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Concerns of Postnatal Mothers about Sexuality

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CONCERNS OF POSTNATAL MOTHERS ABOUT SEXUALITY

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An Abstract of a Thesis

in Partial Fulfillment of the Requirements

for the Degree Master of Science

in the Field of Nursing

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ABSTRACT

An exploratory study was designed to find out what questions mothers had about postnatal sexuality. A questionnaire was prepared by the nurse researcher to find out answers to the following questions.

1. What specific questions do mothers have about sexual relations following delivery?
2. Do mothers feel free to initiate discussion about resumption of intercourse following delivery?
3. Do mothers like their husbands to be included in the discussion?
4. When do mothers prefer to receive information regarding sexual relationships following delivery?

The questionnaire was mailed to fifty primipara mothers between three and four weeks after delivery. Mothers with pronounced anaemia, heart and lung problems, history of mental breakdown within three years prior to pregnancy, psychiatric consultation during pregnancy, malignancy in reproductive system and those who required two weeks or more hospitalization for complications were considered as high risk mothers and were excluded from the sample. Twenty-four questionnaires were completed and analyzed.

The data revealed that culture, religion and race did not have marked influence either on the type or number of questions mothers had. Age and education appeared to have some influence, the younger and the least and highly educated mothers specifying less questions regarding sexual relations following delivery. All mothers indicated that they had some questions about sexuality.

Most mothers preferred professionals as a source for getting correct and scientific information and indicated they would appreciate physicians and nurses to initiate the discussion. A majority of the mothers were concerned about having their husbands in the discussion mainly to decrease uncertainties between them. Most mothers wish to have the information before they leave the hospital. Almost all mothers had questions related to the possible effects of sexual relations if resumed earlier than four to six weeks and were concerned to know how soon they could resume sexual relations following delivery.

Through the study it was concluded that there is a great need for the mothers to have more information in this area.

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Each person whose signature appears below certifies that she has read this thesis and that in her opinion it is adequate in scope and quality as a thesis for the Degree of Master of Science.

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Sheela A. Gideon

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Chapter 1

INTRODUCTION

The focus of maternity nursing is on the well-being of the mother and her infant within the context of the family. Begetting children is a family affair and nursing care of maternity patients must always be family-centered. The family is often considered the most significant unit in society. The family is an organized system and any event within any part of the system effects the whole. Childbirth is such an event affecting the whole family (Howells, 1972, 127-148; Fitzpatrick et al., 1971, 3, 4).

According to Blisten and Fortes the type of family most common in America today is the nuclear family. Extended families are few and they exist mostly in rural areas and among the very rich (Blisten, 1963; Fortes, 1963).

Conditions which have tended to change and modify the nature of the relationships among families are increase in size of the population, increased opportunities for geographic mobility due to new forms of transportation, changes in economic techniques, and increased division of labor (Blisten, 1963).

In earlier generations the culture which included norms and values which people held was passed from generation to generation (Bernard and Farber, 1964). Under present conditions much less information is obtained from other family members.

During the maternity cycle change may occur in the sexual

practices of the couple. One reason for this is that women often experience changes in sexual desire and performance due to hormonal changes or emotional problems (Caplan, 1959, 48-49). In other cases the physician suggests abstinence during the latter part of the pregnancy and the first six weeks after delivery of the child. This prolonged period of abstinence may impose severe stress on the husband and wife. Studies show that many couples lack basic information in this area and are reticent to discuss this with the physician. There is also evidence that physicians through reticence or neglect fail to discuss this matter fully with patients (Fitzpatrick et al., 1971, 338; Auerback, 1964, 227; Caplan, 1959, 49).

In most cases professional personnel provide excellent physical care, and give instructions on follow-up care of the mother and infant. But studies suggest that there are still postnatal concerns of young mothers for which no satisfactory information is provided. Sexuality in the postnatal period is one area of potential stress for the family with a new baby.

Pregnancy and childbirth can be a stressful experience to many families. The impact of the first child on the parents and their marriage is of concern to all health professionals who deal with the family during this period. In the family, roles must be reassigned, new needs must be met in new ways, and behaviors must change. This period of readjustment has been viewed as a crisis period by several authorities (Caplan, 1959, 45-47; Duval, 1967, 188).

Parents often have a lack of knowledge about this new phase of family development; they may have partial or inaccurate information

which causes them to be anxious and uncertain (Duval, 1967, 186-190). There is evidence to suggest that even limited educational intervention at the appropriate time reduces the stress on the family and allows for the transition to occur more easily. Nurses are in a particularly favorable position to identify educational needs and to use their knowledge and skills in intervention (Auerback, 1968; Hogan, 1968).

Need for the Study

In an attempt to discover from mothers themselves how they felt about the issue of postnatal sexual activity, an informal survey was carried out by the nurse researcher with postnatal mothers. These mothers were interviewed regarding their concerns and their knowledge in three areas: care of the baby, care of self (diet, rest, exercise, etc.), and sexual relationships. Most of the mothers felt confident about self care, and many stated that they had received adequate information about the care of the baby. However, most of the mothers interviewed stated that they were given little or no information about sexual relationships following delivery. They also stated that they were hesitant about asking for professional help and would appreciate having professional people initiate discussion of the subject.

The foregoing agrees with Szasz (1971) whose studies revealed that questions about sexuality are unlikely to arise in conversation unless introduced by professionals. From this it appeared that mothers had unanswered questions about resumption of sexual relationships following delivery. If professionals were aware of the type of questions mothers have, they could plan and implement effective teaching at the

appropriate time. This would enable them to provide better care and to assist the family in this period of readjustment.

Statement of the Problem

The problem was whether or not mothers have a need for more information about the resumption of sexual relationships following delivery. The problem posed the following questions:

1. What specific questions do mothers have about sexual relations following delivery?
2. Do mothers feel free in initiating discussion about resumption of intercourse following delivery?
3. Where do mothers prefer to get answers to their questions?
4. Do mothers like their husbands to be included in the discussion?
5. When do mothers prefer to receive information regarding sexual relationships following delivery?

The study was developed to provide answers to these questions. (See Appendix.)

Assumptions

1. A majority of mothers chosen for the study would be willing to participate in answering the questionnaire with reliable information.

2. The informational needs of mothers about sexual relations following delivery are not affected by the type of delivery.

Research Design

A descriptive survey method was utilized in this study. The tool was a questionnaire which was prepared by the nurse researcher to find out the types of questions and concerns the mother had about resuming

sexual relationships following delivery. A pilot study was conducted on five postnatal mothers by the nurse researcher and the necessary adjustments were made in the tool.

The survey was limited to primipara mothers who delivered at the Loma Linda University Medical Center. Fifty questionnaires were mailed within three to four weeks of delivery to all mothers meeting criteria during the time of data collection. The type of delivery mothers had was not controlled. Unwed mothers, those with history of mental illness, and those who were considered high risk mothers were excluded from the sample.

Limitations

1. The tool was limited to a questionnaire developed by the nurse researcher. It is not standardized or tested for validity.

2. The sample size was small and limited to primipara mothers.

Chapter 2

REVIEW OF THE LITERATURE

The literature was reviewed on (1) human sexuality and the family, (2) sexuality in the maternity cycle, (3) current recommendations about sexual relations in the maternity cycle, (4) the educational preparation of physicians and nurses, and their attitudes toward sexuality, (5) the normal physiology of the postpartal period, and (6) formulating a questionnaire.

Human Sexuality and the Family

Sexual satisfaction is one of the needs of man which has been traditionally met in marriage and the family. The family is based on three pillars. These are sexual, emotional and economic. The sexual code is designed to protect and strengthen all of these aspects. Because of the importance of the family structure in maintaining and preserving values and mores, society has maintained customs and practices which protect marriage and the family as an institution. A reasonably happy successful marriage can be a source of deep personal satisfaction and inspiration to the married couple and their children and can provide a bulwark in a frenzied world with rapidly changing social and moral values, whereas unsuccessful marriage can precipitate a long and complex series of reaction and interaction with a wide range of social, psychological and psychosomatic effects upon the married couple, their children and all of their acquaintances. One

cannot disregard the influence of sex as the great cementing force in the relations between two people as founders and maintainers of the family (Vincent, 1968; Fullerton, 1966; Blisten, 1963).

Sex has long been considered the prerogative of family life and is a strong connecting element in the family. If not used for the development and happiness of the family, problems relating to sex can destroy the family. The members of the nuclear family expect to receive affection and security from within the family group. A good marriage usually requires high moral values, healthy sexuality, warm parent-children and adult interpersonal relationships.

In American society, preoccupation with sex is encouraged by all media of communication such as advertising, movies, television, plays and other entertainment. Literature, magazine articles and illustrations glamorize sex and heighten sex interest. The young and the old read, hear, and see few denials that sex is anything but fun.

Further emphasis to the central importance of sexuality is given by Freud:

> The way life makes love the center of everything, makes everyone look for complete satisfaction in loving and being loved. A psychial attitude of this sort comes naturally enough to all of us. One of the forms in which love manifests itself--sexual love--has given us our most intense experience of an overwhelming sensation of pleasure and has thus furnished us with a pattern for our search for happiness. What is more natural than that we should persist in looking for happiness along the path on which we first encountered it? The weak side of this technique of living is easy to see, otherwise no human being would have thought of abandoning this path to happiness for any other. It is that we are never so defenseless against suffering as when we love, never so helplessly unhappy as when we have lost our loved object or its love (Freud, 29) . . . . that man's discovery that sexual (genital) love afforded him with the prototype of all happiness, must have suggested to him

> that he should continue to seek the satisfaction of happiness in his life along the path of sexual relations and that he should make genital eroticism the central point of his life. . . . in doing so, he made himself dependent in a most dangerous way on a portion of the external world, namely, his chosen love object, and exposed himself to extreme suffering if he should be rejected by that object or should lose it through unfaithfulness or death (Freud, 48).

Some psychopathologists, mental hygienists and physicians of today agree that diseases both mental and physical have their basis in unsound and unavoidable sex complexes. Many agree and admit that sex influences everything we do and this influence may be used measurably to bind as well as to tear down personality and happiness (Blisten, 1963, 274; Barber, 1953, 656; Kagan, 1972, 207; Vincent, 1968, 597).

Rainwater has reported interviewing couples about sexuality and marital relations. Several comments emphasize the importance of this aspect:

> . . . I feel that it is an immense emotional experience, an act of unity, to me it has a deep and holy significance. We are both receiving and giving, it gives you a feeling of being wanted. There is the feeling of closeness and the expression of love for each other.
>
> . . . It's a complete union in which you both get physical and emotional satisfaction.
>
> . . . It's a mutual feeling of love between you and your wife, a manner of conveying love.
>
> . . . Sex is very important to marriage. If a man is denied it regularly, it will cause trouble, disloyalty sometimes (Rainwater, 1965).

In summary Rainwater makes the following statement:

> . . . Sexual behavior in marriage can be viewed as both an expression of and a conditioner of the general character of marital relationship. Again and again, couples speak of sexual relations as the central fact and expression of marriage, as the basis from which grows most of what is

> important about marriage and family. . . . (Rainwater, 1965, 110).

Man seeks to find meaning in himself and in relationships and he looks first and most often to a continuing sexual relation to find an answer (Eisner, 1970).

> Sex is a mere relationship whether sanctified by marriage or not. It functions joyfully in that closest and most intimate of all relationships. It is a transcendental feeling of ecstacy leading to a unity not only of his whole being, physical, emotional and psychic, but also fusion with another human being and the experience of ever expanding levels of consciousness all the way to the universal (Eisner, 1970).

Sexuality in the Maternity Cycle

During part of the maternity cycle abstinence of sexual relations may be practiced either by choice or as suggested by the physician. Many agree that sexual abstinence, though it does not involve risk to life or sanity, is apt to cause minor disturbances of physical well being and on the psychic side much worry and a constantly recurring struggle with erotic obsessions. Marriage is supposed to provide both rewarding and exclusive sex for its partners at a time when the pressure toward sexual variety and experimentation is at a high tide.

In most mammalian species, females do not seek intercourse during pregnancy but in certain primates and human beings, intercourse does occur during this period. According to Booth's observation, female primates do not seek coitus actively but under male pressure in confined conditions, will submit. In the human female, intercourse during pregnancy is common. The human female undergoes a complicated

series of physical, hormonal and psychological changes during pregnancy. The response to these changes is quite variable in different individuals. Pregnancy appears to be a unique event in terms of a woman's sexuality and should be treated as such (Solberg, 1973).

Prochazki, in his study about sexual activity in pregnancy, states that some women continue to have intercourse during pregnancy for fear their husbands would become unfaithful even though a large group had negative feelings and abstained from coitus after the eighth month (Prochazki and Cernock, 1970).

In the past, many physicians have recommended that intercourse should be avoided during the last month of the pregnancy and the first six weeks postpartum. A long continued period of enforced abstinence may be a considerable hardship on the husband and wife, and may even represent a threat to the marriage. Many a male strays from the marital bed for the first time under these circumstances (Siecus, 1967). Lunde's study showed that a certain percentage of men felt driven to extramarital sexual affairs during the period of abstinence (Conn, 1973, 125).

Masters and Johnson discovered, in their interview of men, that the major concern expressed after delivery by all men was how soon active intercourse could be resumed without physical harm and emotional distress to their wives (Masters and Johnson, 1966, chapter 10). Szasz states that sexual partners are often unable to communicate with each other or with the physician or nurse about sexual problems because they fear censure. Consequently, they rely on hearsay and folklore

and often turn to popular books or encyclopedias for information. He also states that the expectant father should have a ready access to his wife's physician to discuss sexual problems so that parents might continue to function as a unit during the child-bearing experience (Szasz, 1971).

Majerowitz and Feldman indicate that the area of sexual adjustment was the leading specific complaint between spouses (Majerowitz and Feldman, 1966). Chester states that wives frequently report that they are confused about what they should do after delivery (Chester, 1971).

Intercourse imposed in violation of obstetrical rules is likely to create a serious psychic trauma for the wife. According to Greenhill et al. fear of conception might contribute to mental illness following delivery. Problems like postpartal blues and the rivalry of the parents with the child might be due to postpartum sexual difficulties (Szasz, 1971, 41).

Reporting on his study about sexual adjustment during pregnancy and postpartum, Fallicov states that there is no change noticed in frequency of coitus in the early postpartum but there does appear to be less incidence of coitus during the first and second trimesters of pregnancy. Postpartal mothers' desire for having coitus appeared to be increased slightly when compared to pregnany women and increased eroticism was seen in more mothers during the early postpartum period. He also states that a great deal of anxiety surrounded the resumption of sexual activities after the birth of the baby. In spite of high levels of sexual desire at least seven women delayed its occurrence for fear

of soreness caused by the episiotomy. Two thirds of the couples resumed intercourse in the early postpartum period and half of them could not achieve previous levels of sexual interaction due to engorgement of breasts and soreness of episiotomy. Tension and fatigue in caring for the infant seemed to interfere with ability to relax during the postpartum period. Some of the reasons put forward by those who did not resume sexual relationships were: had not had medical check-up, tenderness in episiotomy, fatigue, and lack of time or inclination (Fallicov, 1973).

Fallicov also states that affectionate demonstration and suggestions on the part of the husband also seemed to play an important facilitating role, i.e., women whose husbands manifested eagerness tended to resume sexual activity earlier. The time and the level of resumption of postpartum sexual activity seem to be related to present physical condition, and her husband's attitude towards the abstinence. In summary, Fallicov states the pre-pregnancy degree of sexual investment was related to sexual adjustment during pregnancy and the last postpartum period but not during the early postpartum period. He also states that lack of knowledge about normal sexual changes during pregnancy and the postpartum period causes women considerable anxiety about the normality of their reactions. There was diminution of sexual drive during the early months of pregnancy but this was regained by the third trimester (Fallicov, 1973, 997-999).

Solberg states that there is a linear declination of coitus during pregnancy. Many women will respond with generalized decreased

libido but the previous level is regained by the third trimester. Therefore, Fallicov suggests that the strength of the evidence supporting the need for sexual abstinence starting often as early as six weeks prior to the delivery date should be weighted against the fact that for a number of women sexual relations appeared to become more satisfactory during the third trimester. Greater certainty about these issues would contribute toward making the entrance into motherhood a more fulfilling and less anxious period (Fallicov, 1973).

In Solberg's study about sexual behavior in pregnancy, an intensive and detailed personal interview with 260 women in the immediate post-partum period concerning their sexual behavior was conducted.

Findings of the study were that coital frequency was related to the age, i.e., older women tended to less active coital frequency at all times independent of race, religion and education. No correlation between coital frequency and number of pregnancies was observed. The level of interest in sex prior to pregnancy was associated with the amount of sexual activity during pregnancy. Reasons for change in sexual activity during pregnancy: physical comfort - 46 percent; fear of injury to the baby - 27 percent; loss of interest - 23 percent; awkwardness - 17 percent; recommendation of physicians - 8 percent; reasons extraneous to pregnancy - 6 percent; loss of attractiveness on women's point of view - 4 percent; other recommendations apart from physicians - 1 percent; other reasons - 15 percent. However, 29 percent of the populace received abstinence instruction from their physicians (Solberg, 1973, 1101).

Solberg states that the following findings were not supported in his study: (1) there is increased sex drive during second trimester, (2) physical attractiveness increases inclination toward sexual activity, (3) association between parity and sexual interest, (4) a high percentage of population received abstinence instruction from physician (Solberg, 1973).

Solberg strongly augmented the fact that the sexual intercourse plays no role in the initiation of labor and suggested that the clinicians must give correct answers when asked for such information. However, Goodlin, in his study, found that in the women who had frequently experienced orgasms after 32 weeks of gestation subsequently delivered prematurely (1971).

Current Recommendations About Sexual Relationships in Maternity Cycle

Although not all medical and nursing texts discuss sexual relationships following delivery, the majority state that intercourse can be safely resumed four to six weeks after delivery (Fitzpatrick, 1972; Greenhill, 1965; Danforth, 1971; Hellman and Pritchard, 1971).

McLennan states that sexual intercourse should be avoided until the lochial discharge has ceased and the episiotomy scar is no longer tender (McLennan, 1962). Most doctors would probably agree that the six-week period they commonly suggest for refraining from intercourse is somewhat arbitrary and really for their own convenience to see that the birth canal has healed well. If a patient is comfortable in intercourse, it is not dangerous (Rozdilsky and Barnet, 1972).

According to Solberg (1973) sexual activity may continue until

the last month of pregnancy unless complications such as symptoms of threatened abortion arise. If an individual has the history of repeated abortions at a certain period, she should abstain from sexual intercourse during those particular periods of gestation. Boyd approves of resuming sexual relations within four weeks postpartum, and suggests that women use birth control (Boyd, 1973).

According to Harback, the question as to when to resume sexual relationships is only answered at the time of the first postnatal visit which is traditionally about six weeks after parturition. However, Solberg suggested advancing this date for resuming sexual relationships. In his survey, done on 50 mothers, he found that mothers resumed normal sexual relationships between three to four weeks postpartum without any apparent ill effects (Harback, 1963, 333). Twenty-nine percent of Solberg's study (1973) received instruction from physicians to abstain from coitus beginning at times ranging from two to eight weeks before expected date of confinement, but only 8 percent were able to follow the instructions. Masters and Johnson state that the whole question of intercourse during the period following delivery should be considered by the doctor on an individual basis. The situation should be discussed, personal fears explained away and a firm understanding between the husband and the wife established (Masters and Johnson, 1966). On the other hand Eastman and Russel state "under no circumstance is sexual intercourse permissible during the last month of pregnancy. This is one rule which is extremely important and absolute. Prior to last month intercourse is harmless in moderation" (Eastman and Russel, 1970).

The Educational Preparation of Physicians and Nurses and Their Attitudes Toward Sexuality

Schools that provide education for various medical related professions are giving increased attention and are teaching students about man's sexual behavior in all of its many aspects. Physicians and nurses are especially concerned with this aspect of patient care. Sex education should give not only help and insight for the present, but it should equip the recipients for future leadership roles in their professions and their communities (Harback, 1963).

Physicians' education and attitudes. On the basis of the information reported on a survey of American Medical Schools on sex education by Harback, 1963, Vincent conducted a survey during the summer of 1967 to learn how much change had occurred in the field of sex education in medical schools. An intensive one-week conference on human sexuality at the Bowans Gray School of Medicine was attended by representatives from 29 medical schools throughout the United States and Canada. The participants included eight psychiatrists, twelve obstetricians (one was a psychiatrist as well as an obstetrician gynecologist) and ten medical students. Each person attending the conference was interviewed about the current programs and attitudes toward sex education at the medical center he represented. The survey included nearly one-third of the medical schools in North America. The title of the text which reports on this conference is, Human Sexuality in Medical Education and Practice, by Vincent. As a result of the survey, Vincent states that the physician's training in the area of sexuality is so deficient that he is

often poorly prepared to give assistance with such problems. The survey showed that only one school had any required systematic instruction on the subject of marriage and human sexuality; another school was found to offer such a course as an elective, and students were advised to read widely on this subject. Professors seem to have agreed that the residents and interns were not helped much with their own feelings of embarrassment. Consequently, the physician may be more embarrassed than the patient. Deans of most of the medical schools were perceived as giving at least passive support for sex education. Although many administrative officials were preoccupied with more immediately pressing problems such as building expansions, the deans at several schools had been active in planning and initiating these courses. The most common attitude of the faculty appeared to be that sex education is important and should be an integral part of the curriculum but at the same time they thought that someone else should do the integrating. Students at some medical schools were described as "gung ho" and "hopped up" about having more sex education and petitioned the administration to have this done. At other schools the interest of students made faculty members believe that there was great need and demand for these courses. Several professors indicated that they had great difficulty in desensitizing their students so that they would be more comfortable with the subject.

Vincent says there was a strong attitude on the part of those in the survey that medical schools should be responsible for sex education for students. The reasons mentioned for such responsibility are the following: (1) patients expectation about physicians, (2) students

misconceptions and anxieties, (3) medical adaptation and progress, (4) sexual revolutions and the student demand, (5) the doctor's image.

Participants' attitude toward the adequacy of current education of the physicians is that the majority of schools do a poor job, some do fairly well and others do a mediocre job. The reasons put forward are: (1) discomfort of the faculty, since very few have received any training in this area, (2) recent development of interest in sex education throughout society, (3) the need to put first things first, (4) cultural lag, (5) administrative problems and value commitment, (6) professional pride.

According to Vincent, the two practical problems for integrating human sexuality in the medical curriculum are: (1) the organizational structure which is wedded to traditional beliefs and values with minimum of sex education presented in behavioral sciences that is either scattered all through the curriculum or offered as an elective course, (2) it is difficult to find personnel who are sufficiently trained to be comfortable in talking about sex-oriented topics which is traditionally a taboo subject. He further states unless these are met, the change occurs very seldom and it is a challenge to the present medical schools (Vincent, 1968). According to Fullerton the reaction of 98 percent of physicians about publishing a journal on medical aspects of human sexuality is positive as they can get to know more information on clinical aspects of human sexuality. All physicians are convinced despite other differences in opinion that sex related problems are the proper concerns of every physician. Perhaps one reason that many physicians have abdicated their role in providing sexual advice is a

recognition that their knowledge is deficient.

According to Fullerton, physicians rarely offer contraceptive advice voluntarily to premarital couples, postpartum patients, or the grand multipara who exhibits physical and emotional exhaustion, unless a major contraindication to pregnancy is present. Many will give such advice when they are asked for it. Physicians need more knowledge and skills with which to help patients to manage the marital and sexual components of physical and emotional disease. He further questions whether physicians could ignore influence of sex in the relationships of the family (Fullerton, 1973). More and more physicians are being asked to take an active role in programs of sex education sponsored by religion as well as educational institutions (Fullerton, 1973; Schmidt, 1973).

Mead urges that the physician should be clear in his opinions about sexual relations during pregnancy and the postpartum period before counseling patients and that the communication should be kept open. He further states that obstetrics and gynecology men should be able to do a better job of calming and reassuring their patients. If they cannot spend the time needed in reassurance and explanation, they should look for educational aids like television, tapes, filmstrips, or books (Mead, June, 1974).

Goode states that to confirm a sexual related problem requires verbalization by the patient and rarely occurs without the physician's promoting it. Since the patient is always communicating, it is necessary for the obstetrician to tune in and listen with the "third ear"

(observation of nonverbal communication) as a physician cannot limit his observation only to what the patient says or does not say. He must also be aware of the changes in attitudes of body movement, posture, evidence of tension and other signs of nonverbal communication. The best opportunity an obstetrician can have to identify sexual problems is at the first postnatal visit when the patient is informed about resuming sexual activities. This is where the patient can present the sexual problems with various kinds of nonverbal communications to which a physician can learn more by probing into his observations. Once the physician starts exploring, the patient speaks very freely about her attitudes and problems in sex. Thus it is necessary for the obstetrician to observe and interpret nonverbal communication to provide optimal care. He further states that an obstacle which often blocks such learning experiences is that the physician is not comfortable with his own feelings in the area of human sexuality and therefore unconsciously avoids the sexual aspects of the history. It is necessary that these feelings be dealt with before such observations can be useful. The verbalization of sexual and marital problems frequently provide a clue to emotional status which may influence not only interpersonal relations but also somatic conditions. Thus the listening physician who is comfortable with his own sexuality is better able to assist and counsel his patients (Goode, 1973).

According to Harback, the physician accepts some of the myths about sexual behavior when no harm would follow. This is partly because they do not want to raise questions about myths, and partly

because they are very busy with other problems (Harback, 1963, 115).

Dr. Varerie states, "A generation of sexually liberated women want a generation of sexually educated gynecologists." She further states women want physicians who are willing to take time to listen to their emotional problems and treat them with understanding, who are willing to give the highest grade of medical care, and who are willing to give pertinent, objective sexual information without moralization.

Nurses preparation and attitude toward sexuality. A few well-known nursing texts (Fitzpatrick et al., 1972; Clausen, 1973; Wiedenback, 1967; Ziegal, 1972; DeLees, 1973) were reviewed to see how much education nurses receive in the area of sexuality and how the topic is presented in the curriculum of both baccalaureate and master programs. Extremely little related to sex was found in these books. However, some authors do think that education related to sexuality should be included in the curriculum in order to improve patient care.

Fonseca urges nursing schools to see if they are preparing their students adequately to deal with sex-related problems of patients (Fonseca, 1970). According to Fitzpatrick et al., patients are reluctant to discuss sex-related matters especially in a new situation. Some doctors and nurses avoid exploring any problems and therefore counseling is done only on the subject of prohibition of sexual relations (Fitzpatrick et al., 1972, 159). Mothers would like to discuss the problem but only when the nurse takes an interest in them and recognizes that such problems do exist (Mariner, 1971; Lytle, 1967).

According to Szasz, some doctors and nurses believe that

interest in sex is shameful, therefore they are afraid about their colleagues and patients' reactions if they indicate interest. She further states that some supervisors and nursing educators feel that sex-oriented assessment of the patient has little or no place in patient care (Szasz, 1971). Patients have a constant need for guidance and support in continuing to use resources which are available and in obtaining scientific information. Therefore doctors and nurses should recognize the teachable moments for sex-oriented subjects and develop not only the ability to hear questions on sexual relations but courage and skills in interviewing (Szasz, 1971; Smith, 1963).

According to Elder, nurses fail to assume the responsibility for discussing sex-related topics mainly for the following reasons:

> Education majors and graduate nursing students who eventually may teach sex education to the public have inadequate knowledge of the physiology of sex.
>
> Nurses and doctors feel insecure about their sexuality and to cope with their insecurity they either avoid counseling situations or counsel with decreased sensitivity, objectivity and empathy to patients' needs (Elder, 1970).

Clausen and Weidenbach suggest that maternity nursing should be family-centered with depth in practice and breadth in education. Fitzpatrick et al. state that in order to become a good counselor the nurse should possess a sound knowledge of physiological and psychological aspects involved and she should be able to ascertain from the physician the mother's restrictions and limitations in sexual relations following delivery. The nurse should possess extremely good communication skills in listening and gentle probing, especially when topics related to sex are discussed (Fitzpatrick et al., 1972).

Physiology of the Puerperium

When the literature was reviewed about physicians' recommendations for resuming sexual relations, it was found that a majority recommend sexual intercourse to begin four to six weeks following delivery. In most normal women the reproductive organs take about the same length of time to resume the prepregnant state. In order to determine the time required for normal healing of the endometrium which would permit resumption of sexual relations the physiology of the puerperium was reviewed.

Soon after termination of the third state of labor the uterus is well contracted and firm in consistency and about 12 cm. above the symphysis pubis, weighing about 1000 gms. The posterior and anterior walls of the uterus are in close contact and about 4 to 5 cm. in thickness. For two days the uterus does not change either in size or consistency. Later it involutes very rapidly so that by the end of the first week it weighs only 500 gms., and by the end of two weeks, 375 gms., and by the end of the postpartum period only 60 gms. Involution usually occurs by diminution of size of the cells from 240 to24 microns but not by decrease in number of cells. Except at the placental site rapid regeneration takes place within a week to ten days and the entire endometrium is restored by three weeks. By the tenth day the uterus goes back into the true pelvis, hence it is no longer palpable above the symphysis pubis (Greenhill et al., 1965; Eastman and Hellman, 1971; Fitzpatrick et al., 1972; Danforth, 1972). Greenhill further describes the position of the uterus immediately after delivery, "Due to its

previous displacement, its ligaments and vaginal attachment are so loose that it may be moved up to any part of the abdomen or it may be pushed down so that the cervix hangs out of the vulva" (Greenhill et al., 1965, 467).

According to Eastman and Hellman's stateements about histological studies done on 626 postpartal uteri by Sherman, the earliest evidence of ovulation was on the 44th day. Some variations were seen when mothers were nursing their infants. However, regeneration of the endometrium was seen as early as the sixteenth day in many cases. The ligaments that support the uterus during pregnancy took some time to regain their former state.

Changes in the placental site. Normally the separation of the placenta and its membranes takes place from the spongy layer of the decidua. To begin with, the placental site appears irregular, nodular, with many sinusoides, and has a jagged appearance. The size of the placental site soon after delivery is about that of the palm of the hand. It shrinks to 3 to 4 centimeters at the end of the second week and 1 to 2 centimeters, and at the end of the puerperium fibrous tissue is seen at the site (Hellman and Pritchard, 1971; Danforth, 1971; Greenhill et al., 1965; Eastman and Hellman, 1966).

The involution of the placental site

> is not effected by absorption in situ but by a process of exfoliation brought about by the undermining of the placental site by the growth of endometrial tissue. This is effected in part by extension and overgrowth of endometrium from the margins of the placental site and partly by the development of endometrial tissue from glands and stroma left in the depths of the decidua basalis after separation of the placenta (Greenhill et al., 1965, 469).

Changes in the cervix and vagina. Soon after the completion of the third stage, the lower segments of the uterus and the cervix collapse and appear so flabby that it is hard to distinguish their boundaries. The external os may have marked depressions due to lacerations and is large enough to admit two fingers. But by the end of one week the os becomes so narrow it is hard to introduce one finger. The lacerations are healed by the formation of new tissue in variable extent by the end of the postpartum period. The depressions are believed to be due to healing of lacerations and these with the widening of the os give the impression of a parous cervix. The vaginal wall appears smooth soon after delivery and takes some time to recover from the distention occurring during labor. The rugae begin to reappear by the third week but the myriform coruncles at the site of healed lacerations rarely return to the prepartum state (Eastman and Hellman, 1966; Greenhill et al., 1965; Hellman and Pritchard, 1971; Danforth, 1971).

Formulating the Questionnaire

Since this study was on sexuality and this is often a sensitive area, it was thought that administering a questionnaire would be the best way to get reliable information. Goldman suggests that if a client-centered questionnaire is prepared, participants may be better motivated as they see a relationship between the questions and their goals. They would therefore respond with less defensiveness to follow-up or further questions (Goldman, 1961, 39).

According to Wood and others the quality of a questionnaire can

be judged by its objectivity, specificity, reliability, fairness, speed and ease of scoring, clarity of interpretation and client acceptance (Wood, 1961, 26; Chauncey, 1963, 55; Miller, 1961, 71; and Gronhund, 1966, 140).

Some of the advantages stated by Selltiz in considering the questionnaire in comparison to an interview are, (1) questionnaires are a less expensive procedure than interviews, (2) much less skill is required to administer a questionnaire, (3) the questionnaire can be mailed or handed to the respondent with minimum explanation, (4) it can be administered to a larger group at the same time, (5) a wider area can be covered and thus more information obtained, and (6) there is more uniformity when results are being analyzed. They also state that respondents develop more confidence and feel less pressured in answering at their own convenience. In developing the questionnaire, Selltiz suggests that the following factors also be considered, (1) psychological sequence, (2) the importance of question content, and (3) using the best wording to convey the intended meaning. The questionnaire must not cause the respondent to feel resistive or evasive and must use language easily understood (Selltiz et al., 1967).

The disadvantages mentioned by Selltiz are that the questionnaire cannot be reformulated easily once it is completed and it is not possible to explore areas in the questionnaire which may be misunderstood or the meaning is obscure. However, in the questionnaire developed for this study an effort has been made to use simple language and client-centered approach.

Summary

On review of the literature it was found that sexual relations strengthens family ties and is important for the couples to lead a happy and healthy life. Therefore, it is necessary for doctors and nurses to be prepared adequately to deal with problems associated with sex. They should develop more meaningful relationships with mothers and develop insight into the needs of the mothers in the area of sexuality following delivery. Professionals should encourage the discussion of sexual problems as it is difficult for the patients to initiate the discussions.

Continuance of sexual activity in pregnancy is common and most women whose desire for sexual activity is impaired during pregnancy will regain it by the end of the third trimester. Most women resume sexual relations within three weeks after delivery or as recommended by physicians. No evidence of any danger is seen in persons who are sexually active throughout normal pregnancy. Informed mothers will have less fears and more healthy attitudes toward sexuality. Individuals should be able to get knowledgeable answers to their questions regarding sexual activity. Despite physician's instructions about abstinence during the six-week postpartal period many mothers resume sexual activity earlier without any discomfort or apparent trauma. While the physiology of the puerperium appears to be important in determining the resumption of sexuality following delivery in different individuals, little was found to document this supposition.

Chapter 3

METHODOLOGY

The purpose of the study was to ascertain the type of questions mothers have regarding resumption of sexual activity following the delivery of the first child and the conditions under which they would like to receive information.

A review of literature was conducted in the following areas: (1) human sexuality, (2) sexuality in the maternity cycle, (3) current recommendations about sexual relations in maternity cycle, (4) the educational preparations of physicians and nurses and their attitude toward sexuality, (5) the normal physiology of the postpartal period and (6) formulating the questionnaire.

Method of Research

The descriptive survey was the method employed in this study. According to Mayer and Heidgerkan (1962), the survey approach represents a means to discovery. The researcher explores and observes things as they ordinarily happen but he never attempts to make an extraordinary change with his own devices. Further, they define survey as a planned sequence of discoveries. The researcher controls his discoveries by deliberately selecting only those situations that relate to the conditions of his tool. The survey is planned so that it will conform as nearly as possible to the study design. According to Treece and Treece, "Surveys are used to obtain demographic data, information about people's

behavior, and indications about their intentions, future behavior, beliefs, attitudes, opinions and interests. Surveys are frequently conducted by mail, telephone or interview" (Treece and Treece, 1973, 163).

The questionnaire method was chosen in order that the mothers might be able to express their feelings and attitudes freely without any pressure. Selltiz states that the observational method is not effective in getting information about personal perceptions, beliefs, feelings, motivations, anticipations or future plans and is completely ineffective in obtaining information about past behavior or private behaviors such as sexual activity or dreaming. It is also unfeasible or impossible to obtain such information by interview. Therefore the questionnaire and the projective methods have been devised. The response is more reliable as the respondent is sure he or she will not be identified as in an interview. In answering a questionnaire respondents may also feel less pressure because ample time is allowed for filling out the questionnaire. In answering a questionnaire, the respondent can consider each point carefully rather than replying with the first thought that comes to mind as often happens in an interview (Selltiz, 1967).

Selection of the Study Sample

Fifty questionnaires were sent to primipara mothers within three to four weeks following delivery. These mothers were delivered at Loma Linda University Medical Center during the months of March and April, 1974. The records were checked and those who did not reach certain

criteria were not included in the sample. Mothers were requested to participate in the study by the nurse researcher through a letter that accompanied the questionnaire. (See Appendix.) In this study a primipara was defined as any woman who had given birth to her first infant after at least twenty-eight weeks of gestation.

Criteria for Exclusion from the Study

(a) Mothers with a history of mental illness within three years before this pregnancy and those who had had psychiatric consultation during the pregnancy were eliminated from the study. The change of role from wife to mother can cause disturbed mental equilibrium (Cooper, 1969, 721; Salk, 1970; Schwartz, 1969; Ward, 1972).

(b) High risk mothers were excluded from the sample. In this study mothers with any of the following conditions during this pregnancy were considered as high risk: (1) malignancy in the reproductive system, (2) pronounced anemia, a P.C.V. level below 32 per 100 ml., (3) acute and chronic cardiac and lung conditions and (4) any other postpartum condition that required more than two weeks hospitalization. Mothers with these conditions might have received specific information about resuming sexual relations following delivery which could have affected their answers to the questionnaire.

(c) Unwed mothers and those who were divorced, separated or widowed were excluded. The emotional reaction to the questionnaire might have had an effect on the objectivity and reliability of the information.

Setting of the Study

Collection of data occurred approximately one month postpartum by means of a questionnaire sent to the patient's home. Mothers giving birth at Loma Linda University Medical Center were chosen as the sample for the study. This hospital has an average of 60 to 80 deliveries per month. Therefore it was assumed that the number of primipara mothers would be sufficient for collecting data. Collecting the data from those delivered at the county hospital of San Bernardino and Riverside was also considered in case the sample was not sufficient at the Medical Center. However, fifty mothers meeting criteria were readily found. Permission for conducting the study was obtained from the University Human Experimentation Committee and from the Chairman of the Department of Obstetrics.

Pilot Study

The questionnaire was administered to five mothers to evaluate the time required to complete it and to determine whether it was clear or needed revision. Mothers were assured they would not be identified in any way and that the study was being done in order to plan better health care.

The Study

After the necessary revisions were made the questionnaire with a prepaid return envelope was mailed to the fifty mothers selected for the sample. A covering letter accompanied the questionnaire. (See Appendix.)

Analysis

The variables for analysis were age, socioeocnomic factors and education. (See Appendix.)

The central question was whether mothers had questions about sexual matters following delivery of the first child. The data were also analyzed to see from whom the mothers preferred to get information, what information they wanted and under what circumstances and when they preferred to receive it. The descriptive rather than the statistical method was used in analyzing the findings. Percentages were used to present the findings.

Chapter 4

DESCRIPTION AND ANALYSIS OF DATA

Fifty questionnaires were sent to postpartum mothers four weeks following delivery. Seven questionnaires were returned saying that the mothers were no longer living at the given address. The total number of mothers responding to the questionnaire was twenty-four. In most cases the responses to each question were considered separately by the nurse researcher when the data were analyzed. In the tables "not indicated" refers to mothers who did not check any item under that particular section.

The statements of mothers having questions about postnatal sexuality in relation to the given variables was analyzed. Whether or not the variable has any correlation with the mother's questions was considered a central and important aspect of the questionnaire. Fifty-nine percent of those in the 20 to 30 group indicated that they had questions whereas only 17 percent indicated they did not have any. Table 1 can be referred to to get the information.

Only four out of twenty-four mothers had questions about the effectiveness of breast feeding as a method of protection from becoming pregnant. Thirteen out of twenty-four were concerned about how soon they could resume sexual relations following delivery. Most of the respondents who did not have any questions about breast feeding as a contraceptive measure also stated that they did not have any questions related to sex following delivery. These responses were to questions

Table 1

RESPONDENTS HAVING QUESTIONS ABOUT POSTPARTAL SEXUALITY
IN RELATION TO VARIABLES
Total Number Responding--24

	YES		NO	
	#	%	#	%
Having Questions on Sexuality	15	63	9	38
AGE				
Less than 20 years	1	4	5	21
20-25 years	9	38	4	17
25-30 years	5	21	-	-
RACE OR ETHNIC GROUP				
White	12	50	6	25
Mexican	2	8	3	13
Oriental	1	4	-	-
RELIGION				
Catholic	2	8	3	13
Protestant	10	42	4	17
Jewish	-	-	-	-
Other	1	4	1	4
Not Indicated	2	8	-	-
SOCIOECONOMIC GROUP				
Below $500/month or Low Income	4	17	2	8
$500-$1500/month or Middle Income	9	38	7	29
Above $1500/month or High Income	-	-	-	-
Not Indicated	2	8	-	-
EDUCATION				
High School or less	2	8	4	17
Jr. College, Vocational, or Technical	8	33	1	4
College or Professional	5	22	4	17

#2 and #3.

The percentage of mothers having questions about the results of early resumption of sexual relations was analyzed and tabulated. Most of the respondents indicated that they need more information about all aspects of the question. Only one indicated that she did not have any, while all the others wanted to know more about one or the other aspects. In connection with this question it is interesting to note some of the comments from the mothers. Table 2 gives a compilation of responses to question #4.

> "I resent so little information on this subject given before or ofter delivery. Doctors seem so obsessed with birth control. (It was all they asked and worried about after delivery.) They aren't concerned with comfort and knowledge about sex. It was hard to know what to ask because with the first child everything was new. So information should be given as if everyone didn't know the questions. Question #4 was very good. I wish I'd been told. Also hope you do something productive with compiling this questionnaire. Point out results to hospital personnel."

> "I find these questions kind of useless to me now. I had intercourse two weeks after my delivery and felt no discomfort. I was told to wait six weeks but I was not told why."

> "I found that there are many things doctors do not tell you. Therefore during pregnancy I did a great deal of reading on my own questions. That is one reason I answered 'no' to many of your questions. I do think however you have an excellent idea and sex should be discussed."

> "I would like to know about sexual relations with my husband right after delivery because my husband started having sexual relations four weeks after delivery."

The respondents' preference for the source of information was also tabulated. Seven out of seventeen mothers who checked that they preferred a physician also checked that they preferred a nurse to be the source of information. Two of those who preferred books also indicated

Table 2

RESPONDENTS QUESTIONS ON EFFECTS OF EARLY
RESUMPTION OF SEXUAL RELATIONS
Total Number Responding--24

	YES		NO	
	#	%	#	%
Pain and Discomfort	12	50	12	50
Pregnancy	15	64	9	36
Variation in Involution Period	15	64	9	36
Trauma to Reproductory Organs	15	64	9	36
Infection of Reproductive Organs	17	71	7	29

either a nurse or a physician as a preferred source of information. Table 3 depicts response to question #5.

According to respondents statement about their choice of the best source of information a majority stated the reason they chose their particular source was that they believed they would receive correct or scientific information. Most of them also indicated they were comfortable with the source of information. One mother who mentioned ease of getting information as the reason for her choice also checked being comfortable with the source and believing she would receive scientific information. One respondent who stated that a less expensive way of getting information was desirable also indicated that obtaining correct information was another reason for her choice. She chose the nurse as the best source of information. The percentages of their choices to question #6 are found in Table 4.

The time preferred by the mothers for getting information was analyzed separately. Seventy-five percent of mothers preferred to receive such information either during hospitalization for delivery or along with discharge instructions. Fifty-four percent stated that some time during the pregnancy was the ideal time. Only three respondents checked that the first postpartum visit would be the most helfpul time for such information but they also checked either during pregnancy or any of the times given in the questionnaire as suitable for getting information. Table 5 shows the responses to question #7.

According to responses in relation to question #8, twenty-two of the twenty-four mothers felt that professionals should talk more

Table 3

RESPONDENTS PREFERENCE FOR SOURCE
OF INFORMATION
Total Number Responding--24

	YES		NO	
	#	%	#	%
Relative	-	-	-	-
Friend	1	4	23	96
Physician	17	73	7	27
Nurse	10	42	14	58
Social Worker	-	-	-	-
Books	4	17	20	83

Table 4

RESPONDENTS REASONS FOR CHOICE OF SOURCE
OF INFORMATION
Total Number Responding--24

	YES		NO	
	#	%	#	%
Correct Information	20	83	4	17
Feel Comfortable	10	42	14	58
Scientific Information	7	29	17	71
Easy Source	1	4	23	96
Less Expensive	1	4	23	96

Table 5

MOST HELPTUL TIME TO RECEIVE
INFORMATION
Total Number Responding--24

	YES		NO	
	#	%	#	%
During Pregnancy	13	54	11	46
During Hospitalization for Delivery	6	25	18	75
With Discharge Instructions	12	50	12	50
At the Time of First Postnatal Visit	3	13	21	87

about sexual relations following delivery. In relation to question #9, ten out of fifteen mothers who had questions related to sexuality stated that they did not feel free to ask questions. Eight of nine mothers who did not have questions about postpartal sexuality stated that they felt free to ask questions related to sex.

Data about question #10 revealed that twenty-two mothers out of twenty-four wished to have their husbands present during discussions. One mother was not decided about this issue. Responses to question #11 indicated that twenty-two mothers thought that having their husbands present might help decrease the uncertainties which might arise between them later. One mother was uncertain about this. One respondent did not indicate on the questionnaire that she wanted her husband present in answer to question #10, yet she stated she would like to have him attend to receive scientific information as a response to question #14. None of the respondents to questions #12 and #13 stated that it was part of their culture for husbands to refrain from such a discussion. They did not expect to encounter any difficulty in the explanation. Other comments put forward by the respondents under question #15 included four about breast feeding. One thought she had developed a breast abscess because of her ignorance about a satisfactory technique for breast feeding.

Chapter 5

DISCUSSION AND INTERPRETATION, CONCLUSIONS AND RECOMMENDATIONS

According to data received, it appears that questions relating to sexuality following delivery are common to all. They do not appear to vary according to any particular culture, religion or socioeconomic condition. But two extremes, the least and most highly educated, do seem to have less questions. It may be the fact that either they are ignorant or well versed. The people who indicated books as the best source of information belonged to the group with college or professional education. This probably explains why these mothers could get information by reading books. Of the respondents who did not have any questions related to postnatal sexuality, more than half were under 20 years of age and the others were all in the 20-25 range. It may be that this younger generation does not know what to ask or fears censure, or are not willing to show their ignorance as they think that they are sexually knowledgeable because they get some aspects of sexual education in school. Nearly half of these mothers indicated that their educational level was high school or less, which may add to their lack of knowledge about sexuality. Although 27 percent of the total group of mothers indicated that they did not have any questions related to sexuality, their responses and statements in the questionnaire show that they did have some questions about resuming sexuality following delivery. This would seem to suggest that all mothers needed some information on sexual relations

following delivery.

Only one respondent stated that her husband's presence was not desired during the discussion and she did not indicate any reason for this choice. One mother who stated that her husband would receive scientific information by being present at the discussion was still undecided about the desirability of his presence.

Of the mothers who had concerns about the results of early resumption of sexual relations following delivery, only one indicated that she was able to obtain information from reading matter. This mother had a college education and she probably represents a group who more readily rely on this method of acquiring information. This would seem to suggest that all mothers would benefit from a discussion of this area but those mothers with less education might be of particular concern.

Results of the questionnaire also showed a clear preference for receiving information from doctors and nurses as contrasted to friends or relatives. Since all respondents indicated a desire for accurate information it is quite likely that they perceive professionals as the best source. Some responses gave reasons why physicians were not approached for information. These were mainly in the areas of perceiving the physician as too busy and uneasiness on the part of the mother in approaching the subject. The following statements indicate their feelings:

> "These are good, pertinent questions and I wish I could have had more of the answers before my baby was born. Somehow I did not feel real free to talk with my doctor and would have appreciated his discussing them with me."

"I don't ask enough questions of the doctor or nurse because I feel they know what's going on and if they don't tell me anything everything is O.K. Yet there are still things I would like to know, but I am afraid to ask because it might sound dumb."

From the foregoing statements it seems clear that nurses working with expectant and postpartum mothers should have the information needed and feel at ease in discussing sexual matters with them. In addition, it would seem to be profitable for the nurse to initiate the discussion rather than waiting for specific questions from the patient.

Of particular interest to the researcher was the fact that none of the mothers stated that their cultural background would make it undesirable for their husbands to be present when sexual matters were being discussed. From the literature reviewed it was expected that this might be the case in the Mexican American culture. Willingness for husbands to be present may reflect the fact that many Mexican American families do not hold on to the old traditions and practices.

In general nurses have opportunity to spend more time with mothers than physicians do. Therefore, for the following reasons, it would be feasible for nurses to take a more active role in counseling patients:

1. The professional nurse has preparation and skill in counseling patients.
2. Since most nurses are female, mothers might be more free to discuss this area with them.
3. She has many opportunities to use teachable moments while mothers are waiting to see the physicians or while performing other nursing functions.
4. She has more opportunities to get involved with the patient and her family.

Conclusions

After careful analysis of the data, the researcher has come to the following conclusions:

1. Most of the mothers, whether they answered the central question in the affirmative or not, had questions related to sexual relations following the delivery of their first child.

2. A large majority were concerned about knowing how soon they could resume sexual relations.

3. All mothers had questions about possible effects of early resumption of sexual relations.

4. Most mothers preferred a physician or a nurse as the best source of correct and scientific information and indicated they would feel comfortable in participating in the discussion if the professional person initiated the discussion.

5. A majority of mothers felt the need to have the information before leaving the hospital.

6. Mothers indicated a preference for professionals to initiate discussion of sexuality.

7. In most cases mothers would like to include their husbands in the discussion so that uncertainties between themselves would be decreased and so that they would have accurate information.

8. The variables of race, religion, socioeconomic status, and ethnic group did not seem to have a marked influence on the outcome of the study. But education and age appeared to have influenced the number of questions about sexuality which the mother had.

Recommendations

A larger sample might be taken to study further the effects of the different variables. The sample could be restricted to one ethnic group to determine more clearly the possible effects of cultural aspects. Since this sample contains only primiparas, a similar

study of multiparous women would show if this group has the same need for information regarding sexuality in the period following delivery. Since all mothers indicated that they have unanswered questions about sexual relations following delivery, nurses should take a more active role in patient teaching in this area.

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APPENDIX

10713 Curtis Street
Loma Linda, CA 92354

Dear Mrs.

I am a graduate student in nursing at Loma Linda University. I am majoring in the field of Mother and Child Nursing and trying to find out what concerns mothers have about sexual relationships following delivery.

By such a study, I hope to help mothers use professional service more effectively. It would also help those giving care to identify where more information needs to be given in the area of sexuality.

I would very much appreciate your cooperation in answering the enclosed questionnaire which is a part of my graduate study. All information will be kept strictly confidential. It should take only a few minutes of your time to answer the questionnaire. Please return it in the self-addressed envelope which is enclosed.

Thank you for your help.

Yours sincerely,

Sheila A. Gideon
Graduate Student

SAG:hm
Enclosures

QUESTIONNAIRE

This is designed to find out the type of questions mothers might have about sexual relationships following delivery. Please return the completed forms in the enclosed envelope as soon as possible. I am hoping for a 100% return. By answering the questionnaire you will be providing me with the means of giving future mothers at our hospital more complete care. Thank you for your willingness to be a part of this study.

Directions:

The following statements are either preceded by a blank or "Y" for Yes, "N" for No and "U" for Undecided. Please check or circle the response which best reflects your own opinions, not as you think others might feel. You need not sign your name.

Age: ___below 20 years, ___20-25 yrs., ___25-30 yrs., ___30-35 years., ___above 35 yrs.

Race: ___White, ___Negro, ___American Indian, ___Mexican, ___Oriental.

Religion: ___Catholic, ___Protestant, ___Jewish, ___Other.

Family Income: ___below $500/month, ___$500-$1500/mo., ___above $1500/mo.

Education: ___High school or less, ___Junior College or Vocational or technical, ___College or professional.

Y N U 1. I have questions relating to sex following delivery.

Y N U 2. I have a question about the effectiveness of breast feeding as a method of protection from becoming pregnant.

Y N U 3. I have a question about how soon sexual intercourse may be resumed following delivery.

4. If sexual relationships are resumed sooner than 4-6 weeks following delivery, I have a question about whether this will result in:

Y N U a. Pain and discomfort

Y N U b. Pregnancy.

Y N U c. Difference in time for the reproductive organs to return to normal.

Y N U d. Harm to the reproductive organs.

Y N U e. Infection of birth canal or reproductive organs.

5. I would prefer to get information regarding sexual relationships following delivery from:

_____ a. Relative

_____ b. Friend

_____ c. Physician

_____ d. Nurse

_____ e. Social Worker

_____ f. Books

6. The reasons for choosing the best source of information is: (more than one item may be checked)

_____ a. To get correct information.

_____ b. Because I feel more comfortable with this means of getting information.

_____ c. To get scientific information.

_____ d. Because it is easy to get information.

_____ e. Because it is a less expensive way of getting information.

7. It would be most helpful to get answers to any questions:

_____ a. During pregnancy.

_____ b. During the time of hospitalization for delivery.

_____ c. With hospital discharge instructions.

_____ d. At the time of the first visit to the doctor after delivery.

Y N U 8. Doctors, nurses and social workers should talk more about sexual relationships following delivery.

Y N U 9. I feel free to ask professionals any questions regarding sex following delivery.

Y N U 10. I would like to have my husband present when information about sexual relationships is given.

Y N U 11. My husband's presence during the discussion may help to decrease the uncertainties which may arise between us about when to resume sexual relationships.

Y N U 12. My husband needs to be present as I would find it difficult to explain what has been discussed with me.

Y N U 13. My husband should not be included as it is not acceptable in our culture.

Y N U 14. My husband should be included in the discussion as he would like to have the information explained in a scientific manner.

15. Additional questions and comments.

Thank you for completing the questionnaire.

LOMA LINDA UNIVERSITY

Graduate School

CONCERNS OF POSTNATAL MOTHERS ABOUT SEXUALITY

by

Sheela A. Gideon

An Abstract of a Thesis

in Partial Fulfillment of the Requirements

for the Degree Master of Science

in the Field of Nursing

September 1974

ABSTRACT

An exploratory study was designed to find out what questions mothers had about postnatal sexuality. A questionnaire was prepared by the nurse researcher to find out answers to the following questions.

1. What specific questions do mothers have about sexual relations following delivery?
2. Do mothers feel free to initiate discussion about resumption of intercourse following delivery?
3. Do mothers like their husbands to be included in the discussion?
4. When do mothers prefer to receive information regarding sexual relationships following delivery?

The questionnaire was mailed to fifty primipara mothers between three and four weeks after delivery. Mothers with pronounced anaemia, heart and lung problems, history of mental breakdown within three years prior to pregnancy, psychiatric consultation during pregnancy, malignancy in reproductive system and those who required two weeks or more hospitalization for complications were considered as high risk mothers and were excluded from the sample. Twenty-four questionnaires were completed and analyzed.

The data revealed that culture, religion and race did not have marked influence either on the type or number of questions mothers had. Age and education appeared to have some influence, the younger and the least and highly educated mothers specifying less questions regarding sexual relations following delivery. All mothers indicated that they had some questions about sexuality.

Most mothers preferred professionals as a source for getting correct and scientific information and indicated they would appreciate physicians and nurses to initiate the discussion. A majority of the mothers were concerned about having their husbands in the discussion mainly to decrease uncertainties between them. Most mothers wish to have the information before they leave the hospital. Almost all mothers had questions related to the possible effects of sexual relations if resumed earlier than four to six weeks and were concerned to know how soon they could resume sexual relations following delivery.

Through the study it was concluded that there is a great need for the mothers to have more information in this area.