

A Study of Men's Sexuality and their Attitude during their Wives' Pregnancy

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ABSTRACT

Introduction: Pregnancy is a very sensitive period that is often accompanied by changes in the couple's sexual relationship due to various physical and psychological changes.

Aim: The purpose of this study was to evaluate men's sexuality and their attitude toward sexual relationship during their wife's pregnancy.

Materials and Methods: The present cross-sectional study was conducted on the husbands of 272 pregnant women who attended healthcare centers of Jahrom, Iran, from March 2016 to May 2016. International Index of Erectile Function (IIEF) questionnaire was used to assess the sexual function. T-test utilised to compare overall satisfaction score with characteristics of the participants, ANOVA test used in order to compare domains of male sexual function with pregnancy trimesters. Besides, p-value <0.05 was considered as statistically significant.

Results: The husband's mean age was 32.57±6.12 years. Of the total 62, 81, and 129 subjects were in their first, second and third trimesters, respectively. Comparison of the first, second and the third trimesters revealed a significant difference in the scores of all IIEF domains. Among the study subjects, 82.7% had erectile dysfunction, 84.2% had orgasmic dysfunction, 92.64% had sexual desire dysfunction, 95.6% had intercourse dissatisfaction, and 80.1% had overall dissatisfaction. Almost 62.2% of the men displayed a negative attitude towards sexuality and only 11% men had positive attitude.

Conclusion: The results of the present study showed that sexual disorders were highly prevalent among men. The most prevalent sexual dysfunction was desire disorder and intercourse dissatisfaction. Since, attitude towards sexuality affected their general sexual behaviour during pregnancy, it is crucial to provide proper consultation regarding sexual relations in prenatal care services.

Keywords: Desire disorder, International index of erectile function, Sexual function, Sexual intercourse

INTRODUCTION

It was declared at the International Conference on Population and Development in Cairo (1999) that people must have access to high-quality education on sexual hygiene. Main components of healthcare are providing education on the principles of a healthy sexual relationship and dealing with couple's sexual disorders [1,2]. Pregnancy is a very sensitive period that is often accompanied by changes in the couple's sexual relationship due to various physical and psychological changes.

Factors such as physiological and anatomical changes in pregnant women and avoiding sex during pregnancy can adversely affect their sexual responses and eventually have a negative impact on the couple's relationship, leading to anxiety and low self-confidence as well as disrupting the psychological hygiene of the family [3]. On the other hand, sexual behaviour during pregnancy can be influenced by common beliefs and ideas. Most of the sexual disorders occurring during this period originate from false notions and understanding of the physical and emotional changes experienced by women when they are pregnant [4].

Pregnancy is an important time in a woman's life and her need for emotional support is more during this period; however, couple's inadequate knowledge about sexual behaviour during pregnancy and their negative attitude to have sex when the woman is pregnant results in limiting their sexual relationship or stopping it altogether affecting their emotional relationship adversely and causing problems. According to a study, 60% of women and 40% of their spouses have problems in each phase of the sexual response cycle during pregnancy [5]. The results of some studies show that men commit adultery for the first time when their wives are pregnant

[6,7]. Smith M and Shimp L reported that intimate partner violence often begins during pregnancy, as this is the time when women often avoid having sex [8]. Medical science does not restrict sexual relationships during a natural pregnancy, except high-risk groups, and couples can have moderate sex during pregnancy [9].

Ethnic and cultural factors can influence society and individuals' perception of sexuality and sexual behaviours. On the other hand, due to social and religious obstacles, there are not enough studies on the sexual function of couples in pregnancy from Iran. In addition, due to cultural restrictions, there is limited information on men's sexual behaviours and attitudes. Therefore, the purpose of this study was to evaluate men's sexuality and their attitude toward sexual relationship during their wife's pregnancy.

MATERIALS AND METHODS

The present descriptive cross-sectional study was conducted between March 2016 to May 2016. The study population consisted of the husbands of all the pregnant women who visited the hygiene and healthcare centers of Jahrom, Iran, to receive prenatal care and whose records were maintained in the centers. Once the objectives of the study were explained to the subjects and their informed consent had been obtained, the researchers asked the qualified subjects to participate in the study. The study was approved by the Ethics Committee of the Jahrom University of Medical Sciences (REC.1392.042.JUMS).

Using the convenience sampling method, the researchers selected a certain number of pregnant women visiting one of the 11 hygiene and healthcare centers of Jahrom; the subjects were selected from all the three trimesters and their number was determined based on

the population size. The formula was utilised for calculation of the sample size [9].

$$n = \frac{Z_{1-\frac{\alpha}{2}}^2 pq}{d^2}$$

According to the formula, the sample size was 254, and, by adding 15% for drop-outs, the sample size was increased to 292. Out of the 292 cases, 272 completed the questionnaire, and 20 were excluded because they didn't fill out the questionnaires completely.

Inclusion Criteria

Husbands of all the pregnant women receiving prenatal care at the 11 hygiene and healthcare center of Jahrom were included: The husbands living with their wives and having regular sexual relationship with their wives over four previous weeks.

Exclusion Criteria

Husbands with history of alcohol use, smoking, drug abuse, use of medication affecting one's sexual urges such as antidepressants and hypertension medicines, and mental and physical problems such as spinal cord injury, paralysis, and mutilation were excluded. Moreover, the husbands of the women who had placenta previa, high blood pressure in pregnancy, prone to miscarriage or preterm labour were excluded from the study.

Data collection tool was a questionnaire. The questionnaire was composed of three parts. The first part was concerned with demographics, including age, education, and occupation. The second part aimed to assess sexual function by the IIEF. The third part was regarding the men's attitudes toward sexual activity in pregnancy.

The IIEF questionnaire was introduced by Rosen R et al. This questionnaire consisted of 15 questions investigating the subjects in five domains of erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction. In this questionnaire, the questions were scored based on 0-5 scoring system and the score of each domain was calculated through summing up the scores of the domain questions and multiplying the obtained number by the domain multiplier factor. Overall, the IIEF questionnaire is a general standard, one whose reliability and validity were determined by Rosen R et al. In another study conducted by Mehraban D et al., at Tehran University, Iran also confirmed reliability and validity of the questionnaire [10,11].

The sexual attitudes questionnaire included nine questions requiring respondents to indicate whether they agree or disagree with the statements using the following scales: 1) disagree; 2) uncertain; and 3) agree. A final score was obtained for the total scale by summing responses graded with scores, ranging from 9 to 27. Lower scores represented negative sexual attitudes, while higher scores showed positive attitudes. They were divided into three categories: negative (scores 9-15), medium (scores 16-21), and positive (scores 17-27). The questionnaire face and content validity ($r=0.88$) were evaluated by 10 gynaecologists and psychiatrists expert in the field of sexual health. The questionnaire was changed based on their comments [12]. The questionnaire's reliability was assessed using test-retest and inter-rater method. In these methods, first, a trained questioner completed the questionnaire for 30 participants, then another observer filled the same questionnaire.

STATISTICAL ANALYSIS

All the study data were statistically analysed using the SPSS software (Statistical Package for the Social Sciences, Version 21.0, SPSS Inc., and Chicago, Ill, USA). Descriptive statistics, frequency, percent, mean, standard deviation, maximum, and minimum were used in this study. In [Table/Fig-1], ANOVA test used to compare overall satisfaction score with female age, female education and male education and T- test utilised to compare overall satisfaction score with employment status. ANOVA test used in order to compare domains of male sexual function with pregnancy trimesters. Moreover, p-value <0.05 was considered statistically significant.

Variables	(Mean±SD)
Male age (year)	32.57±6.12
Duration of marriage (year)	6.68±5.15
Age difference between spouses (year)	5.35±3.75
Spouse's age (year)	27.37±5.10

[Table/Fig-1]: Demographic characteristics of the participants (n=272). Numbers are presented as Mean±SD

RESULTS

The present study was conducted on 272 men in the age range of 21-65 years and with the mean age of 32.57±6.12 years [Table/Fig-1]. Additionally, most of the participants were unemployed (82%), and had secondary school degree (44.1%) [Table/Fig-2]. Furthermore, wife's of 22.7%, 29.7%, and 47.4% husbands were in the first, second, and third trimesters, respectively.

Variables		N (%)	Overall satisfaction score (Mean±SD)	p-value
Female age (years)	<20	24 (8.8)	8.12±1.11	p=0.01 F=4.02
	21-30	172 (63.2)	7.20±1.51	
	>30	76 (28)	7.22±1.57	
Female education	Uneducated	5 (1.8)	6.82±1.34	p=0.01 F=3.36
	Primary school	56 (20.6)	7.25±1.69	
	Secondary school	120 (44.1)	7.60±1.33	
	College or university	91 (33.5)	7.80±0.83	
Employment of status	Unemployed	223 (82)	7.20±1.45	p=0.01
	Employed	49 (18)	7.78±1.65	
Male education	Uneducated	11 (4)	6.72±1.27	p=0.02 F=3.23
	Primary school	88 (32.4)	7.13±1.49	
	Secondary school	109 (40.1)	7.19±1.54	
	College or university	64 (23.5)	7.78±1.46	

[Table/Fig-2]: The association between overall satisfaction score and characteristics of the participants (n=272).

*p-value: ANOVA and Student's t-test: between male sexual function index score and characteristics of the participants

There were statistically significant relationships between men's sexual satisfaction with age of their wives ($p=0.01$), their own education ($p=0.02$), education of their wives ($p=0.01$) and their job ($p=0.01$) [Table/Fig-2].

Prevalence of Male Sexual Dysfunction

Comparing the sexual dysfunction in each domain, the lowest mean score was observed in the domain of orgasmic function (5.56±2.85), and sexual desire (5.92±1.88). Domain scores suggestive of difficulties related to erectile dysfunction, sexual desire dysfunction, orgasmic dysfunction, intercourse satisfaction dysfunction, and overall satisfaction were prevalent in 224 (82.7%), 251 (92.6%), 229 (84.2%), 260 (95.6%), 218 (80.5%) subjects, respectively. [Table/Fig-3] shows the prevalence of the sexual problems.

Domain	First trimester (n=62)	Second trimester (n=81)	Third trimester (n=129)	Total (n=272)
Erectile dysfunction	51 (82.2%)	63 (77.8%)	110 (85.3%)	224 (82.7%)
Orgasmic dysfunction	54 (87.1%)	64 (79%)	111 (86%)	229 (84.2%)
Sexual desire dysfunction	59 (95.2%)	68 (84%)	124 (96.1%)	251 (92.64%)
Intercourse satisfaction dysfunction	59 (95.2%)	77 (95.1%)	124 (96.1%)	260 (95.6%)
Overall satisfaction dysfunction	50 (80.6%)	61 (75.3%)	107 (82.9%)	218 (80.51%)

[Table/Fig-3]: Frequency of male sexual dysfunction in each domain in the three trimesters.

The study results indicated that 80.6%, 75.3% and 82.9% of the subjects had experienced sexual disorders in the first, second and third trimester of their wife's pregnancy, respectively. In all the three trimesters of pregnancy, inhibited sexual desire was found to be the most prevalent form of sexual disorder in men. Of the total 25.3% of the husbands mentioned that they had very little sexual desire during their wife's pregnancy and 25% stated that they did not enjoy sex with their wives during this period at all.

As the results show, the domains of sexual function score in the first and third trimester were lower than second. In addition, a statistically significant relationship was observed among the domains of sexual function in all the three trimesters ($p < 0.05$). In fact, the three trimesters were significantly correlated with erectile function ($p = 0.019$), orgasmic function ($p = 0.013$), sexual desire ($p = 0.02$), intercourse satisfaction ($p = 0.002$), and overall satisfaction ($p = 0.1$) [Table/Fig-4].

Domain	First trimester GA<14 (n=62)	Second trimester GA=14-28 (n=81)	Third trimester GA=14-28 (n=129)	p-value	Total (n=272)
	(Mean±SD)	(Mean±SD)	(Mean±SD)		
Erectile function	17.29±6.91	19.22±6.76	16.25±7.91	0.019	17.37±7.45
Orgasmic function	5.62±2.61	6.27±2.63	5.08±3.02	0.013	5.56±2.85
Sexual desire	5.87±2.00	6.38±1.87	5.65±1.81	0.024	5.92±1.88
Intercourse satisfaction	7.11±3.31	8.41±3.04	7.65±3.77	0.002	7.28±3.53
Overall satisfaction	7.22±1.61	7.56±1.38	7.43±1.55	0.14	7.29±1.52

[Table/Fig-4]: Male sexual function score in each domain and sexual function total score in the three trimesters of pregnancy.

* p-value ANOVA test: between first, second, and third trimesters

The Participants' Attitude towards Sexuality in Pregnancy

A total of 62.2%, 28.7%, and 11% of men had negative, moderate, and positive attitude towards sexual function during pregnancy, respectively.

A total of 64.7% believed that sex during pregnancy could cause discomfort and pain to the mother; 55% stated that physical changes in their wives, such as a distended abdomen, prevented sex during pregnancy; 41.2% believed that sex could injure the foetus [Table/Fig-5].

Belief	Agree	Disagree	Uncertain
SI injures the foetus	41.2%	38.6%	20.3%
SI causes preterm labour	33.8%	35.3%	30.9%
SI causes miscarriage	39%	34.2%	26.8%
SI causes infection of the foetus	28.4%	38.7%	32.8%
SI during pregnancy is a sin	10.3%	77.2%	12.5%
I find my wife less sexually attractive	27.6%	59.2%	13.2%
SI causes premature rupture of membranes	39.3%	29%	31.6%
SI during pregnancy causes pain to the mother	64.7%	22.8%	12.5%
Physical changes, e.g., distended stomach, etc., prevent SI	55%	33.9%	11.1%

[Table/Fig-5]: Frequencies of the possible consequences of sex activity in pregnancy cited by participants.

SI: Sexual intercourse

In addition, a total of 82.7% of the subjects referring to health care centers had erectile dysfunction during sex with their pregnant wives, correlating with feeling guilty about having sex during pregnancy ($df = 2$, $\chi^2 = 7.03$, $p = 0.04$), fear of infecting the foetus ($df = 2$, $\chi^2 = 7.64$, $p = 0.02$) and fear of causing a preterm labour ($df = 2$, $\chi^2 = 9.53$, $p = 0.008$).

Furthermore, a total of 84.2% of the subjects mentioned orgasmic dysfunction correlating with feeling guilty about having sex during pregnancy ($\chi^2 = 5.98$, $p = 0.04$) and the physical changes and increased size of their wife's abdomen ($\chi^2 = 8.74$, $p = 0.01$).

Moreover, a total of 92.3% of the subjects referring to health care centers inhibited their sexual desire, having a statistically significant relationship with fear of infecting the foetus ($df = 2$, $\chi^2 = 13.60$, $p = 0.001$), fear of causing miscarriage ($df = 2$, $\chi^2 = 7.64$, $p = 0.02$) and fear of injuring the foetus ($df = 3$, $\chi^2 = 8.21$, $p = 0.04$). Also, the results of the chi-square test showed a statistically significant relationship between sexual dissatisfaction during sex and fear of infecting the foetus ($p = 0.04$).

DISCUSSION

This study shows that sexual dysfunction and sexual response cycle disorder are the least prevalent in the second trimester and the most prevalent in the third trimester of pregnancy. These findings are consistent with the results of the study of Bayrami R et al., [12].

Most women, as a result of their physiological changes experienced in the second trimester of pregnancy, find sex more comfortable in this period and resume their sexual relationship [7]. This can affect their husband's sexual behaviours and lead to have a better sexual performance at this time for them. On the other hand, in the third trimester, concerns over labour and the foetus health and discomfort about the distension of the woman's stomach intensify. During this period, the sexual relationship of many couples become limited or stops altogether, accounting for the increase in husband's sexual disorders.

More than half of the participants in the present study were found to have a negative attitude towards sex during pregnancy; less than half of the participants believed that sex could injure the foetus; number of them held the opinion that sex could lead to premature rupture of membranes, and more than half of the participants stated that sex during pregnancy could cause pain or discomfort to the mother. Bogren LY reported that worry concerning the foetus was related to changes in men's sexual behaviour [13]. Kiemtorè S et al., explained that men refused sex in pregnancy due fear of abortion or a dead foetus [14]. Matteson P mentioned that men avoid sexual activity because of fear of injury to the foetus [15]. These studies coincided with the present study. According to Heidari M et al., 54.5% of men have a negative attitude towards sex during pregnancy [16]. A variety of factors contribute to the negative attitude toward sex during pregnancy, including physiological and anatomical changes in pregnant women, restricting and feeling guilty about the act of having sex during pregnancy, change in women's impression of their own bodies, women's feeling of being less sexually attractive to their husbands, fear of injuring the foetus and fear of causing miscarriage or preterm labour [3,17]. Thus, providing couples with sex education and consultation before and during pregnancy to encourage a positive attitude toward sex during pregnancy, teach them proper sexual behaviours, and help them to have self-confidence towards the opposite sex is necessary.

Maximum number of respondents in the present study referring to health care centers showed a decrease in their sexual desire, having a statistically significant relationship with fear of injuring the foetus, fear of miscarriage and fear of infecting the foetus. Heidari M et al., reported the prevalence of decreased sexual desire among men to be 43% and out of them 75.5% of the cases stated that they considered their pregnant wife's conditions; 23.3% mentioned that they were unwilling to have sex due to the changes in the anatomy of their wives; and 65.2% were worried about injuring the foetus [16]. In a study, women stated that their husbands had lost sexual

urge beginning from the last part of the second trimester or start of the third trimester of their pregnancy; all the women maintained that their husbands avoided having sex with them for the following reasons: physical appearance, discomfort, and fear of injuring the foetus [18].

Maximum number of the husbands in the present study referred to health care centers for their erectile disorders during their wife's pregnancy. This disorder was correlated with fear of injuring the foetus, fear of causing miscarriage; fear of infecting the foetus and regarding sex during pregnancy as sinful.

According to Bayrami R et al., study, the rate of erectile disorder increases with the progress of pregnancy [12]. Onah H et al., report that 36.6% of men have difficulty in maintaining an erection during their wife's pregnancy [17]. Erectile disorders in men can be attributed to anxiety and stress caused by such factors such as fear of injuring the foetus, fear of causing a preterm labour and fear of infecting the foetus.

Additionally, maximum number of the respondents in the present study mentioned that they had an orgasmic disorder, correlating with regarding sex during pregnancy as sinful and physical changes in women and the distension of their stomachs. The results of Barclay LM et al., study showed that 28% of men cannot reach orgasm during their wife's pregnancy [19]. Similarly, Onah H et al., reported that 32.2% of men have difficulty in maintaining an erection and reaching orgasm when their wives are pregnant [17]. Bayrami R et al., concluded that the rate of orgasmic disorders in men increases as pregnancy advances [12]. Anxiety, a sense of guilt, distress, occupation with other thoughts and failure to focus on sexual arousal all function as negative stimuli disrupting reaching orgasm [5].

Maximum number of the respondents complained about sexual dissatisfaction, having a positive correlation with fear of infecting the foetus. In their study, they concluded that the risk of injuring the foetus restricts sexual relationship between couples and leaves men sexually dissatisfied in the last trimester of pregnancy [12].

There was a statistically significant relationship between men's overall sexual satisfaction with women's age, men and women's education and men's employment. Zahraee RH et al., mentioned the role of women's age and education in a sexual relationship [20]. Other studies have shown that there is a significant relationship between low education and sexual dissatisfaction [21-28]. Johnson M et al., and Voydanoff P shows that the level of marital satisfaction is higher in working women than in housewives [29,30]. In other words, they have higher levels of awareness and are more competent in relationship skills; this, in turn improves their marital satisfaction, including sexual satisfaction.

LIMITATION

The researchers asked the women who visited the governmental healthcare centers only. Private healthcare centers were not investigated. Furthermore, as sexuality is one of the most private matters of a marital relationship and due to cultural and religious taboos in Iran, it is possible that some respondents had not completely shared the details of their sexual relationships with the researchers, which was out of the researchers' control.

CONCLUSION

The results of the study show that most men were affected by sexual dysfunction during their wife's pregnancy. Negative attitudes and false beliefs on the part of men about sex during pregnancy contribute to their sexual disorders. Accordingly, it is recommended that couples should be provided with correct and scientific information on the physical, psychological and

emotional changes occurring during pregnancy. It is also recommended that education sessions should be designed and scheduled in such a way that husbands of pregnant women are able to attend them with their wives and get benefit from consultation.

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