are at a higher risk if they lack support during their delivery, experience increased obstetrical interventions and feel a loss of control during the birth. The authors, Horstmann et al. (2024) found midwives were a preferred source of support and counselling due to the relationship built on trust throughout their pregnancy and postpartum. These findings highlight the benefits of antenatal counselling, as it allows individuals to develop a therapeutic relationship and counsellors can assess for risk factors before birth and the postpartum period.

Recommendations for Practice

Sexuality includes how we feel in our bodies, how we experience arousal and pleasure, and how we understand ourselves as sexual beings - and it can be independent of a partner (Singh et al., 2020). Counsellors can support this by discussing topics like self-touch, fantasy, bodily awareness, or simply one's internal relationship to desire. Sexual pleasure is a fundamental human right and should be included within sex education. Positive views of sexuality support individuals in practicing safer sex, consistently use contraception, experience higher sexual self-esteem and are more assertive (Singh et al., 2020).

Integrating sexual health conversations in perinatal therapy has many potential benefits as it reduces stigma, and psychoeducation can help normalize postpartum sexual experiences (Zamani et al., 2019). Postpartum individuals want to receive more information about postnatal sexual issues and health from their care providers. A lack of sexual health counselling is a key factor contributing to sexual dysfunction in the postpartum period. Castellanos-Usigli & Braeken-van Schaik (2019) suggest that many health conversations take a risk-based approach,

focusing on the negative consequences of sexual relationships rather than promoting sexual pleasure and well-being. If we are not including pleasure within our discussions of sexual health, we are ignoring the full scope of an individual's sexual well-being, which can have negative effects on safer sex practices and health. The authors encourage the use of the Pleasuremeter, which is a conceptual tool to support health professionals in discovering the links between sexual health, sexual rights and sexual pleasure during sexual history-taking and counselling. Counsellors should be prepared to follow up on concerns or issues that may arise and refer clients to other services and professionals when indicated. This could include pelvic floor physiotherapists, their family practitioner, or a gynecologist.

The Women's Postpartum Sexual Health Program (WPSHP) is a multidisciplinary approach to sexual counselling in the postpartum period (McBride et al., 2016 & Zamani et al., 2019). The program includes individual, couple, and group counselling. This program supported sexual satisfaction, improved conflict management skills, and facilitated a smoother transition to parenthood for couples. Group counselling in the WPSHP was effective in normalizing sexual problems and concerns in the postpartum period. Individuals had an opportunity to discuss with others and realize that they are not alone in their experience. The couples counselling session addressed the sexual concerns of spouses as well, a consideration that is often missing in other programs and research. The authors noted that throughout the program, the participants reported reduced stress, anxiety, and depression, which, in turn, increased their sexual satisfaction and decreased sexual distress. They also found that midwife-led counselling interventions that addressed distressing birth experiences appeared to reduce the symptoms of trauma, depression, and stress. Unfortunately, individuals are not always able to process these experiences with their

birth team. In such cases, counsellors with knowledge of birth and postpartum care can play a valuable role in helping clients make sense of and integrate their experiences.

Relationship satisfaction and sexual satisfaction are closely linked and influenced by the quality of communication between partners (Siboni et al., 2021). Furthermore, it was found that romantic relationships are one of the most pivotal factors in supporting an individual's well-being and quality of life, particularly as adults. A positive and fulfilling relationship is associated with better coping skills, higher self-esteem, and better mental and physical health. Sexual health and satisfaction also contribute to an individual's overall quality of life and are associated with relationship satisfaction, emotional intimacy, and communication. Therefore, it is evident that a strong relationship has strong implications for an individual's postpartum sexual experience. As such, couples counselling is a strong intervention in supporting relationships throughout the transition to parenthood.

Cultural Implications

In many cultures, sexuality remains a taboo topic. Social, religious, and cultural norms strongly influence an individual's sexuality, yet many people have insufficient knowledge about postpartum sexuality. Social media and cultural myths are often the primary sources of information, which often perpetuates misinformation. Counsellors can play a vital role in exploring clients' beliefs about sexuality, as well as their cultural and religious values, all of which can shape postpartum sexual experiences and perception of parenthood concerning sexuality. Canada is home to individuals from diverse backgrounds, cultures, and religions, and counsellors must recognize and account for this diversity in their practice.

Postpartum sexual abstinence is a strong cultural practice in some societies in Africa and other regions (Shabangu & Madiba, 2019). Sexual abstinence can range from three months to

over one year, or until the child can walk or is weaned from the breast. However, the WHO indicates that the period of postpartum abstinence is decreasing and now tends to end between five to seven weeks. Shabangu and Madiba (2019) indicate that resumption is often determined by the needs of the baby, the father, the age of the mother, marital status, and cultural beliefs. Their study discusses the perceived benefit of women choosing to resume early intercourse, as it is believed to reduce the risk of HIV transmission and other STIs by discouraging men from seeking sex outside the relationship. However, there are many health challenges with having sex earlier, particularly in communities without access to contraceptive methods or comprehensive sexual health education, which can increase physical health risks and complicate the postpartum recovery process. Recognizing and understanding how sociocultural norms interact with individual, relational, and biological factors is key to supporting postpartum individuals.

2SLGBTQ+ Experiences

Historically, there is considerable disparity in reproductive healthcare, including access to safe, supportive and inclusive healthcare for 2SLGBTQ+ families (Singer et al., 2019; Klittmark et al., 2024). These disparities arise through lack of knowledge about health issues specific to this population, combined with misconceptions and prejudices among healthcare providers. Many providers do not consider 2SLGBTQ+ individuals in their practice, leading to heteronormative clinic designs, pamphlets, and language. Such environments exclude or alienate individuals, reinforce stigma, reduce the effectiveness of healthcare, and cause discomfort, mistrust, or even harm. Discriminating behaviour among health care providers include disrespect of correct pronouns, hurtful language, and viewing queer individuals as a pathological disease. Stigma, microaggressions, and lack of support undermine mental health and postpartum recovery, influencing postpartum sexuality.

Research demonstrates that 2SLGBTQ+ parents experience higher rates of postpartum depression, poorer birth outcomes, greater financial barriers, and more negative healthcare experiences compared to their heterosexual and cisgender peers (Klittmark et al., 2024; Masterson et al., 2025). In addition, individuals who identify as lesbian, gay, bisexual, transgender, and/or queer often face social and legal discrimination, barriers to creating a family, and inequitable access to healthcare (Singer et al., 2019; Klittmark et al., 2023; Klittmark et al., 2024). Focused training is necessary to improve knowledge, attitudes, and behaviours of perinatal healthcare providers, and should include the use of inclusive language for all pregnant individuals, strategies to minimize heterosexism and cissexism, and ways to ask questions that avoid assumptions.

Counsellors working with this population require more than general experience with postpartum depression; they must also understand the unique experiences of 2SLGBTQ+ childbearing individuals, engage in clinician training, and implement policies that promote equality within their practice. Many clients may resist traditional parenting labels such as “mom” or “dad”, instead expressing a fluid, nonbinary approach to parenting. For example, Jesse, a participant in Masterson et al. 's (2025) study who identifies as nonbinary, Two-Spirit, and a trans man, shared:

> I want to be a mom. And I also want to be a dad. Like, I want to be able to grow and change with my child. I want to be the nurturing mother in the very beginning, and be the strong provider dad, and teach them whatever they want, whether that's music, sports, dancing, or art, or whatever. Like I want to be, I want to encompass all of those things, because that is me.

This quote highlights the importance of acknowledging that clients have individualized experiences within both their body and parenting. Navigating a heteronormative and gendered healthcare system often may intensify gender dysphoria, impact body image, and contribute to anxiety surrounding intimacy and sexual identity after birth. Participants within Masterson et al.'s (2025) study suggested specific improvements to perinatal care: avoiding gendered language, not assuming pronouns, parental roles, or who is capable of pregnancy. These findings underscore the importance of understanding the influence of social and psychological stressors on both pregnancy and postpartum sexuality.

Tools For Postpartum Clients

There are several clinical tools and interventions that are useful when working with postpartum clients. Mindfulness-based cognitive therapy (MBCT) interventions have a positive effect on the sexual performance and sexual self-efficacy of postpartum individuals (Erfanifar et al., 2024). Following the intervention, individuals reported improved libido, arousal, mental health, orgasm, and overall sexual satisfaction.

Virtual cognitive-behavioural therapy (CBT) is another intervention that may be used as an effective treatment to support sexual function and intimacy during pregnancy and in the postpartum period when couples have limited time and resources to make it into a clinic (Fathalian et al., 2022). CBT is effective in supporting individuals to manage dyspareunia, improve their sexual function, as well as benefit their marital and psychosocial adjustment.

Research Recommendations

Throughout this paper, I have identified gaps in the literature. One key area is the postpartum experiences among +2SLGBTQI individuals. Masterson et al. (2025) highlighted the exclusion of gender minority people in reproductive health research and the need for trans-

competent practices to ensure equitable and affirming care for gender-diverse populations. Research that identifies potential impacts of testosterone therapy on fertility and pregnancy would be key in supporting individuals who want to become pregnant at some point in their lives. This would allow individuals to make informed choices about fertility preservation and the timing of pregnancy. This may reduce psychological distress as it potentially minimizes uncertainty and anxiety related to fertility and bodily changes. As well as it helps them anticipate the potential physical experiences, reducing the likelihood of gender dysphoria during pregnancy. This would support them in their postpartum sexuality journey, as we know better mental health is associated with better postpartum sexuality.

Mental health and health care professionals would be equipped with better knowledge and tools to address the nuanced needs of trans and gender minority clients. Research that challenges cisnormative assumptions in reproductive care supports a more inclusive, safer, and equitable healthcare system. Singer et al. (2019) also suggest a gap in research that assesses the long-term impact of +2SLGBTQI-focused education intervention on healthcare delivery. They also highlight the benefit of qualitative research, of focusing on healthcare providers' experiences, including quotes on their experiences, opinions, practice changes, and difficulties. This would offer insight into future research, gaps in knowledge, misconceptions, and biases that could be addressed in quantitative research.

Research exploring how social, structural, and individual factors interact to shape postpartum sexuality remains limited. This gap overlooks the influence of intersectional identities, minority stress, poverty, and cultural contexts on an individual's sexual wellbeing after giving birth. Future research should investigate how sexuality continues to evolve beyond

the first year, examining whether individuals experience increased or decreased satisfaction, changes in arousal and libido.

While postpartum mental health is well-researched, the relationships between postpartum sexuality and mental health challenges remain underexplored. There is a need for further investigation into how these experiences intersect. For example, whether changes in sexuality contribute to poor mental health outcomes, or whether mental health challenges influence postpartum sexual wellbeing. Understanding this bidirectional relationship could provide greater insight into the complex experiences of postpartum individuals. Future research that evaluates relationship patterns throughout conception, pregnancy, and postpartum could provide insight into periods of change, challenges, and growth. This could contribute to a better understanding of how mental health counsellors could support relationships that are undergoing the transition of parenthood. Partner perspectives are often missing within the research, as their experiences are not valued in the same way as the person who gives birth. Qualitative research that studies the experiences of partners, including same sex partners or nonheteronormative relationships, could identify ways in which counsellors could provide support to partners, which could contribute to supporting the birthing person. While there is research on therapeutic interventions for the postpartum period, there is a significant gap in research that is focused on supporting an individual's sexuality, especially during the postpartum period.

Reflexive Self-Statement

As a student counsellor with a background in midwifery, I bring a unique lens to understanding postpartum experiences. As a midwife, my role is done at six weeks, before many people are thinking about or having sexual experiences. Because of this, my understanding of the implications postpartum has on an individual's sexuality has been somewhat limited to my

midwifery experience and cultural discourse. As a White, cisgender woman, I recognize that my understanding of postpartum sexuality is shaped by my midwifery experience, upbringing, world context, and social media. I recognize the privilege I hold financially and geographically, which would allow me to seek out medical care, mental health support, and peer support that is more open-minded to discussing sexual concerns. Throughout this literature review, my own biases have become more apparent. My values and the importance I place on sexuality may differ from those of individuals who prioritize other aspects of life or facets of their identity over their sexuality. This may include assuming people should want to resume sex and actively working towards it. Within this same context is the potential for me to view low sexual desire as inherently problematic or abnormal, rather than a possible healthy adaptation and period of their life. Each experience is shaped by relational dynamics, recovery, mental health, and cultural or spiritual beliefs. Ethical practice involves upholding my clients' autonomy and agency around their sexual health choices. A part of this is understanding the client's values around sexuality, as well as the cultural or societal beliefs and biases that may be influencing their understanding of postpartum sexuality.

I have not experienced the same discrimination, inequitable access to healthcare, and misgendering that many +2SLGBTQ pregnant and postpartum individuals experience. Ethical counselling practice requires inclusive, affirming language acknowledging diverse identities and experiences. This may include using the client's preferred terms for their body, relationships, and family roles. My belief in reproductive justice informs how I approach both midwifery, counselling, and research around postpartum sexuality.

Several articles highlight the risk of infidelity if the birthing person does not recommence sexual intercourse in a timely manner. I found these articles sexist and difficult to read as they

were not recognizing the birthing person's experience, as well as the safety, readiness, or comfort around resuming sexual intercourse. Sexuality is a complex construct that depends on many aspects of an individual's psychological and physical health. If these are neglected or compromised, sexual readiness and desire will be compromised. It also insinuates that an individual's sexuality is related to having intercourse or their marriage, where an individual's sexuality is shaped by a unique combination of biological, psychological, relational, cultural, and lived experiences.

Confidentiality and informed consent are essential in postpartum counselling, as in all sessions. Every client should understand the limits of confidentiality and obtain consent before the initial session. As topics of sexuality can be sensitive, counsellors should approach these conversations with non-pathologizing, open-minded, and non-judgmental questions. It would be beneficial to have trauma-informed training, as many clients may have experienced sexual trauma, birth trauma, or medical discrimination and mistreatment.

Conclusion

Postpartum sexuality is influenced by biological, psychological, relational, and social factors. While the research indicates multiple factors may influence an individual's postpartum sexuality, there are gaps in treatment plans and the long-term implications. Throughout the literature, it has been made evident that every individual experiences the postpartum period in a vastly different way. As such, there is no normative trajectory for sexual desire, timing, or functioning after someone gives birth. An individual's postpartum sexuality will be influenced by their individual, relational, and cultural contexts. Furthermore, the studies reveal a gap in research and knowledge for communities who may be experiencing systemic discrimination, racism, and poverty. Research on the experiences of +2SLGBTQ individuals in the postpartum

period, specifically around sexuality, is extremely lacking. This gap further marginalizes these individuals and decreases their opportunities for safe, affirming, and equitable care.

Counsellors have an opportunity to address gaps in practical knowledge, as well as the potential stigma that the client may be experiencing in discussing their sexuality, by creating a client-centred approach that validates and honours the individual's postpartum experiences. This can be done by utilizing trauma-informed care principles and adopting inclusive and affirming language. The counselling space must welcome discussions on relational changes, desire, intimacy, consent, and identity changes. This creates an environment that reduces shame and supports a sex-positive culture within sessions. Counsellors may also have to hold space for the grief that individuals may be experiencing after a possible traumatic birth, physical loss, or loss of identity. I am committed to challenging my own biases, unlearning, seeking supervision, and advocating for sex-positive, trauma-informed and inclusive care. I plan to contribute to the counselling profession by educating, discussing, and affirming clients' rights to sexual health, dignity, consent, and autonomy throughout the postpartum period and beyond.

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