
Continuing Education Module

Sexuality in Women of Childbearing Age

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ABSTRACT


Women of childbearing age have health-care needs related to sexuality. The health-care needs that are most obvious are the need for contraception and the need for the prevention and treatment of vaginal and sexually transmitted infections. Although providers may have questions related to sexual activity, sexual orientation, sexual practices, sexual satisfaction, and intimate partner violence on patient history forms, they often offer little discussion on issues related to sexuality unless the patient raises the issues. Women's sexuality is intensely personal and individual. Changes may occur in sexuality during pregnancy or as a response to infertility. These changes may be physical or emotional. During her prepregnancy and prenatal care, a woman may meet with a range of health-care providers, including childbirth educators, lactation consultants, nurses, midwives, and physicians. It is within the scope of practice of each of these clinicians to address sexuality concerns, validate women's feelings, and provide suggestions of modifications in sexual practices to meet women's needs for sexual expression within the range of activities that are safe and acceptable.

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Most women of childbearing age are healthy. They may visit primary health-care providers for routine health care and for the investigation of specific problems, but they often do not have an ongoing relationship with a health-care provider. For many women, their first in-depth relationship with the health-care system comes during pregnancy. Some women may not develop long-term provider relationships other than the one they have with their obstetrician/gynecologist, nurse practitioner, or midwife.

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Bennet, and Hutchens (2000) revealed that only 29% of women were able to discuss sexual activity with their doctors, and 76% of the women who did not discuss sexual activity felt that it should have been discussed. Fogel and Lauver (1990) note that couples would have appreciated the opportunity to discuss feelings and concerns related to sexuality with their clinicians. Clinicians may not have received training on how to discuss sexuality, may not be comfortable discussing sexuality, and may not believe that the subject has any bearing on the well-being of the pregnant couple; however, the topic needs to be addressed with sensitivity to cultural and religious variations.

The seminal work in human sexuality was written by Masters and Johnson (1966). In the decade after the publication of *Human Sexual Response*, which included information on sexual response before, during, and after pregnancy, there was considerable interest in the topic, and many studies that corroborated or refuted Masters and Johnson's findings were published. Much less research and discussion has occurred on human sexuality during the past decade.

The purpose of this article is to discuss issues related to sexuality in women during pregnancy, as well as in women experiencing difficulty becoming pregnant. This is an area well within the scope of the practice of childbirth educators and health-care providers, and one where interventions can be especially important and effective. Routine encounters during pregnancy offer the opportunity to discuss and normalize the emotional and physical changes that may affect sexual expression.

PREGNANCY

Pregnancy is a time of change. Women's bodies change, and relationships change as women and their families make plans to incorporate a new arrival into the family structure. Clinicians and educators who work with pregnant women know that their physical and emotional responses to pregnancy are functions of their uniqueness as individ-

uals. However, some general patterns may be observed. The same is true of women's sexual expression during pregnancy.

First Trimester

The hormonal changes resulting from conception account for many of the physiologic changes of early pregnancy, including such common discomforts as fatigue, nausea, and breast tenderness. These same hormonal shifts may account for some of the changes in women's sexuality during the same period. Masters and Johnson (1966) note a decrease in sexual tension and a decrease in performance during this time, which may be due to the progesterone effect that causes systemic vasodilatation, thereby decreasing pelvic engorgement during sexual arousal. Guana-Trujillo and Higgins (1987) note that some women, freed from the fear of pregnancy, experience increased pelvic congestion and, therefore, have heightened sexual responses.

Kitzinger (1983) notes that the nausea and vomiting experienced by many women during the first trimester may cause diminished feelings of eroticism. She further notes that breasts may become enlarged and quite tender. Although a male partner may find larger breasts exciting, the female partner may find any breast or nipple stimulation to be painful rather than erotic. Many women experience profound fatigue during the first trimester, which may lead to insufficient energy to participate in or to enjoy lovemaking.

Another factor that may serve to diminish interest in sexual activities during early pregnancy is the fear of injuring the developing fetus. Bartellas and colleagues (2000) report that 49% of women worry at some point in the pregnancy that sexual intercourse may harm the pregnancy. Some women adhere to belief systems in which sexual activity is acceptable only for the purpose of procreation. Once pregnancy has occurred, procreation is no longer possible, and these women may feel guilty engaging in activities that will not culminate with the possibility of conception.

Men also have reactions to their partners' pregnancies. Although they may not experience the hormonal changes that occur within their partners' bodies, men often have emotional and visceral reactions to the pregnancy. Their reactions may be in concert with their partners' needs, but this is not always the case. Men may identify the mother-to-be with their own mother, and they may feel as if sexual activity has some incestuous quality. They

also may fear that they will injure the fetus if they engage in intercourse and may abstain from all sexual activity.

Couples can be reassured that the woman's nausea, fatigue, and breast tenderness are normal and should subside by the second trimester. This may be a good time for other expressions of intimacy such as kissing, hugging, snuggling, and massage. They also can be reassured that intercourse will not cause a miscarriage; rather, most spontaneous abortions during the first trimester are caused by an abnormality in the developing fetus. They can be informed that the male partner's penis will not contact or harm the fetus, which is protected by the uterus and the amniotic fluid.

Many women have some spotting or bleeding in the first trimester and, in most cases, will proceed to have a successful pregnancy (Mayo Foundation for Medical Education and Research, 2005). If the spotting continues for more than one day or is accompanied by cramping or clots, the couple should know they should contact their clinician because these conditions can be a sign of an ectopic pregnancy, impending miscarriage, or other complication.

Second Trimester

The second trimester is said to be the trimester of well-being. Many of the discomforts of early pregnancy have abated. Women find they have more energy. They begin to experience tangible signs of the reality of the pregnancy, such as hearing the fetal heart beat and experiencing quickening. Although their bodies definitely are changing, pregnant women are not yet experiencing discomforts that come during the third trimester when the fetus increases in size and internal organs are displaced.

Masters and Johnson (1966) note that significant pelvic congestion occurs during the second trimester that leads to a marked increase in eroticism. This pelvic congestion may lead to a marked increase in the intensity of a woman's orgasm. Many women who never have experienced orgasm during intercourse have their first orgasms during this time; women who previously have been orgasmic may have the experience of multiple orgasm. Because of the increased pelvic congestion, women may not experience resolution after orgasm or may require time for pelvic congestion to subside.

An increase in eroticism may be exciting for the woman's partner, but it also may be frustrating if the partner feels incapable of satisfying the pregnant

woman's sexual needs, fears harming the fetus, or has an altered image of his partner as a mother instead of a sexual partner. These concerns may lead to performance anxiety, erectile dysfunction, or complete avoidance of sexual activity.

The second trimester can be a time when couples are encouraged to enjoy lovemaking. Couples who are struggling with the changing role of wife to mother and its impact on sexual expression can be encouraged to discuss this topic. As the woman's body changes shape, couples can be encouraged to try different positions for lovemaking (e.g., woman on top, woman side-lying with the man behind, or woman on hands and knees). As in the first trimester, other methods of achieving intimacy can be encouraged. As the pregnancy advances, deep penile penetration can cause some bleeding. Couples should be advised that when spotting stops within a day, it is probably due to cervical irritation; however, if bleeding continues for more than a day, the clinician should be notified immediately. The most common cause of heavy bleeding during the second trimester is due to a problem with the placenta, such as placenta previa or placental abruption, and these conditions should be identified as early as possible (Mayo Foundation for Medical Education and Research, 2005).

Third Trimester

The external physical changes of pregnancy are obvious by the third trimester. Women may feel less attractive because of their increasing physical size. There is no pretending that the fetus does not exist. Some couples feel as if a third person is in the bed during lovemaking, which can be distracting. Fetal movements, hiccups, and Braxton-Hicks contractions may serve to diminish feelings of intimacy.

The woman's increasingly large abdomen may make usual sexual practices uncomfortable or difficult. If the couple's preferred position for coitus is with the woman supine, she may become faint because of the enlarging uterus obstructing venous return and causing supine hypotension. She may also find that the weight of her partner's body causes pain or discomfort. Women and their partners can be encouraged to experiment with alternate positions, including side-lying, woman superior, and rear entry. If such experimentation has taken place earlier in pregnancy, then the variations may seem more natural than if they are tried for the first time in late pregnancy.

Women may experience a leaking of colostrum or uterine contractions following orgasm. These phenomena may lead to a fear that sexual activities have adversely affected the fetus. If preterm labor begins shortly after lovemaking, the couple may feel a sense of guilt that their self-indulgence caused harm to the fetus.

In previous years, pregnant women may have incorrectly been counseled regarding sexual changes and safe practices during pregnancy. Today, this information may be shared with the pregnant woman by her mother, mother-in-law, grandmother, or female friends. A woman may choose to abstain without consulting with her health-care provider if she is uncomfortable discussing sexuality with someone outside her immediate circle of female friends and relatives. She also may have been advised to try initiating labor through nipple stimulation or intercourse, which may not be safe if the pregnancy is not at term, if the woman has placenta previa, or if she is carrying multiple fetuses. Bleeding in the third trimester may be benign, but it may also be due to placental problems and should be reported immediately to the clinician.

Postpartum

Many postpartum women experience fatigue from the stress of childbearing and the realities of infant care. They may not have sufficient energy to be interested in sexual activity. They also may fear personal injury if coitus is resumed too soon, and they may fear that penetration will cause pain. They also may have concerns about becoming pregnant again before they are ready. The American College of Obstetricians and Gynecologists (2005) estimates the incidence of postpartum depression at about 10%. Women experiencing postpartum depression may have lost interest in pleasurable activities and may withdraw from their partner, in addition to having no energy for lovemaking. Couples need to allow the woman ample time to recover emotionally and physically before she participates in sexual activity. While women may be counseled to wait 6 weeks to resume intercourse, it is safe to begin having intercourse as soon as lochia stops, which indicates that the vagina, cervix, and uterus are finished healing. Contraception should be initiated with resumption of intercourse because the absence of menstrual periods does not mean that ovulation has not occurred.

Women who are breastfeeding may also experience alterations in sexuality. Some partners may

find the physiologic changes that accompany lactation to be stimulating, but others may not. Women may find that their breasts are sensitive to touch and that foreplay involving the breasts is uncomfortable. Some women may find that they leak milk during and after orgasm. Some partners may wish to suckle as a part of sexual activity, which can produce a variety of responses in the woman. Byrd, Hyde, DeLamater, and Plant (1998) suggest that some women may show less interest in sexual activity because their needs for intimate touching are met by breastfeeding. If a woman experiences sexual feelings during infant feeding, this may lead to emotions of sexual guilt and shame. Partners also may feel jealous of the intimate connection that the mother and baby share. These feelings should be normalized for the couple, and they should be encouraged to remain open and supportive of each other's feelings.

INFERTILITY

Approximately 15% of all couples in the United States and Canada experience infertility (Centers for Disease Control and Prevention, 2003; Speroff & Fritz, 2005). Women with infertility may experience alterations in sexuality, regardless of which member of the couple has the diagnosis. For these couples, the act of coitus often assumes a major role in their lives. Sexual activity must be planned around the woman's menstrual calendar. Intercourse must be avoided for several days before anticipated ovulation so that the male's sperm count will be optimal at the time of ovulation. When ovulation occurs, intercourse must happen—whether the couple feels romantic or has just had an argument. The pressure to perform may lead to erectile dysfunction in the man and lack of arousal in the woman. Many couples note that they feel as if the infertility specialist is in the bedroom with them, telling them what to do and when to do it (Lewis, 1990).

During the diagnostic evaluation for infertility, many couples undergo a postcoital test. For this evaluation, intercourse must occur within a specified period of time before the medical appointment. The test consists of a microscopic examination of cervical mucus for the presence of forwardly motile sperm. Many couples express the feeling that they are being graded on their sexual performance during this analysis (Lewis, 1990). If the infertility is due to a female factor, women may feel unfeminine, which may alter their feelings of physical attractiveness. A male-factor diagnosis may lead to an inability

to achieve or maintain an erection. Women have been known to withhold the diagnosis of male-factor infertility from their partners because of perceived potential for a masculine identity crisis.

Many women who are infertile experience a loss of self-esteem and self-confidence, which may lead to a feeling of being less attractive (Olshansky, 2003). Women who believe that sexuality and reproductive capacity are linked may eschew sexual activity if it cannot lead to pregnancy. Couples may feel that their inability to conceive affects their ability to have a warm, loving, physical relationship. In some cases, the diagnosis of infertility that cannot be treated leads to the end of the relationship.

Pregnancy after Infertility

Women who become pregnant after a history of infertility have special needs. These women have experienced failure each month as the arrival of menses signals another cycle without conception. Once they conceive, the pregnancy becomes another opportunity for failure as each minor symptom or change is analyzed for any potentially negative effect on the pregnancy. Many women cease all sexual activity out of fear of injuring the fetus or because sex has, for them, become associated with baby-making rather than personal pleasure or as a means to demonstrate affection.

IMPLICATIONS FOR PRACTICE


Guana-Trujillo and Higgins (1987) found that women reported they received inadequate counseling about sexuality from their health-care providers. This clearly is an area of care within the scope of practice of all health-care providers. Nurses have stated, and other clinicians have agreed, that they do not necessarily acquire the essential information about sexuality in their basic professional education and that they lack the skills required to share information related to sexuality with their clients (Alteneder & Hartzell, 1997). Ideally, curricula in health-care education should address sexuality and give participants from all disciplines opportunities to explore their own feelings about sexuality and to be exposed to cultural and religious influences on sexual expression. Health-care providers and educators have the personal responsibility to explore their own comfort with sexual matters and to practice asking the questions that initially may make them uncomfortable and may discourage open communication with patients. Clinicians and educators do not have to have

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the skills to treat any sexual dysfunction they may uncover in an interview. According to Weiss (2002), the role of the generalist is to educate couples about normal function and to refer them to specialists when problems beyond the generalist's expertise are discovered. Most problems pregnant couples face regarding sexuality are normal and can be resolved with validation and encouragement to work together to find alternative forms of sexual expression that meet the needs of both partners.

Health-care providers can begin by letting women know that they are comfortable discussing sexuality and other issues of physical intimacy. This can be done during the initial patient encounter by initiating a general discussion of sexuality and sexual practices, including a range of normal variations. Information about sexuality can also be included in childbirth education classes where the educator can lead discussions after rapport with class members has been established. Couples can be encouraged to role-play with each other, taking turns initiating discussion about sexual practices and fulfillment. Lactation consultants have the opportunity to discuss changes in sexuality while discussing breastfeeding and changes in the breasts.

Pregnant women often need encouragement to discuss issues related to sexuality and often need specific information about altering normal practices because of changes related to the pregnancy. Alteneder and Hartzell (1997) discuss the PLISSIT model for addressing sexual concerns during pregnancy that is frequently used by sex therapists. The model encourages the provider to give women permission to discuss their sexuality by acknowledging that changes that occur during pregnancy may necessitate changes in sexual expression. Couples can be invited to ask questions, and the provider can offer limited information (normal changes) and specific suggestions (e.g., alternate modes of sexual expression, different positions) regarding those questions and, when appropriate, refer couples to a specialist for more intensive therapy. Open discussion about the "taboo" subject of sex during pregnancy may encourage the woman to discuss other taboo subjects. If the pregnant woman feels comfortable in her communication with her

 For more information on communicating about sexuality and on the PLISSIT model, log on to the following link at The Association of Reproductive Health Professionals Web site: <http://www.arhp.org/healthcareproviders/cme/onlinecme/maturecme/communicating.cfm?ID=37>

provider, she may also reveal information about abuse that may have occurred during the pregnancy, whether it is psychological, physical, or sexual. Spousal abuse typically is under-reported, but it is estimated that 1 in 5 women will be abused during pregnancy (Dunn & Oths, 2004). If these women report abuse, then they can be referred to counseling and support services, which may offer a better chance at a healthier and happier pregnancy.

Women also may need encouragement to share their feelings and concerns with their partners. Many women and men refrain from intercourse because they are afraid of injuring the developing fetus. Although women who are at risk for spontaneous abortion may wish to defer intercourse until after the first trimester, others may be told that, barring evidence of spotting, no correlation exists between sexual intercourse and spontaneous abortion (Star, Shannon, Lommel, & Gutierrez, 1999).

Women in the third trimester traditionally were told to abstain from intercourse from about 34 weeks' gestation until after the 6-week postpartum checkup. Unless the woman is at risk for preterm labor or is bleeding (von Sydow, 1999), there is no reason to abstain from intercourse as long as membranes are intact. After giving birth, intercourse may be resumed once lochia has ceased, indicating that uterine healing is complete, and the woman's perineal area is sufficiently healed so that she will not experience discomfort. Women who are breastfeeding often experience decreased vaginal lubrication and may find that a water-soluble, personal lubricant will increase their level of comfort. Because breastfeeding does not ensure contraception, many women may find the use of a spermicidal lubricant to have this additional benefit.

If a couple must refrain from sexual relations for medical reasons, it is important for the provider to explain the nature of the complication and exactly which forms of sexual activity are advisable or not advisable. If penile penetration and vaginal ejaculation are contraindicated, as with women who have an incompetent cervix, then other forms of intimacy should be discussed, such as mutual mastur-

bation or oral sex. If orgasm should be avoided, as with some women who are at risk for preterm labor, then couples need to understand that any means of achieving orgasm, including intercourse, nipple stimulation, and masturbation, should be avoided.

One of the pregnancy-specific dangers of certain sexual activity is the rare, but often lethal, occurrence of air embolism. Pregnant women should be instructed that it is dangerous to participate in any activity that involves introducing air into the vagina (Kaiser, 1994). These activities would include, among others, oral sex that involves blowing into the vagina, douching, and the use of any apparatus that would introduce air into the vagina.

Towards the end of pregnancy, women often find that the enlarging uterus makes certain sexual positions uncomfortable. Women may experience supine hypotension if they lie on their back with the uterus obstructing venous return. Women and their partners can be encouraged to experiment with alternate positions, including side-lying, woman superior, and rear entry. If such experimentation takes place early in pregnancy, then the variations seem more natural than if they are tried for the first time in late pregnancy.

Many women experience an increased desire for sexual intercourse during certain times of pregnancy. Health-care providers and childbirth educators can validate this experience as within the range of normalcy, and they can encourage women to explore noncoital means of intimacy with their partners, including cuddling, fondling, or masturbation to maintain closeness and relieve sexual tension.

Health-care providers and childbirth educators can provide pregnant women with accurate information about safe and at-risk sexual behaviors. Women with multiple sexual partners need information about the prevention of sexually transmitted infections. All pregnant women need information about when sexual activity should be avoided, such as after membranes have ruptured, or when they are at risk for either preterm labor or spontaneous abortion. Women who have placenta previa and who are at risk for bleeding should also be advised to abstain from intercourse.

Health-care providers and childbirth educators can help pregnant women recognize old wives' tales and assess information they receive from female friends and relatives. Many pregnant women search the Internet and come to their appointments with pages of printouts. Clinicians and educators can

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help women critically review this material to determine what information is accurate and which sources should raise an index of suspicion.

Some pregnant women are single, some have multiple partners while they are pregnant, and others have female sexual partners. It is important to present information on sexuality in a way that does not presume either marriage or heterosexuality. Information can be provided that is useful to women regardless of their sexual orientation or their marital status. For example, if a woman is at risk for preterm labor and should avoid orgasm, it makes no difference how orgasm is achieved. Women with multiple partners should be encouraged to use a barrier method of protection when engaging in sexual activities to protect themselves and the pregnancy from potentially harmful, sexually transmitted infections.

SUMMARY

Sexuality is an important part of a woman's self-concept. This aspect of self may change as a result of the experience of pregnancy or infertility. It is within the scope of practice of clinicians and educators to provide counseling and information to women that will be helpful to them as they experience sexual activity during these life events.

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The following Web sites offer further information on sex during pregnancy: <http://familydoctor.org/783.xml> <http://www.mayoclinic.com> <http://www.marchofdimes.com> <http://www.americanpregnancy.org>

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