The Relationship Between the Sexual Self and the Experience of Pregnancy

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ABSTRACT

Studies reveal that prenatal health-care providers and educators often refrain from discussing sexuality with their patients. The present study explored the relationship between sexuality and pregnancy by considering whether the way in which women view themselves sexually is associated with their experience of pregnancy. Findings revealed that a positive sexual self was significantly related to a positive experience of pregnancy and that particular experiences of pregnancy were more significantly related to how women viewed themselves sexually than others. The findings encourage further discussion regarding the role that comprehensive sex education and training of prenatal health-care providers might play in ultimately establishing open, honest, and nonjudgmental discussions about sexuality between providers and their pregnant patients and partners.

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It is commonly understood that female sexuality is intrinsically related to conception. The sexual revolution beginning in the 1960s brought about widespread use of female oral contraception as well as changing gender roles, ultimately leading women to have more control over the expression of their sexuality than ever before (Heer & Grossbard-Schechtman, 1981). Despite the obvious relationship between female sexuality and conception, once a woman moves beyond the act leading up to conception and becomes pregnant, public discourse appears to refrain from considering her as a sexual entity. Ironically, having become pregnant via sexual

intercourse, it is as though she is no longer perceived as a sexual being. Moreover, dialogue between health-care professionals and pregnant women often neglect the discussion of pregnant women's sexuality, and specifically, how their sexuality may relate to their experience of pregnancy as a whole (Bartellas, Crane, Daley, Bennett, & Hutchens, 2000; Malarewicz, Szymkiewicz, & Rogala, 2006; Oboro & Tabowei, 2002).

A positive sexual self was significantly associated with a positive experience of pregnancy.

Research findings suggest that prenatal health-care providers and educators often do not attend sufficiently to the sexuality of pregnant women, despite the patients' interests in discussing it. One study found that only 29% of pregnant women said that they discussed sexual activity with their physicians during their pregnancies and 49% of those women said they raised the issue first; moreover, of the women in the study who had not discussed sexuality with their physicians, 76% felt it should have been discussed (Bartellas et al, 2000). Another study found that 68% of new mothers reported that they were not informed by their gynecologists or midwives of possible sexual problems in pregnancy nor were they informed they could still derive sexual satisfaction while pregnant (Malarewicz et al., 2006). Indeed, Fogel and Lauver (1990) note that many couples would have preferred to have the chance to discuss their feelings and concerns regarding sexuality with their health-care providers. Findings also reveal that patients are afraid to ask questions pertaining to sexuality as they are afraid that their physicians will be embarrassed or will dismiss them (Lindau, Gavrilova, & Anderson, 2007).

There are various factors that may be influencing the lack of dialogue initiated by prenatal health-care providers with their pregnant patients and partners. For one, our society at large often deemphasizes the sexuality of pregnant women, finding the discussion of sex during pregnancy to be taboo (Kiemtorè et al., 2016). Moreover, Hinchcliff, Gott, Galena, and Elford (2004) noted that prenatal care providers may avoid discussing sexuality proactively as it is a complex issue and requires sensitivity. Saunamäki, Andersson, and Engström (2010) found that 90% of nurses understood that their patients' health concerns could affect their sexuality and two-thirds thought it was their responsibility to discuss it, yet 80% did not discuss it, and 60% reported not feeling confident in the ability to address their patients' concerns. These findings may be a result of health-care providers not receiving enough training in sexuality to feel competent enough to bring up the topic.

The latter point is echoed in findings that suggest that the majority of medical students in North America feel unprepared and inadequately trained

to discuss sexuality with patients, pregnant or not (Frank, Coughlin, & Elon, 2008; Malhotra, Khurshid, Hendricks, & Mann, 2008; Shindel et al., 2010; Wittenberg & Gerber, 2009). Ideally, prenatal care providers, such as obstetrician/gynecologists (OB/GYNs) and midwives would be prepared to discuss sexuality with their pregnant patients in the course of their extensive specialization training (Sobecki, Curlin, Rasinski, & Lindau, 2012). However, the dialogue surrounding sexuality that does occur between OB/GYNs and patients does not appear to include discussion of sexual satisfaction. Sobecki et al. (2012) found that 63% of OB/GYNs reported routinely assessing sexual activities with their patients, while only 29% asked their patients about sexual satisfaction and only 14% asked their patients about obtaining pleasure with sexual activity.

The lack of dialogue surrounding pregnancy and sexual expression, satisfaction, and pleasure is also reflected in research on sexuality during pregnancy, often predominantly focusing only on changes that occur to sexual functioning. Dating back to research originally conducted by Masters and Johnson in 1966, various studies have since been published that summarize general sexual functioning changes that typically occur during pregnancy, including a decline in libido, desire, and orgasm throughout pregnancy, particularly in the third trimester (e.g., Bartellas et al., 2000; De Judicibus & McCabe, 2002; Pauleta, Pereira, & Graça, 2010; Serati et al., 2010).

Significant changes in sexual functioning happen during the gestational period. Changes in sexual functioning could influence other aspects of women's lives beyond sexuality. In comparison, in nonpregnant women, sexual satisfaction has been shown to be linked to happiness, relationship satisfaction, and overall life satisfaction (Desai & Patoliya, 2012; Litzinger & Gordon, 2005). Sexual experiences are often an important aspect of women's relationships with their partners as a means to experience emotional connection and intimacy and to share sexual pleasure (Pauleta et al., 2010). Sexuality has also been shown to be linked to body image and body satisfaction (Aubrey, 2007; Cash, Maikkula, & Yamamiya, 2004; Pujols, Meston, & Seal, 2010; Reissing, Laliberté, & Davis, 2005; Weaver & Byers, 2006).

Similar findings have been found in pregnant women, whereby positive experiences of female sexual functioning (as measured by dimensions including sexual desire, arousal, and satisfaction) were negatively correlated with the experience of stress,

A positive sexual self was significantly related to specific experiences of pregnancy, including body image, bodily changes and relationship outcomes.

anxiety, and depression, and positively correlated with general quality of life during pregnancy (Nik-Azin et al., 2013). Moreover, experiencing fulfilling sexual experiences during pregnancy has been shown to promote well-being and maintain partner-intimacy (Johnson, 2011), while low sexual functioning during pregnancy has been linked to poor body image (Pauls, Occhino, & Dryfhout, 2008).

Although research has begun to consider how one's sense of self as a sexual being might relate to the experience of pregnancy, there is ambiguity in the literature regarding the nature and underpinning of this relationship. Sexuality is an important part of most women's identities (Daniluk, 1993) and at the crux of women's sexual identities is their sexual selfhood (this includes the sexual self-concept and the "sexual self"; Cotten, 2013; Deutsch, Hoffman, & Wilcox, 2014). Sexual self-concept refers to the cognitive representations individuals have of their sexuality, including the perception of themselves as sexual creatures (Talley, Brown, Cukrowicz, & Bagge, 2016; Winter, 1988). The sexual self-concept is intrinsically related to sexual behaviors, feelings, and sexual attitudes (Impett & Tolman, 2006). Meanwhile, the "sexual self" refers to the meaning individuals derive from their sexual self-concepts beyond their cognitive representations of their sexuality (Cotten, 2013).

In the present study, we explored how pregnant women's views of their sexual selves relate to how they experience everyday positive and negative experiences of pregnancy. In particular, we hypothesized that pregnant women's views of their sexual selves would be significantly related to how they would experience their pregnancies. We also hypothesized that certain aspects of women's pregnancy experiences, including body image and relationship quality, would be most significantly linked to the sexual self. We hope to understand better the relationship between sexuality and pregnancy experiences in order to inform the dialogue surrounding sexuality to be initiated by prenatal health-care providers and educators with their patients.

METHODS

Sample

Potential participants who were pregnant at the time of data collection were invited to complete an online survey on their sexuality and the experience of their pregnancy. Participants were recruited through social media, as well as in obstetricians' offices and prenatal classes in Ottawa, Ontario, Canada. Pregnant women at any point in their pregnancies were

TABLE 1

Demographic Characteristics of Participants

Demographics	
Trimester (%)	
1st	13
2nd	53
3rd	35
Age (%)	
≤ 25 years	15
26–35 years	67
≥36 years	18
Parity (%)	
0	38
1+	62
Prenatal Provider (%)	
Obstetrician	62
Midwife	29
Family doctor	2
Other	2

included in the study. Out of 55 participants, 7 (13%) were in their first trimester (1–12 weeks), 29 (53%) in their second (13–27 weeks), and 19 (35%) in their third (>27 weeks). Participants ranged in age from 21 to 43 years old ($M = 30.6$) and 62% of participants had previously given birth. Obstetricians (62%) and midwives (16%) were reported as the most common antenatal care providers. All participants were found to be married or in a domestic partnership at the time they completed the questionnaire. Moreover, all participants were either from the United States (71%) or Canada (29%). Table 1 outlines the demographic characteristics of the participants. The Health Sciences and Science Research Ethics Board of the University of Ottawa approved this study and protocol.

Measures

Sexual Self Survey. To measure the sexual self, "My Sexual Self" (also referred to as the Sexual Self Survey [SSS]) was used (Cotten, 2013). This measure was created to evaluate one's sense of self as a sexual being and is assessed on a series of dimensions, including sexual evaluation, potency, and activity (Cotten, 2013). Sexual evaluation refers to how individuals assess their sexuality in terms of the bipolar adjectives good-bad, valuable-worthless, and honest-dishonest. A woman with a positive sexual self would be more likely to evaluate herself as "good," "valuable," and "honest." Sexual potency refers to evaluations of oneself within her sexual relationship and is represented by the bipolar adjectives together-alone, loved-unloved, and strong-weak. An individual with a positive sexual self would be more likely to endorse the terms "together," "loved," and "strong." Sexual activity is assessed by the

bipolar adjectives assertive-nonassertive, involved-uninvolved, and flexible-rigid. An individual with a positive sexual self would be more likely to endorse the terms “assertive,” “involved,” and “flexible” regarding her sexual activity. The SSS measures the different dimensions of the sexual self using a semantic differential scale for various pairs of bipolar adjectives. Each Likert-type item was comprised of 7 points between the two adjectives, with 1 being the most positive and 7 being the least. Scores on the SSS are calculated using the sum of the ratings for bipolar adjectives, with a higher overall score denoting a more positive view of the sexual self. The SSS was found to have high internal reliability ($\alpha = 0.93$).

Pregnancy Experience Scale—Brief Version. “The Pregnancy Experience Scale” (PES) was originally designed to study the daily, ongoing, positive and negative experiences specific to pregnancy (Dipietro, Ghera, Costigan, & Hawkins, 2004). It has since been adapted into a brief version, which included the 20 most prevalent items from the 41-item original scale (Dipietro, Christensen, & Costigan, 2008). The adapted Pregnancy Experiences Scale—Brief Version (PES-BV) specified 10 “uplifts” of pregnancy and asked how much this made the participant feel “happy, positive or uplifted” and 10 “hassles” of pregnancy and asked how much this made the participant feel “unhappy, negative or upset.” The PES-BV asserts that specific pregnancy experiences are either negative or positive. For example, in the PES-BV “gaining weight” during pregnancy was assumed to be a negative experience, as it fell under the “hassle” category, however not all women perceive weight gain during pregnancy as a negative experience. We therefore modified the scale to reduce bias by adapting the terms into 5-point Likert-type scale items. The formatting of the questions was changed to a 5-point Likert-type scale where 1 was “happy, positive or uplifted,” 3 was neutral, and 5 was “unhappy, negative or upset.” In adapting the questions onto a 5-point Likert-type scale, participants were free to identify whether items like “gaining weight” were positive or negative experiences, thus removing assumptions. This modification appears to maintain the validity of the scale; both the original PES-BV and our modified version were consistent in terms of how women

ranked the items. For instance, results from both the original and modified scales indicated that the item “normal discomforts of pregnancy” was the most negatively reported experience and “how much the baby is moving” was the most positively reported experience. The modified version was also found to have high internal reliability ($\alpha = 0.84$).

Data Analyses

All data were analyzed using the analytics computer software SPSS Version 22.0. A Pearson correlation was conducted between the sums of the scores of the SSS and the modified PES-BV to evaluate the strength of the relationship between sexual self and overall pregnancy experience. Pearson correlation analyses were also conducted between the sums of the scores of the SSS and scores of the individual items of the PES to determine which pregnancy experiences were most strongly correlated to the sexual self.

RESULTS

The results of a Pearson correlation analysis revealed that there is a significant positive relationship between the sexual self and the pregnancy experience ($r = 0.587$; $p < .01$). Pearson correlations were then calculated to identify which individual items of the pregnancy experience were most significantly related to the sexual self. These findings are summarized in Table 2. Of the 20 items incorporated in the PES to encompass the experience of pregnancy, 15 items were significantly related to the sexual self. The most significant relationships, with a Pearson correlation coefficient above 0.3, included physical intimacy ($r = 0.560$; $p < .01$), discussions with spouse ($r = 0.427$; $p < .01$), thinking about labor and delivery ($r = 0.326$; $p < .01$), weight ($r = 0.316$; $p < .01$), thoughts about whether the baby is normal ($r = 0.312$; $p < .01$), and overall feelings about being pregnant at that time ($r = 0.310$; $p < .01$).

DISCUSSION

The goal of this study was to explore the relationship between how women view themselves sexually and their overall satisfaction with the experience of pregnancy. A positive sexual self was significantly associated with a positive experience of pregnancy. Moreover, a positive sexual self view was significantly related to specific experiences of pregnancy, including body image and bodily changes (such as physical appearance, weight, and thoughts about the baby

Prenatal health-care providers and educators can encourage open communication between partners regarding sexuality during pregnancy due to its link to pregnant women's sexual self-views.

TABLE 2

Pearson Correlations between the Sexual Self Survey and Each Individual Item of the Modified Pregnancy Experience Scale—Brief Version

Pregnancy Experience	<i>r</i>
1. How much the baby is moving	0.186
2. Discussions with spouse about baby name	0.269*
3. Comments from others about pregnancy/appearance	0.235*
4. Making or thinking about nursery arrangements	0.186
5. Feelings about being pregnant at this time	0.310**
6. Visits to obstetrician/midwife	0.283**
7. Spiritual feelings about being pregnant	0.150
8. Courtesy/assistance from others because you are pregnant	0.172
9. Thinking about the baby's appearance	0.231*
10. Discussions with spouse about pregnancy/childbirth issues	0.427**
11. Getting enough sleep	0.199
12. Physical intimacy	0.560**
13. Normal discomforts of pregnancy (heartburn, incontinence)	0.284**
14. Weight	0.316**
15. Body changes due to pregnancy	0.276**
16. Thoughts about whether the baby is normal	0.312**
17. Thinking about your labor and delivery	0.326**
18. Ability to do physical tasks/chores	0.291**
19. Concerns about physical symptoms (pain, spotting, etc.)	0.237*
20. Clothes/shoes do not fit	0.292**

Note. *r* = Pearson correlation coefficient.

p* < .05. *p* < .01.

being normal) as well as relationship outcomes (such as physical intimacy and discussions with spouse).

The finding that pregnant women's views of their sexual selves are related to their experiences of pregnancy coincides with similar findings that have analyzed the role of sexuality in life experiences of nonpregnant cohorts. Indeed, factors contributing to women's sexuality, including sexual satisfaction, sexual well-being, and sexual self-schemas have all been significantly related to overall subjective well-being and life satisfaction (Davison, Bell, LaChina, Holden, & Davis, 2009; Donaghue, 2009; Laumann et al., 2006; Stephenson & Meston, 2015; Thompson et al., 2011; Woloski-Wruble, Oriel, Leefsma, &

Hochner-Celnikier, 2010). These findings are also true for those with prominent health concerns or who have experienced significant bodily changes, including those with chronic mental illnesses, cancer patients, individuals with physical disabilities, and recent amputees; their sexuality, including sexual satisfaction and sexual self-concept, was significantly related to life satisfaction and well-being (Davison & Huntington, 2010; Moin, Duvdevany, & Mazor, 2009; Salehi, Tavakol, Shabani, & Ziaei, 2015; Walters & Williamson, 1998). Such studies emphasize that even after the experience of significant physiological changes, such as those that occur during pregnancy, sexuality often remains an important factor in life satisfaction and well-being.

The present study also explored what particular experiences of pregnancy were most significantly related to how women view themselves sexually. Not surprisingly, items related to bodily changes and body image were significantly related to the sexual self. These findings are in line with previous studies that have linked body image to sexual selfhood in nonpregnant women (Aubrey, 2007; Cash et al., 2004; Wiederman & Hurst, 1997). How women view themselves sexually appears to be significantly linked to their body image whether pregnant or not, which ultimately plays a role in overall life satisfaction (Frederick, Sandhu, Morse, & Swami, 2016). It is important to consider the relationship between body image and sexuality in those who are pregnant, where inevitable physical changes that occur are likely to influence body image, both positively and negatively (Goodwin, Astbury, & McMeeken, 2000; Loth, Bauer, Wall, Berge, & Neumark-Sztainer, 2011).

The sexual self was also significantly correlated to feelings toward physical intimacy during pregnancy as well as discussions with a partner. This is consistent with studies that have noted a link between sexual selfhood and physical intimacy (Blunt, 2012; Impett & Tolman, 2006; Ziaei, Farahmand Rad, Rezaei Aval, & Roshandel, 2017). Women with positive sexual selves may feel more comfortable discussing sexuality-related issues and bodily changes with their partners as they are more likely to feel more open, positive, and comfortable about themselves sexually (Cotten, 2013). Indeed, Blunt (2012) found that those with more positive sexual self-concepts were better able to communicate with their partners. This may translate to higher levels of satisfaction with physical intimacy in pregnant women, as both the physical changes and the sexual functioning changes that occur during pregnancy likely require increased communication in order to achieve

sexual satisfaction (Allen & Fountain, 2007). Moreover, increased communication regarding sexuality has been shown to be significantly related to relationship satisfaction overall (Byers, 2005).

Implications for Practice

This study may have important implications for informing prenatal care providers and educators of the possible relationship between sexuality and the experience of pregnancy. Our findings reinforce that prenatal care providers and educators should receive training regarding sexuality during pregnancy in order to facilitate future open discussions with their pregnant patients (see Allen & Fountain, 2007 and Polomeno, 2000 for overviews regarding sex and pregnancy for prenatal care providers and educators). This dialogue can include sexual functioning changes experienced across the duration of the pregnancy, including expected changes during each trimester (see Serati et al., 2010 for a review of the literature).

Prenatal health-care providers and educators can encourage open communication between partners regarding sexuality during pregnancy due to its link to pregnant women's sexual self-views. This could include providing resources that help increase sexual communication. Furthermore, prenatal care providers can help support the bodily changes experienced by pregnant women, including providing resources and referrals to activities that promote positive body image in pregnant women. Finally, it is possible that promoting open, nonjudgmental, and informative communication regarding sexuality between prenatal care providers and pregnant women and their partners might influence how women feel sexually, which may also have positive, enduring effects on their body image throughout pregnancy (Allen & Fountain, 2007).

Limitations

There are various limitations of this study worth noting. All participants in the study were married or in a domestic partnership, and therefore the results lack generalizability to single pregnant women. However, the implications of the present study's findings are mainly directed toward prenatal care providers who are working with pregnant women and their partners. Future research is needed to explore sexual self-views of single pregnant women. More than half of the participants were in their second trimester. Further research should study possible differences found

in each trimester. We did find that there were no significant differences across trimesters in terms of the sexual self, though we did not have enough statistical power to report this with confidence. We were also unable to establish construct validity of the modified PES-BV as we did not have data from the original PES-BV. As this study was exploratory in nature, we were unable to speak to the direction of the relationship between the sexual self and pregnancy experiences. Future pursuits in this field of research might consider taking a longitudinal approach to further our understanding of this relationship.

Conclusions

This study found that women's sexual self-views were significantly related to how they experience pregnancy. In particular, how pregnant women experience themselves sexually is significantly related to how they view their changing bodies as well as how they interpret important aspects of their partner relationships. Ultimately, these findings encourage discussion surrounding the role prenatal health-care providers and educators play in learning about the sexual changes that may occur among pregnant women. It is possible that health-care providers will then be able to translate this education and understanding into open, honest, nonjudgmental conversations with patients and their partners. In turn, we can promote healthy and fulfilling sexual experiences for pregnant women, thus leading to more satisfying experiences of pregnancy overall.

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DISCLOSURE

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