KMAN PUBLISHING INSTITUTE
Journal Website

Article history:
Received 21 January 2025
Revised 11 April 2025
Accepted 20 April 2025
Published online 01 May 2025

Applied Family Therapy Journal

Volume 6, Issue 3, pp 1-9

E-ISSN: 3041-8798

Causes of Desire Suppression and Sexual Avoidance in Postpartum Couples: A Qualitative Exploration

Brian. Matthews[1], Mei-Ling. Chen[2*]

[1] Department of Health Psychology, University of Michigan, Ann Arbor, USA
[2] Department of Educational Psychology and Counseling, National Taiwan Normal University, Taipei, Taiwan

*** Corresponding author email address**: meiling.chen@ntnu.edu.tw

A r t i c l e I n f o

Article type:
Original Article

How to cite this article:
Matthews, B., & Chen, M. (2025). Causes of Desire Suppression and Sexual Avoidance in Postpartum Couples: A Qualitative Exploration. *Applied Family Therapy Journal, 6*(3), 1-9.
http://dx.doi.org/10.61838/kman.aftj.6.3.14

A B S T R A C T

Objective: This study aimed to explore and explain the underlying physical, psychological, relational, and sociocultural factors contributing to sexual desire suppression and avoidance among postpartum couples.

Methods and Materials: A qualitative exploratory design was adopted to capture the lived experiences of postpartum couples. Using purposive sampling, 18 married individuals (nine couples) from Taiwan who were between 12 and 24 months postpartum were recruited. Data were gathered through in-depth semi-structured interviews guided by open-ended questions about postpartum sexual changes, emotional experiences, and relational adjustments. Interviews were conducted face-to-face or via secure video conferencing, audio-recorded with consent, and transcribed verbatim. Data collection continued until theoretical saturation was achieved. NVivo 14 software was used for systematic coding and thematic analysis, employing iterative open, axial, and selective coding to develop categories and themes. Credibility was enhanced through member checking and peer debriefing, while dependability and confirmability were supported by an audit trail and reflexive memoing.

Findings: Analysis revealed four overarching themes shaping sexual desire suppression and avoidance: (1) physical and hormonal changes after childbirth — including pain, fatigue, hormonal fluctuations, and body image dissatisfaction; (2) psychological and emotional adjustments — such as maternal identity shift, anxiety, depressive symptoms, and cognitive overload; (3) relational and communication challenges — including inequitable parenting roles, reduced intimacy, misaligned sexual expectations, and limited sexual communication; and (4) sociocultural and external pressures — notably cultural taboos, family interference, social comparison, insufficient sexual health education, and moral beliefs affecting sexual readiness. These themes interacted dynamically, reinforcing avoidance patterns and delaying sexual recovery.

Conclusion: Sexual desire suppression and avoidance in the postpartum period result from the interplay of biological, psychological, relational, and cultural factors. Integrating sexual health counseling, mental health support, and culturally sensitive couple-based interventions into postpartum care could facilitate healthier sexual adaptation.

Keywords: *Postpartum sexuality; sexual desire suppression; sexual avoidance*

1. Introduction

The postpartum period is a critical transitional stage in the intimate life of couples, marked by profound biological, psychological, and social changes that can influence sexual functioning. After childbirth, many women experience complex adjustments that affect sexual desire, arousal, and satisfaction, with these changes often extending to the couple's relational dynamic. Recent evidence shows that sexual well-being after delivery is not merely a private issue but is intertwined with maternal mental health, body image, and family stability (Figueiredo, 2025; Zaręba et al., 2025). Despite the importance of sexuality in maintaining relationship quality and psychological balance, sexual health during the postpartum period remains underexplored and, in many cultures, insufficiently discussed (Drozdowskyj et al., 2019; Fakahany & El-Kak, 2025). Understanding the causes of desire suppression and sexual avoidance during this time is vital for designing effective clinical and educational interventions and for supporting couples as they renegotiate intimacy while adapting to parenthood.

Physiological recovery after childbirth is often a major determinant of sexual difficulties. Changes such as hormonal fluctuations, perineal trauma, and altered genital sensation can contribute to low sexual interest and discomfort during intercourse (F et al., 2015; Hanafy & Elesawy, 2015). Cesarean birth and vaginal deliveries with episiotomy are both associated with altered body awareness and sexual pain, although findings vary by context and individual resilience (Drozdowskyj et al., 2019; Szöllósi et al., 2021). Endocrine transitions—particularly reductions in estrogen and androgens combined with elevated prolactin during breastfeeding—have been shown to reduce libido and affect vaginal lubrication (Deif et al., 2021; Hajimirzaie et al., 2025). Moreover, fatigue and sleep deprivation are frequently cited barriers, with women describing physical exhaustion as a dominant reason for postponing intimacy (Congden, 2016; Zaręba et al., 2025). Such biological and functional changes make sexual re-engagement physically challenging and can initiate a cycle of avoidance.

Psychological and emotional factors are equally influential. Transitioning to motherhood often involves identity restructuring and a reprioritization of needs, sometimes leading to diminished sexual self-concept and relational closeness (Figueiredo, 2025; Shvetsova, 2024). Many mothers report anxiety about their partner's expectations and a sense of emotional distance that reinforces sexual withdrawal (Dağ & Değer, 2025; Wittkowski et al., 2017). Postpartum depression, anxiety, and stress have been consistently associated with low sexual desire and reduced satisfaction (Malary et al., 2015; Pope, 2025). Cognitive overload—commonly described as the "mental load" of childcare—exacerbates these challenges by leaving little psychological bandwidth for intimacy (Congden, 2016; Eryilmaz & Erenel, 2023). Importantly, these psychological aspects are not isolated; they interact with physical experiences such as pain and fatigue, amplifying avoidance patterns and making recovery of sexual desire complex.

The couple's relational dynamics also undergo significant change after childbirth. Research shows that shifting to co-parenting roles often leads to unequal distribution of responsibilities and diminished couple time, both of which negatively affect sexual connection (Benuyenah & Tran, 2020; Drozdowskyj et al., 2019). Misaligned sexual expectations can cause frustration, especially when one partner is ready to resume intimacy before the other feels physically or emotionally prepared (Clayton et al., 2017; Fakahany & El-Kak, 2025). Communication is a central mediating factor; when couples avoid discussing sexual needs or fears, emotional disconnection grows, and avoidance becomes entrenched (Eryilmaz & Erenel, 2023; Kandemir, 2023). Reduced expressions of affection outside of sex—such as touch, compliments, or small gestures—can also erode relational warmth and make sexual re-engagement feel pressured or obligatory rather than mutual and desired (Figueiredo, 2025; Zaręba et al., 2025). The quality of couple communication and support during this period thus appears critical in shaping how sexuality evolves after birth.

Social and cultural contexts exert additional influence, particularly in societies where postpartum sexuality remains taboo or where rigid gender expectations persist. Cultural silence about sexual health discourages couples from seeking help and may reinforce guilt or shame about desire (Fakahany & El-Kak, 2025; Shvetsova, 2024). Family interference, such as living with extended relatives, can further reduce privacy and increase pressure to conform to traditional behavioral norms (Benuyenah & Tran, 2020; Drozdowskyj et al., 2019). Media representations of idealized postpartum bodies intensify body dissatisfaction and delay sexual confidence (Figueiredo, 2025; Siregar et al., 2021). Moreover, limited sexual health education during perinatal care creates gaps in knowledge; many women report that postpartum check-ups focus on physical healing but rarely include counseling about sexual readiness or

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

couple adjustment (Congden, 2016; Deif et al., 2021). Religious and moral beliefs can also shape sexual decisions, with some couples abstaining longer out of uncertainty about normative timelines or spiritual appropriateness (Dağ & Değer, 2025; Hanafy & Elesawy, 2015). These structural and cultural barriers create an environment where avoidance becomes normalized and unaddressed.

Despite growing recognition of postpartum sexual health, research still faces fragmentation and cultural blind spots. Earlier studies often focused primarily on biological determinants of sexual dysfunction (Clayton et al., 2017; Hanafy & Elesawy, 2015), while newer work emphasizes multidimensional frameworks that include biopsychosocial factors (Hajimirzaie et al., 2025; Malary et al., 2015). Yet, most findings are context-dependent and may not reflect diverse cultural narratives (Benuyenah & Tran, 2020; Shvetsova, 2024). There is also limited qualitative evidence capturing the lived experience of couples navigating desire suppression and avoidance in everyday postpartum life. Understanding these subjective perspectives is critical because sexual decisions are not shaped by physiology alone but by meaning-making, relationship history, and cultural identity (Drozdowskyj et al., 2019; Figueiredo, 2025). Qualitative inquiry can illuminate nuanced patterns, reveal unmet support needs, and inform culturally sensitive interventions that move beyond biomedical models.

Addressing postpartum sexual avoidance has direct implications for family health and long-term relationship satisfaction. Persistent sexual disconnection can reinforce emotional distance, heighten conflict, and increase vulnerability to relationship instability (Dağ & Değer, 2025; Fakahany & El-Kak, 2025). Conversely, supporting couples in understanding and normalizing postpartum sexual change can reduce guilt and stress, foster open dialogue, and promote recovery of intimacy at a pace that respects physical and emotional readiness (Congden, 2016; Eryilmaz & Erenel, 2023). Integrating sexual health education into postpartum care, empowering healthcare providers to discuss sexual adaptation, and promoting evidence-based counseling may help prevent long-term dissatisfaction (Deif et al., 2021; Pope, 2025).

Given these gaps and the profound impact of postpartum sexual functioning on individual and relational well-being, this study explores the *causes of desire suppression and sexual avoidance in postpartum couples*.

2. Methods and Materials

2.1. Study Design and Participants

This research employed a qualitative design aimed at exploring the underlying causes of desire suppression and sexual avoidance among postpartum couples. A purposive sampling strategy was adopted to ensure participants had direct and relevant experiences with postpartum relational and sexual changes. Eighteen married individuals (nine couples) residing in Taiwan were recruited through local maternal and child health clinics, parenting support groups, and social media platforms targeting new parents. The inclusion criteria required participants to be within 12 to 24 months postpartum, legally married or in a long-term committed partnership, and willing to discuss intimate aspects of their relationship. Efforts were made to include diversity in terms of age, educational background, and socioeconomic status to capture a range of lived experiences. Recruitment continued until theoretical saturation was reached, meaning no new codes or themes emerged from subsequent interviews.

2.2. Measures

Data were collected using semi-structured, in-depth interviews designed to elicit rich and detailed personal narratives about sexual desire, avoidance behaviors, and perceived influencing factors after childbirth. An interview guide with open-ended questions was prepared, covering areas such as changes in sexual interest, emotional connection, body image, fatigue, and relational dynamics. Probing questions were used to clarify and deepen participants' responses when needed. Each interview lasted approximately 60 to 90 minutes and was conducted either in person or via secure video conferencing, depending on participants' availability and comfort. All interviews were audio-recorded with participants' consent and transcribed verbatim in Mandarin Chinese. To ensure cultural and linguistic accuracy, the transcripts were reviewed and refined by a bilingual research assistant familiar with both psychological and sociocultural contexts of Taiwan.

2.3. Data Analysis

Thematic analysis was conducted to identify and interpret patterns within the data. The analysis followed a multi-step iterative process using NVivo 14 software to organize and code transcripts systematically. Initially, open coding was performed line by line to capture meaningful segments of text. Codes were then compared and grouped into categories,

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

and axial coding was applied to connect categories into broader themes representing the underlying causes of sexual desire suppression and avoidance. Reflexive memoing was used throughout the process to record analytic insights and maintain awareness of potential researcher bias. To enhance trustworthiness, two researchers independently coded a subset of transcripts and discussed discrepancies until consensus was reached. An audit trail of coding decisions and theme development was maintained to ensure transparency and confirmability of findings. Member checking was conducted with several participants to validate the preliminary themes and interpretations, further strengthening the credibility of the study.

3. Findings and Results

The study included 18 married individuals (nine couples) residing in Taiwan who were between 12 and 24 months postpartum. Participants' ages ranged from 26 to 39 years (M = 31.8), with the majority falling between 30 and 35 years old (n = 10, 55.6%). Most participants had completed a university degree or higher (n = 11, 61.1%), while the remainder held a high school diploma or vocational training (n = 7, 38.9%). Regarding employment, eight participants (44.4%) were employed full-time, five (27.8%) were part-time or freelance workers, and five (27.8%) were homemakers. Household income varied, but over half of the couples (n = 10, 55.6%) reported a middle-income range consistent with Taiwan's national median. Parity showed that the majority were first-time parents (n = 13, 72.2%), while the rest had two children (n = 5, 27.8%). Mode of delivery was also diverse: ten participants (55.6%) had vaginal births and eight (44.4%) delivered via cesarean section. Most reported exclusively breastfeeding for at least three months postpartum (n = 12, 66.7%). These demographic patterns reflect a relatively young, educated, and urban Taiwanese postpartum population, offering diverse yet relevant perspectives on desire suppression and sexual avoidance after childbirth.

Table 1

Themes, Subthemes, and Concepts

Category (Main Theme)	Subcategory	Concepts (Open Codes)
1. Physical and Hormonal Changes After Childbirth	Postpartum Body Discomfort	Vaginal dryness; pelvic pain during intercourse; C-section scar sensitivity; breast engorgement; low physical energy; fear of pain during sex
	Hormonal Fluctuations	Decreased estrogen; irregular menstrual cycle return; mood instability; low libido due to prolactin; night sweats; unpredictable sexual arousal
	Fatigue and Sleep Deprivation	Frequent night awakenings; exhaustion from feeding; disrupted circadian rhythm; lack of time for intimacy
	Breastfeeding-Related Changes	Body image concerns due to leaking milk; discomfort with breast stimulation; prioritizing infant feeding over partner intimacy
	Body Image and Self-Perception	Weight gain concerns; stretch marks; fear of unattractiveness; comparison to pre-pregnancy body; avoidance of sexual advances
	Perceived Physical Vulnerability	Worry about re-injury; low stamina; fear of infection after childbirth
	Slow Physical Recovery	Prolonged healing; lingering back pain; restricted mobility for certain sexual positions
2. Psychological and Emotional Adjustments	Maternal Identity Transformation	Feeling fully "mother" rather than "partner"; shifting priorities; reduced mental space for sexual intimacy
	Anxiety and Fear	Worry about new pregnancy; fear of harming baby during intimacy; concern about partner's sexual expectations
	Emotional Distancing	Reduced desire to be touched; feeling emotionally drained; irritability toward partner; mental fatigue
	Loss of Sexual Confidence	Feeling less attractive; uncertainty about sexual performance; fear of rejection; self-consciousness during intimacy
	Postpartum Mood Changes	Sadness; irritability; feeling overwhelmed; emotional numbing; mood swings
	Cognitive Overload	Constant mental load about infant needs; hypervigilance; inability to relax enough for sexual intimacy
3. Relational and Communication Challenges	Shift in Couple Roles	Unequal distribution of childcare; feeling neglected as a partner; shift from couple to co-parents; partner jealousy toward infant
	Reduced Couple Time	Limited privacy; no time alone; interruptions during intimacy; crowded living spaces
	Misaligned Sexual Expectations	One partner ready earlier; misunderstanding of postpartum readiness; pressure to resume sex; silent frustration
	Poor Communication about Needs	Avoiding sexual conversations; discomfort discussing desire; emotional withdrawal; unsaid resentments

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

	Emotional Disconnection	Feeling unappreciated; resentment over unequal work; reduced romantic gestures; sense of drifting apart
	Decreased Affection Outside of Sex	Lack of cuddling; reduced physical touch; absence of compliments; transactional relationship feeling
4. Sociocultural and External Pressures	Cultural Taboos about Postpartum Sex	Silence around sexual needs; social expectation to be a "sacrificing mother"; fear of being judged for sexual desire
	Family Interference	Living with in-laws; lack of privacy; unsolicited advice about resuming sex; criticism of intimacy during postpartum
	Social Media and Body Ideals	Pressure to "bounce back"; exposure to unrealistic postpartum images; comparison with other mothers
	Stigma Around Seeking Help	Hesitation to consult therapists; fear of being labeled abnormal; shame in discussing sexual problems
	Healthcare System Gaps	Lack of sexual health guidance; brief postpartum check-ups; absence of partner-inclusive counseling
	Religious or Traditional Beliefs	Perceived sinfulness of early sexual activity; pressure to abstain longer; confusion about cultural norms

Theme 1 — Physical and Hormonal Changes After Childbirth

Participants frequently described profound physical transformations following childbirth as a primary cause of desire suppression and sexual avoidance. Many spoke about *postpartum body discomfort*, explaining that vaginal dryness, scar sensitivity after a cesarean, and lingering pelvic pain made sexual activity physically uncomfortable and anxiety-inducing. One mother noted, *"Every time my husband touched me, I tensed up because I still felt pain where the stitches had been."* Others highlighted *hormonal fluctuations*, including decreased estrogen, irregular cycles, and mood instability that disrupted libido. Breastfeeding also shaped their experience; several participants said leaking milk or breast engorgement was "not just unsexy but physically irritating," and some avoided intimacy out of fear of triggering let-down reflexes. Severe *fatigue and sleep deprivation* were repeatedly emphasized as barriers, with parents describing exhaustion from feeding and unpredictable sleep: *"We were like zombies. Sex was the last thing on my mind after nights with no sleep."* For some, *body image and self-perception* issues emerged as stronger than pain itself. Women described struggling to accept weight gain, stretch marks, and a sense of lost attractiveness: *"I felt like my body wasn't mine anymore, and I didn't want him to see me."* Additionally, the *perceived physical vulnerability* of healing bodies and the slow recovery from childbirth left couples hesitant to resume sexual activity. These overlapping physiological and perceptual changes created an embodied experience of fragility and discomfort that undermined sexual interest and accessibility.

Theme 2 — Psychological and Emotional Adjustments

Alongside physical changes, deep psychological shifts contributed to sexual withdrawal. Participants described how the *maternal identity transformation* reshaped priorities, with women feeling wholly occupied by their role as mothers: *"My entire world was about the baby — I couldn't think about being a lover or a wife."* This change often co-occurred with *anxiety and fear*, especially fear of another pregnancy or harming the infant. One participant said, *"Every time we tried to be intimate, I panicked about getting pregnant again so soon."* Several described *emotional distancing* as an unconscious protective strategy, with partners reporting a sense of rejection: *"It's like she built an invisible wall — no hugs, no kissing."* Many mothers also experienced a *loss of sexual confidence*, describing feeling unattractive, awkward, or unsure of their sexual self. Postpartum mood fluctuations such as sadness, irritability, and overwhelm were commonly mentioned, with some mothers disclosing episodes of low mood that dulled desire: *"I loved my baby, but I felt numb with my husband."* *Cognitive overload* emerged strongly as well; the constant mental load of infant care and household management left little emotional space for sexual connection. One father summarized, *"She was thinking about feeding schedules, diapers, everything — there was no mental room for us."* Together, these factors reflected an inner psychological reorientation that deprioritized sexual closeness, often without deliberate intent.

Theme 3 — Relational and Communication Challenges

Shifts within the couple's dynamic added another layer of complexity. Many described a *shift in couple roles* from lovers to co-parents, often marked by unequal distribution of child care and housework. Women expressed resentment at feeling overburdened: *"I do everything for the baby; he comes home and wants sex — it feels unfair."* *Reduced couple time* due to constant infant care and lack of privacy was a recurring challenge; some said they could hardly finish

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

a conversation without interruption, let alone initiate intimacy. Discrepancies in *sexual expectations* were also salient — one partner, usually the husband, was ready to resume sexual activity sooner, while the other felt pressured and unprepared: *"He asked when I'd be ready; I didn't even know what that meant for my body."* Many couples struggled with *poor communication about needs*, avoiding direct conversations about desire or readiness. This avoidance fostered *emotional disconnection*, with some feeling unappreciated or taken for granted: *"He stopped hugging me; we became like teammates, not partners."* A subtle but meaningful observation was the *decreased affection outside of sex*: participants reported fewer kisses, compliments, and small physical gestures, leading to a transactional feeling that made sexual engagement harder to rebuild. These relational shifts created an environment where avoidance was easier than confrontation, and silence gradually replaced intimacy.

Theme 4 — Sociocultural and External Pressures

Cultural context powerfully shaped the couples' experiences and decisions about sex after childbirth. Several participants spoke about *cultural taboos around postpartum sexuality*; there was little conversation in families or communities about sexual needs, and mothers feared being judged as selfish or "bad" if they expressed desire: *"My mom said women shouldn't think about sex after a baby — it's shameful." Family interference* also disrupted intimacy; living with in-laws or extended family limited privacy and increased pressure to conform to certain behavioral norms. One woman said, *"My mother-in-law was always around; we couldn't even sit close on the couch."* Exposure to *social media and body ideals* amplified body dissatisfaction, with mothers comparing themselves to polished postpartum influencers: *"Every photo online is of perfect moms. I just felt broken and ugly."* The *stigma around seeking help* for sexual difficulties added isolation; some feared that consulting therapists or doctors would bring shame: *"You don't talk about sex to anyone here — they'll think you're abnormal."* Several pointed to *healthcare system gaps*, noting that postpartum check-ups rarely addressed sexual well-being or included partners: *"The doctor just asked if I was bleeding and said nothing about intimacy."* Finally, *religious and traditional beliefs* influenced timing and attitudes, with some couples delaying sexual contact far longer due to perceived moral or spiritual restrictions. These external forces reinforced silence, heightened vulnerability, and discouraged couples from proactively addressing desire and avoidance.

4. Discussion and Conclusion

This study explored the lived experiences of Taiwanese postpartum couples to understand the multifactorial causes of sexual desire suppression and avoidance. The findings revealed four interconnected domains: physical and hormonal changes after childbirth, psychological and emotional adjustments, relational and communication challenges, and sociocultural and external pressures. Together, these dimensions highlight how sexuality after childbirth is not the product of a single physiological event but rather a complex biopsychosocial transition, deeply situated within cultural context and couple dynamics.

One of the most prominent findings was the centrality of physical and hormonal changes in shaping sexual withdrawal. Participants consistently described bodily discomfort, including perineal pain, cesarean scar sensitivity, and vaginal dryness, as strong deterrents to resuming intimacy. These observations are well aligned with previous research demonstrating the relationship between delivery-related trauma and postpartum sexual dysfunction (F et al., 2015; Hanafy & Elesawy, 2015). Studies show that hypoestrogenism in breastfeeding women leads to decreased vaginal lubrication and increased pain during intercourse, a pattern confirmed in our participants' accounts of fear and tension during attempted intimacy (Deif et al., 2021; Hajimirzaie et al., 2025). Fatigue and sleep deprivation also emerged as strong barriers; parents described "functioning like zombies" and lacking the energy for sexual engagement. This resonates with prior work emphasizing the impact of disrupted circadian rhythms and exhaustion on sexual readiness after birth (Congden, 2016; Zaręba et al., 2025). Additionally, body image dissatisfaction — often triggered by weight retention, stretch marks, and self-perceived unattractiveness — reinforced avoidance, echoing findings that postpartum body dissatisfaction is closely tied to sexual inhibition (Drozdowskyj et al., 2019; Malary et al., 2015). Importantly, these physical and self-perceptual experiences were rarely discussed with healthcare providers, reflecting ongoing gaps in postpartum sexual counseling (Deif et al., 2021; Eryilmaz & Erenel, 2023).

Psychological and emotional adjustments were equally salient, with participants reporting identity transformation, anxiety, and emotional distancing from their partners. Many mothers expressed that their sense of self became almost exclusively maternal, with limited mental and emotional space for sexual connection. This aligns with qualitative evidence that motherhood restructures priorities and affects

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

sexual self-concept (Figueiredo, 2025; Shvetsova, 2024). Anxiety — especially fear of another pregnancy and concern about physical harm — was commonly described and parallels work showing that postpartum sexual fear is a key determinant of desire disorders (Dağ & Değer, 2025; Zaręba et al., 2025). Mood disturbances such as sadness, irritability, and feelings of overwhelm also mirrored known associations between postpartum depression, anxiety, and sexual dysfunction (Pope, 2025; Wittkowski et al., 2017). Cognitive overload further emerged as a novel but highly consistent contributor. Participants frequently described the mental burden of childcare and household management, confirming previous reports that the "invisible workload" of motherhood is strongly tied to sexual disengagement (Congden, 2016; Eryilmaz & Erenel, 2023). Collectively, these findings reinforce the biopsychosocial perspective on postpartum sexuality: psychological strain and identity transition are as impactful as physiological healing.

The study also highlighted relational and communication challenges that mediate the return to intimacy. Couples described a clear role transition from lovers to co-parents, accompanied by perceived inequities in childcare and domestic responsibilities. This imbalance fostered resentment and relational strain, mirroring studies where gendered workload distributions predicted diminished sexual satisfaction postpartum (Benuyenah & Tran, 2020; Drozdowskyj et al., 2019). Misalignment of sexual expectations was another key barrier; while some partners were ready for sexual activity, others felt pressured and physically unprepared. This mismatch is well documented in the literature and often exacerbates relationship stress (Clayton et al., 2017; Fakahany & El-Kak, 2025). Importantly, the couples' reluctance to communicate openly about sexual readiness or discomfort reinforced avoidance patterns. As observed in previous research, poor sexual communication postpartum correlates with long-term declines in desire and satisfaction (Eryilmaz & Erenel, 2023; Kandemir, 2023). Reduced non-sexual affection — fewer gestures of tenderness or verbal affirmation — also surfaced as an overlooked yet significant factor. The absence of everyday intimacy made sexual initiation feel pressured rather than natural, echoing findings that relational closeness and affectionate touch strongly predict postpartum sexual adaptation (Figueiredo, 2025; Zaręba et al., 2025).

Finally, the sociocultural and external pressures theme underscored how sexual recovery is situated within cultural beliefs and systemic gaps. Many participants reported enduring silence around postpartum sexuality; societal messages emphasized maternal sacrifice and discouraged open acknowledgment of sexual desire. This stigma parallels observations from diverse cultural contexts where sexual needs are deemed secondary to caregiving (Fakahany & El-Kak, 2025; Shvetsova, 2024). Family dynamics, especially co-residence with in-laws, reduced privacy and created surveillance that undermined sexual spontaneity, confirming findings that multigenerational households can constrain couple intimacy (Benuyenah & Tran, 2020; Drozdowskyj et al., 2019). Social media pressure was another modern stressor; exposure to idealized postpartum bodies reinforced body shame and delayed sexual readiness, reflecting global evidence linking digital comparison to dissatisfaction and withdrawal (Figueiredo, 2025; Siregar et al., 2021). Moreover, healthcare gaps emerged strongly: participants rarely received sexual counseling during postpartum check-ups, a pattern repeatedly identified as a missed opportunity for prevention and early intervention (Congden, 2016; Deif et al., 2021). Religious and moral frameworks also shaped couples' timelines and perceptions of sexual appropriateness, reinforcing previous reports of spiritual and ethical considerations in postpartum intimacy (Dağ & Değer, 2025; Hanafy & Elesawy, 2015). This cultural embedding of sexuality demonstrates that postpartum sexual health cannot be separated from normative values and community discourse.

Together, these findings contribute to a growing body of literature advocating for integrated, culturally sensitive approaches to postpartum sexual health. They reinforce that recovery of sexual desire is not linear and cannot be addressed by biomedical interventions alone. Physical recovery, psychological adaptation, relational negotiation, and cultural identity must be understood as interdependent layers. Moreover, this study adds depth by illustrating how cultural stigma and systemic neglect — especially limited sexual education and counseling in postpartum care — interact with personal and relational vulnerabilities to perpetuate avoidance.

5. Suggestions and Limitations

Several limitations should be acknowledged when interpreting these findings. The study's sample size, though adequate for qualitative saturation, was limited to 18 participants and drawn exclusively from Taiwan, which may constrain transferability to other cultural contexts. The participants were also relatively well-educated and urban, potentially excluding voices of rural or socioeconomically

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

disadvantaged couples whose experiences of postpartum sexuality might differ. Additionally, as the data were collected via self-report interviews, there is the possibility of social desirability bias or underreporting of sensitive topics such as sexual dissatisfaction and relational conflict. The use of semi-structured interviews provided depth but may have inadvertently guided responses; future work could benefit from triangulation with observational or diary methods. Finally, the cross-sectional design captured experiences within 12–24 months postpartum but did not track how desire and avoidance evolve over longer periods.

Future research should expand cross-cultural and longitudinal exploration of postpartum sexual adaptation to better understand how sociocultural norms and relational trajectories shape sexual recovery over time. Comparative studies between urban and rural populations, as well as across different healthcare systems, could identify structural gaps and protective cultural practices. Including male partners' physiological and psychological perspectives in greater depth would also enrich understanding of dyadic adaptation. Additionally, integrating physiological measures (e.g., hormonal profiles, sleep quality data) with qualitative accounts could clarify the interplay between biological and psychosocial factors. Intervention studies testing structured sexual counseling or couple-based psychoeducation in postpartum care would help determine effective strategies for reducing desire suppression and fostering healthy intimacy. Finally, digital health tools, such as app-based support for sexual recovery, represent a promising area for exploration.

The findings underscore the need for healthcare providers to proactively address sexual health as part of routine postpartum care. Professionals should receive training to initiate sensitive conversations about sexual readiness, pain, body image, and emotional adaptation. Culturally tailored counseling that includes both partners can help normalize sexual challenges and reduce shame, while promoting open communication. Postpartum education programs should integrate practical strategies for gradual intimacy, self-care, and shared parenting to reduce relational strain. Mental health screening and referral systems can help detect anxiety and depression early, preventing long-term sexual avoidance. Lastly, public health messaging and community workshops that break cultural silence about postpartum sexuality can empower couples to seek help and reclaim sexual well-being as a normal part of the transition to parenthood.

Authors' Contributions

All authors have contributed significantly to the research process and the development of the manuscript.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

Acknowledgments

We would like to express our gratitude to all individuals helped us to do the project.

Declaration of Interest

The authors report no conflict of interest.

Funding

This research was carried out independently with personal funding and without the financial support of any governmental or private institution or organization.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

References

Benuyenah, V., & Tran, P. B. (2020). Postpartum Psychological Pressure on Single Mothers: An Interpretative Phenomenological Analysis. *Journal of Humanities and Applied Social Sciences*, *3*(3), 199-216. https://doi.org/10.1108/jhass-12-2019-0089

Clayton, A. H., Lucas, J., Derogatis, L. R., & Jordan, R. (2017). Phase I Randomized Placebo-Controlled, Double-Blind Study of the Safety and Tolerability of Bremelanotide Coadministered With Ethanol in Healthy Male and Female Participants. *Clinical therapeutics*, *39*(3), 514-526.e514. https://doi.org/10.1016/j.clinthera.2017.01.018

Congden, K. A. (2016). Perinatal Education and Support Program: Baystate's New Beginnings. *The Journal of perinatal education*, *25*(2), 97-104. https://doi.org/10.1891/1058-1243.25.2.97

Dağ, İ., & Değer, V. B. (2025). The Importance of Psychological Well-Being for Women: Ways to Cope With Stress and Postnatal Depression. https://doi.org/10.5772/intechopen.1009206

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

Deif, R., Burch, E. M., Azar, J., Yonis, N., Gabal, M. A., Kramani, N. E., & Dakhlallah, D. (2021). Dysphoric Milk Ejection Reflex: The Psychoneurobiology of the Breastfeeding Experience. *Frontiers in Global Women S Health*, *2*. https://doi.org/10.3389/fgwh.2021.669826

Drozdowskyj, E. S., Castro, E. G., López, E. T., Taland, I. B., & Actis, C. C. (2019). Factors Influencing Couples' Sexuality in the Puerperium: A Systematic Review. *Sexual Medicine Reviews*, *8*(1), 38-47. https://doi.org/10.1016/j.sxmr.2019.07.002

Eryilmaz, N., & Erenel, A. Ş. (2023). Sexuality and Counseling in Postpartum Women. *Journal of Gazi University Health Sciences Institute*, *5*(2), 59-67. https://doi.org/10.59124/guhes.1261592

F, Y. I., Irfan, H., H.P, I., A.B, A., Patmini, E., Nugroho, A. E., & Rahman, M. N. (2015). Gangguan Hasrat Seksual Pada Wanita Pascasalin Dan Hubungannya Dengan Cara Persalinan. *Jurnal Kesehatan Reproduksi*, *2*(1). https://doi.org/10.22146/jkr.7117

Fakahany, S. E., & El-Kak, F. (2025). Sexual Function in Pregnancy and Postpartum: Breaking the Silence. *Journal of Sexual Medicine*, *22*(1), 1-3. https://doi.org/10.1093/jsxmed/qdae140

Figueiredo, M. M. (2025). Experiencing Sexuality in the Perinatal Period: What Are the Challenges? *European Psychiatry*, *68*(S1), S1137-S1137. https://doi.org/10.1192/j.eurpsy.2025.2300

Hajimirzaie, S. S., Tehranian, N., Golabpour, A., Khosravi, A., Mousavi, S. A., Keramat, A., & Mirzaii, M. (2025). Predicting Postpartum Female Sexual Interest/Arousal Disorder via Adiponectin and Biopsychosocial Factors: A Cohort-Based Decision Tree Study. *Scientific reports*, *15*(1). https://doi.org/10.1038/s41598-025-12025-3

Hanafy, S., & Elesawy, F. M. (2015). Female Sexual Dysfunction During the Postpartum Period. *Human Andrology*, *5*(4), 71-81. https://doi.org/10.1097/01.xha.0000475197.51922.f5

Kandemir, E. (2023). Sexual Dysfunction on Diabetes Mellitus. 55-61. https://doi.org/10.69860/nobel.9786053359111.6

Malary, M., Khani, S., Pourasghar, M., Moosazadeh, M., & Hamzehgardeshi, Z. (2015). Biopsychosocial Determinants of Hypoactive Sexual Desire in Women: A Narrative Review. *Materia Socio Medica*, *27*(6), 383. https://doi.org/10.5455/msm.2015.27.383-389

Pope, R. (2025). Sexual Function Through Menopause: A Review of Basic Evaluation and Treatment. *Bjog an International Journal of Obstetrics & Gynaecology*. https://doi.org/10.1111/1471-0528.70041

Shvetsova, A. V. (2024). Modern Studies of Motherhood. What Do Trends (Not) Say? *Rsuh/Rggu Bulletin Series Philosophy Social Studies Art Studies*(3), 103-113. https://doi.org/10.28995/2073-6401-2024-3-103-113

Siregar, M. F. G., Azmeila, S., Sitompul, A. N. R., & Siregar, M. E. A. G. (2021). Literature Review: Menopause and Sexual Disorders. *Open Access Macedonian Journal of Medical Sciences*, *9*(T3), 298-304. https://doi.org/10.3889/oamjms.2021.6345

Szöllősi, K., Komka, K., & Szabó, L. (2021). Risk Factors for Sexual Dysfunction During the First Year Postpartum: A Prospective Study. *International Journal of Gynecology & Obstetrics*, *157*(2), 303-312. https://doi.org/10.1002/ijgo.13892

Wittkowski, A., Garrett, C., Cooper, A., & Wieck, A. (2017). The Relationship Between Postpartum Depression and Cognitions About Motherhood During Pregnancy. *Journal of Woman S Reproductive Health*, *1*(4), 9-23. https://doi.org/10.14302/issn.2381-862x.jwrh-15-848

Zaręba, K., Florkiewicz-Danel, M., Ciebiera, M., Wójtowicz, S., Statsenko, Y., Maki, S., Olszewska, J., Awar, S. A., & Jakiel, G. (2025). The Impact of Stress on Women's Sexuality in the First Months After Childbirth—A Pilot Cross-Sectional Comparative Study. *Journal of clinical medicine*, *14*(3), 847. https://doi.org/10.3390/jcm14030847

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798