PREGNANCY & SEXUALITY: Embracing the Changes & the Challenges!!

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- ***Women's sexual health*** is a vital and important part of life at any age and is influenced by many factors.

- ***Pregnancy and childbirth*** is a special period in a woman's life, which involves significant physical, hormonal, psychological, social, and cultural changes that may ***influence her own sexuality*** as well as the ***health of a couple's sexual relationship***.

COURSE OF THE TALK

- CHANGES in pregnancy
- CHALLENGES
  - Talking sexuality
  - Need of communication
  - Role of prenatal educators
  - Counselling

- Bayrami et al. showed that
  - ***66.3%, 50.7%, and 69.2%*** of women suffered from sexual dysfunction in ***the 1st , 2nd & 3rd , trimesters of pregnancy respectively.***
  - ***SEXUAL DESIRE DISORDER (81%)***is the ***most commonly*** reported sexual dysfunction in ***each trimester*** of pregnancy
  - This reduction does not resolve immediately postpartum, but ***may persist during the first 3–6 months after delivery***, followed by a gradual and steady recovery.

- ***Sexual satisfaction*** also declined

	Male	**Female**
1st trimester	35%	22%
2nd trimester	30%	26%
3rd trimester	**55%**	**76%**

- ***Coital frequency*** declined with advancing gestational age

1st trimester	14.7%
2nd trimester	14.1%
3rd trimester	**41%**

Bogren et al on primiparous women

Recent studies indicate

- Pregnant women experience symptoms of

Diminished clitoral sensation	**94.2%**
Lack of libido	92.6%
Orgasmic disorder	81%

- ***Length of intercourse*** and ability to experience ***orgasm*** variable.

PHYSICAL CHANGES

	POSITIVE IMPACT ON SEXUALITY	NEGATIVE IMPACT ON SEXUALITY
12WEEKS	• Absence of menstruation	• Nausea, vomiting, fatigue
12- 28 WEEKS	• Nausea, vomiting, fatigue • Pregnancy induced hyper-congestion	• Pregnancy induced hyper-congestion
30-36 WEEKS	• Pregnancy induced hyper-congestion	• Pregnancy induced hyper-congestion • Altered body image-lack of attractiveness.
>36 WEEKS		• Engagement of the head • Pains from sciatica/ pubic diastasis • Discomfort of various sexual positions

BREASTS Enlarged Hypersensitive nipples Colostrum leak	URINARY Frequent urination- INSOMNIA SUI
CIRCULATION Varicose veins- lower limb, vulva Hemorrhoids	WEIGHT GAIN EDEMA OF THE ANKLES
RESPIRATORY Physiological Shortness of breath Costochondritis Anemia & calcium deficiency	SKIN Stretch marks Hyperpigmentation
GASTROINTESTINAL TRACT Nausea, vomiting Heart burn	PHYSICAL FUNCTIONING Slowness Clumsiness

HORMONAL CHANGES

• Increased Levels Of Estrogen, Progesterone, And Prolactin	• Nausea, Vomiting, Weight Gain, Fatigue, Breast Tenderness,
• Increased Levels Relaxin	• Vaginal laxity • decrease in vaginal sensation
• Maternal Serum Testosterone levels rise along with serum sex hormone-binding globulin (SHBG)	• The free androgen index in the maternal serum is higher in the first trimester than in the nonpregnant state and returns to the nonpregnant reference range in the second and third trimesters

PSYCHOLOGICAL CHANGES

- ***Anxiety*** of delivery and motherhood
- Fetal movements
- Altered body image—Lack of attractiveness, ***Lack of self-esteem, sexual guilt***
- Experiencing an adverse pregnancy outcome such as a ***miscarriage, stillbirth, or adverse or debilitating neonatal morbidity adds*** additional stress in a couple's sexual relationship.
- Fears and Myths that sexual intercourse ----fetal injuries, miscarriage, infection, bleeding, and preterm labor have been propagated----results in an avoidance of sexual intercourse during pregnancy

SOCIAL CHANGES

- Current life situation
- Sense of security- work/family
- Relationships with others- family/society
- Expectations of motherhood
- Partner support

INTIMATE PARTNER VIOLENCE

- For women in ***abusive relationships***, ***pregnancy can be a vulnerable time***.
- Violence has been shown to ***increase with unintended pregnancies***.
- This violence may be the
  - result of ***resentment toward the unborn child***
  - partner's ***increased feelings of insecurity and possessiveness*** during the pregnancy

- ***Health care providers*** play a critical role
  - in ***assessing for the risk*** of IPV ***while providing antenatal care***
  - provide ***education, care, counseling, also referrals*** to community-based programs, which can help to protect a woman's reproductive health and physical safety.

UNDERLYING MENTAL HEALTH CONDITIONS

- Underlying ***mental health conditions such as anxiety and depression***
  - ***may appear*** and/or
  - ***become exacerbated*** during pregnancy,
  - often ***underdiagnosed and undertreated*** having an impact on a couple's sexual health
- Depressed women----decreased sexual desire -----increased sexual dysfunction

- The ***medications used to treat depression*** may be the etiology of continued sexual dysfunction.
- A review estimated that ***SSRI-related*** sexual dysfunction occurs in ***30 –50% of patients.***

Talking Sexuality

- Communication by the HCP about sexual matters in pregnancy is dependent on the willingness to adopt a personal approach to talking about sex, rather than asking the couple to fill out a form with this information.
- it is essential to address sexuality directly.
- Speaking openly about sex could give the couple a choice about whether to engage or not with this subject and then the confidence to ask their own questions.

- A study, 15–30% of patients may receive limited counseling regarding sexual activity during the antepartum period.
- Most of the information women obtain is therefore through friends, family, or the Internet. If women do receive information from their obstetric provider, most feel the advice is insufficient

Counselling Sexuality to Pregnant Couples: Overcoming the Taboo

Many HCPs avoid talking about sex in pregnancy

- often arguing that they do not want to **invade the couple's privacy.**
- There is a **lack of confidence or skills amongst the healthcare providers**
- Many HCP feel **uncomfortable discussing sexuality** and in some circles it is a taboo to consider these two topics together.
- ‘‘**Opening a Can of Worms**’’, that they do not address sexual health issues proactively with patients because of their belief that such issues are problematic due to their sensitivity, complexity and constraints of time and expertise

Counselling Sexuality to Pregnant Couples: Overcoming the Taboo

- Ideally, the first conversation should occur already when **planning a pregnancy** or at the **beginning of the pregnancy**.
- We should include **both partners** in that conversation about sexuality (if needed, followed by **individual talks**).
- In many countries, men are actively involved in their partner pregnancies, attending pre-natal checks and ultrasound examinations, providing birth support, and caring for the baby, so they are also more emotionally affected by pregnancy.
- HCPs should use their presence at antenatal visits, antenatal classes and counselling sessions to open up the topic of sexuality and intimacy.

- An **open conversation about sexuality during pregnancy** should become a part of **routine holistic care for pregnant couples.**

- **Pre-natal educators** have an important role in helping couples as they explore their sexuality during pregnancy.

- A significant role of the facilitator might be to normalize sexual and relationship upheavals in pregnancy: ‘‘**Sex is normal and safe during pregnancy’**

PRE-NATAL EDUCATORS

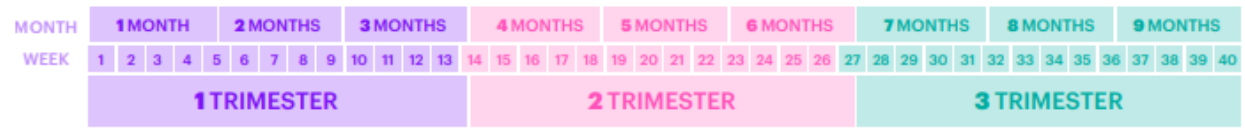
Providing couples with educative material

- Pregnancy changes they may expect,
- the duration of those changes
- the possible influences of those changes
- What to do next
- How to promote a healthy sexual relationship.

SEX THROUGH THE TRIMESTERS: WHAT TO EXPECT

HEALTHY MOMS. STRONG BABIES.

	First trimester (0 to 13 weeks)	Second trimester (14 to 26 weeks)	Third trimester (27 to 40 weeks)
What to expect	Early in pregnancy, common discomforts include fatigue, sore breasts, increased urination and nausea (feeling sick to your stomach). It's no surprise that all these changes may affect your sex drive.	Many of the unpleasant effects of early pregnancy disappear now. You'll likely feel more energy —and even see a change in your sex drive. In fact, you may want to have sex more often than you did before.	During this time, you might experience some late-pregnancy discomforts, like spotting (light bleeding) or leaking breasts. These are normal responses as your body prepares for baby's birth. As your belly grows, you might also find certain sexual positions challenging.
What to do	Try having sex at a different time of day when you might be feeling better. Since nausea tends to strike in the morning, nighttime romance may be just what the doctor ordered.	Although your belly is growing, it's still small enough to have sex comfortably. Experiment with positions, and enjoy your renewed sex drive!	Keep a towel handy, and try out different positions that work with your growing belly. Sitting and straddling your partner, laying sideways with your partner behind you or kneeling on all fours are safe positions.



- What are popular sexual positions and their benefits?
- How can couples explore new positions comfortably and safely?
- Are there specific positions recommended for different physical needs or conditions?
- What are some alternatives to penetrative sex?

Cowgirl/Pregnant Partner on Top

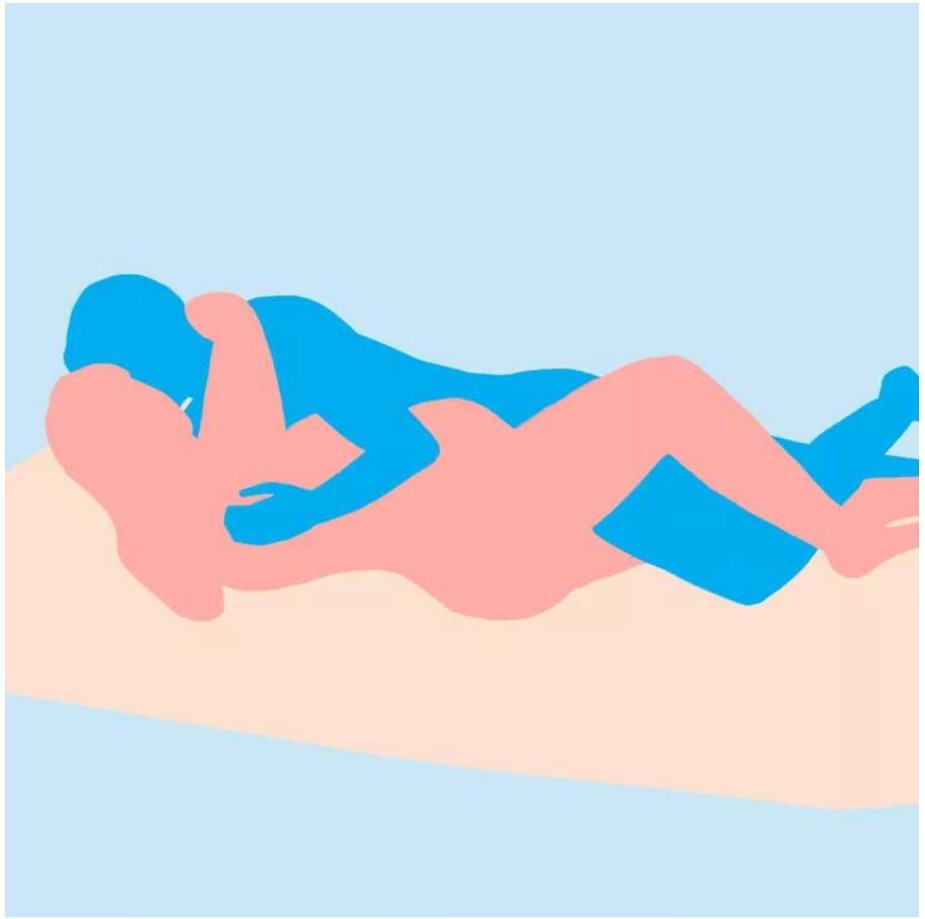
- This pregnancy sex position is ideal for controlling speed and depth of penetration
- Used during any trimester of pregnancy.
- According to studies, it's the most-chosen position during the second trimester.

Doggy Style or Rear Entry

- keeps pressure off the growing stomach.
- This allows the belly to be free & it's more comfortable to hold the extra weight on all fours.
- Penetration is more shallow in rear-entry positions, which may be more comfortable.
- If there is difficult to reach orgasm in this position, add manual stimulation.

Spooning

- Lying on a side while the partner lies behind, facing the same direction, can feel intimately soothing.
- penetration is more slow and sensual
- It allows physical closeness and comfort
- Extra weight in the belly is avoided
- The 2019 study found spooning most popular pregnancy sex positions during the $2^{nd}/3^{rd}$ trimesters.



Side-by-Side

- This face-to-face variation of spooning, bolsters intimacy, which allows for more eye contact, kissing, and romance.

Mutual Masturbation

- Mutual masturbation lets them to connect with each other and also enjoy the heightened libido.

Alternatives to sex during pregnancy

- Cuddling and touching: Couples can still share closeness and affection through cuddling, kissing, and caressing.
- Massage: Couples can help each other relax with a massage or hand or foot rub.
- Sharing vulnerability: Couples can get naked together and share how it feels to be vulnerable.

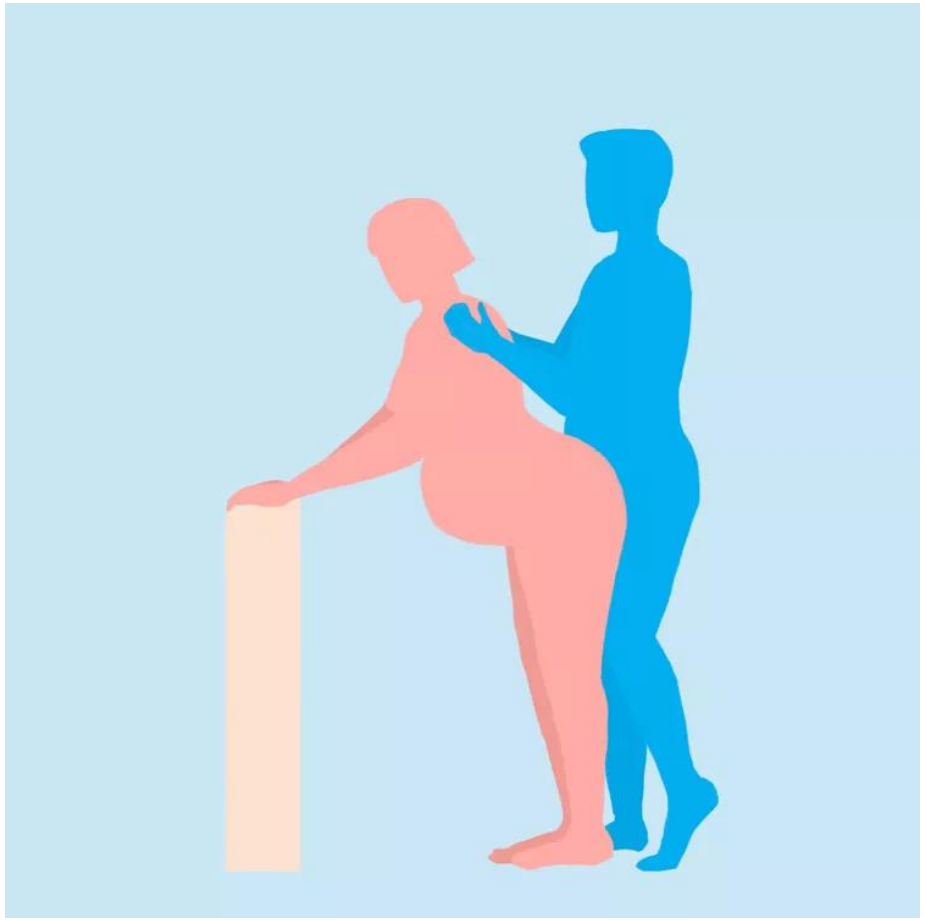
Masturbation

- The safest and most comfortable form of sex during pregnancy when intercourse is not allowed is masturbation involving clitoral stimulation, vaginal stimulation or both.
- Joint masturbation may not be as sensuous as physical sex but it is a safe way to enjoy each other's company in an intimate light.

Toys and sex

- Sex toys can be used during pregnancy as long as the toys do not cause harm to the cervix or the vagina. Using external toys increases the risk of infection, so both parties need to make sure the toys are disinfected before and after each use.

Anal Sex



- Attempt anal sex after at least 20 minutes of foreplay, and always use lube.
- Best avoided in placenta previa, hemorrhoids & constipation

Oral Sex in Resting Position

- Connects intimately with one’s body & partner while also taking a break to relax and be in the present."

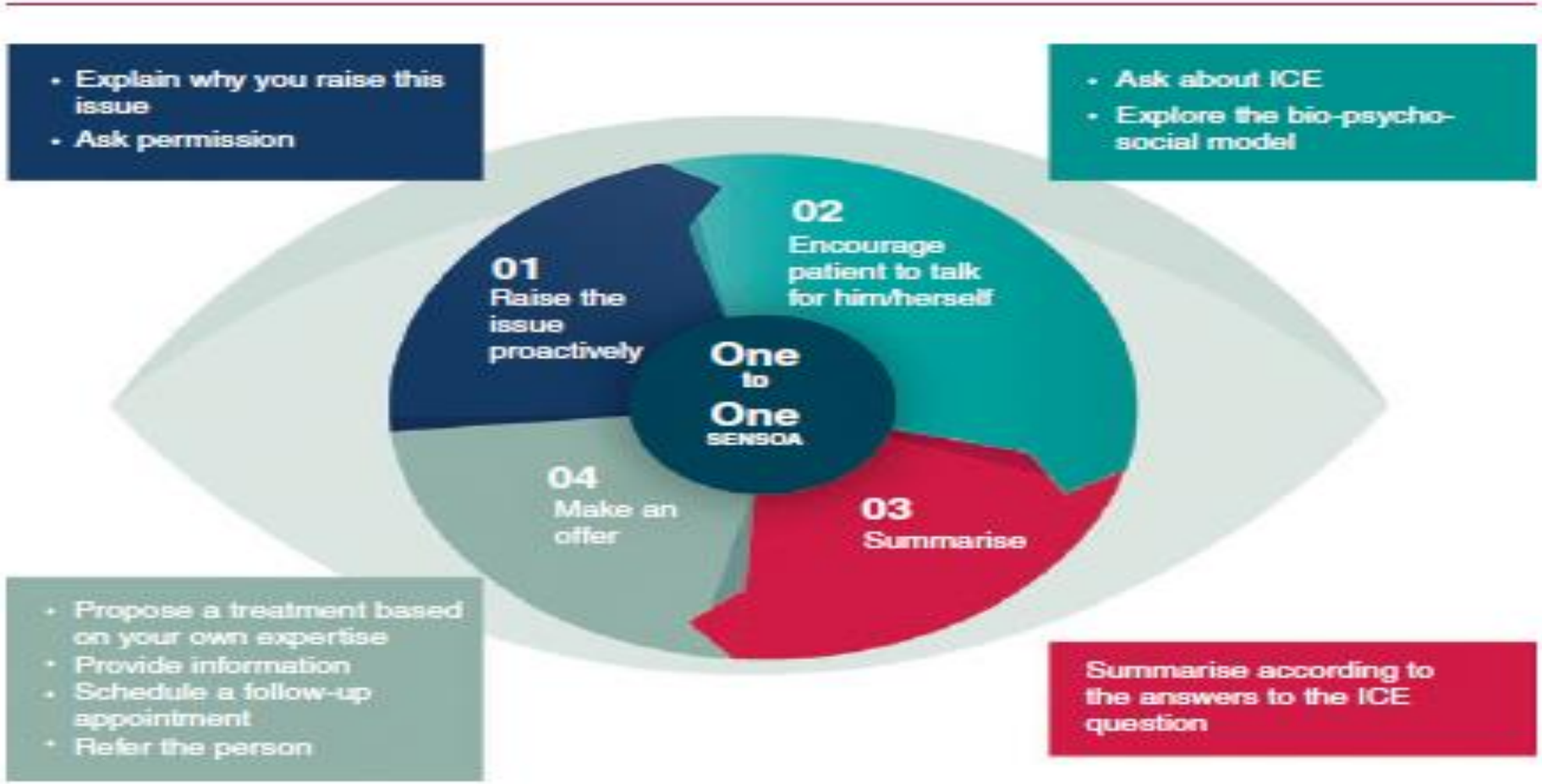
Sexual concerns in the pregnancy, if not addressed, could become bigger problems in the future.

- Some couples may find that their ‘pregnancy low libido’ masks their ‘premorbid sexual problems’ and that pregnancy is a convenient way to take a break from bad sex.
  - Unfortunately, the problem may intensify after birth, as the couple struggles to regain their sex life,
  - What might have been resolved through discrete discussion and reassurance with their healthcare provider may later require psychosexual therapy.

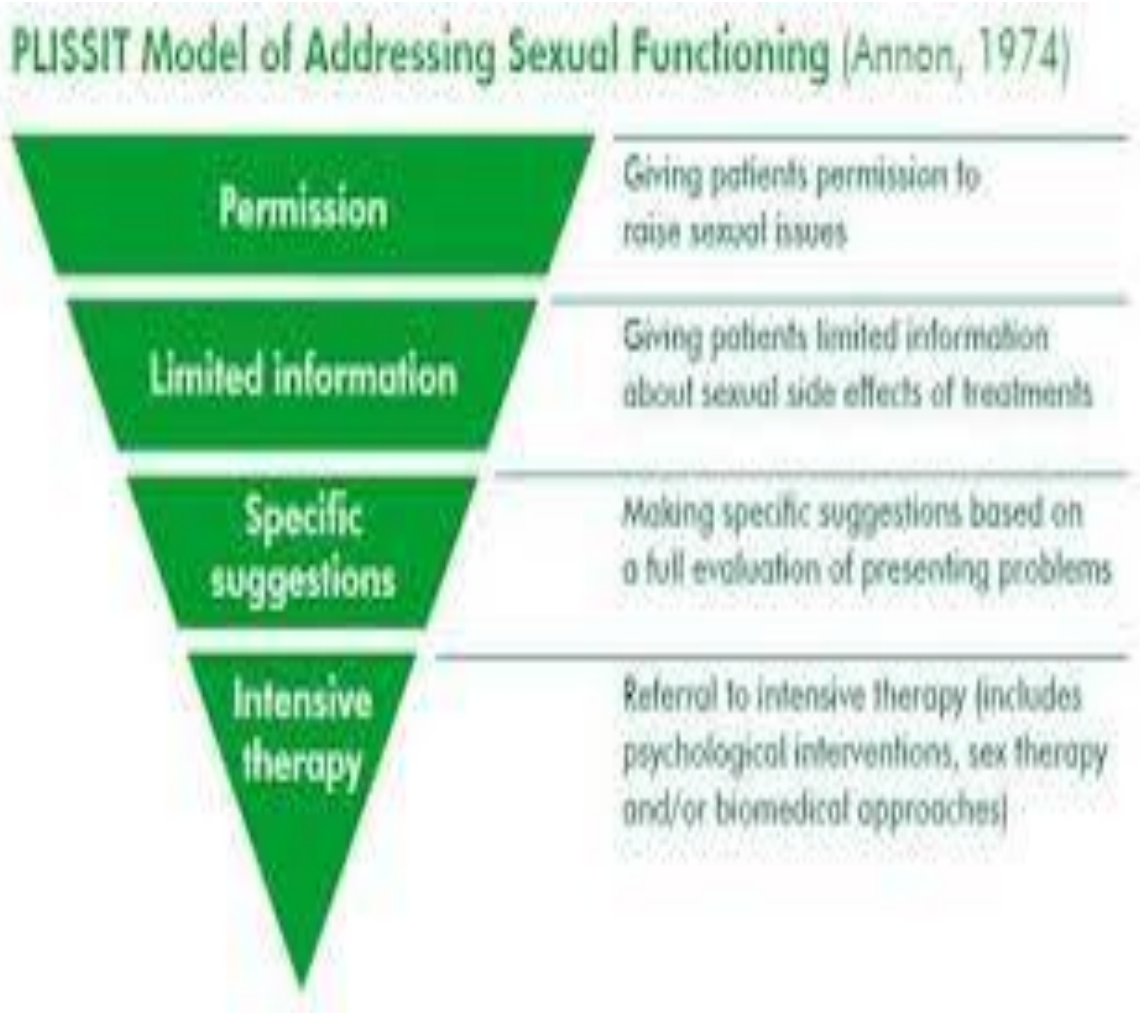
- If healthcare providers are comfortable discussing sexuality and intimacy they might also help the client to feel safe to disclose other relationship issues---abusive domestic situation that may otherwise go undetected.

- Couples with an at-risk pregnancy could also risk losing their intimate connection through this time of intense stress----can create emotional and sexual distance in the relationship. . According to Lewis and Black (2006) these couples have been observed to separate within a few years of the birth.
  - They need extra information and reassurance particularly about sex.
  - If sex is not safe-encouragement to have alternative physical proximity, like hugging, kissing or even masturbation techniques to relieve sexual frustration.

- Based on four easy steps, the HCP, can start a conversation about sexuality,



- The One-To-One (“1T1”) model is based on different (counselling) models
  - the PLISSIT model
  - Motivational Interviewing
  - ICE client history taking
  - biopsychosocial model



- **The ICE technique**
- ICE stands for Ideas, Concerns, and Expectations.
- The HCP inquires about what the woman worries about (− Concerns -), if she has any idea how this came to be (− Ideas -), and what she expects of you as a HCP with regards to these concerns (− Expectations -).
- These questions help focus the conversation on the woman's unique story, experiences, and needs.
- This line of questioning also contributes to developing a better HCP–client relationship, with the woman telling her story and the HCP understanding her experiences

- **Motivational interviewing (MI)** is a client-centered approach that can be used in sex counseling to help people address risky sexual behaviors and other issues

Contraindications

- ***Absolute contraindications***
  - Unexplained vaginal bleeding /placenta previa
  - Threatened preterm labour
  - Preterm premature rupture of membranes. Pprom
  - Cervical incompetence/ cervical encirclage
  - Genito urinary infections
- ***Relative contraindications***
  - History of premature delivery
  - Multiple gestation

- The ***risk of an adverse pregnancy outcome*** as a result of sexual intercourse should be ***individually considered*** and ***discussed*** with her/couple.

Sex for induction of labour

- There's not enough evidence to show that sex is an effective method for inducing labor

Prostaglandins	• Directly – semen • Indirectly- released from pelvic organs after intercourse	• Semen has no bearing on the cervical changes to expediated delivery

Oxytocin	• Foreplay
	• Penetration (Ferguson's reflex)
	• Orgasm
		• CST
		  • Uterine contractions are limited
		  • Less intense
		  • Usually resolve within 15-90 minutes

CLINICAL APPROACH FOR EVALUATION OF SEXUAL CONCERNS

- **INITIAL ASSESSMENT**

  - Ascertainment of whether ***pregnancy was planned***
  - ***Contraception*** (past, current use)

  - ***Previous deliveries*** (mode of delivery/AVD/perineal trauma/complications)
  - ***Outcome previous pregnancies*** (i.e., miscarriage, fetal loss, pregnancy complication, adverse neonatal outcome)
  - ***Current child/children's health***

- Assessment of ***current/past sexual relationship***
- Determine any ***sexual dysfunction*** was present before pregnancy

- Exploration patient/couple's ***support network***
- Watch out for ***abusive/strained relationships and intimate partner violence.***
- Evaluate for presence of ***depression/medications*** during pregnancy

COUNSELLING-ANTEPARTUM PERIOD

COUNSELLING

- Discuss changes in ***anatomy, physiology, and sexual function*** that commonly occur during pregnancy and postpartum.
- ***Avoid pathologizing range of sexual changes*** that may be experienced during pregnancy

- Discuss the ***likely safety of continuing sexual activity*** through pregnancy for most women
- ***Incorporation of education on safe sex practices*** as deemed appropriate (i.e., to reduce exposure to STDs)

- ***Discussing alternatives to intercourse*** and acknowledging the ***importance of maintaining intimacy, enable partners to discover new and satisfying ways of expressing their sexuality***

(Noncoital contact can also be an expression of emotional intimacy reinforcing a couple's sexual health and well-being)

- Encourage women to ***raise sexual concerns*** and have open ***conversations about sexuality*** during pregnancy and postpartum with health care provider.

CONCLUSIONS

- Sexual health is a ***common concern*** but ***seldom discu***.
- Sexual activity is generally considered safe in pregnancy.
- ***Prenatal visits*** are an ideal time for healthcare providers to address these concerns with expectant mothers***.***

- ***Healthcare professionals*** should ***consider the sexual problems*** of women within the ***scope of their service during routine antepartum visits.***
- ***I***t is essential to talk in depth about sexuality, listen actively & without prejudice, create an intimate atmosphere & maintain professional standards while building a trusting relationship in which couples feel safe to share their thoughts, problems & desires

THANK YOU