Journal of Nursing
Revista de Enfermagem
UFPE On Line
ISSN: 1981-8963

INTEGRATIVE REVIEW ARTICLE

FUNCTION, PRACTICES AND SEXUAL POSITIONS OF PREGNANT WOMEN

FUNÇÃO, PRÁTICAS E POSIÇÕES SEXUAIS DE MULHERES GRÁVIDAS

FUNCIÓN, PRÁCTICA Y POSICIONES SEXUALES DE MUJERES EMBARAZADAS

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ABSTRACT

Objective: to characterize the function, practices and sexual positions of pregnant women. ***Method***: this is an integrative review performed in April 2017, in the MEDLINE, Lilacs, IBECS, CINAHL, BDENF and SciELO virtual libraries. There were 1,439 articles identified. After the application of the filters, inclusion, and exclusion criteria, 11 articles composed the sample. ***Results***: the results showed four thematic categories << Sexual practices during pregnancy >>; << Sexual positions during pregnancy >>; << Sexual Function domains >> and << Related Aspects of Sexual Function >>. ***Conclusion***: during pregnancy, there is a reduction in the frequency and/or restriction of sexual practices and positions, besides to changes in all domains and related aspects of sexual function. Sexual practices and positions have not been evaluated and/or specified by most primary studies. **Descriptors**: Women's health; Pregnancy; Sexuality; Sexual behavior; Review.

RESUMO

Objetivo*:** caracterizar função, práticas e posições sexuais de mulheres grávidas. ***Método*:** revisão integrativa realizada em abril de 2017, nas bases de dados *MEDLINE*, Lilacs, IBECS, *CINAHL*, BDENF e biblioteca virtual *SciELO*. Identificaram-se 1.439 artigos, após aplicação dos filtros, critérios de inclusão e exclusão, 11 artigos compuseram amostra. ***Resultados*:** os resultados evidenciaram quatro categorias temáticas << Práticas sexuais na gestação >>; << Posições sexuais na gestação >>; << Domínios da função sexual >> e << Aspectos correlatos da função sexual >>. ***Conclusão: durante a gestação ocorre redução na frequência e/ou restrição de realização de práticas e posições sexuais, além de alterações em todos os domínios e aspectos correlatos da função sexual. Práticas e posições sexuais não foram avaliadas e/ou especificadas pela maioria dos estudos primários. ***Descritores*:** Atenção à Saúde; Saúde da Mulher; Gravidez; Sexualidade; Comportamento Sexual; Revisão.

RESUMEN

Objetivo*:** caracterizar función, prácticas y posiciones sexuales de mujeres embarazadas. ***Método*:** revisión integradora realizada en abril de 2017, en las bases de datos *MEDLINE*, Lilacs, IBECS, *CINAHL*, BDENF y biblioteca virtual *SciELO*. Se identificaron 1.439 artículos, después de la aplicación de los filtros, criterios de inclusión y exclusión, 11 artículos compusieron la muestra. ***Resultados*:** los resultados mostraron cuatro categorías temáticas << Prácticas sexuales en el embarazo >>; << Posiciones sexuales en el embarazo >>; << Dominios de la función sexual >> y << Aspectos correlatos de la función sexual >>. ***Conclusión: durante la gestación ocurre reducción en la frecuencia y o restricción de realización de prácticas y posiciones sexuales, además de alteraciones en todos los dominios y aspectos correlatos de la función sexual. Prácticas y posiciones sexuales no fueron evaluadas y o especificadas por la mayoría de los estudios primarios. ***Descriptores*:** Atención a la Salud; Salud de la mujer; Embarazo; Sexualidad; Comportamiento sexual; Revisión.

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INTRODUCTION

Sexual function encompasses the desire, excitement, orgasm and related aspects (comfort, pain, lubrication, pleasure, interest, satisfaction, initiative and sexual disposition) that result from a complex interaction between biological, sociocultural and psychological factors.[1] While sexual practices can be a means to obtain pleasure and/or sexual satisfaction, regardless of type (vaginal, oral, anal and masturbation) and embodiments; sexual positions are the way in which the body remains during the sexual act.[2]

The domains of sexual function and related aspects may vary by gestational trimester due to hormonal, physical, psychological, experiences, meanings, roles and sociocultural contexts[3], as well as interfere with the sexual practices and positions adopted.[4]

As a result of these aspects, it is observed that scientific publications included in review[5] on the subject tend to emphasize pathological aspects to the detriment of sexual function. In a previous survey on female sexual function in gestation, only one review article[6] was identified including publications indexed in a database and examined in a specific way sexual function in pregnancy and puerperium, relating it to the way of delivery and interventions performed during parturition as factors for sexual dysfunction.

In view of the above, investigations related to the sexual practices and positions performed during pregnancy as constitutive elements of sexuality need further clarification regarding the implications of sexual function.

OBJECTIVE

- To characterize the function, practices, and sexual positions of pregnant women.

METHOD

This article was extracted from the dissertation << *Sexual function during pregnancy: analysis of sexual practices and performance* >>. Postgraduate Program in Nursing at the Regional University of Cariri (URCA), Crato, (CE), Brazil, 2017.

It is an integrative review of the literature that fulfilled the steps: identification of the guiding question; establishment of criteria (inclusion and exclusion); categorization; evaluation of included studies; interpretation of results; and submission of review.[7]

The search was done in a paired form in April 2017, in the databases MEDLINE, Latin American Literature in Health Sciences (LILACS), Spanish Bibliographic Index of Health Sciences (IBECS), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Nursing Database (BDENF) and Virtual Library Scientific Electronic Library Online (SciELO), using advanced search method and categorizing title, abstract and subject. The subject was searched for by Medical Subject Heading (MeSH), National Library of Medicine's National Institutes of Health (PubMed).

The Population, Variables, and Outcomes (PVO) strategy (Table 1) was used to choose the MeSH descriptors to answer the question: How are the practices, positions and sexual function of pregnant women characterized by the literature as dimensions of sexuality?

Table 1. MeSH descriptors for the components of the guiding question. Crato ***(C****E)***, Brazil, 2017.

Strategy Items	Components	Subject Descriptors
Population	Pregnant women	Pregnancy
Variables	Practices, positions, and sexual function	Sexual Behavior
Outcomes	Sexuality	Sexuality

As a search strategy, a crossing in each database and the data library with Boolean operators to were used associate the descriptors: Pregnancy AND Sexual behavior AND Sexuality. The search was conducted through the journal portal of the Coordination of Improvement of Higher Education Personnel (CAPES), with 855 in MEDLINE, 442 in CINAHL, 60 in LILACS, 56 in SciELO, 16 in IBECS, 10 in BDENF, totaling 1,439 references, submitted to a four-stage filtering process: full text available; language (Portuguese, English and Spanish); type of document (article) and year of publication (January 2005 to April 2017).

After the filters were applied, 303 references were left. Then, the titles and abstracts were read, exclusion of duplicates and analysis was performed according to inclusion criteria: original research on the subject; and exclusion criteria: structured in the format of editorials, comments, brief communications, review or reflection articles, documentaries, essays, abstracts, reviews, theses, dissertations, monographs and experience reports; not be available in full text for download or do not answer the study question. We selected 11 articles that composed the final sample.

A flowchart of the Preferred Reporting Items for Systematic Review and Meta-Analyzes (PRISMA)[8] was used to describe information at each step of the search and selection of studies, as can be seen in Figure 1:

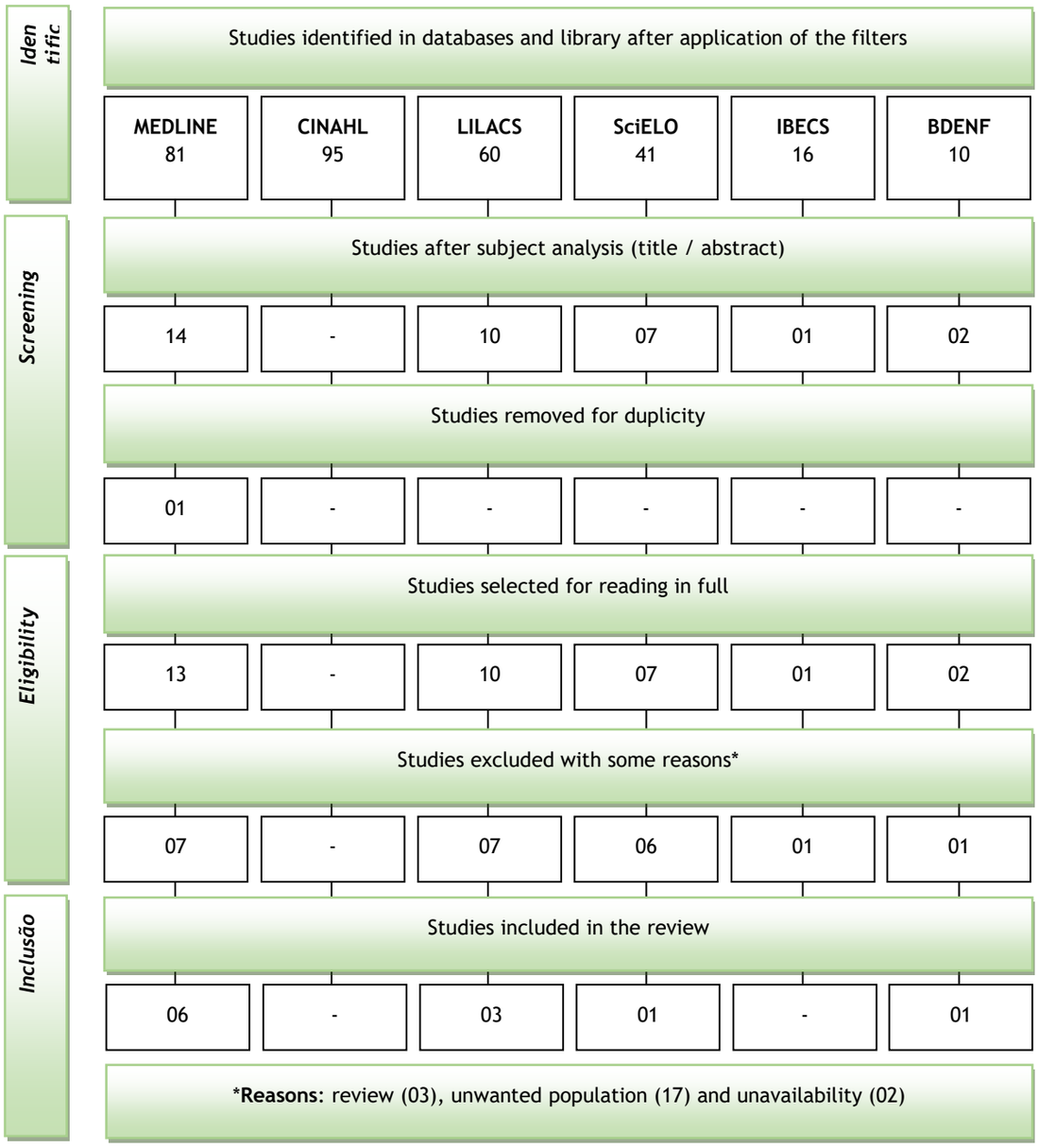

Figure 1. Study selection flowchart. Crato *(CE)*, Brazil, 2017.

The levels of evidence (LE) of the studies that compose the sample were categorized into six levels: Level 1: evidence resulting from the meta-analysis of multiple randomized controlled clinical studies; Level 2: Evidence obtained from individual studies with experimental design; Level 3: evidence from quasi-experimental studies; Level 4: Evidence from descriptive studies (non-experimental) or qualitative approach; Level 5: evidence from case or experience reports; Level 6: evidence based on expert opinions.[9]

The data were organized into four thematic categories, classified and grouped by content similarity according to data extracted from the primary studies. Data analysis was performed using the data reduction method.[10] It involved classification and division techniques in subgroups of primary sources according to the approach and methodological aspects. After coding procedures, extracted information was analyzed according to similarities and divergences; reduced and compiled in electronic spreadsheets, submitted to validation via double typing to eliminate possible errors and guarantee reliability.

This approach allowed organizing data in a logical structure, to simplify, to summarize, to abstract and to compare systematically information contained in the primary sources on specific questions, variables or characteristics of sample.[10]

The characterization of the studies is presented in synthesis-table and the results in thematic categories according to the objective of the study and they were

discussed according to the pertinent literature.

RESULTS

The data contained in Table 2 summarize the main information of the articles analyzed.

Table 2. Characterization of the primary studies analyzed. Crato ***(CE)***, Brazil, 2017.

Author/Year	Journal/Database or Library	Local	Methodological Design	Level of Evidence
Mesinas AG, Delgado TA; Luján-Carpio E, 2015.[11]	Horiz. med. (impressa) LILACS	Peru	Transversal, descriptive, quantitative 1991 pregnant women Questionnaire	Level 4
Balestena JMS, Hernández BF, Negrin JGF, 2014.[12]	Rev. cienc. med. Pinar Rio. SciELO	Cuba	Longitudinal, prospective, analytical, quantitative 218 pregnant women Questionnaire	Level 3
Rocha MGF, Vieira JLB, Nascimento ECG, Alchiere JC, 2014.[13]	Rev. bras. ciênc. saúde. LILACS	Brazil	Descriptive, qualitative 25 pregnant women Questionnaire	Level 4
Güleroglu FT, Beser NG, 2014.[14]	J. sex. med. MEDLINE	Peru	Transversal, descriptive, quantitative 2,117 pregnant women Questionnaire and form	Level 4
Esmer AC, Akca A, Akbayir O, Goksedef BPC, Bakir VL, 2013.[15]	J Obstet Gynaecol Res. MEDLINE	Turkey	Transversal, descriptive, quantitative 363 pregnant women Questionnaire	Level 4
Corbacioglu A, Bakir VL, Akbayir O, Goksedef BPC, Akca A, 2012.[16]	J. sex. med MEDLINE	Turkey	Transversal, descriptive, quantitative 130 pregnant women Questionnaire	Level 4
Ribeiro MC, Nakamura UM, Abdo CHN, Torloni MR, Scanavino MT, Mattar R, 2011.[17]	Rev. bras. ginecol. LILACS	Brazil	Transversal, descriptive, quantitative 87 pregnant women Questionnaire	Level 4
Wannakosit S, Phupong V, 2010.[18]	J. sex. med. MEDLINE	Thailand	Randomized, controlled, quantitative 71 pregnant women Questionnaires	Level 2
Camacho KG, Vargens OMC, Progianti JM, 2010.[19]	Rev. enfer. UERJ BDENF	Brazil	Descriptive, qualitative 11 pregnant women Semi structured interview	Level 4
Aslan G, Aslan D, Kızılyar A, Ispahi C, Esen A, 2005.[20]	Int. j. impot res. MEDLINE	Not mentioned	Transversal, prospective cohort, quantitative 40 pregnant women Questionnaires	Level 2
Fok WY, Chan LY, Yuen PM, 2005.[21]	Acta obstet. gynecol. scand MEDLINE	China	Transversal, prospective, quantitative 298 pregnant women Questionnaire	Level 3

The studies aimed to evaluate[14,15,20] or compare[17] sexual function and the factors that affect it; analyze[13], describe[19] or determine[12] sexuality and its influence on pregnancy; investigate[16] sexuality and sexual function; to know [11] sexual activities; evaluate behavior[17] or sexual activities, attitudes, and behaviors during pregnancy.[21]

Regarding the data collection instruments, there was a predominance of the Female Sexual Function Index (FSFI)[14-16,20], besides to a Likert questionnaire[12], Sexuality Questionnaire in Gestation (QSGx)[13,18,21], Sexual Quotient - Female Version (QS-F)[17] and a validated instrument, not specified[11]. Two studies used a qualitative approach; the first one[19] used a theoretical-methodological reference of Symbolic Interactionism and the Grounded Theory and semi-structured interview; the second study[13], although described as qualitative, it used a questionnaire and analyzed the data by descriptive statistics.

The pregnant women included in the two qualitative studies varied from 11[19] to 25[13], while in the quantitative studies, the sample ranged from 40[20] to 2.117[14], with an approximate average of 591 participants. Regarding the type of sampling, eight studies[11-13,15,16,19-21] reported stratification by quarter. Among these, two[10,11] performed proportionally and the other[13-15,19-21] for convenience, which resulted in greater number of participants in the second[14,15,21], third[13,19] and first[20] gestational trimesters. Three studies[15,17,18] selected women with gestational ages restricted to the first[16], second or third[17] trimesters.

Due to the nature of the topic presented, as well as to the methodological design of the included studies, it was observed that the articles analyzed were predominantly classified as Level 4 of scientific evidence.[11,13-17,19]

♦ Category 1 - Sexual practices of pregnant women

Most of the studies did not specify the sexual practices performed during pregnancy.[11,12,14-16,20] Vaginal sex was described in three studies[13,18,21], oral, anal sex and masturbation in one study[21]. In masturbation, there was interruption in performing anal and partially vaginal sex or only performing preliminary sexual practices in the form of caresses.[19]

A reduction in the frequency of sexual practices during gestation was observed.[11-13,15,16,18-21] Although two studies[14,17] did not evaluate this aspect, some studies[11,13,15,20,21] verified variations according to the gestational quarter which occurred progressively[11,13,20] or non-progressive.[12,15,21] Regardless of this classification, the findings indicated that the third trimester was less favorable for performing sexual practices[11,13,15,20] although two studies pointed out the first[21] and second quarters.[12]

There was a reduction in vaginal sex related to the progression of pregnancy[18,21], advanced maternal age, nulliparity, third quarter, culture, inadequate knowledge, and anxiety.[21] In one study, there was an increase in frequency of vaginal sex and greater willingness of the partner to sexual activity in all quarters, and pregnancy was not an impediment to maintaining them.[13]

Among the possible causes associated with the reduction in the frequency of sexual practices, there were: employment[15], discomfort[13,17,19] related to difficulty accepting and lack of relaxation for penetration[17], dispaurenia[13,17,20], pregnancy awareness[16], difficulties of concentration during sexual act and attunement with partner[17], indisposition for sexual act[13], sexual abstention in the first, 13,15,19 seconds[13,19] and with greater amplitude in the third[13,15,19] quarters; related to the corporal changes[13,19] and cultural conceptions of the partner[13]; fear of injuring the fetus[13,21], losing a partner during pregnancy or not sexually pleasing it[13] or causing obstetric complications: abortion[16,18,21], abnormal bleeding, 18 hemorrhage, preterm labor, infection, premature amniorrhexis21 and fetal damage.[16,18, 21]

Psychological violence perpetrated by an intimate partner was observed to maintain sexual relations during pregnancy[21] and some sexual relations were considered unfavorable by the women when the partner showed no respect for the pregnant body and emotional state.[19]

Preliminary sexual activities were cited in four studies.[13,17,19,21] However, only one specified study that they occurred in the form of fantasies and kisses; and three studies by means of caresses.[13,19,21] There was a reduction of kisses[21] and caresses throughout gestation[13,21], and regardless of the type, the preliminaries were considered insufficient to stimulate sexual intercourse.[17]

♦ Category 2 - Sexual positions of pregnant women

Only two studies specified the sexual positions performed during pregnancy.[11,13] In the first study, there was a change from the “man on top” position in the first trimester to “sideways” in the third trimester.[11] In the second study, there was a progressive decrease in the use of positions “face to face”, “man on top”, “lying down”, “sitting”, “no eye contact”, and “woman on top”, associated with increased abdominal compression and intense physical exertion of the lower limbs of women. There was a less significant reduction in the “no eye contact”, “side by side”, “lying”, “face to face”, “woman lying on her back” and “man aside” positions, disuse of some positions and “side by side” position in the third quarter.[13]

The adaptive changes in the sexual positions represented a need in the face of pregnancy changes to obtain greater comfort or resulted from the fear of hurting the baby, lack of experience in the accomplishment of sex during pregnancy, nausea, myths and or anatomical alterations.[13]

♦ Category 3 - Domains of the sexual function of pregnant women

The sexual desire domain was pointed out as more compromised[17] or there was a more

pronounced progressive reduction in the third trimester.[11,13,14,18,20,21] In the pregnant woman's perception, there was a reduction in the partner's sexual desire[21] and an increase in the associated female desire to the fact that the partner is more affectionate during gestation, although the ambivalence of feelings regarding motherhood and the exercise of sexuality has been evidenced.[19]

In the excitation, a more pronounced progressive reduction was identified in the third trimester[13,17,20] and in the first and third trimesters,[12,14,16,18] besides the difficulty for the woman to become involved, to become aroused and to remain concentrated after sexual stimulation.[17]

Regarding orgasm, the frequency was reduced[11,12,16,18,20,21] and intensity[13] gradually and more markedly in the third trimester.[11,13,17,20] Three studies reported reductions in the first and third trimesters with higher evidence in the third,[12,14,18] two studies reported anorgasmia during gestation.[11,12] This domain was negatively affected by the awareness of pregnancy and positively by love in marriage.[16]

Factors that negatively affect desire, arousal and orgasm have been described: relationship time greater than 10 years, arranged marriages; advanced maternal age; increased number of children, domestic work, responsibility, stress; low education level[14] and employment status[15], difficulty in establishing communication[13,15] and obtaining information about sexuality in pregnancy with health professionals,[18] concern about pregnancy impairment,[15] decreased importance given to sex in the first and third quarters,[13] unwanted pregnancies,[12-14] decline in importance attributed to age-related sexuality and increase in physical illness; sexual dysfunction; common gestational complaints (pain in the lower limbs and dorsal region, constipation, difficulty in breathing and cramps); low education level and income; multiparity; lack of information and knowledge about one's own body; progress of gestational age; low self-esteem,[15] quality or absence of marriage, expectations derived from the cultural level; presence of medical complications and subjective aspects;[12] vulnerability to popular, sociocultural and religious influences.[19]

On the other hand, the domains that positively influenced sexual function were information obtained from midwives, close relatives and the internet,[15] effective communication in the relationship,[14] greater capacity for negotiation and adaptation of sexual behavior with the partner,[19] and acceptance of corporal transformations due to satisfaction with pregnancy.[13]

♦ Category 4 - Related aspects to the sexual function of pregnant women

There was a reduction of sexual interest,[13,19] associated with physical or moral violence when pregnancy was not planned or undesired[19] and lack of interest related to the physiological changes of pregnancy, with consequent fear of the partner losing sexual interest.[13] During gestation, sexual initiative occurred in a mutual way,[15] with reduction of the sexual initiative of the woman[21] or of both partners,[13] associated with cultural characteristics, self-esteem and anatomical conditions.[15]

There was a reduction in the sexual disposition of both partners,[13] more progressive vaginal lubrication in the third trimester,[13,14,16,17,20] increased pain,[14] decreased pleasure[11,21] and sexual satisfaction.[12-14,16, 18,20]

DISCUSSION

Despite being a methodological option, the types of sampling adopted and the use of non-specific instruments for gestation contributed to the non-uniformity of the results obtained in the studies. Considering the adaptations in the sexual behavior and peculiarities of each gestational trimester, it is pointed out the need to use specific instruments to evaluate the effects of gestation on sexual practices, positions and function.[22]

It was evidenced that most of the studies did not specify variables aimed at describing the sexual practices and positions, or when they were not explored in detail, as well as for analysis of their influence on sexual function during gestation. Studies have pointed out that during pregnancy, sexual practices and positions are subject to restrictions and adaptations regarding types, frequency, availability and comfort for accomplishment.[5,23]

It is emphasized that throughout the gestation, the option for other sexual practices in detriment of vaginal sex as alternative forms of seeking pleasure and sexual satisfaction can occur.[24] Hugs, intimate touches, massages and licks are also characterized as preliminary practices.[25]

As with changes in sexual practices and positions, the domains of sexual function declined during gestation with greater evidence in the third trimester. A study that specifically investigated sexuality in the third trimester of pregnancy showed a decrease in sexual activity related to several factors

(desire reduction, dyspareunia, physical tiredness, myths, religious beliefs, level of education and information difficulty)[26], although during pregnancy, they may postpone the puerperium.[27]

In the primary studies socio-demographic, economic, cultural, religious, physical, psychological, obstetrical, reproductive and affective-sexual factors exerted specific influence in each domain or in general in the sexual function and related aspects, as well as sexual practices and positions. This finding corroborates with a study[28] that pointed out that several factors influencing female sexual function should be analyzed individually and included as part of prenatal care and reproductive health programs.

Prenatal consultations and sexual orientation groups are opportune moments to clarify doubts, conflicts, taboos, fears, support strategies and educational actions aimed at promoting the healthy and pleasurable exercise of sexuality during gestation.[29]

However, sexuality is still not seen by health professionals as an important aspect of care, and the guidelines are fragmented and restricted to the use of medication, family planning, and newborn care and breastfeeding, disregarding subjective aspects and following a model of transmission of information that puts the woman in a passive position, which requires greater discussions regarding the formative processes in health.[29-30]

CONCLUSION

The results of this study allowed identifying that there is a reduction in the frequency and/or restriction of the performance of practices and varying sexual positions according to the increase of gestational age. Also, changes in all domains and related aspects of sexual function were evidenced, especially in the third trimester. The sexual practices and positions were not evaluated and/or specified by most of the primary studies, evidencing a knowledge gap.

Also, it should be noted that there was no association between sexual practices, positions, and function, which requires studies with this proposal involving pregnant women and their partner in order to better understand sexual function, practices and positions while dimensions of sexuality in pregnancy.

The limitations of this study are related to the generalization of the results, mainly due to the unilateral perception adopted in the primary studies that did not address the partner when analyzing the sexual function, practices and positions in the gestation; as well as to the time cut adopted and the inclusion of different methodological approaches. However, the findings presented contributed to fill in and/or point out gaps on the subject and, therefore, to promote knowledge about the exercise of sexuality during pregnancy, which may help to enable the expansion and/or strengthening of the guidelines offered during prenatal care, in relation to the promotion of sexual health, with a view to reach the integrality and quality of health care.

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Submission: 2017/11/29
Accepted: 2017/11/12
Publishing: 2018/03/01

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