Adaptation to Pregnancy as a Function of Sex-Role

Summer 1980

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ADAPTATION TO PREGNANCY
AS A FUNCTION OF SEX-ROLE

BY

ANNE HEIDRICH DIEBEL
B. A., St. Mary's College, 1964

THESIS

Submitted in partial fulfillment of the requirements
for the degree of Master of Science: Clinical Psychology
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ABSTRACT

Forty-four pregnant women were examined to determine how individual differences in sex-role orientation, as assessed by the Bem Sex-Role Inventory, were related to continued sexual interest, activity, and satisfaction in pregnancy. Subjects were further examined to determine the effects of sex-role identity upon third trimester anxiety levels as assessed by the State-Trait Anxiety Inventory, upon physical experience of pregnancy, upon emotional response to pregnancy, and upon labor and delivery records.

Subjects were examined periodically in the third trimester of pregnancy to determine current levels of functioning as well as to acquire retrospective prepregnancy and first and second trimester data.

As predicted, androgynous women were found to demonstrate a significantly superior level of sexual adjustment throughout the pregnancy period, \( F (3, 38) = 3.132, p < .037 \). Levels of adjustment for masculine, feminine, and undifferentiated women were also found to be in the predicted direction. Androgynous women were further found to demonstrate a unique pattern of sexual response to pregnancy. Significant effects for stage of pregnancy were also found in terms of both sexual adjustment, \( F (4, 152) = 28.354, p < .0001 \), and physical response to pregnancy, \( F (4, 156) = 3.825, p < .005 \). Hypotheses regarding sex-role orientation and emotional
response to pregnancy, anxiety levels in the third trimester, and labor and delivery records were not supported. Although scores in these areas were in the predicted direction, differences did not reach significant levels. The hypothesis concerning sex-role effects upon physical response to pregnancy was contradicted, but not to significant levels.

Results are discussed in terms of Bem's conceptualizations of sex-role identities and previous findings of studies of sexual behavior in pregnancy. Findings regarding the familial origins of the different sex-role groups are also explored.
Acknowledgements

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Dedication

This thesis is dedicated in loving memory of

my mother, Doris Feuerbacher Heidrich, who, with her loving and accepting nature, encouraged me to become aware of and to respect the needs of self and others;

my second mother, Madeline Fredericks Diebel, who consistently showed me that a woman could be both intelligent and nurturant;

my father-in-law and close friend, Nelson Wright Diebel, MD, who introduced me to the joys of a deep and satisfying commitment to the well-being of self and others.

It is also dedicated, in continuing commitment, to my husband, N. Donald Diebel, MD, PhD, who has been there through my many metamorphoses—sometimes supporting, sometimes accepting, and sometimes protesting—but always there. Your presence, and that of the parents whom you shared with me, have been deeply felt and profoundly appreciated.
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Introduction

Until very recent times, the study of the psychology of the human female has largely been neglected. Research, for the most part, has involved men. The psychological nature of women was simply assumed to be the opposite of the psychological nature of men. Recent cultural changes, however, have sparked an increased awareness of the need for such research. The natural and social sciences, industry, and government have undertaken a search for the 'reality' of women. In this probe between and beneath myths, folklore, and appearances, many aspects of her nature and the dynamic events and relationships of her life have been investigated.

One area which has been vigorously pursued involves such questions as: Is the definition of woman to which we have traditionally adhered accurate? Is the manner in which a 'typical' woman behaves and relates due to her nature or is this the result of the social and cultural system in which she has been raised and has lived? Is there an inherent, genetic difference between men and women which results in different, characteristic approaches to life, or is it an apparent difference, engineered and maintained by sociocultural forces? If a difference exists and it is not genetic and natural, what is 'natural' for a woman? Are the cultural expectations which are currently held accurate, beneficial, and/or desirable for a woman?

The questions have been varied and numerous. They have been asked intellectually, humorously, and emotionally—and responded to
in the same veins. These are important questions whose answers will have far-reaching consequences for societies as well as for individuals. Much of this area of investigation has been summarized under the concepts of sex-role identification.

**Sex-Role Identification**

From the beginning, psychologists have observed the world around them and reflected in their writings the male bias which they found there. Traditionally social scientists have conceived of two sex-roles--masculine and feminine. These have been as neatly divided as the physical characteristics of the two genders. They have been seen as opposites: the possession of the attributes of one necessitating a lack of the attributes of the other. Additionally, an individual's possession of characteristics commonly associated with the opposite gender was regarded as abnormal or maladjusted.

These roles, then, were seen as diametric opposites and one person could not be both masculine and feminine. He/she had to be neatly placed in one group or the other and the characteristics traditionally associated with that group attributed to him/her. Not only were people clearly grouped in this way, but the characteristics which defined each of these groups were carefully ordered and perpetuated through the education of young males and females as to society's expectations of them. This education encompassed behaviors, attitudes, personality characteristics, and 'appropriate' life-styles, as culturally defined.

Sigmund Freud concretized this issue with his "anatomy is destiny" theory. It is helpful to explore Freud's conceptualization in this area as his influence on later theorists and researchers has been
powerful. Freud theorized that sex-role development begins when the young phallic stage child first observes the naked body of the opposite sex. He contended that the basis of male-female personality differences lay in the divergent nature and resolution of the oedipal complex early in childhood. Male and female development was seen as identical up to the point at which the child, desiring mother for him/herself (seeing her as the source of all sexual gratification thus far) begins to view father as a rival. At some point after reaching this developmental stage, the explosive vision of males and females as either possessing or lacking a penis occurs. The conflict aroused by such a vision is resolved positively and constructively for males, but negatively and destructively for females, and leads in each case to the development of gender attributes.

Both genders interpret the female lack of a penis as being the result of her having been castrated. The male responds with fear of suffering the same fate (castration anxiety). He identifies with his powerful father, incorporates his attributes, develops a strong superego, and forms his sexual identity. The end result for the 'normal' male are the characteristics of aggressiveness, powerfulness, dominance, morality, rationality, and active sexuality.

The female, on the other hand, responds with shame, anger, and envy of those beings with a penis (penis envy). She also turns to her father, but her oedipal complex, unlike her brother's, cannot be resolved for father cannot give her either a penis or its symbolic substitute, a baby, and mother cannot be identified with for she is de-
valued and hated. The complex, therefore, lingers on. Due to the disinclination to identify with her unpopular mother, the young female fails to incorporate either her mother's attributes (although, considering Freud's view of 'normal' females, this would hardly seem helpful), or the characteristics of her powerful father. Thus she fails to develop a strong superego or an adequate sexual identity.

The results of this "penis envy" for women are: 1) a superego which is weaker than the male's; 2) feeling inferior to men and contemptuous of women; 3) the development of a personality characterized by passivity, vanity, jealousy, and masochism; and 4) the abandonment of active (masculine, clitoral) searching for sexual pleasure and the acceptance of passive (feminine, vaginal) gratification, as well as the generalization of this passivity into all aspects of life.

While Freud's theory on the psychosexual development of females has been repudiated by many, if not most, current thinkers, its importance in the development of sex-role theory must not be underrated. This theory was Freud's attempt to explain the nature of women based upon the reality he observed. The theory may have been wrong, but the observations were accurate. Further, this theory was then used to explain sexual differences, and indirectly to justify the social order by labeling it 'normal' and 'natural'.

Parsons and Bales (1955) defined the differences between men and women in terms of their approaches to, and divisions of, life's tasks. Masculinity was seen as 'instrumental', entailing actively providing for the family's material maintenance and support, and the
regulation of society so as to create a safe environment for that family. Femininity, on the other hand, was seen as 'expressive'; females being charged with the physical, emotional, and interpersonal health of the family. Males were seen as possessing the personality characteristics (such as aggressiveness, competitiveness, independence, etc.) which were necessary for him to fulfill his role. Accordingly, females were seen as dependent, passive, and nurturant, attributes useful in her role.

Erickson (1964) maintains a similar sexual division: the masculine role is conceived of as that of 'outer' space (interest in what he, as a man, can achieve, build, destroy, and/or maintain in the world at large), while the female's role is designated 'inner' space (referring to her primary interest in caring for, uniting, and nurturing others). In contrast to Freud, however, Erickson sees the feminine orientation as more ethical than the masculine.

To be "adjusted" according to such concepts implied that the individual male or female exhibit and be characterized by the thoughts, feelings, behaviors, and life-styles 'appropriate' to his/her gender. These attributes were felt to be those which would be conducive to fulfilling the individual's necessary role in society, and were further defined as natural.

There were some theorists, however, who suggested that the individual might embody both masculinity and femininity. Jung, in his theory of personality, describes the 'animus' (the masculine component) and the 'anima' (the feminine component). He believed
that the individual possesses both and that this is the means by which men and women understand each other. He further posited the concept of the 'personna' which is the mask which we all wear in relation to others, and which is defined by our social roles.

More recently, Bakan (1966) has described a similar concept—each individual being characterized by an 'agentic' (masculine) component and a 'communal' (feminine) component. The masculine part of the whole is concerned with the self as an individual and therefore with achievement, self-protection, assertiveness, etc. The feminine component, on the other hand, is one of selflessness. It is concerned with and about others and its aim is peaceful relationships with others for the good of all. Bakan feels that the integration of communion and agency is necessary for the individual to function successfully.

These ideas and the biological and cultural revolutions of the past two decades have caused many social scientists to question the accuracy and validity of the previously accepted male–female divisions. Psychologists such as Bem, Heilbrun, Broverman, Spence, Helmreich, and many others have begun to study the idea that 'masculinity' and 'femininity' are not necessarily exclusive concepts. They, like Jung and Bakan, maintain that it is not only possible for an individual to be both 'masculine' (instrumental, agentic, and outer-oriented) and 'feminine' (expressive, communal, and inner-oriented), but that this combination may well be the healthiest and most effective sex-role identity.

In their work, this type of individual has been designated 'an-
drogynous', from the Greek words for man (andro) and woman (gyne). There are numerous conceptual and methodological differences of opinion to be found in the literature of this young field, some as basic as the very definition of androgyny. The original conception was that the androgynous individual, due to his/her endorsement of both masculine and feminine attributes, could comfortably vary his/her behavior according to the needs of the situation rather than according to the stereotypic demands, restrictions, and expectations of society (Bem, 1975). Recently, however, some researchers are suggesting that what is involved is a 'blending' of masculine-typed and feminine-typed behaviors rather than a selection between these two groups (Heilbrun, 1978; Jones, Chernovitz, & Hansson, 1978; LaFrance & Carmen, 1980). Another description currently in use is that the androgynous person tends to be a process-oriented person while the sex-typed individual tends to be role-oriented (Forisha, 1978).

In order to verify the concept of androgyny, efforts have been directed toward the creation of instruments which will measure an individual's sex-role self-concept in terms of the new definitions. Research with such instruments has attempted to specify 1) the attributes and characteristics of 'masculine', 'feminine', and 'androgy­ nous' individuals; and 2) the effects of these self-identifications upon the individual's life-style and behavior. While the work in this area is still in the early stages, data has been gathered to answer, at least partially, some of the questions previously posed.

Bem's Sex-Role Inventory (BSRI) is one of the most frequently used scales and although factorial and validation studies continue,
it appears to be a reliable instrument. 'Masculinity' is represented by a score which demonstrates high self-identification with attributes on the Masculine Scale and low identification with Feminine Scale attributes. 'Femininity' represents the opposite configuration—high scores on the Feminine Scale and corresponding low scores on the Masculine Scale.

Originally, 'Androgyny' was operationally defined by scores indicating relatively equal identification with both masculine and feminine attributes, regardless of the strength of such identification. Behavioral research findings, however, have demonstrated that two different groups of individuals who used to be scored androgynous tend to emerge. While each group reports nearly equivalent endorsement of masculine and feminine attributes, one group places high in both areas while the other scores low in each. It is beginning to appear that this difference is an important one. Consequently, the term 'androgy nous' is now reserved for those individuals who are high scorers on both the Masculine and the Feminine Scales. The lower scoring group is designated 'undifferentiated'. A good deal of effort is currently being devoted to determining the characteristics of masculinity, femininity, androgyny, and undifferentiation, as well as some of the behavioral effects of such self-identification.

**Femininity**

In general, feminine sex-typed individuals of either gender have been found to be less effective, less initiating, and less satisfied with themselves. They tend to have a more negative self-concept than masculine or androgynous individuals (Broverman, Vogel,
They are higher in anxiety (Cosentino & Heilbrun, 1964; Gall, 1969; Gray, 1957), lower in self-esteem (Bem, 1977; Cosentino & Heilbrun, 1964; Gall, 1969; Spence, Helmreich, & Stapp, 1975; Webb, 1963; Harris, Note 3; Schiff, Note 9), and lower in social acceptance (Broverman et al., 1972; Gall, 1969; Gray, 1957; Sears, 1970; Webb, 1963).

Feminine women are not only perceived by others as believing that the events in their lives are controlled either by fate, luck, or the influence of powerful others, but do, in fact, hold an external locus-of-control orientation (Bedeian & Hyder, 1977; Hochreich, 1975). Femininity has been correlated with lower overall intelligence (MacCoby, 1966) and a decrease in motivation for mastery with age (Osofsky & Osofsky, 1972). Identification with a retiring-passive mother (a traditionally feminine mother) has been found to be related both to femininity in both genders and to a lower level of personal adjustment (Williams, 1976).

The 'ideal' woman has been described as emotional, sensitive, concerned with others (Spence & Helmreich, 1978), and as lacking the competency characteristics which are seen as male attributes and are highly valued by society (Broverman et al., 1972). Even though women have been found to have self-concepts which are significantly less feminine than their perception of females in general (Broverman et al., 1972), studies show that their self-concepts are such that they demonstrate deficits in effectiveness, adjustment, and personal satisfaction (Bem & Lenny, 1975; Heilbrun, 1968, 1976). Feminine
women have also been found to be high in nurturance and low in inde­
pendence (Bem, 1975), to have lower levels of self-regard, lower ed­
cucational aspirations, and fewer experiences of competence and success
(Harris, Note 3). Bedeian and Hyder (1977) found feminine individuals
to be lower in n Achievement, while Heilbrun (1968) found them to be
low in goal orientation but high in social sensitivity.

Traditional females are socialized to be dependent, passive, and
comforming (Maccoby, 1966; Maccoby & Jacklin, 1974). Heilbrun (1968)
states that the "expressive role involves a primary concern with the
relationship among others and between others and oneself--the re­
ceiving of pleasurable responses from others by giving pleasure"
(p. 132).

Women become motivated, through sex-role socialization, to main­
tain a 'feminine' self-image by suppressing any behavior considered to
be undesirable or inappropriate for her gender (Kagan, 1964; Kohlberg,
1966). Emulation of the feminine ideal appears to inhibit individua­
tion, achievement, and autonomy. This, in turn, severely minimizes the
number of opportunities for self-actualization. In her study, Nicklaus
(Note 8) demonstrated the detrimental effects of extreme acceptance
of the feminine role. Women accepting this role tended to deny or
avoid problems, to incorporate society's expectations and restrictions
into the self, to base self-esteem upon the opinions of others, and
to resign themselves to their 'fate'. The restrictiveness of the tra­
ditional role, according to Nicklaus' findings, led to feelings of
inadequacy, dependency, and impotence.

To develop femininity, young girls are taught that they are to
be submissive to men, that they need to develop domestic skills, and that they are never to exhibit signs or symptoms of sexual desire (Osofsky & Osofsky, 1972). Bem and Lenny (1975) and LaFrance and Carmen (1980) found that for sex-typed individuals, whether male or female, cross-sex behavior was motivationally problematic with the result that these sex-typed men and women tended to avoid such behavior. They also felt significantly worse than androgynous individuals if they did perform behaviors which were considered appropriate for the opposite sex. This appears to result in restricted and complicated lives. The sex-typed individual, through sex-role socialization, comes to accept and internalize society's definitions and proscriptions of appropriate and inappropriate behavior. Depending upon his/her unique composition of needs, wants, assets, and liabilities, such behavioral constriction may become not only uncomfortable but dysfunctional as well.

**Masculinity**

In most cases, the characteristics and behaviors of masculine and androgynous women have been found to be very similar. Bem (1975) found no difference in terms of independence and found masculine women to be adequately nurturant, although less nurturant than androgynous female subjects. Harris (Note 3) found no differences in terms of self-actualization and locus-of-control between the two groups.

In a study of sex-roles and personality dimensions using the BSRI and the Sixteen Personality Factor Questionnaire, Bernard (1980) found that masculine and androgynous individuals, regardless of gen-
der, shared the same discriminant space and that this space was associated with the instrumental dimensions of "venturous" and "assertive". Heilbrun (1978) found that his androgynous and masculine persons endorsed almost identical behavioral qualities. Masculine, like androgynous, individuals have been found to be high in self-esteem (Bem, 1977; Spence et al., 1975).

Several researchers (Bernard, 1980; Jones et al., 1978; Kelly & Worell, 1977) have suggested that experimental results indicate that it is the incorporation and exhibition of 'masculine' attributes which are correlated with effectiveness, adaptivity, and success, which account for the similar effectiveness of androgynous and masculine subjects. Bernard (1980) states that androgynous behavior was not associated with the simultaneous exhibition of masculine and feminine behavior which flexibility would suggest, but rather primarily with masculine-typed characteristics. It has long been recognized that these instrumental-type behaviors are those which are most valued in our society. Possibly, the androgynous individual achieves reinforcement through the exhibition of these masculine qualities and this results in high self-esteem. This still, however, leaves the fact of his/her high endorsement of feminine attributes, and the effect of such endorsement upon his/her behavior, unexplained.

Androgyny

Androgynous individuals have been found to possess qualities characteristic of both instrumentality and expressiveness, agency and communality, self- and other-direction. They exhibit not only a high
level of masculine independence but also a high level of feminine nurturance, whichever characteristic is appropriate to the situation (Bem, 1975). They have a larger repertoire of behaviors from which to draw and tend to exhibit a wider sample of that behavioral range at any one time than do their sex-typed counterparts (LaFrance & Carmen, 1980). They do not avoid cross-sex behaviors (Bem & Lenny, 1975; LaFrance & Carmen, 1980), but do tend to avoid the sex-consonant behavioral extremes more often exhibited by sex-typed individuals (LaFrance & Carmen, 1980). Heilbrun and Pitman (1979) also found that androgynous people, in situations permitting sex-role alternatives, behaved more flexibly, although their results did not indicate that such flexibility was adaptive.

Androgynous individuals have been found to have higher levels of self-esteem than any of the three other groups (Bem, 1977; Spence & Helmreich, 1978; Spence et al., 1975; Knox, Note 6), and are more comfortable engaging in cross-sex behaviors, particularly in the presence of an observer of the opposite sex (Bem & Lenny, 1975). They are, in general, behaviorally more effective (Bem, 1976; Heilbrun, 1968, 1976).

Heilbrun (1978) found his androgynous women to be different from the feminine females in his sample in terms of specific expressive characteristics, not in terms of expressiveness, per se. The androgynous women were less likely to compromise themselves for the sake of pleasing others or to elicit pleasant responses from them. One can hypothesize that these women have found other sources of satisfaction within themselves, in terms of personal goals. They are able to per-
form effectively both instrumentally and expressively without sacrificing their self-esteem, etc., in order to fulfill someone or something else's expectations or needs.

The acquisition of androgynous characteristics and behaviors, or the lack of them, appears to greatly affect many aspects and/or stages of a woman's life, as well as being an important determinant of the amount and type of satisfaction she gains. Jones et al. (1978), in their study across many behavioral and attitudinal areas, found androgynous women, as compared to feminine women, to be more politically aware, more creative, less sensitive to criticism, less conventional, and more outgoing.

Both androgynous and feminine women were found by Klein (Note 5) to experience role conflict, but androgynous women were much more aware of this conflict than feminine women. Perhaps this awareness encourages them to deal with the conflict resulting in their greater effectiveness, higher self-esteem, etc.

In a study of college women who were grouped in terms of social and sexual roles (either profeminist or profeminine), Hjelle and Butterfield (1974) found that the profeminist subjects were more liberal while the profeminine women were more traditional and conservative. The liberal (profeminist) women exhibited a higher level of personal growth and perceived themselves as feeling more confident about relying upon their own internal standards and norms rather than others'. They valued self-reliance and autonomy, were able to piece together past, present, and future into a more meaningful continuity, and were less troubled by guilt, regret, and resentment. They were
sensitive to what they were feeling and were confident enough to spontaneously express those feelings in actions.

Gump (1972) found with two groups of women with differing orientations (other-oriented and self-oriented) that they did not differ in the extent to which they had serious relationships with men. They did differ, however, in the extent to which they included finding a husband as one of their goals. When these subjects were divided into a high ego-strength group and a low ego-strength group, the division appeared to take place along a dimension based upon the woman's awareness of her needs, her ability to clarify her goals and to plan in terms of both her needs and her goals. Subjects with low ego-strength were dependent and inhibited, demonstrating neither instrumentality nor expressiveness to an effective degree. The highest group, on the other hand, were actively pursuing plans for both a career (instrumentality) and marriage (expressiveness). Gump states:

It is clear that one can be 'feminine' and possess high 'ego strength'... What is questionable is whether it is possible to possess high ego strength in the context of the traditional role, narrowly defined... The present findings suggest that purposiveness, resourcefulness and self-direction may be inconsistent with adoption of a role limited to the traditional, other-oriented goals and satisfaction.... The data suggest that the culturally esteemed quality of ego strength is inversely related to adoption of the female sex role, that more purposive, resourceful women are less traditional in their sex-role orientation. (pp. 90-91)

Undifferentiation

Few results are available at this time for undifferentiated individuals. Generally, however, what has been documented has not been flattering. The findings frequently correspond to those for feminine subjects, and at times indicate even greater ineffectiveness and/or
maladaption. For example, Bernard (1980) found that feminine and undifferentiated subjects shared approximately the same discriminant space (and in direct opposition to masculine and androgynous subjects) on the Sixteen Personality Factor Questionnaire. Neither femininity nor undifferentiation were associated with expressive or communal dimensions as expected.

Bem (1977) and Spence et al. (1975) found that their undifferentiated persons were the lowest in self-esteem. They reported earning less academic awards, experiencing the highest childhood illness rates, and dating less in college than androgynous individuals (Helmreich, Wilhelm, & Stapp, 1975). Kelly, O'Brien, Harford, & Kinsinger (cited in Kelly & Worell, 1977) in a recent investigation of the social skills-assertiveness correlates of sex-role orientations describe this group as "highly inept and socially ineffective" (p. 1112).

Sex-Role Identity and Sexuality

Cross-sex behavior is problematic for feminine women and results in feelings of being less feminine and enjoying themselves less (Bem & Lenny, 1975). This is especially true when the behavior is performed in the presence of an observer of the opposite sex. Ickes and Barnes (1978) have shown that when sex-typed males (i.e., males who report a high level of identification with 'masculine' personality attributes) interact with sex-typed females greater stress and interpersonal incompatibility are exhibited than when one or both individuals are androgynous. Such findings have decidedly negative implications for the male-female relationships in
which a woman finds herself, especially those such as wife and mother for which society has established clearcut role expectations.

Kirkpatrick (Note 4) has observed that women have been traditionally seen as passive, emotional, dependent, and sensitive. The effect of such characteristics or expectations upon female sexuality appears to be negative. The traditional view of women encompasses the view of woman as a sexual being; in this respect she is seen as passive, naive, and disinterested. Kirkpatrick states, however, that research evidence demonstrates that female sexuality actually demands characteristics directly opposed to these if sexual satisfaction is to be achieved. Empirically, she found a negative correlation between sexual satisfaction in women and acceptance of a traditional female role.

Kenrick, Stringfield, Wagenhals, Dahl, and Ransdell (1980) more specifically found that feminine females tended to choose 'soft-core' rather than 'hard-core' erotica, and if given the opportunity to refuse both, would choose to avoid such sexual material altogether. This finding was not true for androgynous women. Thus, although laboratory results have demonstrated that women have the potential to become aroused in response to erotica, they agree with Allgeier (1975) that this tends not to occur due to sex-role socialization.

Jones et al. (1978) found their androgynous and masculine women to be more sexually mature than their feminine women and to report more intimate heterosexual involvement and fewer feelings of inhibition. They also reported themselves to be less awkward, less easily embarrassed, and to have been more active sexually in adolescence.
Kenrick et al. (1980) found that approach rates, in terms of erotica, were very different for their females: the feminine and undifferentiated women showed very low rates, while the androgynous women showed little difference from their masculine and androgynous men. These studies used college women as subjects, a group which is usually considered to be more liberal than others.

If we assume that more traditional, feminine women will be more frequently found in the traditional marital role, Gove and Tudor's theories, published in 1976, on the relationship between the married female role, as defined by our society, and mental illness clearly illustrate the life-style effects of sex-role identification.

It has been noted for many years that women are subject to a disproportionately high rate of mental illness in this country. Based upon a survey and analysis of their own and others' data, Gove and Tudor contend that this imbalance is largely created by the rate of mental disturbance found in married women. Single, divorced, and widowed women all show lower mental illness rates than their male counterparts. These authors reason that the role of married women places such stress upon them that they become more susceptible to mental difficulties.

They cite as examples that 1) married women frequently have only their families as a source of gratification; 2) the primary instrumental role of these women is low in status and frequently below their ability level; 3) the relatively unstructured and invisible nature of the role allows for undetected poor performance and abundant time for brooding; 4) even if she works outside of the home, the married
female is usually again employed at below ability and low status levels; and 5) such women must live in a manner which enables them to adjust to whatever contingencies are provided by the males in their lives.

It seems reasonable to assume that the effects of this conflictual and dissatisfying life-style can be seen in areas more specific than a woman's level of general emotional adjustment. It is the particular contention in this paper that many of the sexually related characteristics and behaviors which are ascribed to women because they are female, are in reality no more attributable to their biological makeup or 'nature' than is their mental illness rate.

In an article written in 1967, M. L. Heinstein states: "The obviously close connection between a woman's sexual attitudes and her acceptance of the feminine role make understandable the function of the former as a predictor of general adjustment during pregnancy" (p. 234). Thus, it is these aspects of female functioning—sexuality and pregnancy—which will be examined in this study. Some of the questions to be posed are: 1) what is the effect of sex-role upon the experience of, and adjustment to, childbearing? and 2) what is the effect, specifically, of sex-role upon female sexuality in pregnancy?

Correlates of Adjustment to Pregnancy

Since the development, in World War II, of new medication, anesthetics and analgesics, as well as surgical techniques and instruments, a good deal of interest has been generated in one of the more important periods of a woman's life—pregnancy and childbirth.
The field of medicine first began exploring the antecedents of symptomatic pregnancy (i.e., pregnancies plagued with an unusual number and/or variety of complaints and complications) and difficult childbirth from a biological perspective. As study after study revealed that certain 'types' of women were prone to experience difficulties, psychiatrists and psychologists joined the task force. For many years, the major efforts were directed towards establishing anxiety, rejection of motherhood and/or own mother, arrested psychosexual development, etc., as the predisposing factors in obstetrical complications. The term 'obstetrical complication' refers both to abnormal conditions experienced during pregnancy and labor, and to the amplification of 'normal' changes and occurrences related to reproduction. Examples include extreme nausea and vomiting, prematurity, toxemia, and dysfunctional (prolonged or precipitous) labor.

Along with other factors, anxiety has been found to be characteristic of women who experience generally poor adjustment to pregnancy (Brown, 1962, 1964; Davids & DeVault, 1962; Davids, DeVault, & Talmadge, 1961; Gunter, 1963; Heinstein, 1967; McDonald, Gunther, & Christakos, 1963; McDonald & Parham, 1964; Zemlick & Watson, 1953). Anxiety has also been positively correlated with nausea and vomiting during pregnancy (Caldwell, 1958; Harvey & Sherfey, 1954), and with habitual abortion (Berle & Javert, 1954; Grimm, 1962; Weil & Stewart, 1957). A significant correlation has also been found between anxious mothers and prolonged labor (Baird, 1952; Caldwell, 1958; Cramond, 1954; McDonald et al., 1963; Scott & Thompson, 1956). McDonald's article (1968) is recommended for a more
Another characteristic consistently linked to problematic reproduction is dependency (Brown, 1962; Davenport-Slack, 1974; Grimm, 1962; Gunter, 1963; Heinstein, 1967; Mann, 1959; Weil & Tupper, 1960; Kirkpatrick, Note 4; Nicklaus, Note 8).

A third correlated attribute is sexual difficulty. The sexual problems cited are many. Brown (1962), Harvey and Sherfey (1954), and Kann (1950) found a decrease in sexual responsiveness to be correlated with symptomatic pregnancies. Rejection of sexuality (Zemlick & Watson, 1953), negative sexual attitudes (Watson, 1959), and sexual confusion (Weil & Tupper, 1960) have also been reported. This extensive list further includes: decreased sexual satisfaction and interest in intercourse, more difficulty with sexual functioning and with sexual intercourse in pregnancy (Brown, 1962), sex-associated guilt (Gunter, 1963), attitudes reflective of sexual maladjustment (Heinstein, 1967), decrease in sexual desire (Levy, Note 7), and reports of sexual disgust (Uddenberg, Nilsson, & Almgren, 1971).

Certainly, the degree of experimental control and adequacy of design has varied greatly in these studies. Some consist of case histories and/or clinical observations. For the most part, they suffer chiefly from the use of retrospective data and/or the use of a single measurement obtained during pregnancy (Spielberger & Jacobs, 1978). The sheer numbers and consistency of the findings, however, yield at very least a strong suggestion of correlation. The case for anxiety has been more clearly substantiated in more recent studies (Williams, Williams, Griswold, & Holmes, 1975; Wolkind,
Still another area which has aroused interest and investigation has been the study of the tendency to adopt a 'sick-role' during pregnancy. This refers to the tendency of some women to conceptualize pregnancy as a time of illness; that is, as a condition which they will have to endure in order to 'get well' again. The acceptance of such a definition results in restricted expectancies in terms of social and familial obligations and responsibilities, behavior 'as if' ill, and being pampered and given extra attention from others. The belief in such a role frequently occurs not only in the pregnant woman, but is also supported by her husband, her doctor, and/or other health personnel as well. A correlation between 'sick-role' adoption and symptomatic pregnancy and/or labor and delivery complications has been shown.

Rosengren, for example, in 1962 found adoption of a 'sick-role' in pregnancy to be positively correlated with longer active labor, social instability, and lower social class. Brown (1962) identifies the woman who adopts a 'sick-role' in pregnancy in the following manner: they are worriers (about money, husbands, and generalities); they are generally conflicted and dissatisfied sexually, a condition which is intensified by pregnancy; they have a history of irregular and troubled menstrual periods; they have difficulty with interpersonal relationships; their relationships with their husbands are troubled and characterized by great dependency and insecurity; they are very anxious and do not seem to handle anxiety well; they are essentially "ambitious but conventional under-achievers reacting to
social disorganization... sick-role appears to be a further incident in a troubled pattern, not a source of problems" (p. 315).

Claus (Note 2) found that women with traditional attitudes toward the female role were higher in illness behavior and sick-role behavior in general, than women with a more modern attitude toward the female role. Auerbach (Note 1) found that the most important social factor in determining the likelihood that a woman would adopt this role during her pregnancy was her socialization for parenthood. More traditional women also tend to report more stressful menstrual symptoms than women with a more modern or liberal role-orientation (Brantesani & Silverthorne, 1978).

From a survey of the literature it is possible to obtain a 'picture' of the woman who is more likely to experience difficulties associated with pregnancy and/or childbirth. We have seen that she is more apt to be anxious and overly dependent (Brown, 1962; Doty, 1967; Heinstein, 1967). She has difficult interpersonal relationships in general and is insecure in her marital relationship (Brown, 1962). She is more apt to be depressed (Heinstein, 1967; Uddenberg, et al., 1971), moody (Heinstein, 1967), and emotionally immature (Blau, Slaff, Easton, Weldowitz, Springarn, & Cohen, 1963). Low ego-strength, low self-esteem, and a proneness to suffer from guilt are also likely characteristics of these women (McDonald, Gynther, & Christakos, 1963). She is probably sexually conflicted, both before (Baxter, 1974a) and during pregnancy (Brown, 1962; Heinstein, 1967; Uddenberg, et al., 1971). The conflict ranges from decreases in desire and satisfaction to outright aversion. She is likely to
adopt a traditionally feminine sex-role (Claus, Note 2). Indeed, such a woman fits our earlier description of a feminine female. This relationship has occurred to other investigators (Brown, 1962; Heinstein, 1967; Uddenberg, et al., 1971).

While the literature is more abundant on the subject of women who experience difficulty in pregnancy, some characteristics of the women who are successful in this undertaking have been identified. Such a woman is more apt to be emotionally stable (Kann, 1950) and to have accepted her pregnancy (Brown, 1962). She is less anxious (Brown, 1962) and yet she exhibits appropriate concern in terms of actively seeking information and preparing for both childbirth and motherhood (Wales, 1979). She is probably of higher social status and experiences greater marital closeness (Norr, 1977). She possess such characteristics as self-reliance, self-control, and independence to a much higher degree than does her opposite; i.e., she has an internal locus-of-control orientation (Davenport-Slack, 1974; Norr, 1977). She also desires and prepares for active participation in childbirth (Davenport-Slack, 1974; Tanzer, 1967). She tends to be orgasmic before pregnancy (Baxter, 1974b) and sometimes experiences an increase in sexual desire during pregnancy (Kann, 1950; Levy, Note 7).

This description is similar to that of an androgynous (and to a slightly lesser degree in some respects, a masculine) woman. Norr (1977) found that less traditional attitudes towards sex-roles were correlated with an increased likelihood to
"prepare for childbirth, to have their husband's help during labor and delivery, and to have less pain and more enjoyment during birth" (p. 260). Thus, these women are able not only to plan, direct, and actively participate themselves (instrumental), but they are also able to reach out to another for assistance (expressive). They combine these two for a more effective and satisfying behavioral outcome.

Anxiety

A brief exploration of anxiety, in general, is appropriate at this time, to be followed by an exploration of anxiety in pregnancy. Spielberger's State-Trait theory of anxiety can be summarized as follows: When an individual is presented with a stimulus event which he or she perceives as threatening, an anxiety state characterized by specific physiological and emotional reactions is experienced. Spielberger (1972) terms this condition an A-State anxiety reaction.

A-State anxiety is conceptualized as a transitory emotional state which may vary in intensity and fluctuate over time. Whether or not this occurs is dependent upon the objective danger inherent in the situation, the individual's perception of that danger, his/her past experience in such situations, and his/her ability to cope with it. Thus, this is an highly subjective experience.

A-State anxiety is experienced as unpleasant. Therefore, the individual will attempt to cope either through the use of coping strategies previously developed to successfully deal
with the stimulus or through the use of defense mechanisms which reduce the experienced intensity of his/her reaction to the stimulus. The duration of his/her reaction is dependent upon the duration of his/her perception of the event/stimulus as threatening. A-State anxiety motivates the individual to action, hopefully adaptive action.

A-Trait anxiety, on the other hand, refers to "relatively stable individual differences in anxiety proneness, that is, to differences in the disposition to perceive a wide range of stimulus situations as dangerous or threatening and in the tendency to respond to such threats with A-State reactions" (Spielberger, 1972, p. 39). Not only do people high in A-Trait anxiety tend to perceive a wider range of situations as threatening, but they also tend to react more intensely to these situations than do people low in A-Trait anxiety.

Research has revealed some interesting characteristics about individuals who are high in A-Trait anxiety. They tend to perceive events involving failure, ego threats, and threats to self-esteem as more threatening than do those low in A-Trait anxiety (Atkinson, 1964; Sarason, 1960). They do not, however, differ from subjects low in A-Trait anxiety when presented with stimuli involving physical danger (Basowitz, Persky, Korchin, & Grinker, 1955; Hodges & Spielberger, 1966; Katkin, 1965).

Anxiety And Sex Roles

While sex-role identity studies have shown feminine women to be the most anxious of all women, (Cosentino & Heilbrum, 1964;
Gall, 1969; Gray, 1957), no literature exists on the nature of the anxiety characterizing these women. When one considers that women high in femininity appear to be low in self-esteem, low in instrumentality, low in internal locus-of-control orientation, and low in the ability to take the initiative (Bem, 1976), it is tempting to conclude that such women are high in A-Trait anxiety. Certainly, on a superficial or common sense level, the possession of longstanding passive and non-assertive characteristics would seem to be an adequate framework for the development of, or a predisposition to, chronic anxiety. Androgynous and masculine women, in contrast, would be expected to exhibit more appropriate A-State reactions.

**Anxiety in Pregnancy**

As noted earlier, anxiety has been consistently linked to obstetrical difficulties. Jean M. Hanford (1968) has proposed an interesting model of pregnancy as a state of conflict. She bases her theory upon the work of Festinger (1957) and his cognitive dissonance theory, and on Selye's model of the General Adaptation Syndrome. She posits a model of both 'normal' and 'non-normal' response to the conflict of pregnancy.

Hanford feels that the discovery of pregnancy is a conflictual situation for all women. No matter how actively the pregnancy may have been desired, there are always some negative aspects. Assuming that, for whatever reasons, abortion is not a viable option for the woman, the fact of pregnancy is a conflict which she cannot avoid or escape. The pregnancy period, therefore,
is a time of conflict resolution or reduction. The task is to bring the negative cognitions into accordance with the reality (the child will be born) and to enhance the positive aspects of the pregnancy condition.

Normal response to this conflict situation is conceptualized in the following manner: In the first trimester the conflict is felt and the physical symptomatology of that conflict is exhibited in terms of the commonly seen symptoms of early pregnancy (nausea and vomiting, fatigue, etc.). The severity and duration of these symptoms corresponds to the severity and duration of the conflict.

In the second trimester, the process of conflict resolution has reduced the severity of the negative cognitions, enhanced the attractiveness of the positive cognitions and thus brought about increased comfort with the reality of the baby's imminent arrival. Moreover, society has rewarded the woman's efforts. Thus, symptoms greatly abate or disappear, and a period of much greater calmness occurs.

In the last half of the third trimester or so, the reality of labor and delivery begins to become exceedingly clear with a resultant rise, again, in anxiety. This, however, is not due to conflict such as occurred early in pregnancy, but to realistic fears of pain, harm, or even death. The level of these fears should be indicative of labor difficulty or ease. Hence, for women bearing their first child, for whom labor and delivery represents the unknown, it is expected that these levels will be higher and labor and delivery more difficult.
In Hanford's 'non-normal' response model, the conflict is greater. This is due either to the perception of more or larger negative aspects of the pregnancy or to the presence of other stressful situations in the woman's life. Therefore, resolution is more difficult and takes longer (if, indeed, resolution is ever accomplished).

The pattern in such a pregnancy, then, begins in the first trimester with pregnancy symptoms which are more severe and of longer duration than is usual. They may continue into the second trimester as well.

Anything which contributes to the degree of conflict or the number of conflicts experienced increases the chances of pregnancy or childbirth complications. These women experience some level of difficulty throughout pregnancy. There is, however, usually some degree of reduction in the second trimester due to the use of denial and/or repression.

In the third trimester, anxiety levels again climb due to the anticipation of delivery. For these women, however, the normal fear of delivery is superimposed upon the conflicts which existed before pregnancy and those arising as a result of pregnancy, none of which have been successfully resolved. Difficulties in labor and delivery may be anticipated in accordance with the level of stress and/or conflict.

Hanford interprets earlier research findings on the relationship of emotional factors and obstetrical difficulties to suggest
certain qualities of these women which render them especially vulnerable during pregnancy. She cites "attitudes to feminine role and all of the associated aspects such as menstrual history, sexual attitudes, attitudes toward mother, father, husband; 'abnormal' ratings of psychological tests; 'sick role' expectations in pregnancy..." (p. 1317), and others as sufficiently disturbing and influential in a woman's life to suppose that conflict due to them would be greater when faced with the birth of a child.

Support in the literature for such a theory may be found. Leifer (1977) found that while most of her sample experienced pregnancy as a period of psychological stress, only part of them were able to use this stress as a means to personal growth. Those who were least stable before pregnancy experienced the greatest difficulty. Wolkind in 1974 found that women who demonstrated greater neurotic symptomatology before pregnancy experienced more psychological and physical difficulties during pregnancy than did women without such problems prenatally.

Chertok, Mondzain, and Bonnau (1963) found a connection between ambivalent, conflictual feelings concerning the desirability of the child and vomiting in pregnancy. The women who were higher in vomiting behavior were ambivalent women generally and had been so since before pregnancy. Heinstein (1967) found that women who rejected being pregnant and did not see themselves as maternal experienced more somatic complaints
and problems in pregnancy. This pattern was only an extension
and/or escalation of patterns existing prior to pregnancy.
Zajicek and Wolkind (1978) found that the women who experienced
the greatest difficulties during pregnancy had a history of
problems before pregnancy. They exhibited emotional instability
whether pregnant or not pregnant. Doty (1967) too found that
attitudes exhibited during pregnancy were reflective of basic
personality characteristics rather than a simple reaction to the
psychological stress of pregnancy.

In her summary of current findings in this area, Wales (1979)
states that highly anxious women have been repeatedly shown to
have a more difficult time in childbirth. She cautions that a
distinction must be drawn between a "normal, generalized anxiety"
and "the high level of anxiety that is likely to be associated
with a difficult or prolonged delivery" (p. 46). She also states
that these highly anxious women tend to handle anxiety through
the means of denial and repression, a finding consistent with
Hanford's explanation of the second trimester period of relative
lessening of symptomatology in the 'non-normal' response
pregnancy.

Morris (1968) reports that the evidence suggests that a high
percentage of women experience depression and feel unwell in the
early stages of pregnancy. Barclay and Barclay (1976), in
studying the second trimester of pregnancy, found that attitudes
and concerns existing before pregnancy are not significantly
affected by pregnancy when assessed at this time. Grimm (1961)
found a significantly higher level of tension among pregnant women in the later parts of the third trimester as compared to earlier. In a study conducted in 1975 by Lubin, Gardner, and Roth, anxiety scores in the first and third trimesters were found to be significantly higher there than in the second trimester.

Results of recent studies which investigated anxiety and pregnancy have demonstrated a clear positive relationship between higher anxiety levels and obstetrical complications (Falorni, Fornsarig, & Stefanile, 1977, cited in Spielberger, & Jacobs, 1979; Lubin et al., 1975; Edwards & Jones, 1970; Gorsuch & Key, 1974; Srabstein, Bejar, Elleson, Weingola, Marinoff & Stefancik, 1977, cited in Spielberger & Jacobs, 1979). Results have been conflicting as to the exact pattern of anxiety levels involved.

Four studies have investigated this. Lubin et al. (1975) found that state anxiety was significantly higher in the first and third trimesters and that high levels of both state and trait anxiety were associated with more symptomatic pregnancies. Edwards and Jones (1970), Gorsuch and Key (1974), and Srabstein et al. (1977) all found no significant differences for trait anxiety as a predictor of obstetrical complications.

Edwards and Jones (1970) administered both the state and trait scales weekly during the third trimester. They found different patterns of change in A-State levels for their mothers
who experienced 'normal' labor and delivery experiences and for those who had 'abnormal' experiences. The mothers who delivered without complications showed a marked increase approximately six weeks before delivery. Their level stayed low until one week pre-delivery when it rose dramatically. The abnormal deliverers were higher consistently until one week before delivery when they showed a striking decrease in A-State level.

Gorsuch and Key (1974) administered both STAI scales to pregnant women at the first prenatal visit and the A-State scale at each subsequent visit to the physician. They found that women who experienced obstetrical complications were significantly higher on the state scale during the third and fourth lunar months and significantly lower in the sixth lunar month than women who delivered without difficulty. Srabstein et al. (1977) found that their abnormally delivering subjects were significantly higher in the second and third trimesters. They also demonstrated specific patterns correlated with specific childbirth problems such as low birth weight.

I feel that acceptance of a traditional feminine role by a woman may result in exactly the predispositions discussed by Hanford and others. These women, as stated previously, tend to be anxious, low in self-esteem, dependent, and to see themselves as controlled by fate or powerful others. Additionally, they are more likely than masculine or androgynous women to be low in the instrumental dimensions necessary to successfully cope in
stressful situations. It is possible that the degree of acceptance of such a role will be found to be directly related to the degree of difficulty experienced in pregnancy and childbirth.

Sexuality in Pregnancy

The area of female sexuality during pregnancy had been investigated minimally in some of the studies involving obstetrical complications which were cited earlier. Masters and Johnson, in 1966, published the first study of any real depth. This was followed in the next ten years by four other investigations (Falicov, 1973; Kenny, 1973; Solberg, Butler, & Wagner, 1973; Tolor & DiGrazia, 1976). Findings have been anything but consistent for most aspects of sexual behavior in pregnancy.

For example, Masters and Johnson (1966) found evidence for an initial decline in sexual interest and activity in the first trimester of pregnancy; a dramatic increase in both to levels higher than before pregnancy in the second trimester; a decrease again in the third trimester; and an increase to prepregnancy levels within six to eight weeks following delivery. Kenny (1973) found essentially the same pattern in his much smaller sample, with the exception that the second trimester levels were not above prepregnancy levels. Falicov (1973) found a pattern similar to Kenny.

Solberg et al. (1973), on the other hand, found a pattern which showed a gradual, almost linear decrease in both sexual
desire and behavior as pregnancy progressed. Tolor and DiGrazia (1976) replicated the Solberg et al. findings.

There are several possible sources of these differences, all arising from the difficulties inherent in studying pregnancy. The ideal method would be to interview subjects throughout the year before pregnancy to establish baseline data, then again at regular intervals during pregnancy and the postpartum year. Obviously the cost in terms of time and money would be great. Also, the fact that the subjects planned to become pregnant would render generalization questionable.

Various compromises have been used, none without their faults. Masters and Johnson used volunteers who were known to their clinic, thereby introducing women whose orientation to sexuality was probably quite different from the average woman. These 111 women were interviewed at various times throughout pregnancy and the postpartum period. This method of interviewing periodically as pregnancy advances seems desirable. However, the possibility exists that this may, of itself, introduce changes in the very behavior which is being measured. For example, questioning may increase awareness and indirectly lead to changes in the behavior under study. This investigation was the only one which included the husbands of the pregnant women. The 79 male volunteers were interviewed once, three months postpartum.

Kenny used a nonrandom sample of 33 women who were known to him. He did not state how they were known to him, but
selection bias and the questionable freedom of their responses due to the nature of the subject material and their possible relationships with the investigator, must be considered. Additionally, eight of the women were currently breastfeeding infants, one was pregnant but not responding in terms of that pregnancy, and the other 24 were neither of these at the time that the questionnaire was administered. A retrospective questionnaire covering the three trimesters of pregnancy and the postpartum period was used. As the ages of the women's youngest children ranged from two months to seven years, the respondents were in highly varied postpartum stages at the time the data was collected and the effects of such long-term recall for some of the women would seem to invalidate these results, or at least render them questionable. The problem of using retrospective instruments is difficult to avoid when studying pregnancy, but possible inaccuracy due to the effects of recall may compromise any conclusions.

Falicov studied nineteen primigravidas (women carrying their first child), thus her findings are not strictly comparable to the others in that multigravidas (women having at least one previous pregnancy) are not represented. However, with the exception of Masters and Johnson's study, differences between primigravidas and multigravidas, in terms of pregnant sexuality, have been negligible. The women in this study were also all white, middle class, and experiencing planned pregnancies. While controlling these factors does eliminate them as sources of
confounding, the generalizability of the results is also limited. The women were interviewed during each of the three trimesters, the immediate postpartum period, and three months postpartum. Sexual adjustment was assessed at each period and compared to retrospective prepregnancy data.

Solberg et al. interviewed 260 women immediately postpartum and did not, therefore, study the postpartum period. The periods studied retrospectively were prepregnancy, the first two trimesters and the seventh, eighth, and ninth months of pregnancy. Sexuality was compared to prepregnancy levels. Exclusively retrospective data again introduces possible accuracy of recall problems.

Tolar and DiGrazia used still another design in order to circumvent the retrospective data issue. They formed groups of women (N = 216): one group in the first trimester, one in the second trimester, one in the third trimester, and one six weeks postpartum. While this eliminates the problem of retrospective data except in the case of prepregnancy behavior, the possibility of extraneous variables should be considered.

Other problems faced in the comparison of results involve such things as different methods of comparison (some studies obtained a retrospective prepregnancy baseline with which to compare pregnant sexual behavior and others did not); different periods under study (the chief difference being that some studies investigated the third trimester as a whole, while others divided
it into three monthly segments); and different definitions of independent and dependent variables (for example, some studies appear to define sexual satisfaction as the achievement of orgasm while others view it as an emotional, psychological entity).

**Findings on Sexual Behavior in Pregnancy**

**Sexual desire.** Masters and Johnson, Kenny, and Falicov all detected a pattern consisting of an initial decrease in the first trimester, an increase during the second trimester, a decrease to below first trimester levels in the third trimester, and an increase to prepregnancy levels postpartum. The only difference in their findings concerns the amount of increase in the second trimester: Masters and Johnson found this to be above prepregnancy levels while the other two did not. Both Tolor and DiGrazia, and Solberg et al. found a gradual, almost linear, decrease in sexual interest as the pregnancy progressed.

**Frequency of intercourse.** For all of the studies, the overall pattern of coital frequency was the same as that for sexual interest.

**Frequency of orgasm.** Paralleling their findings on sexual interest and coital frequency, both Tolor and DiGrazia, and Solberg et al. found a steady decrease in the number of coital encounters which resulted in orgasm as pregnancy advanced. Kenny found no difference at all on this factor. Solberg et al. did find a correlation between whether or not a woman was orgasmic with frequency of coitus for the first and second trimesters, the seventh month, and the eighth month, but not
for the ninth month.

Frequency of multiple orgasm. Solberg et al. found that the frequency of multiple orgasms decreased steadily throughout the pregnancy. Tolar and DiGrazia, on the other hand, found the incidence of multiple orgasms to be about the same as before pregnancy during the first trimester, increased in frequency during the second trimester, and decreased dramatically during the third trimester.

Intensity of orgasms. Kenny found the intensity of orgasms to remain the same throughout pregnancy, while Solberg et al. again found a gradual and general decrease.

Use of non-coital sexual practices. In Kenny's study, the majority of women preferred 'petting' to mutual climax as an alternative to intercourse, if intercourse was prohibited. Falicov addresses this issue only in the third trimester. She found that only 32% of her pregnant women engaged in erotic play with some sexual satisfaction when intercourse ceased.

Solberg et al. found that their women who were highly active coitally were also more likely to employ masturbation. However, in general, there was a dramatic decrease very early in pregnancy in the use of masturbation, oral stimulation, and manual stimulation by the partner. For those who continued to use these practices, only in the case of oral stimulation did the rate of orgasm decline.

Tolor and Digrazia ascertained that the majority of their
subjects preferred vaginal stimulation during the first trimester. However, after this (and including the postpartum period), the type of stimulation preferred was clitoral, followed by breast stimulation. Oral stimulation was much more popular in the postpartum group as compared with the pregnancy groups.

**Satisfaction with sex life.** In her study, Falicov found satisfaction with sex life to follow the same pattern as sexual desire and frequency of intercourse: decrease in first trimester, increase in second, decrease in third. Tolor and DiGrazia found that satisfaction maintained a life of its own—it remained equal to prepregnancy levels during both the first and the second trimesters and decreased slightly in the third.

**Reasons for decrease in sexual desire.** Solberg et al. found that the women in their study gave the following reasons, in order of frequency of response, for their decreased sexual desire: physical discomfort, fear of injury to the baby, loss of interest, awkwardness having coitus, recommendation of physician, reasons extraneous to the pregnancy, loss of attractiveness in woman's own mind, recommendation of person other than physician, and 'other'.

Falicov's and Masters and Johnson's pregnant women gave reasons associated with physical symptoms such as fatigue, nausea, sleepiness, and heartburn most frequently in the first trimester. Other reasons prominently mentioned at this time were fear of injuring the baby or causing a miscarriage, and a feeling of tightness and/or tension in the vagina. In the second trimester
fatigue, tenderness of the breasts, and genital discomfort were cited in Falicov's study. For some, fear of injuring the fetus continued but was diminished, and positional changes necessitated by the size of the abdomen were disturbing.

Late in pregnancy, both Falicov's and Masters and Johnson's women named fear, anxiety, and sleeplessness as causes of reduced desire. Masters and Johnson also found a sizable portion of their women at this time who either avoided sexual contact because they felt personally unattractive or who felt that their husbands avoided them because of their physical appearance.

Coital positions. Solberg et al. found a decrease in the male superior position (the most popular position before pregnancy), and an increase in other positions, especially the side-by-side position, as pregnancy advanced. However, overall, variability in positions steadily declined with stage of pregnancy. They found no significant correlation between frequency of intercourse and position used. A low-order relationship did exist between women who were more coitally active and the side-by-side position. Position used was also not significantly related to rate of orgasm.

Desire to be held. Tolor and DiGrazia found striking evidence of the women's rising need to be held, to have physical contact, as pregnancy advanced. This relationship was also found by Hollender and McGehee (1974) along with an indication that, as sexual interest diminished, this desire to be held increased.
Extramarital sex. Masters and Johnson were the only ones to include an investigation of the extent of extramarital sex during pregnancy, and they only studied this among the husbands of the pregnant women. They found that in the later part of the third trimester, when most doctors banned intercourse, 15% of the husbands surveyed (12 out of 79) sought sexual outlets outside of the marital relationship. During the six week postpartum abstinence period, these men continued this practice and others joined them. The resulting total number of men engaged in extramarital sex during the postpartum abstinence period was 23%.

Hypotheses

A review of the current literature suggests that clear changes, both physiological and psychological, occur in women when they become pregnant. Prior investigations, such as those found in the medical literature, strongly suggest that these changes are interrelated in some way. It is assumed, in the present study, that diverse responses to the condition of pregnancy are the result of aspects of the women themselves interacting with the physical reality of their pregnant condition and its attendant ramifications.

Based upon earlier findings in the areas of sex-role identification and pregnancy complications, it is felt that one important aspect of the woman which is likely to be involved is the nature of her sex-role identification.

The demonstrated correlation between a woman's sex-role and her sexual attitudes and behaviors was discussed earlier.
This paper represents an attempt to verify the contention that pregnancy is a further example of a woman's sexuality and is therefore similarly influenced by the socialization process and her resultant sex-role identity. This is even more strongly suggested when pregnancy and childbirth are considered as a major aspect of a woman's total sexuality. When one considers that a woman commonly spends approximately one-half of her life avoiding, seeking, or experiencing the fertile consequences of her sexual behavior, the integral part which pregnancy plays in her life-long sexual expression is clear.

It is believed that a woman's sex-role identity could be one source of the 'crisis' of which Hanford speaks—a very intimate source. A woman's self-perception deeply affects her efforts to resolve a crisis. Not only is a very feminine (or an undifferentiated) woman characteristically less well equipped than an androgynous or masculine woman to cope with such a crisis, but it is felt that she enters the pregnancy already crisis-ridden. An attempt to empirically demonstrate these suggestions through the use of Bem's Sex-Role Inventory will be made.

Studies on sex-roles have identified certain characteristics of feminine and undifferentiated women, such as anxiety, dependency, low self-esteem, and lowered behavioral effectiveness, which are problematic for them. These same characteristics,
plus sexual conflict and depression, have been found to correlate with complications of pregnancy.

Accordingly, it is hypothesized that:

1) Androgynous and masculine women will achieve higher scores on the Sexual Adjustment to Pregnancy Scale than feminine and undifferentiated women.

2) Androgynous and masculine women will achieve higher scores on the Physical Response to Pregnancy Scale than feminine and undifferentiated women.

3) Androgynous and masculine women will achieve higher scores on the Emotional Response to Pregnancy Scale than feminine and undifferentiated women.

4) Androgynous and masculine women will achieve higher scores on the Response to Childbirth Scale than feminine and undifferentiated women.

5) Feminine and undifferentiated women will exhibit higher levels of state-type anxiety than androgynous and masculine women.

6) Feminine and undifferentiated women will exhibit higher levels of trait-type anxiety than androgynous and masculine women.

7) All women will exhibit the highest levels of state-type anxiety in the ninth month.
Method

Subjects

Volunteer subjects were sought from among the pregnant women participating in the Prepared Childbirth classes taught at the Orlando Regional Medical Center (ORMC) in Orlando, Florida. These classes are taught at the two branches of the Medical Center, the Orange Division and the Holiday Division. Both divisions are used by the same private physicians.

At the Orange Division, this course is taught in a series of six class sessions which meet once a week. The Holiday program consists of a series of eight classes taught twice a week. Each program includes both lecture and exercise components. Course material covers the following areas: education in the physiology of pregnancy, labor and delivery; exercises both in preparation for, and to be used during, labor and delivery; and infant care. Both programs are based upon the Lamaze method of prepared childbirth and are offered during the last trimester of pregnancy.

The majority of subjects became available for study in their seventh month and were questioned retrospectively concerning the earlier portions of their pregnancy. Initial contact was made at the first session of the Holiday classes and the first or second session of the Orange classes. At this time, an oral presentation was made to the entire class (see Appendix I). This presentation described the study as an investigation of the emotional
and sexual changes occurring during pregnancy. The demands upon individuals as subjects were outlined. This included an explanation of the explicit nature of the sexual questions, a warning about the length of the questionnaires, and an explanation of the necessity of repeatedly asking the same questions so as to trace change over time. Subjects were asked not to share their answers with their spouses in order that the honesty of their answers, and therefore, the validity of the study, would not be compromised. An offer to share results with subjects completing the study was made at this time, followed by a request for volunteers. A written statement of purpose and method were also distributed (see Appendix II).

Those women agreeing to participate were asked at this session to 1) sign an agreement to participate (see Appendix III); 2) sign a release of hospital delivery records (see Appendix IV); and 3) complete a General Information form (see Appendix VIII). Support from the nursing staff involved in teaching these classes was excellent, usually including a statement of possible uses by health personnel for the information to be gathered from the study.

It was decided to seek volunteers in these classes as continued contact during the later stages of pregnancy was readily available through their class participation. However, data biases and limits to generalization of data are one result of this decision.

Approximately 45% of the deliveries occurring at this center are 'clinic' patients. Few of these patients participate in the Lamaze classes. The socio-economic and educational levels of the
sample are therefore biased in an upward direction as compared to the general population of this area. The disinclination of clinic patients to avail themselves of these courses also tends to bias the sample racially as few non-Caucasian women attempt this type of childbirth preparation, at least at this center.

Of the 95 women agreeing to participate, 44 (46%) completed all of the schedules covering the different stages of pregnancy. It is the data based on these 44 women which will be reported. Two of these mothers delivered prematurely and therefore did not report on the ninth month.

The only restriction upon participation in the study was that the women were either married or in an ongoing relationship, i.e., they had been living with the father of this baby for at least four months prior to becoming pregnant and were continuing to do so throughout the pregnancy. The purpose of this restriction was to limit the sample to women involved with a relatively constantly available and familiar sexual partner throughout pregnancy.

**Subjects**

The 44 subjects ranged in age from 19 to 32 years of age (19-23 years = 32.6%, 24-28 years = 51.2%, 29-32 years = 16.2%). All of these women had completed at least eleven to twelve years of education (11-12 years = 40.9%, 1-2 years college = 27.3%, 3-4 years college = 27.3%, graduate degree or more = 4.5%). Income ranged from $0-2,000 to $21,000 or more, with 65.9% of the women reporting a family income of $16,000 or more. Eighty-four
percent of the volunteers were employed at least some of the time during this pregnancy.

The sample was 100% Caucasian. Seven non-Caucasian women signed up to participate, but all of these women dropped out before delivery, five of them never sending in any of the forms. Married women comprised 97.7% of the sample. Length of marriage or relationship ranged from six months to eleven years (0-3 years = 56.8%, 4-7 years = 31.8%, 8-11 years = 11.4%). Three women (6.8%) had been married once before, three (6.8%) had been married twice before, and one (2.3%) had been married three times previously.

Twenty-six women (59.1%) reported their religion as Protestant, thirteen (29.5%) were Catholic, and two (4.5%) reported no religious affiliation. Three women did not respond to this question. Of those who professed a religious affiliation, 62.7% stated that they actively practiced their religion.

Twenty-two women (or 50% of the sample) were experiencing their first pregnancy. The other fifty percent had had from one to four previous pregnancies and were divided as follows: one prior pregnancy, 12 women or 27.3% of the total sample; two previous pregnancies, 8 women or 18.2% of the sample; and one (2.3%) each having experienced three or four prior pregnancies. Thirty-one women (70.5%) had no other children at the time of this pregnancy. Ten (22.7%) had one child, and three (6.8%) had two children. All subjects had had prenatal care from obstetricians in private practice, the timing of the first visit
to the doctor varying from two to sixteen weeks of pregnancy (2 weeks = 9.4%, 4 weeks = 47.7%, 8 weeks = 34.1%, 12 weeks = 6.8%, and 16 weeks = 2.3%).

Of the 51 women who dropped out of the study for unknown reasons, 25 (or 49% of the total number of dropouts) completed only the General Information sheet which they were asked to complete upon signing the agreement to participate. These women sent in no further data. The other 26 dropouts discontinued participation at varying points prior to the ninth month. Numbers of dropouts were approximately equal for each of the last three testing periods. It was at this point (the second set of instruments) that subjects had their initial contact both with the sexual questions and the lengthier questionnaires. It is felt that these two factors account for the dropout rate.

The limited demographic data available for the women completing only the General Information form indicates that they did not differ from the continued participation group in terms of likelihood of having been married before, seeking prenatal care, or the time of the initial visit to the physician. This group, however, differed in that there were four women (16% of this dropout group) who were younger (17-18 years) than subjects in the completed schedule group. There was also one woman in the 33-39 years of age group. Five of the non-Caucasian women were also in this group (Afro-American = 2, Asian-American = 2, Indian = 1). There was a slightly higher percentage of women who reported an income of less than $16,000 (41.7% versus 34.1% for the completes) and
three women with less than 11-12 years of education (as compared to none in the complete records group). Three of these women were also not married and three were clinic patients. A higher number (72%) of this dropout group were in the shortest length of marriage group (0-3 years) and a larger number (25%) who had been previously married. As may be expected, this group also had a larger proportion of women experiencing their first pregnancy (68% versus 50% for the complete records group). These women were also more heavily Protestant (70.8%, Catholic = 20.8%, and none = 8.4%).

The twenty-six women who sent in at least some of the forms did not differ from the complete records group in terms of age, income, education, marital status, or length of marital relationship. They were somewhat more likely to have been married at least once before (by 9.5%). They were also slightly higher in terms of women experiencing their first pregnancy (by 7.7%). They did not differ in the matter of prenatal care or the timing of the first visit to their doctor. All were seeing private obstetricians.

This group contained two non-Caucasian women (both Spanish-American). As in the other dropout group, these women were more likely to be Protestant (80.8%), the least likely to be Catholic (7.7%). The two Jewish women who agreed to participate were in this group of dropouts.

Materials

Bem Sex-Role Inventory (BSRI) (Bem, 1974; see Appendix V).

The BSRI was developed in order to measure an individual's
sex-role identification when masculinity and femininity are conceptually defined as not being mutually exclusive domains. Rather, these are conceived of as constituting a spectrum of attitudes and ways of behaving from which individuals may choose in the process of self-definition, and thus in the attitudes and behaviors which they may habitually use in self-expression.

Thus, a single individual might espouse some attitudes and/or behaviors which would traditionally have been seen as 'masculine' and some which would have been seen as 'feminine'. This sixty-item, self-report instrument includes twenty items comprising a masculine scale, twenty items making up a feminine scale, and a twenty item social desirability scale. Subjects are requested to indicate, using a seven-point scale, to what degree a specific masculine or feminine personality characteristic describes them. This inventory was included in the schedule of instruments for the purpose of specifying the women's sex-role identification.

The median-split method of scoring, yielding a four-way classification of subjects, was used. On the basis of test results, an individual was designated as 'masculine' (high endorsement of masculine scale items and low endorsement of feminine scale items); 'feminine' (high identification with feminine scale items and low identification with masculine scale items); 'androgynous' (essentially equal high level endorsement of both masculine and feminine scale attributes); or 'undifferen-
and feminine scale attributes). With this instrument, then, four groups were possible: feminine females, masculine females, androgynous females, and undifferentiated females.

The determination of the median to be used to distinguish 'high' from 'low' scores is currently a subject of controversy. Bem (1977) recommends using the median of the sample for both masculine and feminine scales. Other researchers (LaFrance & Carmen, 1980; Pedhazur & Tetenbaum, 1979) have argued that this presents a problem in that the same individual, depending upon the composition of the group in which he or she is tested, may be classified as androgynous in one group and undifferentiated or sex-typed in another. As this seemed undesirable, the method used by LaFrance and Carmen (1980) was followed in this study. Relatively high medians were set (5.00 for the masculine scale, and 4.90 for the feminine scale).

For the subjects completing all of the schedules, the BSRI was administered twice during the course of the investigation, once at seven months and once at nine months. For the purpose of overall classification into sex-role groups, these scores were averaged for each woman. On the basis of this scoring and classification system, the sample was divided as follows: 28 feminine women (63%), seven androgynous women (16%), six undifferentiated women (14%), and three masculine women (7%). Sex-role data was not available on the first dropout group. For the second group of 26 women who did not complete the schedule of instruments, twelve were scored as feminine (46%),
eight as androgynous (31%), six as undifferentiated (23%), and none as masculine.

This test has been used extensively in research and has been, in the last five years, subjected to several studies to determine its validity. Positive results have been found by several researchers (Bem, 1974; Flaherty & Dusek, 1980; Gaudreau, 1977; Moreland, Gulanick, Montague, & Harren, 1978; Strahan, 1975; Walkup & Abbott, 1978).

Internal consistency reliability studies show all three scales to be highly reliable: Masculinity = .86; Femininity = .81; and Androgyny = .86 (Bem, 1974). The masculinity and femininity scales have been shown to be empirically as well as logically independent. Test-retest reliability is high: Masculinity = .90; Femininity = .90; and Androgyny = .93 (Bem, 1974).

State-Trait Anxiety Inventory (STAI) (Spielberger, Gorsuch, & Lushene, 1970) (see Appendix VI).

The STAI was developed to provide a brief method of assessing the presence of both state (A-State) and trait (A-Trait) anxiety. This instrument has been generally available for use since 1969. By 1975, it had been used in over 200 studies. Spielberger (1975) states: "Current research with the STAI indicates that the A-Trait scale is highly correlated with other measures of trait anxiety and that the A-State scale provides a valid measure of changes in transitory anxiety in response to laboratory and real life stress" (p. 721).

The A-Trait scale is highly correlated with the Taylor Manifest
Anxiety Scale and the IPAT Anxiety Scale (Spielberger, 1972). The A-State scale is correlated with other measures of A-State anxiety such as the Zuckerman Affect Adjective Checklist (AAACL), Today Form, and has been shown to demonstrate increases in the presence of different forms of stress as well as decreases in the presence of relaxation training (Spielberger, 1972). Stability coefficients for the A-Trait Scale are high, but, as would be expected in a test designed to be sensitive to situational factors, coefficients for the A-State Scale are lower (Spielberger et al., 1970).

The A-State scale can be repeatedly administered to assess changes in anxiety levels over time. This instrument has already been used in studies of pregnancy (Edwards & Jones, 1970; Gorsuch & Key, 1974). Differences in patterns of anxiety levels on this test discriminated between 'normal' and 'abnormal' groups in terms of pregnancy and obstetrical complications. This instrument was included in the schedule to assess not only the existence of a predisposition to anxiety in general (A-Trait) but the actual presence of anxiety reactions (A-State) at different pregnancy periods.

**Delivery Records (DR)** (see Appendix VII).

Hospital delivery records for all subjects were reviewed for such factors as length of first and second stages of labor, sex of the child, birth weight and condition of the infant (one and five minute Apgars), amount and type of medication used during labor and delivery, unusual presentation, difficult delivery and other complications of labor and/or delivery. Hospital permission
for such a review of the records, contingent upon the subject's signed release, was requested and obtained.

**Emotional and Sexual Relationship in Pregnancy Questionnaire (ESRP)** (see Appendix VIII).

The ESRP is an original questionnaire developed for use in this study. Therefore, no reliability or validity data for this instrument is available. It is divided into ten sections which were administered at different periods of time during the last trimester of pregnancy. It was decided to use this method of administration in order to avoid using retrospective data as much as possible and to encourage subject participation as some of the sections are lengthy. None of the pregnancy data were collected more than five months after the period under question.

This part of the schedule consisted of background data (age, socioeconomic level, education, family history, and nature of the environment in the family of origin, early sexual education and experiences, etc.); experience of and attitudes toward menstruation; sexual attitudes and practices in the premarital and prepregnancy periods; emotional relationship and attitudes during five stages of pregnancy (first and second trimesters, seventh, eighth, and ninth months); and sexual attitudes, interest, and practices during these same time periods.

The length of the questionnaire is such that if all of the retrospective sections (Family History, Menstrual History, Year Before Pregnancy, First Trimester, and Second Trimester) were to be administered at one time, the subjects' future cooperation
could be seriously compromised. The retrospective sections, therefore, were administered one or two at a time, along with the current sections, according to a prearranged schedule over the course of the testing period. The four remaining sections of the ESRP are the General Information form, the Seventh Month, the Eighth Month, and the Ninth Month questionnaires.

Based upon responses to questions on this instrument, four scores were achieved by each woman: 1) a Physical Response to Pregnancy score (PRP); 2) an Emotional Response to Pregnancy score (ERP); 3) a Labor and Delivery score; and 4) a Sexual Adjustment to Pregnancy score (SAP).

The Physical Response to Pregnancy score reflects the individual's tendency to experience physical symptoms of pregnancy, her rate of reporting these symptoms to her physician, and her level of activity during pregnancy. Points were deducted for each symptomatic response. Possible scores ranged from zero to eighteen, with the higher levels being indicative of low degrees of symptomatology (better adjustment), and lower levels being suggestive of adoption of 'sick-role'.

The Emotional Response to Pregnancy score is indicative of the woman's perceived attractiveness (in terms of both self and others) as compared to before pregnancy; her experienced feelings of anxiety as compared to before pregnancy; her perception of the degree of relationship between anxiety levels and her pregnant condition; and her positive or negative anticipation of labor and delivery. This scale was only administered in the
seventh, eighth, and ninth months. Possible scores range from zero to eleven, with points again being deducted for each negative response. Thus, higher scores reflect better adjustment.

The Labor and Delivery Score is reflective of the ease or difficulty of parturition as experienced by the woman, and the presence or absence of abnormalities and/or complications in the child. Possible scores ranged between zero and twenty with lower scores signifying less ideal experiences of labor and delivery.

The scoring system for the Sexual Adjustment to Pregnancy component was more difficult to devise. This score is intended to reflect the degree of positive attitude about sexuality in pregnancy, as experienced affectively and behaviorally. A positive response was defined as one which indicated a continuing interest and/or participation in a sexual relationship with their partners. In an attempt to circumvent value and/or moral judgments in the scoring system, points were given for any answer indicating sexual interest or activity without consideration of socio-cultural definitions of 'normal' or 'acceptable' types and/or rates of interest or activity. Thus, the higher the score, the more positive the attitude toward sex and the more actively the woman is behaviorally expressing that positive attitude. The scores tend to reflect the extent of sexual interest, the nature of sexual attitudes, affective reaction to perceived interest and attitudes on the part of the mate, expectations about pregnant sexuality, satisfaction with
with sex life, variety and frequency of sexual activities, orgasmic ability, and the presence or absence of guilt about sexual feelings, attitudes or practices. Possible scores ranged from zero to seventy-two, with higher scores indicating more successful adjustment, i.e., more favorable attitude toward sexuality in pregnancy.

**Schedule of Administration of Instruments**

On the occasion of the original meeting with the subjects, and at each of the next three classes, participating women were given instruments to take home for completion and to be mailed in to the investigator. Specifically, the distribution schedule was as follows:

1) First session of classes: distribution of the Family History, the Menstrual History, and the first BSRI and STAI forms.
2) Second session of classes: distribution of the pre-marital History, the Year Before Pregnancy, and the Seventh Month forms.
3) Third session of the classes: distribution of the First Trimester and the Eighth Month forms.
4) Fourth session of the classes: distribution of the Second Trimester, the Ninth Month, and the second BSRI and STAI forms.

Women were instructed to retain the third and fourth sets of forms until they had reached the appropriate stages of pregnancy to complete them. Telephone contact was made with subjects who
delayed sending in their forms for the purpose of encouraging them to continue their participation. If such women indicated that they wished to drop out of the study at this time, there was no pressure to continue nor was a reason for this decision requested.
Results

Background Information

Family Background. Examination of the records shows that 59.1% of the subjects' fathers and 68.2% of their mothers had completed 11-12 years of education (see Table 1). The feminine women were the only group with parents (four fathers and three mothers) who had attended graduate school. The androgynous women's parents, both mothers and fathers, had the lowest average years of schooling. The parents of the masculine women had the highest average educational level, closely followed by the feminine women's parents. In the

Table 1

Educational Level of Subjects' Parents

<table>
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<tr>
<th>Group</th>
<th>8 - 9-10</th>
<th>11-12</th>
<th>1-2</th>
<th>3-4</th>
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<th>Mean</th>
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<tr>
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undifferentiated group, interestingly, the mothers had a slightly higher level of education than the fathers.

Twenty-seven women (61.4%) reported that their mothers worked outside of the home when they were children. All of the masculine subjects' mothers and 71.3% of the androgynous women's mothers were so employed, while smaller proportions were found for the undifferentiated and feminine women (66.7% and 53.6%, respectively).

No subjects had a deceased mother. Two androgynous females, however, had fathers who were deceased. These men both died when their daughters were in their twenties. Another androgynous woman stated that she had never known her father.

All of the undifferentiated, 92.9% of the feminine, and two out of the three masculine subjects reported that their parents were still married. This was true, however, for only 42.9% of the androgynous women, $F(3, 40) = 5.82, p < .01$. Two of these women reported that their parents were divorced and two others that their fathers were dead.

When subjects were asked to evaluate the quality of their parents' marriages, 61.4% of the sample as a whole described these relationships as 'happy', 27.3% as 'indifferent', and 11.4% as 'unhappy'. The pattern established in the question regarding marital status continues here. Two-thirds of the undifferentiated, feminine, and masculine women reported that their parents' marriages were happy. Only 28.6% of the androgynous women were raised in a home where the parents' relationship was perceived as 'happy',
\[ F (3, 19) = 3.75, p < .05. \] They had the highest percentage describing these relationships as 'indifferent' (A = 42.9%, M = 33.3%, F = 25.0%, U = 16.7%), or 'unhappy' (A = 28.5%, U = 16.7%, F = 7.1%, M = 0.0%). Thus, while only approximately 33.3% of the feminine, undifferentiated, and masculine women perceived their parents' marital relationships as unsatisfactory, 71.5% of the androgynous women felt that their parents' marriages had not been successful.

Thirty-one women (70.5% of the sample), when asked to describe the emotional climate of their childhood homes, described it as 'affectionate'. The remaining thirteen women divided their judgments among the following, more negative, descriptions: 'indifferent' = 15.9%, 'distant' = 9.1%, 'cold' = 2.3%, and 'hostile' = 2.3%. The patterns of response found for the different sex-role groups was somewhat unexpected. The undifferentiated women were the most likely to describe a negative atmosphere in the home (66.7%), although this difference did not reach significant levels. The majority of the other groups, led by the feminine women (F = 82.1%, A = 57.1%, M = 66.7%), described their homes as 'affectionate'.

Although differences were not significant, androgynous women tended to come from the smallest families (\( \bar{x} = 3.14 \) children), and the feminine women from the largest (\( \bar{x} = 4.20 \) children). None of the androgynous or masculine women reported any changes in their feelings towards either of their parents due to the pregnancy experience. One third of the feminine and undifferentiated women reported changes in their feelings about their mothers as a result of their pregnancies, and another 18.2% of the same groups reported
altered attitudes towards their fathers at this time.

As a group, then, the androgynous women reported the least 'favorable' background. Their parents' marriages were more likely to be unsatisfactory and they appear to have been well aware of this. Although the number was not large, they were also more likely to have been raised in single parent families due to divorce. However, the majority of these women (57.1%) reported that their parents responded to them affectionately, whatever the relationship between the adults. The undifferentiated women, on the other hand, perceived their parents as very content with one another, but as having little left over for their children.

Reproductive History. The average age for the onset of menstruation for the sample was twelve years, nine months. The averages for the different sex-role groups ranged from 12.0 years (androgynous) to 13.0 years (masculine and feminine).

Menstruation was explained to 93.2% of these young girls before it occurred. Seventy-three percent of the women were told about this process by their mothers. The likelihood of having this source of information ranged between 67.0% and 82.0% for the undifferentiated, feminine, and androgynous groups. None of the masculine women, however, were told the facts of life by their mothers, \( F(3, 40) = 3.609, p < .05 \). The masculine women were significantly different from all other groups on this point: feminine: \( t(43) = 3.270, p < .01 \); undifferentiated: \( t(43) = 2.299, p < .05 \); and androgynous: \( t(43) = 2.512, p < .02 \). Two of these women
learned from their schools and one from a friend.

The androgynous and masculine women were the most likely to report that this subject (menstruation) was not discussed among their friends, $F(3, 39) = 4.977, p < .01$. Post hoc comparisons, using a protected $t$ test, revealed that the androgynous women differed significantly from the undifferentiated women, $t(43) = 2.328, p < .05$, and from the feminine women, $t(43) = 2.559, p < .02$. The masculine women were significantly different from the undifferentiated women, $t(43) = 2.857, p < .01$, and from the feminine group, $t(43) = 2.975, p < .01$.

Seven women (16.7% of the sample) reported that their menstrual cycles were irregular. One of these women was in the undifferentiated group, and the other six in the feminine group. Painful cramps with their periods were experienced, however, by 78.6% of the women. Differences between the sex-role groups on this question were slight, but feminine and undifferentiated women were somewhat more likely to have had this experience ($F = 81.5\%, \ U = 83.3\%, \ A \text{ and } M = 66.7\%$).

Twenty-five women reported a change in body image with the onset of menstruation. Of these women, 52% reported positive changes and 48% negative. For the three androgynous women experiencing this effect of menstruation, this change was negative (i.e., such feelings as 'unclean', 'sick', 'unattractive', 'ashamed', etc.). It was also negative for four of the five undifferentiated mothers, five of the fourteen feminine women, and one
of the three masculine women who felt differently about their bodies.

Half of the sample learned about conception and reproduction between the ages of seven and eleven, 38.6% between twelve and fifteen, and 11.4% when they were sixteen or seventeen. Significant differences were found for the likelihood of learning the facts of life by the age of eleven, \( F(3, 40) = 7.39, p < .01 \). Post hoc comparisons using a protected \( t \) test indicated that the masculine women were significantly older than the androgynous women when they learned about conception and reproduction for the first time, \( t(43) = 2.441, p < .02 \).

Parents were more likely to discuss sexual facts (52.3%) with their daughters than they were to discuss sexual relationships (25.0%). This latter finding was especially true for androgynous and masculine women. Out of the ten women in these two groups, only one androgynous subject's parents discussed sexual relationships with her, while ten out of thirty-four undifferentiated and feminine women's parents (\( U = 2, F = 8 \)) attempted to guide their daughters in this area.

Table 2 illustrates the reproductive history of the sample. As can be seen, the androgynous group has the poorest record. They have the highest proportions reporting miscarriages (28.6%), stillbirths (14.3%), and complications in earlier pregnancies (28.6%). Differences in the tendency to have abortions are slight, but the androgynous women were the least likely to have had an abortion.
### Table 2
Reproductive History of the Sample

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<tr>
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</tr>
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<tr>
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<tr>
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<td>% of Total</td>
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<td>0.0</td>
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</table>
Only 47.7% of the pregnancies in this sample had been planned. This was a surprising finding, considering that all but one of these women were married. Androgynous women were far more likely to have planned to have the child they were carrying than any other group (A = 71.4%; U = 50.0%; F = 42.9%; M = 33.3%), F (3, 40) = 2.99, p < .05. Of those women experiencing unplanned pregnancies, 35.7% were unhappy about being pregnant when the pregnancy was discovered, with the undifferentiated (66.7%) and the masculine (50.0%) women the most likely to be upset (A = 33.3%, F = 30.0%). One-fifth of the mothers with unplanned pregnancies considered abortion but decided against it. The most common reasons given for this decision were 1) spouse's objections, and 2) health risks. There were no masculine women in the group who considered abortion. Twelve percent of the sample reported that their spouses suggested that they have an abortion.

**Premarital History.** For this sample, 61.4% remember playing games with sexual content (i.e., "Doctor") as a child, with androgynous (71.3%) and masculine (100.0%) women being the most apt to have such memories (F = 57.1%, U = 50.0%). Eighty percent of the sample masturbated as a child or as an adolescent. Differences among the sex-role groups in the tendency to masturbate during this premarital period were not found. It appears that if a girl had not attempted this practice by the time that she was sixteen, she was highly unlikely to ever try it. Orgasm with masturbation was achieved by 51.4% of the women, with the undifferentiated women
the least likely to do so (20.0%). The other groups were 40.0% (androgynous), 43.8% (feminine), and 50.0% (masculine) orgasmic. Nineteen women (55.9%) felt guilty about the practice of masturbation, with the androgynous group the most likely to feel guilty (A = 75.0%, F = 56.2%, M = 50.0%, U = 40.0%).

Seventeen of these women (39.0%) had had their first date by the time they were fifteen years old. The largest group (34.9%) were fifteen on this occasion, while 16.9% were sixteen, and 11.6% were seventeen or older. The androgynous women were clearly the earliest daters with 71.4% being fourteen or less. The undifferentiated women also tended to be younger, with 50.0% being fourteen or younger. One masculine woman was fourteen, the other two, fifteen, while only 28.6% of the feminine women dated before age fifteen. The feminine group was the most likely to be sixteen or older on their first date.

Half of this sample reported that their attitude about sex before marriage was 'mixed', 2.5% were 'neutral', and 47.5% viewed sex positively. All of the masculine women, 60.0% of the undifferentiated group, and 51.9% of the feminine women had mixed feelings about sex at this time, while only 16.7% of the androgynous group felt this way. The vast majority of the androgynous group (83.3%) reported positive attitudes towards sex before marriage.

Thirty-seven women (84.1%) reported engaging in 'petting' or 'making out' premaritally. This was not felt to be sexually arousing for 18.4% of the women practicing it (U = 33.3%, A =
28.6%, F = 13.6%). All masculine women reported petting and all reported arousal in response to this activity.

Premarital intercourse was experienced by 88.6% of the sample, with the feminine group (92.9%) being the most likely to do so (A = 85.7%, U = 83.3%, M = 66.7%). Almost all (97.2%) women reported finding coitus arousing at this time (one androgynous woman responded negatively to this question). For those women having intercourse, orgasms were experienced by 87.2% in the premarital period. All of the masculine (two) and undifferentiated (five) women who were having intercourse reported being orgasmic, while one of the five androgynous women and four of the twenty-six feminine women reporting coitus, reported not having orgasms. Seventeen women (42.5%) recalled being orgasmic 50-100% of the time. Fifty percent of the androgynous group, 44.4% of the feminine group, and 33.3% of the undifferentiated group were orgasmic 50-100% of the time. None of the masculine women, however, reported this level of orgasmic frequency with intercourse at this time. Forty percent of the sample achieved multiple orgasms at this time.

The most common age range at first intercourse was between seventeen and nineteen (40.0% of the sample). The first coital activity for 32.5% of the sample occurred between ages thirteen and sixteen, and 27.5% were twenty to twenty-three when this occurred. The androgynous (50.0%), masculine (50.0%), and feminine (40.7%) groups were most likely to be between seventeen and nineteen years of age with their first coital involvement, while 60.0% of the
undifferentiated women were between thirteen and sixteen years old.

Non-coital practices were used to achieve orgasm by 82.5% of the women. The eleven women who responded 'no' to this question were all in the undifferentiated and feminine groups, with the undifferentiated being the least likely (50.0%) to seek outlets of this type. The same pattern holds true for the practice of oral sex (82.5% of the sample responding positively). Sixty percent of the women reported engaging in mutual masturbation for the purpose of reaching orgasm.

Sexual Adjustment

Differences among the sex-role groups, in terms of Sexual Adjustment to Pregnancy scores (SAP), were significant, $F(3, 38) = 3.132, p < .037$, and in the predicted direction, i.e., the androgynous group scored highest, then the masculine, the feminine, and the undifferentiated, in that order. Post hoc comparisons, using a protected $t$ test, indicated that significant differences existed between the androgynous and the feminine group, $t(41) = 3.416$, $p < .001$, and between the androgynous and the undifferentiated groups, $t(41) = 3.334, p < .001$. There were no significant differences, however, between the androgynous and the masculine groups, or for any other pairs. Thus, while the masculine group did have a higher mean than those of the undifferentiated and the feminine groups as hypothesized, this difference did not reach significant levels. An examination of the mean scores for all four groups illustrates this (see Table 3). As can be seen, the undifferentiated, feminine, and masculine groups cluster fairly close to one
another, with their ranking in the predicted order.

Table 3
Mean Scores, Sexual Adjustment to Pregnancy Scale

<table>
<thead>
<tr>
<th>Androgy nous</th>
<th>Masculine</th>
<th>Feminine</th>
<th>Undifferentiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>(N=7)</td>
<td>(N=3)</td>
<td>(N=28)</td>
<td>(N=6)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex-Role Group Mean:</th>
<th>25.53</th>
<th>18.20</th>
<th>17.60</th>
<th>15.33</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy Deficit:</td>
<td>-0.16</td>
<td>-10.34</td>
<td>-12.50</td>
<td>-12.52</td>
</tr>
<tr>
<td>Prepregnancy Mean²:</td>
<td>28.70</td>
<td>25.00</td>
<td>27.57</td>
<td>24.50</td>
</tr>
</tbody>
</table>

Stage of Pregnancy: 1st Tri. 2nd Tri. 7th Mo. 8th Mo. 9th Mo.
Sample Means: 22.55 21.60 19.71 16.31 11.95

²Prepregnancy SAP scores are not directly comparable to pregnancy SAP scores.

The androgynous women not only scored much higher, but also exhibited a totally different pattern of sexual adjustment over time (see Figure 1). The masculine, feminine, and undifferentiated groups showed a slow decrease in sexual interest, satisfaction and activity in the second trimester. This decrease accelerated in the third trimester and continued in a steady decline until delivery. The chief difference among these groups arises from the fact that, for most time periods, the rate of decline for the masculine group is less severe. Difficulties arising from the very small n for the masculine group must be considered in reporting the data on these women. However, they showed a great deal of consistency. The variance between their reported behaviors and attitudes seemed to be very small.
Figure 1. SAP scores across time of pregnancy.
The pattern for the androgynous women, on the other hand, increased in the second trimester, accelerated rapidly to peak in the seventh month, and then demonstrated a decrease in sexuality in the last two months. The mean scores for this group, from the beginning to the end of pregnancy, represents a total loss of only 0.16 points on the SAP. When a sexual adjustment score, which is not directly comparable to those tabulated for the pregnancy periods, was calculated for the year before pregnancy, the androgynous women again demonstrated the most satisfactory adjustment.

According to this data then, androgynous women demonstrate the most satisfactory sexual adjustment both before and during pregnancy. For the period of pregnancy, the scores and patterns of adjustment for the other three groups cluster together and are not significantly different from one another. Within this cluster, the means place the masculine women second in terms of adjustment, followed by the feminine and then the undifferentiated women.

Significant effects on sexual adjustment due to stage of pregnancy were also found, $F(4, 152) = 28.354, p < .0001$. Post hoc comparisons, using a protected $t$ test, revealed that sexual adjustment in most stages of pregnancy was significantly different from that of other stages (see Table 4). Thus, changes in sexual adjustment for the sample as a whole are dramatic and negative.

**General Attitude Towards Sex.** A positive attitude towards sex was reported by 72.1% of the sample in the year before preg-
Table 4  
Post Hoc Comparison of SAP Scores,\textsuperscript{a}  
Different Stages of Pregnancy

<table>
<thead>
<tr>
<th>Stage of Pregnancy</th>
<th>1st Tri.</th>
<th>2nd Tri.</th>
<th>7th Mo.</th>
<th>8th Mo.</th>
<th>9th Mo.</th>
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<td>2.460**</td>
<td>5.420***</td>
<td>9.210***</td>
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<tr>
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</tr>
<tr>
<td>2nd Trimester</td>
<td></td>
<td>NS</td>
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<td>4.595***</td>
<td>8.382***</td>
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<tr>
<td>7th Month</td>
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<td>2.460**</td>
<td></td>
<td>2.960*</td>
<td>6.747***</td>
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<tr>
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<tr>
<td>8th Month</td>
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<td>5.420***</td>
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<td>2.960*</td>
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<tr>
<td>t =</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

\textsuperscript{a}$t$ (155)

* $p < .01$

** $p < .02$

*** $p < .001$

nancy. The remaining twelve women divided with 20.9% describing their attitude as 'mixed', 4.7% (two women) stating that they were 'indifferent' on the subject, and one feminine woman describing her attitude as 'negative'. Androgynous women were the most likely to feel positively about sex (85.7%) with one woman reporting mixed feelings. The masculine, feminine, and undifferentiated groups reported between 67% and 70% positive outlooks.

In the first trimester, 64.3% of the sample reported positive attitudes towards sex ($U = 100.0\%$, $F = 65.4\%$, $A = 57.1\%$, $M = 0.0\%$), $F (3, 38) = 3.20, p < .05$. Using a protected $t$ test,
post hoc comparisons were made, showing that the masculine group's attitude was significantly more negative than all of the other groups at this time, \( U: t (39) = 2.982, p < .01; \) \( F: t (39) = 2.131, p < .05; \) \( A: t (39) = 2.414, p < .05. \)

Attitudes became steadily less favorable about sex as pregnancy advanced to the eighth month (positive = 34.1%), and sex-role differences were no longer significant after the first trimester. A small increase in the proportion of women regarding sex positively occurred in the ninth month (45.5%). 'Negative' attitudes towards sex were reported only by undifferentiated and feminine women, in the first trimester, the seventh and the eighth months.

**Sexual Interest.** Sex was important in their relationships for 76.7% of the women in the prepregnancy period. It was 'somewhat' important to 18.6%, and not important to 4.7% (two feminine women). The feminine women were the least likely to find sex important in their marriages (69.2%), while all of the masculine women valued sex as important in their relationships.

Interest in sex tends to decrease linearly throughout pregnancy. As early as the first trimester, 31% of the sample reported a decreased interest in sex. This rate continued until, by the ninth month, 78.6% of the women reported a decreased interest in sexuality. However, 21.4% of this sample reported no decrease in sexual interest during pregnancy.

As in many areas of sexual behavior, the patterns exhibited by the different sex-role groups are very different, with the undifferentiated and masculine groups showing the greatest
decreases (see Table 5).

<table>
<thead>
<tr>
<th>Group</th>
<th>1st Tri.</th>
<th>2nd Tri.</th>
<th>7th Mo.</th>
<th>8th Mo.</th>
<th>9th Mo.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undifferentiated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=6)</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Androgynous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=7)</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Feminine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=28)</td>
<td>8</td>
<td>10</td>
<td>16</td>
<td>21</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Masculine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=3)</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>% of Total (N=44)</td>
<td>31.0</td>
<td>42.9</td>
<td>59.1</td>
<td>70.5</td>
<td>78.6</td>
<td>81.8</td>
</tr>
</tbody>
</table>

The use of an ANOVA test for significant differences in the first trimester illustrated the presence of such differences, $F(3, 38) = 2.86, p < .05$. Post hoc comparisons with a protected $t$ test indicated that the undifferentiated group differed significantly from both the feminine group, $t(41) = 2.161, p < .05$, and the androgynous group, $t(41) = 2.857, p < .01$. Differences between the undifferentiated and the masculine groups were not significant.

Again the androgynous group shows the least deficit. They had the largest proportion of women reporting a decrease in sexual interest in the first trimester (57.1%). This proportion alters sharply in the second trimester to 28.6%, so that, as a group,
they demonstrate the highest level of interest in sex at this time. Although the number of androgynous women experiencing decreased sexual interest increases throughout the remainder of the pregnancy period, they remain the group whose interest in sex is least affected by pregnancy, from the second trimester on. In the androgynous group, 42.9% of the women reported no decrease in interest in sex after the first trimester. However, only 25.0% of the feminine group, and none of the women in the undifferentiated and masculine groups had this experience.

Reasons for Decreased Interest in Sex. Women reporting a decreased interest in sex at the different points of pregnancy were asked to indicate why they felt that their interest had decreased. They were allowed to indicate more than one reason if this was appropriate. Table 6 shows the number of women giving these reasons for decreased interest in each stage of pregnancy studied.

Feminine women were the only women reporting 'nonpregnancy reasons'. Masculine women were the only subjects who never felt that their decreased desire was due to being less attractive. This group, with the exception of one woman in the second trimester who reported 'loss of interest', cited only 'physical discomfort', 'awkwardness having intercourse', and 'discomfort due to nausea, vomiting, and fatigue, etc.', as the reasons for their decreased interest. Their focus seemed to be very much upon their physical changes.
### Table 6

**Reported Reasons for Decreased Interest in Sex**

<table>
<thead>
<tr>
<th>Reason</th>
<th>1st Tri.</th>
<th>2nd Tri.</th>
<th>7th Mo.</th>
<th>8th Mo.</th>
<th>9th Mo.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Discomfort</td>
<td>5</td>
<td>6</td>
<td>19</td>
<td>21</td>
<td>27</td>
</tr>
<tr>
<td>Awkwardness/Coitus</td>
<td>1</td>
<td>8</td>
<td>16</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Loss of Interest</td>
<td>6</td>
<td>5</td>
<td>8</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Self/Unattractive</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Nausea/Fatigue, Etc.</td>
<td>7</td>
<td>3</td>
<td>8</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Fear Injury to Baby</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Fear Miscarriage</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>MD's Recommendation</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Mate/Unattractive</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Non-Pregnancy</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Baby Intruder</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-MD Recommendation</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**Satisfaction with Sex Life.** Eighty-two percent of the women in this sample reported satisfaction with their sex lives in the year before pregnancy. This number decreases by only 10.0% in the first two trimesters of pregnancy. There is a striking decrease, however, in the proportion of satisfied women in the seventh month as 50.0% of the women describe themselves as dissatisfied. As delivery approaches, satisfaction increases again to slightly below second trimester levels (65.9%). Differences between the sex-role groups were not significant for any time periods.
The masculine women were the least likely to report satisfaction with their prepregnancy sex lives (two out of three). This remained unchanged in the first two trimesters, but became one out of three in the seventh month. Their recovery was immediate, as well as total by the ninth month, as this is the only period in which all masculine women reported satisfaction with their sex lives.

The androgynous group were next in terms of being most dissatisfied with their sex lives. Seventy-five percent reported satisfaction with their sexual relationship in the year before pregnancy. This level remained essentially the same in the first trimester of pregnancy, but showed a sharp decrease in the second trimester with four out of seven women (57.1%) reporting dissatisfaction. Satisfaction increased in the seventh and eighth months until it reaches levels slightly below prepregnancy and first trimester levels. Their pattern in the ninth month is different from the other groups in that they again descend to the second trimester levels (42.9% reporting satisfaction).

The feminine group shows the least variability of satisfaction levels of all of the groups. They show a slight decrease in the first trimester from their prepregnancy level of 85.2% satisfied, and remain at this level throughout the second trimester. They too, show a dramatic drop in satisfaction level in the seventh month (to 53.6% satisfied). This rate begins a gradual increase until it reaches 68.0% in the ninth month.
The undifferentiated group reported 83.3% satisfied with their sex lives in the year before pregnancy. They maintained this level of satisfaction in the first trimester of pregnancy, but like the masculine women, showed a considerable drop in the second trimester to 66.7% satisfied. This sharp decrease continued in the seventh month until they reached a level equalled only by the masculine women (50.0%). Like the feminine and masculine groups, they began an immediate recovery and reached a level of 66.7% satisfied in the ninth month.

Presence of Sexual Problems. In the year before pregnancy, 13.6% of the sample reported the presence of sexual problems in their relationships. Sex-role group differences did not reach significant levels either at this time or throughout the pregnancy period.

Eighteen women (40.9%), however, recalled that there were sexual 'conflicts' in their relationships. The feminine group had the lowest number (33.3%) reporting such difficulties. The nature of the disagreements, in order of frequency of citation, were: frequency of intercourse (61.6% of those reporting conflict); sexual practices (33.3%); lack of affection prior to sexual activity (22.2%); and the importance of sex in the relationship (11.1%). Both masculine women who reported sexual conflicts cited lack of affection prior to sex as the problem.

The number of women experiencing sexual problems during pregnancy (16.7%) remained essentially stable until the last
trimester began. A large increase occurred at this time (to 38.6%), with some tapering off as delivery approached (to 23.0%).

Usual Initiator of Sexual Activity. Subjects were asked to report who, in terms of 'self', 'mate', or 'either, with equal frequency', was most likely to initiate sexual activity. The undifferentiated and the androgynous women were the least likely to assume the initiating position both before and during pregnancy. The majority of the undifferentiated group were in relationships where either partner was likely to initiate with equal frequency during pregnancy. With the exception of the seventh month, the percentage for 'either' stayed around 60.0%.

The androgynous women were consistently most apt to let their mate take the lead in initiating sexual activity. The same was true for the feminine women with the exception that the proportion of 'eithers' tends to be higher for this group.

The masculine women were also consistent throughout pregnancy. Despite their report for the year before pregnancy, when none of these women reported that their mates were most apt to initiate sexual contact, they divided evenly into the three categories throughout pregnancy. Thus, little can be said about the tendencies of these women, in this respect, during pregnancy. Sex-role differences were not significant on this question.

Frequency of Intercourse. For the sample as a whole, the frequency of intercourse decreased linearly from prepregnancy levels (\( \bar{X} = 4.35/2\) weeks) to the ninth month levels (\( \bar{X} = 1.13/ \))
2 weeks) (see Figure 2). Significant differences were found for frequency of intercourse as a function of the stage of pregnancy tested, $F (5, 250) = 13.4982, p < .01$. Post hoc comparisons with a protected $t$ test indicated that the mean frequency of the year before pregnancy was significantly different from that of: 1) the second trimester, $t (255) = 3.0978, p < .01$; 2) the seventh month, $t (255) = 4.8952, p < .001$; 3) the eighth month, $t (255) = 5.6267, p < .001$; and 4) the ninth month, $t (255) = 6.8395, p < .001$.

Thus, although the mean frequency decreased during the first trimester of pregnancy, this was not to levels which were significantly different from the prepregnancy levels. This is illustrated by the fact that the frequency of the first trimester is significantly higher than those of the seventh month, $t (255) = 3.3100, p < .001$; the eighth month, $t (255) = 4.1072, p < .001$; and the ninth month, $t (255) = 5.3240, p < .001$. Significant differences were also found between the second trimester and the eighth month, $t (255) = 2.5583, p < .02$; the second trimester and the ninth month, $t (255) = 3.7653, p < .001$; and between the seventh and the ninth months, $t (255) = 2.0140, p < .05$. These results consistently indicated a significantly lower frequency of intercourse as pregnancy advanced.

A significant main effect for sex-role was also found, $F (5, 258) = 2.4262, p < .05$. Post hoc protected $t$ tests indicated that the overall frequency of intercourse for the masculine group was significantly lower than that of the androgynous group, $t (265) = 2.6856, p < .01$, and that of the feminine group, $t (265) = 2.7761, p < .01$. The fre-
Figure 2. Actual and desired frequencies of intercourse/2 weeks, before and during pregnancy (Sample).
Table 7

Actual and Desired Mean Frequencies of Intercourse/2 Weeks

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Prepregnancy</th>
<th>1st Tri.</th>
<th>2nd Tri.</th>
<th>7th Mo.</th>
<th>8th Mo.</th>
<th>9th Mo.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual Frequency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>3.50</td>
<td>4.50</td>
<td>2.17</td>
<td>0.83</td>
<td>0.83</td>
<td>0.83</td>
</tr>
<tr>
<td>Androgy nous</td>
<td>5.21</td>
<td>3.64</td>
<td>3.36</td>
<td>3.07</td>
<td>3.36</td>
<td>1.93</td>
</tr>
<tr>
<td>Feminine</td>
<td>6.17</td>
<td>4.81</td>
<td>3.96</td>
<td>2.71</td>
<td>1.98</td>
<td>1.27</td>
</tr>
<tr>
<td>Masculine</td>
<td>2.50</td>
<td>1.17</td>
<td>1.17</td>
<td>1.17</td>
<td>0.50</td>
<td>0.50</td>
</tr>
<tr>
<td>Sample</td>
<td>4.35</td>
<td>3.53</td>
<td>2.67</td>
<td>1.95</td>
<td>1.67</td>
<td>1.13</td>
</tr>
<tr>
<td><strong>Female's Desired Frequency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>5.17</td>
<td>5.50</td>
<td>3.17</td>
<td>3.17</td>
<td>2.17</td>
<td>1.83</td>
</tr>
<tr>
<td>Androgy nous</td>
<td>6.57</td>
<td>4.50</td>
<td>4.21</td>
<td>4.79</td>
<td>4.21</td>
<td>3.93</td>
</tr>
<tr>
<td>Feminine</td>
<td>6.84</td>
<td>5.73</td>
<td>5.06</td>
<td>3.91</td>
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<td>2.67</td>
</tr>
<tr>
<td>Masculine</td>
<td>3.83</td>
<td>1.17</td>
<td>1.17</td>
<td>3.83</td>
<td>1.17</td>
<td>1.17</td>
</tr>
<tr>
<td>Sample</td>
<td>5.60</td>
<td>4.23</td>
<td>3.40</td>
<td>3.93</td>
<td>2.68</td>
<td>2.40</td>
</tr>
<tr>
<td><strong>Females' Perception of Males' Desired Frequency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>5.50</td>
<td>5.50</td>
<td>3.17</td>
<td>3.83</td>
<td>3.50</td>
<td>2.50</td>
</tr>
<tr>
<td>Androgy nous</td>
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<td>5.64</td>
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<td>5.36</td>
<td>4.79</td>
</tr>
<tr>
<td>Feminine</td>
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<td>8.29</td>
<td>7.12</td>
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<td>6.88</td>
<td>7.35</td>
</tr>
<tr>
<td>Masculine</td>
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<td>3.17</td>
<td>1.83</td>
<td>3.17</td>
<td>3.17</td>
<td>1.17</td>
</tr>
<tr>
<td>Sample</td>
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<td>5.65</td>
<td>4.37</td>
<td>5.20</td>
<td>4.73</td>
<td>3.95</td>
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</tbody>
</table>
Figure 3. Actual and desired frequencies of intercourse/2 weeks, before and during pregnancy (Feminine Group).

Figure 4. Actual and desired frequencies of intercourse/2 weeks, before and during pregnancy (Masculine Group).
Figure 5. Actual and desired frequencies of intercourse/2 weeks, before and during pregnancy (Undifferentiated Group).

Figure 6. Actual and desired frequencies of intercourse/2 weeks, before and during pregnancy (Androgynous Group).
quency for the undifferentiated group came close to reaching accept-able significance levels with the androgynous and the feminine groups also ($p < .10$) (see Table 7).

As can be seen by examining Figures 3 through 6, the patterns which developed for each sex-role group, in terms of actual coital frequency, are very different (see solid line on figures). The feminine group shows the second greatest loss in mean frequency of intercourse from prepregnancy levels to delivery. They reported the highest frequency in the baseline period (6.17/2 weeks), but by the ninth month had experienced a 79.0% decrease. The pattern of decrease was quite steady in the first two trimesters, but accelerated dramatically in the seventh month.

The masculine women showed an almost identical loss of frequency (80.0%). Their pattern, however, was quite different. They reported the lowest mean frequency of intercourse in the year before pregnancy (2.50/2 weeks). This decreased by more than half in the first trimester and remained at that level until the eighth month. At this point their frequency decreased to less than one coital experience every two weeks (0.50/2 weeks). Even though the $n$ is very small in this group, these women were remarkably consistent in the similarity of their coital behavior, more so than any other group.

The pattern for the undifferentiated women presents a variation not seen in any other group. They experienced a 28.6% mean increase in coital frequency in the first trimester, over pre-
pregnancy levels. However, a very sharp decline began at that point such that by the end of the second trimester, they had experienced a 62.0% decrease from prepregnancy levels. This decline continued into the seventh month, until they had reached a 76.0% loss in mean frequency. This rate of intercourse (0.83/2 weeks) was maintained throughout the remainder of the pregnancy.

The androgynous group demonstrated the smallest deficit in frequency of intercourse due to pregnancy (63.0%). The major losses came in the first trimester and the ninth month. The losses in the second trimester and the seventh month were small (0.28 and 0.32, respectively) and these women experienced an increase in mean frequency in the eighth month. Although they reported a mean frequency for the baseline period which was lower than the feminine group ($\bar{X} = 5.21/2$ weeks), they had the highest frequency in the ninth month ($\bar{X} = 1.93/2$ weeks).

Thus, these results indicate that during pregnancy, the androgynous group maintained the highest overall mean frequency of intercourse ($\bar{X}_A = 3.07; \bar{X}_F = 2.95; \bar{X}_U = 1.83; \bar{X}_M = .90$), $F(3, 260) = 3.2054, p < .05$. Protected $t$ post hoc comparisons indicated that the mean frequency for the masculine group is significantly lower than that of the feminine, $t(264) = 2.4677, p < .02$, and the androgynous groups, $t(264) = 2.6389, p < .01$. No significant differences were found for the masculine and undifferentiated groups. Again, however, the undifferentiated mean frequency approached acceptable significance levels for both the feminine,
The androgynous women also demonstrated the least effect upon mean frequency of intercourse due to pregnancy, although this difference did not reach significant levels.

**Desired Frequency of Intercourse.** Subjects were also asked to specify their desired frequency of intercourse and their perception of their mate's desired frequency of intercourse for each time period studied (see Figures 2 through 6). As can be seen, for the sample as a whole, the actual frequency of intercourse does not equal the desired levels for either the women or their mates, as perceived by the women, at any time, including the year before pregnancy. The greatest discrepancy exists between the actual frequency and the perceived mates' desired frequencies. Interestingly, these frequency patterns are essentially parallel in a decreasing slope until the seventh month when actual frequency dips and both desired frequencies show an increase.

The undifferentiated women's pattern demonstrated, if not agreement between actual and desired frequencies, the greatest amount of agreement between the females' desired frequency and their perception of their mates' desired frequencies. The desired frequencies are more similar than any other group's in the year before pregnancy, but are considerably higher than their actual frequency. The actual frequency of intercourse rises to above prepregnancy levels in the first trimester and thereafter begins a dramatic descent. The male and female desired frequencies are reported as equal until the seventh month. At this point, the
males' desired frequencies are seen to rise briefly and then both begin a descent in the eighth month. This is the only group reporting an increase in their desired frequencies in the ninth month.

The masculine women not only experience the lowest actual frequency of intercourse, but also report the lowest desired frequencies for both themselves and their mates. There is considerable discrepancy between the females' desired frequency and the actual frequency in the year before pregnancy, but this is nullified as pregnancy begins. The actual frequency and the desired frequency for the females decreases rapidly in the first trimester and becomes one in the second. Their mates' perceived frequency also descends until it is closer to their own by the end of the second trimester. In the seventh month, both males and females are seen as more interested in intercourse, the females surpassing the males in interest at this time. While the males retain their increased interest in the eighth month, the females quickly resume their descending interest level. Interestingly, although the desired frequencies of both partners increases in the seventh month, the actual frequency of intercourse does not change.

The androgynous women perceive a slightly greater discrepancy between their desired rate of intercourse and their mates' in the first two trimesters of pregnancy, as compared to the year before pregnancy. In the seventh month, they, like the masculine group, report an increased interest in intercourse. However, they per-
ceive their mates as experiencing a more dramatic increase in interest than they themselves report. Their actual frequency at this time decreases slightly. These women perceive the greatest discrepancy between their mates' desired frequency and the actual rate of intercourse in the ninth month.

**Orgasm.** For the sample as a whole, the rate of orgasms with intercourse decreases steadily throughout pregnancy, with rate of decrease accelerating sharply in the last trimester. In the year before pregnancy, 93.2% of this sample reported having orgasms with intercourse. (Out of the total number of instances of intercourse, 40.5% of these women reported having orgasms 75-100% of the time). By the first trimester, the proportion of orgasmic women was down to 83.3% By the ninth month, only 34.1% of the subjects reported experiencing orgasms with intercourse. Differences among the sex-role groups were not significant.

Again the patterns among the sex-role groups differ from one another. For the undifferentiated, masculine, and feminine groups, the pattern tends to parallel the patterns for decreased interest in sex. For the feminine women, the pattern is more gradual than for the other two groups, with the sharpest increases occurring in the last trimester.

All of the masculine women were orgasmic in the year before pregnancy. As early as the first trimester, one of these three women was no longer reporting orgasms. The other two continued to be orgasmic until the ninth month when another masculine subject also reported no orgasms.
All of the undifferentiated women also reported being orgasmic in the pre-pregnancy period. By the seventh month, 50.0% of these women were no longer having orgasms, and only one remained orgasmic in the ninth month.

The androgynous group was also 100.0% orgasmic in the year before pregnancy. One woman ceased to have orgasms in the first trimester. (This woman had two prior miscarriages and one stillbirth due to a "blood disorder". Sexual activity was restricted by her physician due to bleeding. She was under the same restriction for the same reason in the second trimester and she and her mate elected to forego a sexual relationship for the duration of her pregnancy). The group continued at this rate for the second trimester, and the eighth month. In the seventh and ninth months, another woman reported no orgasms. Thus, for seven of the nine months of pregnancy, all androgynous women who were having intercourse were also having orgasms.

Women were asked not only whether or not they were having orgasms, but also the frequency with which they were having them. For the sample, 40.5% reported having orgasms with 75-100% of the total instances of intercourse, 16.7% reported having orgasms 50-75% of the time, and 21.4%, each, reported having orgasms 25-50% and 1-25% of the time in the pre-pregnancy period. Consistently throughout the pre-pregnancy and pregnancy periods, the androgynous women had the greatest proportion of women reporting orgasms 75-100% of the time (PP = 57.1%, 1st Trimester = 66.7%, 2nd Trimester
Beginning in the second trimester, no masculine women reached this high a frequency of orgasms, and the undifferentiated women joined this second group in the seventh month. A few feminine women remained orgasmic 75-100% of the time after the seventh month, but this number was very small (8th = 3, 9th = 1).

In the ninth month, only five women still achieved orgasm 75-100% of the time and four of these were in the androgynous group (the other was in the feminine group).

**Multiple Orgasms.** In the prepregnancy period, 46.3% of the sample, nineteen women, reported having multiple orgasms with intercourse. In the first trimester of pregnancy, thirty-five women recalled having orgasms, and twelve of these thirty-five women reported multiple orgasms (34.3%). Nine women (20.5%) reported multiple orgasms in the second trimester and the seventh month. In the eighth and ninth months, only five women were having multiple orgasms.

Significant differences were found among the sex-role groups for multiple orgasms, $F (3, 198) = 64.5446, p < .001$. Post hoc comparisons with a protected $t$ test, revealed that these differences occurred for the masculine women, who were significantly different from all other groups: $F$: $t (201) = 5.4342, p < .001$; $U$: $t (201) = 4.0519, p < .001$; $A$: $t (201) = 3.8864, p < .001$.

Significant effects were also found on this question for stages of pregnancy, $F (5, 191) = 1113.33, p < .001$. Post hoc comparisons
with protected \( t \) tests indicated that all time periods, from the prepregnancy to the ninth month period, were significantly different from one another (see Table 8).

Table 8

Post Hoc Comparison of Multiple Orgasm Ability,\(^a\)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Prepreg.</th>
<th>1st</th>
<th>2nd</th>
<th>7th</th>
<th>8th</th>
<th>9th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( t^b = )</td>
<td>50.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Trimester</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( t = )</td>
<td>50.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second Trimester</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( t = )</td>
<td>68.75</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seventh Month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( t = )</td>
<td>36.59</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eighth Month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( t = )</td>
<td>65.85</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ninth Month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( t = )</td>
<td>21.82</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\( ^a \text{E.} (196). \)
\( ^b \) all \( p < .001 \), except for *.  
\( * \ p < .02 \)

In the prepregnancy period, the masculine and androgynous women were the most likely to have multiple orgasms (M = 66.7\%, A = 57.1\%, F = 44.0\%, and U = 33.3\%). These rates all decreased in the first trimester and slowly declined after that. In the ninth month, no undifferentiated women were having multiple orgasms. The only woman reporting achieving multiple orgasms 75-100%
of the time throughout pregnancy was from the androgynous group. With the exception of one feminine woman in the second trimester, she was the only woman to report experiencing this frequency during pregnancy.

**Perceived Intensity and Difficulty of Orgasm.** In the first trimester of pregnancy, approximately 77.0% of this sample reported orgasms to be of the same intensity and level of difficulty to achieve as before pregnancy. One undifferentiated and two feminine women reported increased intensity and decreased difficulty at this time, while four feminine and one masculine woman found them to be less intense and five feminine and one masculine woman found them more difficult to achieve.

From this point in pregnancy on, the number of women finding orgasm more difficult to reach is considerably greater than those reporting decreased intensity. A number of women who no longer achieved orgasm were evidently indicating that increased difficulty in doing so was the reason for the failure. Of the group of women still having orgasms in the ninth month, 64.3% found them to be of the same intensity as before the pregnancy, but only 35.0% found them to be equally difficult to achieve.

Again, in terms of both perceived intensity and perceived difficulty of attainment, the androgynous group is the only highly stable group. The solid majority of this group found both to remain the same throughout pregnancy. The other three groups varied sporadically in different periods of pregnancy, but the overall pattern is one of decrease in intensity and
increase in difficulty (see Table 9).

Table 9

Sex-Role Differences over Time of Pregnancy,
Women Reporting Decreased Intensity of Orgasms and
Increasing Difficulty in Achieving Orgasm

<table>
<thead>
<tr>
<th>Group</th>
<th>1st Tri.</th>
<th>2nd Tri.</th>
<th>7th Mo.</th>
<th>8th Mo.</th>
<th>9th Mo.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Undifferentiated</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensity</td>
<td>0(6)</td>
<td>0(4)</td>
<td>0(3)</td>
<td>1(3)</td>
<td>1(1)</td>
</tr>
<tr>
<td>Difficulty</td>
<td>0(5)</td>
<td>1(4)</td>
<td>3(4)</td>
<td>1(3)</td>
<td>2(2)</td>
</tr>
<tr>
<td><strong>Androgynous</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensity</td>
<td>0(5)</td>
<td>0(6)</td>
<td>1(5)</td>
<td>1(6)</td>
<td>0(5)</td>
</tr>
<tr>
<td>Difficulty</td>
<td>0(6)</td>
<td>1(6)</td>
<td>0(5)</td>
<td>2(6)</td>
<td>1(5)</td>
</tr>
<tr>
<td><strong>Feminine</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensity</td>
<td>4(23)</td>
<td>3(20)</td>
<td>6(19)</td>
<td>5(17)</td>
<td>3(7)</td>
</tr>
<tr>
<td>Difficulty</td>
<td>5(25)</td>
<td>5(20)</td>
<td>14(24)</td>
<td>11(21)</td>
<td>9(12)</td>
</tr>
<tr>
<td><strong>Masculine</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensity</td>
<td>1(3)</td>
<td>2(3)</td>
<td>0(2)</td>
<td>0(2)</td>
<td>1(1)</td>
</tr>
<tr>
<td>Difficulty</td>
<td>1(3)</td>
<td>1(3)</td>
<td>1(3)</td>
<td>1(3)</td>
<td>0(1)</td>
</tr>
<tr>
<td><strong>Sample %</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensity</td>
<td>13.5</td>
<td>15.2</td>
<td>24.1</td>
<td>25.0</td>
<td>35.7</td>
</tr>
<tr>
<td>Difficulty</td>
<td>15.4</td>
<td>24.2</td>
<td>50.0</td>
<td>45.5</td>
<td>60.0</td>
</tr>
</tbody>
</table>

*a Parentheses, ( ), indicate n reporting on this question (only those women having orgasms reported on intensity, while all could report on difficulty).

Positions Used for Intercourse. In the year before pregnancy, the male superior position for coitus was the one most frequently used position and retained this standing throughout pregnancy. Ninety-eight percent of the sample reported using the male superior position in the prepregnancy period, 68.1%
using it 50.0% of the time or more. The next popular position was the female superior position with 90.9% using it. Next was the side-by-side position, with the partners facing each other (used by 47.7%), then the side-by-side position, with the male facing the female's back (45.5% using this), and last the male behind and above the female position (used by 40.9%). Nine percent of these women reported using 'other' positions less than half of the time (see Table 10).

Essentially, for the sample, the overall patterns for the use of sexual positions indicate that variety in positions used for intercourse decreased as pregnancy advanced. All positions showed an overall decrease in mean frequency. In the seventh month, there is a slight increase in both of the side-by-side positions, presumably in an attempt to compensate for or cope with increasing discomfort in other, more customary positions. This does not, however, occur to a large degree. As discomfort became more and more of a problem, couples tended to decrease the frequency of intercourse rather than to substitute other positions.

The undifferentiated women, with the exception of the first trimester, showed a dramatic and uniform decrease in the use of all coital positions. In the first trimester, they continued at prepregnancy levels in the use of all positions with the exception of the male behind and above, which decreased slightly. There was an initial, very small effort in the seventh month to increase the use of the side-by-side, facing position, but this disappeared
Table 10

Sex-Role Differences over Time of Pregnancy

in Coital Positions Used

<table>
<thead>
<tr>
<th>Position</th>
<th>Prepregnancy</th>
<th>Time of Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1st Tri.</td>
</tr>
<tr>
<td>Male Superior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>100.0</td>
<td>67.0</td>
</tr>
<tr>
<td>Androgyous</td>
<td>100.0</td>
<td>57.2</td>
</tr>
<tr>
<td>Feminine</td>
<td>96.3</td>
<td>73.0</td>
</tr>
<tr>
<td>Masculine</td>
<td>100.0</td>
<td>66.7</td>
</tr>
<tr>
<td>Sample</td>
<td>97.7</td>
<td>69.0</td>
</tr>
<tr>
<td>Female Superior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>66.7</td>
<td>33.3</td>
</tr>
<tr>
<td>Androgyous</td>
<td>100.0</td>
<td>71.5</td>
</tr>
<tr>
<td>Feminine</td>
<td>92.3</td>
<td>73.0</td>
</tr>
<tr>
<td>Masculine</td>
<td>100.0</td>
<td>66.7</td>
</tr>
<tr>
<td>Sample</td>
<td>90.9</td>
<td>66.7</td>
</tr>
<tr>
<td>Side-by-Side, Facing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>33.3</td>
<td>50.0</td>
</tr>
<tr>
<td>Androgyous</td>
<td>37.5</td>
<td>42.9</td>
</tr>
<tr>
<td>Feminine</td>
<td>55.6</td>
<td>22.9</td>
</tr>
<tr>
<td>Masculine</td>
<td>33.3</td>
<td>33.3</td>
</tr>
<tr>
<td>Sample</td>
<td>47.7</td>
<td>31.0</td>
</tr>
<tr>
<td>Side-by-Side, Back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>33.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Androgyous</td>
<td>37.5</td>
<td>42.9</td>
</tr>
<tr>
<td>Feminine</td>
<td>51.8</td>
<td>34.5</td>
</tr>
<tr>
<td>Masculine</td>
<td>33.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Sample</td>
<td>45.5</td>
<td>28.6</td>
</tr>
<tr>
<td>Male Behind and Above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>33.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Androgyous</td>
<td>37.5</td>
<td>28.6</td>
</tr>
<tr>
<td>Feminine</td>
<td>44.4</td>
<td>34.6</td>
</tr>
<tr>
<td>Masculine</td>
<td>33.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Sample</td>
<td>40.9</td>
<td>26.2</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Androgyous</td>
<td>12.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Feminine</td>
<td>11.1</td>
<td>3.8</td>
</tr>
<tr>
<td>Masculine</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Sample</td>
<td>9.1</td>
<td>2.3</td>
</tr>
</tbody>
</table>
rapidly. By the ninth month, this group was using only the male superior and the side-by-side, facing positions.

For the feminine group, a steady decrease in the male and female superior positions was noted. They did show some signs of attempting to cope with difficulties inherent in continuing a coital relationship during pregnancy in the second trimester. There was a slight increase which was maintained in the seventh and eighth months in the side-by-side, facing position. The same occurred for the side-by-side, back, position to a lesser degree. This change disappeared in the eighth month. In the ninth month, all positions were being used to some degree by the feminine women.

In this interpersonal area of sexuality, the masculine women show the most severe deficit. They show decreases in all positions, the one maintaining the most successful rate being the female superior position, which is used by two out of three of these women for the first eight months of pregnancy. There is no evidence of efforts to cope by substituting the side-by-side positions as pregnancy advances. At no time do these women use "other" positions. In the seventh and eighth months, these women were the most likely to still be using the male behind and above position. By the ninth month, only one masculine woman is still having intercourse, and she uses only the female superior position.

The androgynous group shows the smallest change in the rate of use for all positions from prepregnancy to ninth month levels. There is considerable evidence of attempts to compensate for or cope with the pregnancy situation as discomfort with coitus increases.
In the seventh month, they increase in both side-by-side positions and the "other" category, over previous pregnancy levels. Moreover, they maintain this use in the eighth month, perhaps contributing to their higher SAP scores for these two months. Overall, they increase over prepregnancy levels in their use of the side-by-side, back, position in the ninth month—the only group to show an overall increase in the use of any position.

At this point it is interesting to look at the number and sex-roles of the women who discontinued intercourse entirely prior to delivery (see Table 11). By the ninth month, fifteen women (34.1%) had ceased to have intercourse. It must be recognized that some of these women had been so advised by their physicians. It must also be recognized that some women had been so advised, but chose not to follow this advice, and that some ceased even without the doctor's recommendation. The only group to have no terminators, the androgynous (it must be remembered that one woman had abstained from intercourse throughout pregnancy due to a history encompassing four unsuccessful pregnancies), were joined by the masculine women until the ninth month. From an examination of Table 11, it is possible to note that 12 out of the 15 women discontinuing coitus are from the undifferentiated and the feminine groups. Even considering that, however, the masculine group still maintains the top spot as the group most likely to have discontinued coital contact with their mate prior to reaching delivery.

Use of Non-Coital Practices. In the year before pregnancy,
Table 11

Women Ceasing to Have Intercourse

<table>
<thead>
<tr>
<th>Group</th>
<th>1st Tri.</th>
<th>2nd Tri.</th>
<th>7th Mo.</th>
<th>8th Mo.</th>
<th>9th Mo.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undifferentiated</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td>Androgynous</td>
<td>1(^a)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>14.3%</td>
</tr>
<tr>
<td>Feminine</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>11</td>
<td>39.3%</td>
</tr>
<tr>
<td>Masculine</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>66.7%</td>
</tr>
<tr>
<td>Sample %</td>
<td>2.3</td>
<td>2.3</td>
<td>9.1</td>
<td>11.4</td>
<td>34.1</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) One androgynous woman abstained from intercourse for the entire pregnancy period due to a history of four unsuccessful pregnancies and bleeding in the first and second trimesters.

79.5% (n = 35) of this sample of women reported the use of sexual practices other than intercourse. All three of these practices showed a decrease in usage during pregnancy (see Table 12).

Characteristically, the feminine women showed a slow decline in the use of all three practices. The proportion of androgynous and masculine women using non-coital sexual activities decreases, but those using these practices showed the most stability over time. The undifferentiated women used only oral sex (with the exception of one woman in the first trimester who continued to use mutual masturbation at that time). Of the three, oral sex was the most popular before pregnancy, and continued to be used by more women than the other two during pregnancy.
Table 12
Percent of Women Using Non-Coital Practices

<table>
<thead>
<tr>
<th>Practices</th>
<th></th>
<th>Prepregnancy</th>
<th>1st Tri.</th>
<th>2nd Tri.</th>
<th>7th Mo.</th>
<th>8th Mo.</th>
<th>9th Mo.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U</td>
<td>66.7</td>
<td>66.7</td>
<td>66.7</td>
<td>66.7</td>
<td>33.3</td>
<td>33.3</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>75.0</td>
<td>57.1</td>
<td>42.9</td>
<td>57.1</td>
<td>57.1</td>
<td>42.9</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>81.5</td>
<td>65.4</td>
<td>53.8</td>
<td>57.1</td>
<td>50.0</td>
<td>38.5</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>100.0</td>
<td>33.3</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>85.7</td>
<td>61.9</td>
<td>50.0</td>
<td>47.7</td>
<td>45.5</td>
<td>35.7</td>
<td></td>
</tr>
<tr>
<td>Mutual Masturbation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U</td>
<td>33.3</td>
<td>16.7</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>50.0</td>
<td>0.0</td>
<td>14.3</td>
<td>42.9</td>
<td>28.6</td>
<td>28.6</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>53.8</td>
<td>22.2</td>
<td>33.3</td>
<td>33.3</td>
<td>33.3</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>100.0</td>
<td>33.3</td>
<td>33.3</td>
<td>33.3</td>
<td>33.3</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>57.1</td>
<td>18.2</td>
<td>21.4</td>
<td>18.2</td>
<td>16.3</td>
<td>16.7</td>
<td></td>
</tr>
<tr>
<td>Masturbation</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>50.0</td>
<td>28.6</td>
<td>14.3</td>
<td>28.6</td>
<td>14.3</td>
<td>14.3</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>40.7</td>
<td>26.9</td>
<td>19.2</td>
<td>17.9</td>
<td>7.1</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>33.3</td>
<td>33.3</td>
<td>33.3</td>
<td>33.3</td>
<td>33.3</td>
<td>33.3</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>36.4</td>
<td>23.8</td>
<td>16.7</td>
<td>18.2</td>
<td>9.1</td>
<td>7.1</td>
<td></td>
</tr>
</tbody>
</table>

 Desire to be Held. Women were asked if they perceived a difference in their desire to be held, without desiring sex to follow, as compared to before pregnancy. They were also asked to indicate whether this change, if experienced, was in the direction of an increased or decreased desire.

The general pattern for the pregnancy period was an increase in the proportion of women reporting an increase in their desire to be held (see Figure 7).
Figure 7. Women reporting an increase in the desire to be held, over time of pregnancy.
In this sample, 52.4% noticed an increase in the first trimester of pregnancy. There was only a small increase from these levels in the second trimester (by two women), but the proportion reporting an increase rose to 72.7% in the seventh month. This proportion dropped off to 69.9% in the eighth month and rose again to 76.9% in the ninth month. This corresponds to the previous findings that as sexual activity decreases, the need to be held increases.

Significant main effects were found for time of pregnancy, \( F (4, 207) = 218.51, p < .01 \). These significant effects were found to be for the androgynous group in the seventh and the eighth months.

In the seventh month, the androgynous need was significantly different from the undifferentiated, \( t (43) = 3.0923, p < .01 \), and from the feminine, \( t (43) = 2.8588, p < .01 \). In the eighth month, differences were, U: \( t (43) = 2.2439, p < .05 \); F: \( t (43) = 3.5556, p < .001 \); and M: \( t (43) = 2.9563, p < .01 \).

Significant main effects were also found for the different sex-role groups, \( F (3, 205) = 3.3471, p < .001 \). Post hoc comparisons with a protected \( t \) test revealed that differences existed for all groups except for the feminine-androgynous and the feminine-masculine. The undifferentiated group differed from the others in the following ways: A: \( t (208) = 12.4654, p < .001 \); F: \( t (208) = 5.3004, p < .001 \); M: \( t (208) = 2.1834, p < .05 \). That is, the desire to be held, overall, throughout pregnancy, was significantly higher for the undifferentiated women than for all others. The androgynous and the masculine groups also differed significantly,
with the masculine women also expressing a greater need to be held, $t (208) = 7.830, p < .001$.

The group which reported the strongest need to be held was the undifferentiated group. Five out of the six women reported an increase in the first trimester and steadily reported this with only slight variations.

The group least likely to report such an increase was the androgynous group. An increase was reported by 42.9% of these women in the first and second trimesters. In the seventh month, only two of these seven women reported wanting to be held more than before pregnancy and only one in the eighth month. They reach their highest levels in the ninth month.

The feminine group follows the general pattern of increase with the greatest jump seen in the seventh month. The masculine women maintain a steady two out of three women reporting an increased desire with the exception of the eighth month when all three women report an increased need to be held.

**Extramarital Sex.** In the year before pregnancy, three women (7.1% of the sample) reported that they were engaged in extramarital affairs at that time. The group consisted of two feminine and one undifferentiated woman. Both feminine women discontinued these relationships during pregnancy. The undifferentiated woman reported such involvement in the first trimester and the seventh month of pregnancy.

**Physical Response to Pregnancy**

This score reflects several things: the number and variety
of physically uncomfortable pregnancy symptoms experienced, the presence of complications during pregnancy, and the woman's behavioral response to these problems—the tendency to report them to her physician and/or to limit her activities in response to discomfort or illness. Hence, a high score here reflects both relative physical comfort and an element best described as psychological acceptance of bodily changes in pregnancy. Some of these symptoms (i.e., mild nausea and vomiting in the first trimester) are to be expected and are scored accordingly.

Using a one-way ANOVA, differences on this measure across the stages of pregnancy reached significant levels, $F(4, 156) = 3.825, p < .005$ (see Table 13). Post hoc comparisons with protected $t$ tests showed that the second trimester was experienced as sufficiently more comfortable to render it significantly different from all other periods of pregnancy: First trimester: $t(43) = 2.722, p < .01$; Seventh month: $t(43) = 2.528, p < .02$; Eighth month: $t(43) = 2.528, p < .02$; and Ninth month: $t(43) = 3.743, p < .001$. The first trimester, in this respect, did not differ significantly from the last three months.

Differences among the sex-role groups on this measure were not significant. As can be seen with Figure 8, however, the undifferentiated women scored best on this scale ($\bar{x} = 14.30$), the feminine women were next ($\bar{x} = 13.19$), then the masculine subjects ($\bar{x} = 12.60$), and the androgynous women reported the greatest amount of discomfort and complications ($\bar{x} = 12.43$).
Figure 8. PRP scores across time of pregnancy.
Table 13
Mean Scores, Physical Response to Pregnancy Scale

<table>
<thead>
<tr>
<th>Sex-Role Group Means:</th>
<th>Androgynous (n=7)</th>
<th>Masculine (n=3)</th>
<th>Feminine (n=28)</th>
<th>Undifferentiated (n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stages of Pregnancy:</td>
<td>1st Tri.</td>
<td>2nd Tri.</td>
<td>7th Mo.</td>
<td>8th Mo.</td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>14.67</td>
<td>16.33</td>
<td>14.67</td>
<td>13.83</td>
</tr>
<tr>
<td>Androgynous</td>
<td>11.43</td>
<td>12.14</td>
<td>14.14</td>
<td>12.86</td>
</tr>
<tr>
<td>Feminine</td>
<td>13.04</td>
<td>14.41</td>
<td>12.59</td>
<td>13.15</td>
</tr>
<tr>
<td>Masculine</td>
<td>12.67</td>
<td>14.00</td>
<td>11.67</td>
<td>11.33</td>
</tr>
<tr>
<td>Sample</td>
<td>12.95</td>
<td>14.22</td>
<td>13.27</td>
<td>12.79</td>
</tr>
</tbody>
</table>

The sample as a whole reports discomfort and difficulties in the first trimester which reflects an average of 5.02 responses per subject indicating either physical symptoms of pregnancy, complications, or effects upon their life-style due to these changes. The second trimester is experienced as the most comfortable period of pregnancy. The women's level of comfort decreases in the seventh month, remains constant in the eighth month, and reaches its lowest point in the month before delivery.

The undifferentiated and feminine patterns of response are essentially the same until the eighth month, the only difference being that the undifferentiated women report less discomfort than the feminine women. At this time, the undifferentiated group
continued to feel more and more uncomfortable until they reach
their all-time low, and for the sample as a whole, report a level
of discomfort exceeded only by the androgynous women. The feminine
group reports feeling somewhat better in the eighth month, but
discomfort increases slightly again in the ninth. This group
reports the smallest amount of change in comfort levels for the
third trimester.

The masculine group follows the same pattern as the undifferen-
tiated and feminine women for the first and second trimesters
but experienced a more severe decrease in comfort level in the
seventh and eighth months. They are the only group reporting
increased comfort in the ninth month.

The androgynous women report being more uncomfortable than
all other women in the sample in the first and second trimesters
and the ninth month, although as cited earlier, this was not to
significant levels. Their unusual response pattern occurs chiefly
in the seventh and eighth months when their level of comfort im-
proves dramatically. In the seventh month, they report being
more comfortable than both the feminine and the masculine women.
A decline begins in the eighth month and continues until delivery,
such that they report the greatest discomfort of all in the ninth
month, and the greatest degree of variability in the third tri-

Emotional Response to Pregnancy

This score reflects 1) the degree to which a woman perceives
herself as attractive to self and others, as awkward, and as un-
Table 14

Mean Scores, Emotional Response to Pregnancy Scale

<table>
<thead>
<tr>
<th>Sex-Role Group Means:</th>
<th>Androgynous</th>
<th>Masculine</th>
<th>Feminine</th>
<th>Undifferentiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n=7)</td>
<td>(n=3)</td>
<td>(n=28)</td>
<td>(n=6)</td>
<td></td>
</tr>
<tr>
<td>Androgynous</td>
<td>2.48</td>
<td>2.11</td>
<td>1.90</td>
<td>2.00</td>
</tr>
<tr>
<td>Feminine</td>
<td>1.56</td>
<td>1.85</td>
<td>2.30</td>
<td></td>
</tr>
<tr>
<td>Masculine</td>
<td>2.70</td>
<td>1.67</td>
<td>2.00</td>
<td></td>
</tr>
<tr>
<td>Sample</td>
<td>1.98</td>
<td>2.05</td>
<td>2.05</td>
<td></td>
</tr>
</tbody>
</table>

Stages of Pregnancy:

<table>
<thead>
<tr>
<th></th>
<th>7th Mo.</th>
<th>8th Mo.</th>
<th>9th Mo.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undifferentiated</td>
<td>2.33</td>
<td>2.17</td>
<td>1.50</td>
</tr>
<tr>
<td>Androgynous</td>
<td>3.00</td>
<td>2.85</td>
<td>1.57</td>
</tr>
<tr>
<td>Feminine</td>
<td>1.56</td>
<td>1.85</td>
<td>2.30</td>
</tr>
<tr>
<td>Masculine</td>
<td>2.70</td>
<td>1.67</td>
<td>2.00</td>
</tr>
<tr>
<td>Sample</td>
<td>1.98</td>
<td>2.05</td>
<td>2.05</td>
</tr>
</tbody>
</table>

comfortable; 2) her reported anxiety level as compared to pre-pregnancy levels, and the perception of that anxiety as related or not related to her pregnant condition; and 3) her positive or negative feelings in anticipation of labor and delivery. This scale was administered only in the months of the last trimester. High scores indicate relative freedom from negative self-concept, anxiety, and/or fearful anticipation of labor and delivery.

Results were in the predicted direction: androgynous women scoring highest, then masculine, undifferentiated, and feminine women. However, these differences did not reach significant levels for either stage of pregnancy or sex-role (see Table 14). Means varied only 0.58 points across time. The point spread
between sex-role groups was greatest in the seventh month (1.44 points), narrowed only slightly in the eighth month to 1.18 points and converged to a much smaller difference by the ninth month (0.80 points).

The patterns exhibited by the different groups varied considerably (see Figure 9). The feminine women reported the greatest amount of distress of all the women in the seventh month, but this steadily improved until they were experiencing the least distress and the most positive outlook of all in the ninth month.

The masculine subjects also demonstrated a unique pattern. They began the last trimester with scores bettered only by the androgynous women. This decreased sharply in the eighth month so that they had the lowest scores of all at that time. By delivery, however, they had increased their scores sufficiently so that they were bettered only by the feminine women.

The undifferentiated and the androgynous women both decreased slightly between the seventh and the eighth months, the chief difference between them at this point being that the undifferentiated women were reporting more distress than the androgynous women. These two groups are composed of the women reporting the least amount of distress in the eighth month. Both groups, however, show an increase in their level of affective discomfort in the ninth month, changing the group rankings such that they were then the two most uncomfortable groups. The androgynous group shows the largest jump of the two in terms of increased distress.
Figure 9. ERP scores across the third trimester of pregnancy.
The androgyrous group, by far, shows the greatest increase in discomfort from the seventh to the ninth months, followed by the undifferentiated and then the masculine groups. The feminine group is the only one showing an overall increase in emotional comfort in the last trimester.

**Delivery Records**

Statistical analysis indicated that differences between sex-role groups on delivery scores were not significant, and were only partially in the predicted direction. Mean scores fell within a 0.83 point range ($X_A = 17.00; X_F = 16.73; X_M = 16.67; X_U = 16.17$). The higher the score, the more problem-free the labor and delivery experience.

There were three Caesarean deliveries ($U = 1; F = 2$), and five forceps deliveries ($U = 1; A = 1; F = 3$) (see Table 15). The average weight gain during pregnancy was 28.9 pounds, with the undifferentiated women gaining the largest amount (31.0 pounds). The feminine women averaged a weight gain of 29.47 pounds, the masculine women averaged 28.33 pounds, and the androgynous women gained 26.83 pounds.

There were twenty-eight males and ten females born to the sample, with the feminine women slightly more likely to have a female than the other groups. The undifferentiated women delivered 100.0% males, the androgynous and the masculine groups produced one female each, and the feminine group delivered the remaining eight females.
Table 15
Summary of Labor and Delivery Data

<table>
<thead>
<tr>
<th>Androgynous</th>
<th>Masculine</th>
<th>Feminine</th>
<th>Undiffer.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n=6)*</td>
<td>(n=3)</td>
<td>(n=23)*</td>
<td>(n=6)</td>
<td>(N=38)*</td>
</tr>
</tbody>
</table>

Labor Induced: 2 1 4 0 7
Membranes Artificially Ruptured: 5 1 11 2 19

Duration of Labor:
- Expected: 7'44" 7'22" 8'31" 8'06"
- Actual: 6'55" 9'23" 8'16" 8'39" 8'34"

Primigravidas
- Expected: 8'49" 8'49" 8'49" 8'49"
- Actual: 4'52" 16'31" 9'17" 10'15" 8'49"

Multigravidas
- Expected: 6'46" 6'46" 6'46" 6'46"
- Actual: 4'52" 5'53" 2'30"a 7'16" 6'46"

Prematurity: 1 0 0 0 1
Prolonged Labor: 1 1 4 0 6
Precipitous Labor: 0 0 2 0 2

Length of Second Stage:
- Expected: 36.8" 29.7" 52.0" 32.5"
- Actual: 30.5" 57.3" 59.0" 38.5" 55.3"

Primigravidas
- Expected: 58.1" 58.1" 58.1" 58.1"
- Actual: 40.3" 151.0" 56.4" 12.5" 58.1"

Multigravidas
- Expected: 15.5" 15.5" 15.5" 15.5"
- Actual: 20.7" 10.5" 15.7" 12.5" 15.5"

Caesarian Section: 0 0 2 1 3
Weight Gain (lbs.): 26.8 28.3 29.5 31.0 28.9
Forceps: 1 0 3 1 5
Male Children: 5 2 15 6 28
Weight of Child: 7'10" 8'07" 7'07" 8'12" 8'01"
Mean Scores: 17.00 16.67 16.73 16.17 16.63

a Mean included two women who delivered precipitously.
* Six women (1 A, 5 F) had not yet delivered.
For the sample, 65.7% of the women used pain medication during labor. The undifferentiated (83.3%) and the masculine (100.0%) women were more likely to use medication at this time than either the feminine (60.1%) or the androgynous (50.0%) women. At the time of delivery, only 21.1% of the women in the sample used medication other than a local for the episiotomy. Three of these eight women gave birth by Caesarian section, and none of them were from the masculine group (U = 2; A = 1; and F = 5).

The weight of the babies averaged 8 pounds, 1 ounce. Feminine women bore the smallest babies (7 pounds, 7 ounces) on an average, next the androgynous women (7 pounds, 10 ounces), then the masculine women (8 pounds, 7 ounces), and finally the undifferentiated women (8 pounds, 12 ounces). Only one abnormality was present at birth, spina bifida. This baby was born to a feminine mother.

The average length of labor for the sample as a whole was 8 hours, 34 minutes. The first-time mothers averaged 8 hours, 49 minutes, while the multigravidas averaged 6 hours, 40 minutes. When reviewing the mean lengths of labor for the different sex-role groups, it must be remembered that the composition of the groups, in terms of parity, varies. The multigravidas are expected to have shorter labors.

An 'expected average' based upon labor lengths of this sample, was calculated for primigravidas (8 hours, 49 minutes) and for the multigravidas (6 hours, 46 minutes). 'Expected average' labor
lengths were then calculated for each group, based upon its particular composition in terms of parity.

If we compare the multigravidas by sex-role groups, it is seen that the feminine multigravidas have considerably shorter labors. This result is heavily influenced by the fact that two out of the three multigravidas in this group experienced a precipitous delivery (1 hour, 49 minutes, and 1 hour, 28 minutes). These represent the only such deliveries in the sample.

For the primigravidas, the androgynous women experienced the shortest deliveries by a considerable amount of time. Again, the averages are strongly affected by two women who experienced very rapid deliveries (3 hours, 5 minutes, and 3 hours, 31 minutes) but did not quite qualify to be called 'precipitous' deliveries (< 3 hours). Overall, the androgynous women tended to have shorter than average labors, masculine women tended to have longer than average labors, and the feminine and undifferentiated women demonstrated labor lengths which were average for this sample.

Length of second stage is also influenced by whether or not a woman has delivered before. For this sample, multigravidas averaged 15.5 minutes, while primigravidas averaged 58.1 minutes. All groups were close to their expected averages except for the masculine group whose expected average length of second stage was 29.7 minutes while their actual average was 57.3 minutes. The undifferentiated group was the only group which did not contain any women experiencing a prolonged labor ($n = 6; A = 1, F = 4, M = 1$).
As predicted, the undifferentiated and the feminine women scored higher on trait anxiety than did the androgynous and the masculine women (see Table 16), but the differences were not significant for either sex-role or stage of pregnancy. The patterns of the undifferentiated, androgynous, and the masculine women are the same (see Figure 10). Trait anxiety levels increased 1.67 points for the undifferentiated group between the seventh and the ninth months, 2.29 and 3.00 points for the androgynous and the masculine groups, respectively. The mean for the undifferentiated group, however, was approximately three points higher than those of the other two groups.

Table 16

Third Trimester Mean Scores, Trait Anxiety

<table>
<thead>
<tr>
<th>Sex-Rule Group</th>
<th>7th Mo.</th>
<th>9th Mo.</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undifferentiated</td>
<td>35.33</td>
<td>37.00</td>
<td>36.17</td>
</tr>
<tr>
<td>Androgynous</td>
<td>31.71</td>
<td>34.00</td>
<td>32.86</td>
</tr>
<tr>
<td>Feminine</td>
<td>37.67</td>
<td>36.59</td>
<td>37.13</td>
</tr>
<tr>
<td>Masculine</td>
<td>31.00</td>
<td>34.00</td>
<td>32.50</td>
</tr>
<tr>
<td>Sample</td>
<td>35.91</td>
<td>36.05</td>
<td></td>
</tr>
</tbody>
</table>
Figure 10. Trait anxiety changes in the third trimester.
The feminine group's pattern differs from the others in that reported trait anxiety levels were higher in the seventh month than in the ninth month. Their mean scores decreased by 1.08 points between the two testing periods. They reported the highest levels of anxiety for the seventh month and are exceeded only slightly by the undifferentiated group in the ninth month.

**State Anxiety**

There are no significant main effects for either sex-role or time of pregnancy with state anxiety scores. There is, however, a significant interaction of the two, $F(3, 39) = 3.092, p < .038$. Post hoc comparisons using protected $t$ tests indicated that in the seventh month, significant differences in level of state anxiety exist between the androgynous women and both the masculine, $t(41) = 2.435, p < .02$, and the feminine women, $t(41) = 2.245, p < .05$, but not the undifferentiated (see Figure 11). The androgynous group reports significantly less anxiety at this time, but this difference disappears in the ninth month.

As can be seen by looking at the means in Table 17, two groups, the androgynous and the undifferentiated women, report an increase in anxiety levels from the seventh to the ninth months. The androgynous group reports relatively low levels of anxiety in the seventh month, but shows the greatest increase as they draw nearer to delivery (+6.85). The undifferentiated group, on the other hand, is more anxious in the seventh month than the androgynous group, and increases in the ninth month, but to a smaller
Figure 11. State anxiety changes in the third trimester.
degree (+4.83).

Both the masculine and the feminine groups report decreases in anxiety levels as delivery approaches. The feminine women demonstrate the smallest change in anxiety levels of all of the groups (-1.74). The masculine group has an unusual pattern in which they report the greatest differences in anxiety levels between the two measurement periods. They show a 10.00 point decrease in experienced anxiety as they prepare for delivery.
Discussion

Conclusions and suggestions based upon the data obtained in this investigation are possible in the areas of sex-role development and the effects of sex-role upon response to pregnancy.

Sex-Role and Family Origins

There are, admittedly, many factors which may be influential in the development of sex-role identification other than those studied in the present investigation (for example, sex-role of the parents). Some of the present findings concerning the early lives and familial backgrounds of these women lend themselves to some interesting speculations.

Background Characteristics of Undifferentiation

Before discussing the dynamics possibly involved in the development of undifferentiation, a reemphasis of certain points will be helpful. Responses from the undifferentiated group suggest that the characteristics of the families in which these women were raised included parents who averaged a high school level education, with the mothers having achieved a higher level than the fathers, for the most part. Most of these mothers worked outside of the home when their daughters were growing up. Parental marriages were perceived by the children as being happy and satisfying, all of them being intact at the time of the subjects' pregnancies.

While these marriages were happy and lasting, this group was
the most likely to report that the atmosphere in their homes was not affectionate. The parents appear to have been able to relate successfully to one another, but to have been either disinterested in, or affectively inhibited with, their daughters (most undifferentiated women described indifferent or distant atmospheres).

The development of the role confusion which is evidenced by undifferentiated women, could result from a long-term negative comparison of self with interpersonally competent models who were perceived as noninterested in the child. That is, the parents could be seen as evidence that it is possible for people to be happy and affectionate, "but not with me". Such a perception would set the stage for the low self-esteem, anxiety, and fear of rejection found in undifferentiated persons. Due to limited experience with both rewarding interpersonal contact and contingent reinforcement of behavior, the development of a self-concept characterized by feelings of environmental impotence is very possible. This inability to identify behaviors which result in positive social consequences could result in a lack of specification of desired or appropriate behavior or roles.

Perhaps because they are confused about roles, these women seemed to be less responsive to events most strongly connected with such roles. Because they haven't determined what is appropriate or preferable behaviorally, they not only exhibit behavioral deficits which deprive them of opportunities to earn reinforcement from others, but they are also less able to adequately reinforce
themselves.

The sexual experiences of this group in the early years were quite limited when they are compared to other groups. Few remember playing any games in childhood with sexual content, they tended to be anorgasmic with masturbation premaritally, and all discontinued the practice of masturbation once they married. These women were sexually active before marriage, but showed limitations in their ability to be sexually successful (i.e., they were lowest in frequency of orgasms and in the ability to have multiple orgasms). In spite of their relatively low frequency of successful sexual experiences, however, they were the youngest group at the time of their first coital experience, 60.0% of them being between the ages of thirteen and sixteen on this occasion. Attitudes towards sex for this group were predominantly 'mixed' at this time, a fact which may have been responsible for their low rates of non-coital practices such as masturbation, mutual masturbation, and oral sex. Their early age at first intercourse may reflect an attempt to relate, to gain closeness and affection from another.

Background Characteristics of Femininity

Feminine women reported a satisfactory home environment in their childhood. Their parents had the second highest educational level, although their daughters reported the lowest level for the sample as a whole. As might be expected, their homes tended to be more traditional than those of the other groups (for example, they had the lowest number of mothers working outside of the home and
the largest families). Their environment tended to include happy parental marriages and affectionate atmospheres in the home.

An interesting finding was that this group of women were the most likely to report such feelings as 'grownup', 'excited', and 'proud' in reaction to the onset of menses. Fully half of these women reported positive changes in body image following menstruation, making them the only group with predominantly positive changes in this respect. There was a suggestion of feelings of having achieved a social milestone that were not found in the other groups. The 'ability' to menstruate was a source of increased self-esteem, perhaps a sign that the girl was reproductively sound and 'female'.

Like the undifferentiated women, the feminine group reported few childhood experiences of a sexual nature and were the only group containing women who reported not 'petting' with dates during adolescence. On the other hand, they had the highest proportion reporting engaging in premarital coitus. The majority of this group also reported 'mixed' attitudes towards sex at this time.

Once again, then, there is a contradiction between reported attitude and reported behavior—an orientation towards sexuality which contains negative elements, yet a very high level of participation in an interpersonal sexual activity. Both the attitude and the behavior may be expressions of the characteristic feminine orientation towards others: the behavior being an attempt to please an important male, while the attitude softens the severity of her breech of the societal proscription against premarital
intercourse (she doesn't really want to have intercourse, but will sacrifice her inclinations in order to maintain an harmonious relationship).

Background Characteristics of Masculinity

In discussing the results obtained for the masculine group, it must be reiterated that the freedom to draw definitive conclusions is restricted due to the small size of this group \( n = 3 \). However, it should also be noted that the attitudinal and behavioral responses contributed by these women showed the greatest within group consistency. It is felt, therefore, that these data may at least be regarded as strongly suggestive of trends.

The masculine women, like the feminine women, present an essentially positive environment in childhood. Their parents had the highest educational levels for the sample, and their daughters had the second highest. All of the mothers of masculine women worked outside of the home, the only group with this high a rate of maternal employment.

The majority of these women reported that their parents' marriages were happy and that the atmosphere within the home was affectionate. Although parents were perceived as affectionate, there was also a degree of distance or discomfort between mothers and daughters. This is evidenced by the fact that none of these mothers told their daughters about menstruation or discussed sexual relationships with them. One, later on, did communicate with her offspring regarding the facts of sexuality. These less traditionally role-oriented mothers may have been personally uncomfor-
table with sexuality, and/or unable to accept their daughters as sexual beings, and communicated this to their children. These girls had the least positive reaction to the appearance of menstruation, two out of three reporting detachment or disappointment.

The masculine women evidenced an early interest in sex, however. All reported playing 'doctor' as a child, and two-thirds masturbated, beginning this practice earlier than most other women. They were orgasmic and tended to masturbate more regularly than did the others. They were active sexually in the premarital stage, displayed more versatility and variety than the undifferentiated and feminine women, and were more likely to report arousal. They were also willing to initiate sexual activity more frequently than these two other groups.

Surprisingly, however, 100.0% of these women reported that their attitude towards sex at this time was 'mixed'. Indeed, heterosexually, they tended to date for the first time at an older age than the rest of the sample, and to be older at the time of the first coital experience. Considering their level of sexual effectiveness on an individual basis, it is tempting to attribute this ambiguous attitude towards sex to a conflict regarding the stereotypic female sexual role (passive, naive, disinterested, etc.). The masculine-typed woman may be unwilling or unable to meet these role requirements.

Thus, instrumentally these women were functioning quite well.
Expressively, however, they may have been experiencing difficulty. The nature of their relationship with their parents, perhaps best termed 'distant-affectionate', may have left them with deficits in the expressiveness which is culturally expected from women and young girls. Adolescent males, heavily influenced in their teens by role standards and expectations, may well have found these girls confusing, threatening, and/or unappealing.

It appears that the masculine women have adopted a motto which states that moderation in all things emotional is to be preferred. They consistently report the lowest frequencies of both sexual and nonsexual interpersonal contact from the premarital period on, while maintaining satisfactory self-stimulation practices. They also most frequently cite 'lack of affection' as a problem in both their emotional and sexual relationships. This finding is suggested more strongly in this study than in previous investigations (Bem, 1975).

**Background Characteristics of Androgyny**

Several of the findings in this study regarding the backgrounds of the androgynous women were very surprising. It was expected that they would have the highest educational level for the sample, which they did. However, it was also expected that the educational level of their parents would be very similar to that of the masculine women's parents. For this sample, however, the androgynous subjects' parents placed at the opposite end of the spectrum, having the lowest educational level for the entire
sample.

This was particularly true for the mothers, whose mean educational level was approximately two grades below the mothers of the undifferentiated, the feminine, and the masculine groups. This finding is contrary to the current assumption that the parents of androgynous women are better educated, their mothers more likely to be employed, and that they model such attitudes and aspirations for their daughters as do the mothers of masculine women (as well as adequate levels of expressiveness). Clearly, the educational assumptions are not upheld in the present data, but the group did report approximately 75% of the mothers working.

Another finding concerning the family backgrounds of the androgynous women which was equally unexpected may be pertinent to the development of androgyny. The conflictual nature of the marital relationships of the parents of the androgynous women, as compared to other women, was not anticipated, nor, to my knowledge, has this been reported in other studies. On the whole, the majority of these women reported that their parents' marriages were unsatisfactory and were more likely than those of any other group's to end in divorce.

However, the children of these marriages most often reported affectionate atmospheres in their homes. Thus, although the marital relationships deteriorated and/or were ended, the parents were able to separate themselves from these disruptive relation-
ships and relate to the children of their marriages with affection and interest. The androgynous women (who were clearly aware of the difficulties in their parents' relationships) may therefore have been exposed to an interpersonal style which showed clear differentiation among situations and relationships.

It is interesting that the undifferentiated group, which also reports approximately equal endorsement of masculine and feminine personality attributes, but on a much lower level, were the most similar to the androgynous group in terms of parental education and the tendency of mothers to be employed outside of the home. The chief differences are in the nature of the parental and the parent-child relationships. It appears, considered on this basis, that the ability of parents to demonstrate effective expressiveness is more important to the development of androgynous offspring (who are psychologically and behaviorally more effective) than is the quality of the heterosexual relationships modeled. It may also be suggested that there is a subtle modeling of agency by these androgynous women's parents. That is, the ability of the parents to limit the generalization of their interpersonal problems in their marital relationships, and not allow this to detrimentally affect their parental relationships, modeled discrimination and personal control over their interpersonal lives.

The androgynous group consistently reported early sexual activity and experience: they remembered playing games with
sexual content as children, the majority masturbated at a relatively young age, and half were orgasmic at that time with self-stimulation. All of these women engaged in petting and all but one were orgasmic with premarital intercourse. Half were also multiply orgasmic at this time. The majority were seventeen or older at their first coital experience, and this is the only group which reported a positive outlook on sexuality (only one woman owning mixed feelings) in the premarital period. They were equally as likely to suggest intercourse as to allow their partners to do so, and were the only group all of whom reported the use of contraception with premarital intercourse. These women displayed the greatest variety of sexual practices of all of the groups, reported the least amount of conflict regarding sex, and were, by far, the most likely to plan their pregnancies.

**Sex-Role and the Experience of Pregnancy**

**Sexual Adjustment to Pregnancy**

*Composite Sample Response.* The results for the sample as a whole in terms of sexual adjustment (i.e., sexual interest, activity, and satisfaction) in pregnancy, agree with the findings of Solberg, Butler, and Wagner (1973), and those of Tolor and DiGrazia (1976). That is, there is a general decrease in sexual adjustment as a whole which tends to accelerate as pregnancy advances. Findings in terms of sexual interest, frequency of intercourse, frequency of orgasm, perceived intensity of orgasm, use of non-coital practices, and coital positions employed support
Solberg et al. and Tolor and DiGrazia, rather than the other studies.

In the present study, physical discomfort was the most frequently cited reason for decreased desire, agreeing with Solberg, et al. Findings on the reasons subjects gave for their decreased sexual desire were very similar, the major difference being that Solberg et al. found that fear of injury to the baby was the second most frequently given reason. The number of women giving 'fear of injury to the baby' as a response in the present investigation, was exceeded by those citing awkwardness having intercourse, loss of interest, feelings of personal unattrac­tiveness, and discomfort due to nausea, fatigue, etc., in that order.

Data on the frequency of multiple orgasms also tends to differ in the present study. A prominent deficit in the first trimester was found with essentially a constant rate being maintained until the eighth month, when a dramatic decrease occurs. Findings for satisfaction with sex life agree with Tolor and DiGrazia's finding that sexual satisfaction maintained a life separate from sexual behavior. Satisfaction remained fairly constant in the first and second trimesters at essentially prepregnancy levels, then decreased in the third trimester. The major differences between these findings is that the present study shows a more severe deficit in the third trimester. The data on the desire to be held is in agreement with that reported by Tolor and DiGrazia and
Hollender and McGehee (1974), that is, as sexual activity decreased, desire to be held increased.

As hypothesized, the androgynous and the masculine women achieved higher scores on the SAP scale than did the feminine and the undifferentiated women. The sex-role main effect was significant, $F(3, 38) = 3.132, p < .037$. However, post hoc comparisons with protected $t$ tests, indicated that while the androgynous scores were significantly higher than both the feminine, $t(40) = 3.334, p < .001$, and the undifferentiated, $t(40) = 3.416, p < .001$, the masculine scores were not significantly different from those of any other group.

Examination of the attitudinal and behavioral responses of the sample clearly illustrates the source of the superiority of the androgynous women's level of sexual adjustment. As seen in the previous section, their overall sexual adjustment is superior in both the developmental and the premarital periods. This superiority continues into the prepregnancy period.

Both the undifferentiated and the feminine women show decreases in many areas of sexuality following marriage. The masculine women maintain their premarital level of performance in most areas and increase their success rates in a few others. The androgynous women, however, show no deficits in sexuality following marriage, and increase either in frequency, positiveness of attitude, or range of behavior in most sexual areas.

This same quality of consistency in sexual attitudes and
behavior is apparent in the androgynous sexual adjustment to both pregnancy in general and to the unique difficulties posed by each advancing stage of pregnancy. All groups show some negative effects upon sexuality as a result of their pregnant condition. For the sample as a whole, these effects over time of pregnancy were significant, $F(3, 38) = 28.354, p < .0001$, and in a negative direction. For the androgynous women, however, the effects were minimal and response rates did not differ greatly from one pregnancy period to another. A significant interaction effect, $F(3, 38) = 1.946, p < .033$, occurs in the seventh month, for the androgynous group, wherein they report improved sexual adjustment, while the other groups report increasing deficits.

Theoretical Considerations. Female sexuality is an area of human behavior which may be viewed as highly susceptible to both instrumentality and expressiveness. An instrumental woman may be highly successful in practices which involve self-stimulation, or in the use of specific techniques, as she is more apt to actively seek out, discover, and use sexual practices which result in satisfaction for her (clitoral sexuality). Thus, both the masculine and the androgynous women may be expected to use their high levels of 'masculine' attributes successfully in this respect.

The feminine woman, who is more accepting of society's sex-role stereotypes, is less likely to actively seek and define
specific behaviors which yield sexual satisfaction for her as an individual. She may, however, in our society, be expected to accept a definition of female sexuality as being a passive, receptive (vaginal) sexuality.

The undifferentiated women, with their characteristic role confusion, may be expected to simply eschew self-erotic behaviors and to seek self-expression and satisfaction chiefly in relation to another person in their (proposed) search for affection and approval.

An expressive woman may be expected to be more successful in terms of heterosexual or interpersonal sexual behaviors. The feminine woman, with her orientation towards others, and her tendency to both seek pleasurable responses by providing others with pleasure, and to evaluate herself more positively in terms of her ability to please others, may be expected to perform well interpersonally. That is, her partner is apt to be pleased and satisfied because she will allow him, for the most part, to determine the nature and frequency of sexual behavior with only minimal regard for her own level of satisfaction (unless this is important to her mate).

The masculine and the undifferentiated women, however, with their low levels of expressiveness, may be expected to do less well in terms of interpersonal sexuality. For the masculine woman, with her basic nonacceptance of societal sex-role standards, a serious disparity between her partner's sexual expectations and
her ability or willingness to meet those expectations (chiefly in terms of a balance of both active and passive, physical and affective aspects of sexuality) may exist. The undifferentiated woman, with her deficit in the expressive as well as the instrumental domain, may be expected to be less effective interpersonally, although this is likely to be her preferred method of sexual expression.

The implications for androgyny and sexual success are clear—the likelihood of performing successfully both in terms of self-stimulation and in terms of heterosexual sex are high. Practically speaking, the androgynous woman is more likely than any other sex-role identity to: 1) actively try different practices, positions, techniques, etc., in order to determine what pleases them most sexually; 2) use these practices herself to acquire sexual gratification; 3) be capable of, and willing to, communicate this information to a partner; and 4) be interpersonally skillful enough to maintain a relationship with her partner which is affectively satisfying, one result of which is his increased desire to please her, both sexually and non-sexually.

These are exactly the results which were seen in terms of overall sexual adjustment. Besides being the least effective and the least satisfied in the premarital and prepregnancy periods, the undifferentiated women tended to show decreasing success and satisfaction in all areas of sexuality. The feminine women showed decreases from the point of marriage on, in self-directed, self-
stimulation practices as well as practices which deviate from the societally endorsed method of sexual expression, sexual intercourse.

The masculine women do not show any deficits after marriage. They continued at their previous levels of performance. However, these levels are low relative to those of the other groups. With the advent of pregnancy, however, deficits are immediately seen in the interpersonal sexual behaviors, while self-stimulatory practices maintain their frequency and level of satisfaction.

The androgynous women showed a generalized improvement following marriage, presumably from increasing levels of experience. They showed some overall decrease in sexuality due to pregnancy, but quickly adjusted and recovered to almost prepregnancy levels. What is most interesting and impressive is the consistency and uniformity of their superior sexual adjustment. While they may be exceeded by other groups in single areas (i.e., the higher feminine frequency of intercourse), the other groups are substantially inferior in terms of overall ability, frequency, positiveness of attitude, and sexual satisfaction.

Physical Response to Pregnancy

For the entire pregnancy period, the sample averaged seven responses each indicating either a symptom or complication of pregnancy, an instance of communicating these symptoms or complications to their physician, or limiting their activity due to these problems. The relationship of physical comfort and/or free-
dom from complications to time of pregnancy was curvilinear, that is, the women felt less comfortable in the first trimester, improved in the second, and then again reported increased discomfort (to slightly greater than first trimester levels) in the third trimester. The relationship between sexual activity and physical well-being was inverse for the first two trimesters and then in agreement for the last (see Figure 12). Sexual adjustment scores did not, therefore, reflect the frequently cited reasons for decreased interest in sex, which tended to be reasons based upon physical discomfort in the main.

Results on this measure not only did not support Hypothesis 2, but were in direct contradiction to the predicted results. That is, the undifferentiated and feminine women scored higher on the PRP scale than did the androgynous and masculine women.

Clearly, this response from the androgynous women was very surprising. A close examination of their records indicated that these women, in keeping with their prior reproductive histories, experienced the greatest number of first and second trimester complications (i.e., three of the seven women experienced bleeding in the first trimester with one of these continuing to do so into the middle months of pregnancy, and one woman developed a benign tumor in her breast which was biopsied).

These women had a unique pattern of responding to the questionnaire as well: they would indicate experiencing a symptom of pregnancy (for example, nausea), but attach a note explaining that
Figure 12. SAP and PRP composite for the sample.
this was so slight that they had felt no need to report it to their physician, or that the symptom was occurring no more frequently or severely than when she was not pregnant, but since the question was asked, she had to respond honestly. They tended to be somewhat compulsive about accurate responding in other ways as well. For example, one androgynous woman who had not reported decreased activity levels at any previous stages of pregnancy, reported this in the ninth month with the explanation that at this point in her pregnancy, she was forced to discontinue playing racquetball!

Aside from representing, as intended, the degree of symptoms and complications experienced, the androgynous scores may be regarded as a demonstration of both high levels of self-monitoring and a high need for accuracy in the reflection of this in their communications. The undifferentiated women, on the other hand, tended to respond to the questionnaires in a way which suggested either a low level of self-monitoring or a more nonchalant attitude about the completeness of their responses. They tended to omit responses more often than the androgynous group, and to write in fewer comments when given the opportunity to do so.

According to Hanford's theory (1968), this high level of symptomatology and complications should indicate a large amount of unresolved conflict, high anxiety levels whether pregnant or not (and in particular, then, trait-type anxiety), and should presage difficult deliveries. It is impossible to see this in
the overall androgynous response to pregnancy. They report the lowest mean pregnancy-related emotional distress, the lowest state and trait anxiety levels, and the best delivery records.

What does become apparent is that these records represent an excellent sampling of the ability of the androgynous woman to cope with stress, both behaviorally and psychologically. At the same time that they are experiencing the sample's highest levels of physical discomfort (and for three of the seven, one assumes psychological stress as well, due to fear of miscarriage in the early parts of pregnancy), they are exhibiting the highest level of sexual adjustment for the sample. Their pattern of sexual response mirrors the pattern of their reported physical well-being, i.e., as they feel better, they become more active sexually. However, even when they feel the worst, and even when their sexual adjustment is at its first trimester low, these women are performing sexually approximately five points higher than the other sex-role groups, all of whom report feeling considerably better physically than the androgynous women.

It is obvious, then, that factors other than experienced physical discomfort, as was most frequently reported, are influencing the sexual interest, behavior, and satisfaction of the other groups as pregnancy advances.

**Emotional Response to Pregnancy**

The results on this measure were not significant. The groups reported only minute differences in levels of emotional distress. The rank-ordering of the mean scores were in the predicted direction,
but differences were so small as to make this meaningless. On the whole, the women reported a uniform level of emotional distress across time and sex-role.

The overall sense of emotional well-being decreased sharply in the eighth month and remained unchanged until delivery. These results tend to disagree with the test results for both state and trait anxiety. The ERP is largely reflective of levels of anxiety and the perception of that anxiety as increased or decreased in terms of prepregnancy levels. Even though the women reported increased anxiety and apprehension of impending labor and delivery, the sample means for state anxiety in the seventh and ninth months are identical. An increase in trait anxiety scores did occur, but this change was barely perceptible. On the whole, ERP scores reflected high levels of distress for all groups.

All that can be said with certainty, based upon these results, is that the women tended to feel unattractive, anxious, and apprehensive to a considerable degree in the third trimester of pregnancy, regardless of their sex-role identification, and regardless of the point at which emotional distress was assessed.

Delivery Records and Anxiety Measures

A comparison of labor and delivery records also failed to yield significant differences for sex-role, although there is limited support for Hypothesis 4 (i.e., that androgynous and masculine women would achieve higher scores on the Response to Childbirth Scale than would feminine and undifferentiated women). The trend is in the predicted direction for the androgynous, but not the masculine,
women. That is, the androgynous women exhibited less complications of labor and delivery than any of the other groups, but the masculine women only performed better than the undifferentiated group who had the lowest scores.

It appears from these results that high levels of both instrumentality and expressiveness are more beneficial in parturition than any other possible combination. This is in keeping with the principles upon which the successful Lamaze method of childbirth preparation is based. This approach bases success upon: 1) increased knowledge of both the biological processes involved in childbirth and of techniques which enable a woman to work with, not against, her body's natural functioning; and 2) the psychological advantage of support and assistance from an informed significant other in the process of childbirth. These can be viewed as a combination of agency and communality, or instrumentality and expressiveness. It seems that high levels of either 'masculine' or 'feminine' attributes (and a corresponding low level of the other), or low levels of both, are not as effective as high levels of each type of attributes, even in this highly 'female' activity.

It can be seen that Hypothesis 7 (i.e., that all women would exhibit the highest levels of state-type anxiety in the ninth month), and that Hypothesis 5 (i.e., that feminine and undifferentiated women would exhibit higher levels of state-type anxiety than androgynous and masculine women) was only partially supported. Results further indicate that support for Hypothesis 6 (i.e., that
feminine and undifferentiated women would exhibit higher levels of trait-type anxiety than androgynous and masculine women) exists, but not to significant levels.

Composite Response to Pregnancy

Undifferentiated Response. As can be seen from Table 14, the undifferentiated women ranked in the lowest two positions for all areas measured, with the exception of the PRP in which they performed the best. That is, with the exception of experiencing the fewest symptoms and complications of pregnancy, reporting these less often to their doctors, and altering lifestyles due to feeling less well, these women experience the poorest adjustment to pregnancy. Sexually they were the most constricted in terms of practices used and the tendency to find substitute means of satisfaction as discomfort increased (see Figure 18). Their decreases are earlier and steeper than all other groups.

They also report feeling less comfortable emotionally as delivery approaches and consistently report this on the state and trait anxiety measures as well. They demonstrate the poorest delivery records. Thus, as these women are reporting feeling the least different physically from the prepregnancy period, they are showing the greatest behavioral deficits.

Feminine Response. The pattern for the feminine group, in terms of overall response to pregnancy, is essentially the same as that of the undifferentiated group, with the exception
Figure 13. SAP and PRP composite for the Undifferentiated Group.
Table 18
Summary of Performance, Rank Orders on Obtained Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Androgynous</th>
<th>Masculine</th>
<th>Feminine</th>
<th>Undifferentiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAP</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>PRP</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>ERP</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Delivery Records</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Trait Anxiety</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>State Anxiety</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Average Ranking</td>
<td>1.67</td>
<td>2.16</td>
<td>2.67</td>
<td>3.00</td>
</tr>
</tbody>
</table>

that they report both feeling slightly less well and show somewhat less behavioral deficit in terms of sexuality (see Figure 14). They report increasing levels of emotional distress in the third trimester, going from the least to the most distressed group. However, in their performance on both the state and the trait anxiety measures, they do not demonstrate this. They report decreasing levels of anxiety on both measures as the third trimester advances. These findings suggest that their emotional distress levels are reflective of a more negative perception of self and/or apprehension of labor and delivery.

**Masculine Response.** The overall masculine response is the most clearly inversely related when PRP and SAP scales are compared
Figure 14. SAP and PRP composite for the Feminine Group.
Figure 15. SAP and PRP composite for the Masculine Group.
(see Figure 15). They do better than the undifferentiated and feminine women on the SAP chiefly due to their consistency and the variety of their sexual behavior, rather than the frequency of their sexual contacts. They are, in general, the least sexually active group. They also tend to feel less well, exceeded only by the androgynous women. Although they report increases in trait anxiety in the last trimester, they manifest agreement only in their ERP and state anxiety scores, decreasing in each as delivery approaches. (In their ERP scores, however, although the overall result is a decrease in distress from the seventh to the ninth month, the greatest decrease came in the eighth month, and the ninth month scores represent an increase from that level). They ranked third in terms of desirable labor and delivery experiences.

Androgynous Response. The dramatic difference in the nature of the androgynous women's response to pregnancy is demonstrated by comparing Figures 13 through 16. Clearly shown are this group's reports of the greatest level of physical discomfort and their highly superior sexual adjustment. The configuration of the two patterns of response, are of interest for two reasons: 1) this is the only group in which sexual activity, interest, and satisfaction tends to mirror the degree of physical comfort experienced; and 2) although these women report feeling the worst in the first trimester, of all groups, their level of sexual adjustment is the highest. This is even more remarkable when we consider the large discrepancy between the mean SAP
Figure 16. SAP and PRP composite for the Androgynous Group.
scores for the other groups as compared to the androgynous mean for the first trimester. This discrepancy increases dramatically for the rest of the pregnancy period, as the androgynous women respond to the fact that they feel physically better. They are the only group for whom feeling better is used as an opportunity to become more active sexually.

In terms of ERP scores, these women report less and less emotional distress as delivery approaches. State anxiety levels for this group in the seventh month are the lowest of all the sample and they are bettered only slightly by the masculine group on the Trait scale. As the ERP does not agree with their anxiety scores for the third trimester period, which both increase, it is suspected that the ERP scores here are more reflective of decreasing apprehension concerning delivery (as they acquire education regarding this process, and tools with which to cope with it, through the childbirth preparation classes). In the ninth month, the only group reporting less anxiety than the androgynous women is the masculine group.

Conclusions and Implications

Pregnancy can be, and often is, a trying time not only for the mother-to-be, but for her mate as well. No matter how eagerly a child may be wanted, changes over which the woman has very limited control begin to occur almost immediately. Alterations in ways of thinking, ways of feeling, and ways of behaving often occur. This is sometimes by design and sometimes with no conscious choice. These changes may be exciting, they may be confusing, or they may be
frightening. Especially for the first-time mother, they may be all-consuming. The stage is set for the loosening of the bonds between the couple, and in many ways our culture fosters this by providing us with ready-made roles: "mother", and "father" (not friends, not lovers, but "parents"). It is as if society were telling us that once we have determined to become parents, frivolity and all of its first cousins must become a thing of the past.

The mothers in this study were all faced with unique sets of circumstances, different strengths, different needs, and different weaknesses. Yet there was an underlying truth which they shared: they were preparing for childbirth and parenthood. They all had numerous physical, emotional and psychological tasks to accomplish as they prepared for these changes. As we have seen, the different groups of women responded to these challenges in different ways and achieved varying degrees of success in adapting to their pregnancies and preparing for their new responsibilities.

This study is just one of many which have been conducted recently, and which have indicated that androgynous individuals appear to be psychologically better adjusted and behaviorally more effective.

What was most striking about the performance of these women was their coping ability. They experienced conflict and difficulties, suffered some behavioral and/or emotional deficits due to these conflicts, then applied their coping skills and handled the situation significantly better than all other women in the sample.
As mentioned earlier, Klein (Note 5) found that androgynous women were not free of role conflict when compared to other, more traditional women, but they were more aware of it. There was good evidence in this study as well, that these women were very efficient self-monitors. They appeared to monitor not only themselves and their relationships well but they then used that information to shape their environment. Their whole approach was different. If they felt better, it was an opportunity to engage in something they enjoyed—sex. For none of the other groups was this true. Feeling bad may have been reason enough to avoid sex, but feeling good wasn't reason enough to reach out for this type of relationship. Perhaps that is the key: the androgynous women appeared to be aware of and involved with, not only themselves, but the others around them.

Not only do the findings from this study endorse the idea that an androgynous sex-role identity is desirable and effective, but they also allay some fears that have been raised about the 'nature' of 'woman' if she becomes liberated or androgynous. Some of these fears include the idea that women will become promiscuous if given sexual freedom, that they will no longer be affectionate and warm with their men but will become ambitious, cold, businesswomen, and that they will no longer be able to function as a "woman" (i.e., wife, mother). The androgynous women in this study have shown us clearly that not only can a 'liberated' woman be sexual, but she is more responsibly sexual than the more traditional
woman (she tended to be somewhat older at first coitus; they were the only group who all used contraception premaritally; and they were by far the most likely to have planned to have this child—and were the least likely to have had an abortion). Not only can she still be caring and affectionate with her spouse, but pregnancy does not mean for her that showing her caring sexually is a thing of the past. Even in an area as 'female' and 'feminine' as pregnancy and childbirth, the androgynous woman (who assumes her share of the responsibility and control, but can still reach out when she needs to and share) is more effective and achieves better results than the women who have accepted the role which society has designed precisely to fit this type of occasion. Not only can the androgynous woman still be a wife and a mother, but she can do it all better than ever!
My name is Anne Diebel. I am a graduate student in Clinical Psychology at the University of Central Florida. My purpose here tonight is to ask for volunteers for a research project which I am conducting as part of the requirements for my Masters degree. Participation in this study is entirely voluntary—the fact that you are in this class in no way obligates you to participate in the study. I'd like you to know at the outset that before I could even speak to the first class, my study had to be read and approved by the Human Subjects Committee at the university to determine that it met national standards for responsible psychological research. It also had to be read by Dr. Van Dyke, a local physician who is the head of the OB-GYN department of Orlando Regional Medical Center, and by Karen Guritz, R.N., the director of the childbirth education program for the Center.

To tell you a little about myself, I have been connected with pregnancy and childbirth both directly and indirectly over the years. I am the oldest of twelve children (and if any of you are interested in challenging that record, we were all born in this hospital, the record still stands, and none of us have any intentions of challenging it!). I am the mother of three children myself, a girl, 15, a boy, 13, and a boy, 6. I worked for a while as a social worker in a home for unwed mothers before my first child was born. I am also the wife of an obstetrician-gynecologist who wasn't even in medical school when we were married. So I listened to a lot of talk about pregnancy and childbirth over the years.

This does not, of course, make me an expert on this subject. However, you can pick up a lot of information by just listening. My interest is not really in the medical aspects of pregnancy, but in the effects of pregnancy upon individuals and couples. Many changes occur during and following pregnancy—social changes, emotional changes, sexual changes, physical changes, and relationship changes, to say nothing of financial changes. All of these changes affect you and your spouse in some way. However, little is known about the exact nature of these changes, much less the effects that they have upon you. Pregnancy is a time when many couples develop problems, but little is known of what kinds of problems and how people deal with them—or don't deal with them. We don't know what kinds of solutions people find for these problems or how they learn to live with them. The answers to these questions can be of enormous help not only to psychologists, but to physicians and other physical and mental health professionals as well. The solutions cannot be discovered, however, until the questions are asked and the answers are given. These, then, are the areas which will be covered in the study: your emotional relationship with your spouse during pregnancy; your reactions to pregnancy in general; your feelings towards your spouse during pregnancy; your feelings about yourself; and your sexual attitudes and behaviors during pregnancy.

Very little interest in this area existed until classes such as this one became popular. Consequently, there have been very few studies done—and a very small body of literature exists from which professionals can learn. All of the articles which you read in
responsible magazines are based upon scientific research which has been done. Even less interest has been shown in the male experience of, and interest in, pregnancy. As a matter of fact, I have only been able to find one such study—one which Masters and Johnson did, involving one interview with 79 fathers three months after delivery.

What research has been done has yielded a good deal of contradictory information. I feel that one major reason for the contradictory information is that when the subject is emotions and sex, many people are very reluctant to agree to participate. There is one group of people who are very comfortable talking about their feelings and their sexual life. These people tend to readily volunteer for studies like mine. And this is great, because their answers are important—they can speak for one kind of pregnancy experience. But these is another large group—and I'll bet that more than one of you sitting out there belongs to this group—who feel that there is no way that they can answer questions about how they feel or what their sex life is like. However, when the researcher writes up his/her results in order to pass on to others what he/she has learned, the opinions and experiences of these people are not included. Then, when a physician reads a report of the study in order to better understand his/her patient's experience of pregnancy, the point of view what he is getting may be one-sided. The very people who may be most representative of pregnant couples in this country, and therefore the most helpful, haven't been heard. I'd like to ask each of you to at least consider taking part.

Let me tell you what the study will involve for you if you participate and then see if you have any questions. First of all, I will distribute questionnaires tonight and at each of the next three class sessions. I will be here myself next week in case anyone has any problems or questions, and after that (teacher's name) will distribute them for me. You will take the forms home with you, complete them, and mail them in to me in the stamped, self-addressed envelopes which I will supply. People who have taken part so far estimate that it takes about 30 to 45 minutes a week to complete them. There are some short pencil and paper psychological tests and some questionnaires. One questionnaire will be given to you while you are in the hospital for delivery, and I will mail one to you three months after delivery.

I use telephone numbers to identify couples rather than names because this makes some people feel more comfortable. For example, if a couple's number is 123-4567, to distinguish the male from the female, the female's number for the study would be 123-4567A and the male's 123-4567B. The reason for this is so that I can trace change in both individuals and couples through different stages of pregnancy. For example, then I can make statements like, "60% of the women who felt bitchy in the 7th month of pregnancy felt silly in the 9th month". Then, maybe, later, when a woman goes in to see her doctor and says, "I don't know what's wrong with me. Suddenly I feel bitchy and I never felt this way before", he can say, "Well, if it's any help, studies have found that 60% of the women who feel bitchy in their 7th month tend to feel silly by their 9th month." Obviously, that's a far-fetched example, but it gives you the idea.

I will need your home address so that I can mail out the post-
partum questionnaire. I will need to have you sign an agreement to participate in the study, and to have the women sign a permission form for the hospital to allow me to look at your delivery records. The reason for this is that some authorities in the field believe that a woman's emotional experience of pregnancy influences her labor and delivery experience. I then will be able to say either that, in my study, I found no such connection, or that, in my study, I found that if certain kinds of experiences occur during pregnancy, certain kinds of effects tend to occur during labor and delivery. I will be looking at such things as length of labor, length of second stage, any complications of labor or delivery, your child's size, and his/her condition at birth. Or even their condition!

I would like to deal now with the issue of confidentiality. All answers on the questionnaires will be held in strictest confidence. Since I have your names, your addresses, and your telephone numbers, your answers obviously aren't really given anonymously. However, for all practical purposes they may as well be. The only forms on which I have your names are the Agreement to Participate and the Hospital Records Release form. Neither of these has your telephone number or your address on it. After those forms are signed tonight, you are couple 123-4567 A and B as far as I know. I want to be honest, so I have to say that if I wanted to identify you, I probably could. However, all I can do is assure you that I am not interested in doing so and that I work very hard to prevent this from happening. I suppose that this is just one area, if this is of concern to you, where you will have to decide whether or not you can trust me. In terms of any written reports, your answers will be reported anonymously, and as part of the group.

It is not necessary for both you and your spouse to both participate in the study, but I really encourage you to consider doing so. The only requirement is that you are either married or have lived together for at least four months prior to the pregnancy and are continuing to do so during the pregnancy.

It is very important that you do not compare your answers with your spouse as it is difficult to be totally honest at times if you feel that someone else might be hurt by your answers, or if you want to appear to be the model wife or husband to someone you care very much about. Obviously, less than candid answers will bias the information that I gather.

Please be very careful to put your telephone number somewhere on the forms—or even on the outside of the envelope. When I receive unidentified forms I have to spend my Sunday afternoons trying to match handwriting with forms received earlier to find possible identities and then call around and find out whose it is—and that is not only time-consuming but it is a hell of a way to spend your Sunday afternoon. I have put identification numbers on the outside of the envelopes so that I can at least know which class it came from, but it's much easier if you just put your number on yourself.

A caution—some people drop out of the study because they get behind on their forms and they can't face having to do them all at once. The later ones are somewhat lengthy and they get a little boring after a while. When you first see a question, you may say, "I can't believe she asked that!" Later on, it's "Oh God, not again! Why
does she care?" I care because the only way to trace change is to ask the same questions at different times and see if and/or how your answers have changed. Take heart! The forms right after delivery and three months afterwards are more varied. I record each form as it is received and will give you a call to jog your memory if you're getting behind.

Depending upon where you are in your pregnancy right now, some of the questionnaires may concern a stage of pregnancy which you have not yet reached. If this happens, just hold on to those forms, complete them at the proper time, and mail them in. I look at due dates before calling people who seem to be late sending in their forms so that I don't bother you unnecessarily.

I am willing to share my results with those who complete the study when I am finished. I can't make any guarantees as to when that will be, at least at this point, but you will hear from me!

Any questions?
APPENDIX II

Expectant Parents:

My name is Anne Diebel and I am a graduate student in Clinical Psychology at the University of Central Florida here in Orlando. The Director of the Parent Education Program at the Orlando Regional Medical Center, Karen Guritz, has graciously allowed me to include this letter with her material in order that I might acquaint you with the fact that I will be conducting a study, as partial fulfillment of the requirements for my Master's degree, involving the couples taking the Prepared Childbirth classes here. As I will also be speaking at one of the class sessions, some of what I have to say may be repetitive—but, I hope, not boring.

Let me first assure you that participation in this study is entirely voluntary. Also, as the material to be covered is sensitive in nature, all responses will be confidential.

As a result of the rise in popularity of childbirth preparation classes in the last ten to fifteen years in this country, pregnancy as a subject of study has received a good deal of attention. Many different aspects of pregnancy and childbirth have been investigated. However, the area in which I am most interested—the effects of pregnancy and childbirth upon the couple's emotional and sexual relationships—has received only limited attention and the results of these studies have been contradictory.

Pregnancy has been seen as a time of crisis for some couples, as a time of growth for some, and as both for others. Whichever it is for you, it is certainly a time of change—physically, emotionally, socially, sexually, and financially. These changes do not occur without effects; they happen to a man, to a woman, and to the relationship between them. These effects are felt not only by that man, that woman, and that relationship, but also by the child who is born and by society at large.

One of the most effective 'treatments' of relationship problems is awareness through education, commonly known as prevention. Such education is not possible, however, unless the material to be taught has been collected, analyzed and prepared to be passed on to others; most importantly to those who can use this information to improve the quality of their lives. Therefore, my interest in conducting this study is to assist the fields of psychology and medicine to acquire a body of such knowledge as may be helpful to couples experiencing pregnancy in the future. Essentially, this is what women, historically, have done by passing down, from one generation to another the old wives' tales about pregnancy. I would like to do the same thing, but on a larger scale and with more accuracy.

As the wife of an obstetrician and the mother of three children, I have a vested interest in pregnancy. As a student of psychology, relationships between people are very important to me. Accordingly, this study will concern such areas as your emotional relationship during pregnancy, your reactions to the pregnancy, the effect of the pregnancy upon you (both individually and as a couple), your attitudes towards sex, and your sexual behaviors and relationship before, during, and after pregnancy. This type of information is obviously highly personal. As stated above, your answers will be used only as a portion of the total number of answers collected from the group.
I would like, at this time, to make a special appeal to those men and women who find their emotional and sexual lives and relationships to be so highly personal as to make them difficult to discuss. I hope that the fact that your answers to questions will be confidential will make it easier for you to participate. Your answers are particularly important to me. One thing which frequently occurs in studies of this type is that people who feel this way refuse to participate. This, unfortunately, leaves their point of view, their good and bad experiences, what they have learned, unspoken in the reports which are written about those studies. These reports are then used to teach others what the experience of pregnancy is all about, with a large group of experiences not accounted for.

I therefore urgently ask each of you to consider participating in this study. It is not necessary for both of you to participate, but it is hoped that you will both agree. Quite often, men are more resistant to the idea of participation in such studies than are women. This is especially true when the study involves very personal areas and/or feelings. However, the same reasoning holds true in this instance as was presented earlier for those people who frequently regard this type of material as too personal to discuss. Pregnancy and childbirth have a profound effect upon many aspects of a man's life and his relationship to his mate. Because pregnancy has been traditionally a 'woman's area', little or no attention has been paid to the man's reactions. Courses such as this one have pointed out clearly that men are, indeed, interested in, and affected by, pregnancy. It cannot be known what kinds of effects and how strong these effects are, unless they are communicated. Men, as well as women, have needs during pregnancy; unless we know what they are, we cannot hope to meet them.

Now that you are all ready to stand up and be counted, what will participation in this study entail for you? It will involve about 30 to 45 minutes of your time each week. You will be asked to complete some brief pencil and paper psychological tests and some questionnaires. These forms will be distributed in class. You will take them home with you, complete them, and mail them in to me in the stamped and addressed envelopes which I will provide. Two testing sessions are involved after delivery, one distributed while you are still in the hospital and another mailed to you three months following delivery. I will also need a signed permission from the women to allow the hospital to release the records of your delivery to me. I am interested in comparing your pregnancy experience with your delivery, with the size and sex of your child, with the length of labor, etc.

Telephone numbers will be used to identify each of the forms you complete. In this way I can follow the changes which occur during pregnancy for each person and for each couple. I also need your home addresses in order to mail the questionnaires to you. When you deliver you will tell the staff that you are participating in the study. They will then check to be certain that they have a signed permission on file and release the necessary information to me.

The decision to have you take the tests at home was made for two reasons: 1) your convenience (the alternative was sessions either before or after classes), and 2) the hope that more of you would agree to participate if extra time away from home was not required. However,
there are some problems involved when this approach is used. For the study to be valid and worthwhile, it is very important that you do not compare your answers on the test materials with your spouse or partner. It is also important that you each, separately, complete the materials and mail them in as soon as possible each week.

If I have not answered all of your questions, I will be happy to do so, and urge you to call me to discuss them at 644-1849. I hope that you will seriously consider participating in this study and look forward to sharing your pregnancy experience with you.

Whether or not you choose to participate, good luck!

Anne H. Diebel
Appendix III

I, ____________________________, agree to participate in a study of attitudes and behaviors in the pregnancy and postpartum period currently being conducted by Anne H. Diebel, Clinical Psychology graduate student at the University of Central Florida, Orlando, Florida. I understand that my responses will be held in the strictest confidence and will be used only as data collected for this study. I further consent to the use of such data in any publication of the results of the study, under the assurance that my participation will be both anonymous and confidential.

_________________________  __________________________
Date                                          Signature
APPENDIX IV

I, __________________________ (please print), give my permission to have Anne H. Diebel, Clinical Psychology graduate student at the University of Central Florida, examine Orlando Regional Medical Center's records concerning the recent delivery of my child(ren).

________________________    ______________________
Date                              Signature
APPENDIX V

Telephone Number: ___________________________(Please Print)

Sex: ____________ Age: ____________ Occupation: _______________________________________________

Telephone: ____________________________

On the following page, you will be shown a large number of personality characteristics. We would like you to use those characteristics in order to describe yourself. That is, we would like you to indicate on a scale from 1 to 7, how true of you these various characteristics are. Please do not leave any characteristic unmarked.

Example: sly

Mark a 1 if it is NEVER OR ALMOST NEVER TRUE that you are sly.
Mark a 2 if it is USUALLY NOT TRUE that you are sly.
Mark a 3 if it is SOMETIMES BUT INFREQUENTLY TRUE that you are sly.
Mark a 4 if it is OCCASIONALLY TRUE that you are sly.
Mark a 5 if it is OFTEN TRUE that you are sly.
Mark a 6 if it is USUALLY TRUE that you are sly.
Mark a 7 if it is ALWAYS OR ALMOST ALWAYS TRUE that you are sly.

Thus, if you feel it is sometimes but infrequently true that you are "sly", never or almost never true that you are "malicious", always or almost always true that you are "irresponsible", and often true that you are "carefree", then you would rate these characteristics as follows:

Sly 3
Malicious 1
Irresponsible 7
Carefree 5
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APPENDIX VI

SELEF-EVALUATION QUESTIONNAIRE

Telephone: ____________________ SEX: M T AGE: ______ DATE: ____________________

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to indicate how you feel right now, that is, at this moment. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

Very much so

1. I feel calm ................................................... 1 2 3 4
2. I feel secure................................................. 1 2 3 4
3. I am tense.................................................... 1 2 3 4
4. I feel strained.............................................. 1 2 3 4
5. I feel at ease............................................... 1 2 3 4
6. I feel upset.................................................. 1 2 3 4
7. I am presently worrying over possible misfortunes........ 1 2 3 4
8. I feel satisfied.............................................. 1 2 3 4
9. I feel frightened.......................................... 1 2 3 4
10. I feel comfortable........................................ 1 2 3 4
11. I feel self-confident..................................... 1 2 3 4
12. I feel nervous............................................. 1 2 3 4
13. I am jittery................................................ 1 2 3 4
14. I feel indecisive.......................................... 1 2 3 4
15. I am relaxed.............................................. 1 2 3 4
16. I feel content............................................. 1 2 3 4
17. I am worried.............................................. 1 2 3 4
18. I feel confused.......................................... 1 2 3 4
19. I feel steady............................................... 1 2 3 4
20. I feel pleasant.......................................... 1 2 3 4

Developed by Charles D. Spielberger in collaboration with R. L. Gorsuch, R. Lushene, and P. R. Vagg.
SELF-EVALUATION QUESTIONNAIRE
STAI FORM: 1-2

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to indicate how you generally feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
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<td>21. I feel pleasant.</td>
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<td>22. I feel nervous and restless.</td>
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<td>23. I feel satisfied with myself.</td>
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<td>24. I wish I could be as happy as others seem to be.</td>
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<td>25. I feel like a failure.</td>
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<td>26. I feel rested.</td>
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<td>27. I am &quot;calm, cool, and collected&quot;.</td>
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<td>28. I feel that difficulties are piling up so that I cannot overcome them.</td>
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<td>29. I worry too much over something that really doesn't matter.</td>
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<td>30. I am happy.</td>
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<td>31. I have disturbing thoughts.</td>
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<td>32. I lack self-confidence.</td>
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<td>33. I feel secure.</td>
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<td>34. I make decisions easily.</td>
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<td>35. I feel inadequate.</td>
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<td>36. I am content.</td>
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<td>37. Some unimportant thought runs through my mind and bothers me.</td>
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<td>38. I take disappointments so keenly that I can't put them out of my mind.</td>
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<td>39. I am a steady person.</td>
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<td>40. I get in a state of tension or turmoil as I think over my recent concerns and interests.</td>
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Subject Number:

1. Labor spontaneous or induced:

2. Membranes spontaneously or artificially ruptured:

3. EDC/Delivery date:

4. Medications during labor:

5. Medications during delivery:

6. Episiotomy/lacerations:

7. Onset of labor/time of delivery:

8. Duration of second stage:

9. Position of child:

10. Delivery type:

11. Tubes tied: Child:

12. Weight gained: 1. Sex:

13. Forceps used: 2. Weight:

               3. Length:

               4. Apgars:

               5. Meconium:

               6. Resuscitation necessary:

               7. Coils of cord:

               8. Abnormalities:

               9. Time elapsed before cried:
**FAMILY HISTORY**

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1. **Father:**
   a. Education:
      - 3 years or less
      - 9-10 years
      - 11-12 years
      - 1-2 years college
      - 3-4 years college
      - Graduate degree or more
   b. Occupation:
   c. Religion: Protestant, Catholic, Jewish, None, Other (please specify)
   d. Deceased: Yes, No

2. **Mother:**
   a. Education:
      - 3 years or less
      - 9-10 years
      - 11-12 years
      - 1-2 years college
      - 3-4 years college
      - Graduate degree or more
   b. Occupation while you were living at home:
   c. Occupation at this time:
   d. Religion: Protestant, Catholic, Jewish, None, Other (please specify)
   e. Deceased: Yes, No

3. **Parents are currently:**
   - Married
   - Divorced
   - Separated
   - One deceased

4. Would you describe your parents' marriage as happy, unhappy, or indifferent?

5. Would you describe your family as a child as affectionate, distant, cold, or indifferent?

6. Was sex discussed freely in your home? Yes, No

7. Did your parents discuss sexual facts with you? Yes, No

8. Did your parents discuss sexual relationships with you? Yes, No

9. How many sisters do you have? __________

10. How many brothers do you have? __________

11. What is your place among the children (for example, first, second, etc.)? __________

12. Are they emotionally involved in this pregnancy? Yes, No

13. Do you expect them to be actively involved as grandparents? Yes, No

14. Do you wish them to be actively involved as grandparents? Yes, No

15. Do you feel that your feelings toward, and your relationship with, your mother have changed as a result of this pregnancy? Yes, No

16. Do you feel that your feelings toward, and your relationship with, your father have changed as a result of this pregnancy? Yes, No

17. If your mother worked outside of the home when you were living there:
   a. Was this financially necessary? Yes, No
   b. Was this arrangement satisfactory to her? Yes, No
   c. Was this arrangement satisfactory to you? Yes, No
   d. Was this arrangement satisfactory to your father? Yes, No
   e. Did your father share in the household chores? Yes, No

---

8 years or less
1-2 years college
9-10 years
3-4 years college
11-12 years
Graduate degree or more
1. At what age did you begin to menstruate?

2. Had menstruation been explained to you in advance? Yes No
   If yes:
   a. Was it explained accurately? Yes No
   b. By whom? Father Mother Brother Sister Older relative Friend

3. Was this subject discussed among your friends? Yes No

4. What were your feelings in anticipation of menstruation?
   Frightened Eager Neutral Other (please specify)
   Disgusted Proud Excited

5. How did you feel once it had begun?
   Frightened Eager Neutral Grownup Other
   Disgusted Proud Excited Disappointed (please specify)

6. Do you recall menstruation affecting your life-style in any way? Yes No

7. Did you feel any differently about yourself and your body? Yes No If yes, in what way?

8. Was it necessary for you to limit your activities in any way? Yes No If yes, in what way?

9. Have you ever had sexual intercourse during your period? Yes No

10. How do you feel about the idea of having sexual intercourse during your period? Okay Neutral Disgusted

11. What was the average length of your period? _______________________

12. What was the average length of your menstrual cycle? _______________________

13. Did you experience painful 'cramps' with your period? Yes No Sometimes
    If yes or sometimes:
    a. For how long?
    b. Were these severe enough to take a drug prescribed for you by your doctor? Yes No
    c. Was it necessary for you to refrain from activities at these times? Yes No
    d. Were you able to work at these times? Yes No
    e. Was it necessary for you to go to bed at these times? Yes No
1. Address: ____________________________________________
   Telephone number: ____________________________________

2. Age: __________

3. Race:  
   Caucasian  Asian-American  Indian  
   Afro-American  Spanish-American  Other (please specify) __________

4. Joint Income:  
   0-2,000  2,000-5,000  5,000-10,000  10,000-15,000  15,000-20,000  
   20,000 and over __________

5. Education:  
   8 years or less  1-2 years college  
   9-10 years  1-4 years college  
   11-12 years  graduate degree or more __________

6. Occupation: ____________________________________________

7. Are you married? Yes  No __________

8. Are you, if not married, in an ongoing relationship (having lived with the father of this child for at least four months prior to conception, and continuing to live together throughout this pregnancy)? Yes  No __________

9. Have you been married before? Yes  No If yes, how often? 1  2  3  4  5  more __________

10. How long have you been married (or in this relationship)? __________

11. What is your due date? __________

12. Is this your first pregnancy? Yes  No If not, how many previous pregnancies? 1  2  3  4  5  more (please specify) __________

13. Number of other children? 1  2  3  4  5  more (please specify) __________

14. Have you ever had an abortion? Yes  No If yes, how many? __________

15. Have you ever had a miscarriage? Yes  No If yes, how many? __________

16. Have you ever delivered a stillborn child? Yes  No If yes, how many? __________

17. Have you ever experienced any complications in previous pregnancies or childbirth? Yes  No If yes, please specify __________

18. Have you ever delivered a child by Cesarean section? Yes  No If yes, how many? __________

19. Have you been under medical care for this pregnancy? Yes  No  
   a. At what point in your pregnancy did you first see a doctor? __________
   b. Is your doctor a private physician? Yes  No __________
   c. Are you being seen in a clinic? Yes  No __________
   d. Is your doctor an obstetrician or a family practitioner? __________

20. If your mate is not participating:  
   a. Mate's occupation:  
      8 years or less  1-2 years college  
      9-10 years  1-4 years college  
      11-12 years  graduate degree or more __________
   b. Mate's education:  
      8 years or less  1-2 years college  
      9-10 years  1-4 years college  
      11-12 years  graduate degree or more __________

21. Religion: Protestant  Catholic  Jewish  None  Other (please specify) __________
   Practicing? Yes  No __________
In all questions, by 'mate' is meant spouse or partner.

1. Do you recall playing any games with sexual content as a child (for example, "Doctor")? Yes___ No___ If yes, do you recall feeling guilty about this? Yes___ No___

2. At what age did you first experiment with masturbation (or any other solitary activity that produced feelings of genital pleasure)? 5 or less____ 6____ 7____ 8____ 9____ 10____ 11____ 12____ 13____ 14____ 15____ 16____ over 16 never____
   a. Did you ever have an orgasm with masturbation? Yes___ No___
   b. Did you feel guilty about masturbation? Yes___ No___
   c. Approximately how many times in two weeks would you engage in this activity? 1-3____ 4-6____ 7-9____ 10-12____ 13-15____ 16 or more____

3. At what age did you first learn about conception and reproduction? 7 or less____ 8____ 9____ 10____ 11____ 12____ 13____ 14____ 15____ 16____ 17____ 18____ 19 or more____

4. At what age did you first date? 10 or less____ 11____ 12____ 13____ 14____ 15____ 16____ 17____ 18____ 19 or more____

5. At what age did you first have a regular boyfriend? 10 or less____ 11____ 12____ 13____ 14____ 15____ 16____ 17____ 18____ 19 or more____

6. Did you engage in 'petting' or 'making out'? Yes___ No___
   a. With most of your dates? Yes___ No___
   b. Only with boys you dated on a regular basis? Yes___ No___
   c. Was this arousing for you? Yes___ No___
   d. Did you feel guilty about this? Yes___ No___

7. Did you engage in premarital intercourse? Yes___ No___
   a. With your present mate? Yes___ No___
   b. With others? Yes___ No___ If yes, approximately how many others?____
   c. Was this sexually arousing for you? Yes___ No___
   d. Did you just 'go along' to please your partner even though not aroused? Yes___ No___
   e. Did you have an orgasm with intercourse? Yes___ No___
   f. Did you have multiple orgasms? Yes___ No___
   g. How old were you the first time you had intercourse? 10 or less____ 11____ 12____ 13____ 14____ 15____ 16____ 17____ 18____ 19 or more____
   h. Did you ever 'fake' an orgasm? Yes___ No___ If yes, frequently? Yes___ No___
   i. Out of the total number of sexual contacts, what percentage of the time would you say that you were able to achieve orgasm? 0-25%____ 25-50%____ 50-75%____ 75-100%____
   j. Did you feel guilty about having premarital intercourse? Yes___ No___

8. Usually, whose ideas was it to have intercourse? Yours____ Your partner’s____ Mutual decision____
   a. Did you discuss it beforehand? Yes___ No___
   b. Did you use a form of contraception? Yes___ No___ If yes, what type? Pill, Condom, IUD, Diaphragm, Foam, Rhythm Other (please specify)____
   c. Who was responsible for contraception? You____ Your partner____
   d. Was this discussed beforehand? Yes___ No___

9. What was your attitude, in general, about sex at this time? Positive____ Negative____ Neutral____ Mixed____

10. Did you ever engage in sexual practices other than intercourse to achieve orgasm? Yes___ No___
    a. Oral sex? Yes___ No___ If yes, did you have orgasms this way? Yes___ No___
    b. Mutual masturbation? Yes___ No___ If yes, did you have orgasms this way? Yes___ No___
    c. Were either of these practices used in place of intercourse, exclusively? Yes___ No___

11. How long have you been in a sexual relationship with your mate? 6 months____ 1 year____ 2-3 years____ 4-5 years____ 6-8 years____ 9-10 years____ 11 or more____
1. At this point in time, what was your general attitude toward sex? Positive  
   Negative  
   Indifferent  
   Mixed  
   a. Was sex important to you in your marriage/relationship? Yes  
   No  
   Somewhat  
   b. Do you feel that sex was important to your mate in your marriage/relationship? Yes  
   No  
   Somewhat  
   c. Were there any conflicts between your attitudes and/or feelings about sex and those of  
   your mate? Yes  
   No  
   d. If yes, in what area? Sexual practices  
   Frequency of intercourse  
   Importance of sex  
   Extramarital sex  
   Lack of affection prior to sex  
   Other (please specify)  

2. Did you feel satisfied with the amount and type of physical affection you received from your  
   mate? Yes  
   No  
   a. Do you feel that your mate was satisfied with the amount and type of physical affection  
   he/she received from you? Yes  
   No  
   b. Approximately how often, in a two-week period, would your mate be affectionate without  
   necessarily expecting sex to follow? 0-2  
   3-5  
   6-10  
   11-15  
   15+  
   c. Approximately how often, in a two-week period, would you be affectionate without neces- 
   sarily expecting sex to follow? 0-2  
   3-5  
   6-10  
   11-15  
   15+  

3. Would you describe your relationship as happy at this period? Yes  
   No  
   So-so  

4. Were there any sexual problems? Yes  
   No  
   If yes, please describe  

5. Were you satisfied with your sex life together? Yes  
   No  
   a. Do you feel that your mate was satisfied with your sex life at this time? Yes  
   No  
   b. Were you engaged in extramarital affairs at this time? Yes  
   No  
   c. Do you know, for certain, that your mate was engaged in extramarital affairs at this time?  
   Yes  
   No  
   d. Did you suspect that your mate was engaged in extramarital affairs at this time? Yes  
   No  
   e. If the answer to either (b) or (c) above is yes, was the other partner aware and/or agree- 
   able to this? Aware  
   Unaware  
   Agreed  
   Disagreed  
   Didn't care  
   f. Did you feel that your mate was on good terms with your mate's sexual affair(s)? Yes  
   No  
   Sometimes  
   Most of the time  

6. What was the approximate frequency of intercourse with your mate in a two-week period? 0-1  
   2-3  
   4-5  
   6-7  
   8-9  
   10-11  
   12-13  
   14 or more  
   a. How often, in a two-week period, would you have liked to have sex with your mate? 0-1  
   2-3  
   4-5  
   6-7  
   8-9  
   10-11  
   12-13  
   14 or more  
   b. How often, in a two-week period, do you feel that your mate would have liked to have sex  
   with you? 0-1  
   2-3  
   4-5  
   6-7  
   8-9  
   10-11  
   12-13  
   14 or more  
   c. Would you have preferred more experimentation with positions, practices, etc., at this  
   time? Yes  
   No  
   d. Do you feel that your mate would have preferred more experimentation with positions,  
   practice, etc., at this time? Yes  
   No  

7. Were you able to have orgasms with intercourse at this time? Yes  
   No  
   a. Out of the total number of instances of intercourse, what percentage of the time would you  
   say that you were able to achieve orgasm? 0-25%  
   25-50%  
   50-75%  
   75-100%  
   b. Were you able to have multiple orgasms (more than one)? Yes  
   No  
   c. Out of the total number of instances of intercourse, what percentage of the time would you  
   say that you were able to have multiple orgasms? 0-25%  
   25-50%  
   50-75%  
   75-100%  

8. What positions did you use? (Please estimate percentages of total instances of intercourse for  
   each; for example: male on top: 40% of the time)  
   a. Male on top:  
   b. Female on top:  
   c. Side-by-side, facing each other:  
   d. Side-by-side, male facing the female's back:
9. Did you ever at this time, with your mate, engage in sexual practices which did not result in intercourse? Yes No
   a. Caressing each other's genitals without orgasm for either? Yes No If yes, how often in a two-week period would this occur?
   b. Did you engage in oral sex? Yes No
      1. With you as the active partner? Yes No
      2. With your mate as the active partner? Yes No
      3. With both of you active simultaneously? Yes No
   c. If yes, were you able to have orgasms in this way? Yes No
   d. Did you engage in mutual masturbation? Yes No
      1. With you as the active partner? Yes No
      2. With your mate as the active partner? Yes No
      3. With each of you active? Yes No
   e. If yes, were you able to have orgasms in this way? Yes No
   f. Were these practices used in place of intercourse (more or less exclusively)—rarely had intercourse? Yes No
   g. Out of the total number of times that you had sexual contact with your mate, what percentage of these did not result in intercourse?

10. Did you masturbate during this period? Yes No
    a. Approximately how often, in a two-week period? 0-1 2-3 4-5 6-7 8-9 10-11 12+
    b. Did you achieve orgasm with masturbation? Yes No
    c. Approximately what percentage of the time were you able to achieve orgasm? 0-25% 25-50% 50-75% 75-100%
    d. Were you able to achieve multiple orgasms? Yes No
    e. Approximately what percentage of the time were you able to achieve multiple orgasms?
       0-25% 25-50% 50-75% 75-100%
    f. Was your mate aware that you were masturbating at this time? Yes No
    g. How did he feel about this (or if he was unaware, how do you think he would have felt had he known)? Approved Disapproved Indifferent
    h. If he was unaware did you feel guilty about masturbcating without his knowledge? Yes No

11. Who most often instigated sex during this time? You Your mate Either of you, with about the same frequency

12. Did you feel 'dirty' or 'guilty' about any of your sexual behavior at this time? Yes No
    If yes, please specify about what and why

13. Did you plan this pregnancy? Yes No
    a. Did you plan this pregnancy? Yes No
    b. If not planned, was your mate unhappy? Yes No
    c. If not planned, was your mate unhappy? Yes No
    d. If planned, how long had you been trying to get pregnant?
    e. If planned, did your mate also want a baby, but not at this time? Yes No
    f. Did you use contraception prior to becoming pregnant? Yes No
    g. If yes, what type? Pill IUD Condom Diaphragm Foam Rhythm Other (please specify)
    h. Did you become pregnant while using a means of contraception? Yes No
    i. If this pregnancy was unplanned, did you consider abortion? Yes No If yes, why did you decide against it?
    j. If this pregnancy was unplanned, did your mate suggest abortion? Yes No
FIRST TRIMESTER (Females)

In all questions, by 'mate' is meant your spouse or partner.

1. Did you experience nausea and/or vomiting for longer than two-weeks during this period? Yes No
   a. If yes, how would you describe this? Mild Moderate Severe
   b. Were you hospitalized for this condition? Yes No
   c. Did you report this to your doctor? Yes No
   d. Did he prescribe medication for this? Yes No

2. Did you experience heart burn during this period? Yes No
   a. If yes, did you report this to your doctor? Yes No
   b. Did he prescribe medication for this? Yes No

3. Did you experience any swelling of the face, arms, hands, legs or feet at this time? Yes No
   a. Did you report this to your doctor? Yes No
   b. Did he prescribe medication or treatment for this? Yes No

4. Did you experience increased fatigue during this period? Yes No

5. Did you experience any other complications of pregnancy at this time? Yes No
   a. If yes, please specify
   b. Did you report this to your doctor? Yes No
   c. Did he prescribe medication or treatment for this? Yes No
   d. Did he limit your activity in any way? Yes No

6. Did you change your usual activities to a significant degree during this time? Yes No
   a. If yes, how? Increased Decreased
   b. If yes, for what reason?
   c. If you decreased your activity, was this on your doctor’s recommendation? Yes No
   d. If you are/were employed before pregnancy, did you continue to work during this time? Yes No
   e. If yes, did you continue to work full time? Yes No

7. Did you feel that your mate was more affectionate than usual at this time? Yes No
   a. Did you feel that you were more affectionate than usual at this time? Yes No
   b. Did you feel satisfied with the amount and type of physical affection he had with your mate at this time? Yes No
   c. Do you feel that your mate was satisfied with the amount and type of physical affection he had with you at this time? Yes No
   d. Approximately how often, in a two-week period, would your mate be affectionate without necessarily expecting sex to follow? 0-2 3-5 6-10 11-15+ 16+
   e. Approximately how often, in a two-week period, would you be affectionate without necessarily expecting sex to follow? 0-2 3-5 6-10 11-15+ 16+

8. Would you describe your relationship as happy at this time? Yes No So-so

9. How would you describe your relationship during this period as compared to before you were pregnant? Closer More distant About the same
   a. Did you feel that your mate’s attitude towards you had changed since the beginning of the pregnancy (beginning of pregnancy being defined as that point at which you knew or strongly suspected you were pregnant)? Yes No
   b. If yes, in what way?
   c. Did you feel that your attitude towards yourself had changed since the beginning of your pregnancy? Yes No
   d. If yes, in what way?
   e. Did you feel that your attitude toward your mate had changed since the beginning of your pregnancy? Yes No
   f. If yes, in what way?

10. What was your attitude toward sex, in general, at this time? Positive Negative Mixed Indifferent
11. Were there any sexual problems at this time? Yes __ No __
   a. How would you describe your interest in sex at this time as compared with your interest
      before pregnancy? Increased ___ Decreased ___ About the same ___
   b. If your sexual desire increased, what do you think was the cause? (If more than one answer
      applies, please rank in order of importance)
      ___________ ___________ ___________ ___________
   c. If your sexual desire decreased, what do you think was the cause? (If more than one answer
      applies, please rank in order of importance)
      ___________ ___________ ___________ ___________
      Physical discomfort  Fear of injury to the baby  Fear of miscarriage  Awkwardness
      having intercourse  Discomfort due to nausea, vomiting, fatigue, etc.  Reason having
      nothing to do with the pregnancy  Recommendation of doctor  Loss of interest  Feelings
      of personal loss of attractiveness  Feelings of mate's loss of attractiveness
   d. How would you describe your mate's interest in sex at this time as compared with his inter-
      est before pregnancy? Increased ___ Decreased ___ About the same ___
   e. If changed, what do you think was the cause of this change?
   f. If your sexual desire decreased:
      1. Did you expect this to happen? Yes ___ No ___
      2. Did you find this upsetting? Yes ___ No ___
      3. Did you feel relieved to be free of the burden of sexual relations? Yes ___ No ___
      4. Did you feel guilty about your decreased desire? Yes ___ No ___
      5. Was this a source of tension between you and your mate? Yes ___ No ___
      6. Was this a subject of arguments between you and your mate? Yes ___ No ___
      7. Was your mate understanding about your decreased desire? Yes ___ No ___
      8. Did you ask your doctor about this? Yes ___ No ___ If so, why not?
      9. Did he/she supply adequate information to answer your questions? Yes ___ No ___
      10. Did he/she offer any helpful suggestions? Yes ___ No ___

12. Approximately how often, in a two-week period, did you have intercourse at this time? 0-1 ___
    2-3 ___ 4-5 ___ 6-7 ___ 8-9 ___ 10-11 ___ 12-13 ___ 14+ ___
   a. How often, in a two-week period, would you have liked to have sex with your mate? 0-1 ___
      2-3 ___ 4-5 ___ 6-7 ___ 8-9 ___ 10-11 ___ 12-13 ___ 14+ ___
   b. How often, in a two-week period, do you feel that your mate would have liked to have sex
      with you? 0-1 ___ 2-3 ___ 4-5 ___ 6-7 ___ 8-9 ___ 10-11 ___ 12-13 ___ 14+ ___
   c. Would you have preferred more experimentation with positions, practices, etc., at this
      time? Yes ___ No ___
   d. Do you feel that your mate would have preferred more experimentation with positions,
      practices, etc., at this time? Yes ___ No ___
   e. As important as before you were pregnant? More important ___ Less important ___ About the
      same ___
   f. Did you feel that sex was important to your mate in your relationship at this time? Yes ___
      No ___
   g. As important as before you were pregnant? More important ___ Less important ___ About the
      same ___

13. Were you able to have orgasms with intercourse at this time? Yes ___ No ___
   a. Out of the total number of instances of intercourse, what percentage of the time would you
      say that you were able to achieve orgasm? 0-25% ___ 25-50% ___ 50-75% ___ 75-100% ___
   b. Were you able to have multiple orgasms? Yes ___ No ___
   c. Out of the total number of instances of intercourse, what percentage of the time would you
      say that you were able to achieve multiple orgasms? 0-25% ___ 25-50% ___ 50-75% ___ 75-100% ___
   d. Did your orgasms seem to be of the same intensity as before pregnancy? More intense ___
      Less intense ___
   e. Did it seem to be more difficult to achieve orgasm than before pregnancy? Easier ___
      About the same ___

14. What positions did you use? (Please estimate percentages of total instances of intercourse for
   each):
a. Male on top
b. Female on top
c. Side-by-side, facing each other
d. Side-by-side, male facing the female’s back
e. Male entering from behind and above the female
f. Other (please specify)

15. Did you ever at this time, with your mate, engage in sexual practices which did not result in intercourse? Yes No
a. Were these practices used in place of intercourse (more or less exclusively—very rarely had intercourse)? Yes No
b. In considering the total number of times that you had sexual contact with your mate, what percentage of these did not result in intercourse?

c. Did you caress each other without orgasm for either? Yes No If yes, how often in a two-week period?
d. Did you engage in oral sex? Yes No
e. Did you engage in mutual masturbation with orgasm as a goal (whether or not orgasm was achieved)? Yes No

If yes:
1. Were you able to have orgasms in this way? Yes No Percent of time? 0-25% 25-50% 50-75% 75-100%
2. Were you able to have multiple orgasms in this way? Yes No Percent of time? 0-25% 25-50% 50-75% 75-100%
3. Did your orgasms seem to be of the same intensity as before pregnancy? More intense? Less intense? About the same?
4. Did it seem to be more difficult to achieve orgasm than before pregnancy? Easier? About the same?

f. Did you engage in mutual masturbation with orgasm as a goal (whether or not orgasm was achieved)? Yes No
g. If yes:
1. Were you able to have orgasms in this way? Yes No Percent of time? 0-25% 25-50% 50-75% 75-100%
2. Were you able to have multiple orgasms in this way? Yes No Percent of time? 0-25% 25-50% 50-75% 75-100%
3. Did your orgasms seem to be of the same intensity as before pregnancy? More intense? Less intense? About the same?
4. Did it seem to be more difficult to achieve orgasm than before pregnancy? Easier? About the same?

16. Did you masturbate at this time? Yes No
a. Approximately how often, in a two-week period? 0-1 1-2 3-4 5-6 7-8 9-10 11-12 13+
b. Did you achieve orgasm with masturbation at this time? Yes No
c. Approximately what percentage of the time were you able to achieve orgasm? 0-25% 25-50% 50-75% 75-100%

d. Were you able to achieve multiple orgasms at this time? Yes No
e. If yes, approximately what percentage of the time were you able to achieve multiple orgasms? 0-25% 25-50% 50-75% 75-100%
f. Was your mate aware that you were masturbating at this time? Yes No
g. How did he feel about this (or, if he was unaware, how do you think he would have felt had he known)? Approved Disapproved Indifferent
h. If he was unaware, did you feel guilty about masturbating without his knowledge? Yes No
i. Did your orgasms seem to be of the same intensity as before pregnancy? More intense? Less intense? About the same?
j. Did it seem to be more difficult to achieve orgasm than before pregnancy? Easier? About the same?
k. If you masturbated before pregnancy, but discontinued this practice after becoming pregnant, could you state your reasons?

17. Did your sexual practices, in general, with your mate, change during this period? Yes No
a. If yes, who desired or requested these changes? You Your mate Both
b. Who most often initiated sex during this time? You Your mate Either of you, with about the same frequency
18. Were you satisfied with your sex life together at this time? Yes No
   a. Did you feel that your mate was satisfied with your sex life at this time? Yes No
   b. Were you engaged in extramarital affairs at this time? Yes No
   c. Do you know, for certain, that your mate was engaged in extramarital affairs at this time? Yes No
   d. Did you suspect that your mate was engaged in extramarital affairs at this time? Yes No
   e. If the answer to (b) or (c) above is yes, was the other partner aware and/or agreeable to this? Aware Unaware Agreed Disagreed Didn’t care
   f. Did you feel that your mate was considerate of your feelings about sex at this time? Yes No Sometimes Most of the time, but not always

19. Did you notice a difference, as compared to before pregnancy, in your desire to be held, without desiring sex to follow? Yes No Increased Decreased
SECOND TRIMESTER (Females)  

1. Did you experience nausea and/or vomiting during this period? Yes No  
   a. If yes, how would you describe this? Mild  Moderate  Severe  
   b. Were you hospitalized for this condition? Yes No  
   c. Did you report this to your doctor? Yes No  
   d. Did he prescribe medication for this? Yes No  

2. Did you experience heartburn during this period? Yes No  
   a. If yes, did you report this to your doctor? Yes No  
   b. Did he prescribe medication for this? Yes No  

3. Did you experience any swelling of the face, arms, hands, legs or feet at this time? Yes No  
   a. Did you report this to your doctor? Yes No  
   b. Did he prescribe medication or treatment for this? Yes No  

4. Did you experience increased fatigue during this period as compared to before pregnancy? Yes No  
   a. Did you experience increased fatigue during this period as compared to the first trimester of pregnancy? Yes No  
   b. Did you report this to your doctor? Yes No  
   c. Did he suggest a modified schedule? Yes No  

5. Did you experience any other complications of pregnancy at this time? Yes No  
   a. If yes, please specify  
   b. Did you report this to your doctor? Yes No  
   c. Did he prescribe medication or treatment? Yes No  
   d. Did he limit your activity in any way? Yes No  If yes, please specify  

6. Did you change your usual activities to a significant degree (as compared to before pregnancy) during this time? Yes No  
   a. Did you change your usual activities (as compared to the first trimester of pregnancy) to a significant degree during this time? Yes No  
   b. If yes, how? Increased? Decreased?  
   c. If yes, why?  
   d. If you decreased your activity, was this on your doctor's recommendation? Yes No  
   e. If you are/were employed before pregnancy, did you continue to work during this time? Yes No  
   f. If yes, did you continue to work full time? Yes No  

7. How would you describe your relationship with your mate during this period, as compared to before you were pregnant? Closer? More distant? About the same?  
   a. How would you describe your relationship with your mate during this period, as compared to the first trimester of pregnancy? Closer? More distant? About the same?  
   b. Did you feel that your mate's attitude toward you had changed during this period? Yes No  
   c. If yes, in what way?  
   d. Did you feel that your attitude towards yourself had changed during this period? Yes No  
   e. If yes, in what way?  
   f. Did you feel that your attitude toward your mate had changed during this period? Yes No  
   g. If yes, in what way?  

8. Would you describe your relationship as happy at this time? Yes No So-so  

9. Did you feel that your mate was more affectionate than usual at this time? Yes No  
   a. Did you feel that he was more affectionate than during the first trimester of your pregnancy? Less affectionate? About the same?  
   b. Did you feel that you were more affectionate than usual at this time? Yes No
c. Did you feel that you were more affectionate than during the first trimester of your pregnancy? Less affectionate? About the same?  
d. Did you feel satisfied with the amount and type of physical affection you had with your mate at this time? Yes No More satisfied than during the first trimester? Yes No  
e. Did you feel that your mate was satisfied with the amount and type of physical affection he had with you at this time? Yes No More satisfied than during the first trimester? Yes No  
f. Approximately how often, in a two-week period, would your mate be affectionate without necessarily expecting sex to follow? 0-2 3-5 6-10 11-15 16+  
g. Approximately how often, in a two-week period, would you be affectionate without necessarily expecting sex to follow? 0-2 3-5 6-10 11-15 16+  

10. What was your attitude toward sex, in general, at this time? Positive Negative Mixed Indifferent  

11. Were there any sexual problems at this time? Yes No  
a. How would you describe your interest in sex at this time as compared with your interest before pregnancy? Increased Decreased About the same  
b. How would you describe your interest in sex at this time as compared with your interest during the first trimester of pregnancy? Increased Decreased About the same  
c. If your sexual desire increased over the first trimester of your pregnancy, what do you think was the cause? (If more than one answer applies, please rank in order of importance)  
   Physical discomfort Fear of injury to the baby Fear of miscarriage Awkwardness having intercourse Discomfort due to nausea, vomiting, fatigue, etc. Reasons having nothing to do with the pregnancy Recommendation of doctor Loss of interest Feelings of mate's loss of attractiveness Feelings of mate's loss of attractiveness Recommendations of person other than doctor Other (please specify)  

a. How would you describe your mate's interest in sex at this time as compared with his interest before pregnancy? Increased Decreased About the same  
f. How would you describe your mate's interest in sex at this time as compared with his interest during the first trimester of pregnancy? Increased Decreased About the same  
g. If changed, what do you think was the cause of this change?  

h. If your sexual desire decreased compared to the first trimester of pregnancy:  
   1. Did you expect this to happen? Yes No  
   2. Did you find this upsetting? Yes No  
   3. Did you feel relieved to be free of the burden of sexual relations? Yes No  
   4. Did you feel guilty about your decreased desire? Yes No  
   5. Was this a source of tension between you and your mate? Yes No  
   6. Was this a subject of arguments between you and your mate? Yes No  
   7. Was your mate understanding about your decrease in desire? Yes No  
   8. Did you ask your doctor about this? Yes No If no, why not?  
   9. Did he supply adequate information to answer your questions? Yes No  
   10. Did he offer any helpful suggestions? Yes No  

12. Approximately how often, in a two-week period, did you have intercourse with your mate at this time? 0-1 2-3 4-5 6-7 8-9 10-11 12-13 14+  
   a. How often, in a two-week period, would you have liked to have sex with your mate? 0-1 2-3 4-5 6-7 8-9 10-11 12-13 14+  
   b. How often, in a two-week period, do you feel that your mate would have liked to have sex with you? 0-1 2-3 4-5 6-7 8-9 10-11 12-13 14+  
   c. Would you have preferred more experimentation with positions, practices, etc., at this time? Yes No  
   d. Do you feel that your mate would have preferred more experimentation with positions, practices, etc., at this time? Yes No  
   e. Was sex important to you in your relationship at this time? Yes No
13. What positions did your partner use? (Please estimate percentages of total instances of intercourse for each)
   a. Male on top
   b. Female on top
   c. Side-by-side, facing each other
   d. Side-by-side, male facing the female's back
   e. Male entering from behind and above the female
   f. Other (please specify)

14. Did you ever, at this time, with your mate, engage in sexual practices which did not result in intercourse? Yes No
   a. Were these practices used in place of intercourse (more or less exclusively—very rarely had intercourse)? Yes No
   b. In considering the total number of times that you had sexual contact with your mate, what percentage of these did not result in intercourse?
   c. Did you caress each other without orgasm for either? Yes No If yes, how often in a two-week period?
   d. Did you engage in oral sex? Yes No
   e. If yes:
      1. Were you able to have orgasms in this way? Yes No Percent of time 0-25% 25-50% 50-75% 75-100%
      2. Were you able to achieve multiple orgasms? Yes No Percent of time 0-25% 25-50% 50-75% 75-100%
      3. Did your orgasms seem to be of the same intensity as before pregnancy? More intense? Less intense?
      4. Did your orgasms seem to be of the same intensity as during the first trimester of pregnancy? More intense? Less intense?
      5. Did it seem to be more difficult to achieve orgasm than before pregnancy? Easier?
      6. Did it seem to be more difficult to achieve orgasm than during the first trimester of pregnancy? Easier?
      7. If yes, how often in a two-week period?
      8. If yes:
         1. Were you able to have orgasms in this way? Yes No Percent of time 0-25% 25-50% 50-75% 75-100%
15. Did you masturbate at this time? Yes No
   a. Approximately how often, in a two-week period? 1-2 3-4 5-6 7-8 9-10 11-12 13+ -
   b. Did you achieve orgasm with masturbation at this time? Yes No
   c. Approximately what percentage of the time were you able to achieve orgasm? 0-25% 25-50% 50-75% 75-100%
   d. Were you able to achieve multiple orgasms at this time? Yes No
   e. Approximately what percentage of the time were you able to achieve multiple orgasms? 0-25% 25-50% 50-75% 75-100%
   f. Was your mate aware that you were masturbating at this time? Yes No
   g. How did he feel about this (or, if he was unaware, how do you think he would have felt had he known)? Approved Disapproved Indifferent ?
   h. If he was unaware, did you feel guilty about masturbating without his knowledge? Yes No
   i. Did the practice of masturbation arouse more guilt at this time than when not pregnant? Yes No Guilt at either time
   j. Did your orgasms seem to be of the same intensity as before pregnancy? More intense? Less intense?
   k. Did your orgasms seem to be of the same intensity as during the first trimester of pregnancy? More intense? Less intense?
   l. Did it seem to be more difficult to achieve orgasm than before pregnancy? Easier? About the same?
   m. Did it seem to be more difficult to achieve orgasm than during the first trimester of pregnancy? Easier? About the same?
   n. If you masturbated before pregnancy, or during the first trimester of pregnancy, but have now discontinued this practice, could you state your reasons?

17. Did your sexual practices, in general, with your mate, change during this period? Yes No
   a. Did you feel that your mate was satisfied with your sex life at this time? Yes No
   b. Were you engaged in extramarital affairs at this time? Yes No
   c. Do you know, for certain, that your mate was engaged in extramarital affairs at this time? Yes No
   d. Did you suspect that your mate was engaged in extramarital affairs at this time? Yes No
   e. If the answer to either (b) or (c) above, is yes, was the other person aware and/or agreed to this? Aware Unaware Agreed Disagreed Didn’t care
   f. Did you feel that your mate was considerate of your feelings about sex at this time? Yes No

19. Did you notice a difference, as compared to before pregnancy, in your desire to be held, with-
20. Did you notice a difference, as compared to during the first trimester of pregnancy, in your desire to be held, without desiring sex to follow? Increased? Decreased? About the same?
SEVENTH MONTH (Females) Number __________________________ A 3

In all questions, by ‘mate’ is meant your spouse or partner.

1. Did you experience nausea and/or vomiting during this period? Yes No
   a. If yes, how would you describe this? Mild Moderate Severe
   b. Did you report this to your doctor? Yes No
   c. Did he prescribe medication for this? Yes No
   d. Were you hospitalized for this condition? Yes No

2. Did you experience heartburn during this period? Yes No
   a. If yes, did you report this to your doctor? Yes No
   b. Did he prescribe medication for this? Yes No

3. Did you experience any swelling of the face, arms, hands, legs or feet at this time? Yes No
   a. If yes, did you report this to your doctor? Yes No
   b. Did he prescribe medication for this? Yes No

4. Did you experience increased fatigue during this period as compared to before pregnancy? Yes No
   a. Did you experience increased fatigue as compared to earlier in this pregnancy? Yes No
   b. Did you report this to your doctor? Yes No
   c. Did he suggest a modified schedule? Yes No

5. Did you experience any other complications of pregnancy at this time? Yes No
   a. If yes, please specify
   b. Did you report this to your doctor? Yes No
   c. Did he prescribe medication or treatment for this? Yes No
   d. Did he limit your activity in any way? Yes No If yes, please specify

6. Did you change your usual activities, as compared to before pregnancy, to a significant degree during this time? Yes No
   a. Did you change your usual activities as compared to earlier in this pregnancy to a significant degree during this time? Yes No
   b. If yes, how? Increased Decreased
   c. If yes, for what reason?
   d. If you decreased your activity, was this on your doctor’s recommendation? Yes No
   e. If you were employed before pregnancy, did you continue to work during this time? Yes No
   f. If yes, did you continue to work full time? Yes No
   g. Do you plan to return to work following childbirth? Yes No Part time

7. Have you experienced physical discomfort due to your pregnancy at this time? Yes No
   a. Are you aware of any feelings of awkwardness? Yes No
   b. Are you aware of feeling unattractive? Yes No
   c. Do you feel that you are more or less attractive than before pregnancy? More Less
   d. Do you feel that your mate finds you more or less attractive than before pregnancy? More Less
   e. Would you describe yourself as an anxious person? Yes No
   f. Do you feel that you are more anxious than you were before this pregnancy? Less?
      About the same?
   g. If yes to either (e) or (f) above, do you feel that your anxiety is related to the pregnancy? Yes No
   h. Does the thought of childbirth make you anxious? Yes No
   i. Are you looking forward to the experience of childbirth? Yes No Mixed
   j. Do you feel that your mate is looking forward to the experience of childbirth? Yes No
   k. Do you feel that your mate will be helpful during childbirth? Yes No A little

8. How would you describe your relationship with your mate during this month, as compared to before you were pregnant? Closer? More distant? About the same?
   a. How would you describe your relationship with your mate during this month, as compared to earlier in this pregnancy? Closer? More distant? About the same?
b. Do you feel that your mate's attitude toward you has changed during this month? Yes _ No __

c. If yes, in what way? __

d. Do you feel that your attitude towards yourself has changed during this month? Yes _ No __

e. If yes, in what way? __

f. Do you feel that your attitude towards your mate has changed during this month? Yes _ No __

g. If yes, in what way? __

h. Would you describe your relationship as happy at this time? Yes _ No _ So-so __

10. Do you feel that your mate is more affectionate than usual at this time? Less affectionate? About the same? __

a. Do you feel that he is more affectionate than earlier in this pregnancy? Less affectionate? About the same? __

b. Do you feel that you are more affectionate than usual at this time? Less affectionate? About the same? __

c. Do you feel satisfied with the amount and type of physical affection you have with your mate at this time? Yes _ No _ More satisfied than earlier in this pregnancy? Yes _ No _ About the same? __

d. Do you feel that your mate is satisfied with the amount and type of physical affection he has with you at this time? Yes _ No _ More satisfied than earlier in this pregnancy? Yes _ No _ About the same? __

e. Approximately how often, in a two-week period, are you affectionate without necessarily expecting sex to follow? 0-2 ___ 3-5 ___ 6-10 ___ 11-15 ___ 16+ ___

g. Approximately how often, in a two-week period, is your mate affectionate without necessarily expecting sex to follow? 0-2 ___ 3-5 ___ 6-10 ___ 11-15 ___ 16+ ___

11. What is your attitude toward sex, in general, at this time? Positive _ Negative _ Mixed _ Indifferent __

12. Are there any sexual problems at this time? Yes _ No __

a. How would you describe your interest in sex at this time as compared with your interest before pregnancy? Increased _ Decreased _ About the same? __

b. How would you describe your interest in sex at this time as compared with your interest earlier in the pregnancy? Increased _ Decreased _ About the same? __

c. If your sexual desire increased as compared with earlier in the pregnancy, what do you think was the cause? (If more than one answer applies, please rank in order of importance) Physical discomfort _ Fear of injury to the baby _ Fear of miscarriage _ Awkwardness having intercourse _ Discomfort due to nausea, vomiting, fatigue, etc. _ Reasons having nothing to do with the pregnancy _ Recommendation of doctor _ Loss of interest _ Feelings of personal loss of attractiveness _ Feelings of mate's loss of attractiveness _ Recommendations of person other than doctor _ Sensation of the presence of the baby as an intruder in an intimate situation _ Other (please specify) __

d. If your sexual desire decreased as compared with earlier in the pregnancy, what do you think was the cause? (If more than one answer applies, please rank in order of importance) Physical discomfort _ Fear of injury to the baby _ Fear of miscarriage _ Awkwardness having intercourse _ Discomfort due to nausea, vomiting, fatigue, etc. _ Reasons having nothing to do with the pregnancy _ Recommendation of doctor _ Loss of interest _ Feelings of personal loss of attractiveness _ Feelings of mate's loss of attractiveness _ Recommendations of person other than doctor _ Sensation of the presence of the baby as an intruder in an intimate situation _ Other (please specify) __

e. How would you describe your mate's interest in sex at this time as compared with his interest before pregnancy? Increased _ Decreased _ About the same? __

f. How would you describe your mate's interest in sex at this time as compared with his interest earlier in the pregnancy? Increased _ Decreased _ About the same? __

3. If changed, what do you think was the cause of this change? __

h. If your sexual desire has decreased compared to earlier in this pregnancy:
   1. Did you expect this to happen at this time? Yes _ No __
   2. Do you find this upsetting? Yes _ No __
   3. Do you believe to be free of the burden of sexual relations? Yes _ No __
   4. Do you feel guilty about your decreased desire? Yes _ No __
   5. Is this a source of tension between you and your mate? Yes _ No __
   6. Is this a source of arguments between you and your mate? Yes _ No __
7. Is your mate understanding about your decrease in desire? Yes No
8. Did you ask your doctor about this? Yes No If not, why not?
9. Did he supply adequate information to answer your questions? Yes No
10. Did he offer any helpful suggestions? Yes No
11. Have you received any information from your doctor regarding sexual behavior during pregnancy? Yes No
   a. If no, would you have liked this? Yes No
   b. Have you asked him/her about this? Yes No
   c. Would such information be helpful? Yes No
12. Have you been advised by your doctor to discontinue sex? Yes No
   a. If yes, when?
   b. If yes, why?
13. Approximately how often, in a two-week period, do you have intercourse with your mate at this time? 0-1 2-3 4-5 6-7 8-9 10-11 12-13 14+
   a. How often, in a two-week period, would you like to have sex with your mate? 0-1 2-3 4-5 6-7 8-9 10-11 12-13 14+
   b. How often, in a two-week period, do you feel that your mate would like to have sex with you 0-1 2-3 4-5 6-7 8-9 10-11 12-13 14+
   c. Would you prefer more experimentation with positions, practices, etc., at this time? Yes No
   d. Do you feel that your mate would prefer more experimentation with positions, practices, etc., at this time? Yes No
   e. Is sex important to you in your relationship at this time? Yes No
      1. As important as before you were pregnant? More important Less important About the same
      2. As important as earlier in the pregnancy? More important Less important About the same
   f. Do you feel that sex is important to your mate in your relationship at this time? Yes No
      1. As important as before you were pregnant? More important Less important About the same
      2. As important as earlier in this pregnancy? More important Less important About the same
14. Are you able to have orgasms at this time? Yes No
   a. Out of the total number of instances of intercourse, what percentage of the time would you say that you are able to achieve orgasm? 0-25% 26-50% 51-75% 76-100%
   b. Are you able to have multiple orgasms? Yes No
   c. Out of the total number of instances of intercourse, what percentage of the time would you say that you are able to achieve multiple orgasms? 0-25% 26-50% 51-75% 76-100%
   d. Do your orgasms seem to be of the same intensity as before pregnancy? More intense Less intense
      1. Do your orgasms seem to be of the same intensity as earlier in this pregnancy? More intense Less intense
      2. Does it seem to be more difficult to achieve orgasm than before pregnancy? Easier About the same
      3. Does it seem to be more difficult to achieve orgasm than earlier in the pregnancy? Easier About the same
15. What positions do you use? (Please estimate percentages of total instances of intercourse for each) a. Male on top b. Female on top c. Side-by-side, facing each other d. Side-by-side, male facing female's back e. Male entering from behind and above the female f. Other (please specify)
16. Do you ever, at this time, with your mate, engage in sexual practices which do not result in intercourse? Yes ___ No ___
   a. Are these practices used in place of intercourse (more or less exclusively—very rarely have intercourse)? Yes ___ No ___
   b. In considering the total number of times that you have sexual contact with your mate, what percentage of these do not result in intercourse? ___
   c. Do you care each other without orgasm for either? Yes ___ No ___ If yes, how often in a two-week period? ___
   d. Do you engage in oral sex? Yes ___ No ___
   e. If yes:  
      1. Are you able to have orgasms in this way? Yes ___ No ___ Percent of time? 0-25% ___ 25-50% ___ 50-75% ___ 75-100% ___
      2. Are you able to have multiple orgasms in this way? Yes ___ No ___ Percent of time? 0-25% ___ 25-50% ___ 50-75% ___ 75-100% ___
      3. Do your orgasms seem to be of the same intensity as before pregnancy? ___ More intense ___ Less intense ___
      4. Do your orgasms seem to be of the same intensity as earlier in this pregnancy? ___ More intense ___ Less intense ___
      5. Does it seem to be more difficult to achieve orgasm than before pregnancy? ___ Easier ___
      6. Does it seem to be more difficult to achieve orgasm than earlier in the pregnancy? ___ Easier ___ About the same ___
   f. Do you engage in mutual masturbation with orgasm as a goal (whether or not orgasm is achieved)? Yes ___ No ___
   g. If yes:  
      1. Are you able to have orgasms in this way? Yes ___ No ___ Percent of time? 0-25% ___ 25-50% ___ 50-75% ___ 75-100% ___
      2. Are you able to have multiple orgasms in this way? Yes ___ No ___ Percent of time? 0-25% ___ 25-50% ___ 50-75% ___ 75-100% ___
      3. Do your orgasms seem to be of the same intensity as before pregnancy? ___ More intense ___ Less intense ___
      4. Do your orgasms seem to be of the same intensity as earlier in this pregnancy? ___ More intense ___ Less intense ___
      5. Does it seem to be more difficult to achieve orgasm than before pregnancy? ___ Easier ___
      6. Does it seem to be more difficult to achieve orgasm than earlier in the pregnancy? ___ Easier ___ About the same ___

17. Do you masturbate at this time? Yes ___ No ___
   a. Approximately how often, in a two-week period? 1-2 3-6 5-6 7-8 9-10 11-12 13+ ___
   b. Do you achieve orgasm with masturbation at this time? Yes ___ No ___
   c. Approximately what percentage of the time are you able to achieve orgasm in this way? 0-25% ___ 25-50% ___ 50-75% ___ 75-100% ___
   d. Are you able to achieve multiple orgasms in this way? Yes ___ No ___
   e. Approximately what percentage of the time are you able to achieve multiple orgasms in this way? 0-25% ___ 25-50% ___ 50-75% ___ 75-100% ___
   f. Is your mate aware that you are masturbating at this time? Yes ___ No ___
   g. How does he feel about this (if, he is unaware, how do you think he would feel if he knew)? Approve ___ Disapprove ___ Indifferent ___
   h. If he is unaware, do you feel guilty about masturbation without his knowledge? Yes ___ No ___
   i. Does the practice of masturbation arouse more guilt at this time than when not pregnant? Yes ___ No ___
   j. Do your orgasms seem to be of the same intensity as before pregnancy? ___ More intense ___
   k. Do your orgasms seem to be of the same intensity as earlier in this pregnancy? ___ More intense ___
   l. Does it seem to be more difficult to achieve orgasm than before pregnancy? ___ Easier ___ About the same ___
   m. Does it seem to be more difficult to achieve orgasm than earlier in pregnancy? ___ Easier ___ About the same ___
n. If you masturbated before pregnancy, or earlier in this pregnancy, but have now discontinued this practice, could you state your reasons?

18. Have your sexual practices, in general, with your mate, changed during this month? Yes ___ No ___
   a. If yes, who desired or requested these changes? You ___ Your mate ___ Both ___
   b. Who most often initiates sex during this time? You ___ Your mate ___ Either of you, with about the same frequency ___
   c. Do you feel 'dirty' or 'guilty' about any of your sexual behaviors at this time? Yes ___ No ___ If yes, please specify what and your feelings about why ___

19. Are you satisfied with your sex life together at this time? Yes ___ No ___
   a. Do you feel that your mate is satisfied with your sex life at this time? Yes ___ No ___
   b. Are you engaged in extramarital affairs at this time? Yes ___ No ___
   c. Do you know, for certain, that your mate is engaged in extramarital affairs at this time? Yes ___ No ___
   d. Do you suspect that your mate is engaged in extramarital affairs at this time? Yes ___ No ___
   e. If the answer to either (b) or (c) above, is yes, was the other partner aware and/or agreeable to this? Yes ___ No ___
   f. Do you feel that your mate is considerate of your feelings about sex at this time? Yes ___ No ___ Sometimes ___ Most of the time, but not always ___

20. Do you notice a difference, as compared to before pregnancy, in your desire to be held, without desiring sex to follow? Yes ___ No ___ Increased ___ Decreased ___
   a. Do you notice a difference, as compared to earlier in this pregnancy, in your desire to be held, without desiring sex to follow? Yes ___ No ___ Increased ___ Decreased ___
   b. Are you aware of a feeling of withdrawing into yourself, of being in a world of your own, as you get further into your pregnancy? Yes ___ No ___
      1. If yes, is this upsetting to you? Yes ___ No ___
      2. If yes, do you feel that your mate is aware of this? Yes ___ No ___
      3. If yes, do you feel that this is upsetting to him? Yes ___ No ___
<table>
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<tr>
<th>EIGHTH MONTH (Females)</th>
<th>Number</th>
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In all questions, by 'mate' is meant your spouse or partner.

1. Did you experience nausea and/or vomiting during this month? Yes No
   a. If yes, how would you describe this? Mild Moderate Severe
   b. Did you report this to your doctor? Yes No
c. Did he prescribe medication for this? Yes No
d. Were you hospitalized for this condition? Yes No

2. Did you experience heartburn during this period? Yes No
   a. If yes, did you report this to your doctor? Yes No
c. If yes, please specify

3. Did you experience any swelling of the face, arms, hands, legs or feet at this time? Yes No
   a. If yes, did you report this to your doctor? Yes No
c. If yes, please specify

4. Did you experience increased fatigue during this period as compared to before pregnancy? Yes No
   a. Did you experience increased fatigue as compared to earlier in this pregnancy? Yes No
c. Did you report this to your doctor? Yes No
d. Did he suggest a modified schedule? Yes No

5. Did you experience any other complications of pregnancy at this time? Yes No
   a. If yes, please specify
   b. Did you report this to your doctor? Yes No
c. Did he prescribe medication or treatment for this? Yes No
d. Did he limit your activity in any way? Yes No If yes, please specify

6. Did you change your usual activities, as compared to before pregnancy, to a significant degree during this time? Yes No
   a. Did you change your usual activities as compared to earlier in this pregnancy to a significant degree during this time? Yes No
c. If yes, how? Increased Decreased
   d. If yes, for what reason?
   e. If you decreased your activity, was this on your doctor's recommendation? Yes No
   f. If you were employed before pregnancy, did you continue to work during this time? Yes No
   g. If yes, did you continue to work full time? Yes No Part time?

7. Have you experienced physical discomfort due to your pregnancy at this time? Yes No
   a. Are you aware of any feelings of awkwardness? Yes No
   b. Are you aware of feeling unattractive? Yes No
c. Do you feel that your are more or less attractive than before pregnancy? More Less
   d. Do you feel that your mate finds you more or less attractive than before pregnancy? More Less
   e. Would you describe yourself as an anxious person? Yes No
   f. Do you feel that you are more anxious than you were before this pregnancy? More Less?
   g. If yes, to either (e) or (f) above, do you feel that your anxiety is related to the pregnancy? Yes No
   h. Does the thought of childbirth make you anxious? Yes No
   i. Are you looking forward to the experience of childbirth? Yes No Mixed
   j. Do you feel that your mate is looking forward to the experience of childbirth? Yes No
   k. Do you feel that your mate will be helpful during childbirth? Yes No A little

8. How would you describe your relationship with your mate during this month, as compared to before you were pregnant? Closer More distant About the same
   a. How would you describe your relationship with your mate during this month, as compared to earlier in this pregnancy? Closer More distant About the same
NINTH MONTH (Females)

In all questions, by 'mate' is meant your spouse or partner.

1. Did you experience nausea and/or vomiting during this period? Yes No
   a. If yes, how would you describe this? Mild Moderate Severe
   b. Did you report this to your doctor? Yes No
   c. Did he prescribe medication for this? Yes No
   d. Were you hospitalized for this condition? Yes No

2. Did you experience heartburn during this period? Yes No
   a. If yes, did you report this to your doctor? Yes No
   b. Did he prescribe medication for this? Yes No

3. Did you experience any swelling of the face, arms, hands, legs or feet at this time? Yes No
   a. If yes, did you report this to your doctor? Yes No
   b. Did he prescribe medication or treatment for this? Yes No

4. Did you experience increased fatigue during this period as compared to before pregnancy? Yes No
   a. Did you experience increased fatigue as compared to earlier in this pregnancy? Yes No
   b. Did you report this to your doctor? Yes No
   c. Did he suggest a modified schedule? Yes No

5. Did you experience any other complications of pregnancy at this time? Yes No
   a. If yes, please specify
   b. Did you report this to your doctor? Yes No
   c. Did he prescribe medication or treatment for this? Yes No
   d. Did he limit your activity in any way? Yes No

6. Did you change your usual activities, as compared to before pregnancy, to a significant degree during this month? Yes No
   a. Did you change your usual activities as compared to earlier in this pregnancy to a significant degree during this time? Yes No
   b. If yes, how? Increased Decreased
   c. If yes, for what reason?
   d. If you decreased your activity, was this on your doctor's recommendation? Yes No
   e. If you were employed before pregnancy, did you continue to work during this time? Yes No
   f. If yes, did you continue to work full time? Yes No
   g. Do you plan to return to work following childbirth? Yes No Part time

7. Have you experienced physical discomfort due to your pregnancy at this time? Yes No
   a. Are you aware of any feeling of awkwardness? Yes No
   b. Are you aware of feeling unattractive? Yes No
   c. Do you feel that you are more or less attractive than before pregnancy? More Less
   d. Do you feel that your mate finds you more or less attractive than before pregnancy? More Less
   e. Would you describe yourself as an anxious person? Yes No
   f. Do you feel that you are more anxious than you were before this pregnancy? Less?
   g. If yes, to either (e) or (f) above, do you feel that your anxiety is related to the pregnancy? Yes No
   h. Does the thought of childbirth make you anxious? Yes No
   i. Are you looking forward to the experience of childbirth? Yes No Mixed
   j. Do you feel that your mate is looking forward to the experience of childbirth? Yes No
   k. Do you feel that your mate will be helpful during childbirth? Yes No A little

8. How would you describe your relationship with your mate during this month, as compared to before you were pregnant? Closer More distant About the same?
   a. How would you describe your relationship with your mate during this month, as compared to earlier in this pregnancy? Closer More distant About the same?
APPENDIX IX

Scoring System for Sexual Adjustment to Pregnancy Scale

1. What is your attitude toward sex, in general, at this time? (Positive = +3, Mixed = +2, Indifferent = +1, Negative = 0)

2. Are there any sexual problems at this time? (No = +1)

3. Is sex important to you in your relationship at this time? (Yes = +1)

4. As important as before you were pregnant? (More = +2, Same = +1, Less = 0)

5. How would you describe your interest in sex at this time as compared to your interest before pregnancy? (Increased = +2, Same = +1, Decreased = 0)

6. Are you satisfied with your sex life together at this time? (Yes = +1)

7. Are you engaged in extramarital affairs at this time? (No = +1)

8. Have your sexual practices, in general, with your mate, changed during this time? (No = +1)

9. If yes, who desired or requested these changes? (You = 0, Both = 0, Mate = +1)

10. Who most often initiates sex during this time? (You = +1, Mate = 0, Either of you, with about the same frequency = +1)

11. Do you feel dirty or guilty about any of your sexual behaviors at this time? (No = +1)

12. Approximately how often, in a two-week period, do you have intercourse with your mate at this time? (Any frequency = +1)

13. How often, in a two-week period, would you like to have sex with your mate? (Any frequency = +1)

14. How often, in a two-week period, do you feel that your mate would like to have sex with you? (Any frequency = +1)

15. Would you prefer more experimentation with positions, practices etc., at this time? (No = +1)

16. Are you able to have orgasms at this time? (Yes = +1)
17. Out of the total number of instances of intercourse, what percentage of the time would you say that you are able to achieve orgasms? (0%-25% = +1, 25%-50% = +1, 50%-75% = +2, 75%-100% = +2)

18. Are you able to have multiple orgasms with intercourse? (Yes = +1)

19. Out of the total number of instances of intercourse, what percentage of the time would you say that you are able to achieve multiple orgasms? (0%-25% = +1, 25%-50% = +1, 50%-75% = +2, 75%-100% = +2)

20. Do your orgasms seem to be of the same intensity as before pregnancy? (Same = +1, More = +2, Less = 0)

21. Does it seem to be more difficult to achieve orgasms than before pregnancy? (More = 0, Same = +1, Less = +2)

22. What positions do you use? (Six possibilities, including 'other' given, +1 for each position indicated)

23. Do you masturbate at this time? (Yes = +1)

24. Do you achieve orgasm with masturbation at this time? (Yes = +1)

25. Approximately what percentage of the time are you able to achieve orgasm in this way? (0%-25% = +1, 25%-50% = +1, 50%-75% = +2, 75%-100% = +2)

26. Are you able to have multiple orgasms in this way? (Yes = +1)

27. Approximately what percent of the time are you able to achieve multiple orgasm in this way? (0%-25% = +1, 25%-50% = +1, 50%-75% = +2, 75%-100% = +2)

28. Do your orgasms seem to be of the same intensity as before the pregnancy? (Same = +1, More = +2, Less = 0)

29. Does it seem to be more difficult to achieve orgasm than before pregnancy? (More = 0, Same = +1, Less = +2)

30. Is your mate aware that you are masturbating at this time? (Yes = +1)

31. How does he feel about this, or, if he is unaware, how do you think he would feel about this if he knew? (Approve = +2, Indifferent = +1, Disapprove = 0)

32. If he is unaware, do you feel guilty about masturbating without his knowledge? (No = +1)
33. Do you engage in oral sex at this time? (Yes = +1)

34. Are you able to have orgasms in this way? (Yes = +1)

35. Approximately what percent of the time are you able to achieve orgasm in this way? (0%-25% = +1, 25%-50% = +1, 50%-75% = +2, 75%-100% = +2)

36. Are you able to have multiple orgasms in this way? (Yes = +1)

37. Approximately what percent of the time are you able to achieve multiple orgasms in this way? (0%-25% = +1, 25%-50% = +1, 50%-75% = +2, 75%-100% = +2)

38. Do your orgasms seem to be of the same intensity as before pregnancy? (Same = +1, More = +2, Less = 0)

39. Does it seem to be more difficult to achieve orgasms than before pregnancy? (More = 0, Same = +1, Less = +2)

40. Do you engage in mutual masturbation at this time? (Yes = +1)

41. Are you able to have orgasms in this way? (Yes = +1)

42. Approximately what percent of the time are you able to achieve orgasm in this way? (0%-25% = +1, 25%-50% = +1, 50%-75% = +2, 75%-100% = +2)

43. Are you able to have multiple orgasms in this way? (Yes = +1)

44. Approximately what percent of the time are you able to achieve multiple orgasms in this way? (0%-25% = +1, 25%-50% = +1, 50%-75% = +2, 75%-100% = +2)

45. Do your orgasms seem to be of the same intensity as before pregnancy? (Same = +1, More = +2, Less = 0)

46. Does it seem to be more difficult to achieve orgasms than before pregnancy? (More = 0, Same = +1, Less = +2)

Possible Score: 0-72
APPENDIX X

Scoring System for Physical Response to Pregnancy Scale

1. Did you experience nausea and/or vomiting during this period? (Yes = -1)

2. Describe this. (First trimester: mild or moderate = -1, severe = -2; All other stages of pregnancy, any response = -2)

3. Did you report this nausea and/or vomiting to your doctor? (Yes = -1)

4. Were you hospitalized for this condition? (yes = -2)

5. Did you experience heartburn during this period? (Yes = -1)

6. Did you report your heartburn to your doctor? (Yes = -1)

7. Did you experience any swelling of the face, arms, hands, legs, or feet at this time? (Yes = -1)

8. Did you report this swelling to your doctor? (Yes = -1)

9. Did you experience increased fatigue during this period as compared to before pregnancy? (Yes = -1)

10. Did you report this increased fatigue to your doctor? (Yes = -1)

11. Did you experience any other complications of pregnancy at this time? (Yes = -1)

12. Did you report this complication to your doctor? (Yes = -1)

13. Did you change your usual activities, as compared to before pregnancy, to a significant degree during this time? (Yes = -1)

14. How did you change? (Increased = +1, Decreased = -1)

15. If you were employed before pregnancy, did you continue to work during this time? (No = -1)

16. Did you continue to work full time? (No = -1)

Possible Score: 0-18
APPENDIX XI

Scoring System for Emotional Response to Pregnancy Scale

1. Have you experienced physical discomfort due to pregnancy at this time? (Yes = -1)

2. Are you aware of any feelings of awkwardness? (Yes = -1)

3. Are you aware of feeling unattractive? (Yes = -1)

4. Do you feel that you are more or less attractive than before pregnancy? (More = 0, Less = -1, Same = 0)

5. Do you feel that your mate finds you more or less attractive than before pregnancy? (More = 0, Less = -1, Same = 0)

6. Would you describe yourself as an anxious person? (Yes = -1)

7. Do you feel that you are more anxious than you were before this pregnancy? (More = -1, Less = 0, Same = 0)

8. Do you feel that your anxiety is related to the pregnancy? (Yes = -1)

9. Does the thought of childbirth make you anxious? (Yes = -1)

10. Are you looking forward to the experience of childbirth? (Yes = 0, Mixed = -1, No = -2)

Possible Score: 0-11
April 3, 1980

Ms. Anne R. Diebel
UNIVERSITY OF CENTRAL FLORIDA
Department of Psychology
Post Office Box 25000
Orlando, Florida 32816

Dear Ms. Diebel:

In response to your recent request, I am very pleased to give you permission to reproduce the:

State-Trait Anxiety Inventory (STAI)

for your M.A. thesis research entitled, "Sexuality in Pregnancy as a Function of Sex-Role Identity"

It is my understanding that your research will be carried out at:

the Orlando Regional Medical Center, Orlando, Florida, under the supervision of Dr. Sandra S. Guest.

I will look forward to receiving further details on your procedures and your results as these become available. Best wishes on your research project.

Sincerely,

Charles D. Spielberger, Ph.D.
Professor of Psychology and Director, Center for Research in Community Psychology

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Reference Notes


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