



# Breastfeeding Update

## “Breastfeeding and Sleep”

### Sleep and the Breastfeeding Baby

**Sleep and the Breastfeeding Baby**  
**Eyla Boies MD, FAAP**

Up to 50% of parents seek professional help regarding sleep problems with their children.<sup>1</sup> Sleep issues are especially troublesome for the new parents and breastfeeding may add to the complexity of sleep in the newborn infant. The following case typifies “sleep issues” parents bring to me every day.

**Case:** Mr. and Mrs. Perlman are seen with their 10 day old infant, Sarah, for her second outpatient visit. Sarah was full term and all appears to be doing well. Sarah is breastfeeding exclusively and is now four ounces over birth weight and on exam she appears alert and vigorous. When I ask about sleep the picture is not so rosy. Whenever her parents try to put her in the bassinette by their bed after breastfeeding, she immediately wakes and starts to cry even though she appeared to be sleeping soundly in their arms before putting her down. Mom and dad look exhausted and are at a loss as to how to proceed. Mrs. Perlman had hoped to exclusively breastfeed for six months but she wonders if she should give formula before she puts Sarah down, because her mother told her formula fed babies sleep better than breastfed ones. When asked how they made it through last night, dad explains that he and his wife took turns holding Sarah on their chest while sitting in a big soft chair where they could rest while holding her. They are tempted to put Sarah in bed with them so they could all get more sleep, but they know the American Academy of Pediatrics (AAP) specifically advises against this practice due to the increased risk of Sudden Infant Death Syndrome (SIDS) if a child sleeps in the same bed as the parent.

As I listen to Mr. and Mrs. Perlman, I consider what is known about infant sleep, especially safe sleep in the context of breastfeeding. The Perlmans and I are in a difficult position because even though

there has been an explosion of information about infant sleep in the last 15 years, there is much controversy and contradictory information.

Polygraphic studies have shown that newborns have very little deep stage III or IV sleep. They transition into REM sleep immediately and spend about 50% of their sleep time in REM sleep and the rest in a light sleep equivalent to Stage I or II in adults. By about four months of age infants have deeper sleep states resembling adult stages III and IV; stages from which arousal is more difficult. Infant breathing patterns and heart rate are dependent upon sleep or state of arousal. Some experts feel the lack of deep sleep in early infancy protects against SIDS. Interestingly, the peak incidence of SIDS occurs in infants is three to four months of age presumably when they are developing deeper sleep states. It is no wonder that Sarah awakens when put in the bassinette, considering she is almost certainly in a light sleep state and has spent the last nine months in direct contact with her mother surrounded by her heart beat, respiratory patterns, and other sensory outputs. She needs the proximity of her mother to transition to a sleep state and to maintain that state.

I then consider some of the compelling work of Meredith Small, an anthropologist, who examined sleeping practices of parents and children around the world and of many different cultures where almost all infants sleep with an adult in the same bed (46%) or in the same room but different sleeping surface (21%).<sup>2</sup> These cultures generally have a lower rate of SIDS than industrialized countries such as the US. Until the last decade the standard American practice recommended by pediatricians was to put an infant to sleep in a separate

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room in a bed (crib) by his or herself. This practice was felt not only to be safer for the infant (i.e. protect against SIDS) but to foster the western philosophy where individualism and independence are traits to be encouraged and prized. With the increased effort to promote breastfeeding and the recognition that co-sleeping (at least in the same room as an adult) protected against SIDS, the AAP now recommends that an infant sleep near the mother but not on the same surface. The 2005 AAP Policy Statement on SIDS admits the topic of bed sharing is controversial and suggest the risk of SIDS while bed sharing is greatest when there is another risk factor such as maternal smoking during pregnancy, sleeping on a sofa, etc.<sup>3</sup>

Dr. James McKenna, an anthropologist who studies mothers and their infants in sleep labs, found that infants, when sharing a bed with their mother, aroused more frequently and breastfed twice as long on those nights as compared to nights when they were sleeping alone. In this study the co-bedding mother and infant got overall more sleep but the sleep is a lighter stage 1 and 2 sleep with more arousals for both throughout the night.<sup>4</sup> He argues that the AAP when making their recommendations did not consider all of the available data, but rather relied on a few epidemiological studies. He also argues that his data support studies that suggest co-sleeping protects against SIDS.

Current nomenclature makes a distinction between co-sleeping and bed sharing. Co-sleeping refers to any sleep arrangement that allows an infant to sleep in close social or physical contact with a caregiver. Co-bedding or bed sharing, where an infant sleeps on the same surface as the mother, is one form of co-sleeping. Studies have shown that co-sleeping promotes breastfeeding and reduces the incidence of SIDS.<sup>3</sup> The work of Dr. McKenna suggests that safe co-bedding is even more beneficial in the promotion of breastfeeding and may also protect against SIDS. Others, however, disagree and feel co-bedding puts an infant in the first 4 months of life at an increased risk of SIDS.<sup>5</sup>

Formula fed babies appear to need fewer feedings throughout the night than breastfed infants. Some experts, and research on stomach emptying times<sup>6</sup>, suggest that breastmilk is more easily digested than formula and moves through the GI tract more quickly, thus the breastfeeding infant needs more frequent feeds throughout the day and night to satisfy hunger. Others speculate that breastfed infants are more prone to develop an association of breastfeeding as a necessary requirement to falling asleep, thus when infants develop better defined sleep stages that include brief periods of waking, they need to breastfeed just to transition back to sleep not necessary to satisfy hunger. A study by Pinilla et al, however, demonstrated that exclusively breastfed infants can be trained to sleep for at least one five hour stretch by eight weeks of age. Parents were enrolled in the study before delivery of their infant and divided into two groups of thirteen.<sup>7</sup> When infants in the treatment group were three weeks of age parents were to give a "focal feed" between 10 pm and midnight, then at the next awakening they were to try and soothe their infant by re-swaddling, patting, diapering, or walking the infant to stretch nighttime feeding intervals by breaking the association between awakening at night and being fed.

Sleeping through the night was defined as sleeping from midnight to 5 am. With training, 100% of infants were able sleep uninterrupted for five hours by eight weeks of age as defined by sleeping for the five hours on two of the three nights sleep diaries were kept. It should be kept in mind, however, that continued night time feeds are associated with longer duration of breastfeeding and a greater supply of breastmilk.<sup>8</sup>

Before I can help Sarah's parents I need more information. What kind of work do they do? Will mom be returning to work out side of the home and if so when? What is their breastfeeding plan and if they were to co-bed what would be their goal for having Sarah sleep independently. In what kind of bed do they sleep? Is there a family history of SIDS? Do Sarah's parents smoke or ever drink in bed or take medications to assist with sleep?

As noted above, Mrs. Perlman plans to exclusively breastfeed for six months but continue breastfeeding for at least one year. She has arranged a six month maternity leave at which time she will be returning to her position as chief financial officer of a local biotechnology company. She will need to have the sleep "issues" worked out by then, and does not feel co-bedding is an option when she returns to work. Dad also works outside the home. They have hired a nanny to come into their home during the day to care for Sarah. They have a firm mattress; do not drink alcoholic beverages before bed or take medications to induce sleep. They have never smoked cigarettes. There is no family history of SIDS.

I review with Mr. and Mrs. Perlman what is known about sleep patterns in the newborn and that Sarah's awakening when they put her down is to be expected. I also share with them my real concerns regarding sleeping on a sofa with an infant being much more dangerous than safe co-bedding. We review safe co-bedding: 1. firm mattress (no waterbed) 2. no pillows near the baby or soft comforters or duvets on the bed 3. no smoking or drinking alcoholic beverages prior to bedtime 4. Sarah needs to sleep on her back when she is not nursing 5. no spaces between the mattress and wall or headboard where Sarah could be trapped.

Sarah's dad is still uncomfortable with the three of them co-bedding because he is a very sound sleeper and sometimes rolls over and hits his wife with his arm in his sleep. They decide to put a firm mattress on the bedroom floor where Sarah and her mother to sleep for the next few weeks as Sarah is adjusting to her new environment.

Follow-up via telephone one week later revealed that mom and Sarah were sleeping most nights on a firm mattress on the floor where she would nurse multiple times throughout the night but both quickly return to sleep after each breastfeeding episode. Sarah was starting to nap for short periods in her bassinet during the day. Mom was feeling more rested and no longer felt like she had the baby blues. Mrs. Perlman planned to place Sarah in the bassinet as she would tolerate and I agreed that at the four month visit if still co-bedding, we would discuss strategies to get Sarah to sleep in her bassinet during the night.

## **Key points:**

1. This case illustrates an alarming trend that I am encountering frequently in my practice, and usually revealed

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only after very direct questioning about the precise location where the newborn and parent slept in the night or two prior to coming to the office. The practice of a parent holding their infant on their chest while they sit in a semi-upright position is likely one of the most dangerous sleeping arrangements. Firstly the infant is not in a supine position and secondly the infant could slip down where there are soft surfaces and spaces where suffocation could occur.

2. For some families, especially those from cultures where co-bedding is the norm, there is no reason to put a finite limit to the co-bedding sleep arrangement. However, for parents who do not want to co-bed for an extended period it is important to have a plan to start working at transitioning the infant out of the parental bed beginning when the infant is three to four months of age when their sleep development should allow this. It is often very difficult to alter sleep transition patterns if parents wait until the latter half of the first year to make changes in sleep arrangements.
3. I try and help moms realize that it is normal and even beneficial for most breastfed infants to nurse at least once during the night even after their infant is six months of age (an age when many books say infants should be sleeping through the night).
4. Asking about the specifics of sleep for mother and infant (how well, where, and position) at each well child check is critical in supporting the breastfeeding mother.

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## Other Reading:

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## COMMUNITY SPOTLIGHT

### Community Spotlight

#### Postpartum Doula Services in San Diego

Kim Elkins EdM, IBCLC, LLLL

A postpartum doula is a woman who is trained to help new mothers adjust to the birth of their baby by offering practical help, accurate information and emotional support.

She will care for the new mother by bringing her meals, encouraging her to rest, offering breastfeeding support, taking care of older siblings, and listening with sensitivity to the new mother's feelings. She will teach the new parents how to take care of their baby, and help them to become more confident as parents. She may also do light housekeeping, such as laundry and dishes, or run errands, so that the new mother can rest and recuperate from the birth.

Some postpartum doulas work only during the day; others are available to help during the night. Night-time services may be especially helpful for mothers with multiples, special needs babies, or postpartum depression. Postpartum doulas do not offer medical advice.

In San Diego, postpartum doulas typically charge \$25 / hour and up. Several referral services are available:

Beautiful Beginnings  
Birth Resource Network  
Doulas of North America  
North County Doulas

[www.beautifulbeginnings.org](http://www.beautifulbeginnings.org)  
[www.birthresourcenetwork.org](http://www.birthresourcenetwork.org)  
[www.dona.org](http://www.dona.org)  
[www.northcountydoulas.com](http://www.northcountydoulas.com)

## ASK THE EXPERT



Eyla G. Boies MD, FAAP, joined the UC San Diego Pediatric Faculty Practice in 1992. She devotes her time at UCSD to teaching residents and students, conducting clinical research on breastfeeding related issues, and seeing patients. She is a member of the Academy of Breastfeeding Medicine, and the Section on Breastfeeding of the American Academy of Pediatrics, and sits on the board of the San Diego Breastfeeding Coalition.

**Question:** How do I wean my seventeen month old daughter, Sarah, when breastfeeding is the only way I get her to sleep at night?

**Answer:** I would first inquire of Sarah's mother her reasons for wanting to wean. Even though breastfeeding beyond one year of age is considered extended breastfeeding and is not the norm in the United States and most Western European countries, it is the norm in many cultures. In fact the World Health Organization recommends mothers breastfeed their infants for at least two years. Often mothers in western cultures receive pressure from family and friends to wean a toddler because they feel a toddler is too old to breastfeed. A discussion about child-led weaning and weaning when it feels right for mom and child will often empower a mother to breastfeed until she and her child are ready, not when others think they should wean.

Upon further questioning I learn that Sarah's mother is a professional, is gone most of the day and the weaning process is well under way. Sarah had been breastfeeding until relaxed and drowsy when her mother would put her in her crib where she

would transition into sleep. Sarah is not nursing during the day, but is nursing as part of the bedtime ritual and gets frustrated and upset because there is little or no milk.

Fortunately Sarah eats a variety of foods- primarily the same food her parents eat. She likes to feed herself mostly using her fingers but will use a spoon. She is growing and gaining weight at the 50<sup>th</sup> percentile for her age. She is bright and is at a developmental stage where her receptive language is good and she is also beginning to engage in symbolic play. Sarah and her mother need to find a substitute activity for a sleep onset association.

I suggest that Sarah's mother rock her holding her closely, approximating the physical closeness of nursing, and explain to her that there is no more milk. They can try and find a comfort object such as a blanket or a doll that Sarah can hold while she relaxes. Sarah might find the idea of "breastfeeding her doll" while she rocks with her mother appealing as children at this age are beginning to engage in symbolic play. She could let Sarah suckle for a short time to help relax but explain to her that there really is no milk. I hesitate to suggest offering a glass of milk as a substitute as that would require Sarah having her teeth brushed afterward. Breastmilk, due to its anti-infective properties, is less likely to cause caries than cow's milk. I warn mom that it will likely take Sarah several nights to adjust, however, most children will settle into the new routine after three to five nights.

This case illustrates the importance of taking a careful history that included a full nutritional history and physical exam to assure an adequate nutritional status and finding a solution that works for the mother and her child.

## BREASTFEEDING FRIENDLY WORKPLACE AWARD

### The San Diego County Breastfeeding 2008 BREASTFEEDING-FRIENDLY WORKPLACE AWARDS

The San Diego County Breastfeeding Coalition is pleased to announce that nominations for the 2008 Breastfeeding-Friendly Workplace Awards are still being accepted. They will be presented in concert with other California counties on Wednesday October 15, 2008. This annual award is presented in celebration of World Breastfeeding Week to one or more businesses that demonstrate significant commitment to supporting their own breastfeeding employees. Past recipients include: A Robert Cromeans Salon, American Academy of pediatrics Chapter 3, and Scripps Institution of Oceanography at UCSD (2007), Johnson & Johnson Pharmaceutical Research & Development, LLC (2006), Sharp Grossmont Hospital (2005) Solar Turbines (2004), UCSD Healthcare (2003), Naval Hospital, Camp Pen-

dleton (2002), The City of Escondido, Kyocera, The San Diego Spirit (2001), Aetna US Healthcare (2000), Qualcomm, People's Organic Foods Market (1999), SeaWorld (1998), Naval Medical Center San Diego (1997), and Hewlett-Packard (1996).

If your company is contributing to the health of San Diego County by providing employees with time and facilities to express milk at work, we would like to acknowledge your accomplishments. Please complete our on-line application at [www.breastfeeding.org](http://www.breastfeeding.org) by August 1, 2008 to nominate your employer for the Breastfeeding-Friendly Workplace Award. We will gladly provide a mail-in application at your request. For further information, please contact SDCBC Board Members, Eyla Boies MD at [eboies@ucsd.edu](mailto:eboies@ucsd.edu) or Mendy Mattingly at [mmattingly@littler.com](mailto:mmattingly@littler.com).

# SAVE THE DATE

**July 10, 2008: 6-8 pm**

**Chula Vista, CA**

Sharp Chula Vista Medical Center, Staff Dining Room  
SDCBC Coalition Meeting: *Polycystic Ovary Syndrome (PCOS) & Breastfeeding*

Lisa Marasco MA, IBCLC, RLC

[www.breastfeeding.org](http://www.breastfeeding.org)

**July 23-27, 2008**

**Red Rock Resort, Spa and Casino**

**Las Vegas, Nevada, USA**

ILCA's 23rd Annual Conference: *One Voice, Uniting the Profession - Practice, Professionalism, Policy*

Sponsored by ILCA and USLCA

Website: [www.ilca.org](http://www.ilca.org)

**August 2, 2008: 8am-12:30 pm**

**San Diego, California**

Rady Children's Hospital and the San Diego County Breastfeeding Coalition

Breastfeeding Mini-Seminar: *Breastmilk in the NICU & Beyond*

Jae Kim MD, PhD, Yvonne Vaucher MD, MPH, & Eyla Boies MD

[www.breastfeeding.org](http://www.breastfeeding.org)

**August 15-16, 2008**

**Providence, Rhode Island**

36<sup>th</sup> Annual Seminar for Physicians on Breastfeeding:

*Partnering for Optimal Lactation Management and Support*

<http://www.lleus.org/physsem08.html>

**September 11, 2008: 6-8 pm**

**Escondido, California**

Palomar Hospital, Education Classroom

SDCBC Coalition Meeting: *Breastfeeding and the Law*

Mendy Mattingly, Esq.

[www.breastfeeding.org](http://www.breastfeeding.org)

**September 8-12, 2008**

**Berkeley, California**

*Professional Education in Breastfeeding and Lactation (including CLE training)*

Presented by SWAG Conferences and Evergreen Perinatal Education

Molly Pessl BSN, IBCLC and Ginna Wall MN, RN, IBCLC

For information, contact Sue Wirth at [SWAGconferences@aol.com](mailto:SWAGconferences@aol.com)

**September 19-20, 2008**

**Berkeley, California**

*Breastfeeding from All Angles: Food for Thought*

Bay Area Lactation Associates

For information: [SWAGconferences@aol.com](mailto:SWAGconferences@aol.com)

**October 23-26, 2008**

**Dearborn, Michigan**

*Breastfeeding: The Road to Health*

Academy of Breastfeeding Medicine 13<sup>th</sup> Annual International Meeting

Basic Breastfeeding Course for Physicians, Main Physician meeting and Health Team meeting

For information: [www.bfmed.org](http://www.bfmed.org)

**November 13, 2008: 6-8 pm**

**Oceanside, California**

Tri-City Medical Center

SDCBC Coalition Meeting: *DHA and ARA for Moms & Babies: Important Supplements or Marketing Hype?* Diana Lee RD,

CNSD, IBCLC and Kelly Barger RD, CLE, CDE

[www.breastfeeding.org](http://www.breastfeeding.org)

**June 4-6, 2009**

**Amarillo, Texas**

Hale & Hartmann's Human Lactation Research Conference

[www.ibreastfeeding.com](http://www.ibreastfeeding.com)

## RESOURCES

**La Leche League Breastfeeding Helpline (US Only)**

Mothers can call 1-877-4 LALECHE (1-877-452-5324) for 24 hour toll-free breastfeeding helpline services.

**Breastfeeding and Drugs Information**

TOXNET/LACTMED

<http://toxnet.nlm.nih.gov/>

Click on LactMed

# DEALING WITH SLEEP DEPRIVATION

## Dealing with Sleep Deprivation - What's a new mother to do?

Kim Elkins EdM, IBCLC, LLLL

Because newborn babies need to feed frequently, the new mother may find it hard to get enough sleep, especially at night. Here are some time-honored tips from breastfeeding mothers.

**Get to know your baby's sleep patterns.** Most newborn babies have one longer stretch of sleep (3-5 hours) in 24 hours. Take advantage of this opportunity to catch a few uninterrupted hours of sleep yourself. At first, your baby's long stretch of sleep may occur during daylight, but soon it will move to night-time.

**Take short naps during the day.** In addition to sleeping during your baby's long stretch of sleep, try to take a few cat-naps during the day. Every little bit helps. Many new moms see baby's nap-time as an opportunity to get things done around the house. Instead, try to look at baby's nap-time as your time to rest as well.

**Get help with other tasks.** So that you can rest while your baby is napping, it is important to delegate housework, errands, and care of older siblings to others, as much as possible. If you do not have family, friends or neighbors available to help, consider hiring a teenager to help you around the house a few afternoons each week. A postpartum doula (see Community Spotlight article) can be invaluable in helping you to get more rest.

**Sleep close to your baby.** Night-time feedings are easier if you do not have to get up and go to another room every time your baby wakes up. Some mothers like to have the baby

next to their bed in a crib or bassinet; others find a safe way to have their baby in bed with them (see Co-sleeping article). Several crib-type items are available which are designed to safely attach to the parents' bed so that the baby has his own space right next to mom. If night-time feedings are disturbing dad's sleep, mom and baby can sleep close to each other in a different room, or dad can spend part of the night in another room.

**Learn how to nurse lying down.** Almost all babies can nurse while mom and baby are lying down. This is a great way to get some rest during the day. And, once your baby can latch on by himself, you may barely have to wake up for night-time feedings. You can just snuggle close to your baby and let him take it from there. Take the usual precautions for safe sleeping arrangements

**Take advantage of growth spurts to spend the day resting.** Babies go through growth spurts several times during the early weeks and months of breastfeeding. They may seem to want to nurse 'all the time' for a few days, and then they go back to their usual nursing frequency. Take advantage of these growth spurts to spend a day or two resting with your baby. If you nurse him lying down, you can get some rest while he nurses on and off throughout the day.

**Get empathy and encouragement from other moms.** Having your sleep interrupted is easier to tolerate if you know that you're not the only one who's not getting 8 straight hours of sleep at night.

**And remember, your baby will grow out of this phase.** In a few years you will have special memories of the times you spent nursing your little baby in the wee hours of the morning.

## ADVOCACY & LEGISLATION

### Advocacy & Legislation

Nancy E. Wight MD, President, SDCBC

**FIRST MPINC RESULTS PUBLISHED.** Maternity practices in hospitals and birth centers can influence breastfeeding behaviors during a period critical to lactation. In 2007, to characterize maternity practices related to breastfeeding, the CDC (Centers for Disease Control and Prevention) conducted the first national Maternity Practices in Infant Nutrition and Care (mPINC) survey. The survey was mailed to 3,143 hospitals and 138 birth centers in the US, the District of Columbia and 3 US Territories. Overall response rate was 82%.

Questions regarding maternity practices were grouped into 7 categories that served as subscales in the analyses: 1. Labor and delivery, 2. Breastfeeding assistance, 3. Mother-newborn contact, 4. Newborn feeding practices, 5. Breastfeeding support after discharge, 6. Nurse/birth attendant breastfeeding training and education, 7. Structural and organizational factors related to breastfeeding. Researchers assigned scores to facility responses on a 0-100 scale, with 100 representing the practice most favor-

able toward breastfeeding. Mean subscale and overall scores were calculated for each responding facility and each State.

The results indicated that a substantial portion of facilities used maternity practices that are not evidence-based and are known to interfere with breastfeeding. Among the States, mean total scores ranged from 48 (out of 100) in Arkansas to 81 in New Hampshire and Vermont, with California coming in at 69, barely above the US average of 63. Scores were generally highest in the western and northeastern regions of the United States and lowest in the southern region. The scores generally correlate with breastfeeding prevalence in those states.

In July 2008 mPINC benchmark reports will be provided to each facility that completed a survey, comparing the individual facility's subscale and total scores with the scores of all other participating facilities, other facilities in that State, and facilities of a similar size nationally. Hopefully this data will be used to improve maternity practices that interfere with establishing breastfeeding. The full preliminary report is available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5723a1.htm>.

# PACIFIERS AND BREASTFEEDING

## Pacifiers, Breastfeeding and SIDS...What's a Mother To Do? Yvonne E. Vaucher, M.D., M.P.H.

Pacifiers are a longstanding, well accepted and worldwide way to soothe fussy infants. Almost all infants either use a pacifier or thumb/finger suck to self-soothe. In some cultures, pacifiers are preferred as a means to discourage thumbsucking. The prevalence of pacifier use varies considerably. In many countries, including the US and Western Europe, the majority of infants do use pacifiers. Pacifiers are usually introduced within the first week after birth, often in the hospital soon after birth. Even among infants whose mothers indicated at the time of delivery that they did not intend to offer a pacifier to their infant, most are using pacifiers at six months. The reason usually given for mother's changing their plan and giving a pacifier was the need to soothe a fussy infant.

*Pacifiers and breastfeeding:* Adverse effects of pacifiers include the increased risk of ear infections (i.e., otitis media), gastroenteritis, oral thrush in infancy and dental malocclusion with very longterm use. In breastfeeding infants, numerous studies have associated pacifier use with decreased number of breastfeeds per day, shorter duration of suckling at each feed, and a shorter duration of both exclusive and total breastfeeding. The adverse effect of pacifier use on duration and exclusivity of breastfeeding is not due to "nipple confusion," since the shortened exclusivity and duration of breastfeeding is far removed from the newborn period. A plausible explanation for the link between pacifier use and decreased breastfeeding behavior is that frequent non-nutritive sucking leads to less desire to suckle at the breast, thereby decreasing prolactin secretion and resulting in insufficient milk production. Low milk supply in turn increases infant fussiness and the need for more formula supplementation. A vicious cycle is thus established, ultimately leading to early weaning. It is important to note, however, that some countries have high rates of *both* exclusive breastfeeding and pacifier use.

The reported adverse effect on breastfeeding, derived from observational studies, has discouraged breastfeeding mothers from giving pacifiers or contributed to guilt in doing so. However, observational trials are often misleading as they are not designed to control for the many factors which may confound the result. A randomized, controlled trial (RCT) is the best way to determine whether an "intervention," in this case pacifier use, is primarily responsible for effects seen. In the few published RCTs of breastfeeding and pacifier use, the adverse effects of pacifier use on breastfeeding were no longer evident except in infants with very early (< 1 week) introduction of pacifiers. No adverse effect on breastfeeding was apparent when pacifier use was begun at later than one month of age after breastfeeding was well established. *It thus appears that adverse effects on breastfeeding reported are not primarily due to the pacifier per se, but rather to the reasons which led to pacifier use in the first place.* For instance, giving a pacifier may reflect underlying breastfeeding problems (e.g., such as poor latch or sore nipples), lack of maternal confidence, cultural expectations, or maternal issues which affect breastfeeding behavior. Mothers who wish to regiment or purposely decrease the frequency of breastfeeding may

use the pacifier to do so, in which case the decrease in breastfeeding is mother, not infant, driven.

*Pacifiers and SIDS:* A consistent, statistically strong, protective effect of pacifiers on the risk of Sudden Infant Death Syndrome (SIDS) has been demonstrated in case-control studies. Compared to control infants, those who died of SIDS were less likely to have been given a pacifier at the time of their last sleep. The risk of SIDS was greatest in those infants who were habitual pacifier users. The protective effect of pacifiers was noted in both bottle and breastfed infants, although no studies specifically examined the effect of exclusivity, frequency, timing of breastfeeding infants on the risk of SIDS. This is important because being breastfed was found to be protective against SIDS in earlier studies. After using meta-analysis to combine information from individual case-control studies, the independent, protective effect of pacifier use on the risk of SIDS persisted even after controlling statistically other known risk factors, such as sleep position, maternal smoking, bed-sharing, breastfeeding, socioeconomic status, and infant illness and infant age (Odds Ratio 0.39, CI 0.31-0.50; a risk reduction of 60%). Although for each individual child the risk of SIDS is very small, it is estimated that in the US one death for every 3000 infants using a pacifier may be prevented by inserting the pacifier before each sleep.

The means by which pacifiers may protect from SIDS is unknown, as is the underlying cause of SIDS itself. Mechanisms proposed include a decreased arousal threshold resulting in lighter sleep, decreased airway obstruction due to forward motion of the mandible and the back of the tongue associated with non-nutritive sucking, reduction of gastroesophageal reflux, and reduction of prone positioning during sleep. It is also possible that pacifier use is a marker for an as yet unidentified risk factor for SIDS.

*Recommendations* concerning pacifier use in breastfeeding infants must balance the possible deleterious effect on breastfeeding with the substantial protective effect of pacifier use on the risk of SIDS and based upon the best information currently available. After careful consideration, the American Academy of Pediatrics Task Force on SIDS concluded that "*the reduced risk of SIDS associated with pacifier use is compelling, and the evidence that pacifier use inhibits breastfeeding or causes later dental complications is not.*" Therefore the AAP recommends that parents consider offering pacifiers to all infants in the first year, regardless of type of feeding, when placing the infant down for any period of sleep. Pacifiers should not be reinserted and the infant should not be forced to take it. For breastfed infants, introduction of the pacifier should be delayed until one month of age after breastfeeding is well established. (This approach is congruent with the WHO Baby Friendly Hospital Initiative (BFHI) 10 Steps which specifically prohibits giving pacifiers to breastfeeding newborns before discharge from the birth hospital.) Ultimately, the responsibility rests with each family to decide whether or not use a pacifier for their breastfeeding infant.

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# PACIFIERS AND BREASTFEEDING

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## SDCBC 2008 MEMBERSHIP DRIVE

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### SDCBC Membership Levels

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

**Contributing Member - \$50** (*Individual*)

**Friends of the Coalition - any amount under \$50**

### 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. We work with many community partners in many ways, to increase breastfeeding initiation and duration rates, thereby improving the health of our community.

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

As a full 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,
- Have a home page or link, as appropriate, on the SDCBC's website: [www.breastfeeding.org](http://www.breastfeeding.org),
- Be listed, with a Sponsor membership, as appropriate, in the "Breastfeeding Resource Guide"
- Receive free CME credits for Coalition meeting education programs

### You can show your support of the San Diego County 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
  - Membership
  - Professional Outreach
  - Research and Evaluation
- Attending Coalition meetings and providing your expertise and experience.

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

General Coalition Meetings are held from 6-8 pm on the 2<sup>nd</sup> Thursday of each odd-numbered month at various hospitals around the county to encourage additional participation. Please call 858-939-4175 or visit our website for locations and directions

([www.breastfeeding.org](http://www.breastfeeding.org)).

# Breastfeeding Update

## "Breastfeeding and Sleep"

SDCBC's Newsletter for June 2008  
Volume 8, Issue 2



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SEE THIS NEWSLETTER ON THE WEB AT  
[www.breastfeeding.org](http://www.breastfeeding.org)

## BOOK REVIEW

### **Sleeping with Your Baby: A Parents' Guide to Cosleeping** **James J. McKenna, PhD** **Platypus Media, Paperback, 2007**

Professor James J. McKenna, PhD, is the Rev Edmund P. Joyce C.S.C. Chair in Anthropology at the University of Notre Dame. Since 1978 Dr McKenna has been investigating the over 100 year old uniquely Western cultural ideas about child rearing, breastfeeding and co-sleeping with your infant child. These Western ideas emphasize preparing an infant for early independence from the parents to become an individual. This is in stark contrast to most of the rest of the world, which emphasizes the close bond between parent and child and the marked and prolonged dependence of the child on the parent for ultimate preparation to face the world alone.

A major element in this Western individuation is to have the infant sleep in a crib separate from the parents in another room as early as possible despite the loud and prolonged protests from most infants. Those who do not protest are the "good babies". The American Academy of Pediatrics now recommends co-sleeping (within an arm's reach of the infant) but not bed-sharing during sleep. There are safe ways to bed-share and unsafe ways. Sleeping in a crib has its own risks. Sudden Infant Death Syndrome (SIDS) was originally referred to as "Crib Death" for a reason. Dr McKenna states "this book is intended to provide a balanced, comprehensive and holistic per-

spective on co-sleeping and bed sharing, specifically while breastfeeding." He then does just that: from sleeping in less deep stages of sleep allowing more rapid arousal when apnea threatens survival, to longer more restful sleep, and more stable physiologic status with skin-to-skin care, the benefits are explained in scientific terms. Breastfeeding mothers and infants both get more rest and sleep when in close proximity to each other.

There are factors which promote safe co-sleeping and factors which make this practice quite unsafe. Dr McKenna discusses these in great detail in the section entitled: How to Sleep Safely with Your Baby. The interpersonal relationship between parents is challenged by having an infant and co-sleeping with your infant must be carefully considered in this context. This is sensitively treated with helpful suggestions.

Lastly there is an extensive list of references and websites for further consideration of this issue, which inquisitive parents will most appreciate as well as a listing of devices useful for co-sleeping. Our own SDCBC President Nancy Wight sums it up nicely in her prelude comment: "Dr McKenna clearly differentiates cultural bias from science in a very balanced and readable way, so that parents are empowered to make the correct choices for themselves regarding safe bed sharing and co-sleeping." I heartily agree.

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