What is the Postpartum Well-Being Study?

This is a National Institute of Mental Health (NIMH)-funded study that explores postpartum well-being among women with diverse sexual histories and sexual orientations. This study is a multisite study and is being conducted by Dr. Abbie Goldberg at Clark University, in collaboration with Dr. Lori Ross at the University of Toronto and Center for Addiction and Mental Health (CAMH).

Who should receive the survey?

Every woman attending the clinic for prenatal care. The ideal time frame is 25-32 weeks gestation, although the questionnaire can be given as early as 20 weeks and as late as 36 weeks.

What do women do with the survey?

Please ask women to complete the survey (it should take 2 minutes), place the survey in the envelope provided, and then put it in the locked, black box on the front desk that says “survey” on their way out today; OR, it can be mailed to Abbie Goldberg at Clark University.

Why should I ask women to complete the survey?

This is ground-breaking research that may assist health professionals to help future new mothers. All information is kept confidential. Participants can earn up to $175.

What should women expect if they fill out the survey?

Some of them will be called by our research team to participate in the next few weeks. Some may not be called, as we cannot invite every woman to participate (some are not eligible).

Who can I contact for more information, or to get more surveys?

Project Director, US, Abbie Goldberg, agoldberg@clarku.edu

Project Director, Canada, Lori Ross, lori.ross@camh.ca

Research Coordinator, US, April Moyer, amoyer@clarku.edu

Research Coordinator, Canada, Corey Flanders
Physical Health After Child Birth and Maternal Depression in the First 12 Months Postpartum: Results of an Australian nulliparous pregnancy cohort study

The relationship between maternal physical health after childbirth, and maternal mental health remains an under-researched area. Numerous studies have documented a range of psychosocial risk factors for maternal depression. In contrast, there has been limited consideration given to the role that poor physical health may play in women's mental health in the year after childbirth, with the result that interventions to promote maternal mental health rarely identify physical health problems as a major focus of intervention.

This paper draws on longitudinal data collected in an Australian multi-center prospective pregnancy cohort study – the Maternal Health Study – to explore the relationship between common physical health problems and depressive symptoms in the 12 months after a first birth. A total of 1507 eligible women returned completed questionnaires.

Women who reported multiple physical health problems in the first three months postpartum were significantly more likely to report concurrent and subsequent depressive symptoms, with evidence of a dose response. Compared to women reporting 0–2 health problems, the odds of reporting concurrent depressive symptoms at three months postpartum were increased almost four-fold for women reporting 3–4 health problems, and more than six-fold for women reporting five or more health problems. The odds of reporting subsequent depressive symptoms at six and/or 12 months postpartum were increased almost two-fold for those reporting 3–4 health problems, and more than three-fold among women reporting five or more physical health problems at three months postpartum.

To view a PDF of the full article click [HERE].

Sad Dads: A Challenge for Pediatrics

A standout feature of the current generation of 67.8 million US fathers is their involvement with their children. Time-diary studies have revealed that US fathers increased time spent on child care duties from 2.5 hours/week in 1965 to 7 hours/week in 2000, an amount greater than fathers in Australia, Canada, France, Britain, and Holland. In 2006, 24% of 11.2 million preschool-aged children whose mothers work are cared for by their fathers during their mother's working hours. The notion of “family pediatrics,” as well as the American Academy of Pediatrics report on fathers and pediatrics, encourages clinicians’ active support of fathers, especially in light of today’s changing families and the positive outcomes associated with father involvement. However, operationalizing provider support for fathers is not always straightforward.

In this issue of Pediatrics, Davis et al draw attention to the way that paternal depression affects fathers' parenting behaviors of their 1-year-old children. In their study, Davis et al focused on 4 behaviors typically discussed by pediatric providers during well-child visits: 3 positive behaviors (playing games, singing songs, and reading) and 1 negative behavior (spanking). The sample came from the Fragile Families and Child Wellbeing Study, a nationally representative, longitudinal birth cohort study of US children, born from 1998 to 2000, and their parents. Of the 1746 fathers in the sample, 7% reported a major depressive episode in the previous year. These depressed fathers were only half as likely to read to their children but 4 times more likely to spank their 1-year-old as non-depressed dads.

To continue reading this article click [HERE].
Nutritional interventions in depression and perinatal depression

Depression is the leading cause of mental disability worldwide. Women who are depressed during pregnancy are at a higher risk for preterm delivery, preeclampsia, birth difficulties, and postpartum depression. The treatment of depression in conventional medicine has focused on physiological factors that lead to impaired neurotransmitter function and treatments to improve neurotransmitter function.

It is important to find a way to treat depression in pregnant and lactating women without harming infants. Nutritional interventions may be a safe and cost-effective way of alleviating depression during pregnancy. The importance of nutritional status as a factor in perinatal depression merits further investigation. There is limited research available in the area of perinatal depression and nutrition. The WHO recommends that pregnant women consume three times more vitamin B-12 in order to compensate for changes in B-12 metabolism during pregnancy. Additionally, pregnant women require 70 percent more folate compared with non-pregnant and non-lactating women. The high nutrient demands of pregnancy coupled with an inadequate intake of nutrients before pregnancy can lead to nutrient depletion by the end of gestation. These nutrients do not easily recover postpartum.

Nutritional interventions may be a cost-effective way of preventing and treating depression in pregnancy. They may decrease the incidence or severity of perinatal depression. They may also reduce the utilization of or the necessary dose of psychotropic drugs. Decreasing the amount of psychotropic drugs used during pregnancy may reduce the risk of harm to the fetus, while still providing the mother with an equivalent amount of therapy. Safely reducing perinatal and postpartum depression rates may lead to more positive birth outcomes and a reduction in the depression cycle in offspring.

To view a PDF of the full article click HERE.

Efficacy of light therapy for perinatal depression: a review

Perinatal depression is an important public health problem affecting 10% to 20% of childbearing women. Perinatal depression is associated with significant morbidity, and has enormous consequences for the well-being of the mother and child. This review describes these rationales, summarizes the available evidence on the efficacy of bright light therapy for perinatal depression, and discusses future directions for investigation of bright light therapy as a treatment for perinatal depression.

- Bright light therapy may be an attractive treatment for perinatal depression because it is low cost, home-based, and has a much lower side effect profile than pharmacotherapy.
- Bright light could alleviate related issues of fatigue and sleep disturbance which might be especially problematic for perinatal depression, when the effects of sleep loss have consequences for both mother and baby.

In summary, antidepressant effects of bright light are well established, and there are several rationales for expecting that bright light might also be efficacious for perinatal depression. In pregnant and/or new mothers, bright light treatment could potentially offset insufficient low levels of light exposure, including disturbed sleep and fatigue.

To view a PDF of the full article click HERE.
Acupuncture for depression: a review of clinical applications

Depression is a serious psychiatric illness that involves symptoms such as depressed or sad mood, loss of interest or pleasure in activities, changes in weight, difficulty sleeping or oversleeping, energy loss, feelings of worthlessness, psychomotor changes, and thoughts of death or suicide. It constitutes a major public health problem, worldwide. The World Health Organization declared that the burden of depression is expected to be second only to heart disease by 2020.

In 2008, a meta-analysis examined the benefits of acupuncture for depression, and suggested that acupuncture could significantly reduce depressive severity. In 2010, another meta-analysis reviewing 207 related clinical studies supported acupuncture as safe and effective for Major Depressive Disorder and Posttraumatic Stress Disorder.

Reviewed studies suggest that acupuncture has the potential to be an effective, safe, and well-tolerated monotherapy for depression. Manual acupuncture may also help to reduce side effects of antidepressant medications. There are no reports on acupuncture for preventing recurrence after recovery from a depressive episode—a key problem in the treatment of depression, given the high recurrence rates. Further investigation into all of these aspects of acupuncture and depression is needed.

To view a PDF of the full article click [HERE].

The effect of prenatal Hatha yoga on affect, cortisol and depressive symptoms

Considerable evidence indicates that women with a lifetime history of depression, high levels of stress, anxiety, and poor social support during pregnancy are at increased risk for perinatal depression. Nevertheless, a great deal of variation in perinatal depression remains unexplained.

A number of successful preventive intervention efforts targeting psychosocial and physiological risk factors for perinatal depression have utilized mind-body practices, which embody the idea that the mind interacts with the body to influence physical functioning, improve symptoms, and promote health. Yoga has provoked particular interest given its increasing acceptance in the West and the growing evidence of its association with improvements in mood, decreases in depressive symptoms, and reductions in cortisol in non-pregnant populations.

Evidence from non-randomized trials suggests that yoga practice is associated with reduced risk of low birth weight and preterm labor. Randomized controlled trials further suggest that perinatal anxiety, perceived stress, psychological health, and autonomic nervous system responses to stress can be improved and the incidence of pregnancy-related hypertension alleviated with yoga.

To view a PDF of the full article click [HERE].
Dampening of positive emotions plays important role in development of postpartum depression

A new KU Leuven study shows for the first time that the dampening or suppression of positive emotions plays an important role in the development of postpartum depression. This has implications for the treatment of depressed mothers.

We often forget that depression is characterized by both negative feelings and a lack of positive feelings. Researchers suspect that this may have to do with the way depression-prone individuals deal with positive or happy feelings. These individuals downplay or suppress positive feelings through a cognitive response style called dampening. Typical dampening responses include: "These good feelings won't last, you'll see"; "I can't forget that things weren't always this good" and "I probably don't deserve to be this happy".

Professor Filip Raes (Faculty of Psychology and Educational Sciences) is the first to investigate whether dampening of positive emotions also lies at the root of postpartum depression. The study polled around 200 women once during and twice after their pregnancies. The women answered a questionnaire between the 24th and 34th weeks of pregnancy to determine depressive symptoms and cognitive responses to negative and positive emotions. They were then polled for depressive symptoms at 12 weeks and 24 weeks postpartum.

In about 8% of the mothers, responses indicated symptoms consistent with postpartum depression. Dampening was found to be a statistically significant predictor of women’s depressive symptoms postpartum. The more a mother indicated dampening responses to happy feelings, the higher the level of depressive symptoms experienced postpartum.

To continue reading this article click [HERE](#).
It's no secret or surprise; babies bring such anticipation, joy and an unexplainable love upon their arrival. They bring a whole new meaning to your life's happiness and touch places deep in your heart that you never even knew existed.

But it's not always smiles, happy tears or a walk in the park. How badly I wish it were, but it just isn't the case. When we begin this journey of becoming pregnant, right then and there, we are turning our bodies over. Right then and there we are living, breathing and eating for someone else. Every decision we make, everything we do, everywhere we go, we are not alone, and it's a safe assumption to make that from this time forward, there will never be a day that goes by that we won't worry or be second-guessing ourselves.

After the baby arrives you will feel such amazement, grandeur and pride that this little perfect person came from you and now belongs to you. But with that comes a constant apprehension about how and what you're doing. You continually question each and every move you make and endure endless worry that something is or will go wrong.

And then for some, without warning, you may you slip to an unfamiliar, earth-shattering place.

I'll never forget the words echoing throughout the doctor's office. It was almost as if I was ready to turn around to look for a woman being diagnosed behind me. I had researched it, I knew it, I certainly felt it, but to actually hear the words out loud, being said to me, was crushing. I felt defeated. I felt so small. I felt helpless. I almost felt as if I was ruined. But most of all, I just felt lost. Postpartum depression. Me? Impossible.

This was my third baby. Sure, I had anxiety and hormones that were all over the place after I delivered my first and second baby, but this, this was something different. Although it was all mental and emotional, it very well may have been one of the worst physical pains my body has ever endured.

One of the biggest challenges I had encountered was, "So when is 'this' going to be gone? I'm done with it already and just want this nightmare to be over with, for good." Unfortunately, there was no magic wand that could be waved over me or a magic pill, for that matter, to make this hurt disappear. Everyone kept telling me I was 'fine.' "You're OK... just try to snap out of it. Just be happy. You are going to be fine." If one more person tried to dismiss or underplay not only my pain but more so, devastation, I thought I would snap. I wasn't fine. I wasn't OK, and I feared that the next person that told me how I was supposed to feel would end up with a blow to the face.

The thing that crushed me that most with this diagnosis was the stigma attached to 'postpartum depression.' Half of me was plain humiliated for anyone to know what I was facing every single moment of every single day and the other half of me had felt such anger and resentment and self-pity, I was ready to go up and share my sob story with the woman behind me checking out at the grocery store.

Was this just me? What did I do? How was I so weak that I left myself slip into this coma that I felt I was in, that at times I was so scared I'd never wake up from?

I remember the first time an acquaintance of mine had questioned my diagnosis. "Well, isn't that where you want to hurt your baby? I mean, could you really ever want to hurt your baby?" To be completely honest, I can't quite remember just how I responded. I do know that I paused for quite some time and had to try to lift my jaw back up from the floor, as I was in such disbelief that someone could have the audacity to say such a thing because for me, it was the farthest thing from truth. But as unfortunate as it is, society is so misinformed between the levels of this and the gaping difference between postpartum depression and postpartum psychosis. And because of this, so many women silently suffer for fear of humiliation and being judged as 'crazy' or even worse, a bad mother.

To continue reading this article click HERE.
Baby Sun Safety

How long is too long for a baby to be in the sun?  

The highest risk from sun exposure comes in childhood. Over half of all lifetime sun exposure occurs before age 18, and the first two or three years of life are when our skin is the most vulnerable. Slathering with a high-SPF, waterproof sunblock is a great idea. It should be repeated every 80 minutes if the person has been in the water.  

It's best for babies to minimize sun exposure when the sun is highest overhead. This occurs between about 10:00 a.m. and 2:00 p.m. in most places, so it's best to stay indoors for some quiet time during those hours.  

The two biggest causes of damaging sunburn are the incorrect use of sunblock (either not putting it on 20 minutes before exposure or not reapplying often enough) and getting sunburned through clothes. Most T-shirts have an SPF of about 4. People burn beneath their shirts without even realizing it. As it turns out, blue shirts are far more effective than any other color.  

Sunblock doesn't block all of the sun's rays, so we shouldn't use sunblock thinking we can then stay in the sun all day. Instead, we should be in the sun a reasonable amount of time and use the sunblock to minimize the damage. 

To access more helpful tips click HERE. 

Nine Ways to Make Time for Your Mate After the Baby Arrives  

Here are a few suggestions for ways to get some special time with your mate:  

- **Strive for a real date night**
  Arrange for babysitting. If cost is an issue – or if you'd just feel more comfortable leaving your baby with someone you know – ask a family member or friend to take over for a few hours or look into starting a babysitting co-op.  

- **Make a date night at home**
  You don't need a sitter to really pay attention to each other. Once your baby has settled down for the night – or at least for a few hours – seize the moment. Resist collapsing on the couch and switching on the TV or slouching off to finish work. Sit together for some face-to-face time.  

- **Get creative**
  You don't have to wait for the sun to go down to spend quality time with each other. For instance, you can commute to work together or grab lunch once a week. It's surprising how relaxing conversation can become when you're meeting in the middle of the day and there's no baby or batch of chores to worry about.  

- **Read your mate a love letter**
  Life with a newborn can make it seem like you and your partner are just ships passing in the night. What better way to slow down and reconnect than by telling her how much you love her. Just jot down a few simple thoughts and then share them out loud.  

- **Buy season tickets**
  If you've already paid for seats to a concert, play, or sporting event, you'll feel committed to going. To cut the cost, split season tickets – and babysitting duties – with another couple with a baby.  

- **Treat weekends like weekends**
  Pack the diaper bag, get out the stroller or a backpack, and enjoy a weekend activity as a family. Malls, parks, and outdoor events are all baby-friendly.  

- **Create some post-work rituals**
  Take a walk together every evening with your baby. Everyone benefits from the exercise and fresh air, and you and your mate can reconnect at the end of the day.  

- **Plan special routines**
  Start a weekly DVD and take-out dinner night. Once your baby settles into a predictable sleeping pattern, life gets a lot easier – yet another great reason to work toward institute a regular bedtime.  

- **Play games**
  Games are a great way to laugh and have fun together, so dust off the backgammon set, deck of cards, or the Scrabble board.  

- **A final note: Make time for yourself, too**
  Make sure to carve out at least a few moments of “me time” each day to regroup – listen to your favorite CD, take a walk around the block, or call a friend. Remember, a happy parent makes for a happier relationship and a happier baby. 

To continue reading this article click HERE.
In our last newsletter, we featured the following article, “The Battle For Safer Home Births”. That article advocated for the passing of the MA bill, “An Act Relative to Certified Professional Midwives.” We thought it would be useful to present an alternative position on the bill in this issue of our newsletter:

6 Myths about licensing and regulating home birth midwifery in MA

by Joyce Kimball

As a Certified Professional Midwife living and actively practicing in MA, I oppose the MA bill “An Act Relative to Certified Professional Midwives.” I actively oppose home birth midwifery legislation in MA. I will work to that end.

1) It’ll make home birth safer for consumers because all home birth midwives will have the same training and fewer moms and babies will be hurt and/or die.

Not true. We all know licensed care providers (doctors, nurses, chiropractors, acupuncturists, etc.) who practice wonderfully and others who practice horribly. We all may have heard of a baby who died after 20 weeks of gestation, in labor, during birth or postpartum. According to Massachusetts Department of Public Health, Bureau of Health Information, Statistics, Research and Evaluation, published March 2013, for all Massachusetts births in 2010, there were 319 infant deaths (deaths of infants less than one year of age) compared with 366 in 2009. The infant mortality rate (IMR) was 4.4 deaths per 1,000 live births in 2010, compared with 4.9 deaths per 1,000 live births in 2009. This change was not statistically significant. Ninety-nine percent of these deaths occur in the hospital in the care of licensed providers. A baby who has died is the most horrible of all situations. In 75% of cases, we don’t know why a mom or baby is harmed or died or the harm or death was not preventable.

2) More women will be able to have home births because one of the goals of licensing is to get insurance companies to pay for home birth and then home birth will be affordable.

Not true. Yes, one of the goals of licensing is push to have each insurance company and the state insurance plan(s) pay for home birth. However, the chance that insurance companies will add home birth as a covered benefit and the chance that that covered benefit will be “meaningful” (i.e. they will cover $500 toward the cost of a home birth) is negligible. Check with NH home birth midwives who have a state law that requires insurance companies to pay for home birth but the reimbursement is so low that consumers have to pay additional fees to the midwives so that the midwives can be paid appropriately.

3) More women will access home birth if home birth midwives were licensed.

Not true. There is a home birth midwife for every woman who wants one. There are free services, low cost services, barter arrangements, and payment plans for home birth midwifery. In addition, many women would be legally barred from accessing homebirth midwives because of licensure restrictions- i.e., twins, breeches, VBACs, post-42 weeks, pre-37 weeks, water broken too long etc, etc, etc. These women would be having their human rights in birth stripped from them in the name of “access.”

4) Licensing home birth midwives will make ob/gyns and other hospital providers respect home birth midwives more; or home birth midwives and clients will be more respected and treated nicer if/when they transfer to the hospital.

Not true. Regardless of your credentials or a piece of paper, patients and home birth midwives transferring are treated based on how the care provider feels at the moment, what their birth was like, how busy it is at work, what’s going on with the patient, if the care provider is hungry, if the care provider is in a bad mood, etc. etc. etc. A license for a home birth midwife has NOTHING to do with how we are treated when we transfer.

5) Licensing will protect the home birth midwife from being sued by a consumer or by the state.

Not true. Licensing does not stop a midwife from being sued by anyone. Two Oregon licensed CPMs are being sued for $5M for damaged baby. MA statute currently protects midwives by clearly ruling that midwifery is not practicing medicine without a license. Let me repeat – licensing and regulation is not “safer” for providers nor does it “protect” providers.

6) It’s expected that the midwife and the consumers may have to compromise via regulations and sometimes to get malpractice insurance to get the benefits of licensing. It’s better that the MA midwives are “at the table” rather than get a law passed that harms us. Not true. The regulations and insurance can be horrific and the benefits are few if any. Some states have horrendous regulations such as required vaginal exams, required labor progress time frames and required transfer time frames (see Delaware and Arizona). Massachusetts has a great system that provides and allows for customized care for each individual mother and her family. I contend: let’s push for something that will harm midwife and consumer.

From: Joyce Kimball, CPM, Massachusetts, jekimball@bigplanet.com, www.birthservices.net

Also see http://www.humanrightsinchildbirth.com/ for more info

Wishing you the best in the upcoming Summer season!
-Abbie & Lori and the rest of the Postpartum Well-Being Team

PS: We’re on Facebook! Even if you don’t have a page of your own, you can look at the Facebook page. To check us out, click HERE.