Description of Sexual Patterns in Pregnant Mothers

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Abstract. Sexual patterns during pregnancy are frequently not given much attention and the consultation with health workers is unfortunately minimum. During pregnancy, intimacy with a partner is no longer considered essential. This phenomenon occurs due to changes in psychological, physiological and marital relations as well as socio-cultural effects. Therefore, the objective of this study is to determine the description of sexual patterns in pregnant women. The research method employed was descriptive correlation with a cross sectional approach. The variables in this study were problematic sexual patterns in pregnant women. The sampling technique employed was quota sampling. The research instrument was the Female Sexuale Function Index questionnaire. The results presented that the pattern of sexuality of pregnant women in the domain of sexual arousal 63% of respondents experienced sexual arousal with a moderate category of 71%. Domain of sexual desire 63% of respondents feel that there is often sexual arousal or interest with moderate intensity and 58% sometimes feel satisfied. The dominance of vaginal discharge is 41% of respondents who occasionally experience vaginal discharge and are almost always able to maintain vaginal discharge until they have completed sexual activity 68%. Orgasm domain of 41% of respondents occasionally achieve orgasm (sexual pleasure) in a balanced way. In the satisfaction domain, 46% of respondents experience that there is a balance of emotional closeness with their partner. In the pain domain, 53% of respondents experienced discomfort or pain during the penis entering the vagina. Suggestions that mothers and husbands require to communicate with each other regarding sexual needs so that the intimacy of mothers and husbands is healthier and possesses an impact on increasing satisfaction.

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1 Introduction

Pregnancy provides physiological and psychological changes for pregnant women, so that every pregnant woman is at risk of experiencing complications that is able to threaten her life. Regular consultation with midwives is an alternative solution to prevent problems during pregnancy [17]. Some women experience a loss of sexual desire due to fear of hurting their baby, fear of giving birth prematurely or because sexual intercourse feels physically uncomfortable. Some studies state that there are 10–15% of pregnant women experience orgasm, and conversely many possess difficulty in achieving orgasm [14].

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The sexual needs of pregnant women are rarely discussed, and sexual intercourse during this period appears to be taboo. Pregnant and postpartum women are more or less suppressed by religious and social norms, particularly in rural areas. From an external point of view, sexual conflict with maternal and social expectations brings conflict assumed by the woman [8]. Research by [2] uncovered that the results in the intervention group compared to the control group revealed that the sexual health education package was effective for enhancing the dimensions of sexual health to maintain and improve the sexual health of pregnant women and other health care [2].

The existence of interference with sex during pregnancy. This disorder occurs because there are still numerous mothers who do not understand how to have safe sex during pregnancy, so they feel anxious when having sex. Doing and not having sex during pregnancy is due to the low knowledge of pregnant women about safe sex during pregnancy. Hence, health workers should provide counseling to pregnant women that there are no restrictions on sex during pregnancy as long as it is performed safely and correctly, the safe position is the supine position with the husband's stomach without putting pressure on the mother's stomach [18].

Efforts that can be performed to overcome life changes in pregnant women, particularly sexual activity, are by providing health education so that they are able to assist pregnant women and their husbands to develop their knowledge and overcome changes in their sexual activity. It reveals that health workers need to pay attention to the reproductive health needs of pregnant women and their husbands. The objective of this study is to determine the characteristics of pregnant women, to identify sexual patterns and problems with sexual patterns in pregnant women at PMB Istri Utami Yogyakarta.

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2 Method

This type of research is a descriptive correlation research with a cross sectional approach. The research was conducted at *Praktik Mandiri Bidan* (PMB) or the Independent Midwife Practice of Istri Utami Yogyakarta. The variables in this study are problematic sexual patterns in pregnant women. The population in this study were all pregnant women in PMB Istri Utami Yogyakarta. The sampling technique administered was quota sampling. Inclusion criteria incorporated pregnant women who checked with PMB, did not suffer from mental illness or were in intensive care, conscious and able to communicate, willing to become respondents, and legally married at KUA (Religious Affairs

Office). The research instrument employed was the FSFI Questionnaire (Female Sexuale Function Index).

3 Result and Discussion

The majority of respondents (43%) are 26–30 years old, indicating that their gestational age is in their reproductive age. The majority of respondents' education (55%) is high school with a job as a housewife (IRT) as much as (68%). The majority of respondents (50%) possess 1 child with the majority of respondents (57%) having been married for more than one year and more than one year.

The research instrument employed the FSFI (Female Sexuale Function Index) questionnaire which comprised of six domains encompassing the domains of Sexual Arousal, Sexual Desire, Vaginal Slime, Orgasm, Satisfaction, and Pain. From the results of research on the domain of sexual arousal, it was revealed that 63% of respondents explained that sometimes in the last 4 weeks, they frequently experienced sexual arousal or interest during pregnancy. As many as 71% of respondents reported that in the last 4 weeks, the degree of sexual arousal or interest of pregnant women was in the moderate category. Domain of sexual desire as many as 63% of respondents in the last 4 weeks, frequently experienced sexual arousal during sexual activity. As many as 73% of respondents own a degree of sexual arousal or interest during sexual intercourse in the moderate category. In the last 4 weeks, 80% belief of pregnant women to be aroused during sexual activity is in the moderate category. As many as 58% of respondents in the last 4 weeks, occasionally experienced satisfied with the reaction to being aroused during sexual activity.

Domain of vaginal discharge in the last 4 weeks, 41% of respondents occasionally experienced vaginal discharge (getting wet) during sexual activity and 68% stated that it is not difficult to experience vaginal discharge (getting wet) during sexual activity and 68% of respondents almost frequently attempting to maintain vaginal discharge until completion of sexual activity. The domain of orgasm is 41% of respondents when they receive sexual stimulation or have sexual intercourse, sometimes achieving orgasm (sexual pleasure) and 55% when respondents receive sexual stimulation or have balanced sexual relations. In the last 4 weeks, 55% of respondents have a balanced ability to acquire orgasm during sexual activity. The domain of sexual satisfaction as much as 46% of respondents feel a balanced emotional closeness with your partner during sexual intercourse. As many as 55% of respondents experienced that they have a balanced relationship with relationships involving sexual relations with their partners. As many as 55% of respondents felt balanced with their overall sexual life. Pain domain as much as 53% of respondents occasionally experienced discomfort or pain during the entry of the penis into the vagina and 46% feel discomfort or pain following the entry of the penis into the vagina. Meanwhile, as many as 53% of respondents had a moderate degree of discomfort or pain during the entry of the penis into the vagina.

Until recently, there has been no research that proves that sexual intercourse and orgasm are contraindicated during pregnancy for women who are medically healthy and have excellent obstetric conditions. As pregnancy progresses, changes in body shape, body image, and discomfort affect both parties' desire to express their sexuality. At

the beginning of pregnancy, the mother does not look pregnant and does not even feel pregnant, but hormonal activity has started to possess an effect in several ways. Entering the second trimester, libido generally reappears and even increases, it is because the body has been able to accept and get accustomed to the conditions of pregnancy, so that pregnant women are able to enjoy activities more freely than in the first trimester. The enlargement of the breasts and the increased vascularity of the vaginal and labial areas can increase pleasure and sexual and orgasmic quality. In the third trimester, the pregnant woman's body begins to look bigger and feels tremendously exhausted. Moreover, pregnant women feel anxiety and feelings of impatience waiting for the birth of the baby. Unlike in the previous trimester, in the third trimester, the libido can drop back due to physiological factors that are significantly visible, which is an enlarged pregnancy, as well as an increase in body fluids resulting in the increased vaginal fluid. Thus, sexual contact is not satisfactory [15].

Primiparous women frequently experience fear of premature labor due to intercourse and uterine contractions. In TM III, the highest incidence of problems during pregnancy, encompassing sexual arousal and female sexual satisfaction.

[12] Pregnancy and childbirth significantly ($p < 0.001$) decreased women's sexual activity by lowering the FSFI score. The number of women who acquired 26 points (which could indicate sexual dysfunction) before pregnancy was 34 (8.54%) and after giving birth 167 (41.96%). Thus, it can be concluded that pregnancy and childbirth significantly reduce women's sexual activity by lowering the FSFI score. The number of women who experience sexual dysfunction escalates fivefold after giving birth, probably even acquiring 40% of young mothers so that the role of medical personnel in maintaining women's sexual health is significantly crucial [10].

Research by [1] elaborates that sexual function declines during pregnancy, getting worse as the pregnancy progresses. Decreased desire and orgasm, increased pain and other sexual dysfunction problems in the first 3 months gradually enhance in the 6 months after delivery. This process is affected by many factors such as socio-cultural, age, parity, breastfeeding, depression, fatigue, sexual activity during the first trimester, postpartum body image, concerns about getting pregnant again, and concomitant urinary tract infections reported as independent risk factors for sexual dysfunction [1].

Research result by [6] presented statistically significant values ($p < 0.05$), correlation ($p < 0.01$), and probability ($p < 0.001$). This study displayed high levels of life satisfaction, medium levels of overall sexual satisfaction, and high levels of satisfaction in sexual relations. Higher levels of life satisfaction were associated with higher levels of sexual satisfaction in each dimension.

The results of [3] study presented that the median total of FSFI score in pregnant women was significantly lower than those who were not pregnant (18.9 vs 22.7; $P < 0.05$). The total FSFI score was significantly lower in the pregnant group compared to the nonpregnant group ($p < 0.05$). Furthermore, the rate of sexual dysfunction in pregnant women was significantly higher than in nonpregnant women (91.08% vs. 67.61%, $P = .0001$). However, in pregnant women, no significant difference in the level of sexual dysfunction was discovered in trimester ($P = 0.632$) [3].

The prevalence of women with changes in female sexual function before pregnancy was 53% and in the first trimester was 88.8%. The frequency of sexual intercourse during

the first pregnancy was lower than before pregnancy ($p < 0.05$). The prior reasons for not engaging in sexual activity during pregnancy were fear of harming the fetus (75.1%) and preferring to be dissatisfied in the short term rather than hurting the baby (73.5%). Factors affecting women's sexual function are age, time of living together, age 1 year of sexual intercourse, pregnancy planning, obstetric history, sexual initiative, religion, academic level, and occupation ($p < 0.05$) [9].

In a study conducted by [11], 65.2% of pregnant women experienced difficulty in having sexual intercourse, 60.9% reported fear of being hurt by their baby during sexual intercourse, 43% said that pregnancy affected their self-esteem and the way they saw their body, 39.1% revealed that they were able to reach orgasm and 43.5% said they were sexually satisfied. Sexual desire and pleasure during pregnancy is dependent on the interaction of the partner, thus, sexual satisfaction can be pleasurable even with a changing libido [11]. In [5], 70% of women experienced sexual dysfunction in all three trimesters. Changes in sexuality during pregnancy are observed with less sexual intercourse, less desire and less arousal. Beliefs and attitudes toward sexuality during pregnancy, as well as the anatomical, physiological, and spiritual changes that women experience, affect sexual life during pregnancy [5].

There are various factors influencing sexual patterns in pregnant women. Relationship with partner is one of the determining factors. Higher levels of orgasmic ability and arousal were associated with sexual satisfaction and conversely, problems with decreased orgasm and arousal were associated with dissatisfaction with sexual intercourse. Lack of interaction between partners, discomfort, lack of intimacy and communication problems in sexual relationships can lead to decreased sexual arousal. Communication is a means to get closer to partner. Discussing the changes which occur with partner to obtain the right solution is essential to conduct to obtain comfort during sexual intercourse. Cognitive and affective factors may affect a person's sexuality, which is the presence of cognitive and concentration disorders, personal characteristics, sexual violence and age factors.

4 Conclusion

Patterns of sexuality of pregnant women in the domain of sexual arousal, 63% of respondents feel sexual arousal in the moderate category (71%). In the domain of sexual desire, 63% of respondents feel that there is frequently sexual arousal or interest with moderate intensity and 58% occasionally feel satisfied. In the domain of vaginal discharge, 41% of respondents occasionally experience vaginal discharge and are almost generally able to maintain vaginal discharge until they have completed sexual activity (68%). In the domain of orgasm, 41% of respondents sometimes achieve orgasm (sexual pleasure) in a balanced way. In the satisfaction domain, 46% of respondents feel that there is a balance of emotional closeness with their partner. In the pain domain, 53% of respondents experienced discomfort or pain during the penis entering the vagina. The researchers recommend that mothers and husbands need to communicate with each other regarding sexual needs so that the intimacy of mothers and husbands is healthier and possesses an impact on increasing satisfaction.

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