1. The wide variety of questionnaires used in the cited studies indicates that there is no ideal instrument for screening for postpartum sexual dysfunction. What do you believe are essential attributes of a perfect screening questionnaire for practical, in-office use?

Response from Drs. Leeman and Rogers:
Many different sexual function questionnaires have been used in clinical research; however, few of these questionnaires are appropriate for office screening. For office use we recommend a brief questionnaire that is easy for patients to understand. The Committee on “Clinical Evaluation and Scales in Sexual Medicine” of the International Consultation in Sexual Medicine has recommended either the Brief Sexual Symptom Checklist for Women (BSSC-W; five responses) or the Sexual Complaints Screener for Women (SCS-W; 19 responses), although neither has been explicitly validated in clinical practice¹. We recommend the BSSC-W for practical use in obstetric practices, as it will take most women only a minute or two to complete.

2. Can a familiar, readily available and inexpensive postpartum screening tool such as the Edinburgh Postnatal Depression Scale be used to estimate the severity or significance of sexual dysfunction in the patient’s life?
Response from Drs. Leeman and Rogers:

The Edinburgh Postnatal Depression Scale is designed to screen for and assess the severity of postpartum depression and is as accurate as an in-depth clinical interview. Although rigorous evidence supporting the benefit of universal screening of all postpartum women is lacking, many obstetrical practices have introduced routine screening (see “Screening for depression during and after pregnancy. Committee Opinion No. 453. American College of Obstetricians and Gynecologists. Obstet Gynecol 2010; 115:394–5”). Women with sexual dysfunction have a greater likelihood of coexisting postpartum depression and we recommend that women with sexual dysfunction also be screened for depression. On the other hand, while depression affects sexual function, it does not tell the entire story and women with depression require separate evaluation of their sexual health.

3. Given the enormous challenges encountered by women during and after pregnancy, it is no surprise that the estimated prevalence rate for sexual dysfunction is high. How does one distinguish normal, appropriate adjustments from abnormal responses?

Response from Drs. Leeman and Rogers:

The International Consultation in Sexual Medicine has defined sexual dysfunction as a sexual disorder that the individual finds distressful. While rates of intercourse decline throughout pregnancy, it is unknown whether or not these declines are bothersome to the majority of women. Many of the common problems encountered by women during or immediately following pregnancy are easily addressed with education and simple interventions, including lubricants to treat vaginal dryness, and reassurance about the safety of vaginal intercourse, even late in pregnancy with uncomplicated pregnancies. Much of what happens to sexual health during pregnancy is unknown, and more research is needed so that we can appropriately counsel our patients regarding what are normal and abnormal changes associated with pregnancy and the postpartum. That said, there are a small cohort of women with adverse pregnancy outcomes that have longstanding sexual dysfunction that is linked to their pregnancy and birth, which is clearly distressing and warrants treatment.

4. Our ability to define—let alone prevent or treat—postpartum sexual dysfunction seems quite limited. Recognizing that a good screening test addresses an important public health need, detects a treatable condition, and is reproducible, is it really cost-effective to universally screen for postpartum sexual dysfunction at all?
Response from Drs. Leeman and Rogers:

Assessment of sexual wellbeing is recognized as an integral part of well woman and gynecological care and is ranked as an important component of health by many women. Cost effectiveness is difficult to assess in this situation, since the costs associated with poor sexual health have not been determined. Nonetheless, we believe that the cost of a brief self-administered screening questionnaire is minimal. In addition, many sexual concerns can be addressed with brief education and counseling, such as an explanation about vaginal dryness with breastfeeding or what to expect after a perineal laceration. Screening may also identify issues such as postpartum depression or sexual dysfunction that preceded the pregnancy that can benefit from referral to appropriate resources for counseling.

5. There are many factors contributing to the etiology of postpartum sexual dysfunction such as hormonal changes, body image, depression, and sleep deprivation. Overall, what is the most common factor in your practice? How important is it to pinpoint the cause for each individual woman in order to treat her most effectively?

Response from Drs. Leeman and Rogers:

We have found that healthy low risk women have low rates of perineal pain following vaginal birth. In addition, body image changes played an important role in postpartum sexual complaints. That said, little investigation has focused on assessment of the relative contributions of various postpartum challenges to sexual health. Sexual dysfunction, whether or not it occurs postpartum or not, is commonly multifactorial, and there is no reason to assume that postpartum sexual function is not the same. We believe that it is important to screen women who have suffered from perineal trauma for dyspareunia and treat women for vaginal dryness associated with the hormonal changes common with lactation.

6. Is there a role for evaluation of the partner’s contribution to the sexual dysfunction; for example, his/her effectiveness as a support person, sleep deprivation, feelings of being overwhelmed, fears of causing pain or fathering another child, etc.? Along the same line, what is the role, if any, for marital counseling or sex therapy in the context of postpartum sexual dysfunction?
Response from Drs. Leeman and Rogers:

Sexual health is intimately related to the health of the relationship with the woman’s partner. Clearly, the birth of a child is associated with many stressors on both the woman and her partner as they cope with sleep deprivation, physical changes and household stressors. Ideally, sexual concerns should be addressed to both the woman and her partner, and providers can set the tone for open communication regarding sexual concerns. Again, little research has explored the role of the partner in sexual function in young women giving birth, while in older women lack of a partner or partner dysfunction has been found to significantly affect sexual health. For sexual function that persists or is beyond the comfort level of an obstetrician/gynecologist, referral to a sex therapist can be very helpful in the treatment and resolution of sexual complaints.

7. Patient education, both prenatal and postnatal, seems key to the prevention and treatment of sexual dysfunction associated with childbirth. What patient education techniques that can be incorporated into a busy obstetrical practice have you found to be effective?

Response from Drs. Leeman and Rogers:

Counseling and education regarding sexuality during pregnancy and after delivery may be discussed at several times during prenatal care. At the time of the initial prenatal visits current sexual health may be discussed as part of a conversation about the usual safety of continuing sexual activity through the pregnancy unless medical complications intervene. During the third trimester we know that many couples decrease their sexual activity sometime due to comfort and sometimes due to unfounded concerns about injuring the fetus. This is a good time to reassure our patients about the safety of continuing sexual activity, as well as the maintenance of intimacy when they choose to forego sexual intercourse and to discuss postpartum expectations. After childbirth counseling should focus more specifically on concerns such as the effect of perineal trauma on dyspareunia, vaginal dryness with lactation or the altered family dynamics and sleep patterns that usually accompany a newborn. By discussing sexuality at different times during pregnancy our patients will be better prepared for the changes that are occurring and the education can occur in small spurts to accommodate the busy obstetrical practice.

8. Are there any data regarding risks of recurrence or exacerbation of sexual dysfunction in subsequent pregnancies? Is recurrence of sexual dysfunction in subsequent pregnancies associated with the return of the probable cause (i.e., episiotomy, depression) of the dysfunction identified in the earlier pregnancy?
Response from Drs. Leeman and Rogers:
We are not aware of any research specific to recurrence of sexual dysfunction in subsequent pregnancies. While the overall incidence of perineal lacerations is much lower in multiparous women, those women who have sustained a severe third or fourth degree laceration are more likely than women who have not had a prior laceration to have a repeat anal sphincter laceration. Severe lacerations are linked to increased rates of dyspareunia. Finally, depression is more likely to recur in women with a past history of depression or postpartum depression in a prior pregnancy.

References