Sex and Pregnancy: A Perinatal Educator's Guide

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Abstract

This article is a continuation in the author's growing series of articles on intimacy and sexuality in the transition to parenthood and its relationship with perinatal education. So many couples in the author's perinatal education practice feel that health professionals are uncomfortable discussing sex and pregnancy. Indeed, the couples have so many questions and concerns regarding this subject; they are seeking answers so that they may better understand and cope with the changes in this aspect of their relationship. Perinatal education group encounters or special sessions are the ideal setting to discuss intimacy and sexuality during pregnancy. The objectives of this article are to provide the perinatal educator with content for the group sessions and tools for teaching strategies and activities.

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Introduction

This article is a guide for the perinatal educator who wishes to expand the discussions of intimacy and sexuality during the transition to parenthood with pregnant women and their partners in either perinatal education group encounters or on a one-to-one basis. Many perinatal health professionals feel uncomfortable discussing sexuality with pregnancy (Polomeno, 1997). In some circles, it is still taboo to consider these two topics together. Some care providers may not have the correct or complete information. It is an appropriate topic for perinatal education and may be offered as part of childbirth education classes or in a special session (see Table

1). The author's intention is to provide the educator with basic and precise information regarding intimacy and sexuality during pregnancy.

The questions and concerns presented in this article are representative of the Montréal population where the author conducts her perinatal education practice. It should be noted that Montréal is in the Canadian province of Quebec, which is considered very open and liberal in matters of sexuality compared to other Canadian provinces. This tendency is evidenced by an annual exhibition on eroticism and sexuality at the downtown convention center each spring, a daily French television talk show on sexuality, a weekly French television talk show that presents more marginal sexual topics, and a popular French magazine called *Corps & Ame* [*Body and Soul*] that features various aspects related to sexual intimacy. Couples who live in this setting are in their 20s and 30s; they are not shy about discussing sex and want answers

Table 1 Guidelines for Perinatal Educators on Integrating Sex and Pregnancy in their Classes

A. The perinatal educator can begin by asking the following questions:
   1. Do I have time to talk about this subject in my classes?
   2. Do I feel comfortable talking about this subject?
   3. If I don't feel comfortable with it, why not?
   4. What do I do about my discomfort, especially if a couple has questions about their sexuality? Should I avoid the question or refer the couple to their health care provider?

B. If a perinatal educator decides to integrate more sexual content into classes, it may be helpful to reflect on the subject, because her/his attitude will influence the teaching approach used. The following questions could be considered:
   1. What does intimacy mean to you?
   2. What does sexuality mean to you?
   3. Is there a difference between sex and sexuality? If so, what are these differences?
   4. How was intimacy experienced in your family of origin?
   5. What was your family's attitude towards sexuality?
   6. How was intimacy demonstrated between your parents? between the parents and children? between the children?
   7. What do you remember about your parents' sex life?
   8. When and how did you first learn about sex? How did this influence your current attitude about sex?
   9. What was your family's attitude about nudity? What is your attitude about nudity?
   10. What do you remember about your first sexual experience? How has this influenced your current attitude towards sex? How have your other sexual experiences been since that first experience?
   11. How you feel about sex during pregnancy?
   12. If you have been pregnant, how was your sexual life at that time?
   13. What is the impact of that experience on your teaching approach?

C. Once a perinatal educator has gone through self-reflection, she may feel more comfortable in broaching the subject in a more open manner in her classes. If a perinatal educator decides to expand her teaching about sex during pregnancy, several decisions will have to be made regarding the content to be presented, the time limit on teaching, and the specific subjects. These decisions depend on the fit with the characteristics of the prenatal group, the teaching activities, the teaching approach, and the educator's public comfort with the subject matter. Some in-class suggestions:
   1. All or some of the same questions as in part B alone can be used in the expectant parent group setting. It may be a homework assignment. In this case, each partner can be invited to answer the questions separately, then they can compare their answers.
   2. Couples can be taught to have a sexual conversation (Hooper, 1992; Pearsall, 1987) in which each conjugal partner expresses his or her sexual desires and needs. There are three areas that can be addressed:
      a.) *Heightened sexual awareness and intimacy*—It is important for the person to know what he or she likes and to know what the partner likes, now that things have changed. Sharing this information increases partners' sexual awareness of each other.
      b.) *Sexual assertiveness*—The couple needs to clarify which partner(s) can take the initiative during the sexual encounter. It involves touching or undressing the partner first or getting the partner to undress her. It can mean being able to give pleasure to the partner without expecting anything in return. Re-establishing confidence in oneself as a lover during pregnancy is important. This can be achieved through open communication and knowledge.
      c.) *Touch and massage*—Conjugal well-being involves touching on a daily basis. The energy may not be available for the full sexual encounter including intercourse, so massage can be used as a compromise for both touch and sexual satisfaction. This can be more important during pregnancy, especially if complications arise. Massage techniques are usually taught in prenatal classes for the comfort of the pregnant woman and for childbirth preparation. Their context can be expanded to include sexuality. Massage can be comforting, just as it can be sensual, sexual, and erotic. Tantric lovemaking involves much stroking and this can also be included. Techniques from Kama sutra can also be explored and integrated to the couple's repertoire.

to their questions, which include sexuality during pregnancy. Perinatal educators from more conservative regions would appropriately modify the approaches suggested here.

Review of Literature

Sexual Frequency during Pregnancy

Hart, Cohen, Gingold, and Homburg (1991) distributed questionnaires to 350 Israeli women 2 to 4 days following a normal pregnancy and an uncomplicated vaginal delivery. Out of the 350 women, only 219 were eligible for the study. The questionnaire consisted of two parts: The first part asked specific questions on sociodemographic and pregnancy- and intrapartum-related data, while the second part was composed of questions relating to coital and noncoital sexual behavior such as libido, coital frequency, orgasm, dyspareunia (difficult or painful intercourse), foreplay, initiation of sex, intercourse positions, masturbation, and oral and anal sex. The data revealed a gradual decline in libido, coital frequency, foreplay prior to sexual relations, and orgasm during pregnancy, especially during the third trimester. Dyspareunia was common, increasing up to 50% in the third trimester. The frequencies of oral and anal sex and masturbation remained unchanged throughout pregnancy. Surprisingly, the percentage of women who initiated sex was higher in pregnancy (18.5%, 16.5%, and 14.7% in the first, second, and third trimesters respectively) as compared to before pregnancy (8.2%). The most frequently used position for sexual intercourse towards the end of pregnancy was the side-by-side position.

Dr. Ganem's Challenge

Dr. Marc Ganem is a gynecologist practicing in France. After querying over 600 pregnant French couples, he is challenging the traditional viewpoint promoted by Masters and Johnson (1966) and Bing and Colman (1977). In the traditional viewpoint, the conceptualization of the pregnant woman's sexual desire is divided into trimesters: desire decreases during the first trimester, increases during the second one, and decreases again during the third trimester. Ganem published a book in French titled *La Sexualité du Couple Pendant la Grossesse* [*The Couple's Sexuality during Pregnancy*] (1992). His book is popular in French perinatal health communities.

Ganem (1992) proposed that sexuality during pregnancy should be divided into four phases: from conception to 2 1/2 months of pregnancy (12 weeks), from 2 1/2 to 8 months (12 to 32 weeks), the eighth month of pregnancy (32 to 36 weeks), and the last month of pregnancy (36 weeks and more). He also summarizes physical changes associated with pregnancy. These changes, discussed below, could affect women's sexuality and their sexual desire (see Appendix A).

The first phase (from conception to 12 weeks). In the first phase, Ganem (1992) reported a 20% decrease in sexual intercourse due to a decrease in sexual desire on the part of the pregnant woman, who may be experiencing nausea, vomiting, fatigue, and sensitive breasts. She is described as now putting energy into her evolving role of mother. Though she experiences many emotional changes, she needs to know that she is still loved by her partner and by other family members. Some women may discover that their sexual desire improves at this time, especially if it was absent or at a lower level before the pregnancy. Some couples fear that sexual intercourse at this time could cause miscarriages. However, a couple could be told to abstain from sexual intercourse during the first three months, only if she has had complications with previous pregnancies or is experiencing cramping or bleeding.

The second phase (12 to 32 weeks). The second phase can be a special time for the couple as they refocus on themselves. Typically, the woman is adjusting to the physical and psychological changes of pregnancy, while the man is starting to deal with impending fatherhood. The pregnancy may enhance the couple's feeling of being a team. Their sexual love is often rekindled as the woman accepts her pregnant body and, thus, can feel sexual and have sexual desire. The baby's movements and making his/her presence felt might herald moments of shared joy and happiness. Ganem (1992) reported that couples felt a sense of security and intimacy in their love, with many of them wanting to isolate themselves at this time in order to concentrate on themselves. However, Ganem also reported that one-third of couples will experience the fifth-month crisis (Ganem, 1992): The woman may turn inward and her partner may feel that he is no longer

important. At this time, some men react by seeking another woman and initiating an extramarital affair. On the other hand, since the pregnant woman's libido is often greatly increased and if her partner does not respond, *she* may be the one who seeks company elsewhere.

According to Ganem (1992), one-fifth of women will discover orgasm for the first time during their pregnancies. Many couples use the woman's heightened libido to experiment and expand their sexual repertoire: for example, they may change their positions for sexual intercourse (Wilkerson & Shrock, 2000), try different caresses, sexual games, and fantasies, and offer mutual pleasuring in the form of mutual masturbation. In Ganem's study, couples reported that the timing of lovemaking changed: Women appeared to desire their partner between 10:00 and 11:00 a.m. and between 4:00 and 6:00 p.m.. Dr. Ganem proposed that a connection exists between these two periods and the timing of potential hypoglycemia during the day for some pregnant women. The only sexual technique that has been questioned during a healthy pregnancy is the man blowing into the woman's vagina during cunnilingus. Some propose that this technique can cause an air embolism (Alteneder & Hartzell, 1997). Ganem reported that 40% of French pregnant women in his practice expressed a desire for anal intercourse.

Some men may experience increased sexual problems at this time, such as premature ejaculation, erection failure, or a problem to maintain the erection once inside the vagina. The man may experience a decrease in libido, less desire for his pregnant partner, concern that he is making love with "a mother" and not a woman, or concern with the baby's presence. Many times, these sexual problems are temporary and a natural return to normal sexual functioning occurs after the baby's birth. Often, men do not talk openly about their sexual problems during pregnancy, and they do not readily consult with sexual therapists. Similarly, health professionals rarely ask if the expectant father is experiencing sexual problems during his partner's pregnancy. When pregnant couples are aware that their sexuality is changing, that adaptation is part of the changes, and that they may want to explore and expand their sexual repertoire, their adaptation to the changes may be enhanced. If they experience problems, they should be aware that they can seek a sexual therapist with expertise in advising pregnant couples.

Some couples are uncomfortable having sexual intercourse during pregnancy and wish to abstain from it temporarily. They can be reassured that couples who abstain from sexual intercourse during this time may resort to other lovemaking techniques and still feel sexually satisfied. They can explore touch, erotic massage, and all forms of caresses. Orgasm no longer becomes the goal of the sexual encounter; instead, mutual pleasure becomes paramount. The enjoyment in being together and in giving and receiving both pleasure and affection can compensate for any change in the usual sexual repertoire.

The third phase (32 to 36 weeks). In the third phase, women may experience increased doubts and uncertainties, which can impact a woman's sexuality to the point that all sexual activity stops. She may have fears that her baby may be malformed or abnormal, or that she could deliver prematurely. If these fears are strong, gaining reassurance from prenatal care visits and knowing about the fetal heartbeat, the adequate size of the pelvis, and the baby's correct position may not be enough. Simultaneously, many changes are occurring in the pelvis: The baby is exerting more pressure, which may result in pinching sensations in different parts of the pelvis, pain deep in the vagina, or discomfort and pain from sciatica and the separation of the pubic symphysis. Pelvic pressure increases if the pregnant woman is carrying several fetuses. Any of these problems may decrease the frequency of intercourse.

It is helpful for the couple to continue to touch each day, such as kissing, hugging, cuddling, and caressing. The high level of libido from the previous months continues. The couple may respond to this heightened libido with more erotic language or increased public touching such as kissing and hugging. This touching is often directed more towards the upper body: face, hair, neck, shoulders, and breasts. Some women may experience pelvic congestion following orgasm, which may be uncomfortable, even painful. More time is required for the congestion to diminish (30 to 60 minutes, compared to 5 to 10 minutes when not pregnant).

Ganem (1992) reported that this third phase is characterized by fluctuations in sexual desire. There may be periods of intense, frenetic lovemaking, along with other periods of great tranquility characterized by a refocusing on the baby and the impending birth. These latter mo-

ments should not be negatively perceived; instead, they should be seen as quiet moments for the couple to reconnect and continue to open their relationship to the baby through ongoing preparation and dialogue about the baby's future. Sexual readjustments may include different sexual positions and even laughter between the partners as they try different sexual techniques. However, either the man or woman may decrease or abandon sexual activity at this time, which could cause conflict in the relationship.

According to Ganem (1992), coping with sexuality in this eighth month of pregnancy is important to the couple's well-being and continued experience of being a team. Satisfactory coping could have an impact on the couple's parental roles and the quality of their relationship, once the baby arrives.

Although the pregnant couple's sexual desire and sexual frequency may change or decrease, they are not less sexual than they were before the pregnancy. How they are sexual is simply different. This message is helpful to couples attending perinatal classes. Each couple must find their own balance between sexual desire, sexual frequency, and simple affection and cuddling.

The fourth phase (36+ weeks). In the last and fourth phase involving the ninth month of pregnancy, couples wonder when the birth will occur. According to Ganem (1992), this phase is also a sensitive time in the couple's relationship because a potential risk for separation exists, even for the most functional of couples and for those who deeply love each other. How the couple deals with this sensitive period will have an impact for labor and birth (Polomeno, 1998a, 1998b) and may set the pattern for postpartum adjustment and future pregnancies (Polomeno, 1999b).

During the time, the woman's sexual and erotic capacity still exists. However, the baby is heavy and pressing down on different parts of her pelvis, and the mother may feel tired or afraid of the impending birth. Pelvic congestion follows orgasm and its absorption is even slower than before (between 48 and 72 hours). It is important that couples know about this physical fact because a delay of 48 to 72 hours may be needed for repeated sexual intercourse. It is important to respect this delay, at least for vaginal orgasm. Clitoral orgasm can be substituted, but some women complain of pain radiating to the outer labia. A compress of lukewarm or cold water applied to the perineum may alleviate this pain. Some women may experience temporary abdominal discomfort, but this does not harm the baby—a fact about which women need to be reassured. Women who enjoy stimulation from the G-Spot may experience congestion without ejaculation or only partial ejaculation.

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Many women find sexual intercourse more difficult due to the discomfort associated with various sexual positions, pelvic congestion, and the baby's engagement in the pelvis (especially for nulliparas). Men find that penetration is limited, not as deep, and less satisfying. A possible solution is increased use of the rear-entry position. Some women do not like this sexual position, especially if they are not used to it, feel that the man is in too dominant of a position, or perceive less direct, face-to-face contact with their partner. The perception of the rear-entry position can be modified. For example, the woman can oscillate her pelvis while the man stays steady. She may then feel that she is in control of penetration and rhythm. As another modified example, the man can gently move his pelvis while the woman stays steady. She can then use his hands to caress her body, especially her breasts and clitoris.

If the rear-entry position is not satisfactory, an alternative one could be the side-by-side position. Many couples find this position the most comfortable and popular one, especially during the last 2 to 4 weeks of the pregnancy. The man can lie behind the woman (spoon fashion) or in front of her. A variant involves the woman lying on her back while the man lies perpendicular to her (like the letter T) and facing her. The woman then puts her legs over his hips. A handout that provides pictures of positions is useful for couples.

Couples can continue to have intercourse throughout the ninth month, right up to the beginning of labor. Some couples use sexual intercourse to initiate labor because prostagladins contained in the seminal fluid soften the cervix and are said to gently start contractions. Sheila

Kitzinger (1983) describes a natural way of starting labor through lovemaking. She suggests that the pregnant woman lies on her back—her head and shoulders well supported by many pillows—while her partner kneels in front of her and between her legs. Kitzinger writes, "Lift one leg so that your foot is over his shoulder, then the other. . . . [This] allows the deepest penetration so that the tip of the penis can touch the cervix. . . . [W]hen he has ejaculated he should stay inside you for 5 minutes or so and you should stay in the same position, with legs raised, for 10 to 15 minutes, so that the cervix is bathed in semen" (Kitzinger, 1983, p. 207). This can be followed by manual or oral stimulation of the nipples to encourage contraction of the uterus. Kitzinger reports, "About 20 minutes of nipple caressing, interspersed with other kinds of loving touch, seems right for most women" (Kitzinger, 1983, p. 209).

At-Risk Pregnancy and Lovemaking

A paucity of information exists regarding at-risk pregnancy and lovemaking. The factors influencing a couple's decision to be sexual will depend upon the following conditions: (1) the type of at-risk pregnancy, (2) the health of the pregnant woman and/or her fetus, (3) an antenatal hospitalization involvement, (4) a bedrest requirement, (5) the type of sexual activities that are or are not permitted, and (6) each of the conjugal partner's definition of sexuality.

In at-risk pregnancy, the health of the pregnant woman and/or her fetus is threatened. Certain conditions of at-risk pregnancy are not as severe or threatening as other conditions. For example, a pregnant woman may develop gestational diabetes, which can be controlled by diet or insulin. However, the woman may continue her daily activities such as going to work, studying, rearing her children, and participating in community activities. Such a woman may feel in control, as well as sexual and sensual. Pregnant women with hypertensive disorders may continue to be sexually functional unless their activities are curtailed.

When more serious conditions are involved—such as premature rupture of the membranes, premature labor, bleeding, placenta previa, certain types of infections, placenta problems leading to intrauterine growth retardation, and other conditions—certain sexual activities must be curtailed. For example, a woman having premature rupture of the membranes will not be permitted to have sexual intercourse because of the risk of introducing infections, vaginally and through their penetration into her body and her fetus. A woman experiencing premature labor may not be permitted to have orgasms because uterine contractions associated with an orgasm may provoke other contractions that lead to more premature labor. This particular ban from sexual activity may involve no intercourse or no stimulation of the breasts, or both. A woman having vaginal bleeding may be told to abstain from sexual intercourse or from having orgasms, or both. This information could also apply for placenta previa; however, this condition depends on its degree of severity—partial versus complete placenta previa.

For most women and their partners, if the pregnant woman needs to be hospitalized, intimacy and sexuality are not a priority. Nevertheless, this author has learned that some of these at-risk couples need to be physically close by kissing, hugging, and cuddling. They want these forms of physical proximity in order to reconnect, reassure each other, and lower their stress levels. The at-risk pregnant woman may be hospitalized, but free to pursue physical activities such as walking, showering, and going to the bathroom. The situation is compounded when complete bedrest is imposed and all activities are restricted. It is very difficult to even think about being sexual under such circumstances. How each of the conjugal partners defines sexuality will influence their coping skills in this aspect of their relationship. This author has clinically observed that the couples who define sexuality as being equated solely with penis, vagina, and sexual intercourse have the most difficulty with coping. While his partner is sexually unavailable, the man may not know how to deal with his own sexual frustration. He may also lack understanding regarding the severity of the pregnancy's at-risk condition. The male partner should be helped to deal with his sexual frustration, even if it involves encouraging him to pursue masturbation, temporarily, in order to relieve himself—if that fits with his cultural and religious values.

Silence on the part of the pregnant woman and the perinatal professional community exists regarding another situation. Some hospitalized, at-risk pregnant women continue to have a high libido and wish to relieve themselves through masturbation. This may become a problem if the woman needs to avoid having an orgasm. She should be encouraged to speak with her health care

professional who may feel that these occasional episodes do not jeopardize her pregnancy, especially when such orgasms may be of shorter duration and intensity and, thus, may not necessarily threaten the outcome of her pregnancy. Otherwise, the woman may accumulate sexual tension that could result in increased uterine contractions. She may be calmer if she relieves herself through masturbation, providing it is medically safe to do so.

Most couples are more inclined to be concerned about the woman's and fetus' condition and are willing to temporarily put aside the sexual aspect of their relationship. They believe that sharing in the situation and mutually supporting each other are still akin to being sexual. They still continue to feel love for each other and believe this experience may even bring them closer together. However, for some couples, the stress may be so overwhelming that an emotional distance slowly creeps in—all aspects of the conjugal relationship, including the sexual dimension, may become affected to the point that the couples never completely recover from such an experience. If, indeed, the pregnant woman succeeds in pursuing her pregnancy and producing a viable child, the couple may be observed to separate within a couple of years after the birth.

Johnston and Kraut (1990) explain that couples must often deal with a loss of familiar ways of being close, especially when sexual activities may pose a risk for the pregnancy. Alternative activities need to be explored, such as foot massages and back rubs. Johnston and Kraut offer the following advice: "When a doctor advises no sex, have him or her spell out which sexual activities are risky and which are likely to be okay. . . . [S]ometimes when the recommendation is no sex, your doctor means no sexual intercourse; sometimes your doctor is advising you to avoid intercourse and all sexual activities that might lead to a woman's orgasm" (p. 177). These authors state that giving up sexual intercourse and orgasm does not mean the couple is giving up all of its sexuality. They can explore other ways of being sexual and physically close without jeopardizing the pregnancy. For example, some at-risk couples have revealed to this author that they developed and refined the art of kissing and mutually caressing. Also, some couples became more open and accepting of fellatio and cunnilingus. Couples should be encouraged to seek out their health care professional in order to discuss the safety of these sexual practices and their impact on the at-risk pregnancy, especially because restrictions may be associated with these practices.

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Specific Sexual Practices and Pregnancy

Perinatal educators have an opportunity to contribute to couples' healthy sexual functioning during pregnancy through open discussion, either in the large group context or on an individual or couple basis. The following information may assist a perinatal educator to field questions from pregnant couples. Questions may arise about the practice of masturbation and intercourse, oral sex, and the use of vibrators, body paints, or other sexual accessories because the couple has engaged in these practices prior to the pregnancy.

All sexual practices are possible, provided that the pregnancy is normal and the partners feel comfortable with them. A pregnant woman can masturbate just as her partner can, or they can engage in mutual masturbation (also called *mutual pleasuring*). Anal intercourse is controversial—but if the couple is used to it, gentleness and the use of a water-based, sterile lubricating gel are suggested. However, if the woman has hemorrhoids, the couple should abstain from anal intercourse. Fellatio and cunnilingus can continue; however, the man may find that the vaginal secretions have a different taste—being more metallic or salty. This taste usually disappears once the woman has an orgasm (Ganem, 1992). The pregnant woman can be more susceptible to infections; thus, some accessories that couples use for sexual play may not be appropriate during pregnancy because the items can cause pain or infections. If sexual accessories are used, couples need to be more careful and, through reasonable judgment, determine if or how they want to continue to use them. Examples of such accessories include vibrators and edible products used with oral sex. Use of these

items inside the vagina may increase the risk of infection. Body paints may cause skin sensitivity during pregnancy. If a couple feels unsure about sexual accessories and their use, they could be encouraged to consult with a sexual therapist who specializes in sexual practices during pregnancy and to inquire about the safety of these items.

If a woman is breastfeeding and pregnant at the same time, her milk will have a different taste at about the 20th week of pregnancy. Children may have a natural tendency to put aside breastfeeding at this time. If the male partner is accustomed to tasting the milk, he will also notice the difference. During this time, women will notice that vaginal dryness is no longer present and that the milk let-down reflex occurring during orgasm is no longer a problem. Women may rediscover the breasts as an erogenous zone (Polomeno, 1999a). The couple can be aware that erogenous zones have a tendency to change with time, especially during pregnancy.

Perineal Massage during Pregnancy: Sexual Potential

Traditionally, when used during pregnancy, perineal massage prepares the perineum for birth. In the classic explanation and teaching of perineal massage, perinatal educators first describe the perineum, then offer an explanation of the technique as well as the importance of Kegel exercises (see Table 2).

Once the woman feels comfortable doing perineal massage, her partner can be invited to perform the same technique (with washed hands and short, clean nails). He can then feel that he is helping to prepare her body for childbirth. During intercourse or using his fingers, he can ask her to do her Kegel exercises and can offer feedback on the progress of her strength. If the partners are receptive to the idea, the use of perineal massage can offer a secondary benefit: a sexual, sensual, and erotic experience (Polomeno, 1995).

Table 2 Perineal Massage during Pregnancy

Perineal massage is conducted starting at 34 weeks till the end of the pregnancy. It is done once a day for 5 minutes, preferably at a moment when the woman is relaxed. When initially beginning the technique, she might be encouraged to take a relaxing bath and, then, sit in a comfortable position on a bed, lying upright on several pillows for support. If desired, she can use a mirror to orient herself. She puts some sterile, water-based lubricating gel on the outside of the vagina and another small quantity in the vagina. Her hands and fingernails must be clean.

She guides her thumb into her vagina, for about 2 inches. She then massages the bulbocavernosus muscle in a gentle U-shaped fashion several times, then exerts pressure with her thumb downwards for several seconds and releases the pressure. When exerting the pressure with the thumb, she might feel a tingling sensation as well as stretching. If she should feel a burning sensation upon exertion with the thumb, then she should be more gentle. It should not burn. She continues the U-shaped massage with downwards thumb exertion for 5 minutes. After 1 to 2 weeks, she will notice that this muscle is more easily stretched. The perineal massage is ideally followed by Kegel exercises. A pregnant woman should be encouraged to do the Kegel exercises at least 50 times a day, if not more. A healthy pelvic floor is always needed, even after childbirth.

Sex is normal and healthy during pregnancy . . . and sexuality is unique to each couple. . . .

Conclusion

Sex is normal and healthy during pregnancy (Sprecher & McKinney, 1993), and sexuality is unique to each couple (Polomeno, 2000b). Some couples and perinatal health care professionals hold a traditional viewpoint regarding sex and pregnancy, while others believe that pregnancy is the ideal time to be creative, imaginative, innovative, and adventuresome. Perinatal educators can help couples as they explore their sexuality during pregnancy (Polomeno, 2000a). Some believe that the intimacy dimension of the couple's relationship is the most affected dimension in the transition to parenthood (Polomeno, 1997; Selder, 1989). Thus, information that helps couples use mutual pleasuring to cement the passion in their relationship during the changes of pregnancy may make pregnancy an exciting time, rather than one of discord.

Many couples do not know how to go about obtaining information regarding sex and pregnancy. Thus, the perinatal educator is the ideal health care provider to broach the subject, especially in early-pregnancy classes. The perinatal educator will need a knowledge base and a level of expertise and comfort in this subject matter. Couples' relationships will undergo major changes, especially in this century when the respective roles of men and women are transforming. This transition can have

an impact on how couples deal with pregnancy. Similarly, perinatal education will continue to evolve to better meet pregnant couples' changing needs. Sexuality will likely become a more important part of a comprehensive perinatal curriculum. The appendices contain sample handouts that the perinatal educator might adapt to fit her own perinatal classes on sexuality during pregnancy (see Appendices A, B, C and D on the following pages).

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Thoughts on Comfort

We act as though comfort and luxury were the chief requirements of life, when all that we need to make us happy is something to be enthusiastic about.

—Charles Kingsley

You have to leave the city of your comfort and go into the wilderness of your intuition. What you'll discover will be wonderful. What you'll discover will be yourself.

—Alan Alda

Appendices

These appendices contain sample handouts that can be modified to fit the practice of the childbirth educator.

Appendix A

Handout 1: A Summary of Common Sexual Activity in Pregnancy

First Phase of Pregnancy (Conception to 12 Weeks)
- 20% decrease in sexual intercourse
- Woman diverts energy from role of lover to that of evolving mother

Second Phase of Pregnancy (12 to 32 Weeks)
- Couple refocuses on itself
- Sexual love rekindled
- Fifth-month crisis: woman's focus turns inwards; man may feel neglected or jealous and may initiate an extramarital affair
- Some women discover orgasm for the first time, due to increased pelvic congestion
- Some men may have sexual problems such as erection failure, erection maintenance, and premature ejaculation

Third Phase of Pregnancy (32 to 36 Weeks)
- Woman may experience uncertainty (abnormal baby and premature delivery), which could affect her sexuality
- Woman feels increased pelvic pressure due to baby (increased pelvic congestion lasts about 60 minutes following orgasm)
- Fluctuations in sexual desire
- Some men may experience sexual problems and decreased libido
- Important for couple to survive and/or cope with this period; the couple is not less sexual, just sexual in a different way

Fourth Phase of Pregnancy (36 Weeks to End of Pregnancy)
- Sensitive time for couple because it offers the potential for separation
- Pelvic congestion following orgasm takes longer to diminish (between 48 and 72 hours); couples should respect this delay in vaginal orgasm and sexual intercourse
- Some women experience pelvic discomfort; however, this will not harm the fetus
- Men could find that penetration is limited and less satisfying due to the baby's being engaged in the pelvis; couples may change position for sexual intercourse (rear-entry or side-by side)
- Lovemaking can be used to provoke labor
- If the G-Spot has been stimulated, release through ejaculation may be more difficult

Appendix B

Handout 2: Pregnant Women's Physical Changes Affecting their Sexuality*

1. *Skin*
   - Erogenous zones may be displaced and must consequently be redefined: the pregnant woman's hands, back of the legs, waist, and the scalp become extra sensitive and more receptive to touch and caresses.
   - Weight gain and uterine development will affect the skin's elasticity during pregnancy, potentially resulting in stretch marks. Stomach, hips, inside of the thighs, and breasts become more susceptible to stretch marks and less receptive to touch as erogenous zones. The male partner can help by rubbing cream or almond oil on these parts in order to keep the skin soft.
   - Pregnant women perspire more easily; thus, daily hygiene becomes more important.

2. *Breasts*
   - Become heavier, bigger
   - Nipples darken and enlarge
   - Very sensitive in the beginning; at about 4 months of pregnancy, return to original sensitivity as before the pregnancy. Certain women have sensitive breasts during the 9 months of pregnancy.
   - At some point in the pregnancy, colostrum may leak from the breasts.

3. *Circulation*
   - Varicose veins can develop around the hips, inside the thighs, on the calves, and around the feet. These areas may become so sensitive that any touch may feel uncomfortable and caresses may cause intolerance and pain.
   - Varicose veins may develop in the vulvar region and inside the vagina, making penetration very uncomfortable and even painful. This condition is more evident towards the end of pregnancy.
   - Lymphatic drainage and blood flow to the clitoris may be compromised so that the area becomes more sensitive. Some women may be more easily aroused, while others have less feeling and no longer experience orgasm from the clitoris.
   - If a pregnant woman has hemorrhoids, orgasm can be more painful for her. Hemorrhoids could bleed after vaginal intercourse or manual caresses of the anus.
   - Anal intercourse for pregnant women remains very controversial. Anal intercourse for a pregnant woman with hemorrhoids is prohibited.

4. *Respiratory*
   - Between 5 and 8 months of pregnancy, some women may experience physiological shortness of breath after orgasm and intercourse. This may be accompanied by minor pain from the rib cage and heart palpitations. A short rest after the sexual encounter is advised. If conditions persist, the woman should be checked for anemia and calcium deficiency.

5. *Intestinal*
   - After 5 months of pregnancy, some women may experience heartburn following orgasm, a condition that may affect their sexual desire. Try changing position after lovemaking and determining any food that increases the heartburn.

6. *Urinary*
   - Urinary frequency increases with pregnancy. It is normal for some pregnant women to lose a small quantity of urine during lovemaking and after intercourse. To avoid this problem, empty the bladder before lovemaking.
   - If the couple uses the rear and/or squatting position for intercourse, the woman may have a sensation of wanting to urinate and/or she may experience small spasmic sensations from the bladder. Some women may even experience orgasm following stimulation of the bladder in this way.

7. *Uterus*
   - The uterus can contract for at least 1 to 2 minutes after orgasm, which is not harmful to the fetus.
   - The fetus can be active after an expectant mother's orgasm for 30 minutes or more, just basking in his or her mother's happiness (Mom happy, Baby happy!)

8. *Vagina*
   - An increase in vaginal secretions occurs during pregnancy.
   - Increased pelvic congestion leads potentially to greater sensation in lower third of vagina. The woman feels the penis more easily during intercourse.
   - Vaginal secretions may have metallic smell, which will decrease during the excitation phase of sexual response.
   - Men have reported that vaginal secretions have a salty taste that disappears with orgasm.

*Adapted from several sources: Bing & Colman, 1977; Ganem, 1992; Germain & Langis, 1990; Masters & Johnson, 1966.

Appendix C

Handout 3: A Man's Guide for Lovemaking during Pregnancy

Sexuality during pregnancy is a dance between the partners. It is affected by the physical and psychological changes occurring within your partner, and those occurring in you. These changes will have both a direct and indirect impact on your relationship.

1. *What to Expect About your Pregnant Partner*
In the beginning, she may be nauseous and tired and have very sensitive breasts. Her emotions may fluctuate easily. By the fourth or fifth month, most women feel better and begin to feel the baby move. She will likely focus more on herself and begin preparing for the baby's arrival. Towards the end, she may be tired from carrying a heavy baby, may have swollen feet and hands, is still sensitive emotionally, and may be worrying about the impending birth. If she asks you for comments about her changing body, she is likely really asking if you still love her as she is. She may have an increased need for reassurance about your love for her until her self-confidence returns.

2. *What to Expect for Yourself*
You will likely also experience many emotions during the pregnancy: joy, ambivalence, worry, fear, frustration, impatience, helplessness and powerlessness. You may have fears about the future, especially those related to finances and your child's education. You may feel an increased sense of responsibility with the pregnancy. Some men may feel overwhelmed and may even be extremely stressed. You may feel like you would like to be pregnant yourself in order to understand what she is experiencing. You could even be jealous of the attention that she is giving to the baby and not to you. Gently remind her that you still exist. Learn about your baby and his/her development because this can bring both of you together. It is helpful to feel that you are in this life-project together and that you are still a couple/team, not two separate individuals.

3. *What You Can Do*
You should understand that as she experiences changes in her body, your partner might benefit from going back to the beginning of your relationship and being courted. She is changing as a person and so are you. You can enjoy rediscovering each other all over again. Romantic rituals become more important in times of change or difficulty and can help you remain connected.

The pregnant woman's libido changes during pregnancy. She may have a greater need for physical closeness and cuddling and less interest for sexual intercourse. Expect that your sexual repertoire will need to change now and after the baby's birth. What worked before the pregnancy may not work at this time—so, explore! Your own libido may change. It may increase because you love those curves and can't keep your hands away or it may decrease because you may be afraid to hurt her or the baby. Some men feel that they are making love with "a mother" and not a woman. Others are concerned that the baby is looking at them when they are inside their partner's vagina because only two inches separate them from the baby. You may also experience an unusual feeling of making love with two people at the same time. Such feelings are common. The baby is well-protected inside the uterus and is safe when you make love.

Such feelings can translate into sexual problems: Some men may find themselves unable to have or sustain an erection. Other men may experience premature ejaculation for the first time. Some men prefer to masturbate at this time to relieve their sexual tension. If these problems occur, they are usually resolved naturally after the baby's birth. In the meantime, you may need to simply seek another way of being intimate or sexual with your partner, separate from erection and ejaculation. Communication with your partner is the key element in all of these situations. If you need professional help, seek it.

Lovemaking during pregnancy requires gentleness on your part. Start in a nonsexual way: kissing, hugging, and cuddling. Change your touch so that slowly it becomes more sexual. Ask for feedback about your touch (does she like it?). Breasts are very sensitive, so go slowly and gently. Explore her erogenous zones because they do change during pregnancy. You may need to change sexual positions for intercourse, with more gymnastics on your part. Towards the end of pregnancy, the side-by-side position is often the most comfortable one.

Lovemaking during at-risk pregnancy—if it occurs—will change, especially if your partner is on bedrest or hospitalized. If the doctor says no sex, seek clear explanations about this. It may simply mean no intercourse or, at the extreme, no orgasms for her. Many couples can continue to kiss, cuddle, and explore. You can continue to be sexual—it will just be different.

Appendix D

Handout 4: Staying Connected as a Couple during Pregnancy

Despite all the physical and psychological changes occurring during pregnancy, your challenge as a couple is to continue to stay connected physically, emotionally, spiritually, and sexually. There is no greater time than pregnancy for couples to be more aware of their biological differences. These differences become more evident during this time; however, concentrating on what is similar or what you have in common is more important. This is one way to stay connected. Both of you are probably feeling out of sorts or that your relationship is not in "sync" or that you are not in tune with each other. This is usually a temporary situation. Some couples take these changes in stride, while others have more difficulty dealing with them. Talk. Express your thoughts and feelings. If this is not possible, then write to each other or send each other audio-taped or video-taped messages. Communicate. You are both human beings with emotions and needs. Your pregnancy experiences may be different, but you are both in the same boat. Find a way of steering this boat together instead of going around in circles. Seek professional help if you have to, but renegotiate your relationship. Above all, continue to seek each other out by daily touching, hugging, and kissing. This is the greatest gift that you can give to your unborn child.