SEX DURING BREAST FEEDING PERIOD

Sexuality and Breastfeeding

Having a baby transforms a couple into a family and surely represents one of the most significant transitions in adult life. Despite the temporary upheaval and increased stress and responsibility, most couples ultimately discover that parenthood brings a whole new dimension to their relationship that enhances their intimacy and strengthens their bond. At first, however, personal and couple time is crowded out by the pressing needs of the infant newcomer, who easily becomes the focus of the family. The unencumbered spontaneity once enjoyed by childless couples soon is replaced by the comfortable familiarity of their infant's daily schedule and predictable routines. Former exciting leisure activities give way to new compelling interests in baby matters-the quality of a breastfeeding, the magnitude of a burp, or the color of a bowel movement. A new mother, physically depleted at the end of the day, understandably might prefer a quiet evening at home over a night out with her partner. And weeks of nighttime feedings can make a little extra shut-eye seem more appealing than a romantic interlude with one's mate. Before long, the enormous demands of parenthood can lead to neglect of the marital relationship and create tension between the partners.

No generalities can be made about the impact of breastfeeding versus bottle-feeding on a couple's sexuality because individual differences vary so widely. After giving birth, women generally are advised to abstain from sexual intercourse until they no longer have bright red vaginal bleeding and they feel comfortable. Most couples resume sexual relations between four and six weeks postpartum and eventually manage to enjoy sexual intimacy at their same prepregnancy level.

Because extreme fatigue, depression, and preoccupation can diminish libido, it's not surprising that particularly exhausted or overwhelmed new parents often have little energy for sexual activity. Mothers with medical complications of pregnancy or delivery or those who have C-section deliveries justifiably may take longer to recover from childbirth. The frequent complaint of being "too tired" for sex is more common among new mothers than new fathers, since a disproportionate burden of infant care responsibilities are borne by women. Although breastfeeding gets more than its share of the blame for maternal exhaustion, the truth is that caring for a baby is very demanding, regardless of which feeding method is used. Many, in fact, would argue that breastfeeding is easier on a mother than formula-feeding.

Sometimes, fear of discomfort during lovemaking causes women to avoid sexual intercourse, and fear of hurting their partner makes men reluctant to initiate sex. Excessive vaginal dryness

(making intercourse more difficult) is a common complaint among breastfeeding women because estrogen levels are low during lactation. Your doctor can recommend a vaginal lubricant if this is a problem for you. Myths and misconceptions about the lactating breasts also can impact lovemaking. Men sometimes assume that when a woman's breasts are used to nourish a baby, they become off-limits sexually. A nursing mother's nipples may be less sensitive to sexual arousal. Other times, uncomfortable breast engorgement or cracked, painful nipples interfere with lovemaking. The intense physical intimacy of the nursing relationship leaves some breastfeeding women with little interest in their partner's sexual advances. With a baby at her breast much of the day, a woman might perceive additional physical contact as just one more demand on her body. Other women find that breastfeeding makes them more comfortable with and confident about their bodies, making them more sexually responsive than ever.

Breastfeeding is an integral part of the full cycle of reproduction. Lactation is not a random occurrence, but a predictable phenomenon that follows childbirth. The hormone oxytocin, which triggers the milk ejection reflex, is the same natural hormone that causes uterine contractions during labor, that shrinks the uterus back to its normal size after delivery, and that produces uterine contractions during sexual intercourse. Since breastfeeding and sexuality are seldom discussed in our society, most couples discover quite by accident the startling connection between orgasm and milk ejection. As a woman climaxes during lovemaking, oxytocin is released and milk spontaneously sprays from her breasts as an amazing reminder of the inextricable link between the sexual and nurturant roles of the breast.

When a woman is lactating, it is only natural for her partner to fantasize about suckling her swollen breasts and tasting the milk. I suspect that most partners do attempt to nurse from their mates during lovemaking and that doing so enriches the couple's intimacy. However, some women feel overly protective about their breasts when they are nursing a baby. A woman may fear that her husband's mouth will contaminate her nipples, that he may steal milk from the baby's next meal, or that his attempts at nursing will prove uncomfortable for her. These concerns are generally unfounded.

Despite your inevitable exhaustion and preoccupation with your new parental responsibilities, I urge you to make time for being intimate with your partner on a regular basis. At a time when your couple relationship is undergoing so much change, maintaining an active sex life will help preserve and strengthen the love bond between you. While spontaneous romance is a nice ideal, many contemporary couples find it useful to schedule time for sex just as they schedule other priorities in their life. Make a bedroom date with your mate. Choose a time when your baby predictably sleeps soundly. Then plan ahead to be as rested and renewed as possible so you will be able to focus on your partner and on giving and receiving pleasure.

How to tackle and enjoy sex for the both

by M. Sara Rosenthal Ph.D.,
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WebMD Medical Reference from "The Breastfeeding Sourcebook"

Breastfeeding is a powerful hormonal process that affects more than just your breasts. Although most parents find that their sex lives change after the birth of a baby, breastfeeding mothers may notice some specific changes. Heather Kritzinger, a La Leche League Leader in Etobicoke, Ontario, says that breastfeeding women may experience some or all of the following:

- **No periods.** You may not have a period for several months after the birth if you're breastfeeding exclusively and frequently. During this time breastfeeding offers some protection against pregnancy but it's not foolproof. You may ovulate before your first period after the birth. If you don't want to get pregnant again, talk to your doctor about birth control.
- **Ouch.** Breastfeeding nipples can be tender and sore at first, or they may be less sensitive than usual.
- **Go gently.** Reduced libido, vaginal dryness and a longer arousal time are common among breastfeeding women, especially at first. Sound exciting? A lubricating gel - and a little patience - can help.
- **Flood warning.** Letdowns and/or milk ejection can occur during sex and at orgasm, especially in the early weeks. Feeding the baby or expressing some milk before making love may prevent this.
- **Keep talking**. Remember that although any changes to how you respond sexually will be obvious to you, they won't be to your partner. Let him know what feels good - and what doesn't - and be prepared to experiment. It may be a truism, but good communication really is the key to rediscovering a satisfying sex life
- **Try other sexual positions.** If you find your breasts are sore or you have sudden leakage if your breasts are touched, you may want to consider alternatives to the missionary position. Woman on top, spooning and hands-and-knees positions may be more comfortable.
- **Avoid having your breasts fondled.** If your breasts are sore or you're worried about sudden leaking, talk to your partner about not touching your breasts during sex or foreplay.
- **Consider wearing a bra with nursing pads in place.** Oxytocin is the hormone that helps control your milk ejection reflex. Oxytocin is released during female orgasm, meaning that you may leak milk during sex. Sometimes this leakage is quite sudden, and may be a lot of milk. If you're worried about surprising your partner or messing up your sheets, consider wearing a bra with nursing pads.
- **Use a lubricant.** With your body busy making breast milk, you may experience a shortage of vaginal lubrication. A water based lubricant should ease any discomfort for you and your partner.

- **Be patient.** Many women feel 'touched out' when nursing every couple of hours. You may not want to have sex, or might be too exhausted and overwhelmed to think about sex after the birth of your baby. Communicate with your partner-many men express affection and comfort through sex. Let your partner know how you're feeling and find other special ways to convey how important he is to you.
- **Consider using contraception or natural family planning.** It's important to try not to get pregnant for about a year after you deliver. Your body needs a chance to recover from pregnancy, and you need some time to enjoy your baby before occupying yourself with another pregnancy. You may have heard that breastfeeding is a natural contraceptive. While it is true that breastfeeding can help prevent pregnancy, this form of birth control is unpredictable and has high failure rates. Consider using a condom or other barrier method. If you don't want to go on the pill, talk to your care provider about using a light hormone birth control. If you want to use a natural contraceptive technique, conduct some research on how to determine when you start and finish ovulating.
- **Wait around six weeks after you deliver to have sex.** This is important for a few reasons. First, the perineum (vaginal area) needs time to heal from any stitches, tearing, or soreness resulting from delivery. If you have sex too soon, you could damage your perineum, causing infection and further damage to this sensitive area.

Second, when the placenta separates from your uterus, it leaves an 'open wound' inside your uterus. This wound is no cause for concern (a great deal of your postpartum bleeding comes from this wound), but your body needs time to recover and heal. For this reason, it's important to avoid douching, sex, tampons and menstrual cups for about six weeks after you deliver. Your goal is to introduce nothing that can cause an infection. However, some care providers will waive the six week minimum; if you experience strong sexual desire before the six weeks expire, check with your care provider.

Arousal, Orgasm and Breastfeeding

The Role of Oxytocin

Possibly because childbirth has historically not been under the control of the medical profession, there are many important experiences of childbirth and postpartum that haven’t made their way

into the medical literature.

Many women who breastfeed have the experience of feeling aroused, and even having an orgasm, while breastfeeding. But because this is something researchers haven't studied, and it isn't a regular part of the education of mothers-to-be, many women experience this and then feel silent shame or guilt, as if there is something wrong with them. But there is a very clear reason for the experience and women neither need to feel shame or embarrassment about it which is caused mostly by a lack of information.

Oxytocin is a hormone that stimulates ejection of milk from the nipples, and its release is triggered by breast stimulation. But oxytocin is implicated in many other physiological processes. It is involved in contractions of the uterus (both during childbirth and during orgasm), as well as being associated with the feeling of relaxation and satiation following orgasm.

It is thought that this is the reason that breastfeeding may produce feelings of sexual arousal and orgasm. And the experience is far from rare.

In a 2000 study of breastfeeding women, 40.5% of the participants reported feeling sexually aroused at some point during infant suckling. 16.7% reported being aroused frequently during breastfeeding.

Source:
Avery, M.D., Duckett, L., Frantzich, C.R. "The Experience of Sexuality During Breastfeeding Among Primiparous Women." *Journal of Midwifery and Women's Health* Vol. 45(3), 2000: 227-236.

While women have long shared stories of how breastfeeding changes their sex lives, researchers have been slow to investigate the specific ways that breastfeeding impacts women's sexuality. A 2000 study published in the Journal of Midwifery and Women's Health was the first to focus solely on this important topic.

The study surveyed 576 women who were breastfeeding their first child and followed them up to twelve months postpartum. While the study is limited due to the narrow group of women involved (most were white, and all were from a private hospital in an urban center) it still offers some important information about the experience of breastfeeding women and their partners when it comes to sex.

The first thing researchers discovered was that there are few, if any, generalizations to be made about the impact of breastfeeding on a woman's sexuality.

Women's responses varied widely, and rarely was there a majority experience. About half of the respondents reported a decrease in sexual interest and about half reported no decrease. The same split was found for women reporting changes in sexual activity.

One of the only generalizations researchers found was that sex is important to women postpartum. 71% of the women surveyed said that it was important to them that sexual interest return soon after having a baby.

Through their review of the literature and their own research, the authors outlined the variety of ways that breastfeeding can impact a woman's sexuality:

Physical changes that may impact sexuality:

- Changes in breast size and tenderness
- Healing perineum or abdomen after a vaginal or cesarean birth
- Milk leaking during arousal and sex play

Hormonal changes that may impact sexuality:

- Breastfeeding is associated with increases in prolactin and oxytocin, and decreases in estrogen all of which can have varied impacts on desire, arousal, and orgasm
- Decreased estrogen usually causes decreased vaginal lubrication which can impact sexual behaviors.

Fatigue:

This was the reason most commonly given for a decrease in sexual activity after the birth of a child. Fatigue can both impact sexual desire as well as overall sexual self-image.

For some women, however, it's really not necessary to set an appointment -- at least, not right away. That's because women with no report of sexual troubles before the birth may simply be at the effect of prolactin. Sometimes a little information is all thatâ€™s needed -- that and some patience.

So, here's that information: Prolactin is the hormone that causes breast feeding to happen. It is also a hormone that decreases sexual interest. It is nature's way of trying to put some space between the birth of one child and the arrival of the next. This allows the first child to get some needed nurturing before another one vies for that same kind of attention. Since many women try to breastfeed for two years, it's not uncommon to find children spaced about two years apart

(though some child psychology experts with whom I've consulted have recommended three years for the benefit of the eldest child and for the mom who then gets a bit of a break).

So, women who are breast feeding have a natural impediment to having sexual interest. It does not mean that all women will feel this way. But, most do find the thought of sexual contact tough to manage, particularly when they couple the effect of prolactin with getting only four hours of sleep in a row day after day.

Prolactin does not drop back to pre-pregnancy rates the day that breast feeding stops. It may take some time. If, after a few months of no breast feeding (and decent amounts of sleep) a woman does not have an increase in her sexual desire, she can have a prolactin blood test to see what her level is. A physician may recommend treatement with Dostinex (cabergoline) if the level is abnormally high. Of course, it's always wise to see how the couple is doing in their overall relationship since that can have an effect of sexual desire as well.

Don't short-circuit breast feeding. Pediatric experts agree that breast feeding is a pathway to strengthening infant health. I do recommend that couples understand that for the sake of their child, they should adjust their sexual expectations and widen the playing field to allow many sexual options as part of their sexual relationship.

Partner’s attitudes:

. While breasts serve an obvious function they are discussed more in the West as a sexual object to be “prized” in particular by male partners. Increased breast size, and milk production and expression (which often happens during sexual arousal) can impact the way a partner perceives their breastfeeding partner. These attitudes can have an impact on how a woman who is breastfeeding feels about herself.

Social attitudes:

Most women experience the sexualization of their breasts at some point in their lives. It’s inevitable given a culture that is, arguably, breast obsessed. When the breasts change in function and size, some women will experience a change in social attitudes as they breastfeed, particularly when they breastfeed in public, and these attitudes can also have an impact on the way a woman feels about herself sexually.

WHEN YOU WANT TO MAKE LOVE, NOT MILK

Your sex life changes after the birth of a baby regardless of whether you're breastfeeding or not. The origins of this change lie principally in a change in *lifestyle.* Because you're more fatigued, it may take time before your prepregnancy libido returns. As you may have noticed by now, looking after a newborn involves twenty-four-hour shifts, with little or no sleep. Suddenly there's this connection to your baby that creates an overwhelming sense of communion and caring, a feeling for which many women are unprepared.

As discussed in chapter 1, prolactin, the "mothering hormone," actually creates an emotional feeling of "mothering" that is quite physical. As a result, this feeling can consume your emotional psyche, leaving little or no room for sexual desire. Some women compare the mother-newborn bond to falling in love; everyone else in your life gets "dropped" as you become preoccupied and even obsessed with your baby's welfare. If this description sounds familiar, you're right on schedule. Every mother goes through this; every new father must learn to adjust. A little honesty, sensitivity, and communication goes a long way.

Many experts interpret this mother-newborn connection as an evolutionary device that helps protect the human race. In other words, your feelings for the baby are a biological trait designed to maximize the chances of the baby surviving. Any decrease in sexual desire acts as a natural contraceptive that contributes to better child spacing, while women who may experience no decrease in libido will benefit from a natural period of "lactational amenorrhea" (LAM), or "no menstrual cycle when you're exclusively breastfeeding," which generally lasts at least six months.

While breastfeeding does play its part as a contraceptive, it is not 100 percent reliable; many women who thought so have the children to prove it. If you're experiencing a decrease in libido, chances are it will return to normal once you begin menstruating again. Estrogen levels will increase when your ovulation cycle returns, which will contribute to vaginal lubrication during intercourse. Androgen levels (small amounts of male hormone all women secrete) will also begin to rise when you resume ovulation, which will engage your libido. But there are many other lifestyle and social factors that can affect your libido that have nothing to do with ovulation.

Your Postpartum Physique

Childbirth practitioners advise that even with a normal vaginal delivery, intercourse should be avoided for about four to six weeks, since your cervix is wide open at this point and vulnerable to bacteria. Moreover, if you had a cesarean section or episiotomy, you *must* heal properly to avoid extreme pain or ripped stitches. Until intercourse resumes between you and your partner, the two of you can manually or orally stimulate each other.

When you begin having intercourse again, it will not be the same as it was prior to the pregnancy. First, prolactin, which inhibits estrogen, will not only reduce your libido but may interfere with vaginal lubrication. In fact, dryness is one of the most common symptoms during menopause due to estrogen loss. This means that you may need to use saliva or a synthetic lubricant for greater comfort during intercourse. You may also need to adjust your positions to accommodate a sore perineal area. Lying on top of your partner or using a side-entry position are options worth considering, because they allow you to insert the penis at your own speed.

A drastic change in your postpartum physique may be caused by a very stretched out vagina. Childbirth does stretch the vagina; it never returns to its nice, taut, prepregnant tension. This may dramatically change the sensation for you and your partner, as the grip will not be as tight as it once was.

Don't despair, however. Kegel exercises (contracting the muscle that starts and stops your urinary stream) and abdominal exercises will help to tighten things up, as well as improve your body image. Some of these exercises may not be possible until your stitches from various procedures have healed, but many women report excellent results and are able to regain their grip quite nicely.

If you're having difficulty with grip and "internal belly dancing," to simulate a tighter vagina, sex counselors suggest what I call the "grip trick." This involves getting into a "hands-free" intercourse position and manually closing your vaginal lips around the base of the penis during thrusting. This will improve matters tremendously. As frustrating as your new vagina may feel to you, please don't *ever* consider surgery to "snug it up" unless there's a very good medical reason.

Go with the Flow

Some breastfeeding women may find that their milk lets down during orgasm and sometimes during foreplay (particularly if your partner is stimulating your breasts). Careful planning should take care of this problem—if in fact it *is* a problem. Either make love after a feeding or express or pump your breasts prior to lovemaking. Of course, many men enjoy and accept the letdown as a natural part of things. Attitudes range from fascination with the letdown to actually tasting the milk. You and your partner must simply make the necessary adjustments that meet your level of comfort and discretion. It may help to apply firm pressure with a towel to "shut off" letdown. (Shutting off letdown is discussed in chapter 4.)

A Word about Breastfeeding Arousal

As you may know or may have heard, you can get sexually aroused when you breastfeed. Nursing releases oxytocin, the hormone that causes both letdown and uterine contractions. Oxytocin is also released during orgasm. Don't be embarrassed by this or feel as though you're a sexual deviant. Many women feel the need to masturbate (or have sex with their partners) after nursing. Many women are also aroused by the stimulation of their nipple—which is, after all, a sexual organ, too. Finally, breastfeeding may make you feel fabulously feminine and maternal, which many women find a turn-on. The worst thing you can do is deny yourself these feelings. Pregnancy, childbearing, and feeding are all *sexual* processes that may wake up every sexual impulse within you. In fact, the arousal women feel from breastfeeding may be *why* breastfeeding was unpopular in the more conservative and "retentive" years of the 1950s and 1960s.

Many women also report that they feel a heightened sense of sexual responsiveness when they're breastfeeding. The "mothering" feelings seem to take over in bed as well, creating a deeper bond with their partners.

MILK AND EGGS

A key factor in your sex life while you're breastfeeding has to do with your fertility. How long does it take for your ovulation cycle to return? That depends on how exclusively you're breastfeeding. In cultures where women exclusively breastfeed for at least a year, children are naturally spaced two or three years apart. If this is true, what do we say to women who assumed breastfeeding canceled out ovulation and became pregnant only a few

months after the birth of their last child? As more research into the contraceptive effects of breastfeeding continue, the mystery is beginning to unravel.

On the LAM

Lactational amenorrhea (LAM) is considered to be an effective form of natural birth control if you had your baby less than six months ago, have not experienced any vaginal bleeding after your fifty-sixth postpartum day, and you're exclusively (or almost exclusively) breastfeeding, in that you're nursing more than every four hours by day and every six hours by night. Research shows that LAM is 98 to 99 percent effective in women who meet these criteria. Once you supplement the baby with other liquids or solids, however, or skip nursings without replacing them with a pumping/expressing session (which may happen once the baby begins to sleep longer through the night), LAM no longer offers this level of protection, and a backup method of birth control is recommended. In addition, if your baby is not latched on properly, LAM will also not be reliable.

The 2 percent failure rate of LAM accounts for the fact that no contraceptive method is 100 percent reliable. Individual differences in ovulation patterns do occur, and sometimes, even if she is a model LAM candidate, a woman may still get pregnant.

The Period Question

For the majority of you, the contraceptive effect of breastfeeding is directly related to how exclusively you're breastfeeding. Therefore, your periods will return faster if you:

- have a poor latch;
- supplement your breastfeeding with formula or other liquids;
- miss nursings for any reason;
- wean your baby partially prior to six months.

This explains why some women who breastfeed remain infertile for only a few months, while others remain infertile for more than two years.

Women in North America who are not ideal LAM candidates can usually expect their periods to return as early as three months after childbirth to as late as twelve months after childbirth. The addition of solids, bottles of juice, or formula supplements to the baby's diet will bring your periods back faster. In addition, as the baby matures and begins to sleep for longer stretches at night, the contraceptive effects of breastfeeding will further diminish. In one study, researchers found that going six hours or more between feedings and nursing fewer than five times per day were associated with the return of fertility.

When nursing is unrestricted, far more time will pass before the period returns. Sheila Kippley, in her book *Breastfeeding and Natural Child Spacing,* reports that women who practiced total, unrestricted breastfeeding did not see their periods return until an average of 14.6 months after childbirth.

Your own body chemistry has something to do with fertility, too. For example, in the same way that the menstrual cycle varies in terms of days and flow for each woman, so does your body's ability to "bounce back" after childbirth. In other words, women who do nurse exclusively often see their periods return within six months anyway, while women who supplement feedings and partially wean can sometimes wait two years between pregnancies.

Ovulation without Periods

Often ovulation resumes without your knowledge, as is the case with "silent ovulation." Here, a follicle (what an egg is called in its first stage of development) develops from your ovary but never undergoes the physiological and hormonal changes that turn it into an egg. The normal levels of estrogen necessary to build up a uterine lining never occur, while similar levels of progesterone necessary to sustain a pregnancy don't occur either. The result is that you ovulate without ever experiencing a period or a pregnancy.

In other cases, you can get pregnant during your first postpartum ovulation—and also never experience a period. Since ovulation occurs midcycle and menstruation at the end of your cycle, if you get pregnant during your first postpartum ovulation, you will not get your period. In fact, according to a 1982 study in Chile, roughly 2 in 100 women get pregnant within six months

of childbirth without experiencing a period.

The Warning Period

The reverse can also occur. You can get a period but not be ovulating yet. This is often the case with the first menstrual period after childbirth, which has been dubbed the "warning period." Here, low, "leftover" levels of estrogen and progesterone (from pregnancy) have caused the uterine lining to build up and shed but have not yet caused your pituitary gland to release FSH (follicle-stimulating hormone), the sex hormone that signals your ovary to spit out a follicle. After such a "warning period," you'll need to practice contraception unless you don't mind getting pregnant again; this is a sign that the fertility goddess is about to visit you. But don't count on a "warning period"—you might not get one.

When Infertility Persists

Sometimes even some suckling is enough to prevent ovulation. In this case, if your child is older than two and you want to get pregnant again, you may need to completely wean your baby before your cycle returns. It's also possible, however, to experience what's known as secondary infertility. Women who had no trouble getting pregnant with their first child can be plagued by infertility when trying for their second. The causes of secondary infertility range from age (the older you are, the less likely you are to get pregnant) to conditions that often manifest after a first pregnancy, such as pelvic infections that can inflame your fallopian tubes (caused by bacteria entering the cervix during or after childbirth or by various STDs), endometriosis, or male-factor problems. If you're not menstruating, however, this is indeed a hormonal problem that warrants a fertility investigation. If you're menstruating but are still unable to conceive, you and your partner should undergo a full fertility workup with an appropriate specialist. (For more details on infertility, consult my book *The Fertility Sourcebook*.)

Can You Stop Your Periods?

Yes. If your baby begins suckling on your breasts for longer periods of time, your ovulation cycle may become inhibited again. In fact, while your periods may return, they may be irregular until you've stopped breastfeeding altogether. Sudden increases in breastfeeding can occur if your baby is ill

and nurses more frequently (discussed in chapter 8), or if you're donating breast milk to a friend and are nursing as well as expressing milk.

Will Periods Affect Milk Supply?

Not only can prolactin inhibit estrogen levels, estrogen can inhibit prolactin levels, causing a slight reduction in milk supply during menstruation. Once your period is over, however, the milk supply bounces right back.

CONTRACEPTION DURING BREASTFEEDING

Abstinence is the only 100 percent way of preventing pregnancy. As discussed above, even if you're exclusively breastfeeding, do not assume that pregnancy is completely preventable unless you don't mind getting pregnant again. Childbirth practitioners recommend spacing your children at least two years a part to give your body a chance to recover from the previous pregnancy. If you're breastfeeding exclusively, it's usually safe to assume at least one to two months of freedom from pregnancy, since it takes at least six weeks for ovulation to resume when you're *not* breastfeeding.

Fortunately, many contraceptive methods are available to breastfeeding women. The only contraceptive that is out of bounds is the combination oral contraceptive (OC) pill. The combination OC, although containing low doses of estrogen, can nonetheless cause changes in the quantity and composition of your milk. As discussed above and in chapter 1, estrogen inhibits prolactin, and vice versa. There is also a risk that the estrogen excreted through your milk could have negative effects on the baby. But you can still take hormonal contraceptives in the form of *progesterone-only* preparations, which can be taken orally, implanted subdermally (under the skin), or injected. Progestin (a synthetic form of progesterone) used alone is also effective because it alters the consistency of your cervical mucus, making it thicker, and causes the lining of your uterus to thin out, thereby discouraging an embryo to implant. Ovulation is also suppressed when the progestin is used for several months.

Of course, barrier methods—diaphragms and gel, cervical caps or sponges, and male and female condoms (the latter not available in Canada) with foam—are alwalys safe and effective.

If you don't want any more children, you may be an excellent candidate for tubal ligation, also known as permanent contraception; similarly, your partner may be a candidate for a vasectomy. Discuss these options with your doctor.

Progesterone-Only Contraceptives

The most popular form of progesterone-only contraception is the "minipill," an OC that has progesterone but not estrogen. Since 1991, however, progesterone-only contraceptives have also been available in North America in a subdermal (under the skin) form, called Norplant, and an injectable form, called Depo-Provera. Norplant and Depo-Provera may be more reliable because they eliminate human error. Currently, Norplant is considered to be comparable with sterilization in terms of effectiveness. In addition, progesterone-only contraception is safe not just for breastfeeders but for women who smoke or have other risk factors that prevent them from taking estrogen.

To use Norplant, your doctor inserts six silicone rubber matchstick-size capsules that contain the same progesterone compound used in both the minipill and the combination OC. The capsules are inserted under the skin of your upper arm. Once in place, they steadily release a low dose of hormone into the bloodstream to prevent pregnancy. Norplant, which can be inserted six weeks after delivery, does not interfere with breastfeeding. If your periods have returned, Norplant should be inserted either during your period or no later than the seventh day of your menstrual cycle. Norplant is effective within twenty-four hours after insertion, and the one insertion keeps working for three to five years, depending on which system you've opted for.

Each Norplant capsule is about one-tenth of an inch in diameter, and just under one and a half inches long. It holds 36 mg of the synthetic progestin levonorgestrel, in the form of powdered crystals. The permeable tubes are made of Silastic, a silicone material through which the hormone seeps into the bloodstream, initially at a rate of about 85 µg a day. The amount declines gradually to about 50 µg by nine months, 35 by eighteen months, and about 30 µg at the end of five years. In comparison, the minipill releases about 75 µg of levonorgestrel a day. When the capsules are removed, fertility is restored five to fourteen days later. No side effects have been reported in children conceived after Norplant removal. (Although the product

is still too new for this data to be compiled.)

Depo-Provera, which the FDA approved in October 1992, is an injection that works exactly the same way as Norplant, as a "time release" progesterone. One injection of Depo-Provera in the muscle of the arm or buttocks protects you against pregnancy for three months. The active ingredient in Depo-Provera is, again, a synthetic progestin hormone. Both Norplant and Depo-Provera are considered 99 percent effective in preventing pregnancy. To get started with Depo-Provera, you'll need to wait about six weeks after delivery, but it may take at least ten months off Depo-Provera before you can conceive again.

What Are the Side Effects?

The most common side effect of progesterone-only contraception is menstrual-cycle irregularity and irregular bleeding. The bleeding irregularities result from the continuous hormone release and the subsequent thinning of the endometrium. Basically, when there's no thickened lining to be shed, no shedding takes place. With combination OCs, on the other hand, estrogen and progesterone are taken for three weeks and withdrawn for one week, causing *regular* bleeding.

Using Norplant as an example, over a five-year period of use, about 45 percent of Norplant users will have irregular periods, and another 45 percent will have normal periods. The remaining 10 percent will have long stretches of time (three to four months) with no bleeding. Usually, the number of days of menstruation increases, while the flow decreases. In the first year, about 70 percent of users will experience changes in their menstrual cycle. If you're on Depo-Provera, it's common not to have any periods at all, but once you go off, your menstrual cycle returns.

The usual pattern is to have irregular periods in the first year on progesterone contraception, with regular periods developing with longer use. So if you're using this form of contraception, chart your periods; if you go longer than six months without one, ask your doctor if you should continue using this form of contraception.

Other side effects reported include headaches, nervousness, depression, nausea, dizziness, skin rash, acne, change of appetite, breast tenderness (which probably won't happen as long as you're breastfeeding), weight gain,

ovarian cysts, and excessive growth of body or facial hair. Breast discharge (in nonlactating women), vaginal discharge, inflammation of the cervix, abdominal discomfort, and muscle and skeletal pain are also reported.

It's important to note, however, that many of these latter side effects are also common *general* complaints, and have not yet been linked specifically to progesterone, as the irregular bleeding has. The most common reason why women discontinue progesterone contraception in the nonlactating population is because of irregular bleeding. But if you're lactating, this shouldn't be a problem, and any bleeding would be very light. Keep in mind that more women have difficulty with combination OCs than progesterone-only forms.

Barrier Methods

If you're planning to employ a barrier method, use condoms without spermicide until six weeks after delivery. Spermicide can enter a dilated cervix and cause irritation. Then you can graduate to a barrier method such as a diaphragm, cervical cap, or vaginal sponge.

Diaphragm

If you already have a diaphragm, put it away now! *You need to be refitted for a new diaphragm following childbirth.* For those of you who have never used a diaphragm, it's a dome-shaped cup with a flexible rim that fits over your cervix and rests behind your pubic bone. It looks like a tiny rubber flying saucer. Inserted before intercourse with spermicide, it blocks the sperm from entering the uterus through the cervix. The failure rate ranges between 10 percent to 20 percent. This is considerably higher than hormonal methods, but much of the failure has to do with improper use and insertion. Diaphragms come in different sizes and styles. You'll need to be fitted for one by either your family doctor or gynecologist. Once you're fitted, you'll be given a prescription, and you can purchase the diaphragm at any drugstore. Then you'll need to go back to your doctor and be shown how to use it yourself. Sometimes you'll need a plastic inserter, sometimes you won't. Go home and practice and see your doctor one more time before you use it, to determine that you're putting it in correctly. Before recommending a diaphragm, your doctor most probably will perform a pelvic exam to make sure that you don't have any physical abnormalities that would prevent you from using one in the first place. It's important to get a diaphragm that fits

well; if it's too small, it will expose the cervix, if it's too big, it will buckle. *Get refitted if you've gained or lost more than five pounds, had pelvic surgery, or had another child or abortion or miscarriage.*

Your diaphragm shouldn't interfere with normal activities. Urination or bowel movements shouldn't be affected, and you should be able to bathe and shower normally. If it is interfering with these activities, it may not be in properly or could be the wrong size.

Cervical Caps

Like diaphragms, cervical caps must be refitted after childbirth. The cervical cap is a small, thimble-shaped cap that blocks only the cervix and not the entire upper part of the vaginal canal the way a diaphragm does. The cervical cap thus serves as a "minidiaphragm" with a tall dome. Simply insert the cap with your forefinger and place it over the cervix yourself. About 6 percent of cervical-cap candidates will not be able to find one that fits (shorter or longer cervices are a problem, apparently).

Bad Ideas

If you value your future fertility and general health, stay away from IUDs (intrauterine devices). IUDs are the second-highest cause of pelvic infections, something to which the postpartum woman is vulnerable anyway. IUDs are also associated with secondary infertility, and can cause heavier cramping and flow during your periods. If you *really* want to use an IUD at this stage, discuss the risks with your doctor and be sure you're making an informed decision.

You should also practice safe sex (i.e., wear a condom) if you're not in a monogamous relationship. In addition to AIDS, you can contract a range of STDs that could affect your future fertility. Either the male or female condom (approved as of 1993) will protect you from STDs.

(For more detailed information on these contraceptive methods, consult my book *The Gynecological Sourcebook*.)

BREASTFEEDING DURING PREGNANCY

If you get pregnant while you're still breastfeeding, there's no real reason to

stop breastfeeding unless you want to or are experiencing physical complications (discussed below) that warrant weaning. In this situation, many women feel torn between what they think they *should* do and what actually feels right to them. While in North American society, continuing to breastfeed during another pregnancy isn't seen very much, it's a common practice in most countries, particularly developing nations. Often the best decision is not to decide and to simply follow your intuition. For example, you may breastfeed for part of the pregnancy and then wean in a later trimester. In fact, sometimes your baby will begin to self-wean at some point in the second trimester, because the taste and consistency of the milk changes. In addition, hormonal changes will probably affect your milk supply. Estrogen, which normally inhibits prolactin, is released at high levels during pregnancy and may cause a cutback in milk production.

Nutrition Matters

If you're planning to breastfeed during your pregnancy, good nutrition is important for all three of you: your nursing baby, your developing baby, and yourself. The best plan is to see a nutritionist and work out a realistic menu that suits your lifestyle and cultural cuisine. Even if your baby is over a year old, as long as you're eating well you shouldn't have any difficulty nourishing the child outside your womb and the child within. Adequate rest and gaining the right amount of weight are also important factors to consider. For example, if you're eating well but seem to be losing weight throughout the pregnancy, this is a concern. Sometimes consuming extra calories—above the recommended intake during pregnancy—is necessary. In addition, you may need to take extra vitamin supplements. Other times, weaning may be necessary if you can't seem to keep your weight or energy up.

Contraction Action

Because you're still breastfeeding, you will probably experience more uterine contractions than do pregnant women who are not breastfeeding. Nipple stimulation will still trigger oxytocin, which will continue to cause your uterus to contract, regardless of how pregnant you are. Generally this is not a problem, even though it sounds like one. Remember that uterine contractions also occur during sexual activity, which most couples continue during pregnancy too.

If you have a history of premature or false labor, make sure you inform your

doctor that you are still breastfeeding. In this case, contractions caused by breastfeeding may interfere with your pregnancy. Moreover, uterine cramping or bleeding is a signal that something's wrong and warrants medical attention. In this case, you may have to stop breastfeeding until after the birth of your new baby.

Feeling Pregnant, Feeding Pregnant

Breastfeeding during pregnancy may be more difficult if you're really *feeling* pregnant! The range of pregnancy symptoms women experience, from nausea to back pain, may make you rethink your weaning decision. In fact, breastfeeding can aggravate certain pregnancy symptoms.

Morning Sickness

Your nausea may intensify when you're breastfeeding. In some cases, the physical process of letting down aggravates nausea, while in other cases, finding a position for the nursing child is the more likely trigger. Nausea, however, will not magically vanish just because you wean; it may simply be an inevitable symptom that plagues you regardless of your breastfeeding decision. Since it's important to eat well if you're breastfeeding this time around, see your doctor to discuss ways to combat severe nausea. In some cases, you may need to wean if you are not able to keep anything down. (For more information on morning sickness, consult my book *The Pregnancy Sourcebook.*)

Nipple Soreness

Remember when chapter 7 pointed out that some causes of nipple soreness are due to another pregnancy? Well, it's still true. Just as you experienced breast changes and nipple tenderness in your previous pregnancy, your next will be no exception. In fact, if nipple soreness persists and you've ruled out infections, weaning may be the only solution. (See chapter 7 for more information on nipple soreness.)

Moodiness

Apparently, it's very common to feel irritated, restless, and just plain antsy when you're breastfeeding during a pregnancy. No one really knows why this occurs, but it's important to be aware of these feelings. This may be nature's

way of protecting the fetus or may be caused by a cross-circuiting of pregnancy and breastfeeding hormones. If these feelings interfere with breastfeeding, it may be time to wean until after the birth.

New Taste, New Product

Due to hormonal "staff changes" beyond your control, your milk will change in taste, quantity, and consistency. For example, during the last few months of pregnancy, the mature milk changes back into colostrum in preparation for the birth of another newborn. Some nursing toddlers don't mind the taste; others get really turned off. If your toddler doesn't mind the new flavor and consistency, there's no reason to stop breastfeeding. And no, your toddler will not exhaust your colostrum supply. You'll just make more.

As discussed earlier, all that estrogen coursing through your system will lower prolactin levels and hence your milk supply. That's why estrogen containing contraceptives are discouraged. If your nursing baby is younger than a year and is breastfeeding exclusively, this decrease in milk production could affect that child's nutritional needs. Make sure you're keeping track of weight gain, wet diapers, and bowel movements. You may need to supplement your breast milk. (See chapter 6 for more details.)

The decrease in your milk may also cause your nursing child to self- wean. The process is gradual and natural, and the child will simply show more interest in other foods and liquids.

A common scenario to prepare for is one in which a nursing child who has self-weaned suddenly develops an appetite for breastfeeding once the new baby is born. At this point, you can decide whether you want to breastfeed the older child for comfort and supplementary nutrition. If you decide to breastfeed both children, or *tandem nurse*, read on.

TANDEM NURSING

Tandem nursing is often confused with breastfeeding during pregnancy, but it refers to breastfeeding two or more of your children when they're at *different* ages. In other words, breastfeeding twins is not tandem nursing. The most common configuration is to be breastfeeding a newborn and a toddler anywhere from one to two years of age. Deciding to tandem nurse is an incredibly individual decision that depends on a number of things:

- your physical health
- the age and health of your older, still-nursing child
- the health of your newborn
- your time
- your partner's feelings about the process
- your emotional comfort with the idea

When Is a Toddler Too Old?

The World Health Organization's guidelines recommend two years of breastfeeding (exclusive at least for the first six months, if possible, and at least four months). By these standards, no toddler is too old, and the decision to wean becomes an issue of individual preference and one that spills over into child-care psychology. Baby-led weaning (when the toddler gradually loses interest in breastfeeding) usually occurs naturally in the toddler stage anyway. If baby-led weaning doesn't occur as quickly as you'd like, you can lead the weaning. Some parents look upon weaning a toddler after the birth of a new baby as an opportunity for the toddler to learn about growing up and becoming more self-reliant (to the extent that a two- or three-year-old is self-reliant!).

Nursing Two under Two

The general rule is to nurse the youngest child first. You may also notice that the older child may suddenly want to nurse more often than before the baby was born. First, the milk is beginning to taste "better"—like the "breastmilk classic" brand the older child is used to. Second, your milk supply will have increased, making more milk available to the older child. Finally, the older child may be nursing for comfort and stability to cope with all the new life changes that the newborn sibling brings. You may find that the more insecure the older child feels, the more that child will want to nurse. This is normal and natural and may be an issue for a child psychologist to solve if it becomes a problem.

It's also important to remember that all those "getting started" issues discussed in earlier chapters, such as latch, positioning, and engorgement, may resurface depending upon how well the newborn is taking to the breast and how frequently your older child is nursing.

A common worry during tandem nursing is what to do when one of your children is ill. Usually, the older child's illness will trigger a protective instinct that may cause you to limit that child to one breast while you feed the newborn from the other. Or you may even feel like restricting breastfeeding or withholding breastfeeding from the older child. None of this is necessary. Because by the time your older child shows signs of a cold or flu, the newborn has already been exposed to the bug for several days. The colostrum will protect the newborn from catching more grown-up garden-variety ailments that either you or other family members might pass on.

Positions

Finding a comfortable position for your newborn will be similar to your search the last time around. Review chapter 4 for more information on positioning. If you're nursing two children simultaneously, review the section on positioning for nursing multiples for some pointers.

The only new information for you in terms of positioning is the fact that your older child will most likely be able to nurse in any position—no matter how awkward! In fact, the best plan is to make sure the newborn is comfortable and let the older child squirm his way to your breast. After a certain point, many older babies practically feed themselves.

Some women find that a baby sling or carrier not only makes tandem nursing easier but also makes raising the older child easier, allowing for hands-free feeding.

The Waiting Game

Older children who are still nursing will need to learn the concept of waiting: either waiting their turn or waiting for a more appropriate place to nurse if you're in public. This may be an easy thing to teach or may turn into an agonizing experience for the older child, causing you great stress.

How well your child responds to waiting depends on her age, temperament,

and frequency of breastfeeding. Some women find that the older child can handle waiting when nursing is restricted to certain places, while others do better when you restrict nursing to certain times. In contrast, some women report that asking the older child to wait even a few minutes is intolerable for that child. But often the same child will react in radically different ways depending on what time of day it is. The only solution is to experiment. And then experiment some more. Much of this waiting game has to do with life with a two-year-old. In fact, you may be familiar with this old joke: What's the difference between a two-year-old and a terrorist? You can *negotiate* with a terrorist!

I Changed My Mind

Tandem nursing may sound wonderful to you in theory, but once begun may turn into not such a wonderful practice after all. Many women reach the point at which they're "touched out." Too much cuddling, too much nursing, too much attention paid to the older child and the newborn can cause a real physical need to simply be left alone. Sometimes the solution is donating half an hour each day to solitude in the form of a bath, a walk, and so on. Sometimes the solution is to wean. The bottom line is that you must do what feels right to *you.* If tandem nursing is too overwhelming or unpleasant for you, it's time to wean.

From sexuality.about.com : Orgasms in Response to Breastfeeding

In a 2000 study of breastfeeding women, 40.5% of the participants reported feeling sexually aroused at some point during infant suckling. Of them, 16.7% reported being aroused frequently during breastfeeding. Many women are embarrassed or even ashamed of this experience, and it’s unfortunate that more women don’t know the physical reason for the response. Arousal and orgasm during breastfeeding has nothing to do with inappropriate sexual feelings and everything to do with a hormone called oxytocin.

Oxytocin stimulates the ejection of milk from the nipples, and its release is triggered by breast stimulation. It’s also involved in contractions of the uterus (both during childbirth and during orgasm), and it's associated with feelings of relaxation and satisfaction following orgasm.

Anal sex: Safe during pregnancy?

Anal sex causes no direct harm to the baby.

When having anal sex it's important to go slowly. The anal sphincter is a ring of muscle that can be voluntarily contracted or relaxed. Penetration before your partner is ready can result in tearing of the sensitive skin.

As part of your foreplay gently insert a lubricated finger, and then two, to be sure your partner is relaxed. Penetration should *always* be comfortable and enjoyable.

If you decide to continue with other love play following anal sex, it's important to always wash the penis well with warm soap and water before reinsertion to avoid a vaginal infection or oral transmission of E. Coli.

Because anal sex has been shown to increase the risk of sexually transmitted diseases and HIV, it's important to always use a condom along with a water-based lubricant, such as AstroGlide. (You might want to avoid condoms with spermicides, as they can irritate the sensitive rectal tissues.)