THE DEVELOPMENT OF A QUESTIONNAIRE TO
ELICIT THE PERCEIVED NEEDS OF
EXPECTANT COUPLES REGARDING
SEXUALITY IN PREGNANCY

by
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ABSTRACT

Pregnancy is a maturational crisis which involves changes in the sexuality-related roles and functions of an expectant couple. The needs and concerns of such couples regarding sexuality are not readily communicated and are therefore potential contributors to marital stress. If nurse-prenatal teachers knew what the concerns of expectant couples were they could assist them through teaching and discussion to deal with their concerns.

Therefore the purpose of this study was to develop a questionnaire which would elicit the perceived needs of expectant couples regarding sexuality during pregnancy.

The process of development consisted of three phases of data collection with volunteers recruited from urban classes for expectant parents. The first phase consisted of unstructured interviews. Structured interviews constituted the second phase and a self-administered questionnaire was used for the third phase. With the aid of interviewee responses and consultants' advice, the questions were developed and refined.

It was determined that concerns and needs related to sexuality during pregnancy could be elicited by the questionnaire and the author demonstrated how this information could be used to direct content for prenatal instruction.
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CHAPTER ONE

Introduction

Sexuality is a basic physiological and psychic aspect of human life. Its expression and fulfilment are an integral part of self-esteem, which, in turn, is so essential to satisfactory human relationships.

Sexuality during pregnancy is a topic which has only recently been explored. The fact that human females seek intercourse during pregnancy has been perhaps ignored since the females of most mammalian species do not.

Pregnancy constitutes a maturational crisis. Role conflict may arise as the husband-wife-partner-lover roles are compounded by the parent role and the additional concerns and responsibilities inherent in it. The sexuality that is so important to the satisfaction, affirmation and communication of the partners becomes a concern during pregnancy because of the physical changes in the female and the new psychological demands on both the male and the female. How can nurses prepare expectant parents to cope appropriately with the effects of this crisis, albeit maturational, on their sexuality?

Because these concerns of expectant parents are worthy of consideration nurses and midwives giving care to these couples should be cognizant of the needs related to sexuality in order to be able to provide appropriate information and counsel about sexual feelings and behaviour during pregnancy.
While practising community health nursing the author was concerned about the lack of published information regarding sexuality during pregnancy, and also about the reticence of couples to express their feelings and needs. Another concern was the lack of agreement among medical practitioners regarding resumption, cessation and the nature of sexual relationships during pregnancy.

Nurses who feel comfortable dealing with the subject and who consider sexuality a topic of priority in prenatal education tend to take an intuitive approach to providing information for expectant couples.

**Problem**

The problem is, that nurses do not know the perceived needs of expectant parents regarding sexuality during pregnancy.

**Overview of Problem**

The studies of Landis, Newton, Masters and Johnson, Solberg, Butler and Wagner, showed that reduced eroticism, fatigue, abdominal enlargement and breast tenderness effect a reduction in sexual activity of the female during pregnancy.²

Lack of knowledge regarding the normalcy of these changes and how to cope with them can be destructive to the self-esteem of the individuals and possibly to the integrity of their marriage.³

In spite of these changes "Sexual relations continue when procreatively unfruitful and even when difficult in humans. This underscores the importance of the bonding value of sex."⁴ That a satisfying sexual relationship between a man and a woman is of
fundamental importance to marital integrity and individual self-esteem is undisputed.\(^5\)

However, many doctors give minimal anticipatory guidance regarding the sexual aspects of maternity care. They are usually hampered by pressure of time, sensitivity regarding the subject, and the fact that usually only the woman comes for prenatal visits. In classes for expectant parents the atmosphere may be conducive to the discussion of sexual adjustments, but the community health nurse, even if she is inclined to deal with sexuality, may not know the needs of the clients and so be unsure about what material should be presented.\(^6\)

**Purpose of Study**

Therefore the purpose of this study is to design a questionnaire which will elicit the perceived needs of expectant parents regarding sexuality during pregnancy.

Reading and conversations with four Vancouver prenatal teachers who are known to place more than the average emphasis on the topic of sexuality in their classes for expectant parents have indicated that needs assessment would be helpful for the following reasons:

- Nurses perceive that the guidelines for teaching sexuality are lacking in the literature and the prescribed curriculum of the agencies for which they are working.

- Expectant couples are reluctant to initiate discussion about their sexual feelings, activities and needs.

- Nurses who at present do not include this aspect in their teaching might do so if specific needs could be delineated.
Knowledge of needs would facilitate the development of appropriate content for teaching and therefore enhance communication between instructors and clients and between the man and woman of each couple.

Expectant couples through acquisition of knowledge and communication of sexual needs with each other would be more likely to maintain their individual self-esteem and improve their mutual relationship. This would provide a firmer foundation for the triadic adaptation when the baby arrives and perhaps help to prevent marital strife and dissolution in the future.

Definition of Terms

Marital Relationship: Since it cannot be assumed that all couples who are expecting babies are married, for the purposes of this study, discussion of the marital relationship will include expectant couples who have lived together since confirmation of conception.

Maturational Crisis Situation: "a predictable set of circumstances associated with a maturational stage, and which involves a change in role and requires the individual to develop new coping behaviours in order to meet basic needs."  

Need: "A requirement of the person which, if supplied, relieves or diminishes his immediate stress or improves his immediate sense of adequacy or well-being."  

Perceive: to discern and express.

"Sexuality is a dimension and expression of personality." It is not only "those conditions of behaviour, fantasy, feelings and attitudes that have as their aim any one or any combination of the following:
(1) tumescence, [vaginal lubrication] (2) erotic stimulation of various parts of the body, and (3) erotic arousal and orgasm;" but also includes sensuality and the feelings one has about one's maleness or femaleness.
CHAPTER TWO

Review of Literature

I. Introduction

The aim of the literature search was to explore the concept of sexuality and to determine the impact of pregnancy on the perception and expression of sexuality in expectant couples. Another aim was to discover if those couples had unmet needs or concerns related to sexuality and if so whether these needs had been assessed by physicians and nurses. In order to elucidate the concept of needs several needs theories were explored so that discussion could be based on a theoretical framework. A fourth aim was to determine the attitudes and knowledge of health care personnel regarding sexuality in pregnancy and to discover how they assist expectant couples to deal with concerns related to this topic.

This chapter is organized under the following topic areas. It begins with an historical overview of sexuality in pregnancy which enables the reader to see the topic in its chronological perspective. There follows a theoretical framework for the discussion of needs so that needs associated with sexuality can be viewed in relation to needs as described by Maslow and Jourard. The review of sexuality is divided into two major categories—psychosocial and physiological. Within the former the topics discussed are narcissism, body image, role and communication because these are of particular relevance to sexuality in pregnancy. The physiological dimension of sexuality, discussed under
the topic of current research, appears to be of most concern to the medical profession and the laity. Included also under current research is a review of studies that have explored the attitudes and activities of expectant couples with regard to sexuality because these attitudes and activities are implicitly related to needs. Finally, the current state of education and practice of nurses and physicians is briefly reviewed in order to demonstrate the potential for care related to sexuality in pregnancy.

II. Historical Perspective

Until recently not much was known about a woman's sexuality during pregnancy nor about the effect of intercourse on the unborn child. Sexual activity was either explicitly proscribed or it was assumed that the pregnant woman and her mate would somehow know that sex during pregnancy was harmful and to be discouraged.11

However, in the early 1950s Pugh and Fernandez carried out a comprehensive survey of five hundred women and analyzed their data in relation to coitus in late pregnancy, delivery and the puerperium.12 They concluded that coitus was not responsible for the various complications of late pregnancy, delivery and the puerperium frequently attributed to it. The authors therefore stated that there was no necessity for emphasis on abstinence during the final weeks of pregnancy.

In spite of such findings, Ashley Montagu, in his book Life Before Birth (1964), cautioned expectant couples about intercourse during pregnancy even during the seventh and eighth months because of the risk of pressure on the fetus and the possibility of infection.13 He reminded his readers that some societies in human history had forbidden
intercourse during the entire pregnancy and stated that the Talmud and Koran specifically forbade it. Montagu, however did stress the importance of sexual relations in the marital relationship and suggested gentleness, cleanliness and the use of lubricants.

The impressive study of sexual behaviour by Kinsey and associates (1953), although it did not investigate sexuality in pregnancy, did open the door to several subsequent studies, the most notable of which was that of Masters and Johnson (1966). The latter team described the physiological and anatomical changes that occurred in female breasts and genital organs during pregnancy in a selective sample of women (N=6) from data obtained through observation and interviews. In addition 111 subjects responded to interrogation in depth with material of behavioural content.

Because of the small number and the biased sample, Masters and Johnson point out that their findings can be considered only as impressions. These authors were not attempting to investigate sexuality in its broad sense as have some: (Colman and Colman (1971), Iffrig (1972), Kenny (1973), Liebenberg (1973), Newton (1955, 1971, 1973), and Tolor and Di Grazia (1976). Therefore the sex role and psychological aspects of sexuality will be discussed in a later section.

Until recently maternity nursing textbooks failed almost entirely to deal with the topic of sexuality during pregnancy. A review of eleven textbooks published since 1970 revealed that three made no reference to sexuality, five gave cursory recognition to it in one brief paragraph, one discussed sexual relations in four paragraphs, one provided a pageful of information, and two designated chapters in which sexual problems and counseling related to both the mother and the father
were discussed.

This illustrates the existing dearth of information in textbooks and journals about the feelings and behaviours of expectant parents and an even greater scarcity of content regarding how nurses should approach the topic of sexuality in pregnancy.

Needs

The intended outcome of this study is the development of a tool which will elicit perceived needs, because without the knowledge of needs, concerns or problems regarding sexuality in pregnancy, nursing care could be ineffective. To clarify the concept of needs beyond the definition already stated a discussion of needs theory is presented.

Needs Theory

For the purposes of this paper, needs will be considered from the viewpoint of Maslow's approach. That is that the deepest wishes, urges and needs of man are instinctual. This follows from Freud's psychoanalytic theory. Maslow calls these basic needs and considers them instinctoid because they have to be gratified or else illness (or diminution of humanness) results. 17

Jourard, in his discussion of healthy personality presents Maslow's criteria:

1. A need can be adjudged basic if
2. Its deprivation breeds illness (mental or physical).  
3. Gratification of the need prevents illness.  
4. Identification and gratification of the need restores health in a person who is presently ill.
4. The deprived person prefers gratification of this need over any other, under conditions of free choice.

5. The need is not in a state of tension in healthy persons.

6. A subjective feeling of yearning, lack, or desire prevails when the need is not fulfilled.

7. Gratification of the need feels good; gratification produces a subjective sense of healthy well-being.  

A list of some basic needs of man which Jourard believes meet these criteria includes: to value life itself, physical needs, love, status, success and self-esteem, freedom and space, challenge, meditation and disengagement, cognitive clarity, meaning and purpose, varied experience, contact with nature and one's body. Many of these are needs related to sexuality, for example: the sex drive or the need for release of sexual tension is a physical need; love goes hand in hand with sex - through sexual love man gains ultimate reward of his efficacy and worth, not merely as a producer but as a person; self-esteem and body image are interdependent needs which are greatly affected by one's perception of one's sexual role and physical body; disengagement can be experienced through sexual fantasizing; cognitive clarity can also be related to sexuality as a need for knowledge and understanding of sexual function and pregnancy and the effects of one upon the other; and finally masturbation and pleasuring relate to the need for contact with one's own body.

Jourard states that there are needs beyond sheer survival needs. These higher needs when met assist man to achieve his potential in the areas of creativity, pleasure and altruistic endeavour. When a man is able to cope with his basic needs his energy and thoughts are then
freed for other purposes. "He can forget himself and become involved in
play, or in another person's problems, and perhaps with the well-being
of mankind as a whole." 21

Maslow conceived of a hierarchy of motives in which the meeting of
needs proceeds developmentally through a hierarchy beginning with
physiological needs and proceeding through safety needs, love and
belonging needs, esteem needs and self actualization needs. It is in this
last stage that there is a push towards the use of creative potential in
a sharing non-selfish manner. Maslow believed that when the basic needs
are met, individuals strive to meet higher needs. These higher needs
called "metaneeds" do not have the generally understood attributes of a
need. Metaneeds function as motives, needs and values at the same time
and have been described as virtues. 22

In setting out to ascertain perceived needs or concerns of expectant
couples regarding sexuality during pregnancy, the author recognizes that
individuals possess the stated basic needs at all times; but because of
the changes which take place during pregnancy some of these basic needs
fail to be met. Through prenatal instruction expectant parents can be
helped to meet some of their needs for physical satisfaction and comfort,
self-esteem, knowledge, understanding and communication.

Psychosocial Aspects of Sexuality

Discussion of this significant dimension of personality, sexuality,
would not be complete without considerable emphasis on its psychosocial
aspects. The changes effected in a woman by pregnancy have considerable
impact on her feelings about herself and her relationships with others,
in particular her marital partner. The psychosocial variables--(1) emotions,
(2) narcissism (3) body image (4) role identity and (5) communication are particularly affected by pregnancy and can greatly influence sexuality and hence marital integrity. Therefore a discussion of each of these five areas follows.

(1) **Emotions**

Niles Newton in her article "Trebly Sensuous Woman" states when males think about female sexuality they usually focus on the one aspect that is of most interest to them: intercourse. When they set out to study female sexuality, they usually investigate only the dimensions that have direct bearing on the pleasure and performance of adult males. After all, mature men can perform reproductive relationships only with women, and only through one act: intercourse.\(^{23}\)

In this and a later article her thesis is that female sexuality includes more than intercourse; it includes three reproductive acts that involve two persons: coitus, parturition and lactation all of which share common physiological and psychological aspects. For example, the emotions of tenderness, closeness and enjoyment are common to coitus and breastfeeding and undisturbed, undrugged parturition. In discussing women's feelings about menstruation, pregnancy, childbirth and breastfeeding Newton states that positive feelings about pregnancy are related to the wish to be a woman and the possession of motherly desires.\(^{24}\)

Masters and Johnson's findings about changes in sexual desire have already been stated, but these were only partially supported in the retrospective Solberg study of 260 post partum women.\(^{25}\) Solberg and
associates found that frequency of sexual intercourse was related to sexual desire and that there was a linear decline throughout pregnancy as compared to the second trimester rise in both dimensions that were reported in the Masters and Johnson study. However, it is difficult to compare the results in that Masters and Johnson interviewed their subjects in each of the three trimesters and therefore might have obtained more reliable data; but on the other hand, their sample was only 111 women as compared to Solberg's 260 women.

(2) Narcissism

A more specifically psychological analysis of pregnancy is the book by Arthur and Libby Colman, *Pregnancy the Psychological Experience*, written from data obtained in their weekly interviews with a group (number not stated) of normal primigravidas. Their method tended to be psychoanalytic in that they were interested in the dreams, fantasies and psychological defense mechanisms of the pregnant woman as evidence of the subject's feelings about her mother, father, unborn child, herself and her husband. Some of the interpretations and facts are pertinent to the sexual aspects of pregnancy. For example, late in the first trimester a woman becomes introspective as she concerns herself with her relationship to her mother in the attempt to form her own unique mothering identity. Benedek, Iffrig and Liebenberg also discuss this phenomenon and attribute it at least in part to the rise in progesterone levels. Benedek describes the pregnant woman as being narcissistic, in a state of vegetative calmness and relaxation with libidinous feelings directed towards herself. Iffrig also states that during this period of passivity the pregnant woman has a definite need for love and
attention. 28

(3) **Body Image**

Freud's conception of the development of sexuality is in many ways a body-image oriented theory. For example his libido organization theory consists of three stages—oral, anal and genital. Many current authors emphasize the influence of one's body perception on one's sexuality. 29 "One's own body image and the body images of others, their beauty and ugliness, . . . becomes the basis of our sexual and social activities." 30

Branden believes that self-esteem (of which body image is an essential component) is the single most pertinent factor in determining a person's sexual attitudes. He states that an affirmative response entails

- a strong, affirmative awareness of one's own sexuality; a positive (fearless, guiltless) response to the phenomenon of sex; a perspective on sex that sees it as integrated to one's mind and values (not a dissociated, mindless, and meaningless physical indulgence) a positive and self-valuing response to one's own body; a strong positive response to the opposite sex; a confident understanding, acceptance and enjoyment of one's own sexual role. 31

In summary, a couple's sexual adjustment during pregnancy will, to a great degree, depend on whether the woman has good feelings about her bodily changes, whether her husband finds them attractive or not (and whether he says so), and whether the woman positively anticipates her role of mother.

Unlike the other authors who have dealt with body image, Rubin
suggests that motion is essential for physical survival; but that one must be able to control it. Negative examples are diarrhea, vomiting and coughing. During pregnancy a woman may, due to urinary frequency, feel shame because of her loss of control; and during labour feel ashamed about crying out.\textsuperscript{32}

Body image, self-esteem and sexuality are three very important interrelated factors which will significantly affect the marital relationship particularly during the critical period, pregnancy.

(4) Role

These expectant couples experience a maturational crisis in that a normal developmental stage of life with its accompanying role conflicts is occurring. Role is one aspect of sexuality which many authors believe cannot be denied.\textsuperscript{33} Cultural patterns significantly shape a couple's reaction to pregnancy and many cultures see the role of the expectant father as that of provider and protector. To complement that role, the pregnant woman has been considered in the past, in western society at least, fragile, ill and requiring deference. It is no wonder then that some men have been put off by the increased eroticism of their pregnant partners.\textsuperscript{34}

Some societies believe that the child is nourished through intercourse,\textsuperscript{35} while some others believe that he is poisoned or damaged by it. In addition, the "idea of intercourse may be irreconcilable with a puritanic concept of 'motherhood'."\textsuperscript{36} For example, a woman who believes her breasts are biologically intended for nourishing her baby may not wish to have her breasts involved in pleasuring.
Not only may a woman experience conflict between the roles of lover and mother, but also between those of career woman and mother. In some there is resentment of impending motherhood and its anticipated interference with career. In these circumstances sexual expression and gratification are likely to be negatively affected by a spillover of resentment.

In that roles are complementary it can be assumed that as the expectant female's role changes, so will that of the expectant male. He will modify his role vis-a-vis the female's and also in relation to the expected child. These contemplated role changes may influence his sexuality. "Historically males have experienced couvade in many cultures" through mimicry of pregnancy symptoms, labour pains and postpartum weakness. This is supposedly an attempt to provide closeness for the father and child.

Also related to role, Jessner and associates "report a typology for describing the orientation seen among a sample of twenty-nine university men awaiting the birth of their first child." They were classified according to their attitudes toward parenting, that is, that it was a maturational experience to be accepted, casually; or a burden to be postponed; or a gift that was accompanied by a closer relationship with their wives. Woods infers that for each typology the nature of the sexual relationship [might differ]. "For the man who regarded parenthood as something to be avoided, the alterations in his wife's body may have served as a constant reminder of an unpleasant future. For the man who felt father-oriented, the closer relationship with his wife probably influenced both sexual behaviour and satisfaction." Activity and emotional control seem to be male role-associated
characteristics in North American culture. But the passive nature of a man's role during pregnancy plus the fact that tenderness and sensitivity are expected of him can lead to psychological conflict for him regarding his maleness. Furthermore, the possibly increased sexual aggressiveness of the expectant mother at least during the second trimester will compound his concerns about his sexual role.

Because pregnancy constitutes a maturational crisis with its inherent role conflicts the relationship of the partners with each other will suffer unless there is effective mutual communication of needs.

(5) Communication

Communication facilitates satisfaction with changing roles. For expectant parents this important factor greatly influences the couple's sexual relationship. Carty and Gordon in their study of post partum sexuality (N=20 couples) noted that there was a lack of communication between the couples about their sexual feelings. When asked "Are you and your spouse comfortable talking about your sexual feelings?"—thirteen women and four men felt partially comfortable, and four women and five men said "no." The investigators noted that "In 6 couples the partners gave the same response; [and] in 14 couples the partners gave a different response."42

Colman and Colman state "Surveys of married couples have found that husbands often think pregnancy will be the low point in the marital situation."43 Masters and Johnson, for example, found that eight nulliparas and twelve multiparas (N=111) expressed concern over . . . apparent lack of male interest in their physical being, and the fear that current rejection
might have some degree of permanent residual. All but 3 women thought that their husbands avoided them on the basis of (1) their physical appearance, (2) concern for their personal comfort, or (3) fear of injuring the fetus, and they were content to wait for the release of delivery. The 3 women expressed specific knowledge of their husbands' interest in other sexual outlets at this time.

Couples often feel that these needs and concerns are to be endured for the duration of the pregnancy; but surely a more positive approach is possible.

Scharff states that "for the individual, sexuality is a central source of both communication and growth in the development of relationships between his parents, spouse and children." In the same vein Clark continues; "Marital harmony often responds to improvement in both verbal and non-verbal communications." Parker, in her article "Coitus During Pregnancy" recommends coitus as an essential form of conjugal communication.

Coitus is an integral and important part of a heterosexual union. It must always be remembered, however, that the tension-releasing, and pleasure-giving aspects of sexuality fulfil genuine human needs. Sexual satisfaction is of particular importance during pregnancy as an essential means of preventing any weakening of the marital relationship and of insuring that the parents continue to function as a unit after the child is born.

She goes on to challenge the proscription of coitus during pregnancy—an issue which will be discussed later in this chapter.
Newton and Sherwyn Woods cite Lee Rainwater as the originator of the operant conditioning approach to marital bonding. The Rainwater studies were cross-cultural and therefore give credence to his theory that "Operant conditioning, reinforced by sexual pleasure, may be the biological foundation on which patterns of family life are built."

One can conclude from the foregoing discussion that pregnancy does precipitate role conflict and that communication through verbal and non-verbal means is essential to the meeting of sexual needs in order to maintain a stable atmosphere for the growing family.

**Current Research**

Since the Masters and Johnson study of 1966 a few authors and researchers have investigated the topic of sexuality in pregnancy. For this discussion the topic will be divided into three categories; (1) the physiological effects of sexual activity during pregnancy, (2) sexual behaviours of expectant parents, and (3) prenatal counseling of expectant parents.

**Physiological Effects of Sexual Activity During Pregnancy**

Although the possibility of infection, bleeding or damage to the fetus have long been stated as reasons for abstaining from sexual intercourse during pregnancy, there appears to be no documentation to support these statements. However, studies have been done to investigate the possible precipitation of premature labour by orgasm and these might be considered relevant to fetal damage in that infants are born prematurely.
Pugh published the results of a study of one hundred women in 1952 regarding "the effect of coitus on late pregnancy, delivery and the puerperium. It produced no evidence to indicate the necessity for emphasis on abstinence during the final weeks of pregnancy, provided that the gravidas were not uncomfortable during or after intercourse." In a follow up study of five hundred unselected patients admitted to a charity obstetric service over a three month period, Pugh and Fernandez asked patients when they had last had intercourse before coming into the hospital. The cases were "appraised as having complications related or unrelated to coitus or as complicated cases." The average and median times between coitus and admission were analyzed in relation to age, parity, marital status and the four complications stated above. No significant relationships were found except in the case of premature labour (t test applied) however, since premature rupture of the membranes had already been found to be unrelated to coitus and twenty-one of the sixty-eight premature labours were precipitated by premature rupture of the membranes, a causal relationship was felt improbable. It was questioned "whether the occurrence of premature labour could not have reduced the interval between last coitus and admission rather than the reverse." The investigators concluded that coitus is not responsible for the various complications of late pregnancy and that therefore there is no necessity for coitus in late pregnancy to be proscribed. No large studies that the author is aware of have since been carried out to investigate the relationship between coitus and complications of labour,
delivery and the puerperium.

In spite of the findings of Pugh in 1953 expectant mothers continue to be advised by their physicians to abstain from coitus during the final weeks of pregnancy. Parker states: "proscription of coitus during pregnancy has been promulgated without consideration of human sexuality, without adequate research knowledge, and without provisional counseling and concern."  

Masters and Johnson (1966) reported that the uterine contractions that accompanied orgasm in a non-pregnant woman resembled those of labour and that manually induced orgasm produced more intense contractions than did orgasm of coitus. A well designed study by Goodlin, Keller and Raffin (1971) investigated orgasm during pregnancy in an attempt to determine the deleterious effects. One hundred women were seen during the "second or third trimester of pregnancy and interviewed concerning their current experience with erotic activity and its association with abdominal discomfort or uterine contractions." An additional one hundred women were interviewed immediately after delivery about matters of general health, obstetrical history and coitus, masturbation and orgasm. Of these, fifty had delivered prematurely. In addition, pregnant women seen in outpatient clinic and complaining of abdominal pain or discomfort were interviewed "specifically about a possible orgasmic relationship to their complaint." Finally, five gravidas at term, who were known to have achieved orgasm by manipulation or coitus, (when their cervix was ripe) were asked to initiate an orgasm by manipulation or coitus to determine if labour could be induced. 

The data from the study indicate that the relative risk of premature labour or rupture of membranes is fifteen percent in gravidas after the
thirty-second week of pregnancy. In those who have a history of previous premature delivery the risk is twenty-one percent. In the group of three hundred antenatal patients, thirty-one complained of back or lower abdominal pain. Eleven of these believed that there was a possible relationship of their pain to the occurrence of orgasm.

Of the five orgasmic gravidas asked to achieve orgasm at a specified time, four were successful. Two were admitted in labor within three hours and the third within nine hours after orgasm. The fourth experienced an episode of false labor. All three patients with orgasmically induced labor had an uneventful labor and hospital course. 58

In comparison, Solberg and associates (1974) stated that none of their 260 subjects noticed an immediate onset of labour following coitus, 59 and the study of twenty-five gravidas by Holtzman (1976) revealed no statistically "significant relationship between sexual activity in late pregnancy, orgasm in late pregnancy and premature birth." 60

Goodlin and associates, on the basis of these data advise that postorgasmic syndrome late in pregnancy be discussed with all gravidas, and that coitus not be proscribed. However, they do "recommend orgasmic abstinence during certain pregnancies such as gravidas with a ripe cervix at 31 weeks of pregnancy or for those with a poor reproductive history." 61

Based on Solberg, Butler, and Wagner's larger survey of sexual practices during pregnancy, Wagner and associates investigated the relationship of prematurity and orgasmic coitus during pregnancy in a small sample. 62 The nineteen subjects who had delivered premature or
immature infants, were matched with a control group of nineteen full term puerperas. All were interviewed on the second or third post partum day.

Wagner and associates found no "significant differences among the premature, control, and total study (N=260) groups in the percentage of women experiencing orgasm at some time during pregnancy." The following questions were prompted: "In early gestation does orgasm per se have a significant relationship to the development of the fetus, resulting in an immature infant at birth? Is it pertinent that 15 of the 19 premature infants were immature by birth weight, even though 6 of these were full term by gestational age?" Considering the fact that other factors normally related to low birth weight (poor nourishment; parental immaturity, low socioeconomic conditions) could not be attributed to this sample the possibility of "physiologic processes arising from frequent orgasmic experiences in early pregnancy" contributing to retardation of fetal development is a question which should be investigated.

Since orgasm has been considered detrimental during pregnancy because of the suspected association with increased rate of abortion, premature labour and fetal distress, Goodlin, Schmidt and Creevy (1972) were prompted to study the effects of orgasm on fetal heart rate. Using a sample of one, twenty-eight year old multipara in her thirty-ninth week of gestation with a closed cervix, the investigators monitored uterine tension and fetal heart rate with a Smith-Kline monitor. The subject and her husband, in the privacy of a hospital room, were asked to initiate female orgasms. Six maternal orgasms were produced in seventeen minutes (out of a total recording of 106 minutes). The resulting uterine contractions apparently increased in intensity with
succeeding orgasms and the fetal heart rate was 155 per minute and
dipped to ninety-six per minute during contractions. Although these
data are reliable and suggest fetal distress and/or hypoxia there are
no data to prove the effects thereof.66

Prostaglandin, a hormone and a known abortifacient which is present
in large amounts in the amniotic fluid during labour exists in many body
fluids and particularly in seminal fluid. Experimentally it has been
found to produce uterine contractions in human females. Although it can
be absorbed vaginally, for the experiment of Karim, Trussell, Hillier
and Patel (1970) it was administered intravenously. Attempts to induce
labour in thirty-five gravidas at or near term were successful in
thirty-three of the subjects. No infant or maternal complications
resulted. The investigators therefore concluded that prostaglandin will
induce labour.67 Taylor (1970) reached the same conclusion.68 The
question yet to be answered is; does intercourse play a role in
prematurity?

Another sexual practice of considerable physiological significance
during pregnancy is oral-genital sex play involving inflation of the
vagina. Fatteh, Leach and Wilkinson (1973) describe a fatality due to
air embolism which resulted from vaginal inflation of a pregnant woman
during sex play. This is a rare occurrence, only eight having been found
to date in world literature; but expectant parents should be cautioned
about this activity.

That uterine contractions, orgasmic or involutional are stimulated
by manipulation or suckling is a well established fact (Newton 1967,
Clark and Affonso 1976, Masters and Johnson (1966). Although there
appear to be no studies of the oxytocic effect of nipple stimulation
during pregnancy, it would seem advisable for prenatal instructors to inform expectant parents of the possibility of uterine contractions.

While the foregoing studies on the physiological effects of sexual activity during pregnancy provide a factual basis for prenatal teaching, the actual sexual behaviour of expectant couples is also pertinent.

Sexual Attitudes and Practices During Pregnancy

Studies of sexual practices during pregnancy have revealed that sexual relations during this time are of sufficient importance to the physical and emotional welfare of the couple to warrant the contravening of medical proscription of coitus.

There is disagreement in the findings of the various investigators of coital frequency during pregnancy. Masters and Johnson (1966) noted an increase in the second trimester and a decrease in the third trimester, while Solberg and associates (1974) found a linear decline during the nine months of pregnancy. Morris obtained data from nine hundred Thai women through weekly interviews carried out by trained Thai public health nurses and found that coital frequency declined during pregnancy. However, the decline was not linear, but became more steep in the last trimester. The frequent direct data collection strengthens the reliability of these data as compared to the retrospective method used by Solberg and associates and Kenny or the tri-monthly Masters and Johnson interviews. Kenny (1973) using a retrospective questionnaire studied a select group of thirty-three post-partum women. He investigated four variables; desire, frequency, enjoyment and orgasm as separate variables of sexual functioning. His findings differed
again from those of the other investigators in that the sexual functioning as reported in his study was "generally the same as for nonpregnant women." Kenny himself points out the weaknesses in his study—the retrospective approach, the select sample and need to divide the last trimester into two-six week periods for more precision. On the basis of his findings, he asserts that morning sickness in the first trimester and awkwardness in the last "need not and does not significantly impair sexual behaviour." "This similarity of prepregnancy and pregnancy sexuality flies in the face of hormonal changes but is consistent with Ford and Beach's finding that there is less hormonal control of female eroticism as one moves up the evolutionary scale from lower to higher mammalian species." 

Solberg, Buter and Wagner's (1974) comprehensive, although retrospective, study investigated a variety of sexual behaviours of 260 pregnant women. Coitus, masturbation (by self or partner), orgasmic function, positions and oral-genital activity were studied in terms of frequency before and during pregnancy, the perceived reasons for changes were elicited from the women. They included, in descending order of frequency: physical discomfort, fear of injury to baby, awkwardness having coitus, recommendation of physician, reasons extraneous to pregnancy, loss of attractiveness, and recommendation of person not a physician. This study revealed a steady, almost linear decline in all parameters of sexual activity as pregnancy progressed. Their findings differed from those of Masters and Johnson in that (a) there was no association between parity and sexual interest, (b) a smaller percentage reported a feeling of loss of physical attractiveness as the reason for changed sexual activity, (c) a smaller percentage conformed to
proscription and (d) there was no significant indication that orgasm could predispose to prematurity.

Holtzman concerned with the limited amount of research on sexuality during pregnancy carried out a study to determine "what actual sexual practices and feelings exist during pregnancy." Since it was a retrospective study of only twenty-five women, the results are not generalizeable to the population of pregnant women, but are of interest. Holtzman noted that some women, when asked to participate in the study, refused because they felt they could not discuss sex with anybody. Another interesting fact is that some physicians refused permission to the author to interview their patients because they felt the subject matter of the questionnaire was not appropriate. These statements are relevant to the next section of the literature review where the current state of knowledge and attitudes of nurses and physicians will be discussed in relation to sexuality during pregnancy.

The finding of Solberg and associates regarding the linear decline of libido and sexual activity were corroborated in Holtzman's study. She found that oral genital sex fell off sharply after the first trimester and mutual masturbation also fell off sharply when pregnancy was detected. A reason for the former could be the increased vaginal discharge which is normal during pregnancy. Holtzman's analysis indicated that the frequency of sexual relations was not affected by race, socioeconomic factors, parity or whether or not the pregnancy was planned. But one cannot accept the statement regarding the socioeconomic factors as representing the population other than the sample. A feature of this study, lacking in others was the inclusion of a few questions inquiring about the women's perceptions of their partners'
feelings and attitudes.

A recently published study of sexual attitudes and behaviours during pregnancy (Tolor and Di Grazia, 1976) addressed the following questions:

(1) What is the woman's typical pattern of actual and preferred sexual behaviour as it unfolds during the course of pregnancy and following childbirth?

(2) To what degree is sexual satisfaction achieved by women during and following pregnancy?

(3) What are the normative attitudes towards sex at this time?

(4) Are there any significant changes in sexual attitudes or behavior as the pregnancy progresses?

(5) Is the woman's sexual behavior during pregnancy and following childbirth related to other factors, such as the degree of her conservatism toward sexuality.

Tolor and Di Grazia's sample of 216 women consisted of four approximately equal-sized sub groups (1) first, (2) second and (3) third trimester of pregnancy and (4) post partum. Each volunteer participant was seen in the private practice of four participating obstetricians and administered three questionnaires. They, as did Holtzman and Bing and Colman, found a wide range of individual differences in patterns of sexual activity. The resulting profile of sexual behaviour was as follows:

(a) a decline in sexual activity and interest as pregnancy progresses.

(b) a displacement of interest from vaginal to clitoral and breast
stimulation
(c) a return to a high level of interest and activity following
delivery
(d) a high incidence of women's need for close physical contact
during pregnancy and following childbirth
(e) being held was by far the most frequently selected as an
alternative to intercourse by all groups of women.\textsuperscript{81}

The resulting profile of sexual satisfaction indicated a decline in
orgasmic frequency from the beginning of the second trimester to the
third which does not fully return to its prior level at six weeks post
partum. The equating of orgasm with satisfaction is an assumption which
might be challenged. Only in the third trimester did any of the women
(4\%) indicate a total lack of sexual interest. The scores for the whole
sample on the group attitudinal scale indicated a relatively liberal
attitude towards sexual matters.

Tolor and Di Grazia also did a comparison of sexual behaviour and
attitudes in the four groups using the Chi Square technique. Desire for
intercourse was significantly different in the four groups and the
difference between the three pregnant groups and the post partum group
was highly significant (p \textless 0.001).\textsuperscript{82} As previously stated there was a
progressive decline in desire for intercourse during pregnancy,
accompanied by a similar decline in coital activity. The degree of
sexual liberalism or conservatism was found to be unrelated to sexual
behaviour during pregnancy.

The author considers the data and interpretation of this study
reliable in view of the direct method of data collection and the
statistical methods used. The findings generally concur with those of Solberg and associates but also extend the knowledge base into the realm of attitudes. It should be noted that all of Tolor's subjects had had the same advice regarding sexual activity during pregnancy: that is, no restrictions except in the presence of medical complications such as bleeding. Post partum subjects were advised to refrain from intercourse for four weeks and then resume according to own preferences, comfort etc.

Another publication which has recently shed some light on the subject of sexuality in pregnancy is Bing and Colman's book about and for expectant and parturient couples--Making Love During Pregnancy. It consists on the whole of comments from couples who had happy sexual experiences during pregnancy. The authors state that non-specific questions with loose guidelines were mailed to two hundred to three hundred couples in an attempt to elicit thoughts, feelings and experiences related to pregnancy, labour and after the baby was born. The rate of return is not stated; but the major limitation of the survey is acknowledged: that is, that couples who had happy experiences reported at length while those who had unsatisfactory experiences for which they could find no solution reported briefly.

The authors support their comments by citing the findings of various researchers (almost all of whom are reviewed in this chapter) in the field of sexuality and childbearing; but a large portion of the text consists of quotations from the responses of the participating couples. It will be of considerable value to expectant parents and prenatal instructors particularly because of its lay language, male point of view and the tremendous variety of experiences reported.

It is apparent that many expectant couples do experience difficulty
coping with some of the changes precipitated by pregnancy which influence their sexuality. In view of the fact these attitudes and behaviours represent a very select sample of the population it would behoove professionals working in the area of childbearing to attempt to determine the needs of the less vocal parents, especially fathers, who at present are not given much opportunity to share their concerns.

Prenatal Counseling

Modern North American maternity care was instituted in the early 1900s by midwives and nurses who gave care to women in their homes. Over the years, care was given more and more by physicians through hospital or office prenatal visits and hospital confinements. Gradually childbearing was taken out of the family setting purportedly to promote safety and prevent infection. This resulted in the fathers being excluded from the scene. To complicate matters, the nuclear family evolved out of the extended family with its various supports and society's attitudes and behaviours regarding sexual activity became respectively more liberal and open.

The nursing and medical professions, while giving expert physical care to pregnant and parturient women and their babies, failed to attend to many of the emotional stresses that resulted from the above sexual and social revolution. Couples experiencing this maturational crisis of pregnancy now had to cope without the former societal supports of families and midwives and were subject to strict maternity care with its various warnings, proscriptions and omissions.

Fortunately during the last two decades partially due to the impetus of consumers there have been efforts to change the attitudes of nurses
and physicians regarding sexuality, and to prepare them to counsel parents in the childbearing cycle about the psychosexual concerns they may have. In order to change, we in the health professions had to sense the unrest among ourselves and our clients. Some of the following authors have helped to create this sense of unrest.

The fact that most medical and nursing textbooks and journals have little factual information about sexual activity during pregnancy might indicate a lack of interest, knowledge or sense of need on the part of the writers to include the topic of sexuality in discussions of the care of childbearing parents (Sex Information and Education Council, Holtzman, Clark and Hale, Mandetta and Woods, Quirk and Hassenein).

Quirk and Hassenein's findings illustrate the confusion and ignorance of nurses regarding the issue of coitus during pregnancy. The authors queried the obstetrical instructors in six schools of nursing (N=6) using open ended questions to determine what student nurses are taught. They found that the nurses were not aware that patients do not observe prenatal and postnatal coital restrictions, and that most nurses were not well informed on the subject and were easily embarrassed by it. Fifty percent believed that coitus should be restricted and fifty percent believed that advice was the doctor's prerogative. However, an earlier patient study indicated that sixty-six percent of patients received no advice from their doctors either. It is therefore the authors' contention that an obstetrical nurse should fulfil her role properly and discuss sexuality with her patients.83

Clark and Hale state: "most textbooks recommend abstention during the last six weeks of pregnancy; none suggests what a couple should do instead of continuing sexual intercourse."84
This lack of information combined with negative or indifferent attitudes and the private nature of the topic of sexuality results in very inconsistent teaching of expectant couples. In addition most couples are reluctant to ask questions.

It was assumed in the past that somehow nurses and doctors would become knowledgeable about sexuality through the study of anatomy, and physiology and through life's experiences. The folly of these assumptions is quite evident. Therefore nursing and medical schools are now beginning to include human sexuality content in their educational programs.

Woods (1969) describes a course on the psychology of sex through training in sociocultural sensitivity that was developed for medical students. The purpose of this teaching method was to provide sexual information and knowledge, the opportunity for each student to achieve some insightful awareness into his own sexual attitudes and beliefs, and to develop sensitivity, empathy and understanding for the sexuality of patients whose social education and background differed from his own. The format was informal with the professor serving primarily as a resource person for the series of nine weekly three hour, small group seminars. "Normal and disordered sexual development, behaviour, and psychology from infancy through geriatrics" were the topics discussed and the "most important structuring was the strong encouragement of the group to view themselves as a cross section of the community." At the end of the course the student evaluations indicated that it had met its purpose to a moderate or great degree. This course was a good example for others in that the social and emotional dimensions of sex education were dealt with in relation to both client and care giver.
However, Marcotte and Kilpatrick contend that in spite of the rapid increase in the number of American medical schools offering human sexuality courses there is still a persistent need for planning such courses. The problems they cite are: the primer level of current courses, the negative student attitudes to a complete curriculum in sex education, inadequate sex information of educators, faculty resistance and obstruction of course planning.86

One university school of nursing has responded to the challenge of sex education needs by having developed a one semester course which is open to all undergraduates. Its purposes were very similar to those stated by Sherwyn Woods. Because of a dirth of tools with which to evaluate the course, Mandetta and Woods (N.F.) developed their own--the Human Sexuality Knowledge and Attitude Inventory (HSKAI).87 However, although they found a significant increase in total knowledge, the students' attitudes were found not to have been significantly altered. It is difficult to compare the effectiveness of these two courses in that the former did not set out to change attitudes but merely make students aware of their attitudes. The former course was evaluated by only twenty-one of the thirty-five participants and the latter apparently by the whole class with the use of a pretest and a post-test. Both courses had in common the use of small group seminars and a very positive response from the students concerning the degree of enjoyment and the amount of information communicated.

This type of course would be invaluable for all baccalaureate students in nursing regardless of where they intended to practice and would be of particular relevance to those caring for childbearing couples. In the meantime efforts are being made by nurses and physicians to
improve the quality of care of expectant parents through content guides (Szasz, 1969; Neubardt, 1973; Szasz and Maurice, 1976; Sex Information and Education Council of the United States, 1970) and method guides (Zalar, 1976; Russell, 1975; Crosby, 1976; and Adams, 1976).

Neubardt's brief guide to office counseling indicates his recognition of the helpfulness of sexual expression in a couple's relationship during pregnancy and states specifically what practices are contraindicated on the basis of research. While this guide is intended as content for doctors, the guidelines of Szasz and Maurice are written for the laity in a sensitive yet explicit manner. In Sexuality and Man, the Sex Information and Education Council of the United States includes a very informative, factually based chapter on "Sexual Relations During Pregnancy and the Post Delivery Period" which should be of considerable help to both the laity and the health professionals.

Possession of facts is of little value to nurses and physicians unless these facts can be communicated skillfully and effectively. The counselor must be aware of her own attitudes and biases, and of the behavioural values of society and must demonstrate sensitivity, objectivity and empathy. Crosby applies the Carkhuff-Berenson model to the situation of a nurse-midwife giving sexuality counseling. In brief, he discusses the core dimensions--empathy, respect, genuineness and concreteness as they relate to this topic in a way that is very constructive for the reader. He concludes by stating: "If the medium is the message then let us recognize that we, as mediums, are highly sexual creatures. And because we are our own message we stand in constant need of continued re-integration of our sexuality into the other various components of our total self-identity which is both the content of our
message and its means of transmission to others."

Summary

It is clear that behaviours and attitudes related to sexuality and pregnancy have changed tremendously in the last forty to fifty years. However, it appears that the pace of change of the consumers has exceeded that of the health care professionals. The lay person, at least in North America, is taking more interest and initiative in his health care; but nurses and physicians are tardy in adapting their educational programmes to this trend and those professionals already established in practice perpetuate their traditional approach to patient care. Courses, both basic and refresher, in human sexuality for health professionals, should be developed in nursing and medical schools. It is time for change, as Neubardt states: "Modern medicine has observed a long list of taboos and proscriptions based on very little scientific evidence. It is past time to reexamine our attitudes toward sex in pregnancy with the initial assumption that free sexual expression, when not specifically harmful, is generally helpful."

Most investigators agree that changes in sexual desire and activity occur during pregnancy. However, different authors have found different patterns of change. The results of the studies cited, not entirely in agreement, should challenge the status quo by stimulating the initiation and performance of further research. Larger studies are required to explore the relationship between orgasm and prematurity and between coitus and premature labour.

The paucity of information on the impact of pregnancy on the expect-
ant father's sexuality indicates a need for further investigation into this dimension of childbearing. There is no evidence of inquiry into the perceived needs and concerns of expectant couples regarding sexuality. One could attempt to interpret needs on the basis of sexual behaviour, but to ascertain these needs from the individuals themselves would yield far more reliable information. Therefore, the intention of this study is to facilitate the determination of these needs in order that health care professionals, in particular, nurse-prenatal instructors can better help clients to meet them.
CHAPTER THREE

Methodology

Introduction

Since the research problem for this study was the assumption that nurses do not know what the needs and concerns of expectant parents are regarding sexuality, an interview or questionnaire seemed the logical method of discovering what these needs are. The author believed that if these needs were determined for each prenatal class, the prenatal instructor could tailor her teaching to suit the expressed needs of that particular group. Therefore the questionnaire would serve as a:

1) basis for needs-related teaching (as stated above)
2) stimulus to assist couples to discuss sexual adjustments with each other
3) stimulus and focus for group discussion of concerns related to sexuality.

It is felt that couples and groups would be less inhibited about discussing their needs if they knew that others shared the same concerns.

Therefore this chapter was included in order to explain and outline the author's methodology for the tool's development. The process will be discussed in chronological order beginning with a brief review of the literature. The writer will then state her rationale for the three phases of development and then indicate how validity and reliability of the tool would be optimized.
Literature Review

A review of the literature in the field of sexuality and pregnancy revealed no tool that could be utilized to ascertain needs. There was, however, one instrument which explored behaviour, but this was suitable only as a reference. Much of the literature on methodology dealt primarily with the measurement of learning or attitudes and so the author was obliged to develop a needs-assessment tool without reference to an example.

The term "questionnaire" is often used for any instrument that has questions to which individuals respond, for example an interview schedule. However, for the purposes of this study it was defined as a self-administered instrument that has items of a closed or fixed alternative type. In spite of the reservations that several authors expressed concerning questionnaire use, it was decided that a carefully constructed one could yield valid and reliable data.

Nixon, Doby, Ferber and Verdoorn, Helmstadter, Mouly and Phillips outline specific guidelines for questionnaire construction in order to help the researcher avoid some of the usual pitfalls--ambiguity, redundancy, difficulty, insensitivity, and annoyance, but Kerlinger is under the conviction that such methods can only be learned through experience. It is possible to learn certain principles of schedule construction, but in order to construct an actual schedule, one requires considerable practice in writing and reviewing items and construction.

The writer believed that this trial and error method of questionnaire development would be enhanced by the observance of certain principles
which a number of authors recommend. From the literature the following list of suggestions guided the writer's questionnaire development. The questionnaire items should:

1) be clear
2) be concise
3) be relevant to a significant topic
4) possess face validity
5) use language that approximates that of the respondent
6) deal with one idea per question
7) not confront the respondent with the necessity of giving a socially unacceptable response
8) not suggest a particular response
9) lead logically from one to the next
10) be ordered from neutral to sensitive, ending with one or two neutral items.

Mouly's checklist of criteria for evaluating a questionnaire was a helpful guide while the tool was being designed.96

Validity of the questionnaire was a factor that had to be considered during the process of development. The content of questions on the physiological, psychological and sociological dimensions of sexuality was based on the writings of such authors as Masters and Johnson, Colman and Colman and Schilder respectively. This content is discussed in chapter one.

However, knowledge of content and question construction are not always sufficient for questionnaire development. The literature indicates that interviewing is an integral part of development and formative
evaluation. Several authors have written books or chapters about this "conversation with a purpose" and its principles and techniques, and for the purposes of this particular study the following guidelines were considered pertinent to discussion of a sensitive topic such as sexuality.

1) Make the interview experience meaningful for the respondent, be spontaneous.
2) Be sensitive, show warmth and permissiveness.
3) Continually check to clarify communication.
4) Never suggest an answer to a question.
5) Do not give your own opinions, even if you are asked for them.
6) Try to keep the respondent on the topic.

The author realized that the meeting of questionnaire and interview criteria would not guarantee a valid, reliable and useable tool and that pretesting would be required to ensure these characteristics.

Rationale for Development in Three Phases

Development in three phases would, in the author's opinion, serve two purposes. It would provide the opportunity for exploration of the concerns regarding sexuality in pregnancy and also for testing questions and refining the tool.

Wandelt states that pretesting (1) assesses the questionnaire's effectiveness (2) informs the investigator about how long it takes to administer the tool and (3) gives the researcher the opportunity to plan for coding, tabulating and classifying the data. Mouly states that it is generally desirable in pretesting to use open ended questions because they can provide information which can be categorized and then be restated.
as closed-ended questions. These four factors influenced the author's decision to develop the questionnaire in three phases.

Based on the concept of grounded theory, the writer planned the first phase of tool development to explore the behaviours and concerns regarding sexuality in pregnancy. It was felt that this could best be done through personal interviews with expectant parents—males and females with the investigator using an unstructured format. Although some categories had been delineated in advance, the interviewer believed that other categories of information might be forthcoming.

The author planned to utilize the data and impressions resulting from the first phase to direct format and content of questions in the second phase of interviewing. Kahn and Cannell's recommendation that interview objectives be stated was felt to be important for both this and the third phase. Since the ultimate goal was the development of a self-administered questionnaire, it was intended that the second interview schedule would be structured in order to more closely approximate the final product.

The third phase of questionnaire development was to evolve through the evaluation of the second phase and result in a tool that could be distributed to individual respondents, completed independently by them and returned to the investigator; because this final tool would have to be one that would be readily distributed and evaluated by a prenatal instructor.

Validity and Reliability

The investigator planned to establish validity through (1) a thorough review of the literature (2) consultation of content experts (3) utilizing
feedback from respondents regarding face validity and additional concerns and through the encouragement of honest answers. The latter would be optimized by the investigator's adherence to the content and method guidelines previously stated.

The establishment of reliability was not anticipated to be problematic because of the uniformity of stimuli. The usual methods for calculating reliability of test data would be difficult to apply here. Split half reliability would not be appropriate because of the relative independence and non-additivity of the component items. Different phrasing of the same question would be a dubious tactic because the respondent would be likely to detect it, and furthermore it would add to the length of the questionnaire. The test re-test method used over a short interval would probably not be useful since respondents would attempt to remember their original responses and secondly, over a long interval within pregnancy there could actually be a change in perceived needs over the trimesters. Studies have shown considerable inconsistency in questionnaire responses, particularly in factual items, but Cuber and Gerberich view the inconsistency to be typical of all personal communication rather than peculiar to the questionnaire. In view of these statements, a small N, and the fact that the interviewee's perceptions were to be elicited, the investigator decided not to test reliability by any formal statistical means.

Conclusion

The investigator believed that a self-administered questionnaire for expectant parents would be the best tool that prenatal instructors could use to elicit perceived needs regarding sexuality during pregnancy. The
tool was to be developed in three phases through a general exploration of perceived needs and a gradual process of tool refinement and pretesting. The following three chapters will discuss and evaluate the conduct of these three phases.
CHAPTER FOUR

Phase I

Development of Interview Schedule for Phase I.

For the first phase of data gathering the intention was to elicit perceived needs and concerns regarding sexuality during pregnancy and to generally explore the topic through interviewing so that there would be a thorough discussion of the breadth and significance of sexuality. The discussion of the latter was to focus on the changes that had taken place since conception in the couple's sexual relationship with the aim of discovering needs not previously perceived. Four different experts were consulted during the process of the drafting and revising of the interview schedule. One was a nurse-midwife and professor who had researched postpartum sexuality, the second was a professor of nursing with maternity as her clinical specialty, the third was a sociologist with considerable experience in questionnaire construction and the fourth, a physician, was a sex therapist. The version utilized for the first phase of interviewing (N=10) appears in appendix D.

Recruitment of Volunteers

Permission to recruit volunteers was granted by the Board of the Lower Mainland Childbearing Association. The investigator subsequently arranged with two prenatal instructors to introduce her study briefly at the beginning of each of the two classes, and distribute and collect
consent forms within fifteen minutes. The couples were given five minutes to discuss the possibility of their participation and sign the consents. All of the consent forms, signed and unsigned were then collected by the investigator who thanked the class for their time and assistance and departed.

Within a few days, the volunteers-five couples out of a total of approximately thirty couples were telephoned and arrangements were made for interviews in their homes. Each respondent was to be treated as an individual (N=10).

Description of Group I

All of the subjects in the first phase were married and of Western European or North American origin. Their ages ranged from twenty-one to thirty-five (mode 26-30) and their highest level of education ranged from grade twelve to doctoral student. The range of length of time living with partner was five to nine years (mean = 6.9). Three of the women were nulliparas and two were multiparas.

The Interviews

The first few minutes after the arrival of the interviewer at the subjects' homes were spent in informal conversation and then one of the partners (decided by the interviewees) would absent himself to attend to work or recreation in some other part of the home. In one case, because the apartment was so small the husband went out for a walk while his wife was interviewed. In only one of the situations was it apparent that some of the interview might have been audible to the non-participating partner.
The purpose of the interview (Appendix D) was explained to the respondent and he/she was invited to indicate if explanation or clarification of questions was needed, or if he/she did not wish to answer any of the questions. The latter did not occur. For the first interview the respondent was given the list of behaviours (Appendix D, p.122) at the beginning. However, when she stated afterwards that this had tended to direct her thinking towards the physical aspects of sexuality for the whole interview, the interviewer decided for subsequent interviews to present the list to subjects only immediately before behaviour changes during pregnancy were discussed.

As was intended discussion of questions was free and unstructured. There were occasional probes from the interviewer to elicit fears and knowledge or skill needs related to both the physiological and psychological aspects of sexuality. Discussion tended to range freely across both areas and so the interviewer had to be alert to insert comments on the correct page of the data collection tool. In some cases, more than the required information was noted because of its significance for future question development.

The interviewer attempted to note non-verbal behaviour so that she might be aware of the state of comfort or discomfort of the respondents. These observations were subject to the perception and interpretation of the interviewer and so may not have yielded valid information.

Discussion of Questions

Question One (see Appendix D for questions)

The data obtained are considered only impressions because of the
small N and lack of firm structure in the interview format.

1. (a) What would you like to know about facts related to the physical aspects of sexuality during pregnancy?

   (i) Concerns expressed by men:
   - What are the hormonal effects of pregnancy on the eroticism of the female?
   - Does the need to protect the pregnancy supercede the sexual drive?
   - How do I gratify myself and my partner when "sex" is difficult?
   - How much can I involve my partner's breasts in sex play?
   - Is manual stimulation of the female all right?
   - Does sex normally decline during pregnancy?
   - What are the dangers of sexual activity?
   - How do we handle the contractions that result from female orgasm?
   - When should intercourse cease during pregnancy?

   (ii) What concerns (fears) do you have about the physical aspects of sexuality during pregnancy?

   Fears expressed by men:
   - fear of harming the fetus by pressure on the abdomen
   - fear of transmitting upper respiratory infection to wife
   - fear of harming cervix

   (b) What would you like to know about facts related to the feelings or emotions you have that are related to sexuality during pregnancy?

   Concerns expressed by men:
   - concern about fact that male has orgasm before female and sometimes female climaxes not all. "She says she is satisfied, but I am not sure she really means it."
- a male prenatal instructor might be of more assistance to males
- what are the psychological effects of pregnancy on a woman?
- need a male to talk to prenatal women to give male point of view in prenatal classes.
- How can I show my partner that I care?
- How can I feel less 'left out'?
- How can I communicate?
- fear of being rebuffed
- fear of hurting partner's feelings
- How can one cope with one's partner's depression in early pregnancy?
- concern about being unneeded
- concern about feelings of regret or guilt after intercourse
- concern about how to deal with sexual frustration
- How can I find out if she wants sex without her thinking that she must please me?
- How can I deal with my wife's irritability?

1. (a) What would you like to know about facts related to the physical aspects of sexuality during pregnancy?
   
   (i) Concerns expressed by women:
   - What is the relevance of breast size to ability to breastfeed?
   - What kinds of sexual activities are safe during pregnancy?
   - concern about pressure on abdomen--wants to protect it
   - concern about decline in sex drive both in early and late pregnancy
   - concern about how to get "turned on" physically
- Is drop in sexual activity normal?
- How long before due date should intercourse be discontinued?

(ii) What concerns (fears) do you have about the physical aspects of sexuality during pregnancy?

Fears expressed by women:
- fear of trauma to breasts
- fear that some entrance angles will be harmful

(b) What would you like to know about facts related to the feelings or emotions you have that are related to sexuality during pregnancy?

Concerns expressed by women:
- needs communication skills--to communicate feelings to partner and to have the reverse
- needs a physician who will be empathetic regarding the feelings of a pregnant woman
- needs to talk to someone who has experienced career/mother role conflicts
- feels men need to know more about psychological changes that occur in pregnant woman
- needs improved body image
- needs more cuddling—not necessarily intercourse
- concern about conflict in mother/lover roles
- concern about husband's lack of outlet for sexual needs
- concern about whether husband will want her after the baby is born
- need to share feelings of being big and unbeautiful with other women
- concern about regaining slim body
- concern about hurting husband's feelings
- concern about mood swings
- How can I deal with my husband's lack of sexual interest in me because of the baby inside?
- concern about inability to make self look attractive
- How can I adapt to my increased drive?

Question Two

Nine of the ten subjects were given the list of possible sexuality-related behaviours on completion of discussion of question one. All ten were given an opportunity to read over the list before it was discussed.

List of Possible Sexual Behaviours That You Feel Might Have Been Affected by the Pregnancy

Please note that the order has no significance.

When we are discussing sexuality we are referring to a wide range of behaviours and feelings which might occur at any time during a twenty-four hour period.

Therefore I am providing you with this list of some behaviours related to sexuality which might help you to understand my questions more fully and assist me to develop my questions appropriately.

1. touching
2. mutual eye contact
3. stroking - for example - breasts, buttocks, thighs, abdomen
4. kissing - face, mouth, body; open or closed mouth
5. breast-fondling
6. breast-kissing
7. self-stimulation
8. mouth touching genitals - male, female
9. genitals touching genitals
10. sucking on genitals
11. sucking on nipples
12. licking or sucking elsewhere
13. hugging
14. cuddling
15. penis-vagina penetration
16. penis to mouth
17. penis to anus
18. penis to breasts
19. saying something complimentary, for example, "you look great"
   "you look sexy"
   "I like your shape"
   "you're handsome"
20. saying, "I want you; I love you" etc.
21. mutual oral-genital stimulation
22. manual stimulation of male or female genitals to orgasm
23. inspection, that is, gazing, or looking at body or body part
24. talking about sex
25. mouth to vagina - blowing
26. holding
27. hand-holding
28. looking at "sexy" pictures.

The purpose of this list was to assist the respondent to focus on sexuality-related behaviours. It was made fairly comprehensive in order to minimize the possibility of omitting any behaviours that might be practised by the volunteer subjects. Discussion of these behaviours focussed on changes in satisfaction, frequency, desire and initiator that had been perceived during pregnancy so that concerns related to these changes could be noted. A change in initiator might imply a change in interest or desire.

Discussion of comments under the "mode" heading dealt with additional material that some respondents volunteered regarding feelings about these behaviours and reasons for change.

In some cases, perhaps because it was uncomfortable to use the words, the subjects referred to items by number. Terms were clarified as
required and those items which were never or rarely practised were not discussed.

Satisfaction (changes in degree of satisfaction)

Responses were notably varied but some general tendencies were observed when the data were tabulated. The satisfaction from kissing or fondling of the breasts declined for both males and females as did satisfaction from coitus. However, satisfaction from hugging and cuddling increased for all women and most men. The comment was made on several occasions that there was an increased need for physical contact with one's partner.

Frequency (changes in frequency of behaviours)

The frequency increased for touching, stroking, cuddling, hugging, hand-holding and manual stimulation of the female while breast involvement and oral-genital activity decreased.

Desire (changes in desire for various behaviours)

The desire of females for compliments about their appearance was increased and the desire for touching, hugging and cuddling was increased for both males and females. However, there would appear to be some dissonance regarding manual stimulation of the female since frequency was reported to be increased while desire for it was reported by females to be decreased.

Initiator (changes in who initiates behaviours)

Stroking appeared to be initiated in most cases by males, but this impression could be a function of a biased statement i.e. the listing of
predominantly female body parts. Females tended to initiate verbal expressions of love while males tended to initiate hand-holding.

**Mode (characteristics of changes or feelings)**

These comments indicated a shared concern for the well-being of the couple's relationship in view of their anticipated parenthood. A desire to give and receive reassurance, protection and support was expressed by several males and females.

**Observations (observed non-verbal behaviours)**

On the whole the subjects appeared to be relaxed and comfortable during the interviews. The women tended to be more verbal, smile and maintain eye contact more than the men. Some of their mild chuckles or laughter could be attributed to anxious feelings. Some of the behaviours of some of the men could be interpreted as indications of nervousness, for example, a periodic twitching of the upper lip; vigorous repetitive rubbing of the dog which was on one man's lap; and a tendency to speak in generalities to avoid using more specific terms for sexual activities.

**Question Three**

The purpose of this final question was to evaluate the interview schedule and process. Respondents found items 5, 6 and 11 on the list redundant in that they were all part of progressive involvement of the breasts in sex play. Some individuals asked the interviewer what was the difference in items 13, 14 and 26 (hugging, cuddling, holding). These items therefore could have been grouped as one or described more explicitly. It appeared that the respondents would have been satisfied
to discuss all of the oral-genital behaviours (8,10,16,21,25) as one. Item 9 could have been omitted because it was always linked to sexual intercourse in the minds of the respondents.

Two out of the ten interviewees felt that some words or sentences were unclear while three out of the ten stated that they found some of the topics difficult to talk about. These three plus one other subject felt somewhat uncomfortable or embarrassed initially discussing sexuality since previously they had not really discussed it with anyone except their spouses. However, they stated that the interviewer put them at ease and considerably increased their feeling of comfort. Oral-genital behaviour was singled out by one subject as being difficult to talk about.

Only one individual expressed concerns at the conclusion of the interview. These were: (1) how to say "I love you" to one's spouse and (2) "Will sexual desire return after the baby is born"?

Discussion

It cannot be assumed that the five couples who volunteered for this phase of the study are representative of the population from which they were drawn in that couples demonstrated considerable interest or concern regarding sexuality by merely participating. These respondents were articulate, and at no time did the interviewer encounter negative feelings about the interviews. Two statements, however, are pertinent. One was the comment that the interviewer had, after enquiring about marital status, said "You never know these days." This could be interpreted as negative bias regarding cohabitation without marriage. The second comment indicated the interviewee's mild frustration due to the interviewer's never voicing value judgments during the interview. The
respondent knew that this was standard procedure for such interviews, but could not help but feel the need for affirmation or negation of his statements. The interviewer therefore made some self-disclosing statements at the close of the interview.

**Conclusion**

The relatively unstructured Phase I interviews achieved the aim of eliciting a number of concerns and unmet needs of men and women regarding knowledge and fears related to the physical and psychological aspects of sexuality during pregnancy. While the discussion of changes in sexual behaviours during pregnancy frequently was time-consuming and generated material not particularly relevant to this study, discussion of these behaviours did facilitate the exploration of many emotional and physical concerns. The need for effective communication was a recurrent theme. Many of the concerns about sexual activity and feelings were not peculiar to pregnancy.

Many comments from couples in this phase of the study were utilized in the formulation of questions and statements in the second phase (Appendix E).
CHAPTER FIVE

Phase II

Introduction

The purpose of the second phase of the study was to develop a structured interview schedule based on the process and content findings of the first phase, and to utilize that schedule in interviewing a second group of five expectant couples.

During the process of question formulation three of the four previous advisors were consulted: the two nursing professors and the sociologist. The author deferred consulting the sex therapist-physician until the final phase of questionnaire development because he would then more directly influence the outcome.

In order that the formulation of valid questions be facilitated the following interview objectives were stated.

The subject will indicate:

1. her/his unmet physical, sexual needs or concerns
2. her/his unmet psychosociosexual needs or concerns
3. her/his unmet sexual knowledge needs or concerns
4. the medium or mode by which she/he feels she/he could be assisted to meet (1), (2) and (3) above
5. how she/he is presently being assisted to meet these needs (1), (2) and (3) above.
The Interview Schedule

The intention was to develop a structured interview schedule to closely approximate the questionnaire format intended for the third phase of the study. Each draft of this Phase II questionnaire was revised as a result of comments and suggestions given by one of the consultants. Revisions were thus made on the basis of weaknesses in questions and order perceived by the interviewer and consultants. The expressed concerns of the Phase I expectant parents directly influenced the topics of questions used in Phase II, for example; the increased need for physical contact not necessarily intercourse, the need for inter partner communication of sexual feelings, the need for information about what activities might harm mother or baby, and the need of the expectant woman for reassurance about her physical attractiveness. The interview schedule was prefaced with a brief explanation of its purpose and a request for comments on the questions regarding lack of clarity, difficulty, irrelevance, vagueness, and annoyance. (See Phase II Interview Schedule - Appendix E).

Recruitment of Volunteers

The procedure for recruitment of the ten volunteers for the second phase was identical to that used for the first phase except that for one class the consent forms were collected one week after they were distributed, and for another the consent forms were collected during the class "break" on the same evening they were distributed. This latter method provided the greatest return of all recruitment efforts used in both phases one and two.

The Subjects

The couples ranged in age from twenty-one to thirty-five and in
length of time cohabitating from one and one-half to seven and one-half years. Three of the five couples were married. Six of the ten individuals were university graduates. The remaining four had a grade twelve education. In this group five were of Anglo-Saxon origin and the remaining five represented the Chinese, East Indian, Hungarian, Japanese and Jewish ethnic groups. Three of the women were experiencing their first pregnancies, one her second and one her fifth, while the gestational periods were sixteen, twenty, twenty-four, twenty-four and twenty-five weeks for each of the five women.

The Interviews

The individuals were interviewed in their homes with each one requiring twenty to thirty minute's time. The purpose was explained, the interviewees were asked to comment later on the quality of the questions. Then the interviewer posed the questions to elicit oral responses from the subjects.

The author made notes of difficulties she perceived as well as those stated by the respondents. At the conclusion of each interview the investigator dealt with any concerns expressed or implied by the interviewee.

The respondents generally appeared comfortable with the questions and several stated that the questions were interesting. One very shy male stated that a period of informal conversation at the outset would have put them more at ease. The author recognizes that when she did begin with casual conversation, some of the respondents not only appeared to relax but also stated that it facilitated subsequent communication.
Findings Related to Objectives

The questions used for this second phase of interviewing appear to have met the objectives. The questions were understood by the respondents and elicited data that was classifiable into the five categories stated, that is, data on physical, psychological and cognitive needs related to sexuality in pregnancy and how these needs were being, or could be met.

Discussion

Although the interviewer did not perceive communication to be a significant problem for these couples, it did appear that these individuals had more difficulty communicating their sexual needs to their partners than did those in the first group of interviewees. For one male, shyness was compounded by cultural change. He felt that his partner did not seem to have any sexual needs during pregnancy and also that he did not know her sexual needs. His spouse seemed to accept his shyness and adapted by being the initiator (at least during pregnancy).

Two men and one woman indicated that they felt uncomfortable talking to their partners about their sexual needs, and three women and two men wished their partners would talk to them more about what they needed sexually. However, only one of the ten respondents indicated a need to talk to someone about sex during pregnancy. This latter statement indicates a degree of satisfaction with inter-partner communication which is not born out by the preceding statements.

A few instances of discordance were noted in that one male felt hurt when his partner declined intercourse and she didn't believe he felt hurt. This was paralleled in another couple with the female feeling hurt and
the male not being aware of it. Discordance was also evident in expectations regarding return of the woman to her pre-pregnant shape. All of the five women believed they would regain their figures in a year. Four of the male partners thought they would not—whether this was realism, pessimism or resignation, one can only speculate.

Psychological and knowledge needs were implied by the fact that one male was apprehensive about becoming a father, and only one felt that the new baby would interfere with his "sex life."

Two women and one man felt that male prenatal instructors was an acceptable idea. No one responded with enthusiasm to the proposal.

Three men and one woman believed that intercourse was not appropriate during all periods of pregnancy because their physicians had proscribed it during the last three to four weeks.

It is therefore clear that these expectant couples have unmet needs related to sexuality. These needs can be classified into three categories:

(1) communication

(2) realistic expectations

(3) facts and rationale concerning the safety and appropriateness of various sexual activities during pregnancy.

These categories were considered in the formulation of questions for the third phase of this study.

Critique of Interview Schedule

The following comments indicate strengths and weaknesses found in this tool by the interviewer and the respondents during the second phase of interviewing.
Part A:

The first question

II 1. Most people when not pregnant at times require reassurance about sexuality. Have you found this has changed during pregnancy?
Yes _____ No _____ If yes, more _____ less _____
(If less - go to Q2, if more go to Q3)

was considered by the interviewer to be too long and convoluted. It always had to be repeated and reworded. The directions following this question were too complicated and there were no instructions contingent on answering "no".

Questions two, three and four dealt with elaboration of "reassurance" in question one. The author felt that this area could be more effectively explored through a number of Likert type items (see Table 1, page 69 for Phase III content related to Phase II).

II 2. How are you reassured about your sexuality during pregnancy?
Go to Q5.

II 3. What sexual aspects of yourself do you feel you need reassurance about during pregnancy?
(Explain role referring to definition of sexuality)

degree of attractiveness
role as wife
role as mother
role as sexual partner

II 4. Please specify how you could be reassured about your:
(a) degree of attractiveness (c) role as mother
(b) role as wife (d) role as sexual partner

Questions dealing with the need for reassurance about one's role as wife or husband were not utilized later since they had elicited no responses during the previous interviews.

Questions five and six

II 5. During pregnancy what sexual activities would you like more of?
II 6. During pregnancy what sexual activities would you like less of?

dealt with sensitive material and so should have been located later in the schedule. The listing of some behaviours for these
two questions could have increased their value and perhaps validity. Note that these questions became #6 and 7 in Phase III.

Improved wording for question twelve

II. 12. Who do you go to when you have concerns about the emotions which affect your sexuality during pregnancy?

- prenatal instructor
- mother
- partner
- physician
- other (specify)

would have been "who do you talk to?"... Because respondents tended to focus on the word go. This topic was dealt with in a different way in question three, Phase III.

III. 3. From which source would you like to get more information about sexual activities during pregnancy?

- books
- pamphlets
- magazines
- partner
- parent
- friend
- prenatal instructor
- community health nurse
- physician
- other (state)

Part B:

In part B questions ten, eleven, thirty-seven and thirty-eight would have elicited more precise data if the responses were categorized into trimesters.

II. 10. I feel my partner is not interested in having intercourse with me during the first half of pregnancy.

II 11. I feel my partner is not interested in having intercourse with me during the latter half of pregnancy.

II 37. I tend to initiate "sex" during pregnancy. (a) first half (b) latter half

II 38. My partner tends to initiate "sex" during pregnancy. (a) first half (b) latter half
Questions ten and eleven were revised to become question ten in the Phase III questionnaire,

III 10. This question enquires about your level of enjoyment of sexual intercourse during pregnancy. For you, has sexual intercourse been:

<table>
<thead>
<tr>
<th></th>
<th>very enjoyable</th>
<th>satisfying</th>
<th>unsatisfactory</th>
<th>unpleasant</th>
</tr>
</thead>
<tbody>
<tr>
<td>before this pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>first 3 months</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>second 3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>last 3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Questions thirty-seven and thirty-eight (see page 63) dealt with initiation of sexual intercourse. However this topic was not used in the Phase III questionnaire since the interviewer felt that initiation of sexual intercourse was related to sexuality in general, and, not peculiar to pregnancy.

Question twelve

II 12. I am not interested in having intercourse with my partner during the first half of pregnancy.

might better have been stated "I feel my partner is not interested in having sexual intercourse with me during some period(s) of pregnancy"-- and then followed by -- "Which period(s)?". However, this question was translated into several questions (18, 19, 21) dealing with communication and perception on the final questionnaire.

III 18. I do not know what my partner needs sexually during (her) (my) pregnancy.

very true for me ____
gen generally true for me ____
gen generally not true for me ____
definitely not true for me ____

III 19. (I) (my partner) feel(s) guilty about having sexual intercourse during pregnancy.
III 21. I feel that my partner understands my sexual needs during (her) (my) pregnancy.

Question seventeen

II 17. I am really apprehensive about becoming a mother.

was revised in Phase III question, twenty-nine so that the word "worried" was substituted for "apprehensive" since three subjects did not understand the latter.

Question eighteen

II 18. I am concerned that the new baby will interfere with my sex life.

was excluded because it was considered more appropriate for a post partum questionnaire.

Question twenty-one

II 21. My interest in sex now is the same as it was before pregnancy.

would have better helped respondents indicate needs -- three females had indicated a change in their sexual activity, if an opportunity had been given to indicate the direction of change. This was done in Phase III, ten (see page 64).

Question twenty-six on the male interview schedule

II 26. I feel less like a man when my partner initiates intercourse.

should have had a parallel "I feel that my partner is less manly when I initiate intercourse" on the female schedule. The answer to this statement would have indicated whether there was a problem, and if so, whether it was communication or role stereotyping when compared to its parallel on the male questionnaire. However, this content was not included in the final questionnaire because
other questions dealt with communication and because this type of role stereotyping is not peculiar to pregnancy.

Questions three and thirty-six from the Phase II questionnaire for men

II 3. I feel "left out" when she is pregnant.
II 36. I feel jealous of my partner when she is pregnant.

were not utilized in phase III since none of the male respondents had feelings of jealousy or of being left out during their partners' pregnancies. In fact they all felt very involved in the experience.

Question thirty-two

II 32. I think that there should be male prenatal instructors as well as female.

was eliminated because the interviewees indicated a lack of interest in the prospect of male prenatal instructors and so it was deemed a non-critical need.

Since during the interviews a few men expressed guilt feelings about having intercourse with their pregnant partners, question nineteen was included in the Phase III questionnaire.

III 19. (I) (my partner) feel(s) guilty about having sexual intercourse during pregnancy.

Some of the questions relating to demography in Phase II were not used in Phase III. The author believed that information about age, education, marital status and ethnic group might make it possible to identify respondents. Because of a desire to maintain anonymity and also because
it was felt that these statistics were not essential data, this information was not requested in Phase III.

General Comments

The negatively-phrased statements in part B probably elicited more valid responses by discouraging yea-saying. The interviewer felt that these kinds of statements permitted the respondents to make non-idealistic responses. The use of parallel questions on the male and female interview schedules assisted the investigator to evaluate and compare communication and perception of partners. It is assumed that the respondents found it difficult to relate some questions to pregnancy alone. Topics such as communication and feelings of hurt when sexual overtures are declined were probably viewed in relation to sexuality in general rather than isolated to pregnancy, and therefore this type of question is not appropriate for this tool.

Significance for Phase III

Because of the apparent comfort, ease and speed of response to the Likert type items in part B, it was felt that this style of a questionnaire was the most valid and reliable for the purpose for which it was being designed. The previously suggested revisions were made and the more subjective type questions were modified to conform to a Likert scale format. The duplicate question enumeration in sections A and B was a potential source of confusion during evaluation, therefore the author decided to number subsequent questionnaires
serially throughout the sections. Table 1 indicates the relationship by topic of Phase II and III questions.
### TABLE 1

**Question Numbers relating topics in Phase II and III**

The questions of Phases II and III are listed by number only. Each horizontal line indicates which questions of Phase III are related topically to questions in Phase II and the right column indicates the topic. For example, Question A-11 of Phase II and questions 1,2,3,4 and 5 of Phase III deal with the topic of information. All of the Phase II question numbers relate to the female questionnaire except for the circled ones which are from the questionnaire used for the males.

<table>
<thead>
<tr>
<th>Phase II</th>
<th>Phase III</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>A a b c d e f g</td>
<td>1,2,3,4 35 38</td>
<td>gestation, total number of pregnancies, age, gestation, total number of pregnancies, age</td>
</tr>
<tr>
<td></td>
<td>7 6</td>
<td>more sexual activity, less sexual activity, possible inappropriate sexual activities, perceived inappropriate sexual activities, knowledge of inappropriate sexual activities</td>
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<tr>
<td>5 6 7</td>
<td>9,23,24,25 8</td>
<td>satisfaction with above knowledge information, concerns about emotions, need for information about emotions</td>
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<tr>
<td>8 9 10 11 12 13</td>
<td>1,3,23,24,25 1,2,3,4,5 2,4,12,13 1,2,3,4,5</td>
<td>knowledge of inappropriate sexual activities, satisfaction with above knowledge information, concerns about emotions, need for information about emotions</td>
</tr>
<tr>
<td>14</td>
<td>2,4</td>
<td>need for information about emotions</td>
</tr>
<tr>
<td>B 1 2 3 4 5 6 7 8 9 10 11 12</td>
<td>17,27 6,7 2,4 21,26 21 15 6,7 6,7 6,7 6,7 6,7</td>
<td>body image, need for cuddling, emotions during pregnancy, communication of sexual needs, perception of male's understanding, feeling hurt when &quot;sex&quot; declined, body image expectations, need for breast fondling, need for intercourse, need for intercourse, need for intercourse</td>
</tr>
<tr>
<td>Phase II</td>
<td>Phase III</td>
<td>Topic</td>
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<tr>
<td>12</td>
<td>6,7</td>
<td>need for intercourse</td>
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<tr>
<td>13</td>
<td>6,7</td>
<td>need for intercourse</td>
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<td>14</td>
<td>9</td>
<td>harmful effects of breast fondling?</td>
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<td>15</td>
<td>20</td>
<td>sexual interest in one other than partner</td>
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<tr>
<td>16</td>
<td>16</td>
<td>perception of mate's pleasure with pregnant body</td>
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<td>17</td>
<td>29</td>
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<td>18</td>
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<td>concern about interest in &quot;sex&quot;</td>
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<td>22,26</td>
<td>change in libido</td>
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<td>21</td>
<td>10</td>
<td>need for love and belongingness</td>
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<td>34</td>
<td>satisfaction with parent role</td>
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<td>23</td>
<td>27,12,13,14</td>
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<tr>
<td>24</td>
<td>31</td>
<td>need for variety of sexual behaviours</td>
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<td>25</td>
<td>6,7</td>
<td>feelings about breastfeeding</td>
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<td>26</td>
<td>31</td>
<td>need for variety of sexual behaviours</td>
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<td>27</td>
<td>6,7</td>
<td>knowledge related to breastfeeding</td>
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<td>28</td>
<td>32</td>
<td>parent-career conflict</td>
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<td>30</td>
<td>appropriateness of intercourse during pregnancy</td>
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<td>8,9</td>
<td>sexual interest in one other than partner</td>
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<td>31</td>
<td>20</td>
<td>male prenatal instructors</td>
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<td>16,17,27</td>
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<td>36</td>
<td>3,4</td>
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<td>33</td>
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<td>17</td>
<td>guilt about intercourse with partner during pregnancy</td>
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<tr>
<td></td>
<td>19</td>
<td>number of pregnancies experienced</td>
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<td></td>
<td>35</td>
<td>results of pregnancies</td>
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<td></td>
<td>36</td>
<td>number of years living with partner</td>
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<td>37</td>
<td>gestation</td>
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<td>38</td>
<td>gender</td>
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Note: The data in the table is derived from Table 1 Continued.
CHAPTER SIX

Phase III

Introduction

The purpose of the third phase of the study was to develop a self-administered type of questionnaire to elicit the perceived needs and concerns of expectant parents regarding sexuality. This was to be accomplished through the refinement of questions used in the phase I and II interviews and the distribution of the resulting tool to a different group of ten expectant couples (N=20) so that they could answer them at home and return them by mail to the investigator.

The content of the questions was directed by the same objectives (p.57) that were stated for the second phase of the study, while the tool format was directed by the following objectives.

The questionnaire will:
1. be self-administered by the respondents
2. be completed in fifteen minutes
3. be utilized by both men and women
4. provide data in a manner that can be readily tabulated and summarized by a prenatal instructor.

Construction of Questionnaire

At the outset, the questions, comments and data from the previous interviews were reviewed. The author then attempted to make the new
questions clear and concise to facilitate the respondents' answering quickly, accurately and independently. Four consultants, the nurse-midwife professor, the sociologist, the sex therapist physician and a community health nurse who teaches classes for expectant parents, advised the author regarding the content, clarity and sequencing of questions, and revisions were made accordingly. In addition, two expectant parents (one couple) were asked to pilot test the tool by each completing one at home and then returning them by mail to the author. They were also asked the following questions:

1. Is it clear?
2. Does it offend you?
3. How long did it take you to complete?
4. Do you have any suggestions for improving the questionnaire--for adding, deleting?
5. Other comments?

Their responses indicated that it was clear, inoffensive, needed no additions or deletions and took fifteen to twenty minutes to complete. The few comments that were made were of an elaborative nature and did not indicate a need for revisions.

After the final draft of the questionnaire was completed the various categories of need were listed with the corresponding question numbers in order to assist the researcher to sort future data and relate them to topics to be used for prenatal instruction. (See Appendix H).
Categories of Need

1. source of information  
   1, 2, 3, 4

2. desire for information  
   5, 11, 32

3. need for more sexual activity  
   need for less sexual activity  
   6
   7

4. concern about what sexual activity  
   is all right  
   8, 9, 19, 23, 24, 25

5. need for enjoyment  
   10

6. need for emotional support  
   12, 13

7. need for physical support  
   14

8. need for improved body image concept  
   15, 16, 17

9. need for communication  
   18, 21, 22, 26

10. desire for other sexual outlets  
    20

11. needs for role affirmation  
    27, 28, 29, 30, 31

12. needs regarding sex in general  
    33

13. need for love and belongingness  
    34

Questions 35-38 were intended to provide information about the amount of experience individuals had had with pregnancy and with their partners in order that the investigator be able to determine if there were any relationships between needs and experience. Indication of the gender of the respondent would enable the researcher to relate findings to that factor. The questions follow:

35. How many pregnancies have you gone through (a) with this partner? (b) with another partner? ____________

36. What was the result of these pregnancies (place check in the appropriate space)

<table>
<thead>
<tr>
<th>pregnancy</th>
<th>terminated</th>
<th>live birth</th>
<th>stillbirth</th>
</tr>
</thead>
<tbody>
<tr>
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<td>5</td>
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</table>

37. How many years have you been living with this partner? ____________ years

38. How many weeks pregnant (is your partner) (are you)? ____________ weeks

39. Are you a man? 
    a woman? ____________

Because of a small N, statistical analysis would not be warranted and so the intention was to manually tabulate data and classify it according to the categories stated above. From this classification the researcher or
prenatal instructor could determine the areas in which a particular group had the most need for instruction or discussion. This will be dealt with in more detail in the next chapter.

After the questionnaire and its explanatory face sheet were completed, an appropriate consent form and covering letter were composed for this the third phase of the study.

Recruitment of Volunteers

As in the second phase of the study, volunteers were recruited during the first fifteen minutes of two different prenatal classes. The study was explained, questions entertained, consent forms distributed to each individual and then collected after about five minutes. This method of recruitment was used in order to minimize disruption of the classes and also because the author felt that the class members would feel much less threatened about consenting to complete a self-administered questionnaire than they would about personal interviews. This expectation was fulfilled when eighty-seven percent of the expectant parents agreed to participate, that is, nineteen couples out of two different classes. Two questionnaires and a self-addressed, stamped envelope were given to each couple who had signed consents. Included also in the package was a self-addressed, stamped postcard which was to be signed and mailed separately when the completed questionnaires were mailed. The purpose of this was to reduce the number of telephone calls required to follow up.

Of the thirty-eight questionnaires accepted by volunteers, after two weeks and telephone reminders to twelve couples, thirty-one were returned. Although the proposal stated that twenty subjects would be required, it was decided to use thirty when that many responded,
since an increased N would enhance reliability of the tool.

The Subjects

The volunteer sample consisted of fifteen couples (N=30) all of whom were married or had been cohabitating since before confirmation of conception. The length of time living together ranged from one to eight years, and the number of weeks gestation of the current pregnancy ranged from fifteen to forty weeks. Six couples were in their second trimester while the remaining nine were in their last trimester.

For twenty-three individuals this was the first pregnancy with this partner. Three had experienced pregnancies with previous partners. Nine of the previously experienced pregnancies had been terminated while five had resulted in live births.

Report of Results

The results are organized and summarized under the topics listed previously on page 73. These data are reported in order to indicate first, that the tool was capable of eliciting the desired information and second, so that the author could indicate how this information might be used to direct content for teaching by a prenatal instructor.

Tabulation of Results

One of the author's aims for this tool was that responses would be easily tabulated and interpreted in order that prenatal instructors would find it practicable.

The writer's method of tabulation proved to be fairly rapid and allowed for notation of comments and further analysis of the data. Because a blank questionnaire form was used for tabulation, the data were
not separated from the questions, thus facilitating interpretation and discussion.

Three different colours of ink were used to record the data—one for women, one for men and one for totals. For question 9 a separate sheet of paper was used for recording; but it was discovered that the responses could have been contained in small writing on the questionnaire form. Frequencies were summed in the right margin of each page. Additional comments of respondents regarding the questions or their responses were recorded on the left of each question on the summary sheets.

Topics:

1. **Source of Information**

   Related questions

   1. What is your source of information about sexual **activities** during pregnancy?

      | Source                  |  
      |------------------------|
      | books                  |
      | pamphlets              |
      | magazines              |
      | partner                |
      | parent                 |
      | friend                 |
      | prenatal instructor    |
      | community health nurse |
      | physician              |
      | other (state)          |

   2. What is your source of information about sexual **feelings** during pregnancy?

      | Source                  |  
      |------------------------|
      | books                  |
      | pamphlets              |
      | magazines              |
      | partner                |
      | parent                 |
      | friend                 |
      | prenatal instructor    |
      | community health nurse |
      | physician              |
      | other (state)          |
3. From which source would you like to get more information about sexual activities during pregnancy?

- books
- pamphlets
- magazines
- partner
- parent
- friend
- prenatal instructor
- community health nurse
- physician
- other (state)

4. From which source would you like to get more information about sexual feelings during pregnancy?

- books
- pamphlets
- magazines
- partner
- parent
- friend
- prenatal instructor
- community health nurse
- physician
- other (state)

Books, partners and friends were indicated in that order of frequency as being the source of information about sexual activity during pregnancy. Books and partners were stated with equal frequency as being the source of information about sexual feelings while friends were the next most frequent source. Only three individuals cited prenatal instructors as their source of information about sexual activities and feelings.

The desired sources of information regarding sexual activities most frequently indicated were books, prenatal instructors and physicians while prenatal instructors, books and partners were the most frequently indicated desired sources of information about sexual feelings.
2. Desire for Information

Related questions

5. About which of the following sexual activities would you like more information concerning their practice during pregnancy (Check ✓)

- kissing
- hand-holding
- hugging, cuddling
- touching, stroking
- oral sex
- self masturbation
- masturbation of self by partner
- intercourse
- breast caressing or kissing
- being told you're loved
- other (state)

11. I am satisfied with the amount of knowledge that I have about sexual feeling, and behaviour during pregnancy.

- very true for me
- generally true for me
- generally not true for me
- definitely not true for me

32. Women who have large breasts are more likely to be good breastfeeders.

- very true for me
- generally true for me
- generally not true for me
- definitely not true for me

From the variety of sexual activities listed on the questionnaire, intercourse was indicated most frequently (f=21) as the one about which expectant parents desired more information concerning its practice during pregnancy. Oral sex (f=2) was the next most frequently stated with touching or stroking, self masturbation, masturbation of self by partner, and breast caressing or kissing each having a frequency of one.

The responses to question 11 implied that three respondents had a definite need for more information about sexual behaviour and feelings during pregnancy while two had some need. Only three respondents to question 32 indicated a need for information regarding the relationship of breast size to breastfeeding ability.
3. **Need for More or Less Sexual Activity**

**Related questions**

6. During this pregnancy, which sexual activities would you like **more** of than you are presently experiencing? (more - check ✓)
   - kissing
   - hand-holding
   - touching, stroking
   - oral sex
   - self masturbation
   - masturbation of self by partner
   - intercourse
   - breast caressing or kissing
   - being told you're loved
   - other (state)

7. During this pregnancy, which sexual activities would you like **less** of than you are presently experiencing? (less - check ✓)
   - kissing
   - hand-holding
   - touching, stroking
   - oral sex
   - self masturbation
   - masturbation of self by partner
   - intercourse
   - breast caressing or kissing
   - being told you're loved
   - other (state)

Among the thirty respondents the activities most frequently stated as being desired more often were: being told you're loved, intercourse, touching and stroking and masturbation of self by partner. However, it was women who most often needed to be told they were loved while only men stated they wanted intercourse more often.

There were very few indications of a desire for less sexual activity but those which were noted were: intercourse, breast caressing or kissing and oral sex—in that order and all by women. One man indicated he wished less to be told he was loved (see Table 2).
TABLE 2

Desired Frequency of Sexual Activity

<table>
<thead>
<tr>
<th></th>
<th>More</th>
<th>Less</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>females</td>
<td>males</td>
</tr>
<tr>
<td>intercourse</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>being told you're loved</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>touching, stroking</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>masturbation of self by partner</td>
<td>3</td>
<td>2</td>
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<tr>
<td>kissing</td>
<td>2</td>
<td>2</td>
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<td>hand-holding</td>
<td>3</td>
<td>1</td>
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<tr>
<td>breast caressing or kissing</td>
<td>2</td>
<td>2</td>
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<tr>
<td>oral sex</td>
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<td>2</td>
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<td>self-masturbation</td>
<td>1</td>
<td>1</td>
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<tr>
<td>anal sex</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

4. Concerns About Appropriateness of Sexual Activities During Pregnancy

Related questions

8. Are there any sexual activities which you feel should not be practised during pregnancy? Yes ___ No ___

9. If yes, what sexual activities do you feel should not be practised during pregnancy?

<table>
<thead>
<tr>
<th>Activity</th>
<th>check</th>
<th>During what stage of pregnancy</th>
<th>Why? (briefly; use back of page if needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>kissing</td>
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</table>

19. (I) (my partner) feel(s) guilty about having sexual intercourse during pregnancy.

23. I feel that sexual intercourse during pregnancy might harm the baby.
24. I feel that sexual intercourse during pregnancy might injure (my partner) (me).
25. I feel that sexual intercourse during pregnancy might cause pain for (my partner) (me).

Six women and three men felt that there were some sexual activities which should not be practised during pregnancy. These nine all stated intercourse as being such an activity—for the following reasons:

<table>
<thead>
<tr>
<th>reason</th>
<th>frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>impractical</td>
<td>1</td>
</tr>
<tr>
<td>uncomfortable</td>
<td>3</td>
</tr>
<tr>
<td>no attraction towards sex</td>
<td>1</td>
</tr>
<tr>
<td>possibility of infection</td>
<td>2</td>
</tr>
<tr>
<td>possibility of premature labour</td>
<td>2</td>
</tr>
<tr>
<td>harm or distress to baby</td>
<td>3</td>
</tr>
</tbody>
</table>

The range of periods suggested for avoiding intercourse were from the last four and one-half months to the last few weeks.

The only other activity felt inadvisable was oral sex. Two of the four respondents who indicated this gave no reason and only three of the four indicated a time period. The risk stated was possible infection and the periods of abstinence stated were; the whole pregnancy, last stages of pregnancy and after the rupture of the membranes.

In response to questions 23, 24 and 25 which indicated a feeling that intercourse caused harm or injury to woman or baby only two indicated "very true for me" and eight indicated "generally true for me."

Only one man and one woman felt guilty about having sexual intercourse during pregnancy. However, one man felt that the question was ambiguous (intercourse with one's partner was the intended meaning) and one woman commented that she felt guilty about not wanting intercourse when her partner did. This is a factor related to sexuality in general, not just to pregnancy.
5. **Need for Enjoyment**

**Related question**

10. This question enquires about your level of enjoyment of sexual intercourse during pregnancy. For you, has sexual intercourse been:

<table>
<thead>
<tr>
<th>Directions: Place ✓ in appropriate boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>very enjoyable</td>
</tr>
<tr>
<td>before this pregnancy</td>
</tr>
<tr>
<td>first 3 months</td>
</tr>
<tr>
<td>second 3 months</td>
</tr>
<tr>
<td>last 3 months</td>
</tr>
</tbody>
</table>

The data indicate a decline in the degree of enjoyment of sexual intercourse over the period of pregnancy. The frequency of responses are contained in Table 3. In order to clarify impressions related to this table, it is pointed out that twelve individuals were in their second trimester while the remaining eighteen were in their third trimester.

**TABLE 3**

**Satisfaction with Sexual Intercourse**

<table>
<thead>
<tr>
<th></th>
<th>very enjoyable</th>
<th>satisfying</th>
<th>unsatisfactory</th>
<th>unpleasant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>women</td>
<td>men</td>
<td>total</td>
<td>women</td>
</tr>
<tr>
<td>before this pregnancy</td>
<td>10</td>
<td>10</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>first 3 months</td>
<td>3</td>
<td>7</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>second 3 months</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>last 3 months</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>

6. **Need for Emotional Support**

**Related questions**

12. A man needs emotional support during his partner's pregnancy.

<table>
<thead>
<tr>
<th></th>
<th>very true for me</th>
<th>generally true for me</th>
<th>generally not true for me</th>
<th>definitely not true for me</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
13. A woman needs emotional support during her pregnancy.

The perceptions of the respondents regarding the need of emotional support by expectant mothers and fathers were that women do need support and that men generally do. See Table 4.

TABLE 4
Responses indicating need for emotional support

<table>
<thead>
<tr>
<th></th>
<th>women</th>
<th>men</th>
</tr>
</thead>
<tbody>
<tr>
<td>very true for me</td>
<td>22</td>
<td>8</td>
</tr>
<tr>
<td>generally true for me</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>generally not true for me</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>definitely not true for me</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

7. Need for Physical Assistance

Related question
14. A woman needs more physical assistance during pregnancy.

Twenty-six of the twenty-eight responses to question 14 indicated that pregnant women do need more physical assistance during pregnancy.

8. Needs Related to Body Image

Related questions
15. I expect (my partner) (myself) to regain a pre-pregnant figure within a year.
16. I feel that my partner is really pleased with my body now.
17. I think a pregnant woman's body is beautiful.

The twenty-eight respondents who answered question 15 had realistic and optimistic expectations regarding the return of the woman's figure to its pre-pregnant shape within a year. Twenty-four of the twenty-eight respondents to question 16 felt that their bodies were
viewed positively by their partners while twenty-five of the twenty-nine responses to question 17 indicated a positive perception of a pregnant woman's body. However, five individuals wrote in comments to the effect that some pregnant women's bodies do look ugly.

9. Communication Needs

Related questions

18. I do not know what my partner needs sexually during (her) (my) pregnancy.
21. I feel that my partner understands my sexual needs during (her) (my) pregnancy.
22. I feel uncomfortable talking to my partner about what I need sexually.
26. I tell my partner what my sexual needs and concerns are.

Twenty-eight percent of the responses to the questions related to communication indicated needs in this area of sexuality. These questions (18, 21, 22 and 26) dealt with knowing and understanding the partner's needs, telling a partner one's own needs and doing so comfortably.

10. Desire for Other Sexual Outlets

Related question

20. I tend to be sexually interested in other (women) (men) during (my partner's) (my) pregnancy.

Six of the twenty-eight responses indicated a sexual interest in other men or women during pregnancy. Of these six, five were men. Eleven of the women as compared to three of the men were definitely not interested.
11. **Need for Role Affirmation**

**Related questions**

27. This pregnancy makes me feel glad that I am a (man) (woman).
28. My partner tells me that I will make a good (father) (mother).
29. I am worried about becoming a parent.
30. I am concerned that the new baby will interfere with my career.
31. The possibility of our baby being breast-fed pleases me.

Satisfaction with one's role as man or woman during pregnancy was indicated by twenty-four of twenty-eight respondents. Of the four who were not satisfied, three were men.

Six of the respondents stated that their partners generally did not affirm them in their parenting role while eight expectant parents, especially women, were somewhat worried about becoming parents.

Only one woman expressed a concern about career and mother role conflict.

All but one (a woman) of the respondents indicated positive feelings about the prospect of their babies being breastfed.

12. **General Sexual Needs**

**Related question**

33. I feel that my needs related to sexuality are being met.

In response to this question dealing with perceived meeting of sexual needs six of the respondents indicated that their needs were generally not being met (f=5) or definitely not being met (f=1). Four of these six respondents were men.
13. Need for Love and Belongingness

34. I feel loved and needed.

Four of the respondents indicated that they generally did not feel loved and needed.

Summary

Phase III of the study consisted of the development of a self-administered questionnaire for expectant parents. Nineteen couples volunteered to participate and fifteen and one-half couples returned the questionnaires by mail. The responses were sorted into thirteen categories of need or concern and then tabulated. These data will be discussed in the following chapter and reference will be made to the tool to point out its strengths and weaknesses.
CHAPTER SEVEN

Application, Summary, Limitations, Implications and Recommendations

Introduction

The focus of this chapter is on the evaluation of the tool itself. Its strengths and weaknesses will be noted and plans for revision delineated. In order to indicate how the tool could be used for its intended purpose, that is, to direct content for the instruction of classes for expectant parents, suggestions for teaching will be outlined in relation to the various categories of need as listed on page 73. The author will also address herself to the limitations of this study and will discuss the implications of this project for nursing.

The Questionnaire

For discussion the questions will be grouped into the following categories:
(a) valid questions
(b) revisions
(c) questions to be eliminated
(d) additions

Each question will be referred to by number in order to economize on words. The reader can refer to the questions in Appendix I.
(a) Valid Questions

In the author's judgement the following questions were considered valid because they elicited a high number of responses, were free of modifications written in by the respondents and yielded data that indicated sexuality-related needs during pregnancy and could be used as a basis for prenatal instruction. It should be noted that one male respondent answered only the first ten questions, another male failed to respond to nine of the questions and a third double-checked several questions in Part B. Those considered valid questions are: 1, 2, 3, 8, 9, 10, 11, 12, 13, 14, 18, 21, 22, 26, 28, 29, 31, 32, 33, 34, 38 and 39. Three respondents wrote "don't know" or "not sure" beside 21, 25 and 30. These comments, the author feels, were unconsidered responses or a failure on the part of the respondents to note that the aim was impressions or perceptions--not facts, as suggested by the word "feel."

(b) Revisions

During the process of data compilation the words that respondents had added or substituted were noted and these have influenced the following revisions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Revisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.</td>
<td>&quot;From which sources would you like to get more information about the sexually related feelings one might experience during pregnancy?&quot;</td>
</tr>
<tr>
<td>5.</td>
<td>add &quot;none&quot; to the list</td>
</tr>
<tr>
<td>6.</td>
<td>add &quot;hugging, cuddling&quot; and &quot;none&quot; to the list</td>
</tr>
<tr>
<td>7.</td>
<td>add &quot;hugging, cuddling&quot; and &quot;none&quot; to the list</td>
</tr>
<tr>
<td>15.</td>
<td>&quot;(my partner) (I) will probably regain a pre-pregnant figure within a year.&quot;</td>
</tr>
<tr>
<td>Question</td>
<td>Revisions</td>
</tr>
<tr>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>16.</td>
<td>&quot;I feel that my partner is pleased with my body.&quot;</td>
</tr>
<tr>
<td>17.</td>
<td>&quot;I think a pregnant woman's body can be beautiful.&quot;</td>
</tr>
<tr>
<td>19.</td>
<td>&quot;(I) (my partner) feel(s) guilty about having sexual intercourse with me during pregnancy.&quot;</td>
</tr>
<tr>
<td>20.</td>
<td>&quot;I tend to be more sexually interested in other (women) (men) during (my partner's) (my) pregnancy.&quot;</td>
</tr>
<tr>
<td>23.</td>
<td>Insert &quot;some periods of&quot; before the word pregnancy.</td>
</tr>
<tr>
<td>24.</td>
<td>Insert &quot;some periods of&quot; before the word pregnancy.</td>
</tr>
<tr>
<td>25.</td>
<td>Insert &quot;some periods of&quot; before the word pregnancy.</td>
</tr>
</tbody>
</table>
| 27.      | "The ability to become a (father) (mother) makes me feel glad."

(c) Questions to be Eliminated

Questions 35, 36 and 37 are of marginal value for use in this tool since prenatal classes are currently conducted with the focus on the group needs. However, it is clear that some couples do have needs that would benefit from individualized counseling or home visits by the prenatal instructor. In the event that the need for this form of prenatal care became recognized and available, information provided by these questions would be useful. These questions might, in addition, be useful in a large survey in that a correlational analysis could be done on perceived needs, experience with pregnancy and experience with one's partner.

(d) Additions

It would seem appropriate to add an item to follow item 21 which deals with sexual interest in someone other than one's partner. The following is an example:

"I feel that it is all right for my partner to have sexual intercourse with someone else during our pregnancy."
The foregoing modifications would be carried out before the questionnaire was used again. However, in spite of these needed changes, the tool as developed for Phase III very effectively elicited the desired perceptions of expectant parents and provided data that would give considerable guidance for planning instruction for prenatal classes. The revised questionnaire is located in Appendix I.

Application

Although these data were derived from two different prenatal classes, for the purposes of an hypothetical application they will be grouped together as if from one class. An attempt will be made to suggest topics for discussion which are based on the expressed perceived needs in chapter six.

A fundamental practice in teaching is the statement of behavioural objectives in order to guide the teaching and learning processes. Therefore, the following objectives are stated in relation to the group needs indicated.

<table>
<thead>
<tr>
<th>Related to Need #</th>
<th>Behavioural Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>The expectant parents will:</td>
<td></td>
</tr>
<tr>
<td>1 1. know the titles of several publications, especially books which provide information about sexual activities and feelings in pregnancy.</td>
<td></td>
</tr>
<tr>
<td>1 2. ask their physicians about concerns they have regarding sexual activity in pregnancy.</td>
<td></td>
</tr>
<tr>
<td>1 3. discuss with the prenatal instructor their concerns about sexual activities and feelings in pregnancy.</td>
<td></td>
</tr>
<tr>
<td>1 4. discuss with their partners their sexual feelings during pregnancy.</td>
<td></td>
</tr>
<tr>
<td>2,4 5. know facts about the physical and psychological effects of intercourse during pregnancy.</td>
<td></td>
</tr>
</tbody>
</table>
### Related to Need # Behavioural Objectives

<table>
<thead>
<tr>
<th>Need #</th>
<th>Behavioural Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6. know methods of modifying intercourse during pregnancy.</td>
</tr>
<tr>
<td>3,12</td>
<td>7. know what sexual activities some individuals like more of and what some like less of during pregnancy (relate to specific data).</td>
</tr>
<tr>
<td>2,12</td>
<td>8. know how to adapt their love-making to the needs of each other during pregnancy.</td>
</tr>
<tr>
<td>2,4</td>
<td>9. know some facts about the effects of oral sex on pregnancy.</td>
</tr>
<tr>
<td>2</td>
<td>10. know some facts about the effects of touching, stroking; self-masturbation, masturbation of self by partner and breast caressing or kissing on pregnancy.</td>
</tr>
<tr>
<td>2</td>
<td>11. know some facts about the relationship of breast size to breast feeding ability.</td>
</tr>
<tr>
<td>5</td>
<td>12. know that changes in degree of sexual enjoyment are normal.</td>
</tr>
<tr>
<td>6</td>
<td>13. discuss the needs of expectant parents for emotional support during pregnancy.</td>
</tr>
<tr>
<td>7</td>
<td>14. discuss the needs of expectant mothers for more physical assistance.</td>
</tr>
<tr>
<td>8</td>
<td>15. discuss with class and with partners feelings about the body image of a pregnant woman.</td>
</tr>
<tr>
<td>9,12</td>
<td>16. know some techniques to enable themselves to communicate sexual needs to their partners.</td>
</tr>
<tr>
<td>10</td>
<td>17. discuss their feelings with each other about an hypothetical outside sexual interest.</td>
</tr>
<tr>
<td>11</td>
<td>18. discuss the need for affirmation as parents.</td>
</tr>
<tr>
<td>11</td>
<td>19. discuss briefly feelings about career-mother role conflict.</td>
</tr>
<tr>
<td>11</td>
<td>20. discuss feelings and attitudes about breast feeding.</td>
</tr>
<tr>
<td>13</td>
<td>21. discuss the implications of feeling loved and needed for the couple's relationship and for parenting.</td>
</tr>
</tbody>
</table>

Guided by these objectives a prenatal instructor could develop content for teaching and decide on teaching methods. As the objectives indicate some of the areas would be amenable to informal presentation while others would best be dealt with in small group discussions.

Further suggestions for application will be delineated under the heading, "Implications."
Summary

A sequence of three phases of data gathering and question refinement were utilized as the method of development of a questionnaire to elicit the perceived needs of expectant parents regarding sexuality during pregnancy. Fifty volunteer subjects were recruited from urban prenatal classes.

The first phase consisted of unstructured interviews with five expectant couples (ten individuals) after which a more structured interview format was designed on the basis of the subjects' responses.

For the second phase another group of five expectant couples were individually interviewed with the use of this structured interview schedule in an effort to elicit needs related to sexuality.

Again, comments and responses of the interviewees guided the development of yet a third tool, a self-administered questionnaire which was completed by another group of fifteen expectant couples (thirty individuals).

The needs expressed were tabulated and classified so that the author could determine what the sexuality needs of the subject group were. Since the intention was to give direction to content for prenatal instruction, behavioural objectives were stated in relation to the group needs. These behavioural objectives would assist a prenatal instructor to choose content relevant to these needs.

While the development of this tool to this degree can only be considered a pilot study, the use of the phase III questionnaire has in fact demonstrated its capabilities in eliciting perceived needs related to sexuality in pregnancy. Minor improvements have been suggested and the use of the revised tool with a much larger, more representative group recommended.
Limitations

The author recognizes the following limitations of this study.

(1) It cannot be assumed that the subjects who volunteered to participate in this study represent the population of expectant parents. They were a select group in that they were attending prenatal classes, lived in an urban area, and volunteered to participate. Because of the latter they do not even represent the prenatal class subculture. However, since the Phase III volunteers constituted large proportions of their classes, they could be said to be approaching representativeness. (2) This project should be considered a pilot study since it was based on an N of 50 and since reliability was not formally tested. (3) Judges were not used to assist in the classification of the questions therefore the author's bias could have influenced this process.

Implications

The process of this study has made clear the need for increased awareness of and attention to the needs of expectant parents regarding sexuality. In spite of the current societal permissiveness about sexuality there is still reticence when it comes to discussing sexual concerns in a sensitive, constructive way rather than in a superficial, lighthearted manner. There is a need for more research and articles on the subject of sexuality in pregnancy. This questionnaire should be used by all nurses who are giving care to parents in the maternity cycle. It will provide a wealth of data to contribute to nursing's body of theory on sexuality. Its use will also be a significant asset to neophyte prenatal instructors and student nurses who could use this tool to assist them in interviewing and assessing expectant parents. Prenatal teachers who are informed, sensitive and permissive must provide the opportunity and the
stimulus for couples to improve their level of information about and communication of sexuality. Because not all community health nurses have the aptitude for or interest in prenatal instruction, agencies should be more discriminating in selection of such personnel, because as Crosby has stated in quoting McLuhan "the medium is the message."

Expectant parents have found conflicting advice given by prenatal instructors, physicians and the literature to be confusing. Therefore these professionals need to come to some consensus about the advice they give and base it on scientific research not merely on traditional practice.

There are also implications for another group of professionals—those pastors, psychologists or social workers who are engaged in premarital counseling. Couples need to be made aware of the potential stress that pregnancy can be on a marital relationship so that they can be prepared to communicate and cope.

In order to facilitate the expression and discussion of needs related to sexuality prenatal classes need to be subdivided into smaller groups of eight to twelve.

Recommendations

Further testing of this questionnaire is required after the previously specified changes have been made. A survey of a large number of widely dispersed expectant parents would enable the author to assess validity and reliability of the tool.

Its practicability also needs to be assessed by a few prenatal instructors through their utilizing it in the method recommended in chapters six and seven.

Also recommended is a study of the attitudes and knowledge of prenatal instructors regarding sexuality.
Conclusions

This study has shown that expectant parents do have unmet needs related to sexuality during pregnancy. The volunteer respondents indicated that they had problems communicating some of these needs to their partners and/or health care professionals. There also exists some confusion in the minds of these individuals regarding sexual practices during pregnancy because of the inconsistent information provided by nurses, physicians, and the literature. Finally, the questionnaire developed herein is a tool which elicits the perceived needs of expectant parents regarding sexuality during pregnancy in a way that provides direction for prenatal instruction relevant to these needs.
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Physiological Continued


Psychosocial


Psychosocial Continued


Psychosocial Continued


Education


Counseling


Questionnaire Development


Questionnaire Development Continued


Other


APPENDICES
A. Sample Letter to Agency
B. Brochure for Expectant Parents,
Vancouver Health Department Prenatal Classes
Sexuality in Pregnancy

Sexuality is a basic physiological and psychic aspect of human life. It relates not only to sensual pleasure and procreation but also to our self-esteem and the way we feel about our maleness or femaleness and our roles as lover, mother or father.

The topic of sexuality is often neglected in classes for expectant parents because not much is known about the concerns or needs of childbearing couples regarding sexuality. Couples are often reluctant to ask questions and so instructors aren't sure what to teach.

Perhaps you have been wondering:

- whether you're the only pregnant woman who feels unattractive?
- whether you're the only expectant father who thinks that your sex life is at an all time low?
- whether most women feel very protective of their bodies during pregnancy?
- who could answer some of the questions you have about what is "normal" sexual activity during pregnancy?
- why it seems so difficult for your pregnant female partner to understand your feelings?
- whether the changes in your sex life will revert to "normal" after the baby is born?

You can help other expectant couples, prenatal teachers, nurses and physicians by communicating the concerns you have about how pregnancy has affected or will affect your sexuality.

---

My name is Donelda Ellis. I am a master's student in nursing at U.B.C. in the process of writing a thesis. The objective of my research is to design a questionnaire to identify the needs or concerns of expectant parents regarding sexual adjustments in pregnancy. Very little is known about these concerns. With your help I hope to be able to assist prenatal instructors to find out about your concerns and therefore be better able to teach and counsel you appropriately.

What is Involved?
- a one hour interview by me with each partner of each expectant couple, in your home at your convenience.

What about confidentiality?
- your names will be used only for consent purposes and will be known only to me.
- you are free to withdraw at any time.
- I will exclude material at your request.

What are the qualifications of the interviewer?
- I am a nurse in the last year of the UBC MSN programme.
- I have taught both hospital and community prenatal and postnatal classes.
- I have been an instructor and supervisor on a maternity ward.
- I have a husband and two children.
- I'm keenly interested in the care of childbearing couples.
C. Consent Form - Phases I & II
Dear Parents-to-be,

My name is Donelda Ellis and I am a master's student in nursing at the University of British Columbia. I am particularly interested in the care of couples who are experiencing pregnancy, labour, delivery and beginning parenthood. In order to help nurses to prepare parents for all aspects of pregnancy, I am designing a questionnaire to identify the needs of expectant parents regarding sexual adjustments in pregnancy.

I will be grateful for your assistance.

It would involve an interview in your home -- at a time convenient to both of you. Each of you would be interviewed separately for about one hour.

I realize that it might be difficult for you to discuss this personal material. Information will be handled in a confidential manner. Your names will be used for consent purposes only and for arranging the appointment. Interview sheets will not include your name or identifying code.

Consent Form

I, ______________________________ agree to participate in a study of the sexual needs of expectant parents. I understand that:

- what I say will be confidential
- no risks are involved
- only one interview of approximately one hour will be required
- I am free to withdraw from the study at any time
- responses will be used to develop a questionnaire which will be the basis of the interviewer's thesis
- the aim of the study is to assist in the meeting of needs of expectant parents.
Appendix C Continued

Signature of participant ________________________________

Address of participant __________________________________

Telephone Number ______________________________________

Signature of interviewer ________________________________

Telephone Number ______________________________________

Date __________________________________________________
D. Interview Schedule - Phase I
Appendix D

Phase One Interview Schedule - Male

Preface

The purpose of this interview is to discover some of the needs of expectant parents. Although some of these needs might be discussed with partners, physicians, nurses or friends by some expectant couples, the needs regarding sexuality because of their very personal nature are often neglected in discussion.

I hope, through this and subsequent interviews with others, to be able to develop a questionnaire which could be answered by expectant parents at prenatal classes. This would help the nurses who are teaching these classes to discuss what parents-to-be feel is important to them regarding sexuality during pregnancy and after the baby is born.

Towards the end of the interview you will be given an opportunity to suggest ways in which we nurses and doctors could be of help to you.

Please feel free to tell me at any time if I am not expressing a question clearly or if you don't wish to answer a question. If you should decide to withdraw some of the material that we have discussed, I will, at your request, destroy it in your presence. At your request I will show you the information I have written down.

At the conclusion I will be happy to discuss with you any questions you have about the content of the interview.

Demographic Data
Age 16-20; 21-25; 26-30; 31-35; 36-40; 41-45; 46-50.
Highest level of education
Marital status
Ethnic group
Length of time living with partner
Phase One Interview - Female

Preface

The purpose of this interview is to discover some of the needs of expectant parents. Although some of these needs might be discussed with partners, physicians, nurses or friends by some expectant couples, the needs regarding sexuality because of their very personal nature are often neglected in discussion.

I hope, through this and subsequent interviews with others, to be able to develop a questionnaire which could be answered by expectant parents at prenatal classes. This would help the nurses who are teaching these classes to discuss what parents-to-be feel is important to them regarding sexuality during pregnancy and after the baby is born.

Towards the end of the interview you will be given an opportunity to suggest ways in which we nurses and doctors could be of help to you.

Please feel free to tell me at any time if I am not expressing a question clearly or if you don't wish to answer a question. If you should decide to withdraw some of the material that we have discussed, I will, at your request, destroy it in your presence. At your request I will show you the material I have written down.

At the conclusion I will be happy to discuss with you any questions you have about the content of the interview.

Demographic Data

No. of weeks pregnant ____________________________

Total no. of pregnancies ____________________________

Age 16-20; 21-25; 26-30; 31-35; 36-40; 41-45; 46-50.

Highest level of education ____________________________

Marital status ____________________________

Ethnic group ____________________________

Length of time living with partner ____________________________
Phase One Question Guidelines

1. (a) What would you like to know about:
   - facts related to the physical aspects of sexuality during pregnancy?
   - skills related to the physical aspects of sexuality during pregnancy?
   What concerns (fears) do you have about the physical aspects of sexuality during pregnancy?

   (b) What would you like to know about:
   - facts related to the feelings or emotions you have that are related to sexuality during pregnancy?
   - skills related to sexual feelings or emotions during pregnancy?

2. What changes have you noted in desire, frequency, and satisfaction regarding the practise of any of the activities on the accompanying list of sexual behaviours. That is--has there been an increase, a decrease or no change and what other characteristics of the change, if any, have there been?

3. (a) Were some of the words or sentences I used unclear? Which ones?

   (b) Were there subjects that you found difficult to talk about? What are they?

   (c) Do you have some concerns that I neglected to discuss during the interview? Would you care to tell me about them?
List of Possible Sexual Behaviours that You Feel Might Have been Affected by the Pregnancy

Please note that the order has no significance.

When we are discussing sexuality we are referring to a wide range of behaviours and feelings which might occur at any time during a twenty-four hour period.

Therefore I am providing you with this list of some behaviours related to sexuality which might help you to understand my questions more fully and assist me to develop my questions appropriately.

1. touching
2. mutual eye contact
3. stroking - for example - breasts, buttocks, thighs, abdomen
4. kissing - face, mouth, body; open or closed mouth
5. breast-fondling
6. breast-kissing
7. self-stimulation
8. mouth touching genitals - male, female
9. genitals touching genitals
10. sucking on genitals
11. sucking on nipples
12. licking or sucking elsewhere
13. hugging
14. cuddling
15. penis-vagina penetration
16. penis to mouth
17. penis to anus
18. penis to breasts
19. saying something complimentary, for example "you look great" "you look sexy" "I like your shape" "you're handsome"
20. saying, "I want you; I love you" etc.
21. mutual oral-genital stimulation
22. manual stimulation of male or female genitals to orgasm
23. inspection, that is, gazing or looking at body or body part
24. talking about sex
25. mouth to vagina - blowing
26. holding
27. hand-holding
28. looking at "sexy" pictures.
E. Interview Schedule - Phase II
   (condensed)
Phase II Interview Schedule

Preface

I am interested in finding out what expectant couples feel that their needs are regarding sexuality during pregnancy so that prenatal instructors can better teach to help you meet these needs.

Sexuality refers to how you feel about your body; about your roles of female, partner, mother / male, partner, father; about sensuality and sexual activity.

Please tell me if the questions are unclear, are too difficult to answer, are irritating, appear to be irrelevant or need to be more specific.

A. Demographic Data (Female)

No. of weeks pregnant

Total no. of pregnancies

Age 16-20; 21-25; 26-30; 31-35; 36-40; 41-45; 46-50.

Highest Level of education

Marital status

Ethnic group

Length of time living with partner

Interview Schedule - Female

1. Most people when not pregnant at times require reassurance about sexuality. Have you found this has changed during pregnancy?
   Yes ____  No ____  If yes ____ more ____ less ____
   If less - go to Q2, if more go to Q3

2. How are you reassured about your sexuality during pregnancy?
   Go to Q5

3. What sexual aspects of yourself do you feel you need reassurance about during pregnancy
   (Explain role referring to definition of sexuality) degree of attractiveness ____
   role as wife ____
   role as mother ____
   role as sexual partner ____
4. Please specify how you could be reassured about your:
   (a) degree of attractiveness
   (b) role as wife
   (c) role as mother
   (d) role as sexual partner

5. During pregnancy what sexual activities would you like more of?

6. During pregnancy what sexual activities would you like less of?

7. Some sexual activities are considered by some people to be inappropriate during pregnancy. Do you have any beliefs of this kind?
   Yes ____  No ____
   (if yes - go to Q8)
   (if no - go to Q9)

8. What sexual activities do you consider inappropriate during pregnancy?
   (a) What?  (b) When  (c) Why?

9. What is your source of information about the kinds of sexual activities that are appropriate during pregnancy?
   reading ____  mother ____  partner ____  prenatal instructor ____  physician ____  other (specify) ____

10. Are you satisfied with this information?
    (if yes - go to Q12)  Yes ____  No ____
    (if no - go to Q11)

11. In what ways are you dissatisfied?

12. Who do you go to when you have concerns about the emotions which affect your sexuality during pregnancy?
    prenatal instructor ____  mother ____  partner ____  physician ____  other (specify) ____
    (number in order of priority)

13. Are you satisfied with this reassurance or information?
    (if yes - to to Q15)  Yes ____  No ____
    (if no - go to Q14)

14. In what ways are you dissatisfied?
B. How much would you say that the following statements are: very true for you; true for you; or not true for you?

Answer code to be used by interviewer:

1. very true for me
2. true for me
3. not true for me

1. I feel beautiful when I am pregnant.
2. I dislike being cuddled when I am pregnant.
3. I am edgy and "picky" during pregnancy.
4. I wish I had someone to talk to about sex during pregnancy.
5. I feel that men do not know enough about the psychosexual needs of women during pregnancy.
6. I believe that my partner feels hurt when I indicate that I do not want intercourse.
7. I feel hurt when my partner indicates that he does not want intercourse.
8. I expect to regain my pre-pregnant shape within a year.
9. During pregnancy, sex play involving my breasts pleases me.
10. I feel my partner is not interested in having intercourse with me during the first half of pregnancy.
11. I feel my partner is not interested in having intercourse with me during the latter half of pregnancy.
12. I am not interested in having intercourse with my partner during the first half of pregnancy.
13. I am not interested in having intercourse with my partner during the latter half of pregnancy.
14. I feel that sex play involving my breasts is harmful during pregnancy.
15. I am concerned about my partner's interest in other women while I am pregnant.
16. I do not believe my partner means it when he says I look beautiful now.
17. I am really apprehensive about becoming a mother.
18. I am concerned that the new baby will interfere with my sex life.

19. I am very concerned about my lack of sex interest now that I am pregnant.

20. I feel uncomfortable talking to my partner about what I need sexually.

21. My interest in sex is the same now as it was before pregnancy.

22. I feel loved and needed.

23. Being pregnant makes me feel happy.

24. The prospect of breastfeeding delights me.

25. I try to meet my partner's sexual needs in ways other than intercourse now that I am pregnant.

26. I believe my partner wants me to breastfeed our baby.

27. I try to meet my sexual needs in ways other than intercourse during pregnancy.

28. I believe that if one has large breasts one is more likely to be a good breastfeeder.

29. Right now, I am not sure whether I want to be a mother or pursue my career.

30. I think that intercourse at any time during pregnancy is all right.

31. I tend to be sexually interested in other men during pregnancy.

32. I think that there should be male prenatal instructors as well as female.

33. I need to know how to get "turned on" sexually during pregnancy.

34. I wish my partner would talk to me more about his sexual needs and concerns.

35. I cannot seem to make myself look attractive no matter how much I try.

36. I wish my doctor would tell me more about sexual activity during pregnancy.

37. I tend to initiate "sex" during pregnancy (a) first half (b) latter half

38. My partner tends to initiate "sex" during pregnancy (a) first half (b) latter half
39. I feel that my needs related to sexuality during pregnancy are being met.

Conclusion

Is there an area of concern or need that you have which I neglected to include in this interview?

Please tell me about it.
Appendix E

Phase II Interview Schedule

Preface

I am interested in finding out what expectant couples feel that their needs are regarding sexuality during pregnancy so that prenatal instructors can better teach to help you meet these needs.

Sexuality refers to how you feel about your body; about your roles of female, partner, mother/male, partner, father; about sensuality and sexual activity.

Please tell me if the questions are unclear, are too difficult to answer, are irritating, appear to be irrelevant or need to be more specific.

Demographic Data (Male)

Age 16-20; 21-25; 26-30; 31-35; 36-40; 41-45; 46-50.

Highest level of education

Marital status

Ethnic group

Length of time living with partner

A. Interview Schedule - Male

1. Most people when not expecting a baby at times require reassurance about their sexuality. Have you found this has changed since you became an expectant father?  

   Yes ____  No ____

   If yes _____ more _____ less _____

   (If less - go to Q2, if more go to Q3)

2. How are you reassured about your sexuality during your partner's pregnancy? Go to Q5.

3. What sexual aspects of yourself do you feel you need reassurance about during your partner's pregnancy? (explain role referring to definition of sexuality)  

   degree of handsomeness _____

   role as husband _____

   role as father _____

   role as sexual partner _____
4. Please specify how you could be reassured about your:
   (a) degree of handsomeness:
   (b) role as husband:
   (c) role as father:
   (d) role as sexual partner:

5. During your partner's pregnancy, what sexual activities would you like more of?

6. During your partner's pregnancy, what sexual activities would you like less of?

7. Some sexual activities are considered by some people to be inappropriate during pregnancy. Do you have any beliefs of this kind? Yes ____  No ____
   (if yes - go to Q8)
   (if no - go to Q9)

8. What sexual activities do you consider inappropriate during your partner's pregnancy
   (a) What?  (b) When?  (c) Why?

9. What is your source of information about the kinds of sexual activities that are appropriate during your partner's pregnancy?
   reading ____
   mother ____
   partner ____
   prenatal instructor ____
   physician ____
   other (specify) ____

10. Are you satisfied with this information? Yes ____  No ____
    (if yes - go to Q12)
    (if no go to Q11)

11. In what ways are you dissatisfied?

12. Who do you go to when you have concerns about the feelings which affect your sexuality during your partner's pregnancy?
    prenatal instructor ____
    partner ____
    (number in order of priority)  physician ____
                                friend ____
                                other (specify) ____

13. Are you satisfied with this reassurance or information? Yes ____  No ____
    (if yes go to Q15)
    (if no go to Q14)
14. In what ways are you dissatisfied?

B. How much would you say that the following statements are: very true for you; true for you; or not true for you?

Answer code to be used by interviewer:

1. very true for me
2. true for me
3. not true for me

1. I feel very masculine when my partner is pregnant.
2. I dislike cuddling her when she is pregnant.
3. I feel "left out" when she is pregnant.
4. I wish I had someone to talk to about sex during pregnancy.
5. I find it difficult to understand my partner's sexual needs and behaviour when she is pregnant.
6. I believe that my partner feels hurt when I indicate that I do not want intercourse.
7. I feel hurt when my partner indicates that she does not want intercourse.
8. I expect my partner to regain her pre-pregnant shape within a year.
9. During pregnancy I am more interested than before in fondling my partner's breasts in sex play.
10. I am not interested in having sexual intercourse with my partner during the first half of pregnancy.
11. I am not interested in having sexual intercourse with my partner during the second half of pregnancy.
12. I feel my partner is not interested in having sexual intercourse with me during the first half of pregnancy.
13. I feel my partner is not interested in having sexual intercourse with me during the latter half of pregnancy.
14. During pregnancy I believe my partner does not like her breasts fondled in sex play.
15. I tend to be sexually interested in other women when my partner is pregnant.
16. I sometimes tell my partner that she looks beautiful now.
17. I am really apprehensive about becoming a father.
18. I am concerned that the new baby will interfere with my sex life.
19. My need for sex now is the same as it was before my partner's pregnancy.
20. I feel uncomfortable talking to my partner about what I need sexually.
21. I feel that my partner is not interested in sex now that she is pregnant.
22. I feel loved and needed.
23. I think my partner needs more support when she is pregnant.
24. I am not keen about the possibility of my partner breastfeeding.
25. I try to meet my partner's sexual needs in ways other than intercourse now that she is pregnant.
26. I feel less like a man when my partner initiates intercourse.
27. I try to meet my sexual needs in ways other than intercourse when my partner is pregnant.
28. I believe that women who have large breasts are more likely to be good breastfeeders.
29. I am not sure whether I want to be a father yet.
30. I think that intercourse at any time during pregnancy is all right.
31. I do not know what my partner needs sexually.
32. I think that there should be male prenatal instructors as well as female.
33. I feel guilty about imposing sexual intercourse on my partner.
34. I wish my partner would talk to me more about her sexual needs and concerns.
35. My partner does not seem to have any sexual needs during pregnancy.
36. I feel jealous of my partner when she is pregnant.
37. I tend to initiate "sex" when my partner is pregnant.
   (a) first half of pregnancy
   (b) second half of pregnancy
38. My partner tends to initiate "sex" when she is pregnant.
   (a) first half of pregnancy
   (b) second half of pregnancy

39. I feel that my needs related to sexuality during my partner's pregnancy are being met.

40. I think my partner looks beautiful now.

Conclusion

Is there an area of concern or need that you have which I neglected to include in this interview?

Please tell me about it.
F. Consent Form - Phase III
Appendix F

Consent Form

My name is Donelda Ellis and I am a master's student in nursing at the University of British Columbia. For my thesis I am designing a questionnaire to help prenatal instructors find out what the needs and concerns of expectant couples are regarding sexuality during pregnancy so that they will be better able to teach parents-to-be what they need to know.

For this study, the topic of sexuality deals with how one feels about (1) being a man or a woman (2) becoming a parent (3) one's body and (4) one's sexual relationships.

Therefore I am asking each expectant mother and father to participate in this study by completing a fifteen-minute questionnaire in order eventually to assist other expectant parents through appropriate prenatal instruction.

I realize that the questions deal with personal material, but anonymity and confidentiality are guaranteed. No name or code number will be used except for consent purposes. The questionnaire will be given to you to answer at home individually and return to me in an enclosed stamped, self-addressed envelope.

Consent

I have read the above explanation and agree to participate in the study by completing one brief questionnaire.

signed __________________________________

date __________________________________

telephone number _______________________
6. Covering Letter - Phase III
H. Questionnaire - Phase III
Sexuality During Pregnancy

Expectant couples often need to make adjustments in their relationship as they anticipate the birth of a baby. Many of these adjustments are related to sexuality.

Because it is important that couples provide a stable foundation for family growth; concerns regarding sexuality need to be discussed and dealt with. This questionnaire gives you the opportunity to indicate your needs and concerns so that your prenatal instructor can, through her teaching and discussion, assist you to meet them.

Please note:

1. Your name does not appear anywhere on this questionnaire.
2. There are no right or wrong answers.
3. Answer questions quickly without stopping to think very long about them.
4. It takes about fifteen minutes to complete this questionnaire.
5. You do not have to answer any questions that you do not want to answer.
6. Confidentiality is guaranteed.
7. This questionnaire is intended for use by both men and women – hence the use of her/my/my partner etc.

Donelda Ellis 1978
PART A

Directions: Indicate your answers with a ✓

1. What is your source of information about sexual activities during pregnancy?
   - books
   - pamphlets
   - magazines
   - partner
   - parent
   - friend
   - prenatal instructor
   - community health nurse
   - physician
   - other (state)

2. What is your source of information about sexual feelings during pregnancy?
   - books
   - pamphlets
   - magazines
   - partner
   - parent
   - friend
   - prenatal instructor
   - community health nurse
   - physician
   - other (state)

3. From which source would you like to get more information about sexual activities during pregnancy?
   - books
   - pamphlets
   - magazines
   - partner
   - parent
   - friend
   - prenatal instructor
   - community health nurse
   - physician
   - other (state)
4. From which source would you like to get more information about sexual feelings during pregnancy?

books
pamphlets
magazines
partner
parent
friend
prenatal instructor
community health nurse
physician
other (state)

5. About which of the following sexual activities would you like more information concerning their practice during pregnancy? (Check ✔)

kissing
hand-holding
hugging, cuddling
touching, stroking
oral sex
self masturbation
masturbation of self by partner
intercourse
breast caressing or kissing
being told you're loved
other (state)
6. During this pregnancy, which sexual activities would you like more of than you are presently experiencing? (more - check ✓)

- kissing
- hand-holding
- touching, stroking
- oral sex
- self masturbation
- masturbation of self by partner
- intercourse
- breast caressing or kissing
- being told you're loved
- other (state)

7. During this pregnancy, which sexual activities would you like less of than you are presently experiencing? (less - check ✓)

- kissing
- hand-holding
- touching, stroking
- oral sex
- self masturbation
- masturbation of self by partner
- intercourse
- breast caressing or kissing
- being told you're loved
- other (state)
8. Are there any sexual activities which you feel should not be practised during pregnancy?

Yes

No

9. If yes, what sexual activities do you feel should not be practised during pregnancy?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Check</th>
<th>During what stage of pregnancy</th>
<th>Why? (briefly; use back of page if needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>kissing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>hand-holding</td>
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<tr>
<td>touching, stroking</td>
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<tr>
<td>oral sex</td>
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<td>self masturbation</td>
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<tr>
<td>masturbation of self by partner</td>
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<td>intercourse</td>
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<tr>
<td>breast caressing or kissing</td>
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<tr>
<td>other (state)</td>
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</tbody>
</table>

10. This question enquires about your level of enjoyment of sexual intercourse during pregnancy. For you, has sexual intercourse been:

Directions: Place ✓ in appropriate boxes

<table>
<thead>
<tr>
<th></th>
<th>very enjoyable</th>
<th>satisfying</th>
<th>unsatisfactory</th>
<th>unpleasant</th>
</tr>
</thead>
<tbody>
<tr>
<td>before this pregnancy</td>
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<td>first 3 months</td>
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<tr>
<td>second 3 months</td>
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<tr>
<td>last 3 months</td>
<td></td>
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</table>
PART B

Directions: Indicate whether the statement or expression of feeling is very true for you, generally true for you, generally not true for you or definitely not true for you by placing a ✓ after the appropriate phrase, and underline the words in brackets that refer to you.

11. I am satisfied with the amount of knowledge that I have about sexual feeling, and behaviour during pregnancy.

very true for me
generally true for me
generally not true for me
definitely not true for me

12. A man needs emotional support during his partner's pregnancy.

very true for me
generally true for me
generally not true for me
definitely not true for me

13. A woman needs emotional support during her pregnancy.

very true for me
generally true for me
generally not true for me
definitely not true for me

14. A woman needs more physical assistance during pregnancy.

very true for me
generally true for me
generally not true for me
definitely not true for me

15. I expect (my partner) (myself) to regain a pre-pregnant figure within a year.

very true for me
generally true for me
generally not true for me
definitely not true for me
16. I feel that my partner is really pleased with my body now.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

17. I think a pregnant woman's body is beautiful.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

18. I do not know what my partner needs sexually during (her) (my) pregnancy.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

19. (I) (my partner) feel(s) guilty about having sexual intercourse during pregnancy.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

20. I tend to be sexually interested in other (women) (men) during (my partner's) (my) pregnancy.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

21. I feel that my partner understands my sexual needs during (her) (my) pregnancy.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me
22. I feel uncomfortable talking to my partner about what I need sexually.

very true for me

23. I feel that sexual intercourse during pregnancy might harm the baby.

definitely not true for me

generally not true for me

generally true for me

very true for me

generally not true for me

generally true for me

definitely not true for me

24. I feel that sexual intercourse during pregnancy might injure (my partner) (me).

definitely not true for me

generally not true for me

generally true for me

very true for me

definitely not true for me

generally true for me

generally not true for me

25. I feel that sexual intercourse during pregnancy might cause pain for (my partner) (me).

definitely not true for me

generally not true for me

generally true for me

very true for me

26. I tell my partner what my sexual needs and concerns are.

definitely not true for me

generally not true for me

generally true for me

very true for me

27. This pregnancy makes me feel glad that I am a (man) (woman).

definitely not true for me

generally not true for me

generally true for me

very true for me
28. My partner tells me that I will make a good (father) (mother).

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very True for Me</th>
<th>Generally True for Me</th>
<th>Generally Not True for Me</th>
<th>Definitely Not True for Me</th>
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29. I am worried about becoming a parent.

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<tr>
<th>Statement</th>
<th>Very True for Me</th>
<th>Generally True for Me</th>
<th>Generally Not True for Me</th>
<th>Definitely Not True for Me</th>
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</table>

30. I am concerned that the new baby will interfere with my career.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very True for Me</th>
<th>Generally True for Me</th>
<th>Generally Not True for Me</th>
<th>Definitely Not True for Me</th>
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</table>

31. The possibility of our baby being breast-fed pleases me.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very True for Me</th>
<th>Generally True for Me</th>
<th>Generally Not True for Me</th>
<th>Definitely Not True for Me</th>
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32. Women who have large breasts are more likely to be good breastfeeding.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very True for Me</th>
<th>Generally True for Me</th>
<th>Generally Not True for Me</th>
<th>Definitely Not True for Me</th>
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</table>

33. I feel that my needs related to sexuality are being met.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very True for Me</th>
<th>Generally True for Me</th>
<th>Generally Not True for Me</th>
<th>Definitely Not True for Me</th>
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34. I feel loved and needed.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very True for Me</th>
<th>Generally True for Me</th>
<th>Generally Not True for Me</th>
<th>Definitely Not True for Me</th>
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</table>
PART C. Directions: Please complete the questionnaire by providing the following information.

35. How many pregnancies have you gone through
   (a) with this partner? 
   (b) with another partner?

36. What was the result of these pregnancies?
   (place check ✓ in the appropriate space)

<table>
<thead>
<tr>
<th>pregnancy</th>
<th>terminated</th>
<th>live birth</th>
<th>stillbirth</th>
</tr>
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<td>2</td>
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<tr>
<td>5</td>
<td></td>
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</tbody>
</table>

37. How many years have you been living with this partner?
   ____________ years

38. How many weeks pregnant (is your partner) (are you)?
   ____________ weeks

39. Are you a man? 
   ____________
   a woman? 
   ____________
I. Revised Questionnaire
Expectant couples often need to make adjustments in their relationship as they anticipate the birth of a baby. Many of these adjustments are related to sexuality.

Because it is important that couples provide a stable foundation for family growth; concerns regarding sexuality need to be discussed and dealt with. This questionnaire gives you the opportunity to indicate your needs and concerns so that your prenatal instructor can, through her teaching and discussion, assist you to meet them.

Please note:

1. Your name does not appear anywhere on this questionnaire.
2. There are no right or wrong answers.
3. Answer questions quickly without stopping to think very long about them.
4. It takes about fifteen minutes to complete this questionnaire.
5. You do not have to answer any questions that you do not want to answer.
6. Confidentiality is guaranteed.
7. This questionnaire is intended for use by both men and women - hence the use of her/my/my partner etc.

Donelda Ellis 1978
PART A  
Directions: Indicate your answers with a ✓

1. What is your source of information about sexual activities during pregnancy?
   - books
   - pamphlets
   - magazines
   - partner
   - parent
   - friend
   - prenatal instructor
   - community health nurse
   - physician
   - other (state)

2. What is your source of information about sexual feelings during pregnancy:
   - books
   - pamphlets
   - magazines
   - partner
   - parent
   - friend
   - prenatal instructor
   - community health nurse
   - physician
   - other (state)

3. From which source would you like to get more information about sexual activities during pregnancy?
   - books
   - pamphlets
   - magazines
   - partner
   - parent
   - friend
   - prenatal instructor
   - community health nurse
   - physician
   - other (state)
4. From which sources would you like to get more information about sexually related feelings one might experience during pregnancy?

- books
- pamphlets
- magazines
- partner
- parent
- friend
- prenatal instructor
- community health nurse
- physician
- other (state)

5. About which of the following sexual activities would you like more information concerning their practice during pregnancy? (Check ✓)

- kissing
- hand-holding
- hugging, cuddling
- touching, stroking
- oral sex
- self masturbation
- masturbation of self by partner
- intercourse
- breast caressing or kissing
- being told you're loved
- other (state)

none
6. During this pregnancy, which sexual activities would you like more of than you are presently experiencing? (more - check ✓)

- kissing
- hand-holding
- hugging, cuddling
- touching, stroking
- oral sex
- self masturbation
- masturbation of self by partner
- intercourse
- breast caressing or kissing
- being told you're loved
- other (state)

none

7. During this pregnancy, which sexual activities would you like less of than you are presently experiencing? (less - check ✓)

- kissing
- hand-holding
- hugging, cuddling
- touching, stroking
- oral sex
- self masturbation
- masturbation of self by partner
- intercourse
- breast caressing or kissing
- being told you're loved
- other (state)

none
8. Are there any sexual activities which you feel should not be practised during pregnancy?  
Yes  
No

9. If yes, what sexual activities do you feel should not be practised during pregnancy?

<table>
<thead>
<tr>
<th>Check</th>
<th>During what stage of pregnancy</th>
<th>Why? (briefly; use back of page if needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>kissing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hand-holding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>touching, stroking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>oral sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>self masturbation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>masturbation of self by partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>intercourse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>breast caressing or kissing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>other (state)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. This question enquires about your level of enjoyment of sexual intercourse during pregnancy. For you, has sexual intercourse been:

Directions: Place ✓ in appropriate boxes

<table>
<thead>
<tr>
<th>Time Period</th>
<th>very enjoyable</th>
<th>satisfying</th>
<th>unsatisfactory</th>
<th>unpleasant</th>
</tr>
</thead>
<tbody>
<tr>
<td>before this pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>first 3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>second 3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>last 3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PART B

Directions: Indicate whether the statement or expression of feeling is very true for you, generally true for you, generally not true for you or definitely not true for you by placing a ✓ after the appropriate phrase, and underline the word(s) in brackets that refer to you.

11. I am satisfied with the amount of knowledge that I have about sexual feeling, and behaviour during pregnancy.
   - very true for me
   - generally true for me
   - generally not true for me
   - definitely not true for me

12. A man needs emotional support during his partner's pregnancy.
   - very true for me
   - generally true for me
   - generally not true for me
   - definitely not true for me

13. A woman needs emotional support during her pregnancy.
   - very true for me
   - generally true for me
   - generally not true for me
   - definitely not true for me

14. A woman needs more physical assistance during pregnancy.
   - very true for me
   - generally true for me
   - generally not true for me
   - definitely not true for me

15. (My partner) (I) will probably regain a pre-pregnant figure within a year.
   - very true for me
   - generally true for me
   - generally not true for me
   - definitely not true for me
16. I feel that my partner is pleased with my body.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

17. I think a pregnant woman's body can be beautiful.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

18. I do not know what my partner needs sexually during (her) (my) pregnancy.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

19. (I) (my partner) feel(s) guilty about having sexual intercourse with me during pregnancy.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

20. I tend to be sexually interested in other (women) (men) during (my partner's) (my) pregnancy.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

21. I feel that it is all right for my partner to have sexual intercourse with someone else during our pregnancy.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me
22. I feel that my partner understands my sexual needs during (her) (my) pregnancy.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

23. I feel uncomfortable talking to my partner about what I need sexually.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

24. I feel that sexual intercourse during some periods of pregnancy might harm the baby.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

25. I feel that sexual intercourse during some periods of pregnancy might injure (my partner) (me).
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

26. I feel that sexual intercourse during some periods of pregnancy might cause pain for (my partner) (me).
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me

27. I tell my partner what my sexual needs and concerns are.
   very true for me
   generally true for me
   generally not true for me
   definitely not true for me
28. The ability to become a (father) (mother) makes me feel glad.
   - very true for me
   - generally true for me
   - generally not true for me
   - definitely not true for me

29. My partner tells me that I will make a good (father) (mother).
   - very true for me
   - generally true for me
   - generally not true for me
   - definitely not true for me

30. I am worried about becoming a parent.
   - very true for me
   - generally true for me
   - generally not true for me
   - definitely not true for me

31. I am concerned that the new baby will interfere with my career.
   - very true for me
   - generally true for me
   - generally not true for me
   - definitely not true for me

32. The possibility of our baby being breast-fed pleases me.
   - very true for me
   - generally true for me
   - generally not true for me
   - definitely not true for me

33. Women who have large breasts are more likely to be good breastfeeders.
   - very true for me
   - generally true for me
   - generally not true for me
   - definitely not true for me

34. I feel that my needs related to sexuality are being met.
   - very true for me
   - generally true for me
   - generally not true for me
   - definitely not true for me
35. I feel loved and needed.

- very true for me
- generally true for me
- generally not true for me
- definitely not true for me

PART C. Directions: Please complete the questionnaire by providing the following information. The prenatal instructor will state whether questions 36-39 are required.

36. How many pregnancies have you gone through

(a) with this partner

(b) with another partner

37. What was the result of these pregnancies?
   (place check ✓ in the appropriate space)

<table>
<thead>
<tr>
<th>pregnancy</th>
<th>terminated</th>
<th>live birth</th>
<th>stillbirth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td></td>
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<tr>
<td>4</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

38. How many years have you been living with this partner? __________ years

39. How many weeks pregnant (is your partner) (are you)? __________ weeks

40. Are you a man? __________ a woman? __________