



B reastfeeding U pdate

“Good health begins with breastfeeding.”

POSTPARTUM MOOD DISORDERS

Caroline Brown, DEd, WHNP, IBCLC

The birth of a baby is a significant event. A new baby brings both joy and challenges to the family. Changes in mood associated with childbearing and childbirth present a problem within the family system that can yield long lasting effects. Research has shown that depression negatively impacts maternal infant attachment during the first year (Beck, 1992; Kaplan et al, 1999). Depressed mothers demonstrated less affection, reduced responsiveness, and withdrawal. The infants were found to be fussier and less interactive than infants with non-depressed mothers. A range of mood disorders associated with childbearing has been described in the literature including the baby blues, postpartum depression, postpartum anxiety/panic disorders, and postpartum psychosis.

Baby Blues

Many mothers experience blues, an emotional let down following the birth. The incidence of postpartum blues varies in the literature from 30%-80% (Beck et al, 1992; Kendall-Tackett & Kantor, 1993). It usually starts a few days after birth, peaks on day four to five, lifting ten to fourteen days after birth. Symptoms can include anxiety, mood swings, confusion, negative feelings for the infant, altered sleep patterns, irritability, and crying.

A research study by Beck and associates (1992) explored the experience of blues and depression in primiparous mothers finding that those women experiencing the blues were at higher risk for developing postpartum depression. The women in this study experienced a peak in blues symptoms on the 5th postpartum day. The researchers suggested screening for postpartum blues and continued follow-up for those women with blues symptoms. With subsequent research Beck

(1998) has further developed a screening tool for use with childbearing women.

Beyond the Baby Blues: Postpartum Depression

Postpartum depression (PPD) is different from the baby blues and can develop with any pregnancy. The onset of symptoms occurs within the initial weeks after the birth and can continue, if untreated, for a year (Dalton & Holton, 2001). The incidence of postpartum depression is 10%-25% with variation in expression of depressive symptomatology (Beck, 1993; 1998; Kendall-Tackett & Kantor, 1993). The symptoms include:

1. Changes in sleep patterns, i.e. waking early in the morning, difficulty falling and staying asleep, extreme fatigue, and not feeling rested.
2. Changes in eating habits, i.e. forgetting meals, changes in appetite, either increase or decrease, or substance abuse.
3. Changes in energy level, i.e. feeling sluggish, irritable, and physical aches and pains.
4. Changes in thinking, i.e. difficulty concentrating, over- or underconcern for baby, loss of interest in life and pleasure activities, decrease in libido, suicidal thoughts, fear of hurting the baby.
5. Changes in feelings, i.e. moodiness, sadness, crying, anger, feeling hopeless or helpless.

Psychosis

Postpartum psychosis occurs in 1-2 women in 1000 (Kendall-Tackett, 1993). The onset of symptoms can occur between 2 to 8 weeks postpartum with duration depending on diagnosis and treatment. Symptoms include altered activity, delusions, hallucinations, marked mood swings, depression or mania, and confusion (Kendall-Tackett & Kantor, 1993).

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Editors:

Liz Creer, RN, FNP, MPH
 Meredith Kennedy, MPH
 Jo Ann Shaw, RD, IBCLC
 Nancy Wight, MD, FAAP, IBCLC
 Leslie Wynn, RN, PHN

Designed by:

Creative Impacts
www.creative-impacts.com

Inquiries can be sent to:

San Diego County
 Breastfeeding Coalition
 Children's Hospital
 3020 Children's Way,
 MC 5073
 San Diego, CA 92123-4282

Or

sdcbc@breastfeeding.org

ASK THE EXPERT

Question: Breastfeeding and maternal SSRI use: is it safe?

Answer: Depression is becoming one of the major health issues of our time. Young women have significant rates of depression, and pregnancy and the post-partum period are very high-risk times for depression. The SSRIs (selective serotonin reuptake inhibitors) have become the first-line treatment for depressive disorders in women. These facts, combined with the higher rates of breastfeeding in the last decade have made the safety profile of SSRI use in breastfeeding a hot topic.

The numerous benefits of breastfeeding to both mother and baby require us to use caution in our recommendations about the infant effects of maternal medication. There are increasing amounts of data about the levels of these medications in mothers milk and breastfeeding infants. We have some good information about the safety of these medications in terms of observable effects in infants. However, there is little information about the neurodevelopmental effects in babies, and almost no data about long-term effects in children (such as a predisposition to depression) who were exposed to these medications in utero or through breastfeeding. What follows is a brief discussion of the milk and infant levels of SSRIs, observed side effects and our current recommendations.

Dr. Phil Anderson of UCSD's Drug Information Service recommends that we look at how much medication the infant is exposed to by calculating the *weight adjusted percent of maternal dosage*; milk to plasma ratios just don't tell you how much the baby may actually get. The *weight adjusted percent maternal dosage is equal to infant daily dosage (mg/kg) / mat daily dosage (mg/kg) x 100*. Keep in mind that there are several variables here: how much medication the mother takes, how much the mother weighs, how much medication is excreted into her milk, the characteristics of drug concentration in her milk (hindmilk often has more drug due to its higher fat content), how much milk the baby takes, how much he weighs, how old he is, etc. Even when infants have a low or undetectable level, we know that there is medication in the milk and that the baby is exposed. We don't know if there will be subtle effects on susceptible organs such as the central nervous system.

It is generally felt that if the *wt adjusted % maternal dosage* is less than 10% this is an acceptable level of exposure, unlikely to cause side effects. Dr. Anderson also has data (about to be published in Clinical Pediatrics) to suggest that of infant adverse reactions to medications in breastmilk, 79% occur in the first 2 months of breastfeeding, and 97% in the first 6 months of breastfeeding. Also, remember that any time the mother has been taking a medication during her pregnancy, the infant's exposure is much greater in utero than during breastfeeding.

Here are the average wt adjusted % of maternal doses for our common antidepressants:

<u>Antidepressant</u>	<u>Trade</u>	<u>Wt adj. % mat dose</u>	<u>Use during BF OK?</u>
Fluoxetine	Prozac	6.5%	Least desirable SSRI
Bupropion	Wellbutrin	<3.0%	Probably OK
Citalopram	Celexa	4.4%	Probably OK

<u>Antidepressant</u>	<u>Trade</u>	<u>Wt adj. % mat dose</u>	<u>Use during BF OK?</u>
Nefazodone	Serzone	<1.0%	Probably OK
Paroxetine	Paxil	2.0%	Preferred
Sertraline	Zoloft	1.8%	Preferred
Venlafaxine	Effexor	4.6%	Probably OK

Some recent studies on the subject confirm the above information, and give us more information about low infant levels and the safety of these medications in the post-partum period. In 2001 Epperson et al. looked at the effect of sertraline on breastfeeding mothers by checking platelet levels of serotonin (a measure of transporter blockade to assess medication effect). The mothers had marked declines in their platelet serotonin levels, but the infants had little or no change during breastfeeding. Blood levels in the infants (who had been breastfed for 6-16 weeks of medication administration of the mothers) had low or undetectable blood levels of the sertraline. Ilett et al. in 2002 checked mother's milk and baby levels in mothers taking venlafaxine. Milk levels were 2.5-2.7x maternal serum levels, but the weight-adjusted % of maternal dosage was only 6.5%. There were no adverse infant effects noted. A recent paper by Heikkinen et al. reviewed their experience with citalopram. They looked at 11 mother-baby pairs. At delivery the infants had approximately 60% of their mothers' blood level. Milk concentrations were 2-3x higher than maternal blood levels, but the infant blood levels were very low or undetectable. In 2001, Hendrick et al. at UCLA, looked at 50 mother-baby pairs taking paroxetine, fluvoxamine or sertraline. The infants exposed to paroxetine and fluvoxamine had undetectable levels. Of the infants whose mothers took sertraline, only 24% had detectable levels, and these tended to be mothers taking more than 100 mg/day. No adverse effects were noted in any of the study infants. Paroxetine has also been shown to have variable amounts excreted into breastmilk, and undetectable levels in infants. Stowe et al. in 2000 nicely documented variability in breastmilk concentrations from the foremilk (lower levels) to the hindmilk (higher levels).

Fluoxetine, on the other hand is known to be a problem. It has an extremely long half-life, higher milk levels, and there have been reports of infant toxicity. Infant colic, GI symptoms, a seizure-like episode and poor weight gain have all been reported (Chambers et al., 1999). However, most of the infants do well. What is important to remember is that each mother is different; some excrete as little as 3% of the fluoxetine dose in their milk and others as much as 12%. Furthermore, if a mother has been on fluoxetine throughout her pregnancy, the post-partum period is probably not the time to make a medication change. We would recommend that these children be watched closely for adverse effects and weight gain.

In summary, most SSRIs are felt to be safe to use during pregnancy and breastfeeding. Sertraline and paroxetine are the safest due to low milk levels, and lack of reported side effects in the infant. Fluoxet-

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POSTPARTUM MOOD DISORDERS

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Postpartum Anxiety/Panic Disorders

Some mothers experienced anxiety to an extreme, including panic symptoms following birth. Symptoms include anxiety, rapid breathing/hyperventilation, rapid heart rate, body temperature changes, chest pain, shakiness, or dizziness. This phenomenon is not as well described in the literature.

Contributing Factors

Research has not demonstrated a clear etiology of mood disorders associated with childbearing. Many factors have been identified as contributing to the development of postpartum affective disorders. Biochemical changes resulting from dramatic alterations in hormones following birth are a contributing factor (Kendall-Tackett & Kantor, 1993). Social isolation has been identified as a contributing factor (Ray & Hodnett, 2002; Stern & Kruckman, 1983). Many women in Western culture, and those displaced from their country of origin, can be faced with social isolation. The relationship of the woman with her partner has been identified as a strong influence on the woman's emotional state (Fisher et al, 2002). Birth experiences, which are perceived in a negative way by women, can contribute to women's depressive symptoms. Traumatic births result in physical sequelae for women, feelings of failure or inadequacy, feelings of mistrust or betrayal, and helplessness or powerlessness. Medical complications during pregnancy were found more likely to develop into depressive symptoms (Burger et al, 1993).

Self-esteem, cognitive style, and psychiatric history influence the way a woman perceives her life and copes with challenging events. Life events, separate from childbirth, can have an additive effect thus reducing a woman's overall coping ability.

Finally, the temperament of the infant brings with it a separate set of variables to consider (Cutrona & Troutman, 1986). Infants who cry excessively can wear on a new mother's ability to cope and leave her feeling like a failure. Beck (1998; 2002) found eight factors which were significantly related to the development of postnatal depression. These factors included prenatal depression, history of depression, social support, marital satisfaction, life stress, childcare stress, and maternity blues. Bozoky and Corwin (2002) found fatigue to be predictive of postpartum depression.

Consideration for Lactation Consultants

The lactation consultant should be alert to cues new mothers offer in the early postpartum period. Concerns expressed by women should not be minimized but explored and evaluated. Knowledge of the woman's past experiences, as well as her current birth experience and existing social support networks, can give insight into early family transitions.

Useful strategies for women experiencing mood disorders in pregnancy and following birth have been demonstrated in research (Ray & Hodnett, 2002). Early detection and management are essential to minimize the potential long-term consequences to the woman and her family. Treatment typically involves a combination of medication, psychotherapy, and support group. Social support networks within the woman's domain can mediate some of the stressors and challenges pregnancy and early child rearing can bring. Social support has demonstrated some positive outcomes for women with depression (Kendall-Tackett & Kantor, 1993; Ray & Hodnett, 2002). The use of morning light therapy has been applied to the treatment of depression during pregnancy yielding a positive effect (Oren et al, 2002). Pharmacologic treatment of postnatal depression has increased in recent years and is considered to yield more good than harm, which may result from failure to treat (Hale & Ilett, 2002; Hoffbrand et al, 2002).

Postpartum mood disorders can be treated with early detection and management. The lactation consultant is optimally positioned to make a difference in the outcomes of women developing postpartum affective disorders.

Additional Information:

Internet:

Depression after delivery: www.depressionafterdelivery.com

The National Women's Health Information Center: www.4women.gov/faq/postpartum.html

Postpartum Support International: www.chssiup.edu/postpartum

Medline Plus: www.nlm.nih.gov/medlineplus/postpartumdepression.html

The Postpartum stress center: www.postpartumstress.com

Books:

Beyond the Blues: Prenatal and Postpartum Depression by Shoshana Bennet and Pec Indman

Shouldn't I Be Happy? Emotional Problems of Pregnant and Postpartum Women by Shalila Misri

This Isn't What I Expected by Karen Kleiman and Valerie Raskin

The New Mother Syndrome by Carol Dix

Depression after Childbirth by Katharina Dalton

Postpartum Depression and Child Development by Lynne Murray

Postpartum Depression: Every Woman's Guide to Diagnosis, Treatment and Prevention by Sharon Roan

Rebounding from Childbirth: Toward Emotional Recovery by Lynn Madsen

When Words Are Not Enough: The Women's Prescription for Depression and Anxiety by Valerie Raskin

Postpartum Survival Guide by Ann Dunnewold and Diane Sanford

I Wish Someone Had Told Me: A Realistic Guide to Early Motherhood by Nina Barnett

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SDCBC 2003 MEMBERSHIP DRIVE

Your continued support is needed!

If you are interested in becoming a member or renewing your membership for 2003, please visit our website at www.breastfeeding.org or contact our office for more information at (858) 966-5981 or email sdcbc@breastfeeding.org. If you would like to be listed as a lactation provider in the **2003 Resource Guide**, join as a Sponsor* member now!

Become a member of the San Diego County Breastfeeding Coalition!

SDCBC Membership Levels

Sponsor* - \$100 (*Business/Organization/Professional*)

Contributing Member - \$50 (*Individual*)

Friends of the Coalition - any amount under \$50

You can show your support of the San Diego Breastfeeding Coalition by:

- Making a monetary contribution to support coalition activities.
- Donating your time by serving on a committee:

Advocacy/Political Action	Community Outreach
Fundraising	Grant Research
Membership	Professional Outreach
Research and Evaluation	Volunteer Coordination
- Attending Coalition meetings and providing your expertise and experience.

Interested in what we do? Attend one of our meetings!

General Coalition Meetings are held the second Thursday of each odd month at Sharp Mary Birch Hospital for Women, 3003 Health Center Drive, San Diego, in the Grace Benbough Room, located on the 2nd floor, 3:00 – 5:00 pm. Please call (858) 541-4185 for directions. 2003 meeting dates are as follows: **January 9, March 13, May 8, July 10, September 11, November 13.**

What is the San Diego County Breastfeeding Coalition?

The San Diego County Breastfeeding Coalition is a non-profit association whose mission is to promote and support breastfeeding through education and outreach in our community.

What are the benefits of being a San Diego County Breastfeeding Coalition Member?

As a member of the San Diego County Breastfeeding Coalition you will:

- Network with a growing body of people dedicated to the promotion and support of breastfeeding.
- Have access to lactation professionals and the most up-to-date breastfeeding resources.
- Receive a free supply of Breastfeeding Resource Guides in English and Spanish.
- Receive a discount for Coalition sponsored education programs.
- The first 50 that join will receive a free copy of “*Selling Out Mothers and Babies; Marketing of Breast Milk Substitutes in the USA*” by Marsha Walker
- Have a home page or link, as appropriate, on the SDCBC's website: www.breastfeeding.org
- With a Sponsor* membership, be listed, as appropriate, in the "Breastfeeding Resource Guide" without a fee.

Not To Worry, Inc.

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and/or tube feedings, pre- or post-surgery. When baby blues, postpartum depression, or family mental health issues are a concern, loving, competent professional support can make a huge difference for everyone at home.

We happily visit our families at home before the baby is born. The prenatal visit allows our families the comfort of meeting staff prior to their babies' arrival. We offer great suggestions regarding the baby's nursery and changing area, too.

Infant and Child Care: Not To Worry childcare services can be utilized on a long-term, short-term or interim basis. We care for mildly ill infants and children; healthy kids with sick parents, too. Our staff is available to assist busy and working families during the daytime, evening or weekend, and full-time, part-time or once in a while is available. Not To Worry caregivers travel with our families as well so that parents can enjoy both a wonderful trip *and* vacation with their young children.

Many of our families are able to use pretax dollars for our services as a work-life benefit through their employer. Our service minimum is four hours per day. Please call us at (858) 350-6552 or visit our website at www.nottoworryinc.com for additional information about our work in the San Diego area.

SAVE THE DATE

JOB CENTER

2003 California Childhood Obesity Conference
Marriott Hotel & Marina, San Diego, CA, January 6-8, 2003.
"Making an Impact Now: Environmental, Family & Clinical Approaches." Hosted by the California Department of Health Services and the Center for Weight and Health, University of California, Berkeley.
For more information, visit www.CNR.Berkeley.EDU/cwh/news/announcements.shtml#save.

2003 International Conference on the Theory and Practice of Human Lactation Research and Breastfeeding Management
Orlando, FL, January 13-17, 2003.
For more information, visit: www.healthychildren.cc/international.htm

Ask the Expert

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ine is probably best avoided if possible, but we don't recommend changing maternal medication during the vulnerable post-partum period. Close follow up of mothers and babies is important due to variations in maternal dose, milk levels, baby intake and baby sensitivity. There are still many unknowns, and health providers need to take the time to counsel families about the risk-to-benefit ratio of taking needed medication while breastfeeding.

References:

1. Chambers, C.D., Anderson, P.O., Thomas, R.G., Dick, L.M., Felix, R.J., Johnson, K.A., Jones, K.L., (1999). Weight gain in infants breastfed by mothers who take fluoxetine. *Pediatrics*; 104 (5), e61.
2. Epperson, N., Czarkowski, K.A., Ward-O'Brien, D., Weiss, E., Gueorguieva, R., Jatlow, P., Anderson, G.M., (2001). Maternal sertraline treatment and serotonin transport in breastfeeding mother-infant pairs. *Am J Psychiatry*; 158 (10), 1631-7.
3. Heikkinen, T., Ekblad, U., Kero, P., Ekblad, S., Laine, K., (2002). Citalopram in pregnancy and lactation. *Clin Pharmacol Ther*; 72 (2), 184-91.
4. Hendrick, V., Fukuchi, A., Altshuler, L., Widawski, M., Wertheimer, A., Brunhuber, M.V., (2001). Use of sertraline, paroxetine, and fluvoxamine by nursing women. *The British Journal of Psychiatry*; 179, 163-6.
5. Ilett, K.F., Kristensen, J.H., Hackett, L.P., Paech, M., Kohan, R., Rampon, J., (2002). Distribution of venlafaxine and its O-desmethyl metabolite in human milk and their effects in breastfed infants. *Br J Clin Pharmacol*; 53 (1), 17-22.
6. Stowe, Z.N., Cohen, L.S., Hostetter, A., Ritchie, J.C., Owens, M.J., Nemeroff, C.B., (2000). Paroxetine in human breastmilk and nursing infants. *Am J Psychiatry*; 157, 185-9.



Lisa Stellwagen, MD, trained in general pediatrics at Mass General Hospital, fulfilled a National health service corps obligation in Ramona, and then was in private practice in Vista for 7 years. She was also the medical director of the level 1&2 nurseries (96-99) in Boston and has been the medical director of the newborn service at UCSD for 2 years.

Written with the assistance of: *Phil Anderson, Pharm.D. (UCSD Drug Information Service), & Eyla Boies, MD (Medical Director of UCSD Lactation Taskforce).*

Volunteer Opportunities: If you want to join a motivated group and are interested in joining an active committee, the SDCBC needs you!

Paid Opportunities: Are you IBCLC certified? Have experience teaching? We need presenters for our in-office lactation education program. (\$50 honorarium/presentation)

Please contact the SDCBC office at (858) 966-5981 or email sdcbc@breastfeeding.org for more info.

Postpartum Mood Disorders

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References:

1. Beck, C., (2002). Postpartum depression: a metasynthesis. *Qualitative Health Research*; 12 (4), 453-472.
2. Beck, C., (2002). Revision of the postpartum depression predictors inventory. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*; 31 (4), 394-402.
3. Beck, C., (1998). A checklist to identify women at risk for developing postpartum depression. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*; 27 (1), 39-46.
4. Beck, C., (1993). Teetering on the edge: a substantive theory of post partum depression. *Nursing Research*; 42, 42-48.
5. Beck, C., Reynolds, M., & Rutowski, P., (1992). Maternity blues and post partum depression. *JOGNN*, 21, 287-293.
6. Bozoky, I. & Corwin, E., (2002). Fatigue as a predictor of postpartum depression. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*; 31 (4), 436-443.
7. Burger, J., Horwitz, S., Forsyth, B., Leventhal, J. & Leaf, P., (1993). Psychological sequelae of medical complications during pregnancy. *Pediatrics*; 91 (3), 566-572.
8. Cutrona, C., & Troutman, B., (1986). Social support, infant temperament, and infant self care efficacy: a mediational model of postpartum depression. *Child Development*; 57, 1507-1518.
9. Dalton, K. & Holton, W., (2001). *Depression After Childbirth* (fourth edition). Oxford: Oxford University Press.
10. Fisher, J., Feery, C. & Rowe-Murray, H., (2002). Nature severity and correlates of psychological distress in women admitted to a private mother-baby unit. *Journal of Pediatric Child Health*; 38 (2), 140-145.
11. Hale, T & Ilett, K., (2002). *Drug Therapy and Breastfeeding*. New York: Parthenon Publishing.
12. Hoffbrand, S., Howard, L. & Crawley, H., (2002). Antidepressant treatment for post-natal depression (Cochrane Review). In: *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software.
13. Kendall-Tackett, K & Kantor, G., (1993). Postpartum depression: a comprehensive approach for nurses. Newbury Park: Sage Publisher.
14. Kaplan, P., Bachorowski, J. & Zarlengo-Strouse, P., (1999). Child-directed speech produced by mothers with symptoms of depression fails to promote associative learning in 4-month old infants. *Child Development*; 70, 560-570.
15. Newport, D., Hostetter, A., Arnold, A. & Stowe, Z., (2002). The treatment of postpartum depression: minimizing infant exposures. *Journal of Clinical Psychiatry*; 63 (7), 31-44.
16. Oren, D., Wisner, K., Spinelli, M., Epperson, C., Peindl, K., Terman, J. & Terman, M., (2002). An open trial of morning light therapy for treatment of antepartum depression. *American Journal of Psychiatry*; 159 (4), 666-669.
17. Ray, K & Hodnett, E., (2000). Caregiver support for postpartum depression. In: *The Cochran Library 2000*. Oxford: Update Series.
18. Stern, G & Kruckman, L., (1983). Multi-disciplinary perspectives on postpartum depression: an anthropologic critique. *Social Science and Medicine*; 17, 1027-1041.

COMMUNITY SPOTLIGHT

Not To Worry, Inc.
Ellen K. Brown, RN, BSN, MPH
Martha Lantz, RN, MSN, FNP

“Whom can I trust to care for my children?” We understand your concern.

Founded by a registered nurse and mother of three, Not To Worry, Inc. offers a comforting solution for families in need of quality new baby/postpartum care and the support for infants and young children at home. Our services bring welcome relief, education and confidence to new parents and those struggling to balance their adult commitments with the needs of their children.

Our staff consists of maternal/child, newborn and newborn intensive care registered nurses, childcare professionals and experienced parents. Each staff member is thoroughly screened by Not To Worry to ensure the finest care possible. Our pre-employment screening process includes personal interviews and extensive background searches as well as psychological evaluations. All baby nurses and caregivers are over 21 years of age and CPR certified for infants, children and adults.

Not To Worry, Inc. is not a registry or agency. Our company emphasizes teamwork and a deep commitment to clinical excellence. Not To Worry nurses and loving caregivers are professionals with the education and experience necessary for safe care, comprehensive health teaching, and timely recognition of and assistance with pediatric and family health concerns.

Our high level services fall into two categories:

New Baby Care: The first few weeks at home with a newborn can be difficult, both physically and emotionally, for the entire family. Not To Worry offers daytime and nighttime support with hands-on education

for new parents, help with fussy babies, relief for exhausted parents, care for twins and multiples, breastfeeding support for mom and baby, nutritional guidance for the breastfeeding mom, safety education for new parents, and proper sleep positioning for newborns and infants. We believe that hands-on teaching empowers families to begin their parenting journey with greater confidence, comfort and ease. We understand that parents need clinically sound health information, and we are committed to giving them current, evidence-based advice they can trust.

Our professional care and services are carefully tailored to the unique needs and concerns of each family. Our staff has tremendous experience with the care of low birth weight and premature babies, neonatal intensive care graduates, and babies with reflux and digestive challenges. We offer continuous nighttime support to assist families with babies' sleep through the night. We help families with the adjustment to more than one child at home. We support post-operative moms recovering from cesarean section deliveries. We provide gentle, comforting and experienced professional care before and after a baby's circumcision—whether the circumcision is done in a clinical setting or at a traditional birthing center. We provide ongoing and medically sound support for breastfeeding mothers and babies, and have assisted many mothers to achieve their breastfeeding goals. We offer the new mom time for herself, particularly when the workplace demands time from one or both parents.

We provide excellent support to children and parents with special needs and disabilities. Our registered nurses provide tremendous relief to parents with infants and children who are at home with monitors,

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POLITICS, ADVOCACY AND LEGISLATION

Nancy E. Wight MD, FAAP, IBCLC

This *should* be a book review. The American Academy of Pediatrics has just published an excellent new breastfeeding book for mothers and families. The “New Mother’s Guide to Breastfeeding”, was edited by Joan Meek MD, MS, RD, IBCLC and many of the executive board of the AAP Section on Breastfeeding. Unfortunately, this excellent book has been tainted, and instead of a book review, this will be political commentary.

Without the knowledge of Dr. Meek or the Section on Breastfeeding, the Executive Board of the AAP cut a deal with Ross Products Division of Abbot Labs (Similac) to purchase 300,000 copies of the new book, with the cover modified to include the Ross logo. It is uncertain as to whether the books were meant to be placed in discharge gift bags, or given to mothers or health care professionals. The AAP Executive Board and marketing division felt this was an excellent way to get the book out in circulation.

The outcry from the lactation support community, including the Pediatricians of the AAP Section on Breastfeeding, was immediate and profound. Dr. Lawrence Gartner, the chairman of the Section, wrote a detailed letter explaining our concerns regarding conflict of interest, legitimizing the formula company, and devaluing an excellent book. He made several recommendations, including a review of such publication policies by the AAP Ethics Committee.

Unfortunately the response received from the AAP Executive Board was not encouraging, citing financial issues and completely ignoring the conflict with the AAP’s own 1997 policy statement. As a life member of the American Academy of Pediatrics, I am both angered and disappointed by my own organization’s lack of recognition of the potential for harm in its close association with artificial milk manufacturers. I will, however, remain a member, and work from the inside. I urge all breastfeeding advocates to continue to educate and inform, both from within and outside organizations, to protect and support our breastfeeding families.

BOOK REVIEW

Selling Out Mother's and Babies

By *Marsha Walker, RN, IBCLC*

Reviewed by:

Leslie Wynn, RN, PHN

In the 1970's there was an overall decline in breastfeeding rates and international concern that mothers were being led to believe that breastmilk substitutes were better and encouraged to supplement. The World Health Organization (WHO) and World Health Assembly (WHA) advocated that there be guidelines established regarding the marketing of breastmilk substitutes. After many years of debate and persuasion, the International Code of Marketing of Breastmilk Substitutes was adopted. The intent of the Code is to curb the unethical marketing practices, false/misleading advertising, and complicity by health care professionals, health care systems and governments that combine to influence a mother to replace her breastmilk either completely or partially.

Marsha Walker, in her booklet *Selling Out Mother's and Babies*, describes the extent to which formula companies have gone to influence mothers, health care professionals, institutions and governments. Examples of these influences include new mother's club sign-ups in the OB/GYN office, educational opportunities for healthcare providers, and trips and prizes for healthcare providers that encourage distribution of formula gift bags. Marsha further illustrates how formula companies have created markets for their products when none existed. Marsha's book gives a factual account of how we have gotten to such low breastfeeding rates and how marketing affects the duration of breastfeeding, and much more. Her book will open your eyes and encourage you to be proactive and part of the solution.

**The first 50 members to join the San Diego County Breastfeeding Coalition for 2003 will receive a free copy. JOIN TODAY!!!!*

VIDEO REVIEW

"A Premie Needs His Mother: First Steps to Breastfeeding Your Premature Baby"

Produced by Jane Morton, MD

Clinical Professor of Pediatrics, Stanford University

jamorton@vermontel.net

www.breastmilk solutions.com

1-888-JMORTON

Reviewed by:

Nancy E. Wight MD, FAAP, IBCLC

Rarely do you find a video that is both medically accurate and visually appealing. This much needed video, "A Premie Needs His Mother: First Steps to Breastfeeding Your Premature Baby", produced by pediatrician and breastfeeding proponent Jane Morton, MD, is designed to give the mother of an NICU patient both the information and the inspiration she needs to successfully provide her milk and eventually breastfeed her premature infant.

Divided into two sections to be less intimidating, Part 1 uses a combination of family's own words and factual information to explain the benefits of breastmilk for preterm infants and how to establish and maintain a mother's milk supply through breast pumping. It is recommended that this section be viewed before delivery if possible. Part 2 uses the same combination of parent input and expert instruction to cover learning to breastfeed and "coming home" issues. There is an attempt to include mothers of different ages, ethnicities and educational backgrounds. The point is clearly made that a mother's own milk is best for her infant.

This video is a comprehensive guide to learning how to express milk and breastfeed a preterm infant. Although meant for parents, it is a valuable addition to any NICU or breastfeeding educator's library. The State of California WIC sent a copy of this video to EVERY Neonatologist in the state! I strongly recommend that every neonatologist, NICU nurse, and NICU lactation consultant view this video and make it available to his/her patients' parents.

You are invited to enter your breastfeeding photographs to the FIRST ANNUAL SDCBC BREASTFEEDING PHOTOGRAPHY CONTEST

Twelve selected photos will be part of a SDCBC 2004 Calendar. Please send photos (photos will not be returned) to: SDCBC Photo Contest, c/o Children's Hospital and Health Center, 3020 Children's Way Mail Code 5073, San Diego, CA 92123-4282. The deadline for submissions is February 15, 2003. Exhibit and awards will be held at the Alfred Lee Fine Art Studio. Date to be announced. Please see our website (www.breastfeeding.org) for contest rules and guidelines.

Research Corner

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Though there is minimal research on the reactivity to stressors in breastfeeding mothers, there is a diminished response to stress in women who are lactating. This protection appears to be neuroendocrinologically associated with breastfeeding. This evidenced based research article shows breastfeeding has a calming effect on mothers, resulting in less reactivity to stressors in the postpartum period.

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“Good health begins with breastfeeding.”

SEE THIS NEWSLETTER ON THE WEB AT
www.breastfeeding.org

RESEARCH CORNER

Article Review

Sheila Weibert, WHNP, IBCLC

Postpartum Stress: Current Concepts and the Possible Protective Role in Breastfeeding, Journal of Obstetric, Gynecologic and Neonatal Nursing (JOGNN), Vol. 31, Number 1 July/ August 2002

This article is a review of the literature relating to postpartum stress and research on a possible protective effect of breastfeeding on reducing postpartum stress. A limited number of animal and human studies were reviewed comparing different stress responses. The stress categories during the postpartum period were physical, intrapersonal, and interpersonal.

There are a wide variety of physical symptoms in the postpartum time. In the physical category, fatigue consistently increases stress in breastfeeding, self-care, mothering and infant care. On average, the amount of sleep in a 24-hour period during the 4th week postpartum is 7.5 hours, with only 6.15 hours during the night. Sleep deprivation may continue for some women for months, causing acute and cumulative problems. Other physical stressors include sexual concerns, poor appetite, breast symptoms, constipation, hemorrhoids, and hand numbness

and tingling.

The development of maternal identity (maternal role) is in the intrapersonal category. Interpersonal relates to the interaction between the mother and others. High levels of maternal role stress at one month postpartum showed a decreased maternal sensitivity to infant cues at 4 months postpartum. The woman's weight in the postpartum period is another intrapersonal stress. Daily stress, self-esteem, and child care stress were predictors of postpartum depression in the intrapersonal stress category. The majority of mothers have concerns about their ability to meet the needs of the family, the infant, and to find time for themselves. Cultural expectations may be an interpersonal stressor for postpartum women also. This can lead to overload, role transition problems, guilt and depression.

An endocrine and immune state occurs in lactating mothers promoting calmness and nurturing behavior, reducing maternal reactivity to the environment, enhancing quantity and quality of milk, and enhancing immune function. The anti-stress nature of lactation is partially due to the hormone oxytocin. In human mothers this hormone has been found to be amnesic, reducing anxiety and producing sedation.

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