SEXUALITY & REPRODUCTION

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UNDERSTANDING SEXUALITY

The study of sexuality is vast and its significance is really only just being recognised within health care. The purpose of this article is to consider some of the ways in which sexuality affects women's experiences of reproduction and to explore how these might impinge upon midwifery practice.

The World Health Organisation suggests that sexuality should be more fully recognised within healthcare, arguing that all individuals should be able to enjoy and control sexual and reproductive behaviour and be free from shame, fear, guilt and false beliefs (Mace *et al.* 1974). An holistic and client-centred approach to care recognises that individuals *'are only given their full respect as people when . . . care has firm foundations in a truly holistic approach incorporating human sexuality as a vital component of humanity'* (McCann 2000: 134).

The National Strategy for Sexual Health and HIV also recognises the importance of positive sexual health arguing that:

> Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services . . . (DoH 2001: 5)

There is no simple common definition of what sexuality is (Billington 1998). For example, Foucault (1979: 7) describes sexuality as 'the truth of our being' and Godfrey (1999: 172) has suggested that sexuality 'enables us to define ourselves'. Sexual expression has been identified as an important feature of self-esteem, self-acceptance and overall well-being and a lack of sexual intimacy is associated with incidence of depression (Jerrome 1993). However it is defined, sexuality is recognised as an important part of identity for people in all societies (Nye 1999).

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Motherhood, conception and lesbian parents

We live in a society that establishes clear boundaries within which women should bear children, as Bennett comments:

> Want to have a child? Well don't do it too early. Don't leave it too late. Don't do it before you're nicely settled. Don't have an abortion. Don't have an unwanted child. Don't be a single parent. Don't miss out on the joy of childbirth. Don't think you can do it alone. Don't let your children be reared by strangers. Don't sponge off the State. Don't have a child for selfish reasons. Don't be childless for selfish reasons. Don't end up in barren solitude. Don't expect fertility treatment to work. (Bennett 1996: 8)

Lesbian women who are mothers, or who choose to become mothers, subvert the norms of 'normal' heterosexual motherhood. For many, such women are 'self-indulgent' and 'immature' conjuring images of 'conceptions by turkey baster' (Lewin 1998). However, it is worth noting that lesbian motherhood is a form of accommodation, as well as resistance, to the idea that all women should want to become mothers. Since lesbian parenting challenges the 'traditional' model of heterosexual parenting, it has perpetuated the image of the lesbian woman as an unfit mother (Hastie 2000).

Technological innovations in reproduction and genetics are having far-reaching implications for society and these innovations can *'arouse strong emotions and passions, ranging from outright horror through to unquestioning acceptance'* (Earle and Letherby, 2003: 1). Indeed, single women and lesbian women who disclose their sexuality, often receive unequal access to fertility services. The clinics regulated by the Human Fertilization and Embryology Authority (HFEA) have traditionally denied single and lesbian women access to fertility treatments on the basis of the need of the child for a father. However, the new appointed chair of the HFEA, Suzi Leather, takes a more contemporary stance on this issue, and is reported to have argued that all women should have the opportunity to treatment regardless of their 'partnership status' (Laurance 2004: 6).

Faced with issues of discrimination and prejudice, lesbian women have sought alternative ways of conceiving. Informal donor insemination has, over the last thirty years, become part of the lesbian culture with the increase in the number of self insemination manuals and kits available.

Whilst the decision to become a mother is an important one for women, the lesbian perspective is often ignored. Hastie (2000: 67) explores the complex issues in relation to lesbian motherhood , arguing:

> Cultural and social issues specific to the lesbian experience include whether to choose a known or unknown sperm donor, how to balance a co-parenting relationship with a lesbian partner when only one partner is legally recognised as a parent, whether or not to involve the biological father after birth, and overcoming societal assumptions that children live in a heterosexual household.

Lesbian women may have limited contact with health professionals or even delay seeking midwifery care for fear of criticism (Zeidenstein 1990). Due homophobic attitudes, the discrimination which arises from the disclosure of sexuality results in poor quality of care (Wilton 1996) and this has *'a direct impact on health inequality and contravenes the ideology of the NHS and various health professional's codes and rules of practice'* (Jackson 2003: 435). Midwives are placed to provide woman-centred care, irrespective of sexuality. However, midwives need to be aware that lesbian woman may have specific psychosocial and health care needs which require consideration (Jackson 2003).

The provision of maternity care should be non-judgmental and reject socially constructed stereotypes, respecting the right of each woman to equality of care. An awareness of the issues of heterosexism and homophobia as barriers to effective communication and the provision of quality care, are crucial to the enhancement of the maternity services. The Royal College of Midwives (2000) has set out recommendations for midwives on the provision of maternity care that recognises sexual difference and diversity (Table 1).

Table 1 Lesbian mothers: RCM recommendations

- Take care with your use of language.
- Signal your readiness to support lesbian mothers.
- Create an environment that is accepting of sexual diversity.
- Keep informed about relevant services for lesbian women.

- Avoid asking unnecessary, intrusive questions.

- Challenge discriminatory language and behaviour.

Sex and sexual identity in pregnancy

Although the significance of sexuality for the maintenance of good health is recognised, there is very little research on sex and sexual identity in pregnancy.

Talking about sex can, of course, be quite difficult. It is often considered to be one of the most 'private' parts of an individual's identity. The language used to discuss sexuality is often one couched in euphemisms such as 'making love' and obscurities such as 'you know' and 'down there' (Holland *et al.* 1994) and research suggests that both clients and professionals find it difficult to talk about sex (Tomlinson 1998).

The little evidence that does exist on sexuality in pregnancy suggests that both sexual activity and sexual satisfaction decline during this time (Tolor and diGracia 1976, Tobert 1990, Hyde *et al.* 1996). There are many possible explanations for this, although each individual's experience will be unique (Table 2).

Table 2 Explaining the decline in sexual activity & satisfaction in pregnancy

- a fear of harming the baby;
- overwhelming maternal/paternal feelings;
- tiredness, lethargy and lack of sexual desire;
- physical discomfort during intercourse;
- a negative self image, or feeling 'fat' and 'unattractive'.

Definitions of 'sex' and sexuality are also important as Ussher (1989: 94) argues:

> this emphasis on intercourse, or genital acts, as the only means of expressing sexuality or experiencing sexual arousal reinforces the narrow definition of sexuality which restricts women in our society. If a wider definition of sexuality were used the potential discomfort of intercourse during the pre- or post-partum period would not be of such significance.

It is important to recognise that 'sex' does not solely refer to penetrative sexual intercourse and that clients may wish to explore their sexuality during pregnancy.

Breastfeeding and the transition to motherhood

In many cultures, sexual intercourse during breastfeeding has, historically, been either avoided or discouraged (Dundes 2003). This can probably be explained by the desire to prevent pregnancy whilst nursing and includes varied practices ranging from enforced abstinence, coitus interruptus and encouraging couples to live apart until weaning (Niehoff and Meister, 2003).

Within contemporary Western cultures breastfeeding is situated between dichotomous discourses. On the one hand, the breast is a potent symbol of female sexuality, vicariously portrayed in popular newspapers and used in the sale of consumer goods. On the other, the breast is an organic source of nutrients for the infant (Carter 1995). Sociologists have long argued that during pregnancy and motherhood women are no longer seen as attractive; that is, they become asexual. Price (1988), for example, suggests that women shift from being perceived as 'seducers' to 'producers' and Charles and Kerr (1986) argue that women are perceived as 'functional' rather than 'ornamental'. All research suggests that this creates considerable ambivalence for women (Carter 1995, Murphy 1999, Earle, 2000) and for many women this becomes expressed as the decision not to breastfeed.

However, in spite of this ambivalence many women express feelings of pleasure during breastfeeding (Rowbotham, 1989; Rodriquez and Frazier, 1995). Research also suggests that, for some women, breastfeeding can make them feel 'sexy' (Kitzinger, 1987; Price, 1988).

Implications for midwives in practice

1. Midwives should consider their own sexual identity and reflect on how this might influence practice.

2. As providers of woman-centred and individual care, midwives should recognise the significance of sexuality as integral to an individual's experiences and expectations of reproduction.

3. Sexual diversity and sexual differences should be recognised and accepted.

4. Whilst it is recognised that discussing sex and sexuality can be difficult, midwives should reflect on their use of language and develop the skills to talk about sex.

Useful reading

Carter P. (1996) Breastfeeding and the Social Construction of Heterosexuality, or 'What Breasts are Really for'. In J. Holland and L. Adkins (Eds), *Sex, Sensibility and the Gendered Body.* London: Macmillan Press, pp. 99-119.

Haimes E. and Weiner K. (2000) 'Everybody's got a dad ...' Issues for lesbian families in the management of donor insemination, *Sociology of Health & Illness,* 22(4), 477 – 499.

Hastie N. (2000) 'Cultural conceptions': lesbian parenting and midwifery practice. In: D. Fraser (ed) *Professional Studies for Midwifery Practice*. Edinburgh: Churchill Livingstone, pp. 63-75.

RCM (2000) *Maternity Care For Lesbian Mothers*, Position paper 22. London: RCM.

Wilton T. (2000) *Sexualities in Health and Social Care*. Buckingham: Open University Press.

References

Bennett A. (1996) 'Leading Article', *The Guardian*, February 28(2), 8.

Billington R., Hockey J. and Strawbridge S. (1998) *Exploring Self and Society*. London: Macmillan.

Carter P. (1995) *Feminism, Breasts and Breastfeeding*. London: Macmillan Press.

Charles N. and Kerr M. (1986) Food for feminist thought. *The Sociological Review,* 34(3), 537-572.

DoH (2001) *The National Strategy for Sexual Health and HIV*. London: DoH.

Dundes L. (ed.) (2003) *The Manner Born: Birth Rites in Cross-Cultural Perspective*. Oxford: Alta Mira.

Earle S. (2000) Why some women do not breastfeed: formula feeding and fathers' role. *Midwifery*, 16, 323-330.

Earle S. and Letherby G. (2003) *Gender, Identity & Reproduction: social perspectives.* London: Palgrave.

Foucault M. (1979) *The History of Sexuality, Vol. 1: An Introduction.* London: Allen Lane.

Godfrey J. (1999) Empowerment through sexuality. In: G. Wilkinson & M. Miers (eds) *Power and Nursing Practice*, London: Macmillan, 172–186.

Hastie N (2000) 'Cultural conceptions': lesbian parenting and midwifery practice. In: Fraser D (ed) Professional Studies for Midwifery Practice. Edinburgh: Churchill Livingstone, 63-75.

Holland J., Ramazanoglu C., Sharpe S. and Thomson R. (1994) Power and Desire: The Embodiment of Female Sexuality. *Feminist Review,* 46(Spring), 21-38.

Hyde J. S., DeLamater J. D., Plant E. A. and Byrd J. M. (1996) Sexuality During Pregnancy and the Year Postpartum, *The Journal of Sex Research,* 33(2), 143-151.

Jackson K. (2003) Midwifery care and the lesbian client. British Journal of Midwifery 11(7), 434-437.

Jerrome D. (1993) Intimate Relationships. In: *Ageing in Society: an introduction to social gerontology*. In: J. Bond J, P. Coleman and S. Peace (eds), London: Sage, 226–254.

Kitzinger S. (1987) *The Experience of Birth,* 5th Edition. London: Penguin.

Laurance J (2004) IVF REVOLUTION Head of fertility watchdog says writing fathers out of the rules will extend the chance of treatment to all women. 'It's the relationship's quality that counts, not people's sex'. The Independent Wednesday 21 January : 6

Lewin E. (1998) Wives, mothers, and lesbians: resistace in the US. In: M. Lock and P. A. Kaufert (eds), *Pragmatic Women and Body Politics.* Cambridge: Cambridge University Press, 164 – 177.

Mace D. R., Banneman R. H. and Burton J. (1974) *The Teaching of Human Sexuality in Schools for Health Professionals*. Geneva: World Health Organisation.

McCann E. (2000) The expression of sexuality in people with psychosis: breaking the taboos. *Journal of Advanced Nursing,* 32(1), 132–138.

Murphy M. (1999) 'Breast is best': Infant feeding decisions and maternal deviance. *Sociology of Health and Illness*, 21(2), 187-208.

Niehoff A. and Meister N. (2003) The Cultural Characteristics of Breastfeeding: a survey. In L. Dundes (ed.), *The Manner Born: Birth Rites in Cross-Cultural Perspective*. Oxford: Alta Mira, pp. 181 – 190.

Nye R. A. (ed) (1999) *Sexuality*. Oxford: Oxford University Press.

Price J. (1988) *Motherhood: What it does to your mind.* London: Pandora.

RCM (2000) *Maternity Care For Lesbian Mothers, Position paper 22*. London: RCM.

Rodriguez-Frazier R. and Frazier L. (1995) Cultural Paradoxes Relating to Sexuality and Breastfeeding. *Journal of Human Lactation,* 11(2), 111-115.

Rowbotham S. (1989) To be or not to be: The Dilemmas of Mothering. *Feminist Review,* 31(Spring), 82-93.

Tobert A. (1990) Sexual Problems in Pregnancy and the Post-natal Period. *Midwife, Health Visitor and Community Nurse,* 26(5), 177-180.

Tolor A. and DiGracia P. V. (1976) Sexual Attitudes and Behaviour Patterns During and Following Pregnancy. *Archives of Sexual Behaviour,* 5(6), 539-551.

Tomlinson J. (1998) ABC of Sexual Health: Taking a sexual history. *British Medical Journal,* 317(5 December), 1573-1576.

Ussher J. M. (1989) *The Psychology of the Female Body.* London: Routledge.

Wilton T. (1996) Caring for the lesbian client: homophobia and midwifery. 4(3), 126-131.

Zeidenstein L (1990) Gynaecological and childbearing needs of lesbians. Journal of Nurse Midwifery. 35(1), 10-18.