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ANXIETY AND SEXUAL FUNCTION OF PREGNANT WOMEN IN PRIMARY HEALTH CARE SEWON BANTUL INDONESIA

Abstract

Introduction: *Changes throughout pregnancy can have an impact on a pregnant woman's sexual function. Anxiety is one psychological factor which can impair a pregnant woman's sexual function. The incidence of anxiety with sexual activity is high. Sexual dysfunction during pregnancy can have a negative effect on one's life quality and household harmony.*

Aims: *The purpose of this research is to find out the relationship of anxiety and sexual function during pregnancy at the Sewon Bantul Primary Health Care.*

Methods: *This study employs quantitative research methods and a cross-sectional design. As many as 62 samples were collected using purposive sampling techniques in conformance with sample selection. The Perinatal Anxiety Screening Scale and the Female Sexual Function Index were used. The spearman test was used in this study as a statistical test.*

Results*: The respondent's anxiety level was dominated by 41.9% and 85.5% experienced sexual dysfunction. The outcomes of the Spearman test have a p-value of 0.000 and the correlation results. 0.475.*

Conclusion: *There is an association among anxiety and sexual function in pregnant women. It is essential to assist the nurses and health workers can increase promotional efforts through education or counseling about pregnant women's anxiety and sexual function and couples.*

Keywords: *Anxiety; Sexual Function; Pregnancy*

INTRODUCTION

Hormonal, physiological, and psychological changes can all have an effect on a woman's sexuality and her sex life with her partner. Changes in sexual function can occur after the first trimester because the mother is still in a period of adaptation related to her pregnancy and will increase with gestational age. Sexual dysfunction is common mostly 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 occurs prematurely, and placenta previa all cause the mother to avoid sexual intercourse during this period (Erbil, 2018).

The incidence of sexual dysfunction in pregnant women in Iran in the first trimester who experienced sexual dysfunction was 84.4%, in the second trimester it was 81.2%, and in the third trimester, it was 84.3% (Davari-Tanha et al., 2020). A study on sexuality in pregnant women involving 44 pregnant women that third-trimester pregnant women have the highest rate of sexual dysfunction, was 86.9%; 76.5% in the second trimester, and 25% in the first trimester. This is because pregnant women have a decrease in desire and there is no desire to have sexual intercourse during the period of pregnancy (Saraswati & Pangkahila, 2018).

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 have an impact on pregnant women's sexual function. The number of anxiety pregnant women in Yogyakarta was obtained from respondents in their second and third trimesters as many as 43.3% of respondents were not anxious, 26.7% of respondents were mildly anxious, 23.3% of respondents were moderately anxious, and 6.7% of respondents were heavy 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 a decrease in 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, which ultimately makes the motherless satisfied (Gałazka et al., 2017).

Sexual needs during pregnancy are one of the important aspects of sexuality for both mother and husband. Sexual needs that are met can improve closeness and quality of life in family life. Sexual intercourse that is fulfilled during the gestation period can provide several benefits, including training the pelvic muscles, making blood circulation smooth, and improving family harmony (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. Education throughout prenatal is one of the most effective ways for pregnant women to improve their health (Oktafia et al., 2018).

A partner's sexual needs that are met properly 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 if something happens to their fetus. 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 felt by the mother during her pregnancy, including sexual arousal, arousal, feeling uncomfortable or painful during penetration, so that pregnant women rarely or rarely feel satisfied during sexual activity with a partner.

Depending on this phenomenon, researchers want to conduct a study to look into the relationship between anxiety and sexual function in pregnant women at the Primary Health Care Sewon Bantul Indonesia. It is hoped that this research will be useful for pregnant women and their partners so that they can receive health education about sexual activity during pregnancy and so that pregnant women and their partners' sexual needs can be met. To create an increased bond of togetherness between husband and wife, an increased quality of life, and family harmony.

METHODS

The research use 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. In this study, the following exclusion criteria were used: pregnant women with pregnancy conditions such as placenta previa, history of miscarriage, and premature delivery. The size of the sample is determined by the slovin formula, so we obtained a sample of 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 used 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, namely desire, arousal, lubrication, orgasm, satisfaction, and pain. The questionnaire FSFI consisted of a score of > 26.55 categorized as normal or not sexual dysfunction while the < 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 is between 0.737 to 0.943, the value of r>0.361 so it is declared valid. The results of the reliability test 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 "The Perinatal Anxiety Screening Scale: Development and Preliminary Validation". PASS has a total of 31 questions with scores of 0 - 20: No anxious, 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 so this questionnaire was declared valid and reliable (Ulfa, 2017). The Spearman Rank correlation test is used in this study's statistical analysis. This study had received ethical approval with letter number 006/EC-KEPK FKIK UMY/I/2022.

RESULTS

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

Variable	Median	Standard Deviation	Minimum	Maximum
Age	27.5	5.33	18	42

The median value of the respondent's age is 27.5 years old and the standard deviation is 5.33. The oldest participant was 42 years old, as well as the youngest participant was 18 years old.

Table 2. Characteristics Respondent (n=62)

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

It finds that the characteristics of the participants of gestational age are mostly 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, as many as 34 participants, with a percentage of 54.8%. Characteristics of participants from education the majority of respondents are from Senior High School, with a total of 37 respondents, with a percentage of 59.7%. The majority of respondents work as housewives, with a total of 34 (54.8%) respondents, and a small percentage of participants work as civil servants, with a total of 4 (6.5%) respondents.

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%

The 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 as many as 7 respondents with a percentage of 11.3%. The sexual function of respondents in this study was 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 as many as 9 respondents with a percentage of 14.5%.

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

The results of the spearman rank correlation test between anxiety and sexual function of pregnant women, p=0.000, there is a significant correlation between anxiety and sexual function of pregnant women. The value of the correlation coefficient r=0.475 and the direction of the correlation is positive, indicating that the two variables have sufficient positive correlation strength, meaning that the lower the level of anxiety, the more normal the sexual function of pregnant women.

DISCUSSIONS

Maternal age affects sexual intercourse during pregnancy. Pregnant women who have reached adulthood will affect their way of thinking and their views on sexual relations during pregnancy. Pregnant women under the age of 20 years lack physical and psychological readiness which makes mothers less willing to learn about pregnancy and get older. people think pregnancy is something normal, so there is no desire to seek new knowledge (Fajrin, 2018). Mothers who have low knowledge can discourage mothers from having sexual relations because they do not know which sexual positions are good to do during pregnancy (Afriyanti & Oktaviani, 2019).

The gestational age in this research tells that most participants were in their last trimester. Many pregnant women in the third trimester are reported to experience various complaints during pregnancy which makes pregnant women do more frequent pregnancy check-ups. These findings are consistent with

the research, which states that one of the complaints encountered in third-trimester pregnant women is their sexual function (Hayati, 2019). This is supported by research that reported that women's sexuality decreased with increasing gestational age, which seems to be hormonal, physiological, and psychological changes throughout pregnancy that affect the desire to have sexual activity and will subsequently affect all domains that result in sexual dysfunction (Fuchs et al., 2019).

The findings revealed that the majority of respondents were multigravida. Primigravida mothers are mostly concerned about sexual intercourse during pregnancy, whereas in later pregnancies they report 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 information about sexuality during pregnancy also affects the anxiety of pregnant women (Prihatiningsih, 2017).

The last education taken by respondents in this study was mostly high school. Pregnant women who have higher education then 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 the awareness of mothers to carry out ANC (Khasanah, 2017). Through ANC activities, mothers also get 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 so that the mother can have safe and riskless sexual intercourse during pregnancy (Ryandini & Pitaloka, 2019).

The type of work in this study is mostly as a housewife. Pregnant women who are not in working conditions have more opportunities to be able to schedule or plan pregnancy check-ups optimally (Rachmawati et al., 2017). Respondents who get additional exposure to their knowledge information will be different from those who are not exposed to information. Sexual education or information obtained by pregnant women and their partners related to meeting sexual needs during pregnancy can make pregnant women have a better understanding than before being given sexual education (Muhrimmah, 2020).

The results showed that most of the respondents experienced mild anxiety. 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 thought to influence their level of anxiety, indicating 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, the better one's emotional maturity and ability to handle various problems (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 thought to affect the occurrence of anxiety during pregnancy. These factors include the work of pregnant women, history of abortion, complications in previous pregnancies, the mother's desire to get pregnant, and husband or family support (Nelsi et al., 2019).

The findings of this study contradict previous studies, which found that the majority of study 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. 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 because 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 make a pregnant woman's self-confidence decrease. The lack of self-confidence experienced can make pregnant women feel uncomfortable during sexual activity so it can trigger a state of sexual dysfunction (Bouzouita et al., 2018). Along with the physical changes experienced by the mother, there will be psychological changes. Psychological changes experienced by pregnant women can also affect their sexual function. During 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 because there will be a change in role that can also influence the mother to carry out sexual activity (Rustikayanti et al., 2016).

Mothers who are still in the adaptation period during the first trimester, experience nausea, pain, bust sensitivity, as well as a deterioration in one's sense of well-being, which influences the frequency of sexual contact. In the last trimester, the mother again experienced a decrease in sexual function scores because most mothers feel pain throughout sexual intercourse than the foregoing trimester. Furthermore to the pain experienced by the mother during sexual intercourse, this 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 felt by the mother in the second trimester of pregnancy. This 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-confident (Mousazadeh & Motavalli, 2018). In addition, because the mother's condition gradually becomes more stable in the second trimester, it can give the mother 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, and self-confidence, and negative effects such as anxiety, stress, and depression so that it can provide satisfaction for pregnant women in one's sexual relations (Zhang et al., 2020).

According to the findings of this research, there is a link among anxiety and pregnant women's sexual function. This study supports previous research that found a correlation among anxiety levels and sexual function. This study says that anxiety arises due to nausea and vomiting that mothers experience in early pregnancy so that it affects hormones, moods, and emotions that can 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 which states that the level of Pregnancy anxiety has a significant impact on the quality of the sexual activity. The mother's psychological state, especially anxiety, can make the mother uncomfortable and feel tired during sexual intercourse, thus affecting the frequency of her sexual activity (Gałazka et al., 2017).

Physically and mentally changes that occur during pregnancy influence having sex during gestation and affects the health and sexual function of pregnant women (Pebrina, 2017). 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 be an influence on 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 that is felt, such as anxiety about the condition of the fetus, anxiety about having a miscarriage, and increased anxiety towards childbirth, can make the mother feel a

lack of desire to have sexual intercourse (Nurmitasari et al., 2019). Research states that psychology affects arousal, sexual pleasure, and difficulty 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 get 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). So, 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. This can happen because the pregnancy period is a period that has the potential to have stressors and a period that has a high risk of women being psychologically vulnerable and can develop into mental health problems, although mild symptoms of anxiety in dealing with pregnancy are common (Arinda & Herdayati, 2021). Mothers who experience mild anxiety will increase their sense of alertness and increase their focus of attention (Amalia et al., 2020). This feeling of anxiety will affect the mother's sexual arousal so that the anxious mother will experience a decrease in sexual pleasure because 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 motherless flexible and feel satisfied when doing sexual activity with a partner (Nur, 2018). So it is not surprising that in this study it was found that most of the respondents who had mild anxiety also experienced an impaired sexual function and needed appropriate treatment to overcome it.

One of the ways that can be done is by providing education. Providing education from health professionals to pregnant women regarding the changes experienced during pregnancy and safe sexual activities during pregnancy is very necessary. Pregnant women who get enough information will be aware of the changes that happen during each pregnancy trimester (Serpina, 2018). This knowledge is expected to reduce the mother's feelings of anxiety about her pregnancy and improve their sexual life.

CONCLUSIONS & NURSING IMPLICATION

The Sexual function of most of the respondents has sexual dysfunction and there is a significant relationship in anxiety and the sexual function of pregnant women in the Primary Health Care Sewon Bantul Indonesia. The implications of this study can be used as an overview of sexual function during pregnancy. Depend on this research, it is known that mild anxiety and sexual dysfunction occur during pregnancy. Nurses are expected to provide health education to married couples and motivate couples so that couples also get adequate information about sexuality during pregnancy. The information obtained thoroughly can reduce anxiety during pregnancy.

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