Sexual Activity during Pregnancy in Taiwan: A Qualitative Study

Hsin-Li Liu, RN, MSN,* Pohan Hsu, sophomore, † and Kuang-Ho Chen, PhD‡

*Nursing Department, College of Nursing, Central Taiwan University of Science and Technology, Taichung, Taiwan; †The First National Taichung Senior High School, Taichung, Taiwan; ‡Central Taiwan University of Science and Technology, Taichung, Taiwan

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ABSTRACT

Background. Pregnancy is a special period in a woman’s life that involves physical and mental changes. These changes are influenced by cultural, social, religious, and emotional factors among others.

Aim. The aims of this article were to gather information, to describe the changes and behavior of sexual experiences in pregnancy, and to identify the reasons why pregnant women from central Taiwan decrease coital frequency during pregnancy.

Methods. This phenomenological qualitative research was intended to respond to open-ended questions that allowed the respondents to elaborate on the individuals’ experiences. We collected data from in-depth, tape-recorded, and semi-structured interviews conducted in a cross-sectional study of 62 healthy pregnant women. The investigation ended when three consecutive interviewed subjects could not offer any new activities, which indicated that the study had reached its saturation point.

Main Outcome Measures. We performed data collection and content analysis to ensure standards of rigor and reliability. Credibility was enhanced by prolonged engagement, triangulation, referential adequacy, member checking, and expert review; we categorized meaningful unit-codes in a mutually exclusive and exhaustive manner into perceptions, experiences, and practices such that common themes were grouped into categories.

Results. Three themes emerged: negative aspects of sexual experiences; stress and emotional responses; and changes in sexual practices. The majority of the women stopped engaging in coital activities during pregnancy. We determined that in most cases, the 62 participants obtained information regarding sexual activity during pregnancy from postpartum women and the Internet.

Conclusions. The current evidence-based findings encourage the provision of sexuality education to newlyweds and the discussion of sex-related issues during pregnancy. We propose developing strategies for increasing sexual knowledge and focusing on emotional support to decrease pregnant women’s anxiety regarding sexuality in Taiwan.

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minimally during the first and second trimesters of pregnancy [1–3]. Over the years, several studies have attempted to explore sexual activities during pregnancy by concentrating on measurable sexual function and frequency [1,3–19]. For many people, a reduction in the frequency of sexual intercourse, desire, and satisfaction occurs during the third trimester compared with the period before pregnancy [4–8,20–22]. Numerous physical and psychological factors may cause this decrease in sexual activity [10,23]. Concerning physical changes, hormonal changes can increase levels of estrogen, progesterone, and prolactin, which are considered to be responsible for nausea and vomiting, breast tenderness, and weight gain; breast tenderness, in addition to fatigue and anxiety, may contribute to general malaise and difficulty in becoming aroused [1,24]. Because sexual desire and arousal influence sexual satisfaction and intercourse frequency, it is understandable that sexual activities tend to decrease during pregnancy [1,25]. Moreover, the duration of intercourse and the ability to experience orgasm decrease during the later phases of pregnancy compared with prepregnancy, and dyspareunia increases significantly throughout pregnancy [2]. However, many sexually active pregnant women and their partners are concerned that sexual intercourse will result in pregnancy complications [4–6].

The Chinese medicine has many prohibitions on sexual activities during pregnancy. The pregnancy restrictions aim to protect the child from “malign influences” and to avoid problems associated with pregnancy [26]. Chinese medicine is generally practiced in different ways in China, Hong Kong, and Taiwan. Traditional Chinese medicine (TCM) places great emphasis on dietary and behavioral restrictions to restore physical and emotional harmony [27–29]. In the 1689 Chinese medicine book, “Bible on Women,” Xia wrote about the paternal connections between generations of Chinese families: “If a woman is pregnant, her man is not allowed to have sexual intercourse with her.” Anything that influences a woman’s mind and behavior affects the fetus in the uterus. According to Xuan [30] and Uwapusitanon and Choobun [31], due to the restrictions, many pregnant Chinese women feel uncomfortable asking about or discussing sexual topics with their doctors of that any quantitative investigation cannot be identified.

Aims

This report describes a qualitative study of sexual activities during pregnancy. The aims of this article were to gather information, to describe the changes and sexual behavior in pregnancy, and to identify the reasons why pregnant women from central Taiwan tend to decrease coital frequency during pregnancy.

Methods

The relevant literature considered physical and psychological factors to be the primary contributing factors during the perinatal period. Based on the literature review, we hypothesized that the reasons for decreasing and avoiding sexual activities were the fear of harming the fetus [3–5,8,10,11] and the discomfort during intercourse [2,4,8,10,12]. The objectives of this study were to use a phenomenological method to determine the impact that pregnant women’s sexual activities have during pregnancy, to identify the reasons why Taiwanese women tend to decrease the frequency of coitus as their pregnancy advances and to identify the ways in which pregnant women meet their sexual needs with their spouses. In the current qualitative investigation, to confirm the coitus phenomenon during pregnancy, we performed a statistical analysis only in the three trimesters in the no coitus group vs. the coitus group in categories. We found a statistical significance in the no coitus group vs. other categories. The statistics are presented in the footnote of Table 1 and confirm a decreased frequency

| Group          | 1st trimester | 2nd trimester | 3rd trimester |
|----------------|---------------|---------------|---------------|
|                | n (% , SE)    | n (% , SE)    | n (% , SE)    |
| No coitus      | 31 (50.00%, 0.50)* | 20 (32.26%, 0.48)* | 40 (64.52%, 0.48)* |
| No change      | 6 (9.68%, 0.18)   | 10 (16.13%, 0.37) | 6 (9.68%, 0.30)   |
| Decreased      | 23 (37.10%, 0.48)  | 31 (50.00%, 0.50) | 14 (22.58%, 0.42)  |
| Not reported   | 2 (3.23%, 0.18)    | 1 (1.61%, 0.13)   | 2 (3.23%, 0.18)    |
| total          | 62 (100%)       | 62 (100%)       | 62 (100%)         |

None of the women reported an increase in the frequency of coitus in any of the trimesters. All the four groups are significantly different among the three trimesters the 4 by 3 table with $P = 0.02$.

* No coitus group vs. the coitus group, the sum of the other three groups is significant with $P = 0.002$.

SE = standard error
of coitus. Finally, we integrated the underlying meanings into clusters and formulated them, based on our conceptual model, into the following three domains: (i) stress and fear of harming the fetus; (ii) discomfort during sexual intercourse; and (iii) changes in sexual practices. We hypothesized that each of these domains individually affects sexual activities and changes intimate relationships during pregnancy.

**Subjects**
The subjects were pregnant Taiwanese women recruited between March 2006 and July 2007. The participants were approached individually without a third party present; their spouses were absent when they were asked to participate in the study interview. The participants were screened based on the inclusion and exclusion criteria. The inclusion criteria required the participants to be at least 20 years old, between 25 and 38 weeks pregnant, and living with their spouses. Individuals were excluded from the study if their physicians had placed restrictions on their sexual activities, a history of premature membrane rupture, and risk factors for premature birth. We excluded six participants because they did not live with their spouses, and we excluded two because they had been diagnosed with placenta previa. None of the women provided incomplete responses to any questions.

**Methodology**
The study design used the naturalistic paradigm of qualitative content analysis, which involves counting and comparing collected data to explore live experiences related to sexual activity during pregnancy. We obtained approval for this study from the Institutional Review Board before data collection. All of the participants were recruited in a hospital clinic waiting room. After agreeing to participate in the study, all participants were interviewed individually. With the participant’s permission, we adopted an open conversational format, taking an unstructured flexible approach to the face-to-face discussion. The in-depth and semi-structured interviews were audiotaped and transcribed verbatim by the first author. Units of meaning, referred to as codes, are words, sentences, or paragraphs that are related to each other in content and context [32–35]. A category is a group of content codes that share a commonality; moreover, the categories must be exhaustive and mutually exclusive [35]. The tentative categories were repeatedly discussed by the authors and subsequently revised. Reflection and discussion resulted in agreement about how to group the codes; disagreements were discussed until all discrepancies were resolved [34]. We consulted three professional experts to confirm that the categories were internally homogeneous and externally heterogeneous [34], which indicated that no data related to sexual activity were excluded due to the lack of a suitable category and that no data fell between two categories or fit into more than one category [32]. In general, this concept was used to categorize meaningful unit-codes in a mutually exclusive and exhaustive manner into perceptions, experiences, and practices so that common themes were grouped into categories. The goal of qualitative research is to identify major themes and consistent response patterns [36]. The only questionnaire used was focused exclusively on sociodemographic variables and the frequency of sexual activity.

**Results**

**Participant Characteristics**
A total of 62 pregnant women completed this study. The mean participant age was 28.59 years, and the range was 20–40 years. Thirty-eight (61.29%) participants reported that they were primiparous, and 24 (38.71%) reported that they were multiparous. The majority (85.47%) of the participants had full-time jobs, and 79.03% had more than 12 years of education.

**Coital Frequency during Pregnancy**
Table 1 lists the frequency of sexual activity in each trimester. None of the patients reported an increase in coital frequency after pregnancy. For the participants, the mean number of coital experiences per month was 9.02 before pregnancy, 1.71 during the first trimester, 1.59 during the second trimester, and 0.39 during the third trimester. The data indicated that 14 (22.58%) participants decreased coital activity, six (9.68%) participants reported no change, and 40 (64.52%) participants ceased coital activity during the third trimester.

**Advice to Stop Coitus**
Of the 62 women interviewed, 65.0% made the decision to stop coitus themselves, 15.0% made this decision after discussing it with their spouses, 13.3% were advised by their spouses to do so, 3.3% were advised by their mothers-in-law to do so, and 3.3% were advised by their mothers to do so.
Information about Coitus

Of the women in the study, 38.7% used the Internet to obtain information about coitus during pregnancy. Other information regarding this topic came from traditional sources, such as friends and books, rather than from newspapers or physicians. Other resources included nurses, healthcare providers, pregnancy manuals and discussions with postpartum women. The percentage of women who used these resources ranged from 35% to approximately 50% (Table 2).

Clustering Categories into Three Themes

Throughout the analysis, three themes emerged: Theme 1, negative aspects of sexual experiences; Theme 2, stress and emotional responses; and Theme 3, changes in sexual practices. The condensed units of meaning units were compared based on their differences and similarities using the naturalistic paradigm of summative qualitative content analysis, and they were sorted into 27 codes that are labeled in Table 3–5.

Negative Aspects of Sexual Experiences

The five categories within this theme were as follows: 1) dyspareunia, including (a) pain during coitus and (b) painful genital skin; 2) uterine discomfort, including (c) gravid uterus and (d) uterine contractions; 3) vaginal discomfort because of (e) dry vaginal mucosa; 4) physical discomfort, including (f) soreness or pain in the pelvis and (g) feeling too heavy to turn the body; and 5) fatigue, i.e., (h) tiredness (Table 3). Most of the women experienced physical discomfort or pain during intercourse.

Stress and Emotional Responses

There were two categories within the theme of emotional responses: 1) anxiety, including (i) a preference for sacrificing satisfaction in the short-term rather than hurting the baby, (j) the belief that coitus was dangerous, (k) worry that the coital posture was incorrect, and (l) a fear of harming the fetus; and 2) fear, including (m) fear of early birth, (n) fear of miscarriage, (o) fear of bleeding, (p) fear of vaginal infection, (q) fear that the spouse would refuse coitus, and (r) fear that coitus would cause premature birth (Table 4). This theme was closely related to self-perceptions and attitudes toward sexual behavior during pregnancy.

Changes in Sexual Practices

There were four categories within the theme of sexual practices (Table 5): 1) manual sex, including (s) the spouse giving the subject a massage, (t)
giving the spouse a body massage, (u) using one’s hands to touch and massage the spouse’s thighs, and (v) using one’s hands to help the spouse masturbate; 2) masturbation, i.e., (w) the spouse engaging in sexual activity alone when the spouse is libidinous; 3) anal sex, i.e., (x) anal intercourse; and 4) coital adjustments, including (y) performing coitus more gently, (z) not inserting the penis as deeply and (aa) the spouse showing consideration for the subject. The findings indicated that pregnant women accepted variations in sexual activity.

### Discussion

#### Sexual Activity during Pregnancy

The present study found no one increase in coital frequency during pregnancy and a substantial decrease in frequency (37.10%, 50.00%, and 22.58% in the first, second, and third trimesters, respectively) that was much higher than previously reported in the literature [1–12]. Huang [37] reported that 13.9% of couples cease coitus during pregnancy in Taiwan. The most important aspect of

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**Table 4** Stress and emotional responses, percentage of all subjects affected (N = 62)

| Category          | Code       | n (%)     |
|-------------------|------------|-----------|
| Anxiety           | (i) Preferred not to be satisfied in the short-term rather than hurt the baby | 47 (75.8) |
|                   | (j) Believed coitus was dangerous | 43 (69.4) |
|                   | (k) Worried that the coital position was incorrect | 44 (71.0) |
|                   | (l) Feared harming the fetus | 54 (86.9) |
| Fear              | (m) Fear of early birth | 16 (25.8) |
|                   | (n) Fear of miscarriage | 18 (29.0) |
|                   | (o) Fear of bleeding | 7 (11.3) |
|                   | (p) Fear of vaginal infection | 7 (11.3) |
|                   | (q) Spouse refuses coitus | 4 (6.5) |
|                   | (r) Fear that coitus will cause premature birth | 36 (58.1) |

Table 5 Changes in sexual practices, percentage of all subjects affected (N = 62)

| Category          | Code       | n (%)     |
|-------------------|------------|-----------|
| Manual sex        | (s) Spouse gives the subject a massage, which is enough | 20 (32.3) |
|                   | (t) Give spouse a body massage | 20 (32.3) |
|                   | (u) Used hands to touch and massage spouse’s thighs | 20 (32.3) |
|                   | (v) Used hands to help spouse masturbate | 24 (38.7) |
| Masturbation      | (w) When the spouse is libidinous, he resolves it alone | 16 (25.8) |
| Anal sex          | (x) Anal intercourse | 2 (3.2) |
| Coitus adjustment | (y) Coitus more gentle | 13 (21.0) |
|                   | (z) Penis not inserted deeply | 27 (43.5) |
|                   | (aa) Spouse shows consideration for the subject | 7 (11.3) |

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the qualitative findings was that pregnant Taiwanese women were engaging in coitus but choosing to stop vaginal intercourse (50.00%, 32.26%, and 64.52% in the first, second, and third trimesters, respectively). The results indicated that pregnant women accepted variations in sexual activity, such as manual sex, anal intercourse, and coital adjustments. The women in this study had a great deal of support from their mothers-in-law and mothers who had advised them to cease engaging in vaginal intercourse. Therefore, researchers cannot discard the social, cultural, and religious influences in this analysis according to Pauleta et al. [1]. This finding could reflect the transmission of cultural norms across generations. Our findings demonstrated that many pregnant Taiwanese women believe it is better not to engage in vaginal intercourse; they typically conceptualize to restrict sexual behavior to maintain physical and emotional harmony during pregnancy. These findings that TCM balance still influence the Taiwanese family unit and childbirth. Taiwanese pregnant women prefer to seek support from family members in times of stress supporting what have seen [38–40].

This study found that sexual information was obtained from the postpartum women (41.9%), books (40.3%), friends (35.5%), and the Internet (38.7%). Furthermore, doctors and nurses should be aware that pregnant women consult the Internet and mass media for information and that the large amount of information circulating in the public media may be too abundant or too complex for pregnant woman to absorb easily. Educational materials should include information regarding the symptoms of miscarriage and preterm labor.

**Reasons to Decrease Vaginal Intercourse**

The research findings indicate that several factors contribute to the decision to refrain from vaginal intercourse, suggesting the need for input from healthcare providers. The most important finding was that the women in this study were anxious: more than half of the women believed that coitus could be dangerous, and they feared harming the fetus. These findings are consistent with previous studies demonstrating similar emotional responses, such as “fear of inducing a miscarriage” [5,10,11,41], “fear of preterm labor” [3,10,11], “fear of the onset of labor” [4,8], “fear of bleeding” [4,5,8,10], and “fear of an infection” [3,4,8,10,41].

Previous studies have revealed that pregnant women have unpleasant experiences during sexual intercourse, including fatigue [10,41], dyspareunia [2,4,8,10,12,42], changes in vaginal lubrication [4], abdominal cramping [4,8], urinary incontinence [4,8], lack of attraction to their spouse’s odor [10], and positioning difficulties [2]. The present study supports the findings of previous studies by providing a more detailed examination of women’s sexual experiences. The findings in the current literature can assist health practitioners in recommending masturbation, the use of lubricant jelly, and alternative coital positions, such as the female on top, rear entry, spooning, the use of several pillows, a side-by-side position or the scissors position [2,6].

Notably, in this study, several participants indicated that they maintained an intimate relationship through sexual activity because the pregnant women used manual sex or helped their spouses masturbate in other ways. Pregnancy may affect the sexual behavior and feelings of men. The few studies that have been conducted on this subject reported the following spouse-related reasons for discontinuing or decreasing the frequency of coitus during pregnancy: “spouse avoids coitus,” [10] “spouse worries during coitus,” [42] and “spouse worries about sexual satisfaction” [2]. The findings of the present study could help clinicians and health professionals offer practical recommendations concerning sexuality during pregnancy. Technical advice regarding the range of sexual options during pregnancy, including noncoital sexual activities, such as manual and oral partner stimulation, could also be helpful [43].

**Limitations**

One limitation of this study is that it was conducted using women from only one population of Chinese culture without cross-cultural comparison; thus, the results may not be generalizable. The interviews with pregnant women were not conducted using a validated questionnaire to identify the characteristics of their sexual activities. However, it is difficult to gain a comprehensive understanding of sexual activities during pregnancy when the activities are measured by a questionnaire. Therefore, the observations in this study should be used as hypotheses for future quantitative longitudinal studies that assess sexual activity during pregnancy using questionnaires.

**Conclusions**

The current evidence-based findings encourage the provision of sexuality education to newlyweds and the discussion of sex-related issues during pregnancy. We aimed to develop strategies for
increasing sexual knowledge and focusing on emotional support to decrease the pregnant women’s anxiety regarding sexuality in Taiwan. Obstetricians or nurse practitioners are in an ideal position to provide long-term sexuality education to pregnant women. Moreover, future research should include a longitudinal study that assesses both pregnant women and their spouses separately using hypotheses based on the present study’s findings. Ultimately, healthcare providers should devote time to provide appropriate information to couples to reduce their anxiety and improve their quality of life during pregnancy.

Corresponding Author: Kuang-Ho Chen, PhD, Founder and Emeritus Professor, Central Taiwan University of Science and Technology, Taichung, Taiwan 40601. Tel: +886-988241135; Fax: +886-4-23174625; E-mail: KuangHoChen@gmail.com

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