SEXUALITY OF WOMEN WITH YOUNG CHILDREN: A FEMINIST MODEL OF MENTAL HEALTH COUNSELING

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Although postpartum recovery and women’s sexual behavior have received significant attention, little is known about the experiences of mothers with young children. Socially constructed images of mothers often depict them both as rebounding with sexual enthusiasm and sensuality and as devoted primary caregivers, while also holding a job. This fantasy breadwinner/homemaker model denies the challenges many mothers of young children face in struggling to reclaim their sexual selves. Such constructions are incongruent with the realities of motherhood and the psychological challenges women face to reassemble sexual identity, self-image, and sexual scripts. This article presents a feminist model of mental health counseling that offers women affirmation, encouragement, and support as they explore their identities as sexual women and as mothers.

I think it’s really conflicting…the messages…because you’re supposed to do all these things…. The role of being a perfect mom—that to me is impossible, and so the sexuality part of that is impossible as well—and being a perfect mom on top of that! I don’t feel like there’s a lot of support from other women…. They’ll try to put on the persona that they’re doing it, when in fact they’re not…. So, I think it’s really sad…for women.

Theresa, age 35, married mother of two children (Trice-Black, 2010a)

Social, historical, and personal contexts shape both expectations and representations of motherhood. Dominant media images suggest a relatively
seamless transition to having it all together—perfect bodies, great sex with spouses, loving and cheerful relationships with children, active social lives, and professional success. Attempting to live up to such unrealistic expectations can be frustrating, confusing, and often isolating. These images essentially reinforce the conception of motherhood as a test of a woman’s psychological adequacy. Motherhood might be more realistically drawn as “an identity that limits women and is a difficult job that is generally done is isolation with little practical help, but one for which the standards are constantly shifting” (Leidner, 1994, p. 783). Fatigue, overwork, and lack of sexual interest are typical problems that mothers of young children bring to physicians (Candib, 2001).

Theresa, the married mother of two, articulated her fears that not fulfilling the role of the ideal mother may thwart women from honestly communicating their personal needs and struggles as both sexual selves and mothers. Women’s sexual desire and satisfaction may depend not only on the physical, interpersonal aspects of sexual interactions but also on the affective, interpersonal aspects. Thus changing roles related to parenting, specifically motherhood, influence the constructions and quality of sexual identity and sexual relationships (Byers, 2002).

This article explores the impact of the cultural construction of sexuality on mothers, particularly mothers of young children. Images are contradictory, simultaneously depicting mothers as rebounding with sexual enthusiasm and sensuality while maintaining professional roles and as devoted primary caregivers in a breadwinner/homemaker model that denies that mothers who struggle to reclaim their sexual selves are overburdened. Contemporary sociocultural constructions of motherhood, coupled with unrealistic media images, are incongruent with the realities of motherhood and the challenges of reassembling sexual identity, self-image, and sexual scripts. Feminist-informed counseling may offer an engaging and affirming crucible within which mothers, especially those with young children, can construct a fresh, personally identified sexual self, exploring the connections between sexual desires, practices, attitudes, ideals, and duties that shift throughout their lifespan (Long, Burnett & Thomas, 2006).

THE IDEAL MOTHER—SOCIETAL MESSAGES

The dominant culture shapes how motherhood affects self-identity, expectations, and meanings of motherhood, relationships with self and others, and the behaviors and actions of mothers, appropriate and inappropriate (Johnston & Swanson, 2003). Dominant-culture media offer images of mothers who care for the home, taxi children to school and extracurricular activities, have careers, and also manage to look and behave sexually enticing (Guendouzi, 2005). A recent study by Clarke (2009) showed that the media persistently portray
middle-aged women as responsible for both the emotional stability of the family and the marital sexual relationship. Sex was often described as a job or a burden for women in this age bracket. Moreover, media representations of women’s familial obligations included monitoring the sexuality of female children. Thus, responsibility for sexuality is passed down from mothers to daughters, generation to generation. Such unrealistic and oppressive social expectations negatively influence women’s experiences and responses (Worrel & Remer, 2002). Feelings of inadequacy and fears of failure emerge as women attempt to live up to the socially constructed ideal of motherhood (Choi, Henshaw, Baker, & Tree, 2005).

As mothers women are socialized to put the needs of children and partners before the needs of self (Tardy, 2000). Sheriff and Weatherall (2009) suggest that the perceptions of motherhood as a “natural and inevitable part of womanhood are a type of social mandate” (p. 90). Radical changes to the self are intrinsic to the process of making room for a child (Baraitser, 2006). A mother is no longer free to think only about her needs; she must also think about, plan for, and often sacrifice for the needs of her child. Sometimes a mother’s needs and desires get lost in the process. Socially constructed expectations of motherhood, rather than the actuality of motherhood, contribute to the isolation and loss of identity that mothers with young children may experience (Baraitser, 2006).

Modern images of women as mothers are shaped by marketing approaches through a “super text” that links women’s sexuality on screen to interviews with high-profile actresses who clarify that their real priority is their role as mothers. Thus women are expected to effortlessly project both a sexual and a maternal image. Angelina Jolie has asserted that “her satisfaction comes not from her work but from her kids … (and husband Brad Pitt)” (Cohen, 2010, p. 172). She is described as “completely absorbed in the role of the matriarch, architect of a perfect family. For this role, she will cast aside all others” (p. 173). Tally (2006) suggests that this construction and similar depictions in films reaffirms women’s primary roles as mothers in the center of a nuclear family while allowing them to “inhabit their ‘lost’ sexuality” (p. 52).

Self-denial and sacrifice often accompany motherhood, resulting in women feeling isolation, self-negation, and role conflict. Observations of mothers and children in playgroups revealed mothers’ continual denials of self and placement of family’s needs and desires above their own (Guendouzi, 2007). The societal pressures to do this can result in situations where resources and time are spent on children’s preferences and appearance to the neglect of mothers’ needs (Collett, 2005). In caring for a family, house, and job, the wants and needs of the self are often disregarded. The continual denial of one’s own feelings and needs may lead to confusion and difficulty in determining what one desires.
MOTHERS OF YOUNG CHILDREN

Children’s preschool years are a period when decisions for the child are the responsibility of the parents. The stresses of early motherhood do not end after the first year postpartum, although most research focuses on this stage. Fagot and Kavanagh (1993) studied marital relationships in couples with quite young children, using questionnaires and observations in the home with 67 couples whose children were 12 months old and 70 who had 18-month-old children. They found lower levels of marital adjustment and pleasure for parents of challenging verbal, mobile 18-month-old children than parents of the younger children. More recently Craig & Sawriker (2009) found differences in satisfaction with the balance of work and life among parents of children under 5 and parents of children aged 11–14. The satisfaction with life-work balance was found to be higher among mothers of the older children than those with the less independent preschoolers.

In an early study Boulton (1983) interviewed 50 mothers of preschool children. They expressed a range of conflicting emotions, among them such negative feelings as isolation, self-sacrifice, and a loss of identity and such positive feelings as being needed, satisfaction and significance in being a mother, and pride in their children. Both positive and negative emotions signified heavy dependence between mothers and their young children. Similarly, in a study by Davies and Welch (1986) mothers with preschool children reported feelings of isolation, self-negation, loss of identity, and role conflict. They reported that motherhood itself did not lead to conflicting feelings about a loss of their identity but the isolation and beliefs associated with motherhood did.

SEXUALITY IN MOTHERHOOD

Motherhood is a period when women may face changes in their own sexuality, which may in turn affect their perceptions of self and interactions with others. Most research has studied sexual changes during the first year postpartum, especially biological and hormonal changes due to pregnancy, childbirth, and breastfeeding (Ahlborg, Dahlol, & Hallberg, 2005; DeJudicibus & McCabe, 2002; Huang & Mathers, 2006; Hyde, DeLamater, & Hewitt, 1998; Seimyr, Edhborg, Lundh, & Sjogren, 2004). Research has neglected social and psychological changes, such as those in the area of sexuality, that occur after the first year postpartum.

Societal definitions of sexuality within the context of motherhood can be particularly challenging as women try to make sense of themselves as both sexual individuals and mothers. Expectations of motherhood and female sexuality are shaped by a patriarchal culture that stifles women’s true voices. Daphne de Marneffe, a mother and psychologist, notes,
Throughout history, women often have not been free to make and take responsibility for their own decisions about sexuality and motherhood, and it has been easy enough to create identities for them, to make them stand for good or evil (2004, p. 254).

She urges “the need to move toward fairer, more truthful, more complex views” (p. 254) of sexuality and motherhood.

Although most recent studies focus on sexuality in mothers during the first year after giving birth, an earlier study (Apt & Hurlbert, 1992) compared the responses of 50 mothers with children aged from 13 to 44 months to the responses of 50 women without children. The mothers reported less sexual activity and more negative attitudes toward sex. They also indicated more desire for social desirability and more willingness to conform to societal expectations. The researchers noted that “[a] mother concerned with social desirability may be placing herself in a situation fraught with conflicts and mixed messages about her identity and her roles as wife and mother” (p. 111). More recently Pastore, Owens, and Raymond (2006) found that sexuality concerns for parents of 4-month-old children focused on factual information about, e.g., breastfeeding and birth control. In contrast, parents of 12-month old children expressed more personal concerns, such as mothers’ negative body image and low sexual desire. Thus, issues of primary sexual concern moved from physical facts to more subjective issues intertwined with self and relationship.

**A SPLIT BETWEEN MOTHERHOOD AND SEXUALITY**

As mothers, women may struggle to define themselves as sexual beings. From observations of and interviews with 30 mothers in a playgroup setting, Tardy (2000) reported a dissociation between sex and motherhood and noted that mothers “are reduced to asexual beings, as sex is the antithesis of archetypal motherhood images” (p. 463). It appears that both men and women perceive a split between motherhood and sexuality (Friedman, Wineberg, & Pines, 1998). The more sexual a woman is presented to be, the less she is perceived to be a good mother. De Marneffe (2004) elaborates on the perceived split in motherhood and sexuality, stating that “treating eros and motherhood as separate, even incompatible, has contributed to a general mischaracterization of female erotic experience” (p. 303). Thus mothers may struggle to normalize and validate sexual changes integral to their lives.

Many media representations of motherhood offer confusing messages about sexuality. The term, “MILF” which stands for “Mothers I’d Like to Fuck” was made popular by the teen movie *American Pie* (Weitz & Weitz, 1999), in which one character exclaims, “Dude, that chick’s a MILF,” after looking at a sexy picture of a teen friend’s mother. A quick Google of “MILF” reveals over 59 million websites that use the term. Most carry pornographic pictures of middle-
aged women. Popular television shows such as “30 Rock” and “Weeds” have
dedicated entire episodes to the subject. Here the objectification and polariza-
tion of female, specifically mothers’, sexuality becomes apparent. Some
women may consider “MILF” complimentary, others may find it derogatory.
One mother noted, “[When] my kids are with me, I hope they think, that’s a
MILF right there … I remember the first time someone called me a MILF, I had
no idea what it was, but when I found out, I was flattered” (Trice-Black, 2009).
Even though the term is blatantly sexist and objectifying, mothers who fear that
they may no longer be considered sexually desirable may find themselves reas-
sured by it if there are no other reassurances in their relationships and in their
self-image.

BODY IMAGE

The transition to motherhood involves an extremely physical transformation,
including weight gain and changes in body shape, size, and appearance. Women
commonly report dissatisfaction with physical changes after having children
(Olsson, Lundqvist, Faxelid, & Nissen, 2005; Pastore, Owens, & Raymond,
2006). Postpartum dissatisfaction with specific body parts has been reported
across ethnicities (Walker, Timmerman, Kim, & Sterling, 2002) and ages
(Birkeland, Thompson, & Phares, 2005).

Women who breastfeed may struggle with the transition from breasts being
perceived as a sexual body part to one with the primary function of feeding
children. Women’s breasts are commonly displayed in media forms that empha-
size sexuality and sensuality and objectify the female body for the pleasure of
men (Ward, Merriwether, & Caruthers, 2006). In contrast, for mothers with
infants, breasts can be seen as nurturing and nourishing. Breastfeeding can
affect the size and shape of women’s breasts (Olsson, Lundqvist, Faxelid, &
Nissen, 2005). The transition from breasts as sexual object to something nur-
turing and back to sexual object may add to confusion and dissatisfaction with
body image. In a study in Sweden (Olsson et al., 2005), mothers with young
children reported feelings of exhaustion, low sexual desire, and poor body
image. Participants discussed their unrealistic expectations that pregnancy and
breastfeeding would not leave permanent marks on their bodies and their dis-
turbance and shock at the changes in their bodies after having children. Some
participants mentioned plastic surgery as an option to help alleviate this dissas-
satisfaction. Because such concerns are likely to impact body image and mothers’
perceptions of themselves as attractive to their partners, they may inhibit sex-
ual activity.
SEXUALITY AND COMMUNICATION

Communication with support systems, including partners, can help women as they adjust to changes in their sexuality. Increased awareness of emotions, such as confusion and frustration, and physical feelings, such as fatigue, can help women identify rather than ignore their personal experiences. In observing mothers and young children during actual playgroups and when the mothers spent time together without their children, Tardy (2000) found sex to be one of the “taboo topics” (p. 242) unless it was discussed as a joke, like that of the woman who quipped, “Show me a man with small children who is happy with his sex life and I’ll show you a man who is having an affair” (Tardy, p. 462).

Similarly, in a qualitative study by Trice-Black (2010b) mothers of young children expressed a need to protect the privacy of their sexuality and only felt comfortable discussing fun or fantasy sexual topics with friends. Participants suggested they felt comfortable discussing sex with their partners, yet most reported putting their partners’ needs and desires above their own. They discussed faking orgasms to flatter their partners about their sexual abilities, having sex so that the partner would not seek sex from others, and having sex in order to keep partners satisfied. These reports are congruent with media messages that ascribe the responsibilities of spousal sexual satisfaction to women (Clarke, 2009).

Women with preschool children who do not feel supported in their roles as mothers or who are unable to express themselves in a supportive environment may be more vulnerable to depression (Erdwins, Buffardi, Louis, Casper, & O’Brien, 2001). Social support is crucial to adjustment and emotional confirmation in early parenthood and in marital or couple adjustment (Kiehl, Carson, & Dykes, 2007; Black & Lobo, 2008). Earlier, Mauthner (1999) interviewed women with young children (ages 12 months to 7 years) about their experiences with depression after having children. Their stories suggest that women who are able to accept the realities of their experiences, rather than their expectations of what it is to be a good mother, are less likely to suffer from depressive symptoms than women whose expectations of motherhood are unrealistic.

Mental health counselors can provide an optimum setting for women exploring their own needs, identities, and expectations during their journey as mothers. Social discourses of motherhood and sexuality are relevant at a variety of levels of clinical focus, and attention to power dynamics is a central component of feminist therapy (Rader & Gilbert, 2005). Clinical support that is nuanced for mothers of young children would address their unique concerns within the context of gendered socialization and gender roles.
FEMINIST-INFORMED MENTAL HEALTH COUNSELING

Feminist therapy developed in response to frustration with conventional, patriarchal methods of mental health counseling (Worell & Remer, 1992). Fueled by the feminist movement of the 1960s and 1970s, counseling evolved that emphasized the philosophy of feminism (Worrell & Remer). A core contributor to feminist counseling, Laura Brown, defines feminism as “the collection of political philosophies that aims to overthrow patriarchy and end inequities based on gender through cultural transformation and radical social change” (1994, p. 19). Such theory and practice embody questions about differentiation in sexual lives, the nature of male and female sexuality, the effects of oppression on female sexuality, the relationship between sex and gender, and how race, class, ethnicity, and religion affect the experience and perception of sexuality (Foster, 2000). Through the institution of marriage and the double standard of sexual morality for men and women, female sexuality has been restricted to areas sanctioned by our culture.

Issues of gender, power, and culture are at the core of feminist-informed therapy. Recent scholarship has addressed how gender intersects with other social categories, such as race, ethnicity, social class and sexual orientation (Bograd, 1999; Laird, 2000). Early feminist mental health counseling focused exclusively on women as clients and counselors; in contemporary feminist counseling both men and women are clients and counselors (Baird, Szymanski, & Ruebelt, 2007; Szymanski, Baird, & Kornman, 2002). Current explorations of female sexual desire and expression have sought to expand the opportunities for women to move beyond the restrictions of the culture; to give voice to the complexity of relationships, behaviors, and desires present in our daily lives; and to explore distinctions between gender and erotic desire. New approaches to feminist counseling incorporate frameworks that explicitly explore and deconstruct constraining cultural narratives that shape gender, sexuality, and the social contexts of relationships.

Feminist therapies are posited as gender-free (explaining differences only in terms of the socialization process, how one is raised); flexible (concepts and strategies can apply to individuals and groups regardless of age, race, culture, gender, or sexual orientation); interactionist (using concepts about thinking, feeling, and behavior that account for contextual factors); and employing a life-span perspective (assuming that human development is a lifelong process rather than fixed at childhood). Feminist counseling can be considered as informed by a set of principles rather than a particular theoretical treatment model. Such principles (partially drawn from Keeling, Butler, Green, Kruas, & Palit, 2010) might include:
• Overt acknowledgement and deconstruction of privilege and oppression (Leslie & Clossick, 1992)
• Collaborative relationships between therapists and clients (McGeorge, Carlson, Erickson, & Guttormson, 2006)
• Awareness of power dynamics in human relationships and institutions (McDowell & Shelton, 2002)
• Attention to the sociopolitical context of treatment (Foster & May, 2003)
• Critical examination of family therapy models and a critical stance toward discourse that supports oppression (Knudson-Martin, 2008)
• Curiosity about and belief in the revealed experiences of marginalization and oppression (McDowell & Shelton, 2002)
• Clients being expert on their own life and needs (Foster & May, 2003)
• Commitment to empowerment of the individual (Foster & May, 2003)

Corey (2008) says that gender is at the “core of therapeutic practice, that understanding a client’s problems requires adopting a sociocultural perspective, and that empowerment of the individual and societal changes are crucial goals in therapy” (p. 346). Throughout the lifespan, women negotiate various areas of oppression. A feminist lens in counseling emphasizes awareness of societal, cultural, and political messages so that feminist counselors can help clients, within the context of motherhood, to discover and uncover embedded expectations of the ideal mother. The role of motherhood is often fraught with a loss of control as women attempt to live up to unrealistic expectations. Because societal presentations of motherhood are often impossible to achieve, they lead to frustration and a shredding of women’s self-esteem and power.

A feminist-informed approach offers specific attention to sexuality and explores the centrality of “culture and conditioning to sexual life that has created identical sexual dysfunction categories for men and women, ignoring the social inequalities that are so crucial for understanding women’s sexual problems” (Tiefer, 2004, p.128). Because heterosexual erotic scripts are coitus-centered, a focus on erotic diversity may be useful to women and their partners as they renegotiate sexuality while coping with post-pregnancy changes and the requirements of parenting. The medical model of sexuality trivializes women’s socio-sexual reality and rarely highlights the pleasure of women (Tiefer, 2002). Feminist-informed counseling recruits women’s voices to explore their sexual selves as mothers within a relational and sociocultural context. Specifically, such a model differentiates between medical, mental health, and social/cultural models of women’s sexuality. The process identifies the medical and economic forces that shape our understanding of “female sexual disorders” and motherhood. Mental health counselor and client can explore the cultural, socio-economic, interpersonal, and psychological elements that shape women’s
relational and sexual concerns and presenting problems. Using a feminist lens, the counselor and client co-construct the elements of a nonmedicalized, social/cultural framework for women’s sexual concerns throughout their lives.

CASE STUDY

The following is derived from a composite of actual cases in which a feminist approach to counseling has been applied.

Regina is a White, married, 30-year-old mother of a daughter, 4, and a son, 2. She works part-time as a nurse. Her husband, 34, White, is a salesman and often works out of town. She began seeing a mental health counselor, Mia, a White female, three weeks ago. Regina’s presenting problems included anxiety about the balance of work and home life. In the early sessions, Mia and Regina created a written therapy contract that specified jointly created goals for the counseling relationship. Using everyday language, the contract stated such goals as exploring the expectations of motherhood and the power differential between men and women, and finding and empowering Regina’s voice and identity as a woman in her many roles.

A feminist therapeutic approach emphasizes decreasing the power differential between client and counselor and promoting an egalitarian relationship. Counselors who identify as feminist practitioners and their clients are both more likely to engage in power-sharing behaviors than counselors who do not identify as feminist practitioners and their clients (Rader & Gilbert, 2005). Collaboratively created contracts can help to demystify the therapeutic process. Regina will be encouraged to work alongside the counselor to learn more about herself and discover solutions to her unique situation, hopefully experiencing a supportive atmosphere in which she is empowered rather than rescued or oppressed. Through participating in an egalitarian relationship in the safety of the counseling environment, mothers as clients can empower themselves beyond the counseling setting.

Mia: Good morning, Regina. Last week, as we ended our discussion, you talked about persistent feelings of guilt. Can you expand some more on these feelings?
Regina: Well, I feel guilty about almost everything! Sometimes I dread going home because I anticipate everyone calling my name and asking me for something—and I feel terrible for having these feelings. I should look forward to seeing my family. I’m just so tired and want a moment of peace. Other mothers seem to be able to do it all—they seem to be smiling, not yelling at their kids like I do. I read in magazines and books about ways to be a better mother and I end up feeling like a total failure.
Mia: Dreading going home seems like an appropriate response when you’re exhausted and overwhelmed. I’m wondering about the guilt you feel and your ideas of what you think you’re supposed to be feeling or doing as a mother. What messages about being a mother have you received from these books and magazines? Do they seem realistic? Do they seem healthy for women? What might you tell new mothers that might be more accurate and helpful?
Feminist mental health counselors provide safe, supportive environments for women to explore their honest, unique feelings and their identities as women with young children. Attention is given to both women’s identities of the self and their identities within various environments, including family, friends, and the workplace. Their responses to their environments are viewed within the context of their subjective realities rather than in terms of abnormal responses or pathology. Here Regina’s individual story is valued and her feelings are viewed as a response to an oppressive environment. Together, Mia and Regina can explore the role of motherhood in a patriarchal society, giving attention to the oppression of women as they discuss the unrealistic societal expectations of motherhood, which can strip away women’s self-esteem and power. With an emphasis on autonomy and power, counselors working from a feminist therapeutic approach can help women achieve skills and a sense of control over their own lives (Morrow & Hawxhurst, 1998).

*Regina:* I always viewed myself as this strong, sexy, independent woman. I worked hard in my job, I worked hard to stay in shape, and I felt good about myself. Now I feel worn out and unnoticed unless someone needs something. Instead of a strong, sexy woman, I feel like I look like a harried, frumpy mom whose only purpose is to care for my family. I’m just not okay with the way I look now—my body should be in better shape … I should work out more … I should dress better. Where has my sexiness gone? Is this all I have to look forward to? I see these cute moms in their designer jeans and perfectly dressed toddlers and that’s not where I fit in either. I realize that may sound shallow, but the role of overworked mom was not what I signed up for. Maybe if being a mom was all I wanted in life, I might not care so much.

The role of gender is a core component of feminist approaches in mental health counseling. They give attention to the effects of societal oppression on women. Feminist counselors and clients may discuss how societal assumptions about appearance may conflict with reality and with their personal lives. Mia may encourage Regina and help her to explore societal messages about body image and women’s appearance and how she may have incorporated these messages and related expectations.

*Mia:* One thing you’ve mentioned is the lack of time you have for yourself. Many women work so hard to care for others that they neglect the time they need to refuel and take care of themselves. Even though I don’t have children, I often struggle with putting others’ needs before my own. I think that women have been socially conditioned to put others before ourselves. What are some of your personal desires for your life?

Mia demonstrates self-disclosure in revealing that although she is not a mother, she struggles in recognizing and fulfilling her own needs. Counselor self-disclosure is central to feminist mental health counseling; it is another way to reduce the power differential (Worrell & Remer, 2003). Mia also brings attention to the personal aspects of another core component of a feminist
counseling approach: the personal is political (Brown, 1994). Mia can help Regina begin to recognize the societal messages and expectations that oppress women by suppressing and neglecting personal feelings, needs, and desires and placing the needs of others before their own.

*Regina:* I’m not sure I even know any more what my own feelings are—I’m so busy just trying to hold it all together for everyone. I feel like guilt motivates me to do most things. I don’t think about what I want—I don’t even know what that is. And I feel like most of the time as a mom and wife, I do things based on what’s most likely to lessen these feelings of guilt. Some of it is so embarrassing. But after I had my second child, I felt like my sex drive just got sucked right out of my body. I used to love to dress up and go out on a date with my husband—I felt sexy and fun. I try to have sex to make sure my husband stays satisfied, but honestly, it’s like checking a box off of one of the thousand things I have to do each week. (Regina begins to cry silently.)

*Mia:* I know sex can be a difficult topic to discuss.

*Regina (crying):* I just never thought this would happen to me. I used to love sex. I loved how I used to feel. My husband and I had a good sex life. Now, I’m just so tired most of the time and I don’t feel attractive, my body has really changed. I feel like I have to fake it just so I won’t feel guilty about depriving him of sex. It’s ridiculous the things I do to avoid sex sometimes, and that makes me feel even worse. Like, I’ll pretend that I have to go downstairs to do some work, in hopes that my husband will fall asleep and I won’t have to lie there worrying about it. And when I go downstairs, I usually end up eating some kind of crap food or just sitting on the back porch in silence for a while. But, I always make sure we have some kind of sex once a week. For some reason, that’s my rule.

*Mia:* Can you talk some more about your fear of depriving your husband?

*Regina:* I guess I feel like that is what a good wife does—satisfies her husband sexually. Even though I may not be into it, I think the guilt would kill me if we didn’t do it once a week. I do love him. I’m just not that into it these days and I don’t like the lights on.

*Mia:* I hear you telling me about how your life has changed since having children. And some of those things that you’ve talked about are your feelings about yourself sexually. As women, our sexuality is a fluid process throughout our lives. For women with young children, the transition to motherhood is a change that can affect how they feel about their bodies, their sexuality, and their roles as individuals and as mothers. It sounds like you neglect your own needs in the area of sex, as well as other areas, in order to please others. As women, many of us have been conditioned by society to place others’ needs, especially men’s needs, above our own. Sex is one area where many women emphasize the pleasure of men rather than their own. I’m wondering if you feel comfortable talking to me about some things that have sexually pleased you in the past. Try to think about yourself as an individual here and try to push aside expectations of what you believe you are supposed to do.

*Regina:* I used to love taking a long bath with candles. And then relaxing in bed with my husband and talking and then having sex—but there was no pressure then, it was so natural.

*Mia:* So, a bath with candles and then relaxing in bed with your husband, without the expectation of sex, sounds pleasurable to you?

*Regina:* Yeah, I guess.

*Mia:* What are your thoughts and feelings about actually doing that—bath, candles, and time in bed with your husband without the pressure or expectations of sex? What would that look like to you?

As counseling continues, Mia encourages Regina to identify her own needs.
and desires. As trust and safety are fostered in the counseling relationship, Mia and Regina are able to discuss and integrate aspects of Regina’s cultural identity, including socioeconomic status, spirituality, and race. With Mia’s support and encouragement, Regina begins setting aside 15 minutes at night for her own quiet time and reconnection with her spirituality, something she once enjoyed but has ignored since the birth of her children. Counseling provides Regina with a safe place to explore her identity as a mother, a wife, and a sexual woman and begin to discover and define her personal wants and needs. Eventually, she is able to communicate her wants and needs to others outside the counseling relationship. Specifically, she begins to express her sexual desires to her husband and begins to set aside a few nights a month for dinner or coffee with her friends. With her friends, Regina begins to share things about herself as a mom, wife, and mother and discovers that many of her friends share similar stories. She experiences freedom and encouragement in discovering that many women experience similar insecurities and struggles, as mothers and as individuals.

Feminist counseling is well suited to helping mothers reconnect with their unique personal desires as they journey toward empowerment. Their knowledge and awareness of their own identities and their self-esteem may increase as they learn more about themselves and are able to define personal wants, needs, and strengths. A mother’s quest to define her own identity does not occur in isolation; it is connected to the quality of her communication. In the case of Regina, a lack of support or understanding of motherhood can stifle this discovery and may affect relationships with others. A woman may interpret a perceived lack of support to be a disregard or a misunderstanding of her role as a mother (de Marneffe, 2004). By exploring wants and desires with counselors, clients can better identify personal needs that may have been held dormant, and then communicate those needs to family and friends more effectively.

CONCLUSION

Feminist theory and its application to counseling argue that the social world is constructed on a premise of male superiority; that is, human relations are organized on the foundations of gender and the power asymmetries predicated on it. Sexual behavior and feelings encompass all the contradictions of these power relations; thus, the realities of sexual expectations and experiences throughout the life cycle, especially after giving birth, are constructed realities limited and controlled by the patriarchal power structure (Foster, 2000). Feminist mental health counselors recognize that because their own beliefs and values are present in their relationship with the client, openness about them is ethically necessary and creates the possibility of opening up dialogues within the family about topics that may have been ignored or suppressed. Unnoticed
or invisible social sanctions can inhibit discussion and restrain meaning-making on such complex topics as sexuality, sexual orientation, gender, and race. By articulating a belief that sexuality is central to family life, a feminist family therapist can incorporate the first step toward integrating a healthy approach to sexuality into the therapeutic process for mothers of young children and their partners. A feminist counseling approach encourages mothers to learn and embrace their identities as sexual beings and as mothers.

The approach outlined here can be applied by both feminist mental health counselors and counselors working from other theoretical approaches. Core principles of feminist counseling, such as an egalitarian, collaborative relationship with clients and knowledge and awareness of oppression and privilege, can help empower clients. Through supervision and consultation, counselors can become more aware of areas of oppression affecting clients. An increased consciousness of how unrealistic and idealized expectations of motherhood are presented in media and society will help counselors better understand the challenges for women with young children. Training and education about sexuality across the lifespan are essential to ethical clinical practice in any realm, especially when counseling vulnerable types of clients. Such training ideally addresses what is special, demanding, and unique about sexuality and its problems: the political, historical, and professional contexts of its enormously important and controversial subject matter (Tiefer, 2009). Despite an emphasis on pharmacology for treating sexual concerns, reducing guilt and anxiety is as necessary now as it seems to have been three decades ago. We recommend more attention to lifespan sexuality in counselor education programs and in professional development.

Research on sexuality during motherhood, especially when children are young, seems necessary. Studies of diverse groups of women that incorporate mixed methods can reveal both patterns of sexual behavior and the thoughts, beliefs, and lived experiences of mothers with young children. Such data would inform parent education and clinical practice to alleviate and even prevent sexual difficulties, enhance and strengthen couple relationships, and challenge oppressive messages and practices. Studies that assess the outcome of feminist counseling practices would clarify specific interventions and approaches related to the sexuality of young mothers.

Feminist models that take a couples or family approach and are particularly designed to address sexuality and motherhood can build on such data to promote more genuine humanistic and culturally diverse sex counseling/therapy that challenges sexist stereotypes, biologic reductionism, and the medicalization of the sexual concerns of both women and men.
REFERENCES


