Module 5: Transition to early parenthood

Introduction

Learning outcomes

On completion of this module and your midwifery practice subject, you should be able to:

- Explore optimal parenting strategies based on the best possible evidence and knowledge of infant growth and development with parents.

Video

Watch this topic introduction video.

Discussion Board

Use the Topic Discussion Board to discuss your thoughts and questions relating to this topic. You may also like to share current issues found in the media or an experience you have had in your midwifery practice. If sharing experiences from the clinical world, please be mindful of confidentiality.

Topic 1: Transition to parenthood

By definition, woman-centred midwifery care involves any person who the woman identifies as being significant to her. This is most commonly but not necessarily, a male partner and the father of her baby.

Read (again!)

Textbook: Dixon & Schmied. (2015). Supporting women becoming mothers. In *Midwifery: Preparation for practice* (3rd ed. ch. 30. pp. 728-750).

Textbook: Pincombe, Reibel & Catchlove. (2015). Transitions to motherhood. In *Midwifery: Preparation for practice* (3rd. ed. ch. 31. pp. 751-763).

Activity

The moments after a baby's birth are unique precious and for some women and their partners/families, sacred. The mother and baby are 'hot-wired' to connect with each other.

What activities have you observed that inhibit this connection?

How can midwives optimise this opportunity for connections?

Infant massage has many advantages for both the newborn and the parent.

What are the principles of infant massage that you share with parents?

Birth! by MabyCakes (2008)
https://www.flickr.com/photos/vestfamily/2591063761/
Attribution (http://creativecommons.org/licenses/by2.0/)Photo Atribution by PhotosForClass.com

The transition to motherhood for women in today's society presents a whole range of issues that were not necessarily relevant to women many years ago. This module will present some of the different approaches being examined by researchers in this area and provide you with some ideas about the issues involved in adapting to parenthood. This topic will also increase your awareness about postnatal emotional health issues.

Read

Textbook: Dahlen, H. (2015). Care of women with perineal trauma in the postnatal period. In *Midwifery: Preparation for practice* (3rd ed., ch. 28. pp. 707-710).

Incontinence of urine, flatus and faeces can have a devastating effect on women at any time of their lives but especially when they are adjusting to parenthood.

Activity

What strategies can the midwife use to reduce the incidence and impact of incontinence postpartum.

Topic 2: Emotional health postpartum

Fatigue in new mothers is common and is linked to postpartum depression and the discontinuation of breastfeeding.

To reduce the incidence and impact of fatigue, postpartum depression and the discontinuation of breastfeeding, some women choose to utilise 'attachment parenting' strategies. One attachment strategy is parental co-sleeping (bedsharing with their baby).

Read

Raising Children Network (Australia). (2016). Co-sleeping with your baby. Retrieved from http://raisingchildren.net.au/articles/cosleeping_with_your_baby.html

Activity

List the benefits/advantages associated with co-sleeping.

List the risks/disadvantages of co-sleeping.

What information on safe co-sleeping would you share with a woman wishing to use 'attachment parenting' strategies?

Read

Explore the PANDA (Perinatal Anxiety and Depression Australia) website http://www.panda.org.au/

Explore the Beyond Blue Pregnancy and Early parenthood website https://www.beyondblue.org.au/the-facts/pregnancy-and-early-parenthood

Activity

How can the midwife work with woman to reduce the incidence and impact of postnatal depression?

What resources can you recommend for pregnant women and new parents for dealing with the transition to parenting?

Read

Textbook: Davies & Kitschke (2010). Completing the midwife-woman partnership. In *Midwifery: Preparation for practice* (3rd ed., pp. 842-857).

If you are a pre-registration student, involved in the CCE, the information you have read in the chapter above, will assist you as you bring closure to the relationship you have with women in your CCE.

Topic 3: Contraception and sexuality

Many women and their partners are concerned about issues related to sexuality and contraception in the postpartum period. They will often turn to the midwife for advice.

Read

Textbook: Calabretto, H. (2015). Contraception. In *Midwifery: Preparation for practice* (3rd ed., ch. 34, pp. 891-913).

Explore the Family Planning Victoria website Factsheets: http://www.fpv.org.au/resource-centre/fact-sheets/

The notes to follow are written from recall from when Dr. Elaine Dietsch was practising clinically as a sexual counsellor.

It is important to remember that not all couples will be heterosexual, nor will all desire penis-vagina sex, in the weeks and months to follow childbirth. Others will be keen to recommence sexual activity. As a midwife it is important that you can discuss sexuality and answer questions.

Many couples are apprehensive about the effect of a baby's birth on their sexual relationship. Remembering that sex is not just a physical relationship but is also an emotional and spiritual experience, consider:

Common fears the new parents may have about sexual expression.

The commonest fears for new parents seem to be related to pain and risk of injury to the woman. The affect of altered body image on perceived attractiveness and sexual satisfaction for one or both partners and the fear of further conception. Each of these will be discussed.

The impact of post-partum body image on a couple's sexual relationship.

In the first few weeks after childbirth the woman may be bleeding as much as if she had a heavy period. Her pads stick to skin which may have been nicked and be incredibly tender (especially if she has had an episiotomy).

Further changes take place in the weeks following birth; the uterus is contracting and returning to its pre-pregnancy position and size. The woman loses the body fluids she stored in the pregnancy, partly from her bladder but also from her body in the form of sweat. She may then feel hot, smelly and sticky. Her breasts start to lactate and become heavy and swollen. They may ache and feel tender and milk might ooze or squirt from her nipples. As the lochia changes to brown a woman may feel soiled. Unrealistic expectations of flat tummies immediately after birth also affect a woman's body image. It is no wonder that some women find their post-partum bodies repugnant and sometimes distasteful, if they compare themselves with what society admires as the "body beautiful". Given, the Western emphasis on the body beautiful, it is not surprising that many women will be dissatisfied with their physical appearance and their perception of themselves as overweight and unattractive.

Not all women feel negative about their body image. Others feel quite differently about their new softness and openness. Even the odour of puerperal blood may be exciting and the capacity to produce milk so abundantly and unexpectantly seems like a miracle.

Following a positive birth experience, women may feel confident and in touch with their womanhood, more sensually and sexually aware.

Some women think that the experience of birth brings them to the point where they can surrender conscious control of their bodies so that they can enjoy orgasm (sometimes for the first time).

The sexual partner's response may be as varied as the new mothers.

The demands of parenting and sexual response.

Although the woman may be physiologically capable of resuming intercourse within a couple of weeks of the birth of the baby, a couple may not be emotionally ready to do so, particularly after the birth of the first baby. The new parents often feel tired following broken nights and may feel anxious, because of their inexperience; these factors can affect their sexual libido. Having a third person, namely the baby, in a relationship requires considerable adjustment. Sometimes caring and loving emotions that might formerly have been shared by the couple are now directed towards the baby.

Loss of libido may occur postpartum and when it does, the two main reasons given are fatigue and the woman's physical discomforts. Fatigue is not related to employment status or whether the mother breast or bottle-feeds.

However, the picture is not always bleak, sometimes a couple will find the joys of parenting far outweigh the negatives. They may feel confident and more loving towards each other.

Both new parents may find breastfeeding to be a sensual experience, and libido increased. A combination of the two above scenarios in common.

I have heard it said that new parents are the ones who fantasise about sleep during sex!

Alternatives to penis/vagina intercourse as ways of expressing sexuality.

The time immediately following birth is a time of growing. Though birth is the dramatic climax of pregnancy and labour, it is only the beginning of a host of other changes which take place both in the relationship between you and your newborn baby and between you as parents and lovers too. It is for many people a time of stress and challenge, but also one of opportunity for maturation and growth. Sexually it offers an opportunity for a fresh discovery of each other and the exploration of new aspects of pleasure and new dimensions of communication and closeness.

The new mother may sometimes feel as though she becomes an "empty tank" as far as affection is concerned. She gives herself physically to her baby continuously and often feels she needs to be refilled, not necessarily by sexual intercourse, but rather by gentle affectionate touching, e.g. a long, slow sensuous massage will often be more appreciated by both partners than sexual intercourse.

Oxytocin plays a major role in breastfeeding and sexual excitement.

Oxytocin is released during both breastfeeding and sexual arousal. It is responsible for uterine contractions, some genitalia changes and milk let down. Therefore the relationship between sexual arousal and milk let down are often reciprocatory.

Oxytocin triggers caretaking behaviours: males become more protective or females and in return females provide comfort and support for males. This closeness may be an important mechanism for ensuring that offspring have two parents as caretakers.

During sexual intercourse, oxytocin increases the motility of the fallopian tubes, which influences sperm transport. Sperm transport is also assisted by the in-sucking action of the uterus caused by oxytocin driven uterine contractions.

Skin temperature is affected by the presence of oxytocin - the body and particularly the breast becomes warmer. Following orgasm, and the release of oxytocin, anxiety states and depression are reduced.

Oxytocin release during lactation has been shown to induce maternal, nurturing behaviours. Oxytocin enhances uterine involution.

Answers to some common questions

Some responses and background information.

i. When can we resume having sexual intercourse?

There are a lot of myths about when sexual intercourse can be started after the birth of the baby. Why is it that American women are advised to wait six weeks and French women three weeks after a normal birth?

Most of the instructions that are given to new parents are based on mythology rather than fact. Bleeding from the area where the placenta was attached to the uterine wall usually stops within two to four weeks of birth. Episiotomies are usually well healed (but not always completely comfortable) within two-three weeks of birth. So once the bright bleeding has stopped and the episiotomy has healed, the couple can resume sexual intercourse as soon as they both feel like it.

Women are often encouraged to resume sexual relations as soon as possible after childbirth. But remember there is nothing wrong with a longer period of abstinence while women and their partners grapple with parenthood.

Although the woman may be physiologically *capable of resuming sexual intercourse within three weeks of birth, she may not be emotionally ready. Emotional readiness and desire is every bit as important as physical readiness.*

Resumption of sexual intercourse may be influenced by many factors such as tiredness, decreased libido, continuing lochia, either partner’s fear of causing pain or absence of partner.

If perineal trauma has occurred there are two opposing thoughts as to when it is medically advisable to resume intercourse. One argument is that the longer resumption is delayed, the less likely post-natal

superficial dyspareunia (PSD) is to occur. Conversely, it could be suggested that the application of external forces e.g. stretch in the remodelling phase of healing, leads to enhanced collagen alignment within scarring.

Midwives must think before they speak. It is very easy to raise a cheap laugh in the postnatal ward by making joking references to postnatal sex, but the laughter can ring pretty hollow later. Play it straight. Outline possible constraints, physical and emotional, emphasise the very wide range of 'normality' and explain when and where to go for professional help if that is what is ultimately needed...help mothers to rejoice in motherhood. Talk about cuddling, holding and protecting; use words such as warmth, security, love, joy, intimacy and instinct. Help parents to anticipate just how overwhelming early parenthood can be. **Don't talk about 'getting back to normal'; mothers don't go back, they go forwards**.

ii. Will it hurt to make love? If so, is there anything we can do to make sex more comfortable?

There is a strong correlation between perineal pain and sexual problems, which is indicative of probable causality. There is a prolonged effect of instrumental delivery on perineal pain which must give rise to a concern about its effect on sexual function.

Making love can and does mean a lot more than "penis into vagina = sex!" When talking about penetrative sex, fear that they are going to have pain is very likely to make a woman tense up inside, which then produces the constriction which makes them feel further pain. So it is important to be able to release their pelvic floor muscles and make them soft, loose and velvety as a male partner enters the vagina. Some men think that the only way to penetrate is to push. This is not so. If a man has a strong erection he should be able to wait at the entrance of the vagina, only the tip of his penis between the outer folds of the vagina, and the woman then comes down to meet him with her muscles. He can then avoids all thrusting and leaves the action up to his partner.

Choose a position where the woman has control over the angle and depth of penetration e.g. woman on top.

In the first few weeks after childbirth most women find their vaginas do not lubricate as much or as readily during sexual excitement. A water-based lubricant such as KY Jelly (never vaseline) will help.

iii. Will my vagina ever be the same again?

It can be even better!

Some women (and men) think that having a baby must mean the vagina is a completely different shape afterwards. They picture themselves as stretched and sagging. It is true that the pelvic floor muscles are soft after birth and some sagging can occur if you have a bad cough, are constipated, or, since the pelvic floor registers and expresses moods like the muscles of our faces, if you are depressed.

Pelvic floor exercises are essential in restoring snugness. Good pelvic floor tone will probably take at least eight weeks of regular exercise to achieve, so do not give up after just a few practice sessions. The effort is worth every elevation!

iv. What effect can breastfeeding have on a woman's libido and responsiveness?

This is often different for every woman and for each breastfeeding experience.

Factors affecting libido during lactation are complex and multifactorial. They include situational factors not related to breastfeeding, libido inhibition secondary to parturition, libido inhibition secondary to lactation, libido enhancement factors secondary to the birth process and lactation, and factors relating to the partner.

Many men are proud of their partner's breastfeeding and find that it magnifies the femaleness of their partners. Men are also subject to libidinal influences *and may be adjusting to a parenthood role. A man may feel his partner is more or less attractive as a mother. A man may also fear hurting his partner in intercourse, and this may affect sexual expression. Some couples enjoy sex more during lactation, knowing there is less chance of conception.*

Many women find their libido reduced and their vagina's dry while breastfeeding. This is usually temporary and believed to be related to the low oestrogen levels found in a woman's body during breastfeeding. Breastfeeding may result in a relative hypoestrogenic state. This may result in temporary atrophic vaginal epithelium that excretes very little fluid during sexual arousal. Hence vaginal dryness and dyspareunia may be experienced and vaginal tears are possible. This effect tends to improve spontaneously over time and with the use of water-based lubricants.

Some women find their libido decreased, others increased during breastfeeding. This is thought to be because *breastfeeding is a sexual experience. It is a phase in our sexual lives. It*

is not just the fact that the breasts are organs of sexual arousal, but that the rhythms of breastfeeding - the build up to breast fullness as the baby gets hungry, the speed with which the breasts respond with warmth when the baby cries, the erection of the nipples as the baby seeks it with an urgent, searching mouth - have an intensely sexual quality.

This sexuality embarrasses and distresses some women. Others enjoy it and find themselves being more libidinous. Nipple stimulation, both during and after birth, causes the release of oxytocin and stimulates uterine contractions. *Oxytocin is also released during sexual arousal; some women experience sexual arousal and even orgasms occasionally when they feed. Others seldom or never do* (Disappointed Dietsch, 2014).

And here too reactions vary. One woman delights in the unexpected sexuality of breastfeeding, others shy away confused and even repulsed.

During the early weeks of feeding the nipples may feel tender. The feeling of acute sensitivity to a lovers touch can remain all the time you are breastfeeding, some women become more responsive to their partners touch, others prefer him not to touch the breasts.

The oxytocin, which is released during sexual arousal and especially orgasm, is the same hormone responsible for milk let down. There are some that enjoy milk spurting out when their breasts are stimulated; *for others (and for some men too*), *this turns them off*.

Reflection

What information have you given to women/couples about sexuality after the birth of their baby?

Has this information been based on evidence? Give reasons for your answer.

If this information relates specifically to one of the women in your CCE, you may wish to photocopy these pages and place them in the relevant section(s) of your portfolio.