EXPLORING POSTPARTUM SEXUAL HEALTH IN NOVA SCOTIA USING FEMINIST POSTSTRUCTURALISM

by

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DEDICATION

For my grandmother, Louisette.

The kindest soul, who lived and endured with strength, faith, humility, and compassion. Your caring, devoted spirit continues to carry me forward. I love and miss you dearly.

(1925-2015)

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ABSTRACT

Background: Sexual health is a critical component of health throughout a person's lifespan. Among the important periods of transition within one's lifespan, the postpartum period is especially significant. Postpartum individuals may experience many changes to their sexual health, including emotional or physical issues. However, little is known about how postpartum sexual health is experienced from a non-physical lens. As such, there is a need to move beyond the physical and focus on the mental, emotional, social, and relational aspects of sexual health and their subsequent effects on postpartum individuals' experiences, feelings, and functioning after childbirth.

Aims: The purpose of this research was to explore how postpartum individuals in Nova Scotia experience their sexual health during the first six months after birth, as well as how those experiences are influenced and negotiated through relations of power.

Methods: I recruited eleven participants for this study using a purposive sampling strategy. Data was collected using semi-structured interviews. Feminist poststructuralism and feminist poststructuralist discourse analysis guided this inquiry. Core tenets of feminist poststructuralism include subjectivity, agency, relations of power, meaning, and discourse.

Results: Three key issues emerged. These included: 1) Renegotiating the Postpartum Body: Identity, Image, Meaning, & Function; 2) Choosing to Resume Sexual Activity: Feeling Ready; and 3) Feeling Connected: Desire, Intimacy, and Support. The issues presented were very much interwoven and influenced by certain social and institutional discourses. In some instances, participants negotiated relations of power by creating their own meaning(s) of the body, identity, intimacy, and sexual desire.

Significance: This research identified how postpartum individuals create unique meaning of and within their sexual health. This has important implications for pre-, ante-, and post-natal research, health care policy, education, and clinical care.

LIST OF ABBREVIATIONS AND SYMBOLS USED

FPDA	Feminist Poststructuralist Discourse Analysis
FPS	Feminist Poststructuralism
IWK	Izaak Walton Killam Health Centre
REB	Research Ethics Board
WHO	World Health Organization
2SLGBTQ+	Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, etc.

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CHAPTER 1: INTRODUCTION

The postpartum period is a time of great transition and adjustment (Fahey & Shenassa, 2013). Postpartum individuals often experience changes to their emotional, physical, and mental wellbeing, including their sexual health (O'Malley, Higgins, & Smith, 2015). Sexual health is a well-recognized component of overall health and wellbeing (World Health Organization, 2022), yet it has not been comprehensively explored in the postpartum period. One reason for the gap in our understanding of postpartum sexual health is that sex is often considered to be a difficult, taboo or embarrassing topic to discuss. In addition, the published literature and research specific to postpartum sexual health has, for the most part, focused solely on physical symptoms and measures. Therefore, further research is needed to gain an in-depth understanding of how sexual health is experienced and defined by postpartum individuals.

Sexual health has been re-defined and debated over the course of centuries and an agreement as to what constitutes sexual health remains uncertain to this day (Coleman, 2002; Sandfort & Ehrhardt, 2004). Sexual health is defined by the World Health Organization as "a state of physical, mental and social well-being in relation to sexuality. [Sexual health] requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence" (2022). Sexual health is important throughout the lifespan- and at all life stages- yet there is a gap in our understanding of sexual health in the postpartum period (O'Malley et al., 2015). This gap in understanding impacts how we best support postpartum individuals during this important transition period. Women's sexuality, whether it be prior to pregnancy or after birth, has been historically discussed or understood only in specific ways, thus limiting our knowledge of how the sexual health of postpartum individuals may be better supported.

While definitions of sexual health vary widely, women's sexuality is even less understood due to dominant social, political, historical, cultural, and societal influences (Gagnon & Simon, 1973). Throughout history, women's sexuality has been conceptualized in different ways, resulting in norms that dictate what is included or considered legitimate with regards to how women express and experience their sexual health (Foucault, 1978; Haug, 1987). In general, women's sexuality has been framed as a component of identity that is physically-focused, passive, and significant only when it pertains to reproduction (Daniluk, 1993, 1998; Faulkner & Mansfield, 2002; Miller & Fowlkes, 1980; O'Malley, Smith, & Higgins, 2019). This conceptualization of women's sexuality has important implications for how postpartum sexual health is defined and explored (O'Malley et al., 2015). For example, postpartum sexual health is generally discussed and approached from a physically-focused view that prioritizes the physical functions related to, or necessary for, sexual activity or sexual intercourse.

Researchers and philosophers have recognized the importance of considering women's sexuality during pregnancy and postpartum. However, the majority of postpartum sexual health research has focused on physical sexual functioning and one's ability to engage in sexual activity, which may include issues such as pain during sexual intercourse (dyspareunia) (Acele & Karaçam, 2011; Andreucci et al., 2015; Fodstad, Staff, & Laine, 2016; Kramná & Vrublová, 2016; Leeman & Rogers, 2012; McDonald, Gartland, Small, & Brown, 2015; Unsal Boran, Cengiz, Erman, & Erkaya, 2013), breastfeeding (Alligood-Percoco, Kjerulff, & Repke, 2016; Avery, Duckett, & Frantzich, 2000; Brauner Pissolato Pissolato, Neumaier Alves, Alende Prates, Antunes Wilhelm, & Ressel, 2016; Bucher & Spatz, 2019; Gutzeit, Levy, & Lowenstein, 2020; Lagaert, Weyers, Van Kerrebroeck, & Elaut, 2017; Marques & Lemos, 2010; Nobre, 2011; O'Malley, Higgins, Begley, Daly, & Smith, 2018; Triviño-Juárez et al., 2017; Wallwiener et al.,

2017; Yee, Kaimal, Nakagawa, Houston, & Kuppermann, 2013), physical fatigue (Alligood-Percoco et al., 2016; De Judicibus & McCabe, 2002; LaMarre, Paterson, & Gorzalka, 2003; Vannier, Rosen, & Adare, 2018), or sexual functioning measures (Chang, Chang, Chen, & Lin, 2010; Chang, Chen, Lin, Chao, & Lai, 2011; Chang, Lin, Lin, Shyu, & Lin, 2018; Hosseini, Iran-Pour, & Safarinejad, 2012; Kahramanoglu et al., 2017; Khajehei & Doherty, 2017; Lagaert et al., 2017; Lurie et al., 2013; Rezaei, Azadi, Sayehmiri, & Valizadeh, 2017; Wallwiener et al., 2017). Among the topics explored within postpartum sexual health literature, the greatest emphasis to date has been on physical symptoms, measures, and experiences, such as the effects of breastfeeding on sexuality (Avery, Ducktt, & Frantzich, 2000; Pissolato et al., 2016; Bucher & Spatz, 2019; Hipp, Kane Low, & van Anders, 2012; LaMarre et al., 2003; Marques & Lemos, 2010; Matthies et al., 2019; Nobre, 2011; O'Malley et al., 2018; Rowland, Foxcroft, & Patel, 2005; Triviño-Juárez et al., 2017; Wallwiener et al., 2017; Yee et al., 2013), delivery method or interventions during labour and birth (Doğan, Gün, Özdamar, Yılmaz, & Muhçu, 2017; Faisal-Cury, Menezes, Quayle, Matijasevich, & Diniz, 2015; Fodstad et al., 2016; Gutzeit et al., 2020; Kahramanoglu et al., 2017; Karaçam, 2008; Klein et al., 2009; Kramná & Vrublová, 2016; Lurie et al., 2013; McDonald & Brown, 2013; Necesalova et al., 2016; Song et al., 2014), and physical symptoms affecting postpartum sexual intercourse (Acele & Karaçam, 2011; Adanikin, Awoleke, Adeyiolu, Alao, & Adanikin, 2015; Bertozzi, Fruscalzo, Driul, & Marchesoni, 2010; Lagaert et al., 2017; Leeman & Rogers, 2012; McDonald, Gartland, Small, & Brown, 2016; Necesalova et al., 2016; Rathfisch et al., 2010; Triviño-Juárez et al., 2017). As is evident from the research and literature, one way of assessing sexual health postpartum has been based on the physical ability to engage in sexual activity or intercourse as soon as possible. The prioritization of sexual intercourse or sexual activity reflects a social view that postpartum individuals ought to

be engaging in sexual activity. Similar to the ways in which women's sexuality has been conceptualized as passive or giving (Daniluk, 1993, 1998; Faulkner & Mansfield, 2002; Miller & Fowlkes, 1980; O'Malley et al., 2019), postpartum sexual health is often approached from the lens of how often sexual activity is occurring or when it is resuming (Necesalova et al., 2016; Sok, Sanders, Saltzman, & Turok, 2016; Wallwiener et al., 2017; Yee et al., 2013), rather than how the postpartum individual actually experiences or perceives the need for sexual activity. As such, the emotional and psychological aspects of sexual health and sexuality are constructed as being less important components of postpartum individuals' sexual health (O'Malley et al., 2015). Postpartum sexual health may be experienced in physical ways, though non-physical experiences of sexual health, such as emotional or psychological sexual health, are also important.

Postpartum Sexual Health: A Non-Physical Approach

In relation to the current evidence, postpartum sexual health is less understood outside of the physical sphere because non-physical aspects have traditionally been positioned as less important and, therefore, not examined as rigorously (O'Malley et al., 2015). Non-physical influences on women's sexual health after pregnancy and birth identified in the literature include: mental health changes (Chang et al., 2018; De Judicibus & McCabe, 2002; Khajehei & Doherty, 2017), lack of support from partner(s) or loved ones (Cappell, MacDonald, & Pukall, 2016), body image (Akpinar & Yangin, 2018; Bender, Sveinsdóttir, & Fridfinnsdóttir, 2018; Khajehei & Doherty, 2018; Salim, Araújo, & Gualda, 2010), lack of sleep (Alligood-Percoco et al., 2016; De Judicibus & McCabe, 2002; Hipp et al., 2012; Vannier et al., 2018), relationship issues or satisfaction (Bender et al., 2018; Hipp et al., 2012; Khajehei, Doherty, Tilley, & Sauer, 2015; Rosen, Mooney, & Muise, 2017), depression (Khajehei & Doherty, 2017; Khajehei et al.,

2015; Morof, Barrett, Peacock, Victor, & Manyonda, 2003), and role conflict (Khajehei & Doherty, 2018). Given the importance of moving beyond physically-focused outcomes and measures of postpartum sexual health (O'Malley et al., 2015), it is important to more deeply examine the meaning of non-physical aspects of sexuality and sexual health. Although the literature provides some insight into both physical and non-physical aspects of postpartum sexual health, most of the existing research has used surveys or quantitative methods to identify the issues that influence sexual health after birth. Qualitative research has primarily focused on how postpartum women experience or navigate the changes to their physical sexual functioning. The prioritization of physical experiences in both quantitative and qualitative literature causes us to miss critical contextual factors, such as relationships, that may also influence sexual health after birth. There currently exists a lack of understanding of how postpartum individuals experience the numerous, interconnected aspects of their sexual health after birth, which may include but are not limited to emotional, psychological, and physical experiences of sexual health.

As it relates to the topic of postpartum sexual health in particular, qualitative methods may allow for a more in-depth understanding of individual experiences and contextual factors that shape how sexual health is experienced after birth (Bender et al., 2018; Carlander, Andolf, Edman, & Wiklund, 2015; Khajehei & Doherty, 2018). From a theoretical perspective, research or discussion of postpartum sexual health using a critical social lens is virtually non-existent (O'Malley et al., 2015). Critical social methodologies provide specific insight into how sexual health and women's sexuality have been positioned, defined, and conceptualized historically, politically, and socially. Accordingly, the use of feminist poststructuralism (FPS), a critical social methodology and theory, in this research allowed for the exploration of how postpartum sexual health was experienced, and therefore defined, by postpartum individuals. By using the

language of "postpartum individuals" in my research, I aimed to include people who have birthed and had a postpartum experience, regardless of whether they identified as 'women'. Although the empirical and theoretical literature to date has explored sexuality and sexual health in a context specific to ciswomen, there is a need to expand these narrow and constructed notions of 'the woman', womanhood, and sexuality. While the participants in this study did give birth, gender as a social construct was not a limiting factor in my aim to capture the voices of postpartum individuals from various walks of life. Gender and sexuality are intertwined, but are also different concepts and are separate from biological sex. Having a baby is life-changing and there exist different beliefs, values, and practices surrounding postpartum sexual health, some of which I aimed to capture in my research. Feminist poststructuralism as a theory assisted me in deconstructing everyday practices and understandings, as well as in exploring other social and institutional constructions (Aston, 2016) surrounding postpartum sexual health. There is an urgent need to understand the meaning attributed by postpartum individuals to postpartum sexual health, which begins by exploring their experiences so as to understand beliefs, values, and practices. As such, this study aimed to uncover the knowledge gap currently in existence as it relates to how postpartum individuals experience the many facets of their sexual health after birth.

Situation of Self

My ideas for the topic and the methodology of my research were shaped by my experiences as a nurse, academic, and woman. I became interested in sexual health early on in my nursing career and was most impacted by my work as a Level 2 Sexual Health Counsellor at Options for Sexual Health B.C. (2014-2016) while living in Kelowna during my undergraduate degree. My experience working with patients allowed me to see the gaps in care and research,

one of them being that sexual health care services were often very prescriptive without accounting for the diverse desires, health needs, identities, and experiences of patients. With sexual health being a taboo topic, I thought it important for people to have accurate, useful, trustworthy information in order to care for their sexual health. I became interested in sexual health as a nurse because I recognized a need for more relatable, practical, and realistic approaches and information when discussing sexual health with patients. For example, providing information on sexual pleasure and how to pleasure oneself or others sexually while also being safe. In my experience at the clinic, it was not enough to simply instruct patients to use a dental dam, condom, or another barrier method without teaching them how to use it and how to make it a part of pleasurable, enjoyable sexual activity. Sexual health was not only about the prevention of pregnancy or diseases; patients wanted to know how to engage in sexual activity with themselves or others, learn how to approach or negotiate sexual relationships, and be provided a means to explore their sexuality in an environment that was safe and supportive. As a young woman, I also knew from personal experience that women's sexual health was not discussed in ways that were helpful because, oftentimes, sexual health education focused largely on contraception and the prevention of pregnancy or sexually transmitted infections. Topics such as mutual consent, how to talk about sexual health with partners, sexual pleasure, and orgasm were, for the most part, ignored in sexual health education and services. In discussing sexual health not only with co-workers but with friends and new mothers, I came to learn that birthing a baby impacted people's sexual health, yet it was rarely discussed by their health care providers during the postpartum period. As I began graduate studies in nursing, my formal education presented an opportunity to bridge my nursing experience with research.

My graduate learning journey began at Dalhousie University in the Master of Science in Nursing program in the Fall of 2017. Upon beginning my graduate coursework, I was exposed to new ways of thinking about research and how it can be transformative and impactful. Feminist poststructuralism was a methodology that peaked my interest immediately because it fit with how I wanted to conduct my own research. As a qualitative researcher, my positionality is central to my inquiry; there is so much we do not know- and it is important to consider who, why, and how we ask. The use of FPS meant putting my feminist values into action in a way that bridged my education, position, and work as a nurse researcher. My choice to interview postpartum individuals for this study was influenced by my view that they must be the ones to tell their own stories- and that these stories must not only be heard, but valued. There are many ways of understanding and conceptualizing sexuality, the body, gender, and the postpartum period. This study illuminated the diverse discourses and understandings surrounding postpartum sexual health.

CHAPTER 2: LITERATURE REVIEW

The following literature review represents the main, interconnected concepts of interest in the completed study. This chapter is not a systematic review of the relevant literature, but aims to synthesize and present evidence related to sexual health more broadly, as well as physical, emotional, and psychological postpartum sexual health. An emphasis on the differing discourses, perspectives, and definitions surrounding postpartum sexuality and sexual health will be a focus of this literature review. The first part of this chapter will present an historical, conceptual review exploring the definition and conceptualization of sexual health and women's sexuality. The second component will present an empirical review and synthesis of the literature specific to recent postpartum sexual health.

After consultation with a professional medical/nursing librarian, a search of the literature was conducted using the following health databases: Cumulative Index of Nursing and Allied Health (CINAHL), PubMed (including Medline), PsycINFO, and Scopus databases. All empirical literature regarding postpartum sexual health specifically was limited to a publication date between 2010 and 2021 and was required to be written in English. Search terms, either present in the title or in the abstract, included ('postnatal' OR 'postpartum' OR 'after birth' OR 'after baby') and ('sexual health' OR 'sexuality' OR 'sexual wellbeing' OR 'sexual wellness' OR 'sexual behaviour' OR 'sexual activity' OR 'sex'). Given the breadth of this topic, seminal literature published before 2010 was also included in the review to provide additional context and conceptual clarification. The search for conceptual literature was dated further back than that of the empirical literature to ensure that seminal articles on theoretical constructs were included.

This chapter is structured as follows: 1) Defining Sexual Health: A Social & Political Journey; 2) Sexual Health: Distinct & Emerging Discourses; 3) Postpartum Sexual Health:

Critiquing Current Approaches; 4) Postpartum Sexual Health: Physical Experiences; 5) Postpartum Sexual Health: Non-Physical Experiences; and 6) Summary. The chapter will then close with a review of the purpose of this study and the research questions. In this chapter, I often use the term 'postpartum woman/women' to match the language used by the authors of the described study.

Defining Sexual Health: A Social & Political Journey

Sexual health has been defined in a variety of ways based on the needs, values, and structure(s) of the period, context, and society (Giami, 2002). Even today, international health organizations, health care providers, and researchers cannot seem to agree on a definition that fully encompasses, validates, and supports the spectrum and diversity that comprises human sexuality and sexual health (Sandfort & Ehrhardt, 2004). A stark example of this was the World Health Organization's (WHO) decision to dismiss their definition of sexual health in 1987 (originally released in 1975 as the first internationally accepted definition), stating that a universal definition was unattainable and undesirable (Edwards & Coleman, 2004) because it would be normative and restrictive (Giami, 2002). Fifteen years later, in 2002, the WHO definition was reinstated and the main principles included in that same definition are still used today (Edwards & Coleman, 2004). At present, the WHO defines sexual health as "a state of physical, mental and social well-being in relation to sexuality. […] It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence" (2022). This definition was created in 2006. As I will explore further in this section, the discussion of sexual health is not only influenced by large-scale, international health organizations, but by current sociopolitical forces as well (Edwards & Coleman, 2004; Giami, 2002).

Collective understanding of sexual health has been shaped in different ways by social, political, and historical events (Edwards & Coleman, 2004). Some of the major influential events have included the 1960's sexual revolution (Dabhoiwala, 2012), feminist movements supporting access to contraception and safe abortions beginning in the 1950's (Correa, 1997; hooks, 1984; Lottes, 2000), and the maturation of the gay rights movement in the 1980's (Edwards & Coleman, 2004). These equity-focused social movements, be it protests, stand-ins, or formal legal proceedings, as well as public health crises (Francis, 2013), such as the HIV pandemic, have shaped the definitions and conceptualization of sexual health (Dabhoiwala, 2012; Edwards & Coleman, 2004; Giami, 2002).

Since 1975, the World Health Organization's definition of sexual health has evolved to meet social attitudes towards sexual health and sexuality, though has always been underpinned by Mace, Bannerman, and Burton's (1974) three components of sexual health. Mace et al. conceptualized sexual health as having three core components (Mace et al., 1974), which are: "(1) a capacity to enjoy and control sexual and reproductive behavior in accordance with a social and personal ethic; (2) freedom from fear, shame, guilt, false beliefs, and other psychological factors inhibiting sexual response and impairing sexual relationships; and (3) freedom from organic disorders, diseases, and deficiencies that interfere with sexual and reproductive functions" (Mace et al., 1974, p. 6). Over the last four decades, various definitions have sought to incorporate the somatic, intellectual, psychological, social, and emotional aspects of sexual health and wellbeing (Edwards & Coleman, 2004; Lottes, 2000).

The concept of sexuality has also influenced the definition of sexual health. Sexuality encompasses sexual feelings, behaviours, desires, attractions, and thoughts towards others and is highly personal (Aggleton & Parker, 2010; Crowell, Mosley, & Stevens-Watkins, 2017).

Sexuality is also culturally and socially influenced (Moon, 2008). When sexuality became acknowledged as essential to sexual health, sexual health was no longer conceptualized as a rigid, pre-defined state (Edwards & Coleman, 2004). With the shift towards a more holistic understanding of the multiple ways that someone can be sexually healthy, the importance of appreciating and caring for one's own body, respecting others and oneself, and engaging in meaningful sexual relationships have been subsequently acknowledged within various definitions of sexual health (Edwards & Coleman, 2004; Giami, 2002). As such, the World Health Organization incorporated the idea of sexual wellbeing as a "value-defined state" (Edwards & Coleman, 2004, p. 193), rather than a physically-defined state that was based solely on the absence of disease or dysfunction. The evolution of the World Health Organization's definition for sexual health exemplifies how social attitudes and priorities have influenced international organizations, politically or otherwise, and thusly shaped the aims and purpose of creating such a widely-used definition for sexual health.

The definition of sexual health was, and remains, influenced by the current socio-political environment. Throughout the conceptual evolution of sexual health, there have been political motivations that have limited the application and use of the term in varied contexts globally. For example, during the time of sexual revolution and the HIV/AIDS epidemic in the United States of America during the 1980's, many sexual health definitions focused significantly on reducing 'risky' behaviours such as anal sex or sex with multiple partners (Giami, 2002). Definitions of sexual health also aimed to promote contraception, despite the fact that perspectives and/or uses of contraception were very religiously- and culturally-influenced and were not always viewed as positive or socially acceptable (Giami, 2002). However, after the mid-1960's, the acknowledgement of contraception further legitimized sexual health as separate from procreation

(Giami, 2002). The definition of sexual health has also evolved over time to reflect an acknowledgement of diverse perspectives or identities, such as those related to gender and sexual orientation (Aggleton & Parker, 2010; Giami, 2002). After 1987, another significant overhaul of the WHO definition of sexual health occurred. In the 1987 definition, the respect and acknowledgment of differing values, identities, and beliefs was implemented (Giami, 2002). In this case, diversifying the definition of sexual health meant acknowledging sexual activity outside of heterosexual, monogamous relationships (Aggleton & Parker, 2010; Giami, 2002).

The scientific study of human sexuality has also influenced the definition of sexual health. Sexology explores human sexuality and relationships by considering how feelings, behaviours, interactions, and experiences influence sexual health (Rowland, Pinkston, & Reed, 2016). In 2000, the influence of sexology as a field became more prominent and contributed to the evolving definition of sexuality by including women's rights (also influenced by developing feminist theory) and gay and lesbian rights (Aggleton & Parker, 2010; Giami, 2002). Sexology also indirectly furthered women's reproductive health and rights. For example, sexology acknowledged how traditional gender roles and social expectations of women's sexual behaviour influenced their sexual health. In addition to this gendered conceptualization of sexuality was the incorporation of 'responsible' sexual behaviour(s) within the definition of sexual health. For example, the use of barrier methods to prevent disease transmission was linked to sexual health "in favor of a new sexual morality based on the principle and ultimate objective of health" (Giami, 2002, p. 20). In other words, sexual health was beginning to be defined in ways that were measured by behaviour that was considered safe (as synonymous with healthy) and functioned as a way of avoiding disease. For a period of time, sexual health was based on the absence of sexually-transmitted disease(s) (Aggleton & Parker, 2010). Safe sexual behaviours,

such as monogamous sexual relationships (Conley, Matsick, Moors, Ziegler, & Rubin, 2015), abstinence (Jemmott III, Sweet Jemmott, & Fong, 1998), and the use of contraception and barrier methods (Crissman, Adanu, & Harlow, 2012; Philpott, Knerr, & Maher, 2006; Widman, Welsh, McNulty, & Little, 2006), were linked to overall sexual health and wellbeing.

The classification of sexual behaviours as either healthy or unhealthy based on the presence of disease also led to the medicalization and formal conceptualization of sexual diseases or dysfunctions, such as paraphilias (abnormal sexual desires) or compulsive sexual behaviour, most of which were either somatic or psychological in nature (Aggleton & Parker, 2010; Giami, 2002). The consideration of physical disease, and then psychological disease within the conceptualization of sexual health led to the inclusion of psychological considerations (mental health and safety) as essential to sexual wellbeing. As of today, the latest definition of sexual health set in place by the WHO was established in 2006 and demonstrates the continuing shift to acknowledge non-physical aspects of sexual health, such as the importance of safe sexual relationships. The view of sexual health not only as a component of psychological and physical health, but as a fulfilling part of one's life, relationships, and emotional health was also acknowledged in the 2006 definition. Examples indicating the inclusion of emotional aspects of sexual health include the need for positivity, emotional intimacy, and respect, as well as the absence of discrimination or coercion in relation to sexuality (World Health Organization, 2022).

Sexual Health: Distinct & Emerging Discourses

Sexual health, particularly women's sexual health, has long been considered a taboo topic (Younger, 2003). Women's sexual health was only addressed or explored in certain fields of study or settings where it was considered appropriate to discuss, question, or examine. For example, the fields of philosophy, sociology, and gender studies have, for many years, been

centered as critical voices in contributing to new thought that questions how women's sexual health is conceptualized in medicine and in society. Key philosophical writers in the topic of women's sexuality and gender have included Michel Foucault (1978), Alan Soble (1980), and Judith Butler (1993). The following section provides an overview and synthesis of how women's sexuality throughout the lifespan has been discussed in the literature.

Women's sexuality. Women's sexuality has been historically understood in the context of heterosexual marriage. Marriage was conceptualized as the normative 'baseline', even in attempts to explore traditionally othered sexualities, such as lesbian sexuality, the sexuality of older women (Miller & Fowlkes, 1980), or Black women's sexuality (Gilman, 1985). Women were historically depicted as sexual 'givers', attending to the physical and sexual needs of their partners without need for orgasm or sexual release, deriving pleasure in knowing that they contributed to their partners' sexual fulfillment (Miller & Fowlkes, 1980). There was an expectation that women possess certain attributes such as a lower sexual responsiveness or interest in sex, selflessness, and a desire to please others (Ifeka, Ortner, & Whitehead, 1983; Miller & Fowlkes, 1980). There were also expectations about women's behaviors as they related to sex and sexuality (Ifeka et al., 1983), including uniformity of sexual behaviours and a lower sexual flexibility (i.e. less variance in when, where, with whom, and how they engaged in sexual acts) when compared to men (Miller & Fowlkes, 1980). Constructed socio-sexual scripts, defined as ideas or behaviours surrounding sexuality that are created and promoted by society, culture, and history, continue to dominate how female or feminine sexualities are depicted, treated, explored, or interacted with in a variety of contexts (Ifeka et al., 1983). In a heteronormative society, these widely-accepted, traditional scripts generally depict women as "unassertive, compliant, passive receivers of sex" (O'Malley, 2019, p. 57) who uphold 'good

morals' by refusing to discuss or engage in topics or activities of a sexual nature, especially in public (Faulkner & Mansfield, 2002). Within this view, women are expected to be sexually mysterious, yet available; demure, but also assertive in knowing what they want from sexual or romantic partners (Haug, 1987; Miller & Fowlkes, 1980). These opposing narratives surrounding women's sexuality require women to constantly navigate competing expectations of how they should express or share their sexuality (Daniluk, 1993). Moreover, these polarizing discourses are overwhelming and saturate common understandings and expectations of women's sexuality, as promoted and supported by popular media that often depicts women in a hypersexualized way (Haug, 1987). Being a 'true' woman is often linked to sexuality or sexual expression and there are constructed norms that surround women's sexuality, as has been written about by philosophical and academic writers such as Foucault (1978) and Butler (1990).

Understanding and conceptualizing women's sexuality. The constructed, gendered aspects of what it 'is' to be a woman as it relates to sexuality are incredibly complex and deeply interwoven (Butler, 1990; Haug, 1987). Foucault was and remains a prominent thinker in poststructuralist literature and is well-known for his writings exploring human sexuality. Foucault (1978) states that women's bodies, and their sexuality, have been policed, controlled, and surveilled for the purposes of procreation. Historically, a woman's sexual body was only considered valuable and useful through its ability to guarantee offspring, therefore limiting acceptable forms of sexual expression to those intended to lead to pregnancy (Foucault, 1978). Non-physical or non-heterosexual forms of sexual expression or sexual identity, altogether, were viewed as unproductive because they did not serve procreation (Foucault, 1978). Haug (1987) provides further critique that the female body, and therefore women's sexuality, has been constructed as barbaric, dirty, insatiable, and primal based on its reproductive functions, such as

menstruation, breastfeeding, pregnancy, and childbirth. A woman's body, according to Haug (1987), differs from the male body through its ability to carry a pregnancy, give birth, and breastfeed, constructing it as a body (and a being) that is only useful or special in physical ways. In connecting this conceptualization to Foucault's notions of discourse and the body, women's sexuality is identified as crucial to and solely concerned with reproduction and guarantee of the family (1978). Butler (1990) expanded on Foucault's ideas by incorporating issues of gender, and did so by arguing that gender is not 'natural' but rather imposed upon us by heteronormativity. Butler contends that, in society, "reason and the mind are associated with masculinity and agency, while the body and nature are considered to be the mute factity of the feminine" (p. 50). In relating this to women's sexuality, Butler (1990) suggests that the feminine being awaits signification from the masculine and, furthermore, serves the masculine through heterosexual relations that formally bind patriarchal connections. The dominant, accepted ways for women to enact their own sexuality have therefore been limited to the body and normative expressions of gender, such as passivity (Butler, 1990). A woman's assumed connection to her body has also created discourses surrounding gendered aspects of sexuality, being that the feminine sexual being must always appear tidy, clean, groomed, and conventionally attractive in order to be considered sexual by others (Haug, 1987), serving to welcome and attract a masculine sexual gaze. A woman's sexual 'value' is not only monitored by herself, but monitored by others (Haug, 1987), such as men, other women, religion, and the medical profession (Daniluk, 1993).

The different understandings that frame and conceptualize women's sexuality, as well as the female or feminine body, as both powerful and enticing has been a theme present throughout the academic literature. The opinions and perspectives pertaining to women's sexuality are wide-

ranging, emerging from medicine, religion, sexual violence, and the media (Daniluk, 1993). One of the most seminal research studies on the topic of women's sexuality is known as the Hite report (1976). At its forefront, the Hite report dispelled many myths surrounding female sexual pleasure and orgasm, some of which remain today (Hite, 1976). Some of the myths that were disproven by the report include the notion that women value emotional connection over orgasm when engaging in sex, or that vaginal/penetrative orgasms induce more pleasure than clitoral orgasms (Hite, 1976). Another seminal author on the topic of human sexuality, Kinsey, was one of the first sexologists to argue against the idea that vaginal orgasms were superior to clitoral orgasms, as published in what is commonly known as the Kinsey Report, formally titled *Sexual Behaviour in the Human Female* (1953). The Kinsey Report was based on approximately 6,000 personal interviews with women and, at the time of publication, was highly controversial because it discussed taboo topics and challenged common social perceptions of female sexuality (Research., Kinsey, & W.B. Saunders Company, 1953). One of the main criticisms of the Kinsey Report stated that Kinsey did not have the knowledge or educational expertise to discuss medical issues related to female sexuality, yet did so ignorantly (Bergler & Kroger, 1954). Although Hite and Kinsey's books were published over 40 years ago and were met with mixed critique even then, there are key themes that remain relevant to common social understanding and conceptualization of female sexuality (Reumann, 2005). Unfortunately, key citations such as the Hite report and the Kinsey report were based on the assumption that women's sexuality needed to be controlled, monitored, and surveilled; it confined women's sexuality to behaviours that were deemed most natural and, therefore, normal.

Women's sexuality as 'innate'. The dominant biomedical view of women's sexuality, as influenced by scientists such as Hite (1976) and Kinsey (1953), positions what is normal and

what is abnormal. In general, normative women's sexuality is viewed as that which is innately driven and therefore focused on reproduction and heterosexual relationships. As such, the dominant biomedical view also assumes that women experience their sexuality in parallel ways to men or to other women, thus resulting in the harmful and inaccurate pathologization of their sexuality (Sugrue & Whipple, 2001; Wood, Koch, & Mansfield, 2006). Traditionally, women's sexuality has been defined based on the assumption that sexual desire is innate, therefore it is deployed and expressed in ways that contribute to the 'natural' need to seek sexual relationships or intimacy (Wood et al., 2006). Sexuality and sexual desire, however, has been generally defined using a male-centered view of sexuality, prioritizing genital contact as the behaviour that most accurately exemplifies physically-driven, spontaneous human sexual response (Daniluk, 1998; Wood et al., 2006). Based on this definition of sexuality, men are viewed by society as being more sexually-driven because sexual behaviours, such as partnered sex or masturbation, are more common in men (Baumeister, Catanese, & Vohs, 2001; Leitenberg & Henning, 1995). These sexual standards position women as less sexual based on male standards of sexuality, though Leiblum (2002) argues that while hormones and other physical factors play a role in maintaining or initiating sexual desire and sexual relationships for women, psychological factors must also be considered. To state that the 'differences' between male and female sexuality are solely biologically-based is a gross oversimplification and represents an example of biological reductionism (Daniluk, 1998; Leiblum, 2002; Tiefer, 2001a, 2001b). There are several examples of research that oppose biological reductionism with regards to women's sexuality (von Sydow, 1999), many of which do not fit the purpose or focus of this literature review. That being considered, researchers have found that interpersonal and sociocultural factors importantly contribute to experiences of women's sexuality. Basson's ideas contributed to refining the

conceptual and medical definitions of women's sexuality by emphasizing that mutuality, respect, tenderness, communication and sexual pleasure are all fundamental to sexual desire; emotional closeness, sense of attraction, and physical pleasure are all reasons that women give for being sexual with others (Basson, 2002b, 2002a). Daniluk found that medical science (and the medical profession) was one of the primary influencers on how women experienced their sexuality (Daniluk, 1993). Participants in Daniluk's study expressed that medical professionals dictated how they should control their bodies, sexual expressions, and reproductive choices (Daniluk, 1993). Moreover, these female participants felt shamed and blamed by medical professionals in the sense that their bodies were objectified and that many of their functions, such as menstruation, were pathologized (Daniluk, 1993). This resulted in feelings of anger, embarrassment, loss, and helplessness for these women (Daniluk, 1993). As a result of unnecessary pathologization of women's sexuality and the female body, experiencing low sexual desire is perceived by many women as a problem that requires medical or pharmacological intervention (Everaerd & Both, 2001; Tiefer, 2001b). Despite the current knowledge that positions women's sexuality as contextual as well as physical, male-centered sexual norms are emphasized throughout a woman's lifespan, including after childbirth (Daniluk, 1998). Today, different understandings of women's sexuality have emerged as a way of challenging historical and current social norms.

While the historical understandings of women's sexuality during the 1970's, 1980's, and 1990's are important to acknowledge and consider, more recent literature describes how certain historical discourses have evolved. Most prominently, gender has not only become an assumed part of women's sexual identity but, quite contrarily, has been shaped to serve socially acceptable, collective ways of being, relating, and interacting in sexual contexts or among sexual

identities (Van Ness, Miller, Negash, & Morgan, 2017). Judith Daniluk (1998), a Professor Emeritus in the School of Educational and Counselling Psychology at the University of British Columbia, has built on Kinsey's notions of female sexuality in different ways by contributing evidence to the multiple, individual, and evolving ways that women experience their sexuality. Daniluk's book exposed the interwoven social, cultural and biological influences that uniquely combine to become a woman's self-definition of her sexuality (Daniluk, 1998). She emphasized the major influence of historical, social, cultural, and environmental context(s) on the sexuality of women throughout the lifespan, furthering previous scholarly works that had centered primarily on the biophysical aspects of female sexuality (Daniluk, 1998). Even in 1999, von Sydow's meta-content analysis echoed Daniluk's findings in stating that sexuality during pregnancy and postpartum are both physically and psychologically-influenced (von Sydow, 1999). More recently, Foucauldian discourse analysis has been used to explore women's sexuality and eroticism, uncovering several different discursive constructions of women's sexuality (Van Ness et al., 2017). Despite the lack of recent health literature exploring non-dominant views of women's sexuality, it may be concluded that women do not always define their sexuality in the same ways as those which are socially or politically constructed, or considered socially acceptable or 'normal' (Van Ness et al., 2017). During pregnancy and the postpartum period, it is known that there exists high interindividual variance in terms of how sexuality is experienced and defined (von Sydow, 1999).

Diversity and 'deviance' within women's sexuality. When exploring the diverse socially constructed discourses surrounding women's sexual health and sexuality, and the intersect with personal identity, the notion of 'normal' can position certain non-dominant discourses as 'out of the norm'. Using language such as "diverse" can ultimately be a way of

saying ‘different from me’ or ‘different from us’- a disruption of the status quo. Foucault (1978) explores this notion by using the language of ‘deviant’ and expands upon the constructed deviance that lesbian or gay sexual orientations are often met with in greater social discourse. Non-dominant discourses surrounding women’s sexuality are othered and constructed as ways of expressing or experiencing sexuality that are ‘special’ and therefore requiring enhanced attention, criticism, evaluation, assessment, or examination in a way that is not helpful in promoting individual sexual health. While the othering, or examination of othered experiences, has improved since Foucault published his book, there remain present day issues surrounding postpartum sexual health. For example, 2SLGBTQ+ identities and experiences are commonly made invisible, silenced, delegitimized, fetishized, othered, and erased, left to remain seen as outside, and therefore unimportant (Rubinsky & Cooke-Jackson, 2017). Foucault’s notion of deviance (the ‘alien’) is not only rooted in identities and/or language, such as that of ‘queer’ or ‘gay’, but in practices as well (Cisneros, 2013). For example, certain dominant social expectations suggest that women are expected to seek long-term, monogamous sexual relationships with the goal of permanent commitment and partnership through marriage or co-habitation (Anderson, 2013). Practices and behaviours such as co-parenting, polyamory, consensual non-monogamy, and polygamy have been depicted as socially deviant (Anderson, 2013). In the postpartum context, ‘deviant’ identities, practices, or behaviours are layered with expectations of the postpartum body, parenting, and sexual identity (Manley, Legge, Flanders, Goldberg, & Ross, 2018). Moreover, the literature exploring non-heterosexual or non-monogamous experiences of postpartum sexual health is very scarce. Considering the overlap between sexuality, gender, and identity, it is reasonable to wonder how women’s sexuality may be enacted differently during the postpartum period (Malacrida & Boulton, 2012).

The rigid definitions that separate normal and deviant exist throughout one's life as a sexual being, inclusive of the postpartum period. However, 'normalcy' is a set of expectations, based on dominant discourses, that do not always authentically acknowledge the complexity of one's sexuality or sexual health (Allen, 2003; Goicolea, Torres, Edin, & Öhman, 2012). Rather than positioning postpartum sexual health and women's sexual health as a status that is dictated based upon a woman's ability to meet normative expectations of behaviour (i.e. monogamous relationships, use of barrier methods to protect against STIs and pregnancy), or otherwise grouped into socially-accepted 'other identities' (such as 2SLGBTQ+), sexuality and sexual health must be approached as having multiple possibilities. While constructed norms exist, there may also be similarities and differences in how sexual health is experienced during the postpartum period. Due to the fact that, historically, women's sexual health focused on desire or procreation, the postpartum period was not a priority. This oversight of the postpartum period is reflected today in the lack of postpartum sexual health research and the focus of existing research on physical sexual health. That being considered, the view of womanhood and sexuality postpartum is greatly shaped by dominant discourses that praise and celebrate childbirth and, thusly, the 're-birth' of the woman herself (Coats & Fraustino, 2015; Malacrida & Boulton, 2012). The postpartum woman embodies the very miracle of new life, grown and nurtured within her flesh (Haug, 1987). Still today, the postpartum woman as a sexual being is more than her body, yet is restricted only to find meaning through her body (Malacrida & Boulton, 2012; O'Malley et al., 2015). However, researchers have begun to challenge the idea that women's sexuality in the postpartum period is solely experienced or important in physical ways.

Postpartum Sexual Health: Critiquing Current Approaches

The postpartum period involves many possible physical, mental, and emotional changes, including perineal tearing (Gutzeit et al., 2020), bleeding (lochia) (Chi, Bapir, Lee, & Kadir, 2010), postpartum depression or postpartum blues (Berglund, 2020), anxiety (Ashford, Ayers, & Olander, 2017), sleep deprivation and fatigue (Badr & Zauszniewski, 2017), stress (Clout & Brown, 2015), role as a parent and/or a partner (Perun, 2013; Walker, Crain, & Thompson, 1986), relationship with one's partner (Rosen et al., 2017), attachment to the newborn baby (Petri et al., 2018), and feelings of isolation (Eastwood et al., 2013). Sexual health is one change that incorporates emotional, physical, and mental wellbeing (Khajehei & Doherty, 2018). Due to the biomedical focus of existing postpartum sexual health research, physically-focused or objectively measurable definitions of health have become the norm (Cappell et al., 2016). Reductionist biomedical frameworks (that is, frameworks that reduce sexual health to something that is solely concerned with the physical body) focus on the biological and physical changes associated with pregnancy (i.e. change in breast and abdominal size), childbirth (i.e. perineal tearing), and the postpartum period (i.e. breastfeeding). Biomedical frameworks or approaches tend to focus on how physical changes affect sexual intercourse specifically, whether it be the resumption of, or challenges associated with sexual activity (Cappell et al., 2016). What remains problematic, however, is that a biomedical framework does not fully capture the complexity of postpartum sexuality and sexual health. Rather, the use of a biomedical framework entails a focus on penetrative or penile-vaginal intercourse while also upholding the assumption that sexual problems during the postpartum period are a direct result of the physical changes associated with pregnancy, childbirth, and parenting (Cappell et al., 2016). Oftentimes, biomedical frameworks are applied through the use of measuring tools, such as the Female

Sexual Function Index (FSFI) (Chang et al., 2018; Hosseini et al., 2012; Kahramanoglu et al., 2017; Kaya et al., 2017; Khajehei & Doherty, 2017; Kramná & Vrublová, 2016; Lagaert et al., 2017; Lurie et al., 2013; Rezaei et al., 2017; Wallwiener et al., 2017) to assess sexual health postpartum.

These psychometric tools often utilize and include objective indicators, such as vaginal lubrication, initiation of sexual intercourse, frequency of intercourse, and sexual satisfaction scaling (Cappell et al., 2016) to measure postpartum sexual wellbeing based on what is expected and upheld as sexually normative within dominant social discourse (Jawed-Wessel & Sevick, 2017). When sexual activity is investigated or assessed in research, it predominantly focuses on a heteronormative discourse of vaginal sex and heterosexual sexuality (Jawed-Wessel & Sevick, 2017). As a result, individual experiences of sexual identity and sexual health during the postpartum period are problematized in a particular way. Using this lens, penetrative or penile-vaginal intercourse is considered the ultimate marker of sexual health. If the expectation to prioritize penetrative or penile-vaginal intercourse is not met, postpartum individuals are sometimes made to feel as though they've fallen short or are outside of the norm. Another issue arising from the dominance of heterosexual sexual activity measures during the postpartum period is that decreased sexual desire or a 'low' frequency of sexual intercourse is regarded as a problem in need of fixing or treatment (Robinson, Munns, Weber-Main, Lowe, & Raymond, 2011). However, it is known that penile-vaginal intercourse is not necessarily reflective of how all postpartum individuals express their sexuality or engage in sexual activity (Flanders, Legge, Plante, Goldberg, & Ross, 2019; Manley et al., 2018), given that people may identify as asexual, plurisexual, pansexual, queer, or bisexual, among other identities or sexual orientations (Callis, 2014; Gupta, 2018; Morandini, Blaszczynski, & Dar-Nimrod, 2017). Overall, common

approaches to postpartum sexual health research have been problematic in that they are heteronormative and, even when broadened or non-heterosexual definitions of sexuality are explored, research is focused on intercourse or sexual activity. To illustrate the importance of moving beyond heterosexual or physical ways of experiencing postpartum sexual health, Manley et al. (2018) used an inductive qualitative approach to interview 21 bisexual and plurisexual women in Toronto, Canada who were either pregnant or postpartum (Manley et al., 2018). This study aimed to explore the participants' experiences with and perceptions of consensual non-monogamy (CNM) during pregnancy and after birth (Manley et al., 2018). Interviews took place in late pregnancy, then again at 3-4 months postpartum, a third time at 6-8 months postpartum, and then for the last time at 10-12 months postpartum (Manley et al., 2018). Participants found that CNM helped them to explore their sexuality while being supported by their partners but that fear of disclosure and stigma surrounding CNM also made it difficult for participants to explore CNM as a way of expressing or sharing their sexuality (Manley et al., 2018). This study exemplifies the lived reality, shame, and fear that people sometimes experience when they do not fit the conventional, monogamous, heterosexual mold of postpartum sexuality. While physical outcomes and normative heterosexuality dominate the current lens of research in this area, there is a need for more meaningful tools, definitions, and language to describe certain aspects of postpartum sexual health that are beyond the physical components, such as identity, being, and outcomes (O'Malley et al., 2015). In order to effectively situate the current empirical knowledge surrounding postpartum sexual health, I will first present literature related to the physical aspects of postpartum sexual health, followed by the non-physical aspects.

Postpartum Sexual Health: Physical Experiences

In the following section, I will provide an overview of the latest evidence regarding the measure(s) of sexual functioning, sexual dysfunction, dyspareunia and vulvodynia, and sexual activity using a physically-focused lens. Overall, it is difficult to comprehensively collect or conduct research on postpartum sexual health, as terms such as 'sexuality', 'sexual desire', or 'sexual health' have been used interchangeably in research and in practice throughout the past several decades and there is no universal definition to differentiate such terms (O'Malley et al., 2015). Instead, researchers have measured and defined sexual health through the use of tools, rather than specific language or terms. Before delving into physical experiences of postpartum sexual health, it is important to first understand how physical sexual health after birth has been measured, and therefore defined, in research.

'Measuring' postpartum sexual health as physical. Specific attention by researchers has been drawn to the influences of perineal trauma (i.e. vaginal tearing or episiotomy), childbirth, and/or mode of delivery (i.e. vaginal versus Caesarean delivery) on postpartum sexual functioning (Baksu, Davas, Agar, Akyol, & Varolan, 2007; Chang et al., 2011; Kahramanoglu et al., 2017; Karaçam, 2008; Khajehei, Ziyadlou, & Kashefi, 2009; Klein et al., 2009; Lurie et al., 2013; McDonald & Brown, 2013; Necesalova et al., 2016; Rathfisch et al., 2010; Rogers, Borders, Leeman, & Albers, 2009; Triviño-Juárez et al., 2017; Unsal Boran et al., 2013). Using measures such as the Female Sexual Function Index (FSFI), researchers have examined the perceived effects on physical aspects of sexuality and sexual activity for postpartum individuals, most often from the measure of initiation or frequency of sexual intercourse (Chang et al., 2018; Kahramanoglu et al., 2017; Kaya et al., 2017; Khajehei & Doherty, 2017; Kramná & Vrublová, 2016; Lagaert et al., 2017; Lurie et al., 2013; Matthies et al., 2019; Rezaei et al., 2017;

Wallwiener et al., 2017). While a detailed overview of the FSFI studies is outside the scope of this literature review, researchers have primarily used the FSFI to measure sexual functioning after perineal trauma (Chang et al., 2011; Kramná & Vrublová, 2016), maternal morbidity (Andreucci et al., 2015), or to assess the influence of mode of delivery (Hosseini et al., 2012; Kahramanoglu et al., 2017; Klein et al., 2009; Lurie et al., 2013). Using 19 multiple-choice questions, the FSFI aims to capture information about sexual function by evaluating the domains of desire, arousal, lubrication, orgasm, satisfaction, and pain. Using a Likert scale, a score of less than 26 indicates sexual dysfunction (Khajehei & Doherty, 2017) based on physical, emotional, and psychological components of sexuality. The validity and reliability of the FSFI has been well-documented (Burri, Cherkas, & Spector, 2010; Chang et al., 2010; Rivalta, Sighinolfi, Micali, De Stefani, & Bianchi, 2010) and is used quite widely in research exploring postpartum sexual health. In a study conducted in 2009, researchers indicated that there was no difference in FSFI scores at 12-18 months postpartum for patients who had undergone a Caesarean section versus spontaneous vaginal delivery (Klein et al., 2009). Other researchers utilized the same self-report scoring tool, FSFI, to measure sexual functioning after a severe obstetric complication, though found no significant difference at 6 months postpartum between those who had experienced a pregnancy-related morbidity and those who had not (Norhayati & Azman Yacob, 2017). Pain was however cited as the most major issue related to sexual functioning in the postpartum period (Norhayati & Azman Yacob, 2017). The ability of the FSFI to capture accurate results has been recently questioned, given the idea that the postpartum period is naturally a time of changing or decreased sexual function and thus demonstrates the need to adjust the FSFI standards (Matthies et al., 2019). While the FSFI may capture changes in sexual functioning after childbirth, researchers have shown that women do not generally perceive these

changes to be necessarily problematic or severe, despite having results that indicate moderate to severe Female Sexual Dysfunction (FSD) (Matthies et al., 2019). In fact, some researchers have indicated that only one third of women who experience sexual problems are distressed or dissatisfied by them, not only during the postpartum period but throughout the lifespan (Bancroft, Loftus, & Long, 2003; Lutfey, Link, Rosen, Wiegel, & McKinlay, 2009). As such, researchers have questioned the application and use of tools such as the FSFI to measure sexual functioning during the postpartum period when they are meant to be 'universal' or broad (i.e. applicable to people throughout the lifespan) and therefore do not encompass considerations of the postpartum context (Matthies et al., 2019). The FSFI is a tool that has been used in much of the literature surrounding postpartum sexual functioning, though has been critiqued for its limits in accurately capturing the effects of sexual dysfunction on postpartum women's mental, social, and physical wellbeing in relation to sexual health.

Although the FSFI is the most widely used tool to measure postpartum sexual functioning, there are three others present in recent literature as well. Yee et al.'s study explored sexual functioning using another tool, the Sexual Health Outcomes for Women Questionnaire (SHOW-Q), to assess the relationships between mode of birth, sexual functioning, and sexual activity, among other factors (Yee et al., 2013). The SHOW-Q is a 12-item scale that assesses the impact of pelvic problems on sexual desire, frequency, satisfaction, orgasm, and discomfort (Learman, Huang, Nakagawa, Gregorich, & Kuppermann, 2008). Their results indicated that 60.7% of American women who participated in the study had resumed sexual activity by 8-10 weeks postpartum, with multiparity increasing the odds of resuming sexual activity sooner after birth (Yee et al., 2013). In this study, sexual activity included heterosexual, same-sex, and unpartnered sexual activity, thus challenging heteronormative social assumptions about sexuality

(Yee et al., 2013). The Arizona Sexual Experience Scale: Female (ASEX-F) is another tool that has been used in the postpartum sexual health literature. The ASEX-F is a 5-item scale that measures sex drive, arousal, vaginal lubrication, ability to attain orgasm, and satisfaction from orgasm, with a maximum score of 30 and a higher score indicating sexual dysfunction (McGahuey et al., 2000). The ASEX-F was first tested for its reliability and validity in 2000 (McGahuey et al., 2000). One study conducted in Turkey used the ASEX-F and found that 91.3% of women experienced problems related to sexual health and functioning in the first year after childbirth and that, on average, most of them resumed sexual intercourse by seven weeks postpartum (Acele & Karaçam, 2011). Of note, women who were not sexually active at the time of ASEX-F questionnaire distribution were excluded from the study (Acele & Karaçam, 2011). This is relevant because the study may have excluded voices and experiences that are important to capture; postpartum women may have many reasons for choosing not to be sexually active and this needs to be further understood. Another study using the ASEX-F indicated that 43.5% of women between three to six months postpartum had sexual dysfunction and evaluated various factors to assess this, including presence of vaginismus, orgasmic dysfunction, and dyspareunia (de Lima Holanda, de Sá Vieira Abuchaim, Coca, & de Vilhena Abrão, 2014). Again, this tool largely explores physical aspects of sexual intercourse, which cannot be solely relied upon to capture or fully describe women's experiences of their postpartum sexual health. Most recently, the Carol Scale has been developed as a specific tool to measure dyspareunia and sexual functioning after birth (López-Lapeyrere et al., 2018), though has not yet been widely used in clinical research and its validity has not yet been explored in other studies. The Carol Scale measures the domains of preparation for sexual activity, pain or discomfort in caressing the vulvar area, pain or discomfort related to vaginal intercourse, and pain or discomfort after

vaginal intercourse (López-Lapeyrere et al., 2018). Each of these tools measures different physical aspects of sexual health after birth, though overall the measure of either initiation or frequency of sexual activity is often relied upon as an important indicator of postpartum sexual health. These tools capture certain important aspects of postpartum sexual health, though there is a need to more deeply explore sexual health using personal definitions or experiences, rather than relying solely on tools to measure sexual health or sexual wellbeing.

While these measuring tools may be valuable in identifying concerns for postpartum women in relation to sexual relations or physical sensations, such as the ability to have an orgasm through physical stimulation or engagement in penile-vaginal intercourse, these tools fail to acknowledge sexual health and sexuality as a continuum and an experience that transcends the physical body (Cappell et al., 2016). For example, an orgasm is not the only way to achieve sexual pleasure or fulfillment, though it is often what is thought by both postpartum individuals and their care providers to be the ultimate marker of sexual wellbeing and satisfaction. Similarly, intercourse is assumed to be another dominant marker of sexual wellbeing after birth (Vannier et al., 2018). With regards to ongoing research and practice, the sole focus of health outcomes and measures on physical aspects of postpartum sexual health may cause much to be missed or disregarded (Cappell et al., 2016; Khajehei & Doherty, 2018). More specifically, the aspects of sexual health that are invisible, such as emotional or psychological sexual health, are not addressed because they are not currently measured or included as a part of sexual health (Cappell et al., 2016; O'Malley et al., 2015). This has implications for care and research in a global context because it negatively imposes a strict focus- one that is entirely based on physical outcomes. Doing so affects and is affected by psychological, emotional, and relational facets of sexual health and does not account for the interwoven ways that sexual wellbeing may be

enhanced and supported during the postpartum period (Cappell et al., 2016; Khajehei & Doherty, 2018). Effectively, the holistic needs of postpartum individuals are not fully being addressed because the current definitions and outcomes related to sexual health exclude other components that may also be meaningful. Postpartum sexual health cannot effectively be promoted and supported if individuals cannot find meaning in the ways that they, or others, view their sexual health.

Sexual activity. Postpartum women navigate and choose if and how to engage in sexual activity at certain times, or timepoints, after birth for a multitude of reasons (von Sydow, 1999). In the literature, sexual activity tends to focus on penile-vaginal intercourse as the primary indicator of return to sexual activity, though some studies also explore oral sex, masturbation, same-sex sexual activity, or other sexual practices as well. While it is common for postpartum women to wait at least six weeks before resuming intercourse (O'Malley et al., 2019), as recommended by their health care providers, there exists a lack of evidence as to *why* they should wait six weeks (DeMaria et al., 2019). Some say that six weeks tends to coincide with the first postpartum health visit and so presents a convenient time to 'bring [the topic] up' (McDonald & Brown, 2013), and others state that it takes 4-6 weeks for a woman's cervix, vagina, and perineal area to properly heal (Owonikoko, Adeoye, Tijani, & Adeniji, 2017). Researchers have shown that the time points and reasons for resuming or not resuming sexual intercourse are highly variable for postpartum women and dependent on many factors, including fear of pain, apprehension, mode of birth, perineal trauma, physical recovery, baby's napping time and location, and tiredness (both of the partner and of themselves), to name only a few (Alum, Kizza, Osingada, Katende, & Kaye, 2015; O'Malley et al., 2019). Von Sydow published one of the most frequently cited papers on the topic of sexual activity during pregnancy and after

birth, which is an extensive meta-content analysis of 59 research studies published between 1950 and 1996 (1999). Von Sydow's analysis aimed to provide a comprehensive overview of parental sexuality during pregnancy and after birth by combining both obstetrical and psychological literature (1999). Von Sydow found that on average, couples tend to resume sexual intercourse at approximately 2 months after birth, though non-coital sexual activity is generally resumed at 2.7 weeks postpartum (von Sydow, 1999). Alum et al. (2015) investigated the factors influencing the resumption of sexual activity in the most depth. They aimed to explore prevalence and factors associated with resumption of sexual intercourse for new mothers in Uganda using a cross-sectional research design. The research team used a questionnaire, completed by 374 women who had delivered 6 months prior to data collection (Alum et al., 2015). Alum et al. (2015) found that 21.9% of participants had resumed sexual intercourse prior to 6 weeks postpartum. Overall, predictors of early resumption of intercourse after birth included religion, level of education, occupation, parity, age of the baby, use of contraception methods, breastfeeding status, and mode of delivery, all with a p value of <0.01 (Alum et al., 2015). Independent predictors of earlier resumption of sexual intercourse included occupation of the mother ($p=0.000$), parity ($p=0.000$), education of the spouse ($p=0.000$), and use of family planning methods ($p=0.006$) (Alum et al., 2015). More specifically, having a higher income, a higher education level, less children, and use of family planning methods were all factors that increased the likelihood of early resumption of sexual intercourse (Alum et al., 2015). This study's findings are significant in demonstrating that the choice of when to engage in sexual intercourse after birth is multi-faceted and contextual.

For other postpartum women, choosing to engage in or abstain from sexual activity can also be a culturally influenced decision. One study explored women's attitudes and beliefs

surrounding the practice of sexual abstinence in Swazi culture in Eswatini (Swaziland) (Shabangu & Madiba, 2019). After completing 15 individual interviews and using thematic analysis and the Theory of Planned Behaviour (TPB) to analyze the data, the researchers found that, overall, the cultural practice of waiting six months after birth before engaging in sexual activity was well-perceived and viewed as beneficial by participants (Shabangu & Madiba, 2019). More specifically, Swazi women believed that waiting six months to resume sexual activity enhanced their sexual health because it allowed them to physically recover from birth and focus on caring for the baby (Shabangu & Madiba, 2019). However, cultural and social pressure from family and community members to abstain for the full six-month period strongly influenced the participants' decisions surrounding when to resume intercourse with the father of the baby (Shabangu & Madiba, 2019). This study is an example of how cultural norms may also influence expectations, beliefs, or practices surrounding the resumption of sexual activity or sexual intercourse after birth. For many women, resumption of sexual intercourse after birth is not a spontaneous event, but rather requires internal reflection, consideration, and dialogue with their partner (O'Malley et al., 2019) or valued community members (Shabangu & Madiba, 2019). Choosing when and how to engage in sexual activity is not only environmentally influenced but may be shaped by social, cultural, and personal values as well. Furthermore, sexual activity is not only a way of physically connecting with another person, but can help to build emotional intimacy and engagement as well.

Other motivations for resuming sexual intercourse include a desire for emotional intimacy, curiosity as to whether or not sexual intercourse is still possible, and returning to the status quo of the partnership or relationship (O'Malley et al., 2019). On the other hand, women were more likely to wait longer to resume sexual intercourse if they had experienced a perineal

tear or episiotomy, Caesarean delivery, or vaginal birth using vacuum or forceps (McDonald, Gartland, Woolhouse, & Brown, 2019). Collected statistics (Alum et al., 2015; McDonald, Woolhouse, & Brown, 2015; Sok et al., 2016) indicate the following percentage of participants who had resumed sexual intercourse at different time points after birth: 21.9% before 6 weeks (Alum et al., 2015), 43% at 6 weeks (Sok et al., 2016), 56% at 8 weeks, 78% by 12 weeks (McDonald et al., 2019), 92% by 12 weeks (Sok et al., 2016), 94% by 6 months, and 97% by 12 months (McDonald et al., 2019). Even between studies, these percentages change and do not necessarily indicate a universal norm, but rather focus on documenting resumption of sexual activity, which is variable.

In terms of non-partnered sexual activity, there is very little research exploring solitary sexual desire or masturbation during the postpartum period (Cappell et al., 2016). Only a handful of studies have collected data on both solitary and partnered sexual activity, with researchers indicating that 40% of postpartum women masturbated within the first 1-6 weeks after birth (Hipp et al., 2012). In Cappell et al.'s study (2016), which was conducted in Canada, 72.3% of the study participants reported that masturbation was part of their sexual activities prior to birth. At the time of data collection, 83.8% of those postpartum women had resumed masturbation (Cappell et al., 2016). Some researchers have indicated that non-penetrative sexual activity resumes earlier than penetrative or penile-vaginal intercourse, perhaps as early as 2.7 weeks after birth (von Sydow, 1999). Altogether, sexual desire and partnered sexual activity are two different concepts, although intertwined. Postpartum women may choose to engage in partnered sexual activity without experiencing sexual desire, or vice versa (Cappell et al., 2016).

Sexual dysfunction in the postpartum period. Sexual dysfunction is a commonly used diagnostic term in psychology to describe sexual issues, concerns, or physical symptoms that

impede sexual functioning or satisfaction, and is a diagnosis that is often made using the measuring tools previously described. With prevalence rates as high as 76.3% (Rezaei et al., 2017) and 89% (McDonald, Woolhouse, & Brown, 2015) during the postpartum period, Female Sexual Dysfunction (FSD) has been formally defined by the American Psychiatric Association (DSM-5) as "a disturbance in the process[es] that characterize the sexual response cycle or by pain associated with sexual intercourse" (2013) and treatment usually incorporates some form of relaxation training. Chang et al. (2018) aimed to explore if and how sexual dysfunction predicted depressive symptoms during the first 24 months after birth through a prospective cohort study design. The authors conducted their study in Taipei, Taiwan (Chang et al., 2018). They found that postpartum women who experience sexual dysfunction are 1.62 times more likely to experience depressive symptoms during the first 24 months after birth than those without sexual dysfunction ($p=0.029$) (Chang et al., 2018). Causes of depressive symptoms included a high pain score ($p<0.001$), moderate to severe perineal laceration ($p<0.001$), and having a concurrent medical condition ($p=0.0498$). Similarly, Khajehei and Doherty (2017) aimed to explore the association between postpartum depression, relationship dissatisfaction, and sexual dysfunction during the first year after birth using a cross-sectional design. The study was based in Australia (Khajehei & Doherty, 2017). Khajehei & Doherty (2017) found that those who experience sexual dysfunction after birth are 2.5 times more likely to experience postpartum depression (Khajehei & Doherty, 2017), making it an issue of focus for researchers, patients, and health care providers. Both of these studies allow one to conclude that the presence of sexual dysfunction may lead to a higher likelihood of depression or depressive symptoms during the postpartum period. Sexual dysfunction, unsurprisingly, is also influenced by intersecting factors such as religion, working hours, sexual dysfunction before or during pregnancy, mode of delivery (de Lima Holanda et al.,

2014), history of sexual abuse (Gottfried, Lev-Wiesel, Hallak, & Lang-Franco, 2015), maternal morbidity (Andreucci et al., 2015), exclusive breastfeeding, and primiparity (Rezaei et al., 2017). Within research, pain and sexual desire are the two most common contributive factors specific to sexual dysfunction (McDonald et al., 2015; Norhayati & Azman Yacob, 2017; Wallwiener et al., 2017), therefore upholding the assumption that sexual function necessitates a desire for intercourse and an ability to physically engage in sexual activity with another person, even during the postpartum period (Matthies et al., 2019). Unfortunately, none of these studies (McDonald et al., 2015; Norhayati & Azman Yacob, 2017; Wallwiener et al., 2017) investigated what influenced pain or sexual desire, only indicating prevalence using the FSFI scoring. Pain may not only be generally experienced during the postpartum period, but also during sexual intercourse.

Dyspareunia. Dyspareunia, defined as painful sexual intercourse, is common in the postpartum population, with many studies exploring prevalence statistics: 85.7% at first intercourse postpartum (McDonald et al., 2019), 51% at 6 weeks postpartum (Lagaert et al., 2017), 58.3% between 2-12 months postpartum (Acele & Karaçam, 2011), 44.7% at 3 months (McDonald et al., 2015), 30.1% at 3 months (Chayachinda, Titapant, & Ungkanungdecha, 2015), 37% at 6 months (O'Malley et al., 2018), 40.7% at 6 months (Lagaert et al., 2017), 21.2% at 6 months (Alligood-Percoco et al., 2016), and 22.6% at 18 months postpartum (McDonald et al., 2019), though prevalence decreases significantly by 6 months postpartum ($p<0.003$) (Lagaert et al., 2017; McDonald et al., 2015). Measured by tools such as the Carol Scale (López-Lapeyrere et al., 2018), breastfeeding, high levels of fatigue, stress, and perineal pain at 1 month postpartum have all been shown to increase the likelihood of dyspareunia later on in the postpartum period (Alligood-Percoco et al., 2016). Other researchers have found similar results,

with factors shown to increase the risk of postpartum dyspareunia including breastfeeding (Lagaert et al., 2017; O'Malley et al., 2018), third-degree perineal tearing, being 30 years of age or older, dyspareunia prior to pregnancy (O'Malley et al., 2019), primiparity (Lagaert et al., 2017), and Caesarean section delivery (McDonald et al., 2019). O'Malley et al. (2019) were the first and only researchers to explore how postpartum women navigate dyspareunia and their desire for sexual activity or intimacy with their partner(s). They aimed to explore Irish women's sexual health experiences after their first childbirth, with a focus on the solutions used in managing their postpartum sexual health, using a qualitative descriptive design. The sample size was 21 participants, each of whom participated in in-depth, semi-structured interviews as part of a larger mixed methods study. The women in this study spoke of using certain sexual positions that were more comfortable and allowed for pain-free intercourse, taking time to engage in foreplay, practicing perineal massage immediately prior to intercourse, using water-based lubricant, or engaging in alternative sexual activities that did not involve penile-vaginal intercourse to ease and manage their postpartum dyspareunia (O'Malley et al., 2019). It was important for these women to be able to express and engage in sexual intimacy; they utilized their knowledge and adaptability as "positive agents" (p. 57) to work through their sexual health challenges, specifically dyspareunia, after birth in order to experience sexually pleasurable interactions (O'Malley et al., 2019). Dyspareunia is relatively common throughout the postpartum period and tends to dissipate with time for most women. However, more research is needed to understand how women experience issues such as dyspareunia and how they navigate such experiences as individual subjects.

Overall, much is known about physical components of sexual health after birth, though postpartum sexual health is also comprised of non-physical measures and experiences. As per the

WHO definition (2022), sexual health encompasses more than physical experiences, therefore the need to understand non-physical components of sexual health must be acknowledged in postpartum sexual health research.

Postpartum Sexual Health: Non-Physical Experiences

Women's sexuality is multi-faceted; it mirrors psychological, emotional, physical, sociocultural, and inter- and intra-personal influences, coming together to create a well-rounded picture of the whole person, inclusive of their health, wellbeing, and identity (Chang et al., 2018; Khajehei & Doherty, 2018). As such, this section of Chapter 2 will aim to explore the existing health literature in relation to the emotional and psychological aspects of postpartum sexual health.

Emotional. Of the limited qualitative research that has been conducted to explore postpartum sexual health, researchers have indicated that emotional aspects of sexual health and sexual identity are important for women, despite the many changes that occur during the postpartum period (Bender et al., 2018). Moreover, emotional satisfaction is an important component in sexual wellbeing postpartum, though declines steadily after birth, with only 62% of women reporting a high level of emotional satisfaction in their sexual relationships at 6 months postpartum- with that percentage decreasing to 54% at 18 months postpartum (Woolhouse, McDonald, & Brown, 2014). However, there are many terms used to discuss emotional components of sexuality or sexual health, including emotional sexual health, emotional intimacy, emotional closeness, emotional satisfaction, and emotional support.

Throughout this section, I will describe the ways in which different authors have discussed, differentiated, or defined emotional components of sexual health. Researchers in Iceland recruited 8 postpartum women and interviewed them at 6 months postpartum and then

again at 12 months postpartum. With the aim of finding out more about how Icelandic women experience their sexuality during pregnancy and after birth, the researchers used interpretive phenomenology to analyze the data (Bender et al., 2018). They found that postpartum women (n=8) indicated a need for physical and emotional intimacy, though "physical intimacy did not necessarily include the desire for sexual intercourse" (Bender et al., 2018, p. 14); communication, emotional closeness, and consideration were all of importance (Bender et al., 2018). Participant examples of physical intimacy were cuddling on the couch, kissing, holding hands, and wrapping each other's arms around one another (Bender et al., 2018). In this study, emotional intimacy included open communication with the partner about sexual activity, feeling like a team in raising the baby (closeness), understanding and empathy from the partner, and being appreciated by their partner (Bender et al., 2018). Overall, converging evidence (Cappell et al., 2016; Khajehei et al., 2015), has supported the notion that emotional facets of sexual health are important for postpartum women and can greatly impact their experiences of sexual health.

Emotional support, understanding, and empathy from partner(s) have been named as fundamental to postpartum healing and positive wellbeing in relation to sexuality and sexual health (Hipp et al., 2012; Khajehei & Doherty, 2018). Hipp et al. (2012) used retrospective online questionnaires (n= 304) with the aim of identifying influential variables related to postpartum sexuality, assessing latency beyond penile-vaginal intercourse, and exploring the positive aspects of postpartum sexuality. Of note, this North American study conducted in the United States mostly included participants who identified as heterosexual, but also included individuals who identified as bisexual (8%), other (2%), or lesbian (3%) as well. Their findings suggest that sexual desire or activity may not be as influenced by physically associated factors (i.e. body image, vaginal trauma) as once thought, indicating that the partner's perceived sexual

desire, their own sexual feelings, and a need for emotional intimacy were more important for postpartum women.

Khajehei's study (2018) aimed to explore Australian women's experiences with their sexual functioning during pregnancy and after birth using a population-based qualitative survey (Khajehei & Doherty, 2018). In this study, sexual function was defined as including physiological, psychological, inter and intra-personal, and sociocultural phenomena, rather than focusing solely on physical experiences or symptoms (Khajehei & Doherty, 2018). Their study supported the findings of Hipp et al. (2012) in stating that lack of support from partners, lack of intimacy and communication, and domestic violence all caused sexual problems after birth (Khajehei & Doherty, 2018). Some women in this particular study reported that their sexual problems were a result of a lack of emotion, support, emotional intimacy, or closeness with their partners during late pregnancy and after birth, with many of them expressing dissatisfaction and hurt by their partner's focus solely on the physical aspects of sexual intimacy, which did not meet the women's needs (Khajehei & Doherty, 2017, 2018).

Similar to Khajehei et al. (2018), Bender et al. (2018) aimed to explore postpartum sexuality in Iceland using interpretive phenomenology, as described in the previous paragraph. Sexuality was defined as being more than just sexual intercourse; it included "self-concept and body image as well as relationship issues like sensing the needs of one's partner, being able to communicate feelings, and knowing how to touch each other in a tender way" (Bender et al., 2018, p. 14). Overall, Bender et al. (2018) found that in order to enjoy sexual activity, it was important for postpartum women to feel respected, understood, content, relaxed, emotionally close, and able to trust their partner (Bender et al., 2018). However, postpartum women have often reported a gap between their needs for emotional intimacy, rather than sexual intimacy, and

that of their partner's, therefore affecting their sense of balance and comfort in the relationship (Bender et al., 2018). For example, the participants described how sometimes their partner would be interested in sexual activity, though the women would have preferred to spend time alone together, cuddle, or talk as a way of maintaining their romantic relationship (Bender et al., 2018). These studies indicate that emotions play a role in how postpartum sexual health is experienced by women, whether it be through a desire for emotional intimacy or needing a sense of trust and emotional satisfaction in their intimate relationship.

A very recent study conducted by Pardell-Dominguez et al. (2021) holds similar themes to many of the studies previously described in this section, particularly with regards to body image, partner support, and intimacy. Their study utilized a phenomenological approach to interview ten primiparous women who were living in Catalonia (Spain). In this study, many participants described how the priorities in their relationships changed and had to be balanced with new roles and responsibilities in caring for the baby. In addition, many experienced pain with intercourse and also reported decreased sexual desire as well as altered body image, making the relationship they had with their partners all the more important. Collaboration in caring for the baby, good communication, and taking time to be together as a couple was important in facilitating postpartum sexual health, as well as emotional and relational wellbeing. For example, some participants scheduled time for sexual activity rather than having it be spontaneous, though this unfortunately also impeded their sexual desire and often lead to rushed sexual intercourse that participants did not necessarily enjoy. Based on these findings, how sexual relationships are navigated can vary, though there are often new challenges that arise during the postpartum period.

In terms of working through sexual issues, women found it important to discuss topics openly with their sexual partner(s), even if it was something they had not previously explored, such as mutual masturbation, sexual desire, or setting sexual limits (Bender et al., 2018). O'Malley et al. (2019) sought to explore how postpartum Irish women (n= 21) experienced and cared for their sexual health by using a qualitative descriptive design. Based on their findings, the ability to express concerns, emotions, or feelings, including about isolation or loneliness, enabled couples to work through issues as a team and approach sexual concerns as an 'our' problem, rather than a 'her' problem (O'Malley et al., 2019). It was also beneficial for women to feel encouraged, appreciated, understood, and considered by their partners without feeling pressured to engage in intercourse or sexual activity (O'Malley et al., 2019). Feeling supported and reminded of their desirability and attractiveness is known to be positive for postpartum women's sexual health, even if sexual desire or sexual activity itself is not as it was before childbirth (Bender et al., 2018). For the participants in O'Malley et al.'s study (2019), intimacy was ensured in different ways that were not necessarily sexual, whether it be through dedicated time without the baby, sleeping in the same bed, or sitting beside one another on the couch so that they could cuddle (O'Malley et al., 2019). Sexuality was not necessarily expressed or valued through sexual activity, but rather a postpartum woman's ability to remain close and share intimacy with romantic partners, all of which is significant in promoting postpartum sexual health (Cappell et al., 2016; O'Malley et al., 2019). This study's limitations included the absence of women who were single, under 30 years of age, of culturally-diverse cultural backgrounds, or in same sex relationships, thus limiting generalizability (O'Malley et al., 2019).

In summary, the relationship between emotional intimacy and sexual intimacy is significant, and in turn affects experiences of sexual health and wellbeing after birth (Cappell et

al., 2016; Khajehei et al., 2015). In considering this, outward or interpersonal emotional relationships are influential in promoting postpartum sexual health, though introspective feelings, thoughts, and emotions are also important in shaping how women perceive, experience, and care for their sexual health after birth. However, there remains a gap in understanding how emotional sexual health influences the meaning of sexual health after birth for postpartum individuals. Moreover, there is a need to further explore how emotional sexual health is negotiated by postpartum individuals given the existence of external influences, such as discourse.

Experiences and perceptions of the postpartum body. Upon reviewing the literature, body image and perceptions of one's sexual attractiveness were found to be major factors that influenced a woman's postpartum sexuality. Negative body image was associated with sexual dissatisfaction after birth, though women perceived and experienced their physical changes differently (Khajehei & Doherty, 2018). Some women felt uncomfortable with their physical appearance after pregnancy and birth, which could sometimes be evidenced by a lack of confidence due to weight gain, edema, or stretch marks (Khajehei & Doherty, 2018). Others were pleased with the changes that their body experienced after birth and felt more sexually confident. For example, Bender et al.'s (2018) study specifically looked at how Icelandic women experienced their postpartum sexuality, which included the body, using interpretive phenomenology. In this study, sexuality was defined as "how individuals perceive themselves as sexual beings" (p. 14), including everything humans feel, do, and think as sexual beings (Bender et al., 2018). Participants in this study expressed that the increase in their breast size was a welcome and positive experience for them, especially if they had small breasts prior to pregnancy (Bender et al., 2018). This finding not only indicates that larger breasts were seen as more positive by participants, but affirms that bigger breasts are generally seen as better because

they are socially constructed from a patriarchal view. Positive perceptions also included a sense of pride in physical changes, even if they were not viewed as conventionally attractive in their respective societies; women were proud of their stretch marks, leaking breastmilk, or increased abdominal size because it represented, for them, evidence of what their body had achieved in carrying and nourishing a newborn baby (O'Malley et al., 2019). On the other hand, women also spoke of their bodies using negative language, such as 'sagging', 'stretched', and 'baggy', and felt uncomfortable with their partner seeing their naked body, or felt they needed to hide their larger breasts or abdomen (O'Malley et al., 2019).

Using a cross-sectional design, Akpinar and Yangin (2018) sought to determine Turkish women's knowledge and beliefs about postpartum sexuality through face to face interviews (n=400). In their study, 88% of participants thought it best to wait 40 days after birth before resuming sexual intercourse, though participants had mixed thoughts about the acceptability of other sexual acts prior to the 40-day mark (Akpinar & Yangin, 2018). Given that over 98% of the Turkish population is Muslim, their religious beliefs played a large part in how these women cared for and thought of their postpartum sexual bodies (Akpinar & Yangin, 2018). It was found that women may postpone sexual intercourse due to perceptions of their bodies, either by themselves or by others, as 'dirty', though this is also influenced by cultural and religious practices (Akpinar & Yangin, 2018). This study exemplifies how religion is one factor that can influence how sexual health and the sexual body is viewed by women after birth. For the majority of postpartum women, being a sexual person includes their perception of their own bodies, though women do not always feel as 'complete' as a sexual being after childbirth (Bender et al., 2018).

Throughout the academic literature, the example of breasts is used quite frequently to describe the perceived negative or positive effects of body image on postpartum women's experiences of their postpartum sexual health. Many women described a significant shift in the use and perception of their breasts from pre-pregnancy to postpartum and, in the majority of cases, felt their breasts were no longer a part of their sexual body but rather belonged to the breastfeeding baby (Bender et al., 2018; O'Malley et al., 2019). Women also described the changes associated with breastfeeding, with some finding that leaking milk (especially when breasts were touched or caressed) was a hindrance to sexual intimacy (Bender et al., 2018; O'Malley et al., 2019). Others found it to be a point of humour that they could share with their partners (Bender et al., 2018). Some women found it difficult to tell their partners about their concerns surrounding breast leakage because they did not want their partners to associate their breasts with feeding a baby during sexual activity (Bender et al., 2018), exemplifying a socially-constructed binary between perceptions of the breasts as nurturing versus sexual (Bucher & Spatz, 2019; Hinson, Skinner, Lich, & Spatz, 2018; O'Malley et al., 2019). This dichotomous experience and view of the breasts is most exemplified in the guilt, shame, or embarrassment that some women experience if and when they experience sexual pleasure or excitement while breastfeeding (von Sydow, 1999).

Researchers have demonstrated that some postpartum women simply prefer to postpone sexual activity until breastfeeding occurs only 1-2 times per day, at which point the breasts and body have returned more to their pre-pregnancy size and shape (O'Malley et al., 2019). While there are limited studies exploring the influence of lactation or breastfeeding on sexuality after birth, two of the most seminal studies are those of Avery, Duckett, and Frantzich (2000) and Wallweiner at al. (2017) (Gutzeit et al., 2020). Avery, Duckett, and Frantzich (2000) recruited

635 American women as part of a descriptive, longitudinal, prospective study and aimed to describe various aspects of sexuality for primiparous women who were also breastfeeding (Avery et al., 2000). The researchers defined sexuality as a "multidimensional, biopsychosocial phenomenon" (Avery et al., 2000, p. 227), though focused much of their literature review and findings on sexual activity and breastfeeding. Their findings supported that of Bender et al.'s (2019) in stating that although the physiological aspects of breastfeeding had a slightly negative impact on sexuality, the participants found that the perceptions of themselves and their partners on breastfeeding and sexuality was generally quite positive (Avery et al., 2000).

Wallweiner et al. (2017) aimed to explore the prevalence of sexual dysfunction and its associated risk factors in German women (n=315) during the perinatal period using questionnaires. Sexual dysfunction was measured using the Female Sexual Function Index (FSFI), which assesses desire, arousal, lubrication, orgasm, pain, and satisfaction (Wallwiener et al., 2017). They found that breastfeeding significantly increased a woman's likelihood of experiencing sexual dysfunction postpartum based on physiological issues with vaginal atrophy and vaginal dryness throughout lactation (Wallwiener et al., 2017). In summary, women's perceptions of their postpartum bodies are often challenged or re-evaluated based on their similarity or difference with the perceptions of their pre-pregnancy bodies, with body parts being generally categorized as either sexual or non-sexual, thus affecting ability to engage with themselves or others in a sexual way.

Psychological. Very few researchers have explored the psychological aspects of postpartum sexual health, though mental wellbeing is closely tied to emotional experiences and intimacy, as well as the social and relational changes that occur after birth (von Sydow, 1999). In what is described in the literature, women have discussed the process of labour and childbirth

and its influence on their identity and confidence as sexual beings, though this impact can be either positive or negative (Khajehei & Doherty, 2018). Khajehei and Doherty (2018) aimed to explore Australian women's experiences with their sexual function during pregnancy and after birth using a qualitative survey (n=273). Sexual function was defined more holistically in this study, with the authors defining it as "a multifaceted phenomenon that mirrors psychological, physiological, sociocultural, inter- and intra-personal influences, including the health of the whole body and internal systems" (Khajehei & Doherty, 2018, p. 318). Positive changes related to mental health and sexual function in the postpartum period included role transition, feeling empowered by new roles and responsibilities, and feeling relaxed, mature, and centered after labour and birth (Khajehei & Doherty, 2018). Confidence and happiness also positively influenced sexual function (Khajehei & Doherty, 2018). Albeit, mental health was negatively affected for some women and influenced by factors such as the birth experience, hormones, fears and stress, lack of confidence, and feelings of brain-body disconnection, which in turn negatively impacted sexual function (Khajehei & Doherty, 2018). In addition, women who experienced symptoms of postnatal depression may have been underrepresented in this study (Khajehei & Doherty, 2018).

In a similar study published by the same authors only a year prior, Khajehei & Doherty (2017) aimed to investigate the association between postnatal depression, sexual dysfunction, and relationship dissatisfaction during the first year after birth in Australia using a multi-section questionnaire (n=325). However, in this study, the authors defined sexual dysfunction using the Female Sexual Function Index (FSFI), similar to many of the quantitative studies included in this review (Khajehei & Doherty, 2017). When comparing women with symptoms of postpartum depression to those without symptoms, the rate of sexual dysfunction was higher (82% versus

58.7%), as was the rate of relationship dissatisfaction (65.3% versus 28.3%) ($p<0.001$) (Khajehei & Doherty, 2017). However, no significant association was found between symptoms of postpartum depression and frequency of sexual intercourse or resumption of intercourse after birth (Khajehei & Doherty, 2017).

In contrast, De Judicibus and McCabe (2002) sought to examine the influence of role quality, relationship satisfaction, depression, and fatigue on Australian women's sexuality during pregnancy and after birth. Sexuality included sexual satisfaction, sexual desire, relationship satisfaction, and frequency of sexual intercourse (De Judicibus & McCabe, 2002). Using questionnaires to collect data from 138 women who were pregnant for the first time (70 participants responded at 6 months after birth), they found that depression was, in fact, a predictor of decreased sexual desire during the postpartum period (De Judicibus & McCabe, 2002). Sexual desire and sexual satisfaction were both measured using McCabe's (1998) Sexual Dysfunction Scale (SDS), which included Likert scaling of how often partnered sexual activity was enjoyable, the partner's sensitivity as a lover, and physical sexual responses of the postpartum woman (De Judicibus & McCabe, 2002). In their findings, fatigue and depression resulted in less sexual satisfaction and reduced frequency of sexual intercourse, though sexual satisfaction was positively influenced by increased relationship satisfaction and perceived quality of the mothering role (De Judicibus & McCabe, 2002). However, limitations included the absence of partners in the study, which may have also had a significant influence on relationship satisfaction and associated factors (De Judicibus & McCabe, 2002).

There is a current gap in the literature in terms of exploring the effects of emotional and psychological changes, such as role transition, on sexual health and wellbeing after birth, making the need for broadened definitions, and therefore approaches, to exploring postpartum sexual

health all the more apparent. The severe dearth of literature exploring psychological aspects of postpartum sexual health represents a salient theme, being that physical aspects are more prioritized in research. While researchers have indicated that emotional and psychological aspects of sexual health are important, there exists a gap in our understanding of how these aspects of sexual health and influenced and negotiated by postpartum individuals as unique subjects.

Summary

A review of the literature reveals a variety of discourses related to sexual health, particularly women's sexuality and postpartum sexual health. From a theoretical perspective, sexual health and women's sexuality have both been primarily defined and conceptualized in physically-focused ways. However, it is known that sexual health after birth is influenced by numerous physical and non-physical factors, many of which are interconnected (von Sydow, 1999). In the empirical literature, the emphasis of research has been on the physical factors, such as dyspareunia, that affect postpartum sexual health (von Sydow, 1999). While the physical components of postpartum sexual health are important, knowledge regarding non-physical facets of postpartum sexual health remains limited (O'Malley et al., 2015; von Sydow, 1999). As such, there has been a recognition of the need for qualitative research to more comprehensively explore how postpartum sexual health is experienced in physical, emotional, and psychological ways (Bender et al., 2018; Carlander et al., 2015; Khajehei & Doherty, 2018) while also recognizing the diverse contexts and identities of postpartum individuals. As such, my research aimed to explore in depth how postpartum individuals experience their sexual health so as to uncover the meaning of sexual health after birth.

Purpose

This research intended to extend the existing literature by specifically seeking to explore postpartum individuals' experiences with the physical and non-physical aspects of their sexual health after birth. This included relational, psychological, emotional, or physical ways of expressing sexuality and experiencing postpartum sexual health. However, my aim was not to simply describe experiences, but to explore how those experiences were influenced or negotiated by acknowledging relations of power. FPS provided a means of critiquing the power relations present within institutions, individual experiences, or social phenomena (Weedon, 1987). This research was unique in that it considered the influence of social and institutional discourse(s) on physical and/or non-physical experiences of postpartum sexual health. Experiences included meaning, subjectivity, agency, and power, as well as social and institutional constructions of different discourses and how the relations of power that existed in their experiences were negotiated. Experiences were also influenced by participants' beliefs, values, and practices. These terms, which are specific to FPS as a methodology, will be further explained and applied to the topic of postpartum sexual health in Chapter 3.

Research Questions

The primary research question was as follows:

- How do postpartum individuals (who have birthed a baby) experience postpartum sexual health?

Sub-questions included:

- How do postpartum individuals negotiate relations of power related to their sexual health?

- How is postpartum sexual health socially and institutionally constructed through different discourses?

I was intentional in specifically including relations of power in my research questions because I aimed to illuminate how participant experiences were influenced and, therefore, how their sexual health was affected. Paralleling feminist approaches to research (Brown & Strega, 2015), naming discourse was pivotal in identifying the issues that were important to participants (Aston, 2016), which then informed knowledge translation and recommendations for health care practice and policy. By first naming social and institutional constructions and discourses, the implications of this study (and possibilities for change) were directed by participants because it centered them as the experts both in their experience(s) and in their choice(s) when navigating certain discourses.

CHAPTER 3: METHODOLOGY

Feminist poststructuralism (FPS) may be used as a philosophy, theory, and methodology to guide research in a vast number of research areas, including education, nursing, social work, or midwifery. While FPS draws largely from philosophers such as Weedon (1987), Butler (1990, 1992, 1993), Cheek (2000), and Scott (1992), Foucault (1970, 1973, 1977, 1978, 1980, 1982) remains the centerpiece of poststructuralist thought given that many of his books were used as a springboard for feminist philosophers, including bell hooks (1984) and Susan Hekman (1992) (Deveaux, 1994). Feminist poststructuralism is relevant today because, by its very nature, it critiques 'the way things are' and aims to continually foster a process of deconstruction while providing direction for action (Aston, 2016; Weedon, 1987). In the following paragraphs, I will describe the main tenets of FPS in order to establish the alignment of this methodology with my research question(s). This chapter is structured into three main sections: 1) Feminist Poststructuralism; 2) Applying Concepts of Feminist Poststructuralism: A Way Forward; and 3) Feminist Poststructuralist Discourse Analysis.

Feminist Poststructuralism

Postmodernism and poststructuralism. In order to understand the importance and use of FPS as a critical social theory and its relevance to exploring postpartum sexual health, it is important to first know the differences between postmodernism and poststructuralism. Beginning with the exploration of experiences, which is essential to understanding a fluid, multifaceted topic such as postpartum sexual health, postmodernism and poststructuralism move beyond objective descriptions of experiences to attend to the political and social constructions of knowledge, power, and language (Baxter, 2016). Postmodernism is generally regarded as the

umbrella under which poststructuralism falls, given that it has been difficult to trace exactly when poststructuralism was first conceived, and by whom (Baxter, 2016).

Postmodernism, at its core, challenges universal truths and views knowledge as something that is contextual, singular, localized, and socially constructed (Baxter, 2016). Building on postmodernist thought, Foucault (1977) theorized the use of knowledge as a way to power and, in many cases, power over others through the prioritization or hierarchization of knowledge through discourse, thus influencing who had access to and control of knowledge. Foucault (1977) was the first to describe knowledge and power as essentially interwoven, each one dependent on the other. Most importantly, the need to 'fix' knowledge, and render it permanent or unchangeable, is what postmodernists find most dangerous and a sure means of oppression or abuse of power (Baxter, 2016). Due to dominant discourses that result from normalized meta-narratives, postmodernist thought indicates that the individual person must navigate competing ways of both being and knowing (Baxter, 2016). As it relates to 'being' in the world, poststructuralism takes this idea further by stating that language and discourse are the sites from which personal identity is "constructed and performed" (Baxter, 2016, p. 36) or navigated. Meaning is then enacted or produced through language and is plural, contextual, and non-fixed, as is personal identity (Baxter, 2016). As a researcher, this reflection in language and discourse allows one to explore how others experience being in and of the world. Poststructuralists argue that identity is shaped and enacted depending on social context, the availability of specific discourses, and cultural forces (Baxter, 2016). In other words, poststructuralism views identities as constructed and influenced by discourse rather than innate or essential. Similarly, feminist poststructuralism more deeply explores interwoven aspects of

identity through the subject and subjectivity, notions which will be explained in the following paragraph.

Feminist poststructuralism as a theory. FPS emerged from poststructuralist thought and ideas, such as that of Foucault's (1978), by way of Weedon (1987) and Butler's (1990) attention to gender, sexuality, and women. In relation to postpartum sexual health, FPS brings attention to relations of power and discourse while also attending to a feminist lens and agenda by accounting for equity, identity, and subjectivity. Foucault's ideas pertaining to sex and sexuality in particular have provided a useful means to exploring and analyzing the topic of postpartum sexual health (Ollivier, Aston, & Price, 2019), though the additional concepts that make FPS different lie predominantly in its attention to 'the invisible'. From a theoretical perspective, FPS offers a way to explore socially-constructed phenomena while accounting for the multi-faceted nature of human experience, whether it be in relation to race, class, age, ability, gender, sexual orientation, or religion (Ollivier, Aston, & Price, 2018). Philosophically, FPS sets out to challenge the status quo and enact change through critical analysis (Aston, 2016). It also recognizes the existence of multiple truths and views knowledge as contextual, in line with poststructuralism and postmodernism (Aston, 2016). What sets FPS apart from other critical social theories or methodologies is Weedon's (1987) understanding and incorporation of subjectivity. While individuals may be shaped by social and institutional practices, individuals may also be agents of change in identifying, working through, and producing their own meaning(s) within language, practice, or discourse (Ruitenberg, 2018; Weedon, 1987). By way of subjectivity, meaning and identity are always open to contestation, be it by an individual or social group, and redefinition (Baxter, 2016). Given that there is a clear need to redefine and

expand the understanding of postpartum sexual health within nursing and health care, FPS presented an ideal approach to this research.

Feminist poststructuralism's fluid approach to identity, first and foremost, honours the lived experience of postpartum individuals while providing a way of deconstructing the many influences that shape how and why postpartum sexual health is viewed, discussed, cared for, treated, and defined in the ways that it is. Critical in its approach, FPS may be used by researchers as a theoretical guide or research methodology to explore topics that may be contentious, taboo, or misunderstood (Baxter, 2016). By using FPS instead of other theories, such as postmodernism, the postpartum individual's subjectivity is centered in relation to discourse and relations of power. Discourse and relations of power, specifically, continue to be shifted by past and present ways of knowing, conceptualizing, and understanding postpartum sexual health, all of which are important considerations in this research.

Applying Concepts of Feminist Poststructuralism to Postpartum Sexual Health: A Way Forward

In considering discourse and relations of power, it is important to recognize the existence, potential, and possibility present within other, more invisible discourses that surround women's sexuality and postpartum sexual health. From a FPS perspective, there is not one governing, universal truth that is all-powerful, seeing as power is relational in that it "is and comes from everywhere" (Foucault, 1980; Ollivier et al., 2018, p. 698). Considering the aforementioned critiques of the historical and current approaches to postpartum sexual health presented in Chapter 2, FPS provides a framework to examine in-depth how and why certain discourses were formed and continue to exist, as well as how they may shift. In what follows, I will provide an overview of the key theoretical tenets of feminist poststructuralism.

Binary opposites. Foucault's arguments (as well as his critiques of modernist theory) are often rooted in challenging the many constructed binaries that exist (Baxter, 2016; Ruitenberg, 2018). In relation to sexuality and postpartum sexual health, the binaries of physical/mental, heterosexual/homosexual, and male/female are perhaps most relevant. What is most problematic about binaries themselves is the requirement that a subject or individual fit into one category or the other, by its very nature eliminating possibilities for any 'in-between', spectrum, or grey area. Binaries have certainly influenced how sexuality and postpartum sexual health are defined; within each binary, one descriptor is normal while the other represents the deviant, the alien, the mutated, or the lesser (Ruitenberg, 2018). Upon reviewing the literature, it was evident that much of the focus on postpartum sexual health was on physical aspects of sexual activity while also being heteronormative. Sexual health outside of heterosexual relations or physical components was therefore othered. Mental and relational aspects of postpartum sexual health are equally important, yet the binary forces one side (the physical) to be privileged over the other (the mental or emotional) (Baxter, 2016). The privileged side of a binary becomes the normal and is thusly a part of the greater social, political, or institutional discourse that is deemed common knowledge or 'just the way things are'. These polarizing constructs lead to the formation of meta-narratives, which then become dominant discourses that acknowledge only a very specific part of certain phenomena, such as postpartum sexual health (Baxter, 2016). In order for common understanding to move beyond the binary with regards to postpartum sexual health, different ways of experiencing sexual health after birth must first be explored.

Discourse. Discourse, most simply, comprises systems of thought that shape and are shaped by ideas, actions, beliefs, values, practices, attitudes, subjects, and agents within a given society or context (Foucault, 1980). Cheek (2000) describes discourse as "as set of common

assumptions which, although they may be so taken for granted as to be invisible, provide the basis for conscious knowledge" (p. 23). Discourse is shaped by relations of power, knowledge, and language amidst differing political, social, institutional, or personal influences (Baxter, 2016). What is helpful to my research is feminist poststructuralism's view of discourse in relation to how individuals or subjects choose to pull from available or widely-approved discourses depending on the context. Dominant discourses represent approved ways of being, though the existence of "competing or resistant discourses" (Baxter, 2016, p. 38) makes such choice and navigation much more complex. I will discuss institutional and social discourse in relation to postpartum sexual health in subsequent sections of this chapter, though I will first focus on discourse as it relates to the personal identity of postpartum individuals.

Within the limited qualitative research exploring postpartum sexual health, the presence of competing discourses is evident. As such, postpartum individuals may navigate their awareness and the existence of these multiple discourses differently. For example, the binary that exists between a woman as a mother and a woman as a sexual being is that of an expectation of sacrifice, selflessness, and nurturing while also needing to maintain an available sexual status (Haug, 1987). This is just one example of the competing discourses that encourage postpartum individuals to be strong, confident, wise, and all-doing while maintaining an expectation of servitude, selflessness, and giving- foregoing any sense of 'selfish' personality and identity, both as a mother/parent and as a sexual partner. While these competing discourses stem from social discourse, this example of 'push and pull' (and there are certainly others) is especially invisible in that it is negotiated each day in very personal, intimate interactions that are not usually seen or discussed publicly. How postpartum individuals navigate these issues and discourses is grounded in personal identity- their subjectivity. Postpartum individuals may choose to access or resist

these competing discourses at different times, depending on what is accepted, helpful, or normalized (Baxter, 2016), though the availability and navigation of such discourses is deeply embedded in individual subject position(s) and agency.

Subjectivity & agency. Subjectivity and agency are very closely intertwined and contributed considerably to the use of FPS in this research. Subjectivity, in short, is a process of self-reflection and self-awareness that allows one to fully realize their position in the world, as well as how that position is shaped (Weedon, 1987). To quote Weedon, it is "the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world" (1987, p. 32). Agency is one's response to those reflections by way of transformation, challenge, resistance, acceptance, or adaptation (Weedon, 1987). Despite the anger or frustration that can arise simply because of 'the system' or 'how the world works', agency reshapes feminist discourse by lending language and concept to one's ability to act to their own degree, in their own way, as decided by themselves. Through agency, postpartum individuals are their own subjects; they are not victims of a patriarchal society or subject to the gaze of other subject positions, such as that of men or the medical profession. However, it is important to consider that postpartum individuals may have different or varied experiences of enacting agency. That is, their environment, culture, previous life experience(s), or safety may influence their ability to demonstrate agency. Butler (1990) and Weedon (1987) state that agency is discursively influenced, positioning it as essential in connecting the subject to their environment or context. In considering this, discourse and agency work together as agency is needed to navigate through different discourses and may even lead to the discovery of other unknown discourses. While individuals may not be authors of a particular discourse, there are ways to challenge power relations through discourse. For example, how one responds to or

enacts certain discourses (Weedon, 1987). Discourse has no power or value if there is no one to realize it and, in order for this realization to occur, individuals must be subjectively motivated to either reproduce or transform social power through agency (Butler, 1990; Weedon, 1987). As it relates to postpartum sexual health, the dominant discourses that dictate what is normal or included in postpartum sexual health and postpartum sexuality require postpartum individuals to utilize agency in order to uphold, challenge, reproduce, or transform discourse (Ollivier, Aston, & Price, 2019). Discourse is always being navigated by individuals; therefore, the concepts of agency and subjectivity can help us understand how the needs and identity of the postpartum individual as a sexual being are produced and reproduced. One way of enacting agency includes the use of language, another key concept within feminist poststructuralism.

Language. According to FPS, language is that "which enables us to think, speak and give meaning to the world around us. Meaning and consciousness do not exist outside language" (Weedon, 1987, p. 31) but are rather produced within it (Baxter, 2016). Moreover, language is not necessarily reflective of experience but provides us ways of interpreting different versions of experience, making it the site where our sense of selves is constructed (Weedon, 1987). Meaning is never fixed and so neither is language (Weedon, 1987). As a site of political struggle, it is through language that competing or conflicting ways of giving meaning to the world are created and contested (Weedon, 1987). For example, the term 'woman' was frequently used by Saussure (1974) as language that is socially constructed, plural, subject to change, and can also be conflicting (Weedon, 1987). "As we acquire language, we learn to give voice- meaning- to our experience and to understand it according to particular ways of thinking, particular discourses, which pre-date our entry into language" (Weedon, 1987, p. 32). As such, subjects are not the makers of language but, simply by using language, are automatically subject to its social contract

through the language that they acquire and use (Baxter, 2016). Through language, sexuality has been narrowly defined and conceptualized (Foucault, 1978). Changing or broadening the definition of postpartum sexual health is no small feat, though it will begin with how knowledge of postpartum sexual health is constructed through language. When language is reflective of one's understanding or experience, meaning may also be created, honoured, or shifted.

Meaning. Concepts of meaning and meaning-making are intensely subjective, with limitless possibilities for change, evolution, and depth, seeing as "meaning is constituted within language" (Weedon, 1987, p. 22). Meaning may be seen by some as a culmination of many other tenets of feminist poststructuralism; how agency, subjectivity, language, power, and experience come together. The plurality of meaning (Weedon, 1987) as one of the key components of FPS will enable me to explore postpartum sexual health in ways that may challenge or question my own lens, my definition(s), and my experience in order to understand that of others. What is most useful about exploring meaning are the subsequent questions that arise, illuminating the 'taken for granted' within one's worldview, experience, or perceptions through language (Weedon, 1987). Postpartum sexual health may have highly variable meaning for different people, seeing as discourses or subject positions may be taken up by individuals in different ways (Aston, 2016). Meaning, as a whole, is what matters to individuals; it is the site at which personal needs, values, and beliefs are held with personal intention, purpose, and benefit. Overall, meaning as part of FPS must honour the existence of multiple truths, and therefore possibilities as to how and why postpartum sexual health is defined, constructed, or acknowledged within individual experience.

Relations of power. "Power is a relation" (Weedon, 1987, p. 113) in that it is dispersed, dynamic, mobile, and fluid; it is not centralized to any one location, nor is it repressive

(Foucault, 1980; Mease, 2017). Rather, power is productive (Foucault, 1980; Weedon, 1987). "Power is exercised within discourses in the ways in which they constitute and govern individual subjects" (Weedon, 1987, p. 113), meaning that it is ever-present and negotiated by subjects through agency. Oftentimes, the location of resistance or challenge by subjects is not directly in relation to discourse, but the enactment of discourse in organizational or institutional contexts (Foucault, 1977). "Resistance may show up in mundane ways by which individuals refuse to follow norms dictated by dominant discourses" (Mease, 2017, p. 16). In essence, each subject will uphold or challenge the status quo in unique ways, and language such as deviant, delinquent, non-compliant, or incompetent positions an individual's disruption of the status quo as abnormal (Foucault, 1977; Mease, 2017). For postpartum individuals, 'normal' is upheld as something that they should strive to attain and upkeep, no matter the challenges or personal consequences. Unfortunately, constructed norms reflect only a single truth that may not necessarily be a specific individual's truth, limiting the knowledge available about how postpartum individuals may experience their sexual health differently.

Foucault has focused much of his discussions of power on the relationship between knowledge and power; who has access to knowledge, as well as who creates it, ultimately has great influence on power (Foucault, 1980). Albeit, more knowledge does not necessarily mean more power as both are intertwined and dependent on each other (Foucault, 1980). As such, the ways that knowledge is formed and communicated with regards to postpartum sexual health is where the shifting of power may begin. Until now, the privileged voices of 'experts' in the topic of postpartum sexual health have been those with formal education, such as a medical degree (Bancroft, 2002; Tiefer, 1996), without account for the subjective, diverse, and fluid ways that sexuality and sexual health is experienced throughout the lifespan. Postpartum individuals may

challenge or resist discourses they find harmful or unhelpful, though dominant discourse, as well as institutional and social constructions of postpartum sexual health, persist because of how certain forms of knowledge/ways of knowing are prioritized or viewed as better or lesser. Knowledge is plural, contextual, and subjective (Cheek, 2000), as are the ways of caring for, discussing, defining, and exploring postpartum sexual health. To date, knowledge of postpartum sexual health has mostly been shaped and made available through specific social and institutional constructions of the topic.

Social and institutional constructions. Social and institutional constructions were important in situating this research through a FPS lens. In interviewing postpartum individuals about their experiences, it was crucial to consider how concepts within their experiences were socially or institutionally constructed. Feminist poststructuralism aims to challenge social and institutional constructions by first questioning the taken for granted and the status quo. As evidenced by the previous information presented in this dissertation, I am critical of the ways that postpartum sexual health, sexual health, and postpartum health have been defined and 'measured'. This critique has stemmed from how postpartum sexual health has become medicalized due to the fact that biomedical and physically-focused approaches to this topic are currently being emphasized in the literature and in practice. In terms of social construction(s), postpartum sexual health has been depicted as something that postpartum individuals should be responsible for and desiring of only through and by sexual activity, which is only one way that sexuality may be expressed or experienced. Both social and institutional constructions of health overlap in this area, given that health (more generally) is seen as something that an individual has ultimate control over, therefore positioning any illness, difficulties, or uncertainties as a

result of personal failure. In turn, this biomedical focus positions health as static and objectively-measured without considering context.

For postpartum individuals, the current social and institutional constructions of their sexual health do not account for sexuality as a part of identity that is fluid and individual. Postpartum sexual health is institutionally constructed as an attainment of pre-pregnancy feelings, sensations, norms, behaviours, or attitudes. Institutional structures or organizations, such as health centers and hospitals, are "unstable because they are created through human practice (which is subject to change) and because they are circumscribed by the experiences of humans interacting to create them (which leads them to be limited and ultimately faulty)" (Mease, 2017, p. 17). This points to a need to examine and deconstruct the practices that currently exist in postpartum care by providing a reason to question how and why things are the way they are. As such, the concepts of social and institutional constructions provided a base for me to question what is prioritized or given voice, why or why not, and how other discursive elements (Foucault, 1980) may come into play. In the following section, I will detail how feminist poststructuralist discourse analysis was applied to this research, given that it is both a method and a methodology.

Feminist Poststructuralist Discourse Analysis

There exist many forms of discourse analysis, as well as many other ways of exploring a phenomenon or interwoven phenomena in nursing research. While not necessarily emancipatory in its aim, discourse analysis that incorporates a feminist poststructuralist lens provides a way of informing potential change through the examination of discourse(s) (Aston, 2016; Baxter, 2008). Building on the notions central to similar types of discourse analysis, such as critical discourse analysis, the purpose, key concepts, and aims of feminist poststructuralist discourse analysis

(FPDA) will be further discussed in the remainder of this chapter. Given the existence of varying contextual, gendered, and pre-defined notions of postpartum sexual health, and the discourses that shape those notions or definitions, the need for discourse analysis in exploring meaning and experiences surrounding this topic is apparent. In what follows, I aim to describe how and why FPDA was used to explore postpartum sexual health.

Judith Baxter is the first person to have 'coined' the term FPDA (2008). Her definition is as follows, where she describes FPDA as:

> an approach to analysing inter-textualised discourses in spoken interaction and other types of text. It draws upon the poststructuralist principles of complexity, plurality, ambiguity, connection, recognition, diversity, textual playfulness, functionality and transformation. The *feminist* perspective on post-structuralist discourse analysis considers *gender differentiation* to be a dominant discourse among competing discourses when analysing all types of text. FPDA regards gender differentiation as one of the most pervasive discourses across many cultures in terms of its systematic power to discriminate between human beings according to their gender and sexuality. (2008, p. 245)

In considering the topic of this research, as well as those who participated in this study, the influence and careful attention to gender and sexuality as part of FPDA was critical. As a more Foucauldian approach (rather than linguistic, for example) (Baxter, 2008), FPDA attends to sexuality as part of subjectivity, both of which may be influenced by discourse(s).

In relation to exploring postpartum sexual health, FPDA recognizes the performativity of discourse by delving into how and why meaning is made through political, psychological, and social reasons (Nagington, 2014). The purpose of FPDA is to disrupt, critique, problematize, or

trouble the status quo and what is considered normal (Nagington, 2014). Given the many dominant and competing discourses that surround postpartum sexual health, FPDA questions why certain discourses have emerged and what is sustaining them (Nagington, 2014). Through this method of analysis, postpartum individuals are "perceived to be multiply positioned as powerful or powerless within and across a range of competing discourses" (Baxter, 2003, p. 32) depending on the context in which they find themselves. While I am hesitant to use language such as 'powerless' due to its possible indication or assumption that power is an endpoint, rather than multiply positioned and relative, FPDA is equally concerned with avoiding the polarisation of 'categories' (such as women) as disadvantaged or oppressed (Baxter, 2008). In essence, FPDA "argues that female subject positions are complex, shifting, and multiply located" (Baxter, 2008, p. 245) and that the subject is always fluctuating within the 'matrix' of relations of power (Baxter, 2008). FPDA inherently questions universal claims and challenges the binaries that position the female or feminine in opposition to the male or masculine (Baxter, 2016), which may have implications for how women's sexuality is expected to be and how it is actually experienced throughout the postpartum period. While FPDA is primarily employed as an exploratory tool, it also offers means of change and transformation.

Looking at change and the bigger picture, "FPDA can support small-scale, bottom-up, localized social transformations that are vital in its larger quest to challenge dominant discourses" (Baxter, 2008, p. 245). FPDA embraces the ambiguity and unevenness present within relations of power (Baxter, 2016), as well as transformation, by first examining language. Discourse analysis using a feminist poststructuralist lens "guides analysis in a way that interrogates the meaning of words by paying close attention to the way participants tell their stories" (Aston, 2016, p. 2264). My aim in using FPDA was to broaden what is included as part

of postpartum sexual health by exploring meaning, which may then lead to redefinition. The 'bottom-up' approach that FPDA employs was used to return to the roots of how discourses came to be and how they shaped the subjectivities and experiences of the postpartum individuals in this study. Overall, FPDA presented a transformative medium for analysis without overlooking the uniqueness present within individual experiences (Aston, 2016). FPDA uncovered realistic, 'start small' ways to shift postpartum health care, services, and outcomes. As such, FPDA allowed me to illuminate what has historically been invisible with regards to how postpartum individuals experience their sexuality and sexual health, which revealed changes required within maternal health care. In what follows, I will discuss how FPDA combines the philosophical underpinnings of feminist poststructuralism with concrete applications for conducting research.

Feminist poststructuralist discourse analysis: A methodology and a method. Gavey cautions that "when discourse analysis is conducted as just another method, moreover, without due regard for the particular theoretical assumptions and commitments that it is (or should be) embedded within, its more creative potential is arguably lost" (2011, p. 186). While FPDA is a method in its use as a tool for research that informs data collection and analysis, piecing out language and meaning, FPDA is also a methodology because it encompasses one's lens as a researcher and informs the *process* of research (Gavey, 2011). FPDA is not just about how we understand language as a performative act; it is a methodology that must also answer to political and ethical questions (Gavey, 2011). In employing FPDA, researchers bear witness to deconstruction, they do not perform it (Brown & Strega, 2015). As such, FPDA as a process must be honored and given time, energy, and active self-reflection by the researcher(s) aiming to use it. We are all subjects of discourse. As such, discourse analysis using a feminist

poststructuralist approach "understands and forgives our obedience to dominant cultural norms and values […], yet highlights the contingency of these norms. In doing so, it shines light on possibilities for being and acting otherwise- and for imagining more just and ethical conditions" (Gavey, 2011, p. 185). FPDA is both critical and optimistic in its methodology, promoting freedom and the possibility to be, think, and do in more diverse ways (Gavey, 2011). Although it may seem a contradictory statement, FPDA can be more "about unknowing than knowing" (Gavey, 2011, p. 187) being that its process inherently requires deconstructing discourse by questioning or challenging the status quo.

Conclusion. Feminist poststructuralism was well-suited to the aims of my research as well as the topic of postpartum sexual health itself, given that it is taboo, silenced, invisible, or hidden away as something to be discussed only in specific contexts or in certain ways (Ollivier et al., 2019). FPS goes beyond exploring experiences; it allows for deconstruction (Baxter, 2016) as a way of paving new understandings of postpartum sexual health. Concepts within FPS, such as discourse, language, meaning, binary opposites, and subjectivity were used to facilitate this deconstruction. FPDA as both a method and a methodology was well-suited to the aims of this study because it was attentive and welcoming to different possibilities of experience within postpartum sexual health. Through a lens of gender and sexuality, FPDA went further than simply describing experience(s) by specifically attending to relations of power. As a result, FPDA provided practical solutions that were also contextually-focused. In exploring postpartum sexual health from a feminist poststructuralist perspective, the need for change is evident- but there remain questions as to how change may best serve the needs of postpartum individuals. FPDA presented a guided invitation to explore experience and meaning, which then enabled me to deconstruct reality and illuminate the complexities of postpartum sexual health.

CHAPTER 4: METHODS

It was essential that the methods employed in this study were congruent with the key principles and tenets of feminist poststructuralism and FPDA. Moreover, it was important to acknowledge that researchers must carefully reflect upon how best to incorporate the theoretical and philosophical underpinnings of their research (Brown & Strega, 2015). While there exist different ways of incorporating feminist poststructuralism into scholarly work, critical analysis, or research (Arslanian-Engoren, 2002; Aston, Meagher-Stewart, Sheppard-Lemoine, Vukic, & Chircop, 2006; Aston et al., 2018; Breau, Aston, & MacLeod, 2018; Gavey, 2011; Jefferies, Goldberg, Aston, & Tomblin Murphy, 2018; Mbekenga et al., 2018; Mselle et al., 2017; Ollivier, Aston, & Price, 2018; Ollivier et al., 2019; Price et al., 2018; Richardson, Goldberg, Aston, & Campbell-Yeo, 2018), this chapter will aim to provide a clear description of the concrete methods that were used to conduct this study.

Inclusion & Exclusion Criteria

Eligible participants were included in the study if they met the following inclusion criteria: 18 years of age or older, proficient in English, currently living in Nova Scotia, and between one and six months postpartum at the time of data collection. In speaking with people who had recently given birth through my work as a Research Assistant for the Mapping & Understanding Mothers' Social Networks (MUMS) project and as a Registered Nurse at the IWK Health Centre, I concluded that interviewing participants who were within 1-6 months postpartum presented the best time period to ensure richness of the data. Due to the public health orders related to the ongoing COVID-19 pandemic, all interviews were required to take place virtually. Therefore, participants also had to have reliable access to internet or phone service to be included in this study. Exclusion criteria included being less than 18 years of age, outside of

the 1-6 month postpartum time frame, not verbally fluent in English, those who were not currently living in Nova Scotia, or those who did not have reliable access to phone or internet service.

Postpartum individuals recruited for the study were defined as those having carried a pregnancy and birthed, regardless of whether the pregnancy was full-term, the participant was parenting, the baby was currently alive, or the delivery occurred via Caesarean section or vaginally. I aimed to include participants who had a postpartum experience, whether or not they identified as women. Researchers have often approached postpartum sexual health from a sex-based lens, perpetuating the notion of a false gender binary and, oftentimes, mislabeling sex and gender. While it is important to explore ideas surrounding women's sexuality, as I have previously discussed, gender and sexuality must not be pre-defined or assumed. Gender is a social construct (Butler, 1990) and how it is experienced and made meaningful can only be defined by individual participants. As a researcher employing feminist poststructuralism, my use of a broadened definition of who was included in this postpartum sexual health research challenged current norms and pushed the limits of existing literature. While some experiences were retrospective (depending on how many months postpartum the participant was), I aimed to also capture timely information about participants' sexual health experiences as they were happening. Participants were at various stages in their postpartum journey. Anecdotally, it is recognized that sexual health is most impacted during the first 6 months after birth and that even during this time period, there is much variance with regards to how individuals experience their postpartum sexual health.

Setting

I recruited participants who were currently living anywhere in Nova Scotia. Given that my doctoral studies occurred in this province, and in considering the established networks of both myself and my co-supervisors, it was most feasible to conduct the study in Nova Scotia. All interviews occurred via telephone in order to protect the safety of participants and the people they lived with during the COVID-19 pandemic.

Recruitment Strategies

This study utilized a purposive sampling strategy. Recruitment was facilitated through online dispersal of the recruitment poster (see Appendix D) advertising the study. The posters were distributed via email to respective departments within the IWK Health Centre, including to the Public Relations staff, after Research Ethics Board (REB) approval. In addition, the recruitment poster and other information about the study was shared via email or using Facebook Messenger with the Nova Scotia Doula Association, Pride Health, Maggie's Place (Truro, N.S.), Better Together Family Resource Center (Bridgewater, N.S.), Enchanted Forest (Truro, N.S.), Nurtured, the Chebucto Family Resource Center (Halifax, N.S.), the Mapping & Understanding Mothers' Social Networks research project, the Momgasm podcast, and the Nova Scotia Coalition of Midwives. Specific requests were made to the aforementioned entities to promote the study on their respective institutional Twitter, Facebook, Instagram, and other social media sites, if applicable. An online version of the poster was shared on Facebook by posting on various 2020 parenting/new mom groups, such as "HRM Babies 2020", that were based in Nova Scotia. Prior to posting, I reviewed each specific Facebook group's member policies and did not share my recruitment poster if it violated their member terms. In addition, I sought permission from the page Administrator(s) prior to posting. Information on the recruitment poster included:

my name and position, my Dalhousie University institutional email address, the purpose and title of the study, inclusion criteria, and the Research Ethics Board approval number. All recruitment materials were written at a Grade 8 English reading level, as required by the IWK REB, to ensure that they were understandable and accessible to potential participants.

During the recruitment process (September 2020), which occurred primarily on social media, participants who came forward to express interest in the study were asked to confirm their eligibility based on each individual inclusion criteria. I did not collect demographic data but rather allowed for themes to emerge during interviews; all of the information collected was purposeful and revealed authentically. It was important for me to allow participants to decide what was important or relevant in their experience(s), whether that included demographic information or not. Throughout analysis, subjectivity- that is, how the participants subjectively positioned themselves as mothers, romantic or sexual partners, employees, friends, or women (as only some examples)- was incorporated as a way of contextualizing their experiences. Feminist poststructuralism attends to infinite possibilities and my recruitment strategy informed potential participants that I would be asking about postpartum sexual health from a holistic perspective, which could include anything they wanted it to. Diversity and uniqueness was present in each participant's experience. For example, life experience(s) or circumstances such as previous births and access to certain health care services were relevant aspects of participants' postpartum sexual health experiences.

Sample Size

Qualitative research aims to achieve depth, rather than breadth, within understanding (Patton, 1990; Pinnegar & Daynes, 2007). As such, qualitative research often requires smaller sample sizes when compared to quantitative research (Creswell & Poth, 2018). Each interview

was incredibly rich with data and the method of analysis employed was highly layered and non-linear. Given the depth of analysis in using feminist poststructuralist discourse analysis (FPDA), as well as in considering the context, purpose, and setting of the study, eleven participants were recruited (Dukes, 1984).

Data Collection Methods

Semi-structured interviews. Individual interviews are commonly used in qualitative research because they allow for rich, in-depth data to emerge (Brown & Strega, 2005). Semi-structured interviews are consistent with a feminist approach to research because they allow for open dialogue while providing gentle structure and guidance through the use of an interview guide (Brown & Strega, 2005). Data collection involved semi-structured interviews that were approximately 45-70 minutes in length. The interviews followed a semi-structured format (See Appendix C) so as to ensure that certain topics were covered while also allowing the interviewee to lead, explain, or add thoughts throughout (Hesse-Biber & Leavy, 2007). The use of a semi-structured interview format also paralleled feminist methodology as it promoted a horizontal, rather than vertical or hierarchical, relationship between myself and the participant(s) (Brown & Strega, 2005). As a feminist researcher using FPS, interviews allowed me to hear participants' experiences in their own words, offering an unparalleled gaze into their lifeworld (DeVault & Gross, 2006) so as to illuminate subjectivity, agency, beliefs, values, and practices (Weedon, 1987).

Due to the impacts of the ongoing COVID-19 pandemic, all interviews occurred via telephone and were audio-recorded using a digital audio-recording device, in compliance with the temporary guidelines set out by the IWK Health Centre's Vice-President of Research & Innovation. The protection of participants, including from possible exposure to COVID-19, was

of utmost importance. All interviews were transcribed verbatim. As part of ensuring participant comfort, the interviews were occasionally paused at the participant's request if the participant needed to attend to their infant. A professional transcriptionist was hired by the Principal Investigator and required to sign a confidentiality agreement prior to release of the interview data (See Appendix E). For the telephone interviews, limitations existed because body language or other non-verbal cues were not able to be visualized. While this presented a limitation, verbal intonation, pace, and language were considered for telephone interviews to inform emotion, position, and context of the participant. Creswell & Poth (2018) discuss the benefits of an online format for qualitative data collection, which include time efficiency, low cost, flexibility, and the creation of a non-threatening environment so that participants may feel more at ease with discussing sensitive issues.

It was important that participants felt safe and free to share their experiences to the degree that they felt comfortable. As a researcher and interviewer, I maintained an attentive, respectful, and calm demeanor throughout the interview. In addition, I did so without conveying a sense of judgement or personal friendship towards the participant as this would have been considered inappropriate and potentially misleading. From a feminist lens, interviews were used as a way of collaboratively creating knowledge and raising consciousness (DeVault & Gross, 2006). As such, I maintained reflexive awareness of the complex relations of power, constructions, or facets of identity that may have been influential before, during, and after the interview.

Concepts of feminist poststructuralism also shaped how the interview questions were structured. For example, in two questions, I asked participants to tell me about their experiences with certain aspects of their postpartum sexual health. Using this example, I shaped questions in

a way that allowed the participants space to share their thoughts openly and authentically, without direction or structured influence. Given the context of a phone interview, it was important for me as the interviewer to prompt the participants in ways that were appropriate while conveying a genuine presence. The interview is an intervention and trust is essential to the effective use and process of in-depth interviews (Creswell & Poth, 2018). As the interviewer, I aimed to uncover participants' deep reflections, experiences, and thoughts, some of which the participants may not have previously pondered or questioned. Prior to commencement of the interview, I read a scripted introduction that provided participants with an understanding of my intention and use of a broadened definition of sexuality and sexual health. Whatever they brought forward as a part of their experience(s) of postpartum sexual health were honoured as being valid, true, and important.

Investigator field notes. Field notes aid in understanding the context and environment of the interview, which then allows for more accurate interpretation and understanding of the experiences, thoughts, values, beliefs, or emotions shared during the interviews (Lindseth & Norberg, 2004). Investigator field notes were taken during each interview and were included and analyzed as part of the data. Investigator field notes consisted of my own thoughts, reactions, observations, or feelings during each interview.

Data storage. The data consisted of electronic transcriptions of the interviews, investigator field notes, and audio-recordings of the interviews. All electronic data was stored on a password-locked laptop computer and all hard copy data was stored in a locked filing cabinet in my personal home. As soon as audio-recordings of the interviews were uploaded to my computer, the audio files were deleted from the digital recorder. Electronic data will be saved until at least two years after my final thesis defense date. However, in compliance with

Dalhousie University and IWK REB guidelines, all data will be destroyed within 5 years of my final thesis defense date (Dalhousie University, 2021). These methods of ensuring data security are congruent with the recommendations made by Creswell & Poth (2018). Myself, the professional transcriptionist, and my co-supervisors, Dr. Megan Aston and Dr. Sheri Price, were the only individuals allowed access to the raw data.

Reflexivity

Reflexivity is a critical, introspective self-reflection and process of self-awareness that is essential to feminist research (England, 1994). In considering that "research is a *process* not a product" (England, 1994, p. 82), it is important to position and analyze oneself as a researcher, for the process of knowledge production is not separate from the intellectual subject (Burawoy, Burton, Ferguson, & Foxael, 1991). Our subjectivity does influence our research and one can be sure that research, in its process and outcomes, will present uncertainty, unpredictability, and unreliability (England, 1994). This therefore requires a broadened, more flexible approach to research that recognizes the shared meanings of both the research*er* and the researche*d* as an advantage in understanding social phenomena (England, 1994). From a feminist perspective, knowledge is co-created through research, therefore participants must be given space to share their experiences and expertise freely (Brown & Strega, 2005).

As a novice researcher, it was important to position myself within my research and to be transparent to the participants who were part of this research. Prior to commencement of the interview (during the consent process), I described to participants the purpose of this study, confidentiality, risks and benefits, as well as my position as a PhD student and Registered Nurse (see Appendix A). It is my belief that sexuality is fluid throughout the lifespan and that the postpartum context presents a unique period of transition in someone's life. Moreover, I see

sexual health as important to overall health. I myself have never been pregnant or given birth, therefore I wanted to learn more about the experiences of those who have so as to answer my research question(s). This research was conducted because I could not find the answers to my question(s) alone and believed that it was important to not only know more but to know differently about sexual health in the postpartum context. It was also essential to minimize hierarchical power relations within the interview to promote comfort, genuine presence, and openness (Hesse-Biber & Leavy, 2007). For example, I may have been seen by interviewees as being in a position of expertise, privilege, or different social status, which may have been emphasized even more so due to the sensitive nature of my research focus. However, England (1994) emphasizes the importance of acknowledging the research relationship as "inherently hierarchical; this is simply part and parcel of the (conflicted) role of the researcher" (p. 86). While reflexivity cannot dissolve this issue, it can enhance our awareness of asymmetrical relationships by exposing our own partiality, perspectives, and positioning (England, 1994). As such, it was important that I entered each interview treating it as a sacred ground (Oakley, 1981), a place in which I was the learner and interviewees were the experts in their own experiences (Hesse-Biber & Leavy, 2007). As a researcher, I too have been subject to power relations, hierarchical social structures, and dominant discourses regarding pregnancy, sexuality, sexual health education, and childbirth (Hesse-Biber & Leavy, 2007; Oakley, 1981). As previously described, I collected field notes during and after the interview process to account for my judgments, thoughts, observations, or biases.

Data Analysis

This study utilized feminist poststructuralist discourse analysis (FPDA). Aston's FPDA model (Aston, 2016) was used to guide the process of discourse analysis. While the model

provided a guide to performing discourse analysis, it was important to also understand discourse analysis as a layered and non-linear process (Aston, 2016). The process included first identifying beliefs, values, and practices present in the data, and subsequently identifying discourses, relations of power, agency, and subjectivity (Aston, 2016). Discourses may be social, personal, or institutional and are often represented in terms of dichotomizing, dominant, repressed, or invisible discourses, though this is greatly influenced by context (Aston, 2016). Relations of power are fluid and ever-changing, yet ever-present. The purpose of identifying and applying relations of power was to identify the 'taken for granted' so as to challenge the status quo. I analyzed the first interview transcript with my co-supervisors to ensure that interview questions did not need to be adjusted and to ensure there was consensus. From there, ongoing meetings occurred when necessary to discuss emerging themes, issues, questions, or particular findings. I also used personal notes and memos (not included as part of the data and separate from investigator field notes) to gather my initial thoughts following interviews in order to improve subsequent interviews and to maintain detail within my analysis. Detail as well as expert guidance from my committee and co-supervisors ensured trustworthiness of the end findings (Ryan, Coughlin, & Cronin, 2007). Analysis was performed using various tools in Microsoft Word, as this method was more suited to discourse analysis over other qualitative coding software, such as NVivo. In the following section, I will provide an overview of the key concepts and process used as part of FPDA.

Key concepts and process within feminist poststructuralist discourse analysis.

Identifying important issues. When performing FPDA, Aston recommends first teasing out the key issues for the participant that are related to the research question (2016). For those analyzing, this process involves reading through the text and independently naming issues "as

they see it" (Aston, 2016, p. 2262). It can also be useful to read an interview transcript, which was in the form of text/data in this study, alone first and then come together with others to discuss analysis, named issues, specific participant quotations, thoughts, or questions (Aston, 2016). Johnstone describes different ways of approaching a text, many of which are based on linguistic research practices, including the organization of sentences or the use of language conjunctions, slang, rhetoric, sarcasm, humor, contextualization cues, pauses or silence, active or passive voice, and the like (2018). Learning to notice these verbal subtleties when using FPDA also means de-familiarizing oneself with their own knowledge or experience of the issues being named (Johnstone, 2018). This does not, by any account, mean attempting objectivity or neutrality when performing analysis, but rather "learning and imagining different worlds and alternative ways of being, thinking, and talking" (Johnstone, 2018, p. 72). For example, someone performing analysis may question setting, context, or language (Johnstone, 2018) to identify personal biases or standpoints while also illuminating the issues present within each participant's experience(s). Regardless of the issues named, it is important not to necessarily have a goal of coding the research or recognizing common patterns in the data (Aston, 2016). Rather, FPDA aims to include and honor unique experiences and diversity within the data (Aston, 2016), which in my case will be postpartum individuals' experiences of their own postpartum sexual health and sexuality. Naming the issues can bring about many different perspectives from within the data and, at this early stage of analysis, it is essential to keep the debate open and to have dialogue with other analysts (if applicable) so as not to hastily commit oneself to themes or common threads, which may or may not be present within the data (Aston, 2016).

Applying beliefs, values, & practices. It is by first identifying beliefs, values, and practices that issues present may begin to be deconstructed (Aston, 2016). Focusing on the

participants' beliefs allows researchers and analysts to engage more deeply with the perspectives being expressed and to, in some way, set aside their own worldview or beliefs (Aston, 2016). This is also where word choice, adjectives, metaphors, similes, or other more detailed components of language use may be examined and used to guide the identification of underlying values and beliefs (Johnstone, 2018). Firstly, it is important to discern the difference between values and beliefs. Beliefs are personal opinions and may become evident when, for example, a participant describes an event or situation (Aston, 2016). Values are broader in that they influence beliefs and are a general perspective of what is important, how, and why (Aston, 2016). Values then translate into practice (Aston, 2016). In the context of postpartum sexual health, it is in certain moments or circumstances that an internal dialogue or 'tug of war' may occur and therefore greatly illuminate what is "wrong with the status quo" (Johnstone, 2018, p. 25). Through this component of FPDA, researchers must critically examine how and why people choose certain courses of action, or inaction, and make decisions regarding their practices based on these tensions (Aston, 2016). For example, postpartum individuals may have different ways of negotiating sexual interactions, sharing their sexuality with others, or engaging in sexual intercourse based on conflicting internal or external values. These values may be reflected in many facets of sexual health and sexuality postpartum, some of which may include beliefs and values surrounding emotional or physical healing, maintaining relationships with others, role as a mother/parent/wife/partner/friend, use and perception of their own body, and postpartum wellbeing in general.

Social & institutional discourses. "Discourse is both shaped by and helps to shape the human lifeworld, or the world as we experience it" (Johnstone, 2018, p. 35). As FPDA moves deeper into the taken for granted and the invisible, the underlying narratives that dictate how

postpartum individuals should live their lives are met with overlapping discourses that are multiply sourced and sustained. Discourse is emerging from all angles: being a caregiver, a woman, a sexual being, and other facets of identity that may be visible or invisible are met with discourses that decide what is normal and expected of the person as a newly postpartum individual. Both social and institutional discourse(s) are intertwined and influential in a postpartum individual's experience, be it with regards to their sexual health, mental health, parenting practices (if applicable), or medical self-surveillance. These experiences of health are often measured as 'milestones' or accomplishments that indicate one's success in maintaining societal ideals during the postpartum period (Ollivier et al., 2019). Discourses may be uncovered through careful attention to a participant's words and, most especially, their circumstances (Aston, 2016).

Institutional discourse in the area of postpartum sexual health is largely governed by medical institutions and the dominant discourses that are produced and influenced by medical expertise, as previously discussed. Although sexual health is medicalized in different ways than postpartum sexual health, these discourses may also be competing, despite coming from the same source, such as the medical profession. While people may not be able to name discourse, it is something that shapes all of our lives and it cannot be escaped (Johnstone, 2018). It is in this component of FPDA that my personal position and experiences will be most at the forefront because I will be directly drawing upon my own knowledge, but also that of others, including the study participants and my co-supervisors. The discourses that are available to some may not necessarily be available to others (Foucault, 1980), and this is what will both enable and hinder the FPDA process in teasing out the institutional and social discourses present within participant experiences.

Responding to relations of power. In conjunction with identifying social and institutional discourse(s), examining relations of power focuses on looking at how participants *respond* to discourse (Aston, 2016). It is in this part of FPDA that the context and circumstances of the participant again come heavily into play, situating them in relation to other discourses which may be useful, competing, or harmful (Aston, 2016). Relations of power are complex and always shifting, though the focus of most forms of discourse analysis tends to be on how it creates experiences, events, conditions, environments, or situations that are oppressive (Johnstone, 2018). More specifically, these instances often create a disconnect or disagreement between personal needs and the needs of others (Fairclough & Wodak, 1997). "Power has to do with the respects in which relationships are asymmetrical, with some participants more able than others to shape what occurs or how it is interpreted" (Johnstone, 2018, p. 145). As such, if there were no power, human interaction would not be possible (Johnstone, 2018). Each situation presents new possibilities for relations of power in that postpartum individuals may negotiate, express, or view their sexual health differently depending on who they are interacting with, the environment, or the context (as only some examples)- and there are also layers to this. Power is everywhere, yet comes from nowhere (Foucault, 1980), and the relations of power underlying participant experiences will uncover opportunities for change by identifying where and how relations of power affect the sexual health of postpartum individuals.

Subjectivity & agency. Considering that "all discourse is both a reaction to the world and an intervention in it" (Johnstone, 2018, p. 76), the overlap or tension between different discourses that are taken up by a single subject require subjectivity and agency. Subjectivity, in short, may be thought of as how someone positions themselves in the world and reflects on such position(s) (Weedon, 1987). Agency is how one expresses their subject position(s) and/or takes

action (Aston, 2016). In other words, agency focuses on how participants choose to negotiate certain discourses; their beliefs and values come forth and demonstrate how they guide their practices and negotiate different meanings (Aston, 2016). In applying these feminist poststructuralist concepts to FPDA, agency does not necessarily mean an overt resistance or challenge of authority (Aston, 2016). It is important to note that there is no better, more correct, or 'braver' way to enact agency. Johnstone describes agency as "an individual's ebbing and flowing ability to shape the activity at hand" (2018, p. 145), and the way that ability is enacted can be highly variant depending on the person, or perhaps even the circumstance, desired audience, and outcome. When performing FPDA, Aston recommends asking participants how something or a particular situation made them feel as a way of uncovering the individual's position and *choice* within agency (2016).

Rigour

Trustworthiness. Trustworthiness of the data was ensured by providing participants the opportunity to discuss their experiences, thoughts, or feelings during the interviews without prior prompting or focus on certain topics, such as the influence of gender identity, sexual orientation, or sexual intercourse. The research was rigorous and did not triangulate or use member-checking; FPS trusts that the words of the participants are truthful and do not need to be checked by any other means. The data was analyzed by myself for language, discourse, and relations of power (Hesse-Biber & Leavy, 2007). Trustworthiness of the analysis process was ensured through regular, ongoing consultation with my co-supervisors and thesis committee members.

Memos were used during and after the interview to ensure credibility of the collected data (Ryan et al., 2007). In relation to procedural rigour, as recommended by Ryan et al. (2007), I ensured precise data collection through complete audio-recorded data and discourse analysis as a

reflective component to reduce misinterpretation or personal bias. Dependability was ensured by detailing procedures and rationale for decisions regarding analysis, exclusion or inclusion criteria, or other procedural issues as part of my final thesis (Ryan et al., 2007). Throughout the research process, I was guided by two co-supervisors to ensure integrity of the data and maintenance of rigour. The findings of the study are transferable to a variety of health care contexts related to postpartum health or care, whether that be in the community or in acute care settings (Ryan et al., 2007). In combining credibility, dependability, and transferability, confirmability was achieved as a way to prove that findings correlate well with the data (Ryan et al., 2007). Lastly, the concept of goodness was addressed through my implementation of a feminist poststructuralist methodology, which aims to achieve equity and social justice, in order to deepen analysis and subsequent deconstruction (Ryan et al., 2007; Scott, 1988).

Sex & Gender Considerations

This study sought to explore the sexual health of postpartum individuals and for that reason, sex and gender were key considerations throughout the design, analysis, and implementation stages. In using the language of 'postpartum individuals', my research sample was inclusive of a spectrum of gender identities and abided by the guidelines set out by the Canadian Institutes of Health Research (2018). My research questions centered the experiences of postpartum individuals as valid, important, and true. Feminist poststructuralism as my methodology was, in and of itself, emancipatory and voicing to the current invisibility of postpartum sexual health as it aimed to uncover hidden or invisible experiences through examining relations of power. This methodology and the use of discourse analysis was ideal for this project as they enhanced the dialogue surrounding postpartum sexual health while also including a diverse range of experiences, thoughts, or feelings. Discourse analysis allowed me to

more deeply examine the relations of power within participants' experiences to further inform how health care services may not only include but promote sexual health during the postpartum period.

Ethical Considerations

Ethics approval was received from the IWK Health Centre's Research Ethics Board in August 2020 and renewed as necessary. Informed, written consent was obtained prior to data collection using a signed form (See Appendix A & B). Participants were informed of the risks and benefits of participating in the study, purpose of the study, and contact information of the Principal Investigator (See Appendix A). I sought Research Ethics Board approval from the IWK Health Centre because I wished to recruit through the institution. Consent forms were sent using email. During the informed consent process, participants were reminded of their right to withdraw from the study at any time, without reason, up to ten days following the interview. However, no participants withdrew from the study. As a gesture of appreciation and thanks for the participants' time and energy, they were provided a $25 Amazon or Nurtured e-gift card upon receipt of the signed consent form (Creswell & Poth, 2018). All attempts to ensure confidentiality were made, which included removing all identifying information from interview transcripts. Given that participants were required to sign a consent form and provided their name in doing so, anonymity was not possible in this study. Participants were made aware that direct quotes may be used in data reporting, dissertation writing, or in scholarly publications or presentations resulting from this study, though no identifying information would be shared at any time. Prior to each interview, participants were asked to provide a pseudonym of their choice to be used in all data reporting.

Risks & benefits. Benefits to participating in the study included a possible increased awareness of one's thoughts or feelings about postpartum sexual health or the postpartum experience. In addition, it may have provided a means for discussion, reflection, and sharing that some may have found useful or informally therapeutic. However, given the sensitive nature of the topic, there existed risks to participating in the study. While there were no physical risks to participants, some became emotional due to recall of certain events or thoughts (Creswell & Poth, 2018). Participants were asked to share very personal thoughts and experiences and sexual health is generally a very private topic. It was therefore of utmost importance that I ensured that no personal, identifying information was collected or used and that their participation in the study remained completely confidential. As the Principal Investigator, I was the only person who knew participants' names through communication with them and in conducting interviews. Given that data collection centered upon sexual health experiences, some issues or traumatic experiences (i.e., traumatic birthing experience) arose during the interviews. Risks related to recall of these events may have included emotional distress or re-traumatization in speaking about sensitive issues or negative, harmful experiences. While there was no way of predicting what participants chose to disclose or to bring forward during the interviews, measures for a psychologically safe environment were implemented. As part of this, I provided a comfortable and non-judgmental presence during interviews and utilized steps for mental health first aid when required, which included: using a calm voice when speaking to the person; asking them to focus on something they can hear, feel, or see; and encouraging them to take slow, deep breaths. As a way of preventing re-traumatization, participants were able to refuse to answer questions or probes and/or to answer only to the extent that they were comfortable. They were reminded of this immediately prior to commencement of the interview (See Appendix C).

Summary

This study employed a feminist poststructuralist methodology to understand the experiences of postpartum sexual health among Nova Scotians who had recently given birth. Participants were recruited from across the province in late August and early September 2020. Participants were interviewed once in either September or October 2020 using a semi-structured format. Feminist poststructuralist discourse analysis was used to analyze the interview data between October and December 2020, though analysis and writing occurred simultaneously until July 2021.

CHAPTER 5: RENEGOTIATING THE POSTPARTUM BODY: IDENTITY, IMAGE, MEANING, & FUNCTION

The findings from this study will be divided into three separate chapters (Chapter 5, 6, and 7). Organization and structure of the chapters shifted as the writing process unfolded over several months. As outlined in Chapter 4, there was no demographic data collected. Rather, demographic information was allowed to emerge authentically during the interviews. At the time of the interview, all participants met the inclusion criteria. The eleven participants lived across Nova Scotia in both urban and rural settings. For nine out of the eleven participants, this was their first postpartum experience.

When asked about what was most important to them with respect to their sexual health after birth, many participants began with the body. Specifically, how they felt about and experienced their bodies. Some participants expressed statements such as "my body just isn't my body" (Elsie) and felt that the relationship they had with their bodies had changed. That is, how they felt in their bodies as well as how they perceived, defined, explored, and related to their bodies was different after birth. Physical changes such as weight gain, stretch marks, the function(s) of certain body parts, and breast shape/density influenced how participants viewed their bodies and, in turn, their sexuality as well. Participants' negotiation of feelings and meaning associated with their postpartum bodies was influenced by personal, social and institutional discourses. The body was important in shaping how participants experienced their sexuality and sexual health after birth because of how they used their bodies to express their sexuality and sexual identity. Although sexual health may include varying physical, emotional, or relational aspects, participants focused on the body as something that had been significant to their sexual health before birth. Their stories also focused on how changes to their body affected their sexual

health. In what follows, the varying experiences related to participants' relationship with their bodies and postpartum sexual health will be detailed. The findings in this chapter will be presented within the following two sub-themes: 1) Renegotiating Identity, and 2) Negotiating Change: A New Meaning of the Body and Sexuality.

Renegotiating Identity

For participants, it was about first "reclaiming" their physical body to then redefine their identity and sexuality, though this process was not always linear or easy. Initially, some participants resisted their body's changes. Many perceived their postpartum body as a changed body which, in turn, influenced their personal and sexual identity. The body in terms of how it was meaningful to their identity and their subjectivity as sexual beings were intricately connected. That is, renegotiating identity included subjective positioning as a new mother and as a "sexual being"; their "title of mom" was part of how they viewed their sexuality. Becoming a mother/parent can be a significant life event for many, though some postpartum individuals negotiated the experiences surrounding both sexuality and motherhood differently. For Maggie, she viewed her identity as a mother as being complementary to her self-identity prior to pregnancy, something that exemplified subjectivity. She was not a new person; instead, 'mother' was simply a role that she now included as part of her identity. Her quote was as follows:

> Well I think society as a whole likes to reduce people who are mothers to that title of mom which has always really irritated me. […] Because I am a mom that's not the only thing that I am and I think keeping that in the back of my head has helped me a lot 'cause I don't, like I've had a few people say oh like has your identity completely shifted? I don't think that it has, I've added mom to all the other things that I see myself as. And I think thinking about it that way has helped [my sexual health] a lot just because I think

> again just like people don't want to talk about sex during pregnancy, people don't want to talk about moms having sex because for some reason that's not good. Even though MILF is its own porn category. It's weird right?

Maggie utilized subjectivity to define herself not solely as a mother and instead recognized that she could have a layered identity that included being both a mother and a sexual being. Maggie referred to a discourse about motherhood by stating that "a few people say oh like has your identity completely shifted?" and by referring to how "society as a whole likes to reduce people who are mothers to that title of mom". This social discourse positions motherhood as something that involves a major identity shift and is often socially defined as a singular "title" rather than a complex component of one's postpartum identity. This discourse reflects a social construction of motherhood and mothering as something that is all-consuming, therefore requiring mothers to (at least partially) relinquish their pre-parenthood roles or identities and prioritize their role as a mother/parent. It is not to say that this is negative as some people may find the "title" of mother to be a source of pride and fulfillment. In stating that she "added mom to all the other things" that she saw "[her]self as", Maggie shifted the relation of power and challenged this social discourse by defining her self-identity as something that could encompass many different "title[s]". Interestingly, Maggie's experience highlights that there also exists another, slightly different discourse that persists past the postpartum period and positions mothers as eternal, selfless givers, always innocent and pure, and therefore signifies them as non-sexual beings (Damaske, 2013; T. Miller, 2007). Maggie revealed this social discourse in stating that "people don't want to talk about moms having sex because for some reason that's not good" and referred specifically to the social taboo and construction of mothers' sexual identities or sexuality. In contrast, sexuality and sex has long been positioned as dirty, primal, selfish, 'bad' or 'naughty',

risky, and secretive (Foucault, 1978), therefore opposing the socially-constructed maternal identity which simultaneously signifies mothers and maternal bodies as non-sexual beings. Maggie pointed out how this social discourse that positions the maternal identity as non-sexual or desexualized is upheld within society through people not "want[ing] to talk about moms having sex". There is a socially-upheld definition surrounding mothers and motherhood that expects them to take up a nurturing identity and to simultaneously mask their sexual identity (Friedman, Weinberg, & Pines, 1998). Mothers as sexual or sexy is therefore positioned as something that is "bad" or dirty within society (Montemurro & Siefken, 2012) and therefore appropriate only within 'secretive', 'under the radar' mediums such as pornography, as Maggie mentioned. Maggie's experience exemplified how identity as a mother was not necessarily absolute, but rather had different meanings in relation to how it influenced overall self-identity and sexuality.

The participants not only had to negotiate and redefine their sexuality and subjectivity since becoming mothers/parents, but they were also required to balance other new or changed roles. Samantha underwent a process of trying to "figure out" her subjectivity after birth, believing that her pre-pregnancy identity was "gone". This process of 'figuring out' reflected power and agency. Postpartum individuals in this study navigated their roles differently and the process of renegotiating subjective positioning as a sexual being was challenging at times. Samantha stated:

> [I'm] just sort of trying to figure out who I am after having this, now that I'm a mother, it's sort of like makes me almost feel sad because the person that I was before she's gone, so I have to figure out who am I now, I have no idea and trying to fit that in into looking after [my baby], keeping my relationship with my husband, wondering what I'm going to

> do about my work. So it just feels like there's a lot of pressure on me to sort of be this perfect person and I'm not, so that makes me feel like I'm failing. […] I just feel like I'm failing in all aspects of being a woman, being a sexual being, and being a wife.

It was a difficult balance for Samantha with the shift in her identity postpartum because she felt as though she had to let go of her 'old self' in order to find meaning in her identity after birth, as evidenced when she said that she felt "sad because the person that I was before she's gone, so I have to figure out who am I now". In stating that "the person that I was before she's gone", we can see how Samantha's beliefs reflected the discourse that frames motherhood as a significant identity shift- one that is vastly different from pre-pregnancy identity. Her idea of being "this perfect person" caused her to feel "pressure" and subjectively position herself as a "failure". Samantha's feeling of being a "failure" was associated with how she negotiated the meaning of her postpartum identity through personal and social discourse(s). She felt pressure to be a "perfect person" as she navigated the discourse that perpetuated the belief that postpartum individuals and mothers must be able to 'do it all and be it all' (Meeussen & Van Laar, 2018; Newman & Henderson, 2014), as evidenced by the varied concerns she had surrounding childcare, her relationship with her partner, and her employment. Samantha's experience points to the complex and interwoven aspects of postpartum identity, many of which do not solely include the label of 'mother'. Here, Samantha described how "all aspects of being a woman, being a sexual being, and being a wife" were important to her, though she was experiencing a significant change in her life that caused her to redefine and re-evaluate what those specific identities meant to her. Samantha felt a loss of control in feeling like she was "failing", something that was common for other postpartum individuals in this study as well, especially given the significant life event that they had all just experienced in birthing a baby. Being and

becoming a mother/parent was not an isolated event, but rather a new experience that shifted other aspects of both personal and social identities and, in turn, subjectivity. The subjectivity demonstrated by both Maggie and Samantha shows us how participants created different meanings about themselves.

Negotiating Change: A New Meaning of the Body and Sexuality

With regards to body image and meaning of the body, participants' emotions, beliefs, perspectives, and values changed significantly after birth. All of the participants experienced a transition to a different way of understanding their bodies and therefore their sexuality. For example, the parts of their body that held a sexual meaning prior to pregnancy or birth were redefined and viewed by participants in both sexual and non-sexual ways. Oftentimes, there existed binaries related to their bodies that influenced how they chose to ascribe meaning to certain body parts, such as the breasts or vulva.

When participants were asked, "How do you feel connected or disconnected from your sexuality at this moment?", many answered by saying that their body was an important factor. Oftentimes, participants described how they felt disconnected from both their sexuality and their body because they believed it had changed and that it was something they were trying to once again "recognize". Some participants described feeling a general disconnect with their bodies, beginning in pregnancy and lasting through to the postpartum period. "I don't really recognize myself" (Elsie) was a sentiment echoed by several participants and represented a significant shift in how their physical body reflected their postpartum identity, as well as their identity as a sexual being. Elsie illustrated this further in stating:

> I feel yeah the disconnect is more with me and definitely in regard to I guess body image, cause as I said I'm holding on to a lot of weight, so I'm holding on to about 25 pounds

> compared to what I looked like pre-pregnancy and I don't expect to return to what I looked like before, like that isn't a realistic goal, but it's definitely one where when I look in the mirror I have stretch marks and I did not have stretch marks before and then I went from like a B cup to like a G, H cup so like [my breasts are] huge and they hurt. So in terms of like yeah I just have a lot of back pain and my arms are swollen because I have fat that's there for the breast milk, so it's just my body just doesn't look right and I don't like what my body looks like.

If we look carefully at the words Elsie used and how her experience made her feel, we should begin with the phrase "my body just doesn't look right". 'Looking right' could be understood as comparing oneself to a social construct regarding women's bodies and in this instance, how one should look both in general and after having a baby. It is possible that the social discourse that frames postpartum weight gain as something that should be reversed as soon as possible was influential in her experience. However, the sentiment that she didn't "like what [her] body look[ed] like" could have been due to many different reasons. For example, Elsie shared how she was experiencing back pain and "hurt" in her breasts, which may have contributed to her dislike of her current body and its appearance. "Stretch marks" and "fat" on her arms represented specific changes that she experienced postpartum that made her feel disconnected from her sexuality and sexual health. The sentiment that her body did not "look right" may have been due to the general sense that her body had changed and did not look the same way it did prior to pregnancy. In other words, her body did not look like her 'normal' and that is what made her feel disconnected from her sexuality at the time of the interview.

When looking at how Elsie felt disconnected from her sexuality, and specifically her focus on body image, it is important to also connect her experience to other participants. In

responding to the same question, Katie described how she felt "grace for the fact that my body has changed" and described how she wanted to "get back to the way it was before":

> I guess [I feel] disconnected in a sense of like I still in the back of my head there is of course grace for the fact that my body has changed but I can't let it go, I'm just a stubborn person like I want to get back to the way it was before so that I can know that I have that absolute confidence right now where it's more of a grace confidence, a worth confidence if that makes sense, I'm confident, I make myself feel confident because I know what I did, what I went through is like a huge thing of everybody's body changes and realistically compared to some women I'm doing great, so I'm trying to stay grounded in that sense, but I want to get back to that more of a natural confidence towards feeling sexy again and not just kind of talking myself to where I want it to be because like that natural way when you're young and you're able to wear whatever you want to wear, eat whatever you want to eat, you don't really think about it and you just have this free confidence if that makes sense, instead of this force confidence of just accepting where I'm at.

Katie used language such as "absolute confidence", "sexy", "free confidence", and "natural confidence" when discussing how she wanted to feel. For her, "force confidence" was a key part of how she felt disconnected from her sexuality at that moment. She subjectively positioned herself as a "stubborn person" and asserted her agency in being able to "stay grounded" as she negotiated the meaning of body's "changes". However, she also discussed how she needed to "accept[] where I'm at"; it was not that she did not feel confident, but rather her definition of confidence changed after birth in the sense that it was now coming from a place of "grace" rather than being "absolute" or "natural". "Grace confidence" shows us how she chose to view and

define her body image and changes. Katie revealed a social discourse that defines confidence surrounding the body as something that might come from "when you're young and you're able to wear whatever you want to wear, eat whatever you want to eat, you don't really think about it". This may be informed by social ideals surrounding beauty, which may include weight bias. However, Katie chose to take up new meaning in confidence surrounding "the fact that [her] body changed" by "talking to [her]self" and choosing to instead position confidence as a "worth confidence" that acknowledged what her body had accomplished during pregnancy and birth. "Worth" shows us how she specifically defined her postpartum confidence in order to also redefine her sexuality.

In trying to regain her sense of connection with her sexual identity and get her "body back", Anne described how it was a journey that would "take some time":

> I definitely feel so very different than I did in terms of my own sexuality but I'm trying to, trying to come back to some self-care stuff. So just I'm really taking care of myself, again trying to get a bit more exercise in, trying to be more mindful of like time and my head space 'cause you don't feel like you get a lot of that. I definitely still feel disconnected is essentially the answer. That will take some time, I feel like I didn't get my head around things again until after, it was probably the end of my mat leave the last time, my son was turning one and I was just feeling I get my body back and I can you know enjoy the foods I wanted at the time, you know what I mean and I'm in the same boat this time so I feel disconnected is the answer. I feel very disconnected at the moment. But again I'm, I wasn't expecting this immediate return to being this sexual being of post-partum, I wasn't expecting that but I definitely feel disconnected at the moment.

For Anne, reconnecting with her sexuality involved the body as well as other aspects of "self-care", including exercise and "head space". However, the move from feeling "disconnected" to reconnected with her body, as well as the sense of feeling like a "sexual being", was something she believed would "take some time". In shaping her beliefs this way, Anne challenged the discourse that requires postpartum individuals to get their "body back" as soon as possible. Instead, she stated that "I wasn't expecting this immediate return to being this sexual being of postpartum" and positioned her "return" as a journey rather than a goal. In stating that she "wasn't expecting", she utilized power to shift the meaning of regaining a sense of connectedness with oneself after birth. This might be seen as a moment where she was aware of certain social expectations and questioned them. For her, it did not necessarily mean losing weight like it did for Elsie, but rather was about how she felt and how she was able to "take care of" herself. In connecting participant stories, both Katie and Anne reference being able to "enjoy the foods I want" as something that they believed was important to them, though were not able to do at the time of the interviews. Eating what they want may be interpreted as a behaviour that reflects a feeling of confidence in their bodies. The body, specifically its appearance, was viewed as an important component of postpartum sexuality for many participants. Confidence was defined differently, though feelings of attractiveness were what made the body's tie to sexuality significant for all of the participants in this study.

Samantha detailed how her "new body" influenced her feelings of attractiveness and desire for intimacy, specifically in relation to some of the physical changes she experienced postpartum:

> I just sort of was trying to come to terms with the fact that okay this is my new body now and it was, so just like a lot of trying to not only deal with having a new baby but also the

> changes in my body so it was sort of like I didn't feel like myself. I didn't feel very attractive, I didn't feel like, I don't know if I'm getting it across correctly, trying to understand, so for me it just felt weird. Like having this incision and all of a sudden like my breasts were leaking and I'm just like what is going on and none of that made me feel like yes I would love to be intimate with you.

Physical indicators of pregnancy, birth, or breastfeeding for Samantha were perceived as "weird" and negatively impacted her ability to "feel like [her]self". In stating that she was "trying to understand […] what is going on", we can see how she felt confused about the "changes" to her body. The confusion related to her "new body" was influential for Samantha and resulted in her lack of desire to be intimate with her partner. For Samantha, it was also important that she felt "attractive" and "like [her]self" before being sexually intimate with her partner. Samantha provided further detail in the following statement:

> I didn't like the way that it looked so I thought maybe, he said he didn't care and he said whatever it's fine, and I said I just don't like it and also just breastfeeding was like okay I don't want you to come near me that way too, so it was sort of like I had two areas that were key to having any type of physical contact that I was just like no thank you, like don't come near me cause I have milk coming out of my boobs, I have like this incision above my lady parts, no none of it made me feel like attractive in any way and I just didn't want him near me.

She valued feeling "attractive", though she did not like how she looked. Her belief that her body and her postpartum physical changes were not attractive may have been the result of her uptake of a dominant social discourse that desexualizes the postpartum body, specifically the breasts. However, it could have also been that the body parts that she associated with sexuality now had a

new purpose- for example, the "milk coming out of my boobs" was a change that she experienced to the function and purpose of her breasts. It was difficult for her to negotiate these changes, specifically her breasts that were producing milk and the incision above her vulva, because her body's changes also felt very "new", as we saw in her previous quote. She made a choice not to have sexual contact with her partner and demonstrated agency in choosing how she wanted to share her body with others, either sexually or through breastfeeding her child. Samantha identified her breasts and her incision as inhibitors to her sexual desire, as evidenced by her stating that "I was just like no thank you, like don't come near me 'cause I have milk coming out of my boobs, I have like this incision above my lady parts". In addition, Samantha believed certain parts of her body, specifically her breasts and "lady parts", to be "key" for physical sexual interaction, pointing to the social construction of these body parts as primarily serving a sexual function outside of pregnancy, birth, and the postpartum period. While not all postpartum individuals will produce milk or choose to nurse their babies, breasts are often positioned as either sexual or for feeding/nurturing, which is an example of a socially-constructed binary (Stearns, 1999). For Samantha, it was important for her to "feel […] attractive" and this language is important to consider when exploring how she and others felt about and described their bodies in relation to sexuality.

The meaning of the postpartum body and how it was tied to one's sexual identity and sexuality was highly individual and evolved throughout the postpartum period. Overall, body image was important for the participants because sexuality was tied to meaning of the body and perceptions of sexual attractiveness. For example, Maggie chose to find positive meaning within her postpartum body's function(s) and what she had accomplished with her body, which in turn improved her sexual "confidence" and self-perception:

> For me it was almost like a boost, it was like kind of confidence which made me feel a little bit sexy, not that I wanted to have sex immediately after giving birth, but it was kind of like oh my body is a really cool thing and that's kind of awesome, it's a lot stronger than I thought it was even though now I'm doing kind of all the recovery work.

Maggie believed that her body was "stronger" and felt proud of what her body had accomplished throughout pregnancy and birthing. She chose to celebrate her body in a way that she had not before, embracing its changes by feeling "confidence" and ascribing meaning to her body as a "really cool thing". For her, confidence and feeling "sexy" were connected. Her statement that her body is "stronger than I thought" exemplified her belief that birth and the postpartum period require strength, though also demonstrated her awareness of how pregnancy and birthing may be socially viewed as processes that weaken or damage the body, as indicated by her statement that "recovery work" was needed after she gave birth. Instead of viewing her body this way, she chose to describe her body as "stronger than [she] thought", indicating how she shifted her view of her body. Maggie utilized power by choosing to position her body differently and valued her body's ability to grow and nurture a baby, focusing on its abilities and functions as "sexy" and "awesome". For her, strength was synonymous with feeling "sexy" and this is an example of how body image and "confidence" were more equated with strength than with changes. However, no matter the language that participants chose to use, we can see how confidence and feelings of attractiveness were influential in shaping how participants experienced their bodies and therefore their sexuality postpartum. Overall, the meaning of the body, sexuality, and perceptions of sexual attractiveness were intricately tied. Participants not only viewed their bodies as having "changed" but in turn viewed their sexuality as being affected by those changes.

We saw how certain social discourses and socially-constructed binaries influenced if and how participants felt “confident”, “stronger”, and “sexually attractive”.

Some participants believed that the function and purpose of their bodies had changed significantly during pregnancy and after birth. Their bodies were no longer solely for themselves; rather, they viewed their bodies as being for their baby in a nurturing way that provided nutrition, touch, care, and affection. Some participants also expressed surprise at how intense and consuming the demand on their bodies was after birth, specifically with regards to caring for their baby. Elsie explained how she still felt autonomy over her sexual body, though felt as though it was important for her to prioritize sharing her body with her baby, specifically for feeding:

> It just feels like my body right now is for my daughter rather than for my husband. Like I never felt, I’m definitely not one of the women like oh I have to service my man like I’m not, yeah that’s not who I am. I’m definitely one where if I want to have sex then I will have sex, if he wants to have sex and I don’t like I’m not doing that, it’s my body I can do what I want with it. So it’s just one where it kind of feels like right now instead of me being able to use my body for what I want to use it for I’m like the milk source, I’m breastfeeding. […] So with any luck I’ll be able to start using my body for what I want to use it for instead of just like I said being a cow.

In this quote, we can see how Elsie thought about if and how she shared her body with others and made a choice about what she wanted to do. She felt that her body could not be “for” her husband and her baby at the same time and said that her decision “felt right”. Elsie negotiated the balance between breastfeeding and her own sexual needs, something that took time and was difficult to navigate, as evidenced by her statement that “with any luck” she might be able to

shift how she uses, defines, and positions her body to acknowledge her sexual needs as well as her desire to breastfeed her baby. She recognized two different discourses regarding women's bodies by stating that she did not believe that her body was "for [her] husband", but rather "for [her] baby". This statement shows us how postpartum bodies may be constructed through binary relations that position them as either for maternal purposes or sexual purposes. Western constructions of language and subjectivities are often binary (Foucault, 1978); however, Elsie pointed out that she negotiated the two meanings that her body held and, while she felt she had to choose one at this time, the way that she negotiated what she felt and believed about her body demonstrated the complexities of how participants felt about their postpartum bodies. Her statement "I'm definitely not one of the women like oh I have to service my man" is referring to a historical discourse (which she is resisting) about control of women's bodies by men in a patriarchal society, specifically for sexual purposes. She challenged this social belief through her agency when she said "it's my body I can do what I want with it". Elsie clearly demonstrated agency by rejecting social constructions of her sexual body and its purpose as being for the service of others. This is an excellent example of agency because it shows us how Elsie came to choose how she felt about her body and how it was meaningful. However, while she overtly challenged the construction of the female body as being purposeful in its ability to "service" the sexual needs of others, specifically her husband, she at the same time interpreted her postpartum body as being purposeful and meaningful in its ability to be "for [her] baby". She negotiated the relations of power between the discourses by declaring her beliefs based on these two constructions of her body and, instead of adopting a binary definition of her body, tried to find overlap within those binary definitions so that she could use her body how she "want[ed]".

There were also other binaries surrounding the body that were apparent in participant experiences. For example, how participants experienced the binary that shapes the breasts as nurturing/maternal versus sexual was complex. Mary explained how sometimes needing "space" was not necessarily influenced by a binary meaning of her breasts, but rather the feeling that she needed to care for herself too:

> So sometimes when like it's been kind of a demanding day with the kids or they've been kind of on me a lot I don't really want my husband to touch me and especially my boobs where you know I'm breastfeeding and there's a baby on them a lot, I just kind of feel like I need a little bit of space to breathe sometimes.

Mary described how her postpartum body could encompass many different roles and functions throughout the "demanding day". Her breasts were being used for "breastfeeding […] a lot" and so when she was able to have "space to breathe", she made the choice to take that space and articulated that she did not want her "husband to touch [her]". It is important to consider Mary's experience in the greater context of how the body is tied to sexuality and sexual health. Like Elsie, she made choices about if and how her breasts were touched as well as how she wanted to use her body, exemplifying agency. She believed that the primary function of her breasts at that time were to feed her baby though this did not mean that she necessarily had to reject her breasts as serving a sexual purpose as well. Instead, she negotiated relations of power to create her own definition of how she wanted to share her body and have others interact with her body, specifically her breasts.

While breasts and/or breastfeeding was one component of body function(s) that changed after birth, another participant, Caitlin, discussed how her perception of the purpose of her "vagina" changed after birth:

> I almost felt like my vagina wasn't something sexualized at all. Like to me it was just kind of like after giving birth it was like this is like, just like a baby maker or something, it wasn't like something to like have pleasure from, it was like solely for a reason and so, and then you know for weeks it hurt, it wasn't, cause I did have a vaginal birth so it wasn't like I guess I just didn't think of it as a sexual thing in the slightest and so I think for me it just took a while for me to stop seeing my vagina as like okay that's what delivered the baby and that like okay no it actually is something that I can have pleasure and those kinds of things so I think that was a big thing for me.

Caitlin's view of her vagina, something she had known to be a source of sexual pleasure prior to pregnancy, became something that "wasn't sexualized at all" after birth. For her to return to viewing her vulva/vagina in a sexual way, she had to "stop" seeing it as "what delivered the baby" and re-define its function as one that could involve "pleasure and those kinds of things". She demonstrated agency and power in choosing to view her vagina as part of her sexual body again, allowing her to experience sexual pleasure. This shows us that the body may hold different meaning(s) at different times or at the same time after birth and that for some individuals, birth represents an alteration to their usual ways of ascribing meaning to their bodies or certain body parts. Her personal experience highlighted a binary present within how the body, specifically the vulva/vagina, is socially perceived and constructed. Her vagina was viewed as either a "baby maker" or a "sexual thing", indicating that Caitlin was thinking about the potential use of her vagina in two different ways, though could not have sex until she stopped thinking about its use to birth her baby. This shows us the complex negotiation that Caitlin undertook in creating meaning of her vagina as something that was and could be both sexual and for birthing.

The function(s) of the body, and the purpose of those function(s), changed dramatically for some individuals after giving birth. Feeling as though the body was "different" due to its new functions significantly impacted how participants felt they could share their bodies, and with whom. This changed the participants' practices surrounding when and how they used or shared their body, resisted constructed binaries, or enacted agency over it. The meaning of agency was shifted; for some, it meant redefining their body as a body that could be both nurturing and sexual. Their beliefs about their bodies may have been influenced by the social discourse that frames the postpartum body as being primarily for the baby, though there exist other possibilities for how they felt postpartum, which includes the innate 'urge' to nurture and care for their baby. Certain participants viewed their breasts or vagina as serving solely a sexual function prior to pregnancy, though that view generally changed after birth because of the new functions their body had fulfilled during birth or postpartum. In wider social discourse, vulvas/vaginas and breasts may be oversexualized or reduced to being defined solely based on their sexual purpose/function, leading to narrow definitions or perceptions of these body parts. Participants in this study had to negotiate shifting binaries and meanings about their bodies and demonstrated power by choosing to see past the binary and welcoming the possibility for overlap in terms of how they defined their bodies, its purpose(s), and their sexuality.

Summary

Identity as a mother, body image, as well as meaning of the postpartum body, were key issues for participants in this study impacting their overall sense of identity and feelings of sexual attractiveness. Their perceptions of their body specifically impacted sexual health in terms of their sexual self-perception, identity, and sexuality. Many participants felt that their body had "changed" or was "different" after birth and participants experienced those changes in different

ways. For many, the process of once again seeing their sexuality and identity reflected in their bodies required intentional thought and action, a clear example of how they used power and agency to challenge different social discourses, binaries, and meaning(s) about and of their bodies. It was not always easy and participants experienced frustration, uncertainty, and confusion in negotiating how the discourses built their negative and positive understandings of their physical changes. In addition to perceiving their body and identity as having significantly changed, they also believed that their body had purpose and meaning in nurturing their baby throughout pregnancy and the postpartum period.

CHAPTER 6: CHOOSING TO RESUME SEXUAL ACTIVITY: FEELING READY

When participants were asked about what helped or hindered their sexual health after birth, many discussed if and how they felt ready to resume sexual activity after birth. The process of choosing if and when to resume sexual activity, as well as defining what "feeling ready" for sexual activity meant to them, was complex and often encompassed many emotional and physical factors. Although emotional and physical factors were interwoven in their ways of understanding their sexual health, participants each had a desire to eventually resume sexual activity as part of maintaining sexual health. Of note, all participants in this study spoke of a partner at some point during the interview, leading me to believe that they were all partnered. Some of the issues that influenced the process of choosing to resume sexual activity included pelvic floor recovery, fear of pain, and their health care provider's opinion.

While pelvic pain has been well-documented as a factor that can affect postpartum sexual activity (Cooklin, Amir, Jarman, Cullinane, & Donath, 2015; Doğan et al., 2017; Hosseini et al., 2012), the use of feminist poststructuralism allowed me to uncover a new way that postpartum individuals were discussing and thinking about their sexual health- one that focused on pelvic floor health and recovery. The use of FPS also helped me to understand the negotiation and relations of power at play within the health care context, specifically as it pertained to the resumption of sexual activity and perineal healing. For example, many participants valued the advice of their health care providers in assessing if they had physically healed enough to resume sexual activity. Participants spoke of the pressures they faced to feel ready but also of the importance of trusting their "instinct" when it came to physical and emotional readiness to resume sexual activity. Subjectivity and personal knowing were often used to challenge certain dominant discourses that participants did not find helpful to their sexual health. This chapter will

be presented within the following three sub-themes: 1) Navigating Physical Recovery; 2) Personal Knowing and Emotional Readiness; and 3) The Six-Week Check.

While there can be many reasons why a person may wish to resume sexual activity after birth, Caitlin explained how "society's views" about sexual activity postpartum could make her feel "embarrassed":

> I think too and it shouldn't matter, but society's views of, I wouldn't, if I said oh we haven't had sex since I had a baby, I would be embarrassed to say that because of what society expects from relationships. […] I think society kind of puts pressure on couples to have and can I put in quotes "a healthy sex life" which, you know, say if people didn't want to have sex and only have it once a month or once every two months like I think society as a whole would be like oh wow that's not very much, there's something wrong with the relationship.

Caitlin revealed how a social discourse that defined a "healthy sex life" through a lens that positioned "not very much" sexual activity (i.e. "once a month") affected her; it could make her feel "embarrassed to say" that she perhaps was not having sex as soon after birth or as frequently as "society expect[ed]". This discourse may be connected to a social construction of meaning regarding sexual activity as something that is innately part of how romantic couples express intimacy, closeness, or affection. At the beginning of the quote, Caitlin stated that it "shouldn't matter" and then proceeded to state that she would "feel embarrassed to say" that she hadn't "had sex since [she] had the baby", illuminating a tension within her beliefs. Caitlin used her power to challenge the discourse that frames sexual activity as a required part of sexual health- as something that needs to be present in order for couples to be considered sexually "healthy". While she identified the discourse that requires a presence and/or certain frequency of sexual

activity within romantic relationships as one that was not helpful to her sexual health, she acknowledged that it might still be influential in terms of how she might perceive "society's views"; "pressure" and "embarrassed" referred to how the discourse that promoted sexual activity within relationships might make couples feel. Caitlin used her power to shift her beliefs about what a "healthy sex life" looked like. In this quote, she exemplified how, for her, the choice to engage in sexual activity was not solely based on "what society expects of relationships", though it could be of influence. In saying that "it shouldn't matter", she challenged the notion that frequency was equated with "healthy". For her, sexual health included sexual activity, something that was true for the other participants as well. Participants were aware of the social discourse that required sexual activity as part of romantic relationships, though ultimately chose to engage or not engage in sexual activity based on several other factors, including physical readiness and recovery.

Navigating Physical Recovery

Pelvic floor recovery and pain was an important issue for the postpartum individuals in this study, specifically as it related to their ability to feel physically comfortable resuming sexual activity. For many participants, pelvic pain or dyspareunia was an expected part of the postpartum period, perhaps since it was their second time giving birth or because they knew of others who had experienced a pelvic floor injury during childbirth. As such, pelvic floor injury was not only expected but accepted by many participants. Attention to pelvic floor healing and recovery is very new in Western society and was not openly discussed or available as part of postpartum care until quite recently, perhaps in the last one to two decades (Lynch, 2020). However, almost all of the participants spoke of their "pelvic floor", exemplifying how awareness, acknowledgement, and conversation surrounding these issues is becoming more

commonplace, perhaps as a result of agency (Salmon et al., 2020) or discourse in society. For example, many participants voiced concerns surrounding their pelvic floor, ranging from the "muscles" and getting things "up in gear" to pain during sexual activity and experiences of urinary incontinence. Pain and fear of pain was real, therefore personal knowing was important for participants in navigating their experiences. For Sarah, her process of choosing to resume sexual activity required some time for her to explore sexual pleasure by first engaging in masturbation:

> I was less scared I think because when I was [masturbating] I didn't feel any pain or discomfort but he was like, he was more scared of hurting me cause obviously he didn't want to hurt me but like it was, I don't know it didn't really feel like bad but you certainly don't feel sexy right after you have a baby, like things are, like all your bleeding and all that stuff and you don't feel good, and then when you stop bleeding you want to sleep with your boyfriend or significant other again but then you don't feel sexy because you're terrified of your own vagina area.

By first masturbating, Sarah utilized agency to alleviate some of her fears related to "sleep[ing] with [her] boyfriend" and her "vagina area", allowing her to once again feel comfortable with engaging in partnered sexual activity, something she "want[ed]" but initially felt apprehensive about. Her words speak to the transition she experienced, from feeling "terrified" and therefore not "sexy" to feeling "less scared" and not "really [that] bad". Feeling ready to resume sexual activity was not just about physical aspects such as "bleeding" and "discomfort", but the emotions in feeling "not good" and "terrified". This illuminated how feeling ready encompassed both emotional and physical factors. She believed that sexual activity should be free of pain and began "feel[ing] sexy" by exploring how her "vagina area" felt in a safe and comfortable way. In

discussing how feeling "terrified of your own vagina area" due to fear of "pain and discomfort" can be something that postpartum individuals experience, Sarah uncovered a discourse that positions postpartum sexual activity as "pain[ful]" and "terrif[ying]", perhaps due to the social construction of childbirth as something that is traumatic or damaging to the body (Dunn, Paul, Ware, & Corwin, 2015). While there are many reasons that a postpartum individual may be feeling apprehensive or "terrified" to resume sexual activity after birth, it is important to acknowledge that an underlying fear of genito-pelvic pain is oftentimes present. Sarah's choice to engage in sexual activity was very much a personal process that began with unpartnered sexual activity, illuminating how 'feeling ready' was defined and navigated differently between individuals. Masturbating was her way of utilizing agency to navigate the resumption of partnered sexual activity.

Participants shifted relations of power by defining their pelvic floor as something that "impact[ed] sexual health and sexuality" and required "more conversation about like how to get yourself ready physically". The following few paragraphs will focus on Elsie's in-depth experience as a way of honing in on several aspects of one individual's experience of navigating pelvic floor issues and how that influenced her choice(s) surrounding if and when to resume sexual activity postpartum. She stated:

> It's been kind of a cascade where my pelvic floor was wrecked from the pregnancy and it just kind of slowed everything down quite a bit. […] In terms of actual sexual activity, I have a lot of pain. Like for any sort of penetration, the muscles are just way too tight so it's one where my homework for my pelvic floor physio is to try to have sex so and we have yet to be successful with any of the trying just because the muscles are so frigging

> tight that like nothing can make it in. […] Like I feel hopeful but it's definitely a slower return to functioning than I had anticipated.

Elsie's use of the language "wrecked" to describe her pelvic floor illuminated a certain way of viewing the postpartum body and may have been informed by the discourse that frames childbirth as something that is damaging to the body, specifically the pelvic floor. In stating that "it's definitely a slower return to functioning than I had anticipated", we can see how Elsie was aware there would be some degree of pelvic floor injury that was considered normal and expected after childbirth, therefore positioning pelvic floor injury and associated genito-pelvic pain as an expectation of the postpartum period by postpartum individuals. Pain involving the genital area or reproductive organs, such as the uterus, has been normalized through certain discourses of women's bodies both outside of and during the postpartum period (Grace & MacBride-Stewart, 2007; Hamed, Ahlberg, & Trenholm, 2017). However, despite the discourse that positions childbirth as something that is damaging to the body, this research reveals how pelvic pain has also been constructed to perpetuate a meaning where it is not supposed to interfere with sexual activity or sexual "functioning" due to the discourse that deems sexual activity as essential within romantic relationships. This discourse was evidenced when Elsie said that "it's one where my homework for my pelvic floor physio is to try to have sex so and we have yet to be successful with any of the trying just because the muscles are so frigging tight that like nothing can make it in", referring to her experience in resuming sexual activity that involved "penetration". Despite feeling that "the muscles are so frigging tight" and the fact that she was experiencing "a lot of pain" during "sexual activity", she was asked by her pelvic floor physiotherapist to "try to have sex". This shows how pelvic pain during sexual activity can be normalized by both postpartum individuals and their health care providers after birth, as well as

the idea that postpartum individuals should be "try[ing] to have sex" even if they may not be feeling physically ready.

Despite having just given birth, the priority for Elsie was to have her pelvic floor recovery revolve around her ability to comfortably engage in sexual activity. This was supported by a physiotherapist who was caring for Elsie and giving her "homework" to get her pelvic floor back to normal as well as Elsie's personal desire to make sure her pelvic floor had "return[ed] to functioning". As such, it is important for us to also examine the meaning that her pelvic floor held in relation to sexual health after birth:

> Yeah well I feel for me, like I said in terms of actually having sex like I'm still feeling very neutral about it so that's not that big of a worry for me. But in regards to pelvic floor, I want to have another child. […] Right now nothing fits inside [my vagina] because the muscles are too tight, so I feel like a lot of my thoughts around the pelvic floor physio is that I'd like to get the pelvic floor muscles up in gear so that I can actually have sex so that I can have a child again so I guess it's more functional right now my thoughts around it rather than thinking about it in terms of pleasure.

For Elsie, her pelvic floor recovery was meaningful in its "functional" ability and how it might impact her future ability to "have a child again". While it may initially seem that her beliefs reflected the discourse that normalizes pelvic pain after birth, we can see that there is further meaning within how her pelvic floor recovery influenced her sexual health postpartum. By creating her own meaning of pelvic floor recovery as something "more functional right now […] rather than thinking about it in terms of pleasure", she chose to define it as an important component of her postpartum sexual health, exemplifying how she shifted relations of power. She utilized agency to explore if and how her pelvic floor could be "functional" again by

choosing to engage in sexual intercourse. Elsie's experience exemplifies how the choice to resume sexual activity was highly individual and not necessarily always about "pleasure", but was about "get[ting] the pelvic floor muscles up in gear".

Throughout the interview, Elsie shared her beliefs and values surrounding her pelvic floor recovery. She described how her mother navigated postpartum care and how this impacted her own decision to seek postpartum pelvic floor physiotherapy:

> I know with my mom's sexual health she jokes that she can't go to a comedian because she pees when she laughs and that's a component of sexual health, like if she had seen a pelvic floor physio after she had my brother and I, like potentially that component of her health would be better but there was so much shame around it.

In this quote, Elsie clearly valued pelvic floor care and the need to dispel the "shame" surrounding postpartum care and pelvic floor issues in particular. In referencing the "shame around it" that her mother experienced, Elsie uncovered the discourse that positioned postpartum pelvic floor injury as something that was often expected after childbirth and was therefore thought of as normal because pelvic floor rehabilitation care and physiotherapy did not exist at the time. Ultimately, Elsie was very intentional in caring for her postpartum sexual health by accessing certain resources, such as a pelvic floor physiotherapist, in order to inform how she navigated the decision to resume sexual activity postpartum. This exemplifies how she asserted her agency to address the construction of meaning regarding the pelvic floor, specifically the constructed meaning of "shame" around pelvic floor issues. In caring for her pelvic floor recovery, Elsie shifted relations of power to create meaning of her pelvic floor as something that was not about "shame", but rather something that was a "component of […] health".

Maggie also spoke about how, in her experience, she wished there "had been more conversation" about pelvic floor health and recovery:

> I wish there had been more conversation about like how to get yourself ready physically, cause I'm seeing a pelvic floor physiotherapist and she's a wealth of knowledge and I'm like oh wow I wish someone had told me some of these things before I actually gave birth because then I think I would have been even just more prepared for birth but also more prepared of how I might feel physically afterwards and what some of those things might be that would impact sexual health and sexuality.

Maggie positioned the pelvic floor physiotherapist as a "wealth of knowledge" that helped her feel "more prepared" and "ready" for the changes she experienced after birth. It was important for her to consider "how [she] might feel physically afterwards" when making choices about her "sexual health and sexuality", specifically feeling "ready physically". Maggie's experience also highlighted the invisibility surrounding pelvic floor injury and recovery, as evidenced by her statement that she "wish[ed] someone had told [her] some of these things". In Maggie's case, she had heard nothing prior to birthing her baby and although she was able to gather information afterwards from a physiotherapist, in her mind it was too late. While a postpartum health discourse clearly supports talking about pelvic floor issues, it is not a topic that is openly discussed mainstream – or even prenatally in the health care system. In stating that "I wish someone had told me some of these things before I actually gave birth", Maggie offered great advice by suggesting that more conversations should take place prenatally, before you are in the midst of pain and not knowing what is happening with your body. Maggie used agency in seeking pelvic floor physiotherapy and shifted relations of power by positioning pelvic floor

recovery as something that needed to be discussed "more" because of its importance in her ability to feel "prepared for birth" and the postpartum period.

Honouring one's "instinct" in choosing to resume sexual activity was clearly important for participants. Given that this was her second time giving birth, Anne was especially able to trust her experiential knowledge arising from past postpartum experience to inform her choice to resume sexual activity after birth:

> I was a bit more prepared this time about having a conversation around like the actual physical piece, around the healing, around what to ask, so I'm sharing this with you because I didn't know it existed, but I had to ask for a cream, an estrogen cream the first time around. I didn't realize intimacy or being intimate was very painful the first time around so this time I proactively asked but I would never have known to ask that. I never would have known to say like actually it's quite painful to be having intercourse again so this time I proactively asked [my doctor] for it and just knew what I needed.

In stating that she wanted to be "more prepared" but "didn't realize", and "didn't know" about how to support her physical sexual health, Anne illuminated the invisibility that often surrounds the "physical piece[s]" of postpartum sexual health. Issues such as pelvic pain and/or dyspareunia can be hugely important in influencing the choice surrounding if and when to resume sexual activity after birth. While this is not a new experience for most postpartum individuals, what is important to note is how social discourse continues to be perpetuated in a way that silences dialogue about women's postpartum sexuality and pelvic pain. Anne clearly did not expect pain the first time or know how to deal with it, thus demonstrating a dominant social discourse that positions genito-pelvic pain as something that is normal and expected after birth and therefore does not specifically need to be addressed or cared for as part of postpartum

sexual health. Anne's initiative in being "proactive" by approaching the topic of sexual health was powerful and allowed her to open up a "conversation" with her health care provider. In stating that she "proactively asked" for help and "knew what [she] needed", she used subjectivity to position herself as the leader in her health, rather than relying on the physician to tell her about what she might expect or need. She shifted relations of power by asking for what she needed and utilizing her experiential knowledge to inform that, something that was important in her decision to resume sexual activity and have it be free of "pain". Although pelvic floor issues are generally positioned as invisible or normalized due to the discourse that positions childbirth as something that damages the body, participants shifted relations of power by defining their pelvic floor recovery as something that was important to their sexual health postpartum. Given that sexual activity was a key component of sexual health for participants, pelvic floor health, pain, and recovery was critical because it influenced their ability to comfortably engage in sexual activity and/or feel physically ready.

Personal Knowing and Emotional Readiness

Participants believed that it was important that they felt both "emotionally and physically ready" to resume sexual activity. It was evident from participant stories that personal knowing and subjectivity was central to the resumption of sexual activity. Many participants discussed the importance of listening to their "instinct", especially when it came to assessing if and when they felt "emotionally" or mentally ready to resume sexual activity. Jane offered advice to other postpartum individuals and, in doing so, described how she chose to trust her "instinct":

> Just like trust your own body in terms of like what feels right for you both physically and emotionally because as I said like when we tried to [have sex] at four weeks I was not emotionally or physically ready at all and I should have just kind of trusted that instinct.

> But because I had all those worries about what does my sexual health look like now, like I felt like I kind of needed to kind of experiment with that and toy with it when really I should have just trusted my instinct and be like I'm not there yet, I need to wait until I'm more emotionally and physically ready.

Jane believed that trusting her "instinct" and her "own body" was an important part of her sexual health, exemplifying how subjectivity and "trust[ing]" herself informed her choices surrounding the resumption of sexual activity. Feeling ready encompassed both emotional and physical factors for Jane and her attempt to engage in sexual activity at four weeks postpartum was driven by her "need […] to experiment" and "toy with it". Her "experiment[ation]" with sexual activity after birth was a way of enacting agency to better understand how she might experience sexual pleasure and explore if and how she felt "emotionally and physically ready" to engage in sexual activity with others. Jane's "worries" came from a place of feeling as though her sexual health looked different "now". She shared a discourse that positions sexual health and sexual activity as something that changes significantly after birth, as evidenced by her statement that she had "worries about what does my sexual health look like now". It is possible that the discourse that frames birth as something that changes sexual health and the discourse that positions birth as something that damages the body, specifically the genito-pelvic area, are connected. In stating that she "should have […] trusted that instinct", we can see how she did not trust her "instinct" at first but then later valued it. It is also important to note that we can see a tension here in terms of Jane's negotiation of discourse; at first, she engaged in sexual activity despite not feeling "emotionally or physically ready at all", though she later chose to listen to her own feelings and "wait" a bit longer to feel "more emotionally and physically ready". Naturally, "experiment[ing]" can be a way that people "try" with any new experience and so it is important

to consider that Jane did not necessarily feel as though she was forced to "try" engaging in sexual activity- it was still something that she wanted to "toy with" even near the beginning of her postpartum experience. The need to "experiment" with what her sexual health "look[ed] like" may have also been influenced by external pressures or expectations, such as the discourse that requires sexual activity as part of romantic relationships. Her experience validated her "instinct" as a way of enacting agency, an important example of how subjectivity and agency informed one another in the process of choosing to resume sexual activity after birth. From her experience, the resumption of sexual activity relied on personal "instinct" and perceived readiness. As with Caitlin, sexual activity was a significant part of sexual health for Jane.

Mary acknowledged that "everybody is different" when it comes to feeling ready to resume sexual activity after birth. Like others, she also utilized personal knowing to inform her decision surrounding when to resume sexual activity, which was a part of sexual health for her. For Mary, it was important to "honor what [you] feel". Mary stated:

> I would say that probably you know everybody is different and you just have to kind of do what feels right you know to you and if having a lot of sex at this point is you know something that you feel comfortable with or you feel like you want, perfect, go for it and if it's not, if you feel like you don't have the energy for it, if you feel like you don't want to whatever that's fine too and I think it's important for us to just kind of I guess honor what we feel like we can handle and what we feel like we want to do and I would tell [other postpartum people] to just kind of know that everybody is different and just go along with what you feel comfortable with at that time.

Mary emphasized the need to "do what feels right […] to you", whether that meant feeling ready for sexual activity sooner after birth or needing to wait. For her, feeling ready to resume sexual

activity required feeling "comfortable", "having energy", and feeling like you "want to" have sex. In stating that "everybody is different" and that it was "important to honour what we feel we can handle", she demonstrated how the choice to engage in sexual activity is unique to everyone. Her emphasis on "right […] to *you*" highlighted the value of personal knowing for postpartum individuals and represented her way of negotiating relations of power. No matter the individual, the need to "honour" one's own personal needs, desires, "instinct", or experiences was acknowledged by several individuals in this study when choosing to resume sexual activity after birth. Participants often relied on their personal knowing or "instinct", as a way of challenging certain norms or expectations regarding the resumption of sexual activity postpartum that might have been informed by social discourse. No matter, it was important that they felt both "emotionally" and "physically" ready to resume sexual activity after birth. However, trusting their "instinct" was not always easy and was especially challenged or questioned when participants attended their six-week postpartum appointment.

The Six-Week Check

At some point during the interviews, each participant discussed the six-week appointment with their primary care provider, which usually occurred with either a family physician or an obstetrician/gynecologist. Most participants mentioned their experience at the six-week check-up when asked about a specific time when they thought about their postpartum sexual health. Participants often sought approval from their physician and/or primary health care provider before they felt comfortable and safe to resume partnered sexual activity or intercourse, making the six-week appointment a key component of their decision-making regarding when to resume sexual activity. In terms of sexual health, the six-week check was often about having the vagina and perineum assessed by the physician to determine physical readiness for sexual activity. As

such, physicians were often positioned as the experts in postpartum sexual health, though participants challenged this by relying on their own opinions or perspectives regarding their physical recovery and readiness to resume sexual activity. The six-week mark was interpreted differently by participants; some viewed it as crossing a finish line, resulting in a sense of renewed freedom, while others interpreted it as a "deadline", something that felt "too soon". As a result, participants' expectations or beliefs regarding their ability to resume sexual activity were at times challenged or shifted due to the interaction they had with their health care provider at the six-week check-up.

For example, Elsie detailed how she felt a sense of "dread" going into her appointment due to the fact that she herself did not feel ready to resume sexual activity, though was anticipating that her physician may "clear" her for sexual activity nonetheless:

> I remember when I went for my six-week check-up with my doctor to get cleared for whatever [sexual] activities, and I remember like my husband was very hopeful for this visit. And I was not. It's like I knew, we had watched a comedy on Netflix and I had peed myself when I like laughed and the comment wasn't even that funny so I was like "ooh I don't think my pelvic floor is doing so hot" and that was before I knew about pelvic floor physios and I just remember this like feeling like not quite dread but within that category of emotions when I was going in and I was kind of hoping that [the doctor] wouldn't clear me cause I was like I don't want to have to go home and have the discussion about when are we going to have sex, I don't feel like it, things don't feel right down there, I'm still swollen, I'm still bleeding and I just remember this feeling of just being like "please don't say yes, please can I have another month", so it was definitely like that component

where it was like it just felt too soon. And it just felt like such an arbitrary date at six weeks.

For Elsie, her concerns about feeling ready to resume sexual activity revolved around her physical healing, specifically "bleeding", vulvar "swelling", and not "feel[ing] right down there". We can clearly see how Elsie believed that the medical appointment represented a deadline in the sense that "it just felt too soon". This quote reflected a belief that someone else, being her physician, had the authority to dictate what she did with her body, as evidenced when she said "please don't say yes". She valued the physician's knowledge and positioned them as the expert in her health. In saying that she was "dread[ing]" the appointment because she was "hoping" the doctor would not "clear" her, we can clearly see how she was aware of the medical discourse that positions health care providers as the experts on sexual health and how it was a discourse that she anticipated negotiating even before the appointment began. For her, the medical appointment was not just an isolated interaction, but something that might impact her sexual relationship with her partner, as well as her emotional and mental wellbeing, as evidenced when she said that she didn't "want to have to go home and have the discussion of when are we going to have sex, I don't feel like it". In this example, the dominant discourse that requires postpartum individuals to resume sexual activity as soon as possible was being practiced and communicated through Elsie's physician. Due to the existing patient/provider binary in Western health care institutions (Waitzkin, 1989), it was difficult for Elsie to challenge her physician's opinion through her own beliefs about her readiness for sexual activity because her beliefs also reflected the discourse that positions health care providers as the authority on postpartum sexual health and sexual activity. Elsie showed us how this made her feel; things did not "feel right" and it "felt too soon", which led her to hypothetically ask the physician if they could "please [not] say yes" and give her more

time. The institutional discourse that promotes a return to sexual activity by six weeks postpartum created meaning within the appointment as a time when Elsie should feel ready to resume sexual activity. However, Elsie demonstrated power by articulating her beliefs about not feeling ready. She was negotiating the balance between listening to her health care provider and her own instinct.

Katie's experience was similar to Elsie's in that they both positioned their physicians as the experts on sexual health and the resumption of sexual activity postpartum. However, Katie was not able to see her physician until nine weeks after birth and therefore adjusted her practices based on her own beliefs and values regarding the 'six-week mark'. While the physician's "stamp of approval" was important for Katie, it was something that she had to go without for a longer period than expected, leading her to make decisions for herself using agency. She stated the following:

> I'd say also what hindered everything of course is being pushed back and delayed because of COVID so I wanted to have that six-week appointment with my OB [(obstetrician)] to make sure that everything was okay and kind of get that thumbs up for having sex again and being able to go to the gym again but when I went in to make my appointment I wasn't able to make my appointment until I think it was almost nine weeks when I made that appointment. So even though I physically felt better at four weeks post-partum I wasn't even able to wait the extra two weeks, but I had to wait until almost nine weeks post-partum [for the appointment] and we did end up having sex before that but it just, you know you kind of want that stamp of approval to make sure that everything is okay.

The meaning of the "thumbs up" from the physician was different for Katie than it was for Elsie. For Katie, the medical "stamp of approval" was something that she wanted but was not able to seek out at the usual six-week mark, pointing to how the six-week appointment is constructed as a requirement before resuming sexual activity after birth. However, the "thumbs up" was not only about "sex" but also encompassed other aspects such as "being able to go to the gym", which shows how Katie's expectations of the appointment were more about physical healing than about "sex" specifically. Like Elsie, she positioned her physician as a person of authority and importance in informing when she resumed sexual intercourse, though ultimately chose to honor her subjective knowing by choosing to engage in sexual activity before seeing her physician. Elsie received medical permission to resume sexual activity when she did not necessarily want to, while Katie ideally wanted permission but did not have an opportunity to seek it at the usual time. Katie adjusted her practices based on the belief that she was also able to judge her physical readiness for herself, ultimately leading to her choice to have sex with her partner prior to her postpartum check-up. Her choice demonstrated agency and power in shifting the meaning of the health care provider's opinion to one that was useful but not required in informing her choice to resume sexual activity after birth. She instead chose to value her personal knowing.

Brett received an initial "go ahead" from her family physician though later found that although she was feeling "mentally prepared" before choosing to resume sexual activity, she was not "physically healed". Her experience exemplified the complex interplay between emotional and physical readiness as well as the physician/patient binary when it comes to 'expertise' regarding postpartum sexual health. Brett stated:

> I did go to my GP [(family physician)] and then she referred me back to the specialist and they basically checked it out and they said well give it another six months, try using, oh what was it, Crisco [vegetable oil] and they said come back if it doesn't improve. I said "oh that's helpful. Thank you. Nothing makes you feel more sexual than a cup of Crisco". […] I had the [vaginal] tear or whatever so it's kind of like your go-ahead so they did the check and I waited another probably four weeks after that 'til I felt mentally prepared [to resume sexual activity] and so I thought oh this is going to be fine, whatever and then come to find out it is extremely painful and it's not alright which just kind of went to my distrust in the [medical] practice here again but cause they said that everything looked to have physically healed correctly right so they I don't know it was just kind of a lot of misleading information I guess.

Initially, Brett based her beliefs on the medical discourse that positions health care providers as the authority on resuming sexual activity after birth, as evidenced by her statement that she "thought oh this is going to be fine". However, based on her experience of having issues with physical pain during intercourse (despite being told that she was okay to "go ahead" and resume sexual activity), she later chose to challenge this institutional medical discourse and framed her beliefs in a different way, as evidenced by her feelings of "distrust" and being "mislead" by her health care providers. Her experience highlights the limits of health care providers' knowledge; they are only able to assess physical healing but cannot necessarily predict how postpartum individuals will experience pain during sexual activity. Feeling "prepared" or "ready" was highly subjective, as was the experience of sexual activity itself. Brett demonstrated power by choosing to wait "four weeks after" the appointment to resume sexual activity because it was important that she also felt "mentally prepared", exemplifying how she valued both emotional and physical

readiness. Brett believed that she was "mislead" by health care providers, indicating how she positioned them as experts in assessing her postpartum sexual health and readiness for sexual activity. Brett's sarcastic statement in saying "oh that's helpful" refers to how she felt when interacting with health care providers. Despite the challenges she faced with her health care provider, Brett did not feel as though she had to listen either to her personal knowing or the health care provider's opinion but could balance both and still make a decision that she thought was best for herself. Navigating health care provider opinions, which may have been informed by institutional medical discourses, was at times difficult and required participants to use subjectivity, agency, and power to define if and how they felt that "everything was okay" to resume sexual activity postpartum. When their experiences or beliefs about resuming sexual activity did not align with the health care provider's, participants utilized subjectivity and agency to know how they felt and what they needed to feel physically ready. Feeling like they could "go ahead" included feeling "mentally prepared", "physically healed", and like they "want[ed]" to resume sexual activity.

Summary

Although the participants in this study defined sexual health as more than the physical act of sex, their discussion of postpartum sexual health primarily focused on the resumption of sexual activity or intercourse. The choice surrounding if and when to resume sexual activity centered on how participants 'knew their bodies best'. Despite the discourse that requires sexual activity as part of romantic relationships, the participants ultimately chose what was best for them- and when. The choice to resume sexual activity was complex and encompassed different physical and mental factors such as physical healing and pelvic floor recovery, emotional readiness, and health care provider opinion(s). Given that sexual activity was a subjective

experience and unique to each individual, participants often used personal or experiential knowing and subjectivity to challenge certain discourses that they deemed oppressive or unhelpful to their sexual health postpartum, including those that were upheld by their health care providers. Personal knowing was a way that participants challenged certain norms or navigated the "taboo", specifically the invisibility surrounding postpartum pelvic floor issues or injuries. The discourse that positions health care providers as the authority on postpartum sexual health was challenged by several participants, though relations of power could be difficult to negotiate. For example, participants simultaneously valued approval and validation from their health care providers though also, at times, chose not to listen to their health care providers based on their perceived best interests, therefore demonstrating a way of shifting relations of power and using agency. The choice of if and when to resume sexual activity also shifted and was fluid, with some participants feeling "ready" initially and then choosing to "wait" a bit longer before engaging in sexual activity again. This is important when considering how postpartum individuals define and navigate readiness for sexual activity, as well as how they use their agency and power to choose if, when, and how to resume sexual activity.

CHAPTER 7: FEELING CONNECTED: DESIRE, INTIMACY, AND SUPPORT

In the following chapter, I provide the third and final theme of the findings from my analysis. It was not only important for participants to feel connected with and through their sexuality, but how they experienced connection also changed during the postpartum period. Feelings of connection were experienced through desire, intimacy, and support. The postpartum period was rife with many "adjustments", including to sexual desire, which therefore required participants to change or redefine how they were intimate with their partners. In general, many participants experienced a decrease in sexual desire compared to pre-pregnancy, leading participants to redefine intimacy within their romantic relationship(s). For example, intimacy did not always include sexual activity or physical touch, but often focused on "spending time together", "talking", and "being affectionate". The use of FPS allowed me to uncover new meanings of intimacy postpartum, specifically in terms of non-sexual and non-physical ways of expressing intimacy. Support of postpartum sexual health by other moms was also meaningful and significant in specific ways. At its core, support often meant being "helpful" to one another, sharing "stories", and having "real conversations" about sexual health. This chapter will focus on three main aspects of feeling connected with and through sexuality: 1) Navigating Changes in Sexual Desire; 2) Redefining Intimacy; and 3) The Meaning of Support.

Navigating Changes in Sexual Desire

Sexual desire was individual and influenced by a myriad of factors. When I asked participants what emotions they experienced when they thought about their postpartum sexual health, they often spoke of the changes to their sexual desire. Many of the participants in this study described having a lower sexual desire than they did pre-pregnancy largely due to the tasks, stressors, and responsibilities associated with caring for their newborn. Participants felt

emotionally and physically “exhausted”, “touched out”, and distracted because of parenting responsibilities. Others also experienced physical symptoms that decreased their desire to engage in sexual activity, such as dyspareunia, pelvic floor pain, and sore or tender breasts. Sexual desire after birth was experienced by some participants in this study, though others were very much feeling as though they had no desire for sexual activity and instead needed time to readjust to their new role and responsibilities as mothers/parents/caregivers.

In looking at what was important in influencing sexual desire, feeling “exhausted” was a major factor for most participants. Caitlin stated, “I mean I was exhausted with having a newborn, and just like was not, like sex was not on my mind. The only part of sex that was on my mind was the fact that like okay you should want to do it and I don’t”. Caitlin believed that the fact that she “should want to do it and I don’t” was perhaps different from the norm. Her use of the word “should” could be interpreted as a way of looking at social norms and beliefs about sexual desire after birth. Feeling like she “should” want to have sex may have been influenced by certain social expectations, such as the social discourse that positions sexual activity as essential within romantic relationships. However, it is also possible that she felt like she “should” want to have sex for other reasons, perhaps because it was a way that she and her partner expressed intimacy within their relationship prior to pregnancy. Sexual desire and sexual activity are two different concepts and are not necessarily dependent on one another. In exploring Caitlin’s experience, it is important to consider that there more broadly exists a discourse that positions any lack or absence of sexual desire as deviant and abnormal (Basson, 2002b; Leiblum, 2002; Montemurro & Siefken, 2012; Wood et al., 2006), which may have been of influence in her experience. This discourse may stem from a socially constructed view of sexual desire as something that is innate and therefore essential, especially within romantic relationships. In

acknowledging that she was “exhausted” and that sex was “not on [her] mind”, Caitlin shifted relations of power by positioning her own needs as being important, despite feeling like she “should want to do it”. This is an important example of how subjectivity was used to navigate certain discourses that were not necessarily helpful to participants’ sexual health.

Sexual desire was defined differently by participants and generally decreased after birth. Elsie discussed how she didn’t feel “like [she] wanted anything” and how that impacted her “sexual interactions” after birth:

> I haven’t really felt like I wanted anything so the only times that we’ve actually had any sexual interactions is because my physio gave us homework trying to stretch the muscles. So yeah it’s just one where I’m hopeful now that since my period came back last week that I might start actually feeling like I want to have sex again. Cause I don’t want to have sex because of homework and I don’t want to because of feeling like bad for my husband not getting any.

Elsie believed that “want[ing] to have sex again” was important in influencing how “hopeful” she felt about engaging in “sexual interactions”. “Hopeful” might be interpreted as her way of saying things will get better, or that a positive outcome may occur in the future. For her, experiencing sexual desire by “feeling like [she] want[ed] to have sex again” excluded “hav[ing] sex because of homework” or “feeling […] bad for [her] husband”. This is important to pay attention to when exploring the meaning that sexual desire held for participants. While sexual desire could encompass many different factors or emotions, it could also require the absence of other emotions, thoughts, or ways of viewing sexual activity. In this example, having “sexual interactions” be positioned as “homework” was not helpful for Elsie and her desire to “have sex”, so she shifted relations of power to create a new meaning of sexual desire that excluded the

view of “sexual interactions” as “homework”. Elsie’s example shows us how sexual activity and sexual desire could be connected, though were not necessarily dependent on one another. “Feeling bad” may be interpreted as her way of feeling a sense of responsibility in ensuring that her and her husband maintained a sexual relationship. It is not to say that she felt forced to maintain a sexual relationship with him, but rather valued this component of their relationship and therefore redefined how she experienced sexual desire.

Sexual desire changed for different reasons and was therefore made meaningful in different ways. Some participants viewed their decrease in sexual desire as something that was “just fine”. Mary described how, despite the fact that her “interest in having sex [was] less”, she did not put “pressure on [her]self”:

> I would say my interest in having sex is less right now for sure and I would almost completely put that on the fact that I have a toddler and a newborn and I’m just tired and I feel, I breastfeed so I feel completely touched out by the end of the day and like I love my husband very much but still don’t really sometimes want to have sex and I mean I think that’s just fine and he’s fine with that of course and I don’t, I guess I don’t put a whole lot of pressure on myself to feel like you know we need to get back into it or whatever and I guess I just kind of treat it as time passes I’ll feel better about it and I think that’s going to be okay.

Mary believed that several factors, including feeling “tired”, “completely touched out”, and having a “toddler and a newborn” were significant in shaping how she experienced her “interest in having sex” postpartum. As discussed previously, there existed a discourse that positioned sexual activity as essential within romantic relationships, though Mary utilized power to renegotiate the meaning of sexual activity and sexual desire as something that she did not “need

to get back into". Much like Elsie, Mary was aware of the pressure that some postpartum individuals may feel to experience sexual desire, though chose to challenge this by defining sexual desire as something that she did not "need" to experience, which was "just fine". When looking at what influenced sexual desire postpartum, a range of factors were of importance.

Sexual desire was also fluid in the sense that it "just change[d] […] some days". Anne described how factors such as "sleep" and "food" could influence her sexual desire:

> It just changes, I don't know like I think it's just changes but some days I can feel very happy and very like wanting to be intimate and emotionally connected and then other days I don't cause you've had less sleep, you probably have eaten rotten things that you don't like, food also plays a role into it right, perhaps you're not eating the same way as you would or could or want and perhaps you're just you know not feeling the greatest. So all that plays a role I think. And those are the things that people don't talk about.

Anne believed that her sexual desire increased when she felt "very happy" and was "wanting to be intimate and emotionally connected", whereas it was decreased when "eat[ing] rotten things", having "less sleep", and "not feeling the greatest". In acknowledging that "all that plays a role" in "wanting to be intimate", Anne showed us how she viewed sexual desire as something that was influenced by several different factors, similar to how Mary viewed it. For Anne, her desire to engage in sexual activity was largely driven by a desire to feel "emotionally connected", which is important to pay attention to in terms of how sexual desire and needs within intimacy are connected, which will be discussed later in this chapter. In this quote, Anne described both physical and emotional factors as being of influence when it came to how she experienced her sexual desire, much like how emotional and physical factors were important for participants in choosing when to resume sexual activity postpartum. Overall, sexual desire was influenced by

many different factors, such as "exhaust[ion]", and held different meaning(s) and significance throughout the postpartum period. Sexual desire also fluctuated based on how participants perceived sexual activity (i.e. as "homework") as well as how they were "feeling", indicating that sexual activity and sexual desire could be connected but were also two separate components of sexual health.

Redefining Intimacy

Intimacy, both in its meaning and its presence, shifted for some participants. Due to a general decrease in or lack of sexual desire due to the "adjustment" of postpartum, participants had to find new, non-sexual ways of being intimate with their partners. No matter how they experienced intimacy, it was important for participants to feel "connect[ed]" with, and "empathetic towards" their partner. As such, participants created new meanings of intimacy. Intimacy not only helped participants to feel "connect[ed]" to their partners but it also served as a reminder of their sexuality and sexual attractiveness, something that helped them maintain their sexual health after birth.

Intimacy often involved "trying to find time to be affectionate during the day", though it was challenging to find or create that "space" at times, as Anne discussed:

> It's trying to find time to be affectionate during the day and trying to find space to be intimate between work and a toddler and a newborn so it's very sparse at the moment. But we're, you know an adjustment period like I'm just two months postpartum so the first six weeks there was not intimacy even on the table in terms, like we tried to be affectionate in the best way that we could with one another but there was no specific intercourse by any means. But that takes time too right? Everyone is sleep deprived, no one is really feeling in the mood, right? […] So yeah it looks very different and it's just

> kind of trying to be empathetic towards one another and be affectionate all at the same time and doing your best to do that.

Anne believed that the postpartum period was a time of "adjustment" and that feeling "sleep deprived" and not "in the mood" could make it more difficult to be intimate with her partner. Intimacy meant being "affectionate" and "empathetic" towards one another. Anne utilized agency to find ways of alternatively maintaining intimacy within her romantic relationship without necessarily including sexual "intercourse". In stating that "there was no specific intercourse by any means", this indicates that she may have been aware of a dominant way of thinking about intimacy within romantic relationships- a way that is assumed to involve "intercourse". The discourse that positions sexual activity as essential within romantic relationships, in turn, may influence how intimacy within a relationship is socially defined and constructed to include sexual activity. Seeing as both she and her partner were "sleep deprived" and "not in the mood", she utilized power to shift the meaning of intimacy to be something that centered on showing affection and being "empathetic", which is important language to consider. Intimacy did not necessarily require sexual activity or "intercourse" but was more so about showing certain behaviours or emotions towards one's partner, such as empathy.

Intimacy was an important way of caring for both emotional and sexual needs. Intimacy could be sexual, but it did not have to be, and many participants valued intimacy for its "emotional" benefits, meanings, or reasons. Katie shared how she and her partner felt "excitement" in being intimate immediately after birth and throughout the postpartum period:

> Knowing just that we can be intimate with each other again kind of sets that excitement almost as if it was new again kind of like when you first meet each other and everything is really exciting, you kind of get that second wave of it again cause everything is new

> and exciting again. And you really do have to kind of relearn everything so yeah so I guess that's kind of been a fun aspect of intimacy after having a baby and again even though it's not as much as I would like the actual act of sex it's great to have that like that connection and that intimacy on an emotional level and just yeah having words of affirmation for one another and even if it's not the full sexual act, just kiss, deep kisses and like you know hugging and what not can even just be really nice.

Katie believed that the postpartum period required "re-learn[ing]", which for her included how she and her partner were "intimate" within their relationship. Her statement that "even if it's not the full sexual act" and "even though it's not as much as I would like the actual act of sex" may be interpreted as a way of speaking about how she defined intimacy prior to birth. It may also be reflective of a certain way of thinking about or defining intimacy that is socially informed. Katie valued "sex" as part of intimacy though also valued "connection" in non-sexual ways. She therefore shifted the meaning of intimacy for her and her partner to meet their current reality and needs as new parents. For her, intimacy postpartum was about "connection […] on an emotional level", sharing "words of affirmation", "deep kisses", and "hugging". In positioning these aspects of intimacy as "really nice", she showed a new way of creating meaning of intimacy, which demonstrated power. Like Anne, intimacy was defined as something that did not necessarily require sexual activity but rather incorporated emotionally gratifying and meaningful behaviours to maintain "connection" between participants and their romantic partners.

We can see how for many individuals in this study, intimacy was an important component of their sexual health postpartum. For Mary, "spending time together" was especially important and was the focus of intimacy. She stated the following:

> Even just spending time together and really just like talking and being in each other's company is almost like just as good for me right now as having sex probably because it involves a little bit less energy and we still get to spend time together and you know kind of connect in a different way than connecting sexually without I guess putting the energy into having sex, it's kind of a more relaxed way to be together right now.

Mary believed that "talking", "spending time together", and "being in each other's company" were all important components of intimacy and were "just as good for [her] […] as having sex". She valued "different" ways of "spending time together" that "involve[d] a little bit less energy" and this is what shaped the meaning she ascribed to intimacy. Intimacy was about being able to "connect in a different way than connecting sexually", which pointed to a new way of defining what intimacy could look or be like for her. Like Katie, she chose to "connect in a different way" that was "just as good" while still prioritizing her emotional and sexual needs. In using the word "different", we can see how she believed that her way of incorporating and defining intimacy postpartum was perhaps different from the expected 'norm' within romantic relationships, or perhaps even just within her own relationship. Katie's beliefs may reflect her awareness of a social discourse that positions sexual activity as an essential part of intimacy within romantic relationships. In articulating her beliefs about intimacy and by shifting its meaning due to a lack of "energy" for "sex", Mary clearly demonstrated power. Both Mary and Anne use the words "connect" or "connection", which is important to pay attention to when exploring how participants defined intimacy postpartum.

Intimacy meant, for some, "spending time together", being "affectionate", and taking an opportunity to "connect". Katie, however, elaborated to include other examples of how intimacy

was made meaningful by postpartum individuals. For her, time spent "cooking together" was a special way that her and her partner could be "intimate":

> I'd say like even just us cooking together, we have a pretty small kitchen so we always love cooking together and rather than one person make supper, we'll do it together and it's funny like just even walking by or like you know smacking someone's butt and like things like that, we love cooking together because it makes us feel closer and so we get really flirty in the kitchen so even then like that's why we love cooking together it just kind of brings us together and we can be goofy which some people don't see as an intimate thing but we definitely feel like laughter helps with intimacy so cooking together has kind of always brought that goofy flirtyness to us.

She believed that "cooking together" allowed for opportunities to be "flirty" and "goofy" with her partner and helped them to both "feel closer" to one another. Behaviours that reflected intimacy could also include "laughter" and "smacking someone's butt". Her statement "some people don't see as an intimate thing" demonstrated that she was aware of how society and other people might view intimacy in ways that prioritize and value certain behaviours or activities, such as sexual activity, as a required part of intimacy within romantic relationships. She positioned her interactions with her partner as different from what most "people" might understand as "intimate" and, in doing so, shifted relations of power by challenging the dominant social discourse that positions sexual activity as the 'best' or only way to be intimate with one's romantic partner. Overall, intimacy was defined by participants as something that included "connection", "affection", "flirtyness", and "laughter". In shifting the meaning of intimacy to something that could be (and often was) non-sexual, participants were able to still care for their sexual health and show intimacy in ways that were meaningful to them and their partners.

"Spending time together", "flirt[ing]" with their partner, and engaging in meaningful conversation were all ways that participants shared intimacy and maintained feelings of "connection" and "close[ness]" within their romantic relationship(s). This is important to consider when discussing emotional or relational facets of sexual health after birth and how participants felt connected with and through their sexuality postpartum. Emotions and emotional sexual health are influenced by a myriad of factors, including hormones, fatigue, and new responsibilities, all of which can either impede or promote sexual health and wellbeing.

The Meaning of Support

Feelings of connection and support within social networks were significant in shaping how postpartum individuals experienced their sexual health after birth. Participants discussed social networks, as well as how they felt meaningfully supported, when asked about what helped or hindered their sexual health after birth. The postpartum individuals in this study often had a desire to feel as though they could relate to others without feeling "shamed or judged". It was important that participants were able to have "real conversations" about postpartum sexual health with others, whether that was their friends, family members, or fellow moms. Participants used "talking to other moms" as a way of normalizing certain aspects of sexual health after birth. Anne discussed how "talking to other moms" could be "helpful" but how she also experienced "a lot of unspoken mom shaming":

> I think talking to other moms would be helpful but not everyone feels like that's helpful, you know there's a lot of unspoken mom shaming and no one talks about it but there is, there is a lot of unspoken and you know COVID has served as a bit of a, you know this a lot different experience than with my first baby when I was out and doing groups and I was out you know things that don't exist anymore, so you know I surround myself with

> people that are supportive and there's probably less mom shaming because I'm not in these groups and stuff but finding people that are supportive and finding people that you can talk to and finding people that are open to have those real conversations about sexual health and how you're feeling is really important. And I was really lucky and I still am very lucky that I have those supports and I don't think that everyone does so if you don't want to talk to someone about intimacy with your partner if it's not going well, in fear of being shamed or judged. And I think finding those safe spaces to have those conversations is helpful.

Anne believed that "surround[ing] [her]self with people that are supportive" was "important". For her, support meant having people who she could "talk to" and who were "open to hav[ing] those real conversations about sexual health and how you're feeling". Support was also about "safe spaces" that did not include "mom shaming" or any "fear of being shamed or judged". Finding and creating social networks that were deemed "supportive" was one way that Anne cared for her sexual health after birth. "Finding those safe spaces" points to the very need for "safe spaces" and may therefore be interpreted as a way of saying that not all spaces are considered "safe" by postpartum individuals, especially when it comes to "conversations about sexual health" and "intimacy with your partner". This may stem from the social discourse that positions sexual health as taboo and therefore a topic that is considered to be private or inappropriate to discuss in many contexts. This discourse also works to obscure and render invisible many experiences or aspects of postpartum sexual heath specifically, such as pelvic floor injury and "intimacy". Anne may have viewed her "supports" as a way of challenging the taboo and using her agency and power to create "safe spaces" to discuss sexual health, which often included "other moms" as well.

"Supports" could be viewed as a way to initiate "conversations about sexual health", though they could also be used as a way of normalizing experiences of sexual health postpartum. Brett spoke about how talking to other moms could be "helpful and not helpful […] depending on what answers you're looking for":

> I find [talking to other moms] like helpful and sometimes well it can be both I guess, helpful and not helpful at the same time because if they're not experiencing the things that you're experiencing then it's like oh no what is wrong with me, why is this not happening for me and it's happening for them? But then it's also kind of refreshing to hear like some other stories I guess because it's not, I mean there's not a ton of research and there's also, like they don't advertise [postpartum sexual health issues] because you probably wouldn't want to get pregnant for some of the issues, they only advertise the good I guess is what I would say. So it's helpful and it's not, it's like a double-edged sword I guess, depending on what answers you're looking for.

Brett believed that it was important to find other moms who were "experiencing the things that you're experiencing" and willing to share "stories" as part of supporting one another. For Brett, support was about normalizing her own experiences but also gaining a "refreshing" perspective through "stories" that were shared with her. However, when she felt like "oh no what is wrong with me", this made her feel as though talking to others was "not helpful". In stating that "they only advertise the good", it is possible that she was referring to a social way of understanding or talking about the postpartum period or "issues" that postpartum individuals may experience, illuminating the discourse that positions sexual health, specifically in the postpartum context, as a taboo topic within society. By looking at this quote carefully, it is clear that Brett valued sharing "stories" that discussed both the "good" and the not so good. Similar to the way Anne

valued “real conversations”, Brett used supports as a way to hear about what she and others were “experiencing” with regards to their postpartum sexual health, though conversations about sexual health could be a “double edged sword”.

While certain participants discussed supports in terms of “other moms”, supports were also discussed in the context of family, specifically family members from “older generations” who had birthed “many babies”. Sarah shared how her family members could be “helpful” but also “scare[d] the shit out of” her:

> Like all your aunts and cousins and your grandmother, your mom and everybody telling you “don’t go down there”, “don’t look down there”. I think it was kind of the older generations in my family and in my life who kind of like fear-mongered me a bit and that hindered me a lot. Like I definitely rely on their opinion and their help because they’ve all had many babies and I’m a first-time mom and I really, I still don’t know what I’m doing, I feel like your first [child] is kind of like a crash course so I do rely on their input and information. And a lot of what they say is helpful but sometimes it kind of scares the shit out of you. So that definitely hindered me as much as I love them and love their help that did not help me.

Sarah believed that her family members, despite their best intentions, were “fear-monger[ing]” and that this “did not help [her]”. However, she valued when her family members were “helpful”. She subjectively positioned herself as a “first-time mom” who was going through a “crash course” and did not “know what [she was] doing”, indicating her view of herself as perhaps less experienced with the realities of birthing, mothering, and the postpartum period compared to her family members who had “had many babies”. There was tension in terms of how Sarah valued the role of her family members; she “rel[ied] on their opinion and their help”

and found that “a lot of what they sa[id] is helpful” but also found that their “fear-monger[ing] […] scared” her. As such, Sarah exhibited agency in determining which opinions were helpful to her sexual health and which were not, which then informed how and from whom she sought support within her family. When discussing how her family members told her “don’t go down there”, Sarah was referring to “down there” as her genital area. It is possible that in saying that to Sarah, her family members perpetuated and upheld the discourse that positions it as a part of the body that should not be “look[ed]” at or touched during the postpartum period, which may have been dually informed by the discourse that positions childbirth as something that is damaging to the body, specifically the genito-pelvic area. Sarah described how those statements by her family members made her feel “scared”, which was not “helpful” to her sexual health postpartum. As such, we can see how Sarah defined support as feeling like others around her were being “helpful” and were people that she could “rely on”. Overall, support from others could be “helpful and not helpful” and participants were intentional in surrounding themselves “with people that are supportive”, which could include “groups” or “safe spaces”, while also determining which spaces or people were not helpful. Feeling supported meant being able to “rely” upon others and have “real conversations” about sexual health postpartum without “shaming”, which is critical to consider when assessing how postpartum individuals are best supported- and by whom.

Summary

Feeling connected with and through sexuality postpartum encompassed sexual desire, intimacy, and support. The postpartum period felt like an “adjustment” and was filled with many new experiences and emotions. Sexual desire generally decreased due to parenting responsibilities and feeling “tired” or “exhausted”, thereby creating a need for intimacy to be

redefined. However, the postpartum individuals in this study shifted relations of power by defining sexual desire as something that was not required, therefore allowing them to feel "just fine" if they were not experiencing it. The postpartum individuals in this study challenged the social discourse that requires sexual activity within romantic relationships (or as part of intimacy within romantic relationships) by creating non-sexual meanings of intimacy to fulfill certain needs for "connection" and "close[ness]" within their relationships. Support from other moms was viewed as a "double edged sword" and was "helpful" in specific ways by allowing "safe space" for participants to share their "experiences" without any "mom shaming". Participants utilized and accessed supports as a way of challenging the taboo and invisibility surrounding postpartum sexual health by connecting with people who were "open to hav[ing] those real conversations about sexual health and how you're feeling", which was a strong example of agency and power.

CHAPTER 8: DISCUSSION, IMPLICATIONS, AND CONCLUSION

This study's findings uniquely add to the body of literature on postpartum sexual health, specifically in terms of how sexual health is experienced by postpartum individuals. This research utilized feminist poststructuralism to present a different way of understanding how postpartum individuals negotiate relations of power in response to a variety of social and institutional discourses. In applying feminist poststructuralism to this study and the topic of postpartum sexual health more broadly, I was able to uncover a new dimension within how postpartum sexual health is experienced and understood by postpartum individuals. Participants created new meaning within and of their postpartum sexual health, which included meaning of the body, intimacy, support, and feeling ready. Sexual health after birth encompassed emotional, physical, and relational aspects, which is an important finding of this study. Some of the discourses that were uncovered through this research included the postpartum body as sexual, the postpartum body as baby-serving, sexual activity as essential within relationships or as part of intimacy, and health care providers as the experts/authority with regards to sexual health. In terms of the body more specifically, there was a binary created between two different discourses that framed the postpartum body as sexual versus baby-serving. No matter the issue, participants provided many examples of how they negotiated relations of power differently through the same social or institutional discourse to create new meaning(s) within their experience(s). The notion that postpartum individuals are "capable of resistance and innovations" (Baxter, 2016, p. 43) amidst contradictory discourses, practices, or subject positions is clearly evidenced in this research and is what makes it so important (Baxter, 2016).

The first section of this chapter provides a discussion on three salient themes within the findings: 1) Renegotiating the Postpartum Body: Identity, Image, Meaning, & Function; 2)

Resuming Sexual Activity: The Power of the Pelvic Floor and the Six-Week Check; and 3) Feeling Connected: Desire, Intimacy, and Support. This critical discussion also provides an opportunity to consider the findings within the context of the research questions which guided this inquiry: 1) How do postpartum individuals (who have birthed a baby) experience postpartum sexual health?; 2) How do postpartum individuals negotiate relations of power related to their sexual health?; and 3) How is postpartum sexual health socially and institutionally constructed through different discourses? In addition, this chapter will aim to contextualize the findings within other literature to show how certain findings were either similar or unique. I will then discuss strengths and limitations of the study. The chapter will close with the implications of the findings for health education, practice, research, and policy, plans for knowledge translation, and a concluding statement.

Renegotiating the Postpartum Body: Identity, Image, Meaning, & Function

Participants renegotiated the meaning of both their body and their identity in relation to sexuality. In addition, the body and identity were inextricably connected. While certain findings complement what has previously been described in the scholarly literature (see Chapter 2), the use of FPS allowed me to tell the story in a new way. For example, this study uncovered the binary present in how postpartum bodies may be constructed as either sexual or baby-serving through dominant social discourse. In considering how the participants negotiated relations of power, it is important to reflect on the idea that postpartum individuals should not always have to challenge socially constructed binaries (i.e., body as sexual versus baby-serving). This work shows us how perhaps there is a new way of ascribing or creating fluid meanings and understandings of the postpartum body and postpartum identity.

The social construction of mothering has been well-explored by many authors (Coats & Fraustino, 2015; Damaske, 2013; Johnston & Swanson, 2006; Meeussen & Van Laar, 2018; T. Miller, 2007; Newman & Henderson, 2014; Pascoe Leahy, 2019; Wall, 2001), albeit less so when examining how certain constructions shape postpartum sexuality and individual sexual identity. In society, women and mothers are often told what to be, how to be, and when to be (Bailey, 2001; Friedman et al., 1998; Johnston & Swanson, 2006; Montemurro & Siefken, 2012). For example, they are told when to be nurturing, sexual, silent, vocal, emotional, or vulnerable. All of these attributes or ways of behaving are based from "emphasized" (p. 112) assumptions and social constructions of gender, womanhood, and femininity (Bailey, 2001). The same issues that affect daily living are also present in how postpartum individuals themselves shape their own understanding of their sexuality and identity (Hipp et al., 2012), as demonstrated in the findings. Based on the binary that constructs sexual and maternal identities as being in opposition (Bailey, 2001; Friedman et al., 1998; Montemurro & Siefken, 2012), postpartum individuals may feel like they have to choose when to be sexual and when to be a mother/parent (Montemurro & Siefken, 2012; Spencer, Wambach, & Domain, 2014), which may be influenced by culture as well (Alnuaimi & Almalik, 2021; Alnuaimi, Obeisat, Almalik, Ali, & Alshraifeen, 2020; Ifeka et al., 1983; Pardell-Dominguez et al., 2021; Shabangu & Madiba, 2019; Ussher et al., 2017). Montemurro & Siefken (2012) stated the following:

> Motherhood and sexual appeal are rarely linked in Western culture. There seems to be a notion that once a woman has children she is first and foremost an example, and must be responsible and conservative in a culturally specific way (p. 366)

However, my research showed that some postpartum individuals may shape and understand their identity in different ways. The participants in this research often had to create new meaning(s) in

relation to both dominant social discourses and, at times, their own previous experiences. In addition, maternal and sexual identities were not exclusive. Participants believed they could be a mother and hold other roles or identities, such as that of a wife, sexual partner, sister, employee, and woman. The issue of tension between the sexual self and the mothering self is not new and has been described by sociologists and other researchers (Bailey, 2001; Friedman et al., 1998; Montemurro & Siefken, 2012). Participants, at times, had to navigate different emotions and tensions when ascribing meaning to their identity postpartum. My research was unique, however, because it uncovered the shift in *how* participants chose to define themselves as both mothers/parents and as sexual beings. This shift represented an important and unique transition that postpartum individuals chose to navigate differently based on factors such as embodiment and discourse (Bailey, 2001; Montemurro & Siefken, 2012). This is significant in terms of showing us how postpartum individuals evolve throughout the postpartum period and choose to ascribe meaning to their identity through the body.

Palmer-Mehta and Shuler (2017) state that "cultural discourses surrounding motherhood are increasingly policing women's bodies" (p. 360), emphasizing the connection between identity as a mother and body image (Palmer-Mehta & Shuler, 2017). The binary present within how postpartum bodies were socially constructed as either sexual or baby-serving was evident in the findings and therefore merits further discussion. In general, because the body held a maternal 'function' and identity, it could not always simultaneously be sexual. For example, breasts that were being used for feeding were viewed as "weird" or as something that inhibited feelings of sexual attractiveness for some participants. This binary surrounding the breasts has been well-evidenced in other studies exploring the relationship between breastfeeding and sexuality postpartum (Avery et al., 2000; Bucher & Spatz, 2019; LaMarre et al., 2003; Marques & Lemos,

2010; Matthies et al., 2019; Nobre, 2011; M. Rowland et al., 2005). In a ten-year systematic review on breastfeeding and sexuality, Bucher and Spatz (2019) found that breastfeeding significantly influences one's relationship with their body and identity (Rippey & Falconi, 2017), paralleling the findings in this study. More specifically, breastfeeding can affect sexuality and sexual self-image, body image, sexual desire, frequency of sexual intercourse, and physical symptoms that may impede sexual pleasure or sexual functioning such as vaginal dryness or sore nipples (Avery et al., 2000; Bucher & Spatz, 2019; LaMarre et al., 2003; Marques & Lemos, 2010; Matthies et al., 2019; Rippey & Falconi, 2017). Not only are breastfeeding and sexuality mutually exclusive, they may also be competitive (Bucher & Spatz, 2019), though other researchers have shown that postpartum women may choose to view their breasts as both sexual and for nourishment of the baby (Hinson et al., 2018). This study uniquely showed how postpartum individuals react to and perceive socially constructed binaries resulting from discourse and provided evidence that postpartum individuals may find and create unique meaning through and within their bodies. For example, many participants in this study challenged the sexual versus baby-serving binary by critically questioning social constructions of the postpartum body and creating meaning of their breasts as being for both sexual and nurturing purposes. The evidence from my study illuminates the need to include sexuality as part of both social and individual definitions of the maternal body and of postpartum identity; sexual health is relevant and important to postpartum individuals and must therefore not only be acknowledged but celebrated.

Resuming Sexual Activity: The Power of the Pelvic Floor and the Six-Week Check

Physical changes as well as healing from pelvic floor injury seem to be widely acknowledged when discussing postpartum sexual health (Crookall, Fowler, Wood, & Slade,

2018; Pardo et al., 2019; Reimers et al., 2019). Although pelvic floor issues and injuries have always been experienced by postpartum individuals (Fairchild et al., 2020; Gong, Munro, Koenig, & Geoffrion, 2020; Gyhagen, Åkervall, & Milsom, 2015; Handa, Blomquist, McDermott, Friedman, & Muñoz, 2012; Skinner & Dietz, 2015), this research shows that it is only relatively recently (i.e. in the past decade) that a more dominant medical/health discourse surrounding pelvic floor recovery has emerged. This study's findings provide a new understanding of how postpartum individuals are creating a new meaning of postpartum recovery by defining pelvic floor recovery as something that is important to their sexual health. Tracy Dempsey, a nurse continence advisor at the IWK Health Centre's women's health clinic, has further emphasized the importance and newness of destigmatizing pelvic floor issues and recovery. In a recent interview conducted by Erin Lynch (2020), Tracy stated:

> The younger generation of women are viewing pelvic floor health not only as a part of a healthy pregnancy, but as part of a healthy lifestyle. What that says to me is that we are starting to destigmatize women's health issues and have a much-needed open and honest conversation. We're moving in a positive direction (p. 1)

The discourse promoting the importance of pelvic floor health and healing has grown exponentially and is well-evidenced in the findings. Through her frontline clinical experience in Nova Scotia, Tracy has observed the shift in recent discourse and this study clearly demonstrates how postpartum individuals are beginning to challenge the taboo and use their agency to access supports for pelvic floor recovery. This is significant because it tells us where the gap lies; postpartum individuals believe that their pelvic floor health is important and yet health care services in Nova Scotia are lagging behind in terms of providing free and accessible care surrounding postpartum pelvic floor recovery. Pelvic floor physiotherapy and associated care is

critical to quality of life and postpartum wellbeing (Gong et al., 2020; Lawson & Sacks, 2018; Nygaard et al., 2017; Rivalta et al., 2010). Practices of pelvic floor support by health care providers have historically gone unnoticed and it is only more recently that an enhanced focus is being given to pelvic floor health after childbirth. Due to the fact that there has and continues to be a taboo regarding caring for or talking about pelvic floor health within both the health care system and society, it appears that there is a lack of valuing women's health in this regard. However, a different discourse surrounding pelvic floor recovery and health is emerging as new meaning(s) are being created through dialogue and practice in the health care system. From the perspective of the participants in this study, this discourse that frames pelvic floor health as important to postpartum wellbeing and recovery is not yet fully embraced by society or the health care system in terms of access to health services, for example.

This study also uncovered the importance and meaning of the six-week postpartum appointment as a time when postpartum individuals were balancing health care provider advice with personal knowing, specifically in terms of choosing if and when to resume sexual activity. Generally, the six-week postpartum appointment incorporates many aspects of postpartum wellbeing, such as mental health, physical recovery, infant health, and breastfeeding (Jakes, Oakeshott, & Bick, 2019). With regards to sexual activity, however, participants in this study believed that the six-week check-up felt very arbitrary and that it represented a time when their 'instinct' about feeling physically and emotionally ready could be challenged by their health care provider. The significance of the six-week mark was specifically discussed in DeMaria et al.'s recent study (2019) as well. Participants in this study spoke of being "cleared" (p. 1166) for sexual activity postpartum or receiving "doctor's orders" (p. 1166) to resume sexual activity (DeMaria et al., 2019), indicating how the significance of the six-week mark was similarly

viewed as a time when postpartum individuals traditionally receive physician approval to resume sexual activity. Researchers have also described how the six-week mark is not in line with realistic patient needs or desires, specifically as it relates to contraception and timing of the associated return to sexual activity (Glazer, Wolf, & Gorby, 2011). In negotiating the social and institutional discourse that positioned the six-week mark as a time when they should feel ready, some participants responded by expressing how they felt pressured to feel ready even though they knew that they were not. It is not to say that the participants in this study were feeling forced or told by their health care provider to resume sexual activity, but rather responded to the six-week appointment by feeling pressured based on how they created meaning of the physician's approval and the postpartum check-up more generally. This is hugely important in informing how the six-week appointment is made useful or not useful to postpartum individuals in terms of caring for their sexual health. Participant experiences showed us that there is a need to redefine the purpose and meaning of the six-week appointment into an opportunity for meaningful support, information, and open dialogue about sexual health. While the six-week check is not solely focused on sexual health and includes important discussions about physical recovery, perineal healing, infant growth and feeding, and postpartum mental health, it is important to consider that physicians who may be conducting the check-up are perhaps not in the best position to be supporting sexual health conversations due to time constraints, for example. Postpartum individuals want to discuss postpartum sexual health with their health care providers in an open, honest, and direct way, which therefore requires attention to both the physical and emotional components of sexual health after birth (Pardell-Dominguez et al., 2021).

It is also important to discuss the six-week point from a broader lens (i.e. outside of the medical setting) given that it is viewed as significant to sexual health in many parts of the world,

albeit for different reasons. That is, some religions or cultures may have certain beliefs or practices surrounding postpartum sexuality and sexual activity (Cantarino et al., 2016; Mbekenga, Pembe, Darj, Christensson, & Olsson, 2013; Shabangu & Madiba, 2019). For example, some Muslim women may choose to refrain from any sexual activity for forty days after birth based on their religious beliefs (S. Almukhaini, personal communication, September 7, 2021). After that time, they are 'presented' as new brides to their partners and are often socially expected to resume sexual activity, whether they are feeling ready or not (S. Almukhaini, personal communication, September 7, 2021). A similar example has been evidenced in the literature (described in Chapter 2), as Akpinar and Yangin (2018) conducted a study in Turkey and found that 88% of participants (98% of whom were Muslim) believed it was important to wait forty days before resuming sexual intercourse after birth. We can see that there are many very similar examples that are socially, culturally, or religiously embedded. In certain areas of Tanzania, women do not engage in sexual activity for forty-two days after birth due to the cultural belief that a certain amount of time is required to allow them to heal and focus on their postpartum recovery. In one study exploring women's postpartum sexual health experiences, a postpartum Mexican woman described how her cultural beliefs informed postpartum care and how she believed it was important to wait forty days before resuming sexual activity because there would be health "consequences" (p. 1166) if she did not (DeMaria et al., 2019). In reflecting upon these three examples (and there are certainly many others), it appears that the practice of having a specific timeframe where sexual activity does not occur postpartum is informed in multiple ways, though the reasoning or rationale can vary slightly. We can see the binary present in how postpartum physical activity is perceived as harmful or risky immediately after birth and so women are required to have a 'protected' period of time where they do not

engage in any sexual activity. However, the immediate shift that encourages or expects postpartum sexual activity after the chosen time frame ends is very interesting and, quite honestly, difficult to pinpoint in terms of how or why it came to be. What is problematic about the 'six-week rule' is not its presence, but rather how it is perceived by postpartum individuals and how it informs their choice (or ability to choose) if, when, and how they engage in postpartum sexual activity. As we saw in this study's findings, the six-week check may be interpreted by some postpartum individuals as being prescriptive and therefore unacknowledging of one's autonomy over their health and health decisions, or it may be viewed as useful in promoting health, healing, and a return to 'normal' after birth. The evidence from my study points to the need for more clear, explicit expectations regarding the six-week check-up, with opportunity for both the postpartum individual/patient and the health care provider to openly communicate thoughts or questions.

Feeling Connected: Desire, Intimacy, and Support

This section of the findings brought forward the importance and meaning of connection and/or connecting through sexuality- whether that was seeking connection through desire, intimacy, or support. Participant experiences taught us that sexual health is as much relational as it is personal, especially during the postpartum period. However, there were many changes to sexual desire and intimacy, especially in terms of how they were experienced and defined. My research uniquely uncovered how intimacy was experienced through challenging discourses and relations of power. We saw how participants challenged the discourse that requires sexual activity as part of relationships and/or intimacy and chose to create new meaning(s) of intimacy as a way of attending to their emotional needs and caring for their sexual health after birth. I believe it is most important to focus this discussion on how the search for connection was

important to the individuals in this study, and how participants defined support. In what follows, I will explore and critique this study's findings in the context of the literature as it relates to sexual desire, intimacy, and social support.

Sexual desire changed and generally decreased for many participants after birth, which has been a consistent finding in other postpartum sexual health literature as well (Hipp et al., 2012; Khajehei et al., 2015; Saurel-Cubizolles, Romito, Lelong, & Ancel, 2000; Wallwiener et al., 2017; Woolhouse, McDonald, & Brown, 2012; Woolhouse et al., 2014). However, it is important to note that sexual desire and/or libido are highly individual and often fluctuate after birth; some postpartum women may report an increased libido and others may find it has decreased (De Judicibus & McCabe, 2002). Researchers have shown that, due to a perceived difference in sexual desire between postpartum women and their partners after birth (Olsson, Lundqvist, Faxelid, & Nissen, 2005), postpartum women can feel guilty or like a 'failure' when their sexual desire does not match that of their partner or if their sexual desire is lower than it was pre-pregnancy (Woolhouse et al., 2012). When it comes to sexual desire, especially female sexual desire, Western society has long attempted to either fetishize, medicalize, or problematize it (Angel, 2012; Wood et al., 2006). For example, when a woman is assertive or empowered in her ability to choose how often, how, when, and with whom she engages in sexual activity, she is labelled as promiscuous or as a nymphomaniac (Bachechi & Hall, 2015). When a woman chooses not to engage in sexual activity, she is labelled as a prude or a virgin (Bachechi & Hall, 2015). Some of the norms that surround female sexual desire are intensely specific and may therefore be harmful to sexual health because these norms do not acknowledge or honour the spectrum within human sexuality (Angel, 2012; Wood et al., 2006). The use of FPS in this research allowed me to uncover how some postpartum individuals shifted the meaning of sexual

desire as something that they did not necessarily need to be experiencing during the postpartum period. Although participants were aware of a social discourse that positioned sexual desire as something they "should" be experiencing, they ultimately chose to define sexual desire as fluid and individual. They did not problematize a lack of sexual desire, but rather shifted relations of power by creating new meaning(s) of desire as something that changes often and is influenced by many factors such as fatigue, time constraints, nutrition, mood, and parenting responsibilities. This is significant in terms of illuminating how postpartum individuals choose to ascribe meaning to sexual desire, which may also inform their choice to resume or engage in sexual activity after birth or create new meanings of intimacy.

Postpartum intimacy as it relates to new parents has been explored to some extent (Bäckström, Kåreholt, Thorstensson, Golsäter, & Mårtensson, 2018; Lévesque, Bisson, Fernet, & Charton, 2021; Rosen et al., 2017; Stavdal, Skjævestad, & Dahl, 2019). However, there are only a handful of studies that have discussed emotional aspects of sexual health and intimacy postpartum from a first voice perspective, centering only on postpartum women themselves (Bender et al., 2018; Khajehei & Doherty, 2018; O'Malley et al., 2019; Vannier et al., 2018; Woolhouse et al., 2012, 2014). Similar to my findings, postpartum intimacy has been defined in ways that include physical and emotional intimacy, though do not necessarily include sexual intercourse (Bender et al., 2018; O'Malley et al., 2019). Examples of intimacy may include cuddling, kissing, holding hands, open communication, teamwork in parenting the new baby, empathy, and appreciation of one another (Bender et al., 2018; O'Malley et al., 2019). No matter how intimacy was or has been defined, this research uniquely showed how postpartum individuals negotiate relations of power to create new meanings of intimacy as a way of responding to their emotional and sexual needs. Intimacy within romantic relationships is

socially defined to include sexual activity or intercourse, though the postpartum individuals in this study were able to shift what intimacy looked or felt like based on factors such as new parenting responsibilities, decreased sexual desire, fatigue, or stress. This tells us that some postpartum individuals may therefore choose to define intimacy in non-physical or non-sexual ways, either temporarily or as a way of adapting to life after childbirth. This finding is significant in illuminating what postpartum individuals find important as part of their sexual health by revealing how they navigate and adapt to what is, for many, a monumental transition in one's life.

In this study, sexual health support from other postpartum individuals generally centered on having non-judgmental spaces and the ability to relate to one another. A recent study conducted by researchers in Spain described how postpartum women found value in connecting with other mothers when it came to talking about and normalizing their experiences of sexual health (Pardell-Dominguez et al., 2021). While research surrounding mothers' social networks in Nova Scotia does exist (Aston et al., 2018; Price et al., 2018), discussion or exploration of maternal social networks in relation to postpartum sexual health specifically is severely lacking. My study revealed how postpartum individuals define support within their social networks, which included a non-judgmental space and the ability to discuss sexual health openly with other moms/parents. Support was often sought as a way of normalizing their experiences and finding information about what they might expect. Their definition and use of supports illuminated the need for meaningful information about postpartum sexual health and how they used their agency to find it in certain ways, such as through trusted family members or friends. Social supports may be accessed or increased within health care settings given that they are often deemed a trusted, reliable, and relatable presence for postpartum individuals in caring for their postpartum sexual

health. Given that some of the individuals in this study did not often perceive the six-week appointment with their health care provider as being helpful to their sexual health because of how they created meaning of the appointment and the physician's assessment, mothers' social networks may present a solution to the gap in care and information that is currently in existence.

Study Strengths & Limitations

The first and most significant strength of this study was that the approach used enabled me to answer my research questions. Another major strength of this study came from understanding several aspects of how postpartum individuals experience their sexual health and sexuality postpartum, as well as the richness of the data in the examples and personal stories that the participants shared. In applying a feminist poststructuralist lens to the data, several personal, social, and institutional discourses were uncovered. In this study, there was space for participants to share what they wanted- everything was 'on the table' and the interviews were conducted in a way that allowed participants to direct and lead the issues discussed in relation to their postpartum sexual health. I was intentional in interviewing participants who were within one to six months postpartum as it allowed me to hear their experiences, thoughts, and feelings as they were happening. While some participants spoke retrospectively of certain moments or events, their experience was still very much evolving, as was apparent in the issues brought forward by participants based on how recently they had given birth.

One limitation of this study included the recruitment of participants from only one Canadian province, though this was largely due to feasibility. Conducting a similar study in another Canadian province may yield different results depending on factors such as cultural or geographical context, access to health resources, community support or connection, or values in relation to postpartum sexual health. I would therefore suggest that future research studies aim to

explore postpartum sexual health in other areas of Canada. Although no demographic information or data was collected, based on the information shared in each interview, there were no participants who verbally identified themselves as being part of an equity-seeking group/community. Therefore, further research needs to be conducted with a focus on factors such as culture, race, sexual orientation, or gender identity. While no demographics emerged, subjectivities emerged. Participants subjectively positioned themselves as mothers, women, friends, or partners, for example, which helped to contextualize the findings and explore how participants responded to relations of power by creating their own meaning(s). Another limitation was the fact that the postpartum individuals recruited were within one to six months postpartum. While this provided a valuable snapshot of their current experiences, challenges, and raw emotions regarding sexual health after birth, it would be valuable to expand the inclusion criteria for future studies past six months postpartum given that the participants who were interviewed at six months postpartum were still having issues with sexual health. With regards to postpartum sexual health research more broadly, many studies tend to also include romantic and/or sexual partners. For this study, I was intentional in centering the experiences of postpartum individuals, as told by themselves, given that their voices have been historically underrepresented and undervalued in previous research on this topic (Woolhouse et al., 2012). There is a need to prioritize postpartum individuals' experiences as told by themselves in postpartum sexual health research, an opinion that has been echoed by other researchers as well (Woolhouse et al., 2012). However, there is undoubtedly value in including romantic and/or sexual partners when exploring how relational aspects of sexuality may influence sexual health after birth, especially from a qualitative lens as much of the research on postpartum couples' sexual health has come from a psychology-focused, quantitative lens. Many of the references

used in this chapter are relatively dated (i.e., greater than five years since publication) due to the fact that the authors cited are based in feminist philosophy or gender studies, where publications are less common than in nursing or health research. However, the authors cited represent seminal literature. While the sample size was a strength in that it enabled me to apply FPS in a way that could then be shared with the reader to demonstrate how others can use this methodology, this study cannot offer generalizable findings. Therefore, further qualitative or quantitative studies may be done to build on the findings of this study.

Study Implications

This research provides a deeper understanding of how postpartum individuals experience their sexual health after birth. Although no two experiences are the same, similarities across postpartum experience(s) exist. Postpartum sexual health is much more than a separate aspect of health; it intertwines with emotional, physical, relational, and mental wellbeing. In the following sections, I discuss health professions education, practice, policy, and research implications of this study.

Education. The study findings have implications for nurses and other health care providers both during and after their university education. There exist clear gaps with regards to if, when, and how postpartum sexual health is cared for and discussed by health care providers (Evcili, Demirel, Bekar, & Guler, 2020; Saunamäki, Andersson, & Engström, 2010). Health care providers must be prepared to initiate and have these conversations with their patients/clients, especially considering that postpartum women who speak with a nurse are at a lower risk of experiencing sexual dysfunction (Evcili et al., 2020). In order to feel comfortable and competent engaging with patients, health care providers must first have the knowledge and tools necessary to offer meaningful support and patient education (Evcili et al., 2020; Saunamäki et al., 2010).

From the perspective of postpartum individuals, provider-led education must be accessible either virtually or in their communities so that they can receive reliable, informative support. Nurses, for example, are ideally positioned to act as a resource in supporting and promoting sexual health after birth (Evcili et al., 2020) alongside other health care professions, such as obstetricians, uro/gynecologists, family physicians, counsellors, psychologists, nurse practitioners, pelvic floor physiotherapists, and midwives (Zamani, Latifnejad Roudsari, Moradi, & Esmaily, 2019). While many participants in this study believed that health care resources could be helpful to their pelvic floor recovery and sexual health after birth, it is also critical to consider how knowledge is shared and valued. There is a need to talk about sexual health differently (Foucault, 1978) and knowledge about sexual health or pelvic floor recovery does not always necessarily need to be medicalized. Rather, knowledge and education may also be shared and dispersed by postpartum individuals themselves.

Within health professions curriculums, postpartum sexual health must be included as part of important postpartum patient education and care. Students, such as those in medicine, nursing, physiotherapy, psychology, pharmacy, midwifery, or recreational therapy must learn how to approach the topic of sexual health more generally as well as postpartum sexual health in a non-judgemental and respectful manner. There are specific educational considerations related to sexual health during the postpartum period, such as the shifts in the meaning of the body and of identity and the initiation of breastfeeding, as only some examples evidenced in this study. Continuing education for health care providers on how to approach and initiate the topic of sexual health with patients is also paramount (Zhang, Sherman, & Foster, 2020). Health institutions as well as professional nursing bodies/organizations, such as the Canadian Association of Perinatal & Women's Health Nurses or the IWK Health Centre, should be

responsible for offering ongoing training and education for nurses, midwives, and other frontline health care providers who work with postpartum individuals and their families. As of now, there is a lack of health care provider education about certain postpartum sexual health issues, such as sexuality and identity, therefore creating a gap in knowledge that impedes an important aspect of postpartum health, recovery, and care.

Practice. Based on the findings in this study, dialogue with health care providers about postpartum sexual health is largely focused on physical aspects of sexual health, such as contraception and healing of the perineum (Society of Obstetricians & Gynecologists of Canada, 2022). While these issues are undoubtedly important for postpartum individuals, it is imperative that a more wholistic view of postpartum sexual health is implemented into care (O'Malley et al., 2015). Postpartum individuals often require interdisciplinary care and support to promote their sexual health after birth and the adjustments or changes they may be experiencing. It is critical that postpartum patients feel that they can trust health care providers to be informative, attentive, supportive, and non-judgmental (Zhang et al., 2020). In addition, other researchers have discussed the importance of both physical and psychological factors in choosing to resume sexual activity and feeling ready to do so (DeMaria et al., 2019; Jawed-Wessel & Sevick, 2017), which was evidenced in this study as well. Although there are often time constraints associated with postpartum appointments, home visits, or hospital discharges, there must be, at the very least, information given to the postpartum individual about how to care for their postpartum sexual health and a follow-up point of contact if they have questions or concerns. Information may be communicated in the form of a brochure, information sheet, social media posts, podcasts, talk shows, news articles or interviews, or op-eds. Assessment tools such as the Sexual Perceptions of Breastfeeding Scale may also be useful for health care providers (Hurst, 2013) as

a “conversation starter in clinical practice” (Bucher & Spatz, 2019, p. 504). Based on how participants spoke of their support systems and social networks, there lies benefit in including these sources of support more fully in both prenatal and postnatal teaching and care. For example, intergenerational or communal co-learning alongside grandparents, parents, partners, parents-in-law, friends, siblings, or other supports may help postpartum individuals to feel more understood and supported in navigating resources, care interactions, and postpartum wellbeing. The Women’s Postpartum Sexual Health Program (WPSHP), based in Vancouver, B.C., is one example of an innovative, Canadian program that addresses multidimensional aspects of sexual health by involving partners and offering group-based support with other postpartum women (McBride, Olson, Kwee, Klein, & Smith, 2017). However, it is unclear if this program is still in place. In Western society, postpartum individuals often feel that they are expected to ‘know it all’ when navigating the postpartum period, though this study showed how many may experience uncertainty regarding their postpartum sexual health, among other postpartum health issues. As such, prenatal and postnatal resources, informal educational events, or classes must target both postpartum individuals and their identified supports.

Many participants spoke of the significance of the six-week postpartum check-up appointment as a moment when they expected to discuss sexual health, though were sometimes dismissed or told misleading information about their recovery. Based on current public information about what is discussed at the postpartum appointment, there is no mention of emotional or social aspects of sexual health, only that assessment of perineal healing and discussion about contraceptive methods may be expected (Society of Obstetricians & Gynecologists of Canada, 2022). My research showed that this check-in represents a key time when postpartum individuals are beginning to think about their sexual health. As such,

postpartum individuals must be given space to discuss their questions or concerns with their health care provider and be referred to community supports appropriately (Zhang et al., 2020). However, adequate support may very well mean that sexual health is discussed proactively during the prenatal period, rather than during postpartum check-ups where there is already so much education and assessment that needs to occur. The issue of feeling 'dropped off' was apparent for some participants as they were often left to navigate their sexual health issues alone and without consistent, continuous health care provider support or contact. From a public health perspective, public health nurses in this province present a key resource/point of contact for postpartum individuals and their families; all postpartum individuals in Nova Scotia are provided with access to a public health nurse after their birth either in hospital or in their home (Aston et al., 2015). At present, public health nurses are instructed to cover certain topics during their postpartum visit, which usually occurs at some point during the first week after birth, with follow-up visits arranged as needed (Aston et al., 2015). However, postpartum sexual health is not currently included as part of standard public health nursing care during home visits in Nova Scotia, though it could act as a point of access to information, support, and resources. As such, there is a critical need to reconstruct care and involve other supports, as has been previously discussed.

There are several individuals who may help to 'fill the gap' with regards to postpartum sexual health information and support. For example, postpartum doulas, sexual health counsellors, psychologists, or pelvic floor physiotherapists may be accessed by some postpartum individuals and are positioned to provide trustworthy information about sexual health (Zamani et al., 2019; Zhang et al., 2020). Other opportunities for patient education include providing an information sheet or pamphlet about postpartum sexual health prior to discharge from the

hospital. For example, a pamphlet might be included in the information package that is currently given to all postpartum families upon discharge from the Family Newborn Care Unit at the IWK Health Centre. The postpartum period is often a time when postpartum individuals and their families/supports can feel overwhelmed with information and questions (Henshaw et al., 2018; Nan et al., 2020). As such, it would be highly beneficial for postpartum sexual health information to be shared during the prenatal period, perhaps through a model that mixes peer support with professional care. For example, this may occur through prenatal education classes, health appointments, and other public health-led community events or resources pertaining to maternal health.

Policy. For many of the recommendations related to education and practice to be successfully implemented, health care policies must reflect a certain standard of care for all postpartum individuals in Nova Scotia, regardless of their geographical location. The most pressing issue related to postpartum sexual health care in this province is the absence of a standardized institutional or provincial care strategy/directive that guides when, how, and with whom postpartum sexual health should be addressed. As such, current postpartum care relies on the initiative of individual health care providers to discuss sexual health or refer postpartum patients appropriately when they are experiencing issues. The topic may not be easy for some people to bring up with their health care providers and so it is important that discussions surrounding postpartum sexual health are initiated by health care providers when it is deemed an appropriate time and/or space (Zhang et al., 2020). Many postpartum individuals in Nova Scotia 'fall through the cracks' and are left to navigate issues on their own (Ollivier et al., 2021; Price et al., 2018). For example, once discharged from their midwife, some participants in this study felt they had no one to turn to for help or support once they started having concerns beyond the

immediate postpartum period. Sometimes the participants were not aware that pelvic floor physiotherapy existed, for example, until they were three or more months postpartum and beginning to question if their physical symptoms were normal. This research showed that there exists a severe lack of accessible resources for postpartum sexual health and recovery in Nova Scotia. At present, pelvic floor physiotherapy is not financially covered by the province, therefore requiring postpartum individuals to have private health insurance or to pay out of pocket for services that may be required for weeks to months after birth. These services are also quite costly. The provincial health care system in Nova Scotia must better prioritize prenatal and postpartum care (Ollivier et al., 2021). Much like midwifery care or public health nursing services, support from other health care providers such as pelvic floor physiotherapists is essential to promoting sexual health (Lawson & Sacks, 2018) and should therefore be free and universally accessible for postpartum individuals. Many countries in Europe, for example, provide free access to postpartum pelvic floor physiotherapy (Woodley, Boyle, Cody, Mørkved, & Hay-Smith, 2017). The health care system in Nova Scotia must adapt to individuals, not vice versa.

Research. An initial extension of this research would be to explore how postpartum sexual health is experienced in other geographical areas of Canada to uncover how geographical context might influence perceptions, attitudes, and beliefs surrounding the postpartum period and postpartum sexual health. It is quite possible that there exist cultural and geographical differences surrounding how postpartum sexual health is experienced even within the Atlantic provinces. Research in international settings would certainly illuminate how religion, culture, gender, social norms, family, community, and environment influence sexual health after birth.

This study only provided a brief snapshot in time by recruiting participants who were within one to six months postpartum. A natural progression of this research would be to investigate how postpartum sexual health is experienced at one year postpartum, for example, and even more longitudinally. It would be insightful to explore how experiences, including beliefs, values, and practices, evolve after birth and how postpartum individuals navigate these transitions. A future longitudinal study would help us to better understand how postpartum sexual health may or may not affect lifelong sexual health, such as formation and evolution of sexual identity, as well as pelvic floor health.

As was explored and outlined in Chapter 2, there is a need for more research exploring non-physical aspects of postpartum sexual health in order to continue building knowledge and informing postpartum health care. Current research in psychology, nursing, and medicine is often very empirical and patronizing in its approach because it fails to center the experience of the postpartum individual without problematizing it as abnormal or dysfunctional (Ollivier et al., 2019). While there is certainly value in both quantitative and qualitative approaches to postpartum sexual health research, the current postpartum sexual health research sphere would benefit greatly from incorporating feminist and/or critical social approaches to research in order to contribute to more equitable postpartum health care. Research can be used as a tool for change in this topic area (Brown & Strega, 2005).

Knowledge Translation

The sharing and dissemination of this important research is essential to fostering change within maternal health care services. In considering my professional role as a practicing Registered Nurse in Nova Scotia, I am well-positioned to engage with stakeholders from both a clinical and research-based lens. I plan to present at various family resource centers and

postpartum/perinatal hospital units across the province, including Maggie's Place Family Resource Centre and the IWK Health Centre's Perinatal Centre. I have also presented at research or academic-focused events, such as at the IWK Health Centre's Research Rounds and at the Canadian Association of Perinatal & Women's Health Nurses' annual conference in September 2021. Due to the popularity of more 'visible' knowledge translation methods, I also plan to engage with the public on a wider scale through televised or radio interviews and podcasts, such as the Momgasm podcast (based in Nova Scotia) and CTV's The Social (Barton & Merolli, 2019). Discussions surrounding institutional policies, patient education tools, and staff education will occur with the Director of the Women's Health program at the IWK Health Centre, Darlene Inglis, as well as several Clinical Nurse Educators and Unit Managers, such as Renata Kolanko and Rebecca McLeod. Based on conversations I have had with several nurses and nurse educators at the IWK and at Maggie's Place, a one-page patient education document outlining the key findings from my research as well as additional information about caring for sexual health after birth is something they believe would be helpful for postpartum patients. As of now, the only discharge teaching that discusses sexual health is located on one page in the Loving Care book provided by public health. In addition, findings will be disseminated through two to three peer-reviewed journal publications. Ideally, it would be useful to create a video for people who are pregnant or newly postpartum detailing the findings and implications of this study. This video may be shared at prenatal classes or other public health events, such as parent/baby programming at family resource centres across Nova Scotia.

Conclusion

This study provides a unique understanding of how emotional, physical, and social aspects of postpartum sexual health are experienced by postpartum individuals in Nova Scotia.

Carrying a pregnancy and birthing a baby represents, for many, a significant life event. The transition into parenthood/motherhood can also represent a new and exciting, yet challenging period when changes to sexual health are common. Feminist poststructuralism allowed me to unveil new meaning(s) within sexual health after birth and to uncover how postpartum individuals negotiate relations of power differently to prioritize the issues most important to them. For postpartum individuals, the joys and challenges associated with sexual health during the postpartum period are unique to each person, yet hold common threads. This study has significance for postpartum individuals and their supports, as well as for health care providers and policy-makers, given that it provides data to inform how postpartum sexual health may be better supported. Such understanding is critical and has the potential to influence postpartum care priorities and directives, prenatal and postnatal education, and maternal health services that may enhance sexual health support during the postpartum period and beyond.

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Appendix A

Study Information Form

Research Title: Exploring Postpartum Sexual Health in Nova Scotia Using Feminist Poststructuralism

Researchers:

Rachel Ollivier, RN PhD(c), Doctoral Candidate, School of Nursing, Dalhousie University & Registered Nurse, Adult Surgery Unit, IWK Health Centre
Dr. Megan Aston, RN PhD, Professor & Associate Director of Research & International Affairs (Co-Supervisor), School of Nursing, Dalhousie University
Dr. Sheri Price, RN PhD, Professor (Co-Supervisor), School of Nursing, Dalhousie University
Dr. Audrey Steenbeek, RN PhD, Professor & Associate Director of Graduate Studies (Thesis Committee Member & Reader), School of Nursing, Dalhousie University
Dr. Debra Sheppard-LeMoine, RN PhD, Dean (Thesis Committee Member & Reader), Faculty of Nursing, University of Windsor

Funding Sources: Vanier Canada Graduate Scholarship (Canadian Institutes of Health Research), Killam Predoctoral Scholarship (Killam Trust), Nova Scotia Graduate Scholarship (Dalhousie University Faculty of Graduate Studies), Dalhousie University School of Nursing, TD Meloche Monnex Doctoral Award (Canadian Nurses Foundation), Scotia Scholar Award (Research Nova Scotia)

Introduction

You are being invited to participate in the research study named above. This form provides information about the study. Before you decide if you want to take part, it is important that you understand the purpose of the study, the risks and benefits associated with taking part, and what you will be asked to do. You do not have to take part in this study. Taking part is entirely your choice. Informed consent (allowing you to take part) starts with the initial contact about the study and continues until the end of the study. As the Principal Investigator, I will be available to answer any questions you may have. You may decide not to take part and you may withdraw from the study at any time up until 10 days following completion of our interview. This will not affect the care you or your family members receive from your health care provider or the IWK Health Centre in any way.

Why are the researchers doing this study?

The purpose of this study is to explore how people who have recently given birth experience their sexual health after birth. The aim of this study is to better understand how postpartum individuals in Nova Scotia experience their sexual health so that health care providers and services may better support postpartum health, including sexual health.

How will the researchers do the study?

This study is being conducted to engage people in Nova Scotia who have recently given birth in conversation about how they experience their sexual health after having a baby. I would like to speak with you to better understand your experiences of sexuality and sexual health after birth. In total, I expect to interview between 10 and 12 research participants, though each interview is individual. There are no right or wrong answers- I want to know whatever you wish to bring forward and share with me. After I have completed the number of interviews I need to, I will be looking for similarities and differences in people's experiences. When I report my research results, I will use exact words from some of the people who participated in the study to better illustrate their experiences. If any quotes are used, they will remain confidential (your name or any identifying information will not be shared). Participants from all across Nova Scotia are being invited to take part in this study.

Data collection will be conducted starting in September 2020 and will continue until I have interviewed enough participants.

What will I be asked to do?

You may participate in the study if you are over 18 years of age, you can speak, read, and understand English, are currently living in Nova Scotia, and have given birth within the past 1-6 months. If you are interested in participating, you may contact me (Rachel Ollivier) and I will clarify any questions you may have about the study. I will email you a consent form to sign before doing the interview, which you may then send back to me using a scanned copy or a photo of the signed document. If you do not have access to email or a printer, I will obtain your consent verbally over the phone a few days before the interview or immediately prior to the interview. I will then schedule a time that is convenient for you so that I can interview you. The interview will last approximately 60 minutes (1 hour) and will be audio-recorded. I will conduct the interviews using Zoom (video chat) or over the phone, whichever method you prefer. If the interview is conducted using video chat, you are not required to enable the video feature, but may do so if you wish. I will enable my video so that you can see me during the interview. I will ask you to describe your experiences of sexual health and what sexual health means to you after having given birth. Examples of the questions I will ask are:

1. What comes to mind when you just think broadly of sexual health after birth?
2. Tell me about your sexual health and sexuality since giving birth.
3. What is the most important thing to you about your sexual health and sexuality after having a baby?

4. What emotions do you experience when you think of your sexuality or sexual relationships after having a baby?
5. Tell me about a time when you thought about your sexual health and sexuality after
6. What, if anything, has helped or hindered your sexual health and sexuality after birth?

You may choose not to answer any questions or you may stop the interview at any time. You may also withdraw from the study up to 10 days after the interview without reason. After 10 days, my analysis of the interview data may have begun and so to facilitate timely completion of this doctoral thesis project, a limit of 10 days for withdrawal has been set. If you choose to receive the results of this study, I will send you a copy of the research summary when complete. I will ask you if you would like to receive a copy of the research summary on the consent signature form.

What are the burdens, harms and potential harms?

No harms are anticipated as part of participating in this study; however it is possible that reflecting on experiences and situations may cause you to become upset or distressed. If you do become upset, you may stop the interview and you will be able to speak to your primary health care provider (your family doctor, counsellor, psychiatrist, or nurse) about your feelings. Should you feel that mental health support is required after the interview, you may contact the following resources in Nova Scotia, in addition to your Nurse Practitioner, psychiatrist, counsellor, or family physician (if applicable): Call 2-1-1 for free, confidential referral to community services in the province, or visit https://mha.nshealth.ca/en/services to access information about mental health supports. For a mental health emergency requiring immediate attention, call 9-1-1 or go to your nearest Emergency Department. To access the Provincial Health & Addictions Crisis Line, call 1-888-429-8167.

What are the possible benefits?

There is no guarantee that you will benefit personally by taking part in this study. However, the information you provide may help improve health care practices and policies related to pre-natal and post-natal care. This information can be shared with other health care professionals and researchers through workshops, conference presentations, and scholarly publications.

What alternatives to participation do I have?

One option is to not participate in the study. Not participating in the study will not affect the care that you receive at the IWK Health Centre.

Can I withdraw from the study?

You may decide to withdraw from the study without needing to provide any reason(s) for your choice. Withdrawing from the study will not affect the care you or your family receive from your health care providers or the IWK. There are no risks involved with withdrawing from this study at any point. If you choose to withdraw from the study after we have met to speak about your

experiences, your information will be immediately removed and will not be used in the study. You may choose to withdraw from the study up until ten days after the interview has happened.

Will the study cost me anything an, if so, how will be reimbursed?

The study will cost you nothing. I am offering a $25 e-gift card to thank you for in participating in this study. This will be sent to you upon receipt of the signed consent form, prior to the interview.

What about possible profit from commercialization of the study results?

There is no profit from commercialization of the study results to be realized.

Are there any conflicts of interest?

I have no conflict of interest in pursuing this project.

How will I be informed of study results?

Scholarly publications are anticipated to be published by Summer 2022, with my final dissertation completed in Winter 2022 and freely available through the Dalhousie University online thesis portal. If you would like to receive a summary of the overall study results, please provide your name and email or mailing address on the Participant Consent Form and I will send the general summary to you.

How will my privacy be protected?

All attempts to maintain confidentiality will be taken. I will not be collecting any data from any health care records. I will have access to your name in the initial consent forms and interview files. Confidentiality will be further maintained by replacing your name with an identification number and a 'made up' name that you may choose, as well as by removing the names of people, organizations, and agencies referred to in our conversation. You will not be identified by name in any reports or publications of this research. Data stored digitally will be password protected. De-identified recordings may be sent off-site to a professional transcriber through a secure data transfer system and will be deleted upon transcription completion. Data storage devices used, and all printed interview transcripts will be locked in secure filing cabinets located within my home and/or in the Dalhousie University School of Nursing. Only I will have access to files or other materials in the locked filing cabinet. Any data stored on memory sticks will be encrypted and kept in a secure location at all times. The only individuals who will read or hear the interviews are myself, the professional transcriptionist that I hire, Dr. Megan Aston (co-supervisor), and Dr. Sheri Price (co-supervisor). Five years after this research has been published, this data will be permanently destroyed. All studies conducted at the IWK Health Care Center are subject to a potential audit by the IWK Health Centre's Research Ethics Audit committee. Should an audit be conducted, your privacy will continue to be protected to the maximum extent allowable by the law.

What if I have study questions or problems?

If you have any questions or concerns, please do not hesitate to contact me at any time: Rachel Ollivier (Mobile: 403-xxx-xxxx, Email: rachel.ollivier@dal.ca). You may also contact my primary thesis co-supervisor, Dr. Megan Aston: megan.aston@dal.ca or 902-494-6376.

What are my research rights?

Your signature on the consent form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigator(s), sponsors, or involved institution(s) from their legal and professional responsibilities. If you become ill or injured as a direct result of participating in this study, necessary medical treatment will be available at no additional cost to you. You are free to withdraw from the study at any time without jeopardizing the health care you are entitled to receive.

If you have any questions at any time during or after the study about research in general you may contact the Research Office of the IWK Health Centre at (902) 470-8520, Monday to Friday between 8:00a.m. and 4:00p.m.

Please note that, in accordance with provincial laws, in the rare event that we learn anything during the course of the study that would cause us to believe that a child was being harmed or at risk of being harmed, we would be required to report this to a child protection agency.

Thank you for your interest,

Rachel Ollivier, BSN, RN, PhD(c)
PhD Candidate | School of Nursing, Dalhousie University
Registered Nurse | Adult Surgery Unit, IWK Health Centre
Mobile : 403-xxx-xxxx
Email: rachel.ollivier@dal.ca

Appendix B

Participant Consent Signature Form

Study Title: Exploring Postpartum Sexual Health in Nova Scotia Using Feminist Poststructuralism

Participant ID #: ____

Participant INITIALS: _____

PARTICIPANT CONSENT

I have read or had read to me this information and consent form and have had the chance to ask questions which have been answered to my satisfaction before signing my name. I understand the nature of the study and I understand the potential risks. I understand that I have the right to withdraw from the study at any time without affecting my care in any way. I have received a copy of the Information and Consent Form for future reference. I freely agree to participate in this research study.

Name of Participant: _____

Participant Signature: _____

Date: Time: _____

STATEMENT BY PERSON PROVIDING INFORMATION ON STUDY

I have explained the nature and demands of the research study and judge that the participant named above understands the nature and demands of the study.

Name: Rachel Ollivier

Signature: _____ Position: Principal Investigator

Date: _____ Time: _____

STATEMENT BY PERSON OBTAINING CONSENT

I have explained the nature of the consent process to the participant and judge that they understand that participation is voluntary and that they may withdraw at any time from participating

Name: Rachel Ollivier

Signature: _____ Position: Principal Investigator

Date: _____ Time: _____

How will I be informed of study results?
Would you like to receive a summary of the study results? Yes ____ No ____
If you indicated yes to this question, please provide your email and/or mailing address:

Appendix C

Semi-Structured Interview Guide

Introduction: Thank you again for taking the time to meet with me to discuss how you experience your sexual health after birth. In many of these questions, I will ask you about your sexual health, though it is important for you to know that I am using sexual health as a broad term. Sexual health can include how you express and share your sexuality, with yourself or with others, as well as anything or anyone that influences your health and experience as a sexual being. In previous research that has been done about sexual health after birth, some people's experiences have included physical, emotional, or mental aspects of sexual health, including but not limited to relationships, body image, physical changes, sexual activity, or emotional intimacy. Your sexual health, and what is included in that, is whatever you want it to be. I want to know as much as you are comfortable sharing with me and there are no right or wrong answers. If you prefer not to answer a certain question, please let me know and we will move on to the next question. Do you have any questions before we begin?

Questions:

1. What comes to mind when you think not necessarily about your experience, but just broadly about sexual health after birth?
2. Tell me about your sexual health and sexuality since giving birth.

Potential prompts:

- How does that make you feel?
- Help me to understand how you experience _____. What is that like for you?
- Was this a change compared to before or during pregnancy? How did things change or not change after having a baby?
- How do you feel connected or disconnected from your sexuality at this moment?

3. What is the most important thing to you about your sexual health and sexuality after having a baby?

Potential prompts:

- Why is _____ most important?
- What makes you say _____ is most important?

4. What emotions do you experience when you think of your sexuality or sexual relationships after having a baby?

Potential prompts:

- You said you felt _____. What was that like?
- I heard you say _____. Can you tell me more about that?
- How does that make you feel?

5. Tell me about a time when you thought about your sexual health and sexuality after giving birth. What came up for you?

Potential prompts:

- I heard you say _____. Can you tell me more about that?
- What do you think caused that or influenced that?

6. What, if anything, has helped or hindered your sexual health and sexuality after birth?

Potential prompts:

- I am hearing you say _____. Why do you think _____ helped/hindered your sexual health after birth?
- What was/is that like for you?

7. If you were to speak either to your newly postpartum self or, say, to someone who had given birth a month ago, what advice would you give them regarding sexuality and sexual health after birth?
8. Do you have anything else you would like to share?

Conclusion: Thank you very much for sharing your experiences and participating in this study.

Appendix D

Recruitment Poster

RESEARCH OPPORTUNITY

SEXUAL HEALTH AFTER BIRTH

Study Details:

The purpose of this study is to explore how people who have recently given birth experience their **sexuality** and **sexual health** after birth.

All walks of life and experiences are welcome! A token of appreciation will be provided to study participants. The interview will require approximately 1 hour of your time. You will be interviewed either over the phone or using video chat.

Eligibility:

- 18 years of age or older
- Fluent in English
- Currently living in Nova Scotia
- Person who has given birth in the past 1-6 months
- Reliable access to internet or phone

Contact:

Rachel Ollivier (PhD Candidate, School of Nursing, Dalhousie University)
Email: rachel.ollivier@dal.ca

This study has been approved by the IWK Health Centre's Research Ethics Board (#1025879).

Appendix E

Transcriptionist Confidentiality Agreement

Rachel Ollivier, a PhD Candidate at the Dalhousie University School of Nursing, is conducting the study titled, "Exploring Postpartum Sexual Health in Nova Scotia Using Feminist Poststructuralism".

As the Transcriptionist, I agree to keep all the research information shared with me confidential.

I will not discuss or share any of the research information in any form or format (e.g., all data, materials, recordings, transcripts) with anyone other than the Principal Investigator.

I agree to keep all research information in any form or format (e.g., all data, materials disks, tapes, transcripts) secure while it is in my possession.

I agree to return all research information to the Principal Investigator, Rachel Ollivier, once I have completed transcription.

I agree that after consulting with the Principal Investigator, to erase or destroy all information stored on my computer hard drive regarding this research project that is not returnable to the researcher.

_____	_____	___/___/___
Signature of Transcriptionist	Name (Printed)	Date (DD/MM/YY)
_____	_____	___/___/___
Signature of Principal Investigator	Name (Printed)	Date (DD/MM/YY)

Concerns or questions pertaining to this study may be addressed to: Rachel Ollivier (Mobile: 403-xxx-xxxx, Email: rachel.ollivier@dal.ca)