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Anxiety and Sexual Function of Pregnant Women

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Abstract

Background: *Physical and psychological changes during pregnancy can affect sexual function. Sexual function during pregnancy decreases with increasing gestational age, affecting the desire to have sexual activity. Anxiety is one of the psychological factors that can interfere with the sexual function of pregnant women.*

Objective: *This research aims to identify the relationship between anxiety and sexual function during pregnancy.*

Methods: *This study used quantitative research methods and a cross-sectional design. 62 samples of pregnant women in all trimesters in the Bantul Yogyakarta area were selected using a purposive sampling technique. The instruments used in the study were the Perinatal Anxiety Screening Scale and Female Sexual Function Index questionnaires. The statistical test used was the Spearman Rank Correlation Test.*

Result: *The Spearman Rank Correlation test showed p-value=0.000 and r=0.475, indicating a significant relationship between anxiety and sexual function in pregnant women with sufficient corrective power.*

Conclusion: *Anxiety related to the condition of sexual function during pregnancy. Nurses are expected to be able to provide health education to married couples and motivate couples to obtain adequate information about sexuality during pregnancy.*

Keywords*: anxiety; sexual function; pregnancy*

INTRODUCTION

Hormonal, physiological, and psychological changes can affect a woman's sexuality and sex life with her partner. Changes in sexual function can occur after the first trimester as the mother is still adjusting to her pregnancy and will increase with gestational age. Sexual dysfunction commonly happens in the last trimester of pregnancy. The anxiety of uterine contractions, worry of harming the mother and fetus, low libido, reduced sexual self-image, exhaustion, weakness, pain during coitus, membrane rupture occurring prematurely, and placenta previa all cause the mother to avoid sexual intercourse during this period (Erbil, 2018). Sexual function is influenced by the emotional state of pregnant women. The pregnant women's emotional state can be influenced by one of the hormones, namely the hormone dopamine. Dopamine is a

neurotransmitter that is activated when a person feels happy. Sexual desire is activated by dopamine (Krakowsky & Grober, 2018). Physical and psychological changes during pregnancy can affect the sexual function of pregnant women. Sexual function during pregnancy decreases with increasing gestational age, affecting the desire to have sexual activity.

Pregnancy conditions can affect sexual function, as, during the pregnancy period, physical and psychological changes occur (Oh & Kim, 2019). The physical changes experienced by pregnant women, such as nausea, fatigue, changes in body shape on an increasingly enlarged abdomen, and breast sensitivity, can decrease a pregnant woman's self-confidence. The lack of self-confidence can make pregnant women feel uncomfortable when engaging in sexual activity, triggering a state of sexual dysfunction (Bouzouita et al., 2018). In addition to the physical changes experienced by the mother, psychological changes also occur, affecting the sexual function of pregnant women. The psychological changes include feeling anxious about the pregnancy and the fetus and changing roles that can influence the mother to engage in sexual activity (Rustikayanti et al., 2016).

The incidence of sexual dysfunction in Indonesia found that third-trimester pregnant women have the highest rate of sexual dysfunction, which is 86.9%; 76.5% in the second and 25% in the first. It is because pregnant women have a decreased desire and even no desire to have sexual intercourse during the period of pregnancy (Saraswati & Pangkahila, 2018). In Yogyakarta, the results revealed that the frequency and timing of sexual intercourse during pregnancy were in the lower category (41.7%). It happens because pregnant women experience changes in decreased desire and no desire to have sexual intercourse during early pregnancy (Pramudawardhani & Shanti, 2017).

The factors that can influence the occurrence of sexual function disorders are varied, including psychological, biological, and social factors (Afrakoti & Shahhosseini, 2016). Anxiety is one psychological factor that can impact pregnant women's sexual function. The number of anxious pregnant women in Yogyakarta was obtained from respondents in their second and third trimesters; 43.3% of respondents were not anxious, 26.7% of respondents were mildly anxious, 23.3% of respondents were moderately anxious, 6.7% of respondents were heavily anxious (Klara, 2020).

Complaints of anxiety during pregnancy can cause a decrease in sexual activity. According to the study's findings, the level of anxiety during pregnancy greatly affects the quality of sexual activity and causes pregnant women to experience decreased relationships with partners. The mother's anxiety for fear of putting the fetus in danger makes pregnant women more restrictive of movement when carrying out sexual activities, ultimately making the mother less satisfied (Gałazka et al., 2017).

Sexual needs during pregnancy are one of the crucial aspects of sexuality for both mother and husband. Fulfilled sexual needs can improve closeness and quality of life in family life. Fulfilled sexual intercourse during gestation can provide several benefits, including trained pelvic muscles, smooth blood circulation, and family harmony development (Pramudawardhani & Shanti, 2017). The provision of health education during pregnancy can provide benefits for pregnant women and their families. Education throughout prenatal is one of the most effective ways for pregnant women to improve their health (Oktafia et al., 2018).

A partner's fulfilled sexual needs can increase the closeness and quality of life in domestic life. The incidence of sexual function problems in Indonesia, especially in pregnant women, is still not given much attention by the government. Most pregnant women feel taboo when discussing their sexual issues and are afraid that something will happen to their fetuses. The results of the preliminary study of 5 respondents in the Sewon Bantul Area were that 2 pregnant women experienced mild anxiety, 1 pregnant woman experienced moderate anxiety, and 3 pregnant women experienced sexual dysfunction. In addition, pregnant women complain of sexual problems during pregnancy, including sexual arousal and feeling uncomfortable or painful during penetration, so they rarely feel satisfied during sexual activity with a partner.

Based on this phenomenon, researchers attempted to study the relationship between anxiety and sexual function in pregnant women at the Primary Health Care Sewon Bantul Indonesia. It is expected

that this research will be useful for pregnant women and their partners so that they can receive health education about sexual activity during pregnancy. Furthermore, it is expected that pregnant women and their partners' sexual needs can be met. Increased quality of life and family harmony is needed to create an increased bond of togetherness between husband and wife.

METHOD

The research used a quantitative study with a cross-sectional approach and a correlational research design. Non-probability sampling was used with a purposive sampling method. This study included pregnant women who had at least two visits to the Primary Health Care Sewon Bantul Indonesia for antenatal care (ANC), pregnant women who stayed with their husbands throughout pregnancy, and pregnant women who were ready and able to be respondents. This study utilized the following exclusion criteria: pregnant women with pregnancy issues such as placenta previa, history of miscarriage, and premature delivery. The size of the sample was determined by the slovin formula, so we obtained 62 samples of pregnant women in the Primary Health Care Sewon Bantul Indonesia.

The instrument for the sexual function is the Female Sexual Function Index (FSFI), and the instrument for anxiety is the Perinatal Anxiety Screening Scale (PASS). The instrument for measuring sexual function in pregnant women employed in this study was the Female Sexual Function Index (FSFI). This questionnaire was developed by her research "The Female Sexual Function Index (FSFI): A Multidimensional Self-Report Instrument for The Assessment of Female Sexual Function". FSFI is a questionnaire with 19 questions divided into several domains: desire, arousal, lubrication, orgasm, satisfaction, and pain. The questionnaire of FSFI consisted of a score of > 26.55, categorized as normal or not sexual dysfunction. Meanwhile, a score of < 26.55 was categorized as sexual dysfunction (Fuchs et al., 2019). This FSFI instrument has been tested for validity and reliability. The validity test was carried out on 30 respondents of pregnant women using the Pearson product-moment formula. The validity test value was between 0.737 to 0.943, with the value of r>0.361, so it was declared valid. Meanwhile, the reliability test results from the FSFI questionnaire using Chronbach's Alpha formula were 0.7646, so they were declared reliable (Afriski, 2018). This PASS questionnaire was developed in the study entitled "The Perinatal Anxiety Screening Scale: Development and Preliminary Validation". PASS has a total of 31 questions with scores of 0 - 20: No anxiety, 21 -26: Mild anxiety, 27-40: Moderate anxiety, and 41 -93: Severe anxiety (Somerville et al., 2014). The results of the PASS internal construct validity test obtained an r-value ranging from 0.4 to 0.51, and the reliability test using Cronbach's alpha ranged from 0.86 to 0.90. Thus, this questionnaire was declared valid and reliable (Ulfa, 2017). The Spearman Rank correlation test was used in this study's statistical analysis. In addition, this study received ethical approval with letter number 006/EC-KEPK FKIK UMY/I/2022.

RESULT

(see table 1)

Based on the result, the average respondent's age was 27.5 years old, and the standard deviation was 5.33. The oldest participant was 42 years old, and the youngest participant was 18 years old.

(see table 2)

It found that the characteristics of the participants of gestational age were primarily in the third trimester, with a total of 23 people and a percentage of 37.1%. Characteristics of participants based on parity showed that most were multigravida, with as many as 34 participants, with a percentage of 54.8%. In terms of educational background, the majority of respondents were from Senior High School, with a total of 37 respondents, with a percentage of 59.7%. The majority of respondents worked as housewives, with a total of 34 (54.8%) respondents, and a small percentage of participants worked as civil servants, with a total of 4 (6.5%) respondents.

(see table 3)

Based on characteristics of respondents' anxiety levels according to the findings of this study, respondents who were not anxious were 14 respondents with a percentage of 22.6%, mild anxiety with as many as 26 respondents with a

percentage of 41.9%, moderate anxiety with as many as 15 respondents with a percentage of 24.2%, and severe anxiety with as many as 7 respondents with a percentage of 11.3%. Regarding the sexual function of respondents in this study, more than half of the respondents were in a state of sexual dysfunction, as many as 53 respondents with a percentage of 85.5% and respondents who were in a normal state were 9 respondents with a percentage of 14.5%.

(see table 4)

The spearman rank correlation test results between anxiety and the sexual function of pregnant women, p=0.000, showed a significant correlation between anxiety and the sexual function of pregnant women. The value of the correlation coefficient r=0.475 and the direction of the correlation was positive, indicating that the two variables had sufficient positive correlation strength. It means that the lower the level of anxiety is, the more normal the sexual function of pregnant women will be.

DISCUSSION

This study found that the youngest pregnant woman was 18 years old and experiencing sexual function issues with severe anxiety. It was caused by several factors, such as low education level, unemployed, and primigravida. According to Fajrin (2018), maternal age affected sexual intercourse during pregnancy. Pregnant women who have reached adulthood will likely change their way of thinking and their views on sexual relations during pregnancy. Pregnant women under 20 years old lack physical and psychological readiness, making them uninterested in learning about pregnancy. People view pregnancy as a natural phenomenon, so there is no desire to seek new knowledge. Another factor that influences them is maternal parity. Primigravidas experience anxiety about sexual relations during pregnancy. According to Prihatiningsih, (2017), it occurs because the mother experiences uterine contractions, which causes the risk of preterm labor.

The results of this study revealed that, in addition to young age causing problems of sexual dysfunction, mothers' ignorance regarding sexuality during pregnancy was also caused by a lack of awareness of mothers to seek information and myths giving rise to wrong perceptions. According to Afriyanti & Oktaviani (2019), mothers who have low knowledge can discourage them from having sexual relations as they do not know which sexual positions are good to do during pregnancy.

The gestational age in this research showed that most participants were in their last trimester. Many pregnant women in the third trimester were reported to experience various complaints during pregnancy which made them do more frequent pregnancy check-ups. These findings are consistent with the research, revealing that one of the complaints encountered in third-trimester pregnant women was their sexual function (Hayati, 2019). It is supported by research reporting that women's sexuality decreased with increasing gestational age, which seemed to be hormonal, physiological, and psychological changes throughout pregnancy that affected the desire to have sexual activity. It subsequently affects all domains, resulting in sexual dysfunction (Fuchs et al., 2019).

The findings revealed that the majority of respondents were multigravida. Primigravida mothers are primarily concerned about sexual intercourse during pregnancy, whereas in later pregnancies, they reported being more comfortable with sexual intercourse and enjoying their sexual experiences more. Understanding of sexuality is not only obtained from experiences from previous pregnancies but also information about sexuality during pregnancy also affects the anxiety of pregnant women (Prihatiningsih, 2017).

The last education taken by respondents in this study was primarily high school. Pregnant women with higher education have a high awareness of their health issues. The more educated pregnant women are, the more they will understand the importance of doing ANC and the higher mothers' awareness of carrying out ANC (Khasanah, 2017). Through ANC activities, mothers also obtained sexual health education during pregnancy. Mothers who receive safe sexual health education during pregnancy and have sufficient understanding can influence the mother's perception of sexuality. Therefore, the mother can have safe and riskless sexual intercourse during pregnancy (Ryandini & Pitaloka, 2019).

The respondents' occupation in this study was primarily housewife. Pregnant women who did not

work had more opportunities to schedule or plan pregnancy check-ups optimally (Rachmawati et al., 2017). Respondents who obtained additional exposure to their knowledge information would differ from those not exposed to it. Sexual education or information obtained by pregnant women and their partners related to meeting sexual needs during pregnancy could give pregnant women a better understanding of sexual education (Muhrimmah, 2020).

The results revealed that most respondents experienced mild anxiety and seven pregnant women experienced severe anxiety. It happened as the mother was trying to adapt to the changes. According to Nelsi et al. (2019), one factor that could affect the level of anxiety of pregnant women about sexual function was the age of pregnant women. It showed that pregnant women with a risk age category of 53.7% experienced anxiety about sexual intercourse. These factors included the work of pregnant women, history of abortion, complications in previous pregnancies, the mother's desire to get pregnant, and husband or family support.

Changes experienced by pregnant women both physiologically and psychologically can increase the risk of emotional disturbances and changes in mood to negative emotions that arise in pregnant women, one of which is anxiety (Aisyah et al., 2018). The age of pregnant women is among the factors that are considered to influence their level of anxiety. It indicates that pregnant women in the risk age categorization experience anxiety about sexual relations. A person's emotions can be influenced by their age. The higher one's age is, the better one's emotional maturity and ability to handle various problems will be (Rinata & Andayani, 2018). The causes of anxiety in pregnant women vary. In addition to the age, knowledge, and role-changing factors experienced by the mother, there are still causal factors and other risk factors that are considered to affect the occurrence of anxiety during pregnancy.

The findings of this study contradict previous studies, revealing that the majority of respondents had normal sexual functioning values with high levels of sexual satisfaction (Pasaribu et al., 2016). The mother's emotional state can be affected by one of the hormones, namely the hormone dopamine. Dopamine is a neurotransmitter that is active when in a happy state, while the sexual impulse or desire is activated by dopamine. When the mother feels comfortable and calm, dopamine will be active and increases sexual drive or desire (Krakowsky & Grober, 2018).

Several factors influence sexual function in pregnancy. Pregnancy conditions can affect sexual function as physical and psychological changes occur in women during pregnancy, which can cause or exacerbate sexual disorders (Oh & Kim, 2019). Physical changes experienced by pregnant women, such as nausea, easy fatigue, changes in body shape in the stomach that are getting bigger, and breast sensitivity, can decrease a pregnant woman's self-confidence. The lack of self-confidence experienced can make pregnant women feel uncomfortable during sexual activity, triggering a state of sexual dysfunction (Bouzouita et al., 2018). Furthermore, psychological changes also happened along with the physical changes experienced by the mother. Psychological changes experienced by pregnant women can also affect their sexual function. During the gestational period, the mother will experience psychological changes such as feeling anxious about her pregnancy, anxiety about the fetus that may be born with abnormal conditions, and anxiety due to a change in role that can also influence the mother to carry out sexual activity (Rustikayanti et al., 2016).

Mothers still in the adaptation period during the first-trimester experience nausea, pain, and bust sensitivity, as well as a deterioration in their sense of well-being, which influences the frequency of sexual contact. In the last trimester, the mother again experiences a decrease in sexual function scores as most mothers feel pain throughout sexual intercourse than in the previous trimester. Furthermore, to the pain experienced by the mother during sexual intercourse, the decrease in score can be affected by changes in the mother's anatomy as well as concerns about the fetus's health and delivery (Banaei et al., 2019).

Pregnant women have increased sexual function, especially in the desire and arousal they feel in the second trimester of pregnancy. It is influenced by

several conditions, such as in the second trimester, the mother has a greater interest in sexuality, has decreased physiological pregnancy symptoms, feels more comfortable, and has more self-confidence (Mousazadeh & Motavalli, 2018). In addition, as the mother's condition gradually becomes more stable in the second trimester, it can give them a more positive and rational assessment. A positive and rational assessment of various aspects of life can create a balance between the positive effects of pregnancy, such as happiness, willpower, self-confidence, and adverse effects, such as anxiety, stress, and depression, so that it can provide satisfaction for pregnant women in their sexual relations (Zhang et al., 2020).

Based on the findings of this research, there was a link between anxiety and pregnant women's sexual function. This study supports previous research showing a correlation between anxiety levels and sexual function. This study stated that anxiety arouse due to nausea and vomiting that mothers experienced in early pregnancy, so it affects hormones, moods, and emotions that could reduce sexual function, such as reducing maternal interest in sexual intercourse and reducing satisfaction during sexual intercourse (Afriyanti & Oktaviani, 2019). This result is also supported by the research demonstrating that the level of pregnancy anxiety significantly impacted the quality of the sexual activity. The mother's psychological state, especially anxiety, can make the mother uncomfortable and exhausted during sexual intercourse, thus affecting the frequency of her sexual activity (Gałazka et al., 2017).

Furthermore, physical and mental changes that occur during pregnancy influence sexual activity during gestation and affect the health and sexual function of pregnant women (Pebrina, 2017). Moreover, emotional states affect arousal, sexual pleasure, and libido. Mothers experience anxiety for fear of hurting the fetus and delivery, thus making the mother not want to engage in sexual activity while pregnant (Saberi et al., 2018). Anxiety in pregnant women occurs because the mother has failed to use constructive coping so that the mother's ability to adapt to the state of pregnancy and the situation facing the delivery process has decreased. One of the effects of anxiety can influence decreased sexual activity. This decrease in activity can eventually increase the occurrence of sexual dysfunction during pregnancy (Vannier & Rosen, 2017).

Anxiety has a complex relationship with desire, arousal, orgasm, lubrication, and satisfaction in sexual intercourse (Khalesi et al., 2018). Anxiety about the fetus's condition, a miscarriage, and childbirth can make the mother feel a lack of desire to have sexual intercourse (Nurmitasari et al., 2019). Research revealed that psychology affects arousal, sexual pleasure, and difficulty in getting an orgasm (Saberi et al., 2018). Anxiety will cause symptoms such as tense muscles and irregular breathing. These symptoms can cause the mother to experience an orgasm. Excessive feelings of anxiety can also inhibit the lubricating effect on the intimate organs so that the body stiffens. As a result, sexual intercourse will only cause pain (Nur, 2018). Previous research also stated that anxious pregnant women have an 8.4 times greater risk of sexual dysfunction than mothers who are not anxious (Sya'bin et al., 2019). Therefore, the more the mother experiences anxiety, the more the mother has a sexual function disorder.

A result of pregnant women experiencing anxiety will affect their sexual function, namely sexual dysfunction. It is influenced by the pregnancy period, which has the potential to have stressors and a high risk of women being psychologically vulnerable. It can develop into mental health problems, although mild anxiety symptoms in dealing with pregnancy are common (Arinda & Herdayati, 2021). Mothers who experience mild anxiety will increase their sense of alertness and focus of attention (Amalia et al., 2020). This anxiety will affect the mother's sexual arousal, decreasing sexual pleasure as sexual arousal can affect sexual activity (Ratnasari, 2016). In addition, feeling alert to the safety and security of the fetus being conceived can encourage pregnant women to be more careful and limit movements, which ultimately makes the mother flexible and feel satisfied when doing sexual activity with a partner (Nur, 2018). Thus, it is not surprising that this study found that most of the respondents with mild anxiety also experienced impaired sexual function and needed appropriate treatment to overcome it.

This issue can be overcome by providing education from health professionals for pregnant women regarding the changes experienced during

pregnancy and safe sexual activities during pregnancy. Pregnant women who can access information will be aware of the changes during each pregnancy trimester (Serpina, 2018). This knowledge is expected to reduce the mother's anxiety about her pregnancy and improve their sexual life.

CONCLUSION

Based on the result of this study, it can be concluded that most of the respondents had sexual dysfunction. Moreover, there was a significant relationship between anxiety and the sexual function of pregnant women in Primary Health Care in Sewon Bantul, Indonesia. The implications of this study can be used as an overview of sexual function during pregnancy. Based on this research, it is known that mild anxiety and sexual dysfunction occurred during pregnancy. Nurses are expected to provide health education to married couples and motivate them; thus, they also can receive adequate information about sexuality during pregnancy. The information obtained thoroughly can reduce anxiety during pregnancy.

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Table 1. Characteristics of Respondent: gestational age of pregnant women (n=62)

Variable	Minimum	Maximum	Median	Standard Deviation
Age	18	42	27.5	5.33

Table 2. Characteristics Respondent (n=62)

Variable	Frequency	%
Gestational		
Age	21	33.9%
1st trimester	18	29 %
2nd trimester	23	37.1%
3rd trimester		
Parity		
Primigravida	28	45.2%
Multigravida	34	54.8%
Education		
Primary		3.2%
School	2	14.5%
Junior High	9	59.7%
School		22.6%
Senior High		
School	37	
College	14	
Occupation		
Housewife	34	54.8%
General		33.9%
employee	21	4,8%
Entrepreneur	3	6,5%
Civil Servant	4	
Total	**62**	**100%**

Table 3. Pregnant Women's Anxiety Levels and sexual function (n = 62)

Variable	Frequency	%
Anxiety Level		
No Anxiety	14	22.6%
Mild Anxiety	26	41.9%
Moderate Anxiety	15	24.2%
Severe Anxiety	7	11.3%
Sexual Function		
Normal	9	14.5%
Sexual Dysfunction	53	85.5%

Table 4. The relationship between pregnant women's sexual function and Anxiety Levels (n = 62)

Anxiety	Sexual Function				Total		p	r
	Normal		Sexual Dysfunction					
	n	%	n	%	n	%		
No Anxiety	7	11.3	7	11.3	14	22,6		
Mild	2	3.2	24	38.7	26	41,9		
Moderate	0	0	15	24.2	15	24,2	0.000	0.475
Severe	0	0	7	11.3	7	11,3		
Total	9	14.5	53	85.5	62	100		

*p<0.005