Re: Comparison of Sexual Functions in Pregnant and Non-Pregnant Women

There are important physical and psychological changes during pregnancy, and in combination with cultural, social, religious, and emotional impacts, pregnancy might in fluences sexuality and sexual activity. Physicians are often challenged with giving instruction to pregnant women and their husbands concerning these potential changes in pregnancy. Sexual function and sexuality are imperative issues during pregnancy and postpartum period. Although these issues have been addressed in some previously published papers, but we needs more data from different cultures and population. I congratulate the authors on a very nice paper, and am flattered by their interest in the sexual function during pregnancy.

Sexuality is a vital element of health and well-being in a woman's life. Sexual behavior, which is affected by psychological, biological, cultural, and social factors, changes as pregnancy advances.[1] Based on the literature review, the reasons for reducing and avoiding sexual activities during pregnancy are the fright of damaging the fetus[2,3] and the discomfort during intercourse.[4,5] The reported frequency of sexual dysfunction in this study is quite high, but the same results have also been reported by many other researchers. In a study of 141 pregnant women by Bartellas and colleagues,[6] 71% of the participants who completed the questionnaires, reported a decline in intercourse in cidences during pregnancy compared to before pregnancy sexual activities.

As mentioned above, fears of harming the fetus or inducing preterm labor are among other contributors to the decline in sexual activity. Between 45% and 49% of women and 55% to 62% of their partners reported fear of producing some type of obstetric complication resulting from sexual intercourse during pregnancy.[7,8] Nonetheless, the literature does not support a relationship between sexual activity and higher risk of preterm labor and delivery. In an otherwise normal pregnancy, there is no convincing data that demonstrate that sexual intercourse should be considered a risk to the fetus or a risk factor for inducing miscarriage or premature labor and delivery.

In this study only sexual function has been studied, it was worthwhile that, the sexual health concern was also being addressed. The Permission, Limited Information, Specific Suggestions, Intensive Therapy (PLISSIT) model is one method that has been suggested for evaluation of sexual health concerns. This model was developed in 1976 by Annon and has been used as a framework in many clinical settings.[9] Alteneder and colleagues[10] proposed the use of the PLISSIT method by nurses to address and plan interventions concerning sexual needs throughout the antepartum, intrapartum, and postpartum periods.

In addition, this study has been done in married women. The amount of births to unmarried women has raised greatly in recent decades, rising from 5% in 1960 to 32% in 1995. After some steadiness in the mid-1990s, there was a steadyincrease from 1997 through 2008, from 32 to 41%. The rate seems to have stabilized again, and was at 41%. in 2013.[11] Women who achieve pregnancy outside of marriage tend to be more deprived than their married counterparts, both before and after the pregnancy. Unmarried mothers usually have lower salaries, lower education levels, and possibly are dependent on welfare support compared with married mothers.[12,13] Therefore the context of sexual issue in these types of women should be studied in separate researches.

In The National Health and Social Life Survey (NHSLS) of 1749 women and 1410 men 18 to 59 years of age, only 10% to 20% of women reported seeking help for sexually related problems.[14] Women are not talking about their fears to health care providers, and physicians are not routinely comprising sexual health issues or discussions in their office visits.[15] Physicians often have a decreased sense of confidence to address sexual health problems, perceive an absence of treatment modalities, and underestimate how prevalent female sexual dysfunction might be. Opening sexual health discussions and initiating a conversation can be exclusivelyvaluable during prenatal care visits. According to the World Health Organization (WHO), sexual health includes physical, mental, emotional, and social well-being in all sexual behaviors and beliefs.[16]

Many studies assessing sexual function during pregnancy were carried out more than two decades ago. Changes in approaches concerning sexuality in pregnancy since that time may limit the significance of earlier studies. Changing patterns of sexual behavior and sexuality in combination with changing advice from physicians and health care providers may make generalization from these early studies to the present day inappropriate.

REFERENCES

1. Pauleta JR, Pereire NM, Graca LM. Sexuality during pregnancy. J Sex Med. 2010;7:136–142.
2. Serati M, Salvatore S, Siesto G, et al. Female sexual function during pregnancy and after childbirth. J Sex Med. 2010;7:2782–90.
3. Senkumwong N, Chaovisitsaree S, Rugpao S, Chandrawongse W, Yanunto S. The changes of sexuality in Thai women during pregnancy. J Med Assoc Thai. 2006;89(4 suppl):S124–9.
4. Fok WY, Chan LY, Yuen PM. Sexual behavior and activity in Chinese pregnant women. Acta Obstet

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Gynecol Scand. 2005;84:934–8.

5. Eryilmaz G, Ege E, Zincir H. Factors affecting sexual life during pregnancy in eastern Turkey. Gynecol Obstet Invest. 2004;57:103–8.
6. Bartellas E, Crane JM, Daley M, Bennett KA, Hutchens D. Sexuality and sexual activity in pregnancy. BJOG. 2000;107:964-8.
7. Nakić Radoš S, Soljačić Vraneš H, Šunjić M. Sexuality during pregnancy: what is important for sexual satisfaction in expectant fathers? J Sex Marital Ther. 2015;41:282-93.
8. Trutnovsky G, Haas J, Lang U, Petru E. Women's perception of sexuality during pregnancy and after birth. Aust N Z J ObstetGynaecol. 2006;46:282–7.
9. Annon JS. The PLISSIT model: A proposed conceptual scheme for the behavioral treatment of sexual problems. J Sex Educ Ther. 1976;2:1–15.
10. Alteneder RR, Hartzell D. Addressing couples' sexuality concerns during the childbearing period: Use of the PLISSIT model. J Obstet Gynecol Neonatal Nurs. 1997;26:651–8.
11. National Center for Health Statistics, National Vital Statistics System: http://www.cdc.gov/nchs/nvss.htm
12. Lichter DT, Graefe DR, Brown JB. Is marriage a panacea? Union formation among economically disadvantaged unwed mothers. Social Problems. 2033;50:60-86.
13. Terry-Humen E, Manlove J, Moore KA. Births outside of marriage: Perceptions vs. reality. Child Trends Research Brief. Washington, DC: Child Trends. 2001. Available at: http://www.childtrends.org/wp-content/uploads/2013/03/rb_032601.pdf
14. Laumann EO, Paik A, Rosen RC. Sexual dysfunction in the United States: Prevalence and predictors. JAMA. 1999;281:537–44.
15. Politi MC, Clark MA, Armstrong G, McGarry KA, Sciamanna CN. Patient-provider communication about sexual health among unmarried middle-aged and older women. J Gen Intern Med. 2009;24:511–6.
16. World Health Organization. Defining sexual health: Report of a technical consultation on sexual health, January 28–31, 2002. Geneva, Switzerland: World Health Organization; 2006;1–35.