PHYSICIAN'S TOOLKIT 1:  
Sleep Disturbance

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1.1 Sleep Research
Below are selected findings from the sleep disturbance literature:

- 63 - 97% of pregnant women, throughout their pregnancy, fail to get a full night’s sleep.4,5,11,12
- 92% of prenatal women describe their sleep as restless.5
- 30 - 50% of pregnant women continuously complain of heartburn and acid reflux throughout their pregnancy.4
- 30% of pregnant research subjects began to snore during pregnancy and many also reported choking episodes. 70% of the women had no previous history of snoring.1,5,9,10
- Nighttime labor and a history of sleep disruption are related to a higher incidence of post-partum depression.
- 25 - 26% of women reported symptoms consistent with restless leg syndrome and periodic leg movement disorder.2,5,9,11
- During the final trimester of pregnancy, increasing numbers of women have complaints that indicate insomnia (trouble falling asleep, staying asleep, or waking up too early).5,9
- Despite the significant sleep disruption that occurs in pregnancy, most women do not ask for assistance in improving sleep.9,12
- Pregnant women who slept fewer than six hours per night had longer labors and were 4.5 times more likely to have cesarean deliveries.3
- Changing hormone levels are one of the reasons prenatal women suffer from fatigue and insomnia.4,6,9
- Smoking and smoke exposure lead to increased sleep disturbance.
- Nighttime labor and a history of sleep disruption in late stage pregnancy are related to a higher incidence of post-partum blues.6
1.2 Typical Sleep Disruption Causes

First Trimester

- Increased pressure on the bladder, due to the growing fetus, leads to increased urinary frequency
- Physical and emotional stress and anxiety associated with pregnancy
- Progesterone, a hormone secreted by the placenta, increases daytime sleepiness and fatigue and can cause hot flashes
- Increased nausea (e.g. morning sickness) that can be experienced any time of day
- Vomiting
- Back pain
- Inhibitory effects of progesterone on the smooth muscle leads to frequent urination
- A stuffy nose
- Breast tenderness

Second Trimester

- Snoring/choking episodes, often accompanied by heartburn/acid reflux
- Increased pressure on the abdomen
- Continued physical and emotional stress and anxiety associated with pregnancy
- Vivid dreams and realistic, easily recalled nightmares

Third Trimester

- Restless Leg Syndrome
- Periodic limb movement
- Late-stage pregnancy induces changes in the upper airway, increasing snoring in prenatal women
- Third trimester women who snore are at a twofold greater risk for pre-clampsia, fetal growth restriction, SDB, and pregnancy induced hypertension
• Back pain, leg cramps, muscle aches, and general discomfort caused by the loosening of pelvic ligaments and joints to prepare the body for birth—the baby’s increasing size and weight causes the mother to have poor posture, making it difficult to walk, sit, or lie comfortably
• Shortness of breath
• A very active baby who kicks the mother’s bladder or other sensitive areas
• Continued vivid dreams and easily recalled nightmares
• Anxiety and worry about the baby, upcoming birth, etc.

1.3 Physician Suggestions

• Upon assessment, if sleep disruption seems to be due to normal hormonal and physical changes only, offer sleep information handouts. Typically, non-pharmacological interventions should be the initial treatment option.
• If sleep disorders are suspected (restless leg syndrome, periodic limb movement, snoring/obstructive sleep apnea, etc.) the client should be referred to a sleep specialist.
• Discuss both sleep quantity and quality with clients as a basic part of overall prenatal care.
• Encourage a safe daily exercise regimen (walking, swimming, stationary cycling, etc.) as a means of obtaining a better night’s sleep.
• Encourage the expectant mother to utilize a routine wind-down period at night (a light snack, warm milk, a warm bath, back/foot rub, meditation) to help achieve a mind state conducive to sleep.
• Encourage patient to drink adequate amounts of fluid throughout the day, but to cut down on them in the immediate hours before bedtime (it is difficult to sleep with a full bladder).
• Discourage eating large meals, especially late in the evening, as a means of reducing heartburn symptoms.
• Discuss the proper way for 3rd trimester women to position their bodies. Women who are pregnant should avoid sleeping on their back and should instead sleep on the left side, as this allows the best blood flow to the fetus, uterus and kidneys. Suggest the purchase of a pregnancy pillow.

• Encourage the patient to avoid stimulants (caffeine, nicotine, etc.) to promote better sleep. Also, prenatal women should avoid environmental stimulants (jarring, loud music, scary or violent movies, sports events, etc.) before going to bed.

• Soda and other high caffeine, high sugar drinks can cause leg cramps at night. Counsel the patient to avoid these after a certain time of day. In case of cramps, instruct her to extend the leg straight out on the mattress, and flex the foot upward, toward the body.

• Educate the patient via attached handout concerning the do's and don'ts of obtaining better sleep.
<table>
<thead>
<tr>
<th><strong>Do:</strong></th>
<th><strong>Don’t:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• exercise regularly, finishing up at least 3 hours before bedtime  &lt;br&gt; • keep a regular daily routine and bedtime schedule  &lt;br&gt; • keep the bedroom dark, quiet, and at a comfortable temperature  &lt;br&gt; • eat a light snack before bed  &lt;br&gt; • take your prenatal vitamins—this might relieve Restless Leg Syndrome</td>
<td>• consume any caffeine after noon  &lt;br&gt; • eat large meals before going to bed—this can cause indigestion, heartburn and restlessness  &lt;br&gt; • exercise within 3 hours of going to bed—this gets your body revved up and active, making it hard to fall asleep  &lt;br&gt; • drink any alcoholic beverages before going to bed—this causes fragmented sleep  &lt;br&gt; • watch television or read in bed—using the bedroom only for sleeping puts your body in the “sleep mode” when you enter the room  &lt;br&gt; • stay in bed when you are not sleepy—get up and do something boring until you are sleepy  &lt;br&gt; • use nicotine—it is a stimulant and leads to sleep disturbances  &lt;br&gt; • drink lots of liquids before bedtime—a full bladder will keep you running to the bathroom</td>
</tr>
</tbody>
</table>
1.4 References


2.1 Weight Research

Below are selected findings from the pregnancy weight literature:

- In a study of 2,300 women, 27% stated that they received no weight advice during their pregnancy 29.
- In a study which included 20,465 births, only 36.6% of mothers had weight gains within the recommended guidelines; 43.3% gained more than recommended, while 4.8% gained less than 15 pounds 10,14.
- Women who do not gain enough weight have an increased risk for delivering low birth weight babies (less than 2500 gm, or 5.52 pounds), putting the newborn at risk for seizure, meconium aspiration syndrome, and prolonged hospital stay 1,8.
- The National Institute of Health considers low birth weight to be a factor in infant mortality and in the development of childhood physical, developmental, and psychological problems 1,10,23.
- African Americans have the highest incidence of low birth weight babies (13%), followed by Hispanics (6 – 9%), Asian Americans (5 – 8%), and Caucasians (6%) 1.
- 40% of U.S. women are overweight or obese; excessive gestational weight gain is associated with large-for-gestational-age infants and macrosomia, with adverse outcomes for mothers and infants 21,24,26.
- Weight loss before pregnancy reduces the risks of neural tube defects, preterm delivery, diabetes, cesarean section, hypertension and thromboembolic disease 18,25.
- If a woman gains too much weight during her pregnancy, she may have a longer labor and a more difficult delivery, backache, leg pain, varicose veins, and extreme tiredness 9,13.
- Being underweight or obese puts pregnant women at a higher risk of pre-term labor and delivery 9,19.
2.2 Nutrition Research

Below are selected findings from the pregnancy nutrition literature:

- All women who are capable of becoming pregnant should consume folic acid every day to reduce the risk of having a baby affected with Spina Bifida, anencephaly, or other neural tube defects (abnormal or incomplete development of the brain and spinal cord) 7,12
- Women who get 400 micrograms of folic acid (0.4 milligrams) daily prior to conception and during early pregnancy reduce the risk that their baby will be born with a serious neural tube defect by up to 70% 27
- Sources of folic acid include green, leafy vegetables, oranges, bananas, milk, dry beans and peas, grains, and organ meats (such as chicken livers). A doctor also may suggest taking a vitamin containing folic acid. 3,11
- All meals should include the five basic food groups, including: 6-11 servings of grain products, 3-5 servings of vegetables, 2-4 servings of fruits: 4-6 servings of milk and milk products, 3-4 servings of meat and protein foods. Foods low in fat and high in fiber are important to a healthy diet 11
- Folic acid (400mcg daily) is essential for protein synthesis, the formation of new cells, and the production of new blood. It is required for increasing a pregnant woman’s blood supply and the growth of both maternal and fetal tissues 16
- Women of childbearing age should eat a diet rich in iron 28
- During pregnancy, extra fluids (water is best) are needed to increase blood volume. Six to eight glasses of water, fruit juice, or milk are encouraged daily 30
- Maternal phenylketonuria (PKU): women diagnosed with PKU as infants have an increased risk for delivering babies with mental retardation. However, this adverse outcome can be prevented when mothers adhere to a low phenylalanine diet before conception and throughout pregnancy 17

2.3 Exercise Research

Below are selected findings from the pregnancy exercise literature:

- Exercise may make pregnancy more comfortable, shorten labor, and reduce the need for obstetric interventions 5,6,19
- Although data is sparse, there appears to be no reason why women who are in good health should not be permitted to engage in exercise while pregnant. However, women with medical or obstetric complications should be encouraged to avoid vigorous physical activity 6,9,19
- At least 30 minutes of moderate exercise is promoted on most, if not all, days of the week 1,19
- Women who exercise during pregnancy may require a higher energy intake than the extra 150 to 300 calories per day that are recommended for non-exercising pregnant women 6,15,30
- Exercises performed in the supine position are inadvisable after the first trimester, as are prolonged periods of motionless standing 6,19
- Prolonged valsalva maneuvers with isometric exercise such as weight lifting should be avoided because they may result in a decrease in splanchnic blood flow and uterine perfusion 6,19
• Exercise during pregnancy can help prepare for labor and childbirth. Exercising afterward can help the mother get back in shape.
• Pregnant women should avoid exercise that involves the risk of abdominal trauma, falls, or excessive joint stress, particularly contact sports or vigorous racquet sports.
• Because of the potentially teratogenic effect of increased core body temperature, it is prudent to avoid exercise in very hot or humid weather.
• Exercising during pregnancy does not affect a baby's weight, as long as the mother is eating adequately.
• Women who did not exercise regularly during pregnancy are more likely to give birth to a very low birth weight baby.
• Exercise may prevent gestational diabetes.

2.4 Physician Suggestions

• Advise pregnant mothers about the risks to her and her baby if she becomes over/underweight during pregnancy.
• Advise patient to gain an appropriate amount of weight (25 - 37 pounds for a healthy woman, 28 - 48 pounds for an underweight woman, and 15 - 25 pounds for an overweight woman).
• Educate pregnant women about nutrition (i.e. healthy and unhealthy foods, calorie intake per day).
• Screen for women who should avoid exercise (i.e., women with preexisting health problems).
• Advise women to remain active throughout pregnancy, striving for at least 30 minutes a day, using appropriate exercise regimens.
• Explain that a healthy pregnant woman should increase her calorie intake by 150 - 300 calories/day. This amount can be slightly higher with regular exercise.
• Demonstrate safe versus dangerous exercise regimens.
• Inform women in the 3rd trimester that vigorous exercise is now contraindicated.
• Explain the importance of proper hydration and ventilation to avoid the possible teratogenic effects of overheating.
• Educate the expectant mother about warning signals which indicate she needs to stop exercise and, if necessary, call her physician.
• Discontinue supine forms of exercise (sit-ups, etc.) and weight lifting after the first trimester.
### Quick Pregnancy Exercise Chart

<table>
<thead>
<tr>
<th>Encouraged</th>
<th>Discouraged</th>
<th>Contraindications</th>
<th>Warning Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• walking</td>
<td>• all contact sports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• stationary cycling</td>
<td>• hockey</td>
<td></td>
<td></td>
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<tr>
<td>• low-impact aerobics</td>
<td>• boxing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• swimming</td>
<td>• wrestling</td>
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<tr>
<td>• yoga</td>
<td>• football</td>
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<tr>
<td>• kegel exercises</td>
<td>• basketball</td>
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<tr>
<td>• stretching</td>
<td>• horseback riding</td>
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<td></td>
<td>• gymnastics</td>
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<td></td>
<td>• skating</td>
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<tr>
<td></td>
<td>• rock climbing</td>
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<td>• dirt bike riding</td>
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<td></td>
<td>• cycling</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• skiing</td>
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</tbody>
</table>

### Contraindications
- pregnancy induced hypertension
- pre-term rupture of membrane
- history of pre-term labor
- incompetent cervix cerclage placement
- persistent 2nd or 3rd trimester bleeding
- placenta previa
- intrauterine growth retardation
- chronic hypertension
- thyroid abnormality
- serious cardiac disease

### Warning Signs
- excessive fatigue
- pain
- extreme shortness of breath
- vaginal bleeding
- palpitations
- rupture of membrane

### Signs
- Stop
- Exercising
Handout:
Eating and Nutrition During Pregnancy

Meeting your nutritional needs and staying active during pregnancy are essential for your and your baby’s health now and in the future. It is very important to have a well balanced diet; this helps alleviate some of the unpleasant physical symptoms that are often associated with pregnancy.

Healthy Meal Planning List

1. Grains: 6-9 servings/day

Benefits:
- main energy source
- fiber
- iron
- B-vitamins

Serving size examples:
- ½ Bagel
- 6 whole wheat crackers
- ½ cup cold cereal
2. Fruits & Veggies: 3 or more fruit servings/day
               4 or more veggie servings/day

Benefits:

- provides vitamins and minerals
- good source of fiber
- promotes healthy gums and other tissues for you and your baby

Serving size example:

- 1 medium fruit
- 1 small baked potato
- $\frac{1}{2}$ cup fruit or vegetable juice
- $\frac{1}{4}$ cup dried fruit
- $\frac{1}{2}$ - 1 cup cooked or raw veggies
3. Meat, Poultry, Fish, Eggs, and Beans: 2 servings/day

Benefits:

- supplies the body with protein important for the growth of your child, especially during the 2nd and 3rd trimesters
- B-vitamins
- Iron

Serving size example:

- 2-3 ounces of lean red meat, fish* or poultry
- 1 large egg
- \( \frac{1}{2} \) cup of walnuts, pecans, almonds, etc.
- 2 tablespoons of peanut butter

*Some fish and shellfish contain higher levels of mercury that may be harmful to an unborn baby. Please refer to page 132 for specific information of fish to avoid when pregnant.
4. Dairy Products: 4 or more servings/day

Benefits:
- helps build your baby’s bones and teeth
- rich in vitamins A & D
- high in protein
- *if lactose intolerant, calcium fortified orange juice provides the same benefits

5. Fats, Oils, and Sweets: ONLY occasionally

Benefits*:
- chocolate is high in antioxidants
- margarine is high in vitamin A

*these benefits do not apply when foods are eaten in excess—high fat, high cholesterol foods should be eaten in careful moderation
Handout: Exercise During Pregnancy

*Note: **Do Not** begin an exercise regimen without consulting your physician first!

Benefits of Exercise:

- decreased insomnia, anxiety, and depression
- lowered blood pressure
- improved posture
- head start on re-gaining your figure after delivery
- quicker recovery after delivery
- feel more energetic
- relief for backaches, leg cramps, constipation, varicose veins, and swelling
<table>
<thead>
<tr>
<th>Great exercises</th>
<th>Exercises to Avoid</th>
<th>Things to remember</th>
</tr>
</thead>
<tbody>
<tr>
<td>- walking</td>
<td>- contact sports</td>
<td>- warm up gradually</td>
</tr>
<tr>
<td>- swimming</td>
<td>- baseball</td>
<td>- avoid getting over heated or too cold</td>
</tr>
<tr>
<td>- low-impact Aerobics</td>
<td>- softball</td>
<td>- drink plenty of fluids</td>
</tr>
<tr>
<td>- yoga</td>
<td>- basketball</td>
<td>- eat a small snack before exercising</td>
</tr>
<tr>
<td>- stationary bicycling</td>
<td>- football</td>
<td>- wear loose, comfortable clothing</td>
</tr>
<tr>
<td>- stretching</td>
<td>- soccer</td>
<td>- stop and call your doctor if you feel pain or dizziness, begin to bleed, have contractions, difficulty breathing, palpitations, or any other unusual symptoms</td>
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<td>- skating</td>
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</tr>
<tr>
<td></td>
<td>- bicycling</td>
<td>- stop and call your doctor if you feel pain or dizziness, begin to bleed, have contractions, difficulty breathing, palpitations, or any other unusual symptoms</td>
</tr>
<tr>
<td></td>
<td>- gymnastics</td>
<td>- eat a small snack before exercising</td>
</tr>
<tr>
<td></td>
<td>- abdominal exercises or anything requiring you to lie on your back</td>
<td>- stop and call your doctor if you feel pain or dizziness, begin to bleed, have contractions, difficulty breathing, palpitations, or any other unusual symptoms</td>
</tr>
<tr>
<td></td>
<td>- skiing</td>
<td>- eat a small snack before exercising</td>
</tr>
</tbody>
</table>

Remember! Stop and take frequent breaks, especially if you feel tired!
2.6 References


Postpartum Mood Disorders

3.1 Postpartum Depression (PPD):

"Postpartum Depression (PPD) is a serious mental health problem that affects 10-20% of new mothers, and is characterized by a prolonged period of emotional disturbance, occurring at a time of major life change and increased responsibilities in the care of a newborn infant. PPD can have significant consequences for both the new mother and family" (American Psychological Association, 2007, p. 1). The APA's DSM-IV-TR (2000) states that, "Women with Postpartum Major Depressive Disorder often have severe anxiety and even Panic Attacks. Maternal attitudes toward the infant are highly variable but can include disinterest, fearfulness of being alone with the infant, or over-intrusiveness that inhibits adequate infant rest" (p. 423). The APA stresses the importance of differentiating between postpartum mood episodes, which are persistent, debilitating, and long-term, and the more commonly known "baby blues," a mild, temporary, non-debilitating condition that affects up to 80% of postpartum mothers for a period of 10 days postpartum. 3, 4, 7

PPD Research

- In general, clinical depression occurs in approximately 15% - 25% of the population, with women being twice as likely as men to experience depression 14, 28
- Perinatal depression occurs in 10-20% of prenatal women 29
- Because women are most likely to experience depression during the primary reproductive years (ages 24 - 45), they are especially vulnerable to developing depression during pregnancy 28
- Postpartum depression is estimated to occur in 10% - 20% of new mothers 28
- In most cases, PPD is preventable; early identification can lead to early treatment and better outcomes 28
- An estimated 9% - 16% of postpartum women will experience PPD 4
- Women with a history of PPD during previous pregnancy are at increased risk (approximately 41% will experience PPD with future pregnancies) 4
Research points to depression as one of the most common complications during and after pregnancy. Some researchers have found that depression during pregnancy can increase the risk of preterm delivery and low birth weight. Researchers believe that postpartum depression can affect the infant by causing delays in language development, problems with emotional bonding with others, behavioral problems, lower activity levels, sleep problems, and distress. Of every ten pregnant women, one or two have symptoms of major depression. One in four women will experience severe depression at some point in her life. Depression is the number one cause of disability in women. In general, unhappily married women experience more depression than single women do. Only about one-fifth of all women suffering from depression seek treatment. About 20% of women experience mild depression at least once during their lives. Depressive disorders are the most common psychiatric problems in primary care settings, with a prevalence between 4.8% - 9.2%. Some of the risks of untreated postpartum depression include: malnutrition; poor sleep patterns; refusal of prenatal care; abuse of illicit drugs, prescription drugs, and alcohol; and psychotic symptomology. Associations have been suggested between untreated depression and lower Apgar scores, higher rates of poor prenatal outcome, and pre-term labor. The most studied screening tool for postpartum depression is the Edinburgh Postnatal Depression Scale. The EPDS has been shown to be a highly effective tool in detecting PPD, with few false positives or false negatives (see attached Edinburgh Postnatal Depression Scale immediately following Physician Suggestions).

PPD Symptoms

- Intrusive thoughts in which the mother may visualize herself harming her baby.
- Drastic changes in mood, energy, motivation, appetite, etc.
- Sleep disturbance (not due to baby’s night awakenings)
- Somatic complaints, such as headaches, chest pain, etc.
- Anxiety and/or Panic Attacks
- Irritability, anger, and restlessness
- Withdrawal from social contacts, family, and friends
- Crying, feelings of hopelessness and helplessness
3.2 Postpartum “Baby Blues”:

“Postpartum “Baby Blues” are very common, occurring in up to 80% of new mothers. Characterized by mood swings, postpartum blues or “baby blues,” are normal reactions that many mothers experience following childbirth” (National Mental Health Association, 2007, p. 1). “Baby blues” usually onset 3-5 days post-delivery, and remit as the new mother’s hormone levels stabilize. The NMHA cautions that postpartum blues typically do not last longer than a few weeks post-delivery, and that depressive symptoms lasting longer are indicative of PPD. 2, 3, 27

“Baby Blues” Research

- Postpartum blues are very common, occurring in up to 80% of new mothers 14, 28, 34
- Characterized by mood swings, postpartum blues or “baby blues” are normal reactions that many mothers experience following childbirth 14, 29
- Providing oral and written information about baby blues increases the chance women will seek help if needed and eases worry about what they are experiencing 19

“Baby Blues” Symptoms

Note: symptoms usually fade within 2 weeks

- Feeling overwhelmed 32
- Easily irritated or frustrated 31, 32
- Anxiety or panic attacks 32
- Mood swings 14, 31, 32
- Fatigued, sorrowful or weepy 31, 32
- Trouble falling or staying asleep 31

3.3 Postpartum Psychosis:

Postpartum Psychosis, according to the New York State Department of Health (2005), is rare, occurring in 1 or 2 out of every 1000 postpartum women and usually beginning within the first month postpartum. It is defined as a psychiatric emergency requiring immediate psychiatric hospitalization. Women who develop this disorder may have hallucinations, sleep disturbances, and obsessive thoughts about their babies. Also, the woman may have rapid mood swings, switching quickly from depressed irritability to euphoria. Women with postpartum psychosis may lose touch with reality for long periods of time and may have suicidal ideations (The Postpartum Resource Center of New York, Inc., 2007). 30, 43

Postpartum Psychosis Research

- Postpartum Psychosis occurs in 1 or 2 out of every 1000 women and usually begins in the first 6 weeks postpartum 14, 29, 30
- 5% of postpartum women with this disorder commit suicide 30
- Postpartum psychosis has a 4% infanticide rate 30
Postpartum Psychosis Symptoms

- Auditory and visual hallucinations and delusions, which often are about the baby, include a "dark presence," and have religious themes 29, 30, 43
- Insomnia, anxiety, anger and agitation 29
- Paranoia (may inhibit the mother from sharing her delusion) 30
- Delirium: patient may seem normal one moment, then obviously psychotic the next 30
- Confusion 30
- Mania: hyperactivity, euphoria, restlessness 30
- Suicidal or homicidal thoughts 30, 43
- Bizarre delusions, such as claiming to have commands to harm the baby 29, 30

II. Anxiety Disorders

The National Institute of Mental Health (2007) states that, "Anxiety disorders affect about 40 million American adults age 18 years old and older (about 18% of the population) in a given year, causing them to be filled with fearfulness and uncertainty" (p. 1).

Approximately 10% of women develop anxiety symptoms sometime during their lives. 40 Also, according to the NIMH, this form of anxiety is far different from the mild, temporary situational anxiety that arises from such things as public speaking, first dates, or a job interview. The criteria for a disorder requires that the anxiety lasts at least six months. Though many (about 40%) of women experience a precise decrease of the anxiety pattern during pregnancy, the set of anxiety symptoms may reappear postpartum.22 Anxiety Disorders are usually accompanied by other serious problems, including depression, drug abuse, and alcoholism.3, 23 It is especially important to assess for anxiety disorders during pregnancy because high stress and anxiety increase risk of miscarriage, pre-term delivery, and low birth weight babies.9 A strong link has also been demonstrated between maternal anxiety and stress levels during the early months of pregnancy (12th - 23rd week) and the child’s likelihood of later developing Attention Deficit Hyperactivity Disorder (ADHD), behavioral problems, general anxiety, and fibromyalgia.9 Unfortunately, anxiety disorders often go undiagnosed in expectant and new mothers because of the faulty expectation that all prenatal/postpartum women are excessively anxious.40 The focus on depression as the primary mood disturbance among postnatal women can also lead to ignored symptoms of stress and anxiety or misdiagnosis, leaving them at risk of not receiving the treatment they need.19
3.4 Panic Attacks

The American Psychiatric Association’s DSM-IV-TR (2000) defines a panic attack as, “a discrete period of intense fear or discomfort in the absence of real danger that is accompanied by at least 4 of 13 somatic or cognitive symptoms” (p. 430). “Panic attacks can happen at any time and any place without warning. They often happen in grocery stores, malls, crowds, or while traveling” (National Institute of Mental Health, 2005, p. 3). The typical panic attack has a sudden onset and peaks rapidly, usually in 10 minutes or less, and is consistently accompanied by an overwhelming sense of impending disaster or doom. Symptoms may be somatic or cognitive and the sufferer typically feels they must flee and escape the situation or they will be seriously injured or even die. Panic attacks occur more than twice as often in women as in men (approximately 10% of postpartum mothers suffer).

Panic Attack Symptoms
- Palpitations
- Sweating
- Trembling
- Shaking
- Sensing shortness of breath or smothering
- Feeling of choking
- Chest pain or discomfort
- Nausea or abdominal discomfort
- Dizziness or lightheadedness
- Derealization or depersonalization
- Fear of losing control or “going crazy”
- Fear of dying
- Paresthesias
- Chills or hot flashes
- Numbness in hands and feet

3.5 Obsessive Compulsive Disorder (OCD)

The American Psychiatric Association’s DSM-IV-TR (2000) defines OCD as, “Recurrent obsessions or compulsions that are severe enough to be time consuming (i.e., they take more than 1 hour a day) or cause marked distress or significant impairment” (p. 456). Persons with obsessive compulsive disorder are plagued with unwanted recurrent obsessions or compulsions (or both). Imagine people who spend their entire lives trying to avoid stepping on cracks or are driven to counting rituals because they are so afraid that failing to perform these rituals could bring disaster to them or their family (Zide & Gray, 2001). According to the APA (2000),

“Obsessions are persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause marked anxiety and distress. Compulsions are repetitive behaviors such as hand washing, ordering, and checking, or mental acts such as praying, counting, or repeating words silently that are performed with the goal of preventing or reducing anxiety or distress, not providing pleasure or gratification” (p. 457).

Basically, these upsetting thoughts (obsessions) cause rituals (compulsions) which are attempts to reduce anxiety and lower stress levels in the sufferer. OCD affects about 2.2 million American adults each year, and is equally prevalent in men and women.
OCD Symptoms

Obsessions

- Recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
- The thoughts, impulses or images are not simply excessive worries about real life problems
- The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
- The person recognizes that the obsessive thoughts, impulses, or images are a product of his or her own mind (not imposed from outside, as in thought insertion)

Compulsions

- Repetitive behaviors that the person feels driven to perform in response to an obsession, according to rules that must be applied rigidly
- Examples are hand washing (for fear of dirt or germs), rearranging (rug fringe, towels, clothing), or mental acts (such as praying, counting, repeating words silently)
- Aimed at reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with the obsession or are clearly excessive

3.6 Risk Factors for Postpartum Mood & Anxiety Disorders

- Lack of social support
- Stress
- Insomnia
- Preexisting condition or family history of mood disorders
- Poor nutrition
- Previous miscarriage
- Unrealistic expectations
- Hormonal imbalances

3.7 Physician Suggestions

Encourage Postpartum Mothers to:

- Stay active.
- Eat a well balanced diet.
- Find a dependable support person and/or support group.
- Take time for herself and to not be afraid to ask family and friends to help out with household chores, baby feedings, shopping, etc., as a means of obtaining adequate rest.
- Sleep when the baby sleeps.
- Set realistic goals that she can keep, and remember that she should not be too hard on herself by assuming too much responsibility.
• Get her priorities in order, and break large tasks down into smaller, more manageable ones.
• Be with people, talk with people, laugh with people—don’t sit home alone.
• Do things that make her feel good about herself.
• Take walks, see a funny movie, watch a baseball game, participate in spiritual or religious activities, socials, etc.
• Realize that depression doesn’t just disappear; it gets better gradually over weeks or months. Feeling better takes time and effort.
• Notify attending physician or visit the emergency room if symptoms worsen.
• Read through educational material and handouts provided by the attending physician.
• Ask the healthcare team if she has any questions.

Note: Assess all postnatal women to determine if they are having any symptoms or complaints consistent with any mental health disorder, particularly to assess for symptoms of postpartum psychosis such as visual or audio hallucinations (voices telling them to harm themselves or anyone else, including their baby, children, or other family members). If postpartum depression is suspected, refer patient for further assessment with a mental health professional. If postpartum psychosis symptoms are present, seek emergency psychiatric hospitalization for patient immediately! 43

*It is suggested that the physician screen all postpartum women using the attached Edinburgh Postnatal Depression Scale and educate symptomatic patients through patient handouts about PPD.
Edinburgh Postnatal Depression Scale (EPDS)

Postpartum depression is the most common complication of childbearing. The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for 'perinatal' depression. The EPDS is easy to administer and has been proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases, it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center (www.4women.gov) and from groups such as Postpartum Support International (www.chss.iup.edu/postpartum) and Depression After Delivery (www.depressionafterdelivery.com).

Scoring

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2, or 3 with top box scored as 0 and the bottom box scored as 3

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0

| Maximum score: | 30 |
| Possible Depression: | 10 or greater |
| Always look at item 10 (suicidal thoughts) |

Instructions for using the Edinburgh Postnatal Depression Scale:

- The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
- All the items must be completed.
- Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman).
- The mother should complete the scale herself, unless she has limited English or has difficulty with reading.


Edinburgh Postnatal Depression Scale (EPDS)

Name: ___________________________
Address: _________________________
Your Date of Birth: _________________
Baby's Date of Birth: ________________
Phone: ___________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

During the past week, I have felt happy:
• Yes, all the time
  Yes, most of the time
• No, not very often
• No, not at all
Please complete the other questions in the same way.
In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

5. I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

6. Things have been getting on top of me
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

8. I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

9. I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

10. The thought of harming myself has occurred to me
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

Administered/Reviewed by __________________________

Date __________________________

Sources:


Handout: Postpartum Depression

Do you feel **overwhelmed**?

**Nervous?**

Not **sleeping** well?

Do little things seem to **irritate** you?

Are there things (conversations with friends or family, TV, shopping, putting on makeup, eating favorite foods or meals, etc.) that you used to enjoy doing, but now have little or no interest in?

Do you feel **tired** most of the time?

Find yourself **crying** often?

Would you rather be **alone** than spend time with family or friends?

Do these **symptoms** sound familiar?

If so, then you may be suffering from either Postpartum Baby Blues or Postpartum Depression.
Things You Need to Know About Postpartum Depression

Postpartum “Baby Blues”:
Postpartum “Baby Blues” is very common among new mothers. In fact, up to 80% of new moms have mild symptoms that include mood swings, feeling sad, crying spells, loss of appetite, and so on. However, these symptoms, which usually begin 3-5 days after you have your baby, should end in about 10 days as your hormone levels begin to level out.

Postpartum Depression:
Postpartum Depression (PPD) is a major form of depression and is less common than postpartum blues. PPD includes all the symptoms of depression but occurs only following childbirth. This type of depression can begin any time after delivery and can last up to 1 year. PPD affects 10 -- 20% of all new mothers.

Things You Can Do to Feel Better

Below is a list of self-help suggestions that may ease the sting of your symptoms throughout the course of your recovery. Keep in mind that you may not feel well enough to do many of the things listed here. They are, however, reminders that you continue to hold power over the way you feel while you are healing.

The most important thing for you to do right now is to follow your doctor's treatment plan, continue to take any prescribed medication, and keep in touch with those close to you, letting them know how you are feeling. After that, do what you are able, no more and no less. Take small steps, try not to be too hard on yourself and take one day at a time....

• Rest when your baby sleeps
• Let your partner know how you are feeling
• Make your needs a priority
• Let others know what they can do to help
• Avoid strict or rigid schedules
• Give yourself permission to have negative feelings
• Screen phone calls
• Do not expect too much from yourself right now
• Allow yourself a moment to laugh
• Avoid overdoing anything
• Be careful asking too many people for advice
• Trust your instincts
• Set limits with your guests
• Avoid people who make you feel bad
• Set boundaries with people you can't avoid
• Eat well
• Avoid caffeine and alcohol
• Take a walk
• Set small goals for yourself
• Stay on all medications you have been instructed to take
• Don't be afraid to ask for help
• Get out of the house
• Don't feel guilty—it wastes energy
• Play
• Expect some good days and some bad days
• Prioritize what needs to be done and what can wait
• Thank your partner for helping you
• Don't compare yourself to others
• Be very specific about what you need from your partner
• Do not blame yourself
• Delegate household duties
• Do the best you can—if it doesn't feel like enough, it's enough for now
• Encourage your partner to seek support from friends and outside activities
• Confide in someone you trust

*Remind yourself that all adjustments take time*

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Mom, seek help or call 911 immediately if, at any time, you have thoughts about harming your baby, yourself, or anyone else.
3.8 References


PHYSICIAN'S TOOLKIT 4:
Tobacco, Alcohol, and Other Drugs

Toolkit 4 contents
I. Tobacco
   4.1 Tobacco Research
   4.2 Health Risks During Pregnancy
   4.3 Nicotine Withdrawal Symptoms
   4.4 The 5A's & 5 R's Approach to Smoking Cessation!
II. Alcohol
   4.5 Alcohol Research
   4.6 Fetal Alcohol Syndrome (FAS)
   4.7 Physician Suggestions
III. Other Drugs: Illicit and Prescription
   4.8 Drug Research
   4.9 Substances Commonly Abused by Pregnant Women
   4.10 Common Health Risks for Mother & Child
   4.11 Physician Suggestions
   4.12 References

I. Tobacco

Tobacco is the single greatest cause of disease and premature death in the United States today, and is responsible for more than 430,000 deaths each year. Nearly 25% of adult Americans currently smoke. According to the Centers for Disease Control (2007), women who smoke are more likely to experience ectopic pregnancies, spontaneous abortions, a 30% increase in infertility, and are 50% more likely to experience pre-term premature rupture of membranes, placental abruption, and placenta previa during pregnancy. Further, the CDC has also found that babies born to women who smoke have 30% higher odds of being born prematurely, and are 3 times more likely to die from SIDS. More than 70% of all current smokers have expressed a desire to stop smoking; if they successfully quit, this can result in immediate and long-term health improvements. 14,21

"Clinicians have a vital role in helping these smokers kick their habits" (Fiore & Bailey, 2000, p. 5). "Ending tobacco dependence among pregnant patients is doubly important considering the fact that smoking is the single most preventable cause of illness and death among mothers and infants" (National Center for Chronic Disease Prevention and Health Promotion, 2005, p. 1). An estimated 26,208 smoking attributable low birth weight babies were born in the U.S. in 2001. 5,21

However, there is hope for these pregnant smokers and their babies; it has been found that pregnant mothers are far more likely to kick the smoking habit when their doctors use the 5 A’s approach to smoking cessation). 13,24
4.1 Tobacco Research

- 12 – 20% of all pregnant women smoke tobacco \(5,46,48\)
- Babies of smokers are far more likely to die from Sudden Infant Death (SIDS) than babies of non-smokers \(46,48\)
- Smoking during pregnancy has been linked to 10% of all infant deaths \(46,48\)
- Tobacco use during pregnancy may impair normal fetal brain and nervous system development \(46,48\)
- An estimated 26,208 smoking attributable low birth weight babies were born in the U.S. in 2001 \(5\)
- Smoking directly contributes up to 20 – 30% of all low birth weight babies, 14% of pre-term deliveries, and 10% of all infant deaths \(6\)
- Women who smoke during pregnancy are at risk for premature birth, pregnancy complications, low birth weight infants, stillbirth, and infant mortality \(13\)
- There is a significant health benefit for women who quit smoking during pregnancy; risk of low birth weights could be reduced by 17 – 26% by eliminating cigarettes during pregnancy \(13\)
- Women with nicotine dependence are more likely to meet criteria for at least one mental disorder compared to those who did not use cigarettes during pregnancy \(34\)
- Mothers who smoke can pass nicotine to their babies through breast milk \(7\)
- Reducing the frequency of smoking during pregnancy may not benefit the baby. Women who reduce frequency of smoking or change to lower tar/nicotine cigarettes simply inhale smoke deeper or take more puffs, nullifying the intent and supplying similar amounts of nicotine to the fetus \(7\)

4.2 Health Risks During Pregnancy \(57\)

- Acute risks: Shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, infertility, and increased serum carbon monoxide
- Long-term risks: Heart attack, stroke, cancer (lung, larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long-term disability, and need for extended care
- Environmental risks: Increased risk of lung cancer and heart disease in spouses; higher rates of smoking in children of tobacco users; increased risk for low birth weight, Sudden Infant Death Syndrome, asthma, middle ear disease, and respiratory infections in children of smokers

4.3 Nicotine Withdrawal Symptoms \(33\)

- An intense craving for nicotine
- Muscle tension
- Irritability
- Muscle aches
- Headaches
- Difficulty concentrating
- Drowsiness, fatigue, or trouble sleeping
- Increased appetite/weight gain
4.4 The 5A’s and 5 R’s Approach to Smoking Cessation!

Identification and Assessment of Tobacco Use
The single most important step in addressing tobacco use and dependence is screening for it. After the clinician has asked about tobacco use and has assessed the pregnant smoker’s willingness to quit, he or she can then provide the appropriate intervention, either the 5 A’s (for those who are willing to make a quit attempt), or the 5 R’s (a motivational intervention for those who are unwilling to quit at the present time).

5 A’s for Tobacco Users Willing To Quit!

Step 1. Ask—Systematically identify all tobacco users at every visit.

<table>
<thead>
<tr>
<th>Action</th>
<th>Strategies for Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement an office-wide system that ensures that, for every patient at every clinic visit, tobacco-use status is queried and documented.</td>
<td>Expand the vital signs to include tobacco use or use an alternative universal identification system.</td>
</tr>
</tbody>
</table>

Vital Signs

Blood Pressure:__________________________________________

Pulse: _____________________ Weight: _____________________

Temperature: ____________________________________________

Respiratory Rate: ________________________________________

Tobacco Use: (circle one) Current Former Never

a. Repeated assessment is not necessary in the case of the adult who has never used tobacco or has not used tobacco for many years, and for whom this information is clearly documented in the medical record.

b. Alternatives to expanding the vital signs are to place tobacco-use status stickers on all patient charts or to indicate tobacco use status using electronic medical records or computer reminder systems.
Step 2. **Advise**—Strongly urge all tobacco users to quit

<table>
<thead>
<tr>
<th>Action</th>
<th>Strategies for Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>In a <em>clear, strong, and personalized</em> manner, urge every tobacco user to quit.</td>
<td>Advice should be:</td>
</tr>
<tr>
<td></td>
<td>- <em>Clear</em>—&quot;I think it is important for you to quit smoking now and I can help you. Cutting down while you are pregnant is not enough.&quot;</td>
</tr>
<tr>
<td></td>
<td>- <em>Strong</em>—&quot;As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health and your baby now and in the future. The clinic staff and I will help you.&quot;</td>
</tr>
<tr>
<td></td>
<td>- <em>Personalized</em>—Tie tobacco use to pregnancy, social and economic costs, motivation level, readiness to quit, and the impact of tobacco use on children and others in the household.</td>
</tr>
</tbody>
</table>

Step 3. **Assess**—Determine willingness to make a quit attempt

<table>
<thead>
<tr>
<th>Action</th>
<th>Strategies for Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask every tobacco user if they are willing to make a quit attempt at this time (e.g., within the next 30 days).</td>
<td>Assess pregnant smoker’s willingness to quit:</td>
</tr>
<tr>
<td></td>
<td>- If the pregnant smoker is willing to make a quit attempt at this time, provide assistance.</td>
</tr>
<tr>
<td></td>
<td>- If the patient will participate in an intensive treatment, deliver such a treatment or refer to an intensive intervention.</td>
</tr>
<tr>
<td></td>
<td>- If the patient clearly states she is unwilling to make a quit attempt at this time, provide a motivational intervention (5 R’s below).</td>
</tr>
</tbody>
</table>
Step 4. **Assist**—Aid the patient in quitting

<table>
<thead>
<tr>
<th>Action</th>
<th>Strategies for Implementation</th>
</tr>
</thead>
</table>
| Help the patient with a quit plan. | A patient’s preparation for quitting:  
- *Set a quit date*—ideally, the quit date should be within 2 weeks.  
- *Tell* family, friends, and coworkers about quitting and request understanding and support.  
- *Anticipate* challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms.  
- *Remove* tobacco products from the environment. Prior to quitting, avoid smoking in common places (e.g., work, home, car). |
| Provide practical counseling (problem solving training). | 1. **Abstinence**—Total abstinence is essential. "Not even a single puff after the quit date."  
2. **Past quit experience**—Review past quit attempts including identification of what helped during the quit attempt and what factors contributed to relapse.  
3. **Anticipate triggers or challenges in upcoming attempt**—Discuss challenges/triggers and how patient will successfully overcome them.  
4. **Alcohol**—Alcohol can lead to relapse. The patient should abstain from alcohol while quitting and while pregnant.  
5. **Other smokers in the household**— Quitting is more difficult when there is another smoker in the household. Patients should encourage housemates to quit with them or not smoke in their presence. |
| Provide intra-treatment social support. | Provide a supportive clinical environment while encouraging the pregnant smoker patient in her quit attempt. "My office staff and I are available to assist you." |
| Help patient obtain extra-treatment social support. | Help pregnant smoker develop social support for her quit attempt in her environments outside of treatment. "Ask your spouse/partner, friends, and coworkers to support you in your quit attempt." |
| Provide supplementary materials. | **Sources**—Federal agencies, nonprofit agencies, or local/state health departments.  
**Type**—Culturally/racially/educationally/age appropriate for the patient.  
**Location**—Readily available at every clinician’s workstation. |
Step 5. *Arrange* and follow-up

<table>
<thead>
<tr>
<th>Action</th>
<th>Beneficial Techniques</th>
</tr>
</thead>
</table>
| **Issues to Consider** | • Prepare for slips  
• Early relapses are common  
• Slips are often perceived as relapses  
• Mood changes may impact success  
• Support and follow-up are essential | **Beneficial Techniques** |
| **Maintenance Stage/Relapse Prevention** | • Prepare for slips  
• Early telephone follow-up  
• Office follow-up appointment  
• In office resources  
  o TIPS Program  
  o Web sites  
  o 800 help lines  
  o Handouts | | **Postpartum Relapse Prevention strategies** |
| **Maintenance Stage/Relapse Prevention** | • Address reasons for quitting  
• Provide positive reinforcement  
• Assess expectations and plans for relapse prevention  
• Assess smoking habits of and support from partner, friends and family  
• Assist patient with development of relapse prevention plan  
• Continue relapse prevention throughout pregnancy  
Provide follow-up contact, i.e., office visits and phone calls | **Postpartum Relapse Prevention strategies** |

Note: Nicotine withdrawal symptoms can aggravate the symptoms of other psychiatric disorders. Advise patient to contact the attending physician if symptoms appear worse than normal for tobacco/nicotine withdrawal (APA).
The 5 R’s: Relevance, Risks, Rewards, Roadblocks, and Repetition, are designed to motivate smokers who are unwilling to quit at present. Pregnant smokers may be unwilling to quit due to misinformation, concern about the effects of quitting, or demoralization because of previous unsuccessful quit attempts. Therefore, after asking about tobacco use, advising the smoker to quit, and assessing the willingness of the smoker to quit, it is very important to provide the “5 R’s” motivational intervention.  

Step 1. **Relevance**

Encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient’s disease status or risk, pregnancy, family, social situation (e.g., having children in the home), health concerns, age, gender, or other important characteristics (e.g., prior quitting experience, personal barriers to cessation).  

Step 2. **Risks**

The clinician should ask the pregnant smoker to identify potential negative consequences of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low-tar/low-nicotine cigarettes or using other forms of tobacco (e.g., smokeless tobacco, cigars, and pipes) will not eliminate these risks.  

- **Examples of risks are:**  
  - **Acute risks:** Shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, infertility, and increased serum carbon monoxide.  
  - **Long-term risks:** Heart attacks and strokes, cancer (lung, larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long-term disability, and need for extended care.  
  - **Environmental risks:** Increased risk of lung cancer and heart disease in spouses; higher rates of smoking (50%) in children of tobacco users; increased risk for low birth weight, Sudden Infant Death Syndrome, asthma, middle ear disease, and respiratory infections in children of smokers.
Step 3. **Rewards**

The clinician should ask the pregnant smoker to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient.

**Examples of rewards:**
- Improve health
- Food will taste better
- Improved sense of smell
- Save money
- Feel better about yourself
- Home, car, clothing, breath will smell better
- Can stop worrying about quitting
- Set a good example for children
- Have healthier babies and children
- Not worry about exposing others to smoke
- Feel better physically
- Perform better in physical activities
- Reduced wrinkling/aging of skin

Step 4. **Roadblocks** to Quitting

The clinician should ask the pregnant smoker to identify barriers or impediments to quitting and note elements of treatment (problem solving) that could address barriers.

**Typical barriers might include:**
- Withdrawal symptoms
- Fear of failure
- Weight gain
- Lack of support
- Depression
- Enjoyment of tobacco

Step 5. **Repetition**

The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

Source:
Choosing to smoke while pregnant may:

- Keep food and nutrients from your baby
- Put carbon dioxide and carbon monoxide into your baby’s body
- Release cancer causing chemicals into your baby’s blood stream
- Increase the chance your baby will have ADHD or conduct/behavior problems
- Impair the development of your baby’s brain and nervous system
- Increase the chance that your baby will have developmental/learning problems

Choosing NOT to smoke while pregnant will:

- Cause your baby to have a low birth weight
- Greatly multiply the chance that your baby might go into premature labor
- Increase the chance of still birth or Sudden Infant Death Syndrome (SIDS)
- Cause your baby to have disabilities like cerebral palsy or mental retardation
- Increase the chance your baby will have more colds, asthma, ear infections

Get oxygen/nutrients where they need to go—to your baby
Increase your chances of having a healthy baby
Raise your baby’s birth weight
Make it more likely to bring your baby home from the hospital with you
Decrease doctor visits—and your baby will sleep sounder, cry, and cough less
Give your baby every chance possible to be born without long-term conduct, behavioral, or mental disabilities
Greatly reduce the chance your baby could have SIDS
The Things You Gain with Smoking Cessation:

- Improved health
- Food will taste better
- Improved sense of smell
- Save money
- Feel better about yourself
- Home, car, clothing, breath will smell better
- Can stop worrying about quitting
- Set a good example for children
- Have healthier babies and children
- Not worry about exposing others to smoke
- Feel better physically
- Perform better in physical activities
- Reduced wrinkling/aging of skin

Nicotine Withdrawal Symptoms You Should Know About:

- An intense craving for nicotine
- Muscle tension
- Irritability
- Headaches
- Difficulty with concentration
- Drowsiness, fatigue, or trouble sleeping
- Increased appetite/weight gain
- Muscle aches

Coping with Nicotine Withdrawal

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Cause</th>
<th>Duration</th>
<th>Relief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irritability</td>
<td>Body’s craving for nicotine</td>
<td>2 - 4 weeks</td>
<td>Walks, hot baths, relaxation</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Nicotine is a stimulant</td>
<td>2 - 4 weeks</td>
<td>Take naps</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Nicotine affects brain waves</td>
<td>2 - 4 weeks</td>
<td>Avoid caffeine after 6 P.M.</td>
</tr>
<tr>
<td>Cough, nasal drip</td>
<td>Body is getting rid of mucus</td>
<td>A few days</td>
<td>Drink plenty of liquids</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Body is getting extra oxygen</td>
<td>1 - 2 days</td>
<td>Change positions slowly</td>
</tr>
<tr>
<td>Lack of Concentration</td>
<td>Lack of nicotine stimulation</td>
<td>A few days</td>
<td>Plan your workload, avoid stress</td>
</tr>
<tr>
<td>Constipation, gas</td>
<td>Decreased intestinal movement</td>
<td>1 - 2 weeks</td>
<td>Add fiber to diet</td>
</tr>
<tr>
<td>Hunger</td>
<td>Craving for cigarette</td>
<td>Several weeks</td>
<td>Low calorie snacks</td>
</tr>
<tr>
<td>Craving for cigarette</td>
<td>Nicotine withdrawal</td>
<td>4 days - months</td>
<td>Wait out urges, distract yourself</td>
</tr>
<tr>
<td>Headaches</td>
<td>More oxygen in system</td>
<td>1 - 2 weeks</td>
<td>Drink water, relaxation exercises</td>
</tr>
</tbody>
</table>

Source:
After You Stop Smoking:

20 Minutes:
• Your blood pressure drops to normal
• Pulse rate drops to normal
• Temperature of your hands and feet increases to normal

8 Hours:
• The carbon monoxide level in your blood drops to normal
• Your oxygen blood level increases to normal

24 Hours:
• Your chance of heart attack decreases

48 Hours:
• Your nerve endings start to re-grow
• Your sense of smell and taste start improving

2 Weeks to 3 Months:
• Circulation improves
• Lung function increases up to 30%

1-9 Years:
• Lung cilia re-grow, increasing ability to handle mucus, clean the lungs, reduce infection
• Coughing, sinus congestion, fatigue, shortness of breath decrease

1 Year:
• Your risk of coronary heart disease is half that of a smoker

5 years:
• Your stroke risk is reduced to that of a nonsmoker 5 to 15 years after quitting

10 years:
• Your lung cancer death rate is about half that of a continuing smoker’s
• Your risk of cancer of the mouth, throat, esophagus, bladder, cervix, and pancreas decrease

15 years after quitting:
• The risk of coronary heart disease is that of a nonsmoker’s.

Source:
American Cancer Society, http://www.cancer.org/docroot/SPC/content/SPC_1_When_Smokers_Quit.asp
II. Alcohol

The U.S. Department of Health and Human Services (2006) states that, "For centuries, people have known that alcohol can harm a fetus" (p. 1). The modern term for babies who have been affected by alcohol in the womb is Fetal Alcohol Syndrome (FAS), and is further broken down into FASD (Fetal Alcohol Spectrum Disorders), which is the umbrella term used to describe the broad range of effects due to prenatal alcohol exposure. Drinking alcohol while pregnant is the leading cause of many preventable disabilities and illnesses, including mental retardation, physical, mental, emotional, behavioral, learning, and growth abnormalities. Nearly 1 out of every 750 babies is born with full FAS. 2, 10, 54

4.5 Alcohol Research

- Fetal Alcohol Syndrome (FAS) is the leading cause of mental retardation in the United States. 2
- Approximately 1 out of every 750 infants are born each year in the U.S. with full FAS 2
- Of all abused substances, including heroin, cocaine, and marijuana, alcohol produces by far the most serious neurobehavioral effects in the fetus 24
- As many as 20% of women who know they are pregnant continue to drink during their pregnancy 10, 24
- Persons with FAS have serious problems with attention, impulse control, judgment, and memory. Although many of the physical characteristics associated with FAS become less prominent after puberty, behavioral and emotional problems become more pronounced 35
- Over 50% of women of child bearing age drink alcohol 25
- Of the women who reported drinking during their pregnancy, 66% reported drinking in the first trimester, and 54% reported drinking during the third trimester 10
- According to the birth defects monitoring program, FAS rates among American Indians are significantly higher than among whites. 10
- No amount of alcohol consumption can be considered safe during pregnancy 1, 55
- Alcohol-related birth defects and disabilities are 100% preventable 2, 55
- Disabilities associated with Fetal Alcohol Spectrum Disorders are irreversible and life-long 2, 32
4.6 Fetal Alcohol Syndrome (FAS) \[10,54\]

a. A characteristic pattern of facial abnormalities (small eye openings, indistinct or flat philtrum, and a thin upper lip)

b. Growth deficiencies, i.e., low birth weight and continued growth restriction.

c. Brain damage, such as small skull at birth or structural defects, and neurological abnormalities, including impaired fine motor skills, poor eye-hand coordination, and tremors

d. Maternal alcohol use during pregnancy

---

**Figure 1: FAS Facial Characteristics**

---

**Symptoms & Signs of FAS:**

The most serious characteristics of FAS are the invisible symptoms of neurological damage that result from prenatal exposure to alcohol. These symptoms include:

- Memory & attention deficits, hyperactivity
- Difficulty with abstract concepts
- Inability to manage money
- Poor problem solving skills
- Difficulty learning from consequences
- Inappropriate social behavior
- Inappropriate friendliness with strangers
- Lack of emotional control
- Poor impulse control
- Poor judgment
- Visual and hearing problems
- Growth problems
- Poor coordination
Who is most likely to consume alcohol during pregnancy?  

- Women who smoke cigarettes
- Single women
- Women with a history of substance abuse
- Women with a history of mental health problems
- Women who already have a child with FAS
- Women who have multiple sex partners
- Recent victims of violence and abuse

4.7 Physician Suggestions

- Assess alcohol usage in women who are pregnant or may become pregnant in the near future by using the T-ACE Questionnaire, modified for alcoholism screening in obstetric patients (see attached T-ACE Questionnaire following physician suggestions section)  
- Inform pregnant patients and those planning a pregnancy about the risks of alcohol consumption during pregnancy and advise them on the fact that any alcohol can harm their baby
- Have face-to-face discussions with pregnant patients concerning the hazards of drinking alcohol during pregnancy (studies have shown that this type of discussion works far better than handouts alone). All discussions should be done using a non-judgmental approach, with repetition of drinking hazards during each follow-up prenatal appointment
- Refer those prenatal patients who have attempted to quit alcohol and were unsuccessful to appropriate professionals for further help
- Refer those prenatal patients who continue to use alcohol despite negative health and social consequences to appropriate professionals for further help
- Assist the patient in making an appointment with a substance abuse specialist while she is in your office (this can be very helpful to her)
- Reassure the patient that even though she was drinking when she became pregnant or drank during her pregnancy, abstaining from alcohol now will increase the likelihood that her baby will be born healthy
- Educate the prenatal patient about the danger to which she is exposing her unborn child
T-ACE

Name:____________________

Date:____________________

Score:____________________

T  How many drinks does it take to make you feel high (TOLERANCE)?
    = 0 if <3 drinks
    = 2 if 3 or more drinks
    (3 beers, 3 glasses of wine, 3 drinks liquor)

A  Have people ANNOYED you by criticizing your drinking?
    = 1 if positive

C  Have you felt you ought to CUT DOWN on your drinking?
    = 1 if positive

E  Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
    = 1 if positive

Two points or more indicates high-risk alcohol use.

Source:
Handout: The Dangers of Drinking While Pregnant

Did You Know That:

- Alcohol can harm your baby at ANY time during your pregnancy? 1st, 2nd, or 3rd trimester—If you drink, you put your baby at risk.
- You don’t have to be a heavy drinker to have a baby that has Fetal Alcohol Syndrome?
- If you drink while pregnant, your baby can be born with brain, kidney, heart, eye, eardrum, and central nervous system problems?

What is Fetal Alcohol Syndrome?

Fetal Alcohol Syndrome (FAS) is the term used to describe characteristic symptoms of babies who have been exposed to alcohol in their mother’s womb. FASD (Fetal Alcohol Spectrum Disorders) is the generic term used to describe the broad range of effects on a baby when his or her mother drank alcohol during pregnancy. Drinking alcohol while pregnant is the leading cause of many preventable disabilities and illnesses associated with babies, including mental retardation, physical, mental, emotional, behavioral, learning, and growth abnormalities. Nearly 1 out of every 750 babies are born with the full range of FAS disabilities, and as many as 1 out of every 300 children have some FAS related illness or and disability. No amount of alcohol is safe! However, if you have been drinking, the sooner you quit, the better it is for your unborn child!
What Can Happen to Your Baby if You Drink?

- Attention deficits
- Memory deficits
- Hyperactivity
- Difficulty with abstract concepts
- Inability to manage money
- Poor problem solving skills
- Difficulty learning from consequences
- Inappropriate social behavior
- Inappropriate friendliness with strangers
- Lack of emotional control
- Poor impulse control
- Poor judgment
- Visual and hearing problems
- Growth problems
- Brain damage
- Heart, kidney, and other organ damage
- Impaired fine motor skills, poor eye-hand coordination, and tremors
- Facial abnormalities (small eye openings, indistinct or flat nose, skin discoloration, and a thin upper lip)

If you have been drinking, it is never too late to protect your baby from the affects of Fetal Alcohol Syndrome! The sooner you quit, the safer your baby is!

Remember, there is no cure for Fetal Alcohol Syndrome: its effects last for life.

Fetal Alcohol Syndrome is completely preventable: simply don’t drink alcohol and there is no risk to your baby!
III. Other Drugs: Illicit and Prescription

“Today, more than 4 million women in this country use drugs. Women of all ages, races, and cultures. Drug abuse is a serious, continuing illness. There are no easy cures” (National Institute on Drug Abuse, 2006, p. 1). Many of these women are of child-bearing age, and are, or could become, pregnant at any given time. Further, the NIDA’s (2006) report Women and Drug Abuse states that, “When a pregnant woman uses drugs, she and her unborn child face serious health problems. During pregnancy, drugs taken by the mother can enter the baby’s bloodstream. The most serious effects on the baby can be HIV infection, addiction, low birth weight, SIDS, small head size, stunted growth, poor motor skills, and behavior problems” (p. 1). What exactly are illicit drugs? An illicit drug is one that is used non-medically. The most common illicit drugs are marijuana, hashish, cocaine (powder and crack cocaine), inhalants, hallucinogens (LSD, Mescaline, etc.), heroin, and opium. Also, prescription or over-the-counter drugs can be misused, placing them into a similar category. Commonly abused prescription drugs include opiates (codeine, morphine, etc.), benzodiazepines (Zanax, Ativan, Klonepin, etc.), barbiturates (Phenobarbital, Seconal, etc.), stimulants (amphetamines), and Dextromethorphan (cough and cold medicines). However, it is never too late to reduce the health risks associated with drug abuse. The National Institute on Drug Abuse (2006) assures both physicians and pregnant patients that providing professional care and treatment can reduce many of the negative effects on the unborn child.

4.8 Drug Research

- In 2005, nearly 4% of pregnant women surveyed used illicit drugs such as marijuana, cocaine, ecstasy, methamphetamine, and heroin.
- NIDA research has found that more than 4 million U.S. women abuse drugs.
- Almost 50% of women aged 15-44 have used drugs at least once in their lifetime. Of these women, nearly 2 million have used cocaine, and 6 million have used marijuana.
- In the U.S., it is estimated that more than 4 million women need treatment for drug abuse.
- Female drug abusers improve at much higher rates when treatment takes into consideration, and helps meet their basic needs.
- 4% of women aged 15-44 who entered publicly funded substance abuse treatment centers were pregnant; 84% of these women were 35 or younger.
- Pregnant women who sought admission to substance abuse treatment programs were less likely to report alcohol abuse as a primary substance of abuse (18%) than non-pregnant women (31%).
- Unfortunately, abusers rarely use only a single substance. Often, illicit substance use is accompanied by use of legal drugs like nicotine/tobacco, alcohol, benzodiazepines, Dextromethorphan (cough and cold medicines), etc.
- 94% of pregnant women completing the National Household Survey on Drug Abuse admitted to using illegal drugs during the previous year.
- An estimated 55% of women use illegal drugs at least once during pregnancy.
• Maternal substance abuse among Medicaid recipients in Washington State was related to infant mortality rates as high as 14.9 per one thousand births, compared to only 10.7 infant deaths per one thousand among non-drug using Medicaid recipients.  
• Babies born to drug-abusing women are 2.5 times more likely to die from Sudden Infant Death Syndrome (SIDS).  
• Unmarried pregnant women living with a partner were found to more frequently abuse tobacco and drugs than were married women.  
• Pregnant women who abuse drugs are linked to far higher rates of malnutrition than are non-drug using pregnant women.  
• About 15% of women who present for prenatal care are shown to have a positive urine test for one or more of the following: alcohol, marijuana, cocaine, and opiates (such as heroin).  
• It is estimated that more than 5% of the 4 million women who have given birth in the U.S. used illegal drugs while they were pregnant.  

4.9 Substances Commonly Abused by Pregnant Women

<table>
<thead>
<tr>
<th>Substances: Category and Name</th>
<th>Examples of Commercial and Street Names</th>
<th>DEA Schedule*/How Administered**</th>
<th>Intoxication Effects/Potential Health Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cannabinoids</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hashish</td>
<td>boom, chronic, gangster, hash, hash oil, hemp</td>
<td>swallowed, smoked</td>
<td>euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination, cough, frequent respiratory infections; impaired memory and learning; increased heart rate, anxiety; panic attacks; tolerance, addiction</td>
</tr>
<tr>
<td>marijuana</td>
<td>blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, weed</td>
<td>swallowed, smoked</td>
<td></td>
</tr>
<tr>
<td><strong>Depressants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>barbiturates</td>
<td>Amytal, Nembutal, Seconal, Phenobarbital: barbs, reds, red birds, phennies, tooies, yellows, yellow jackets</td>
<td>swallowed, injected</td>
<td>reduced anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration; fatigue; confusion; impaired coordination, memory and judgment; addiction; respiratory depression and arrest; death</td>
</tr>
</tbody>
</table>
### Benzodiazepines (other than flunitrazepam)

- **Ativan, Halcion, Librium, Valium, Xanax:** candy, downers, sleeping pills, tranks
- **swallowed, injected**

For barbiturates—sedation, drowsiness, depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness, life-threatening withdrawal

For benzodiazepines—sedation, drowsiness/dizziness

### Opioids and Morphine Derivatives

<table>
<thead>
<tr>
<th>Substance</th>
<th>Common Names</th>
<th>Uses</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Codeine</strong></td>
<td>Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine: Captain Cody, schoolboy (with glutethimide) doors &amp; fours, loads, pancakes and syrup</td>
<td>injected, swallowed</td>
<td>pain relief, euphoria, drowsiness/nausea, constipation, confusion, sedation, respiratory depression and arrest, tolerance, addiction, unconsciousness, coma, death</td>
</tr>
<tr>
<td><strong>Fentanyl and Fentanyl Analogs</strong></td>
<td>Actiq, Duragesic, Sublimaze: Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash</td>
<td>injected, smoked, snorted</td>
<td>for heroin—staggering gait</td>
</tr>
<tr>
<td><strong>Heroin</strong></td>
<td>diacetylmorphine: brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse</td>
<td>injected, smoked, snorted</td>
<td></td>
</tr>
<tr>
<td><strong>Morphine</strong></td>
<td>Roxanol, Duramorph: M, Miss Emma, monkey, white stuff</td>
<td>injected, swallowed, smoked</td>
<td></td>
</tr>
<tr>
<td><strong>Opium</strong></td>
<td>laudanum, paregoric: big O, black stuff, block, gum, hop</td>
<td>swallowed, smoked</td>
<td></td>
</tr>
<tr>
<td><strong>Oxycodone HCL</strong></td>
<td>Oxycontin: Oxy, O.C., killer</td>
<td>swallowed, snorted, injected</td>
<td></td>
</tr>
<tr>
<td><strong>Hydrocodone Bitartrate, Acetaminophen</strong></td>
<td>Loratab, Vicodin: vike, Watson-387</td>
<td>swallowed</td>
<td></td>
</tr>
</tbody>
</table>

### Stimulants

- **Amphetamine**

- Biphettamine, Dexedrine: bennies, black beauties, crosses, hearts, LA, turnaround, speed, truck drivers, uppers

- **injected, swallowed, smoked, snorted**

- Increased heart rate, blood pressure, metabolism: feelings of exhilaration, energy, increased mental alertness; rapid or irregular heart beat; reduced appetite, weight loss, heart failure, nervousness, insomnia
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Abuse Methods</th>
<th>Effects/Addictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine hydrochloride</td>
<td>Injected, smoked, snorted</td>
<td>Also, for amphetamine—rapid breathing/tremor, loss of coordination; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction, psychosis.</td>
</tr>
<tr>
<td>MDMA (methylene dioxy-methamphetamine)</td>
<td>Swallowed</td>
<td>for cocaine—increased temperature/chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition, panic attacks.</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>Injected, swallowed, smoked, snorted</td>
<td>for MDMA—mild hallucinogenic effects, increased tactile sensitivity, empathic feelings/impaired memory and learning, hyperthermia, cardiac toxicity, renal failure, liver toxicity.</td>
</tr>
<tr>
<td>Methylphenidate (safe and effective for treatment of ADHD)</td>
<td>Injected, swallowed, snorted</td>
<td>for methamphetamine—aggression, violence, psychotic behavior/memory loss, cardiac and neurological damage; impaired memory and learning, tolerance, addiction.</td>
</tr>
<tr>
<td>Nicotine</td>
<td>Smoked, snorted, taken in snuff and spit tobacco</td>
<td>for nicotine—additional effects attributable to tobacco exposure; adverse pregnancy outcomes; chronic lung disease, cardiovascular disease, stroke, cancer, tolerance, addiction.</td>
</tr>
<tr>
<td>Dextromethorphan (DXM)</td>
<td>Scheduled/swallowed</td>
<td>Dissociative effects, distorted visual perceptions to complete dissociative effects/for effects at higher doses see 'dissociative anesthetics'.</td>
</tr>
<tr>
<td>Inhalants</td>
<td>Inhaled through nose or mouth</td>
<td>Stimulation, loss of inhibition; headache; nausea or vomiting; slurred speech, loss of motor coordination; wheezing; unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death.</td>
</tr>
</tbody>
</table>

4.10 Common Health Risks for Mother & Child

Mother:
- Poor nutrition
- High blood pressure
- Rapid heart beat
- Low birth weight
- Low self-esteem
- Pre-term labor
- Stillbirth & miscarriage
- Sexually transmitted infections
- Early delivery
- HIV/AIDS
- Depression
- Physical Abuse

Child:
- Pre-maturity, low birth weight
- Withdrawal symptoms
- Infections
- Small cranium
- SIDS
- Birth defects
- Stunted/retarded growth
- Poor motor skills
- HIV/AIDS
- Learning disabilities
- Neurological problems

4.11 Physician Suggestions

If an expectant mother is suspected of abusing drugs, the physician should:

- State the need for her to stop using alcohol and drugs during her pregnancy.
- The U.S.P.S.T.P. does not recommend routine drug testing via blood or urine when treating pregnant women; routine prenatal physician visits, risk advisement, and referral work best with this population of drug abusers.
- Keep in mind that most clients who are abusing drugs during their pregnancy are not addicted, but instead are emotionally dependent on them and do not have physical withdrawal symptoms when they stop using.
- Emphasize to the expectant mother the fact that the benefits of quitting drug use begin immediately for both her and her baby.
- Remember that face-to-face discussions regarding the hazards of substance abuse during pregnancy work far better than do hand-outs alone.
- Assure her that you will work with her to achieve a substance free pregnancy.
- Have referral sources, i.e., substance abuse counselors who can complete in-depth specialized assessments, agencies who could offer help meeting client basic needs (electricity, food, transportation), support service numbers, etc., because studies have found that those treatment options which strive to help pregnant women meet their basic needs during treatment are far more successful than those who offer no support.
• If possible, make an appointment while the patient is in the office, and follow up with an appointment to see her after any drug/alcohol assessment (keeping an ongoing interest in the client’s progress is essential to her success and the baby’s long-term outcome) 26, 59

• Offer praise when she attends substance abuse referral appointments, makes progress in reducing or stopping drug abuse, improves nutrition and appearance, etc. 26, 59

• Remember that those physicians who are open and non-judgmental are far more likely to receive honest answers from patients 26, 51

• Refer to Figures 1 and 2 immediately following Physician Suggestions to view and print the 4 P’s Plus screening tool and the T-ACE Substance Abuse Screening Tool 31.
Questions: Parents, Partner, Past, Pregnancy

Name:______________________
Date:______________________
Score:______________________

Yes       No
• Did either of your parents ever have a drug or drinking problem?     ___         ___
• Does your partner have a problem with drugs or alcohol?                  ___         ___
• In the past, have you drunk alcohol or taken drugs?                          ___         ___
• In the month before you knew you were pregnant, did you smoke? ___  ___

Screening Tool Description:

This screening tool is often used to start the discussion about alcohol and drug use since it naturally flows from the family history. The original 4 P’s test was designed to rapidly identify obstetric patients in need of intervention.

Scoring:

A “yes” answer to any question is considered “positive.” The modified 4 P’s Plus screen adds two questions to the current pregnancy and a positive answer to either identifies 34% of drug and alcohol and drug users. With a “positive” answer about “partner,” 65% were found to need drug referral and treatment.
Figure 2. The T-ACE Screening Tool for Obstetric Patients

T-ACE

Name:____________________
Date:____________________
Score:____________________

T How many drinks does it take to make you feel high (TOLERANCE) ?
= 0 if <3 drinks
= 2 if 3 or more drinks
(3 beers, 3 glasses of wine, 3 drinks liquor)

A Have people ANNOYED you by criticizing your drinking?
= 1 if positive

C Have you felt you ought to CUT DOWN on your drinking?
= 1 if positive

E Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
= 1 if positive

Two points or more indicates high-risk alcohol use.

Source:
Do You Use Drugs?

Cocaine?
Marijuana?
Meth?
Heroin?

Substance abuse during pregnancy is a bigger problem than you think. Most people think of crack cocaine or heroin addiction when they hear the phrase "substance abuse." However, legal substances like tobacco, cough syrup, cold medicines, beer, wine, liquor, amphetamines (weight loss pills), paint, glue, and benzodiazepines (Zanax, Ativan, Klonopin, etc.) can also be abused. When a pregnant woman abuses substances, she is not only harming herself, but is putting her unborn baby at risk. Also, sadly, many pregnant women expose their babies to multiple drugs, amplifying the negative effects.
What are some of the **Risks to Mother and Child**?

If you are abusing **Amphetamines** (speed), **Methamphetamine** (crank, crystal meth), **Methylphenidate** (Ritalin), or **Nicotine** (tobacco), here are some symptoms you and your baby can suffer from:

Your **Symptoms**:
- Malnourishment
- Elevated blood pressure
- Premature labor & delivery
- Excess maternal bleeding during/after delivery
- Damaged placenta
- Miscarriage/stillbirth

Your Baby's Symptoms:
- Birth defects such as cleft palate, etc.
- Low birth weight
- Heart defects
- Foot, arm, and hand defects

If you are abusing **Opiates** (codeine, morphine, hydrocodone):

Your **Symptoms**:
1. Miscarriages
2. Premature birth
3. Poor fetal development and growth
4. Premature rupture of membranes
5. Stillbirth

Your Baby Could:
1. Have withdrawal symptoms
2. Have a higher risk of Sudden Infant Death Syndrome
3. Possibly have debilitating birth defects

**Keep in mind...**

If you abuse drugs, illegal or prescription, while pregnant, then both you and your baby are getting the “high” associated with that drug; you use narcotics, your unborn baby uses narcotics; you get drunk, your baby gets drunk.

If you use cocaine:

Your **Symptoms**:
- Spontaneous abortion
- Your water could rupture early
- You could deliver stillbirth
Your Baby Could:

- Have lower birth weight
- Be unable to be comforted
- Not respond to your voice
- Be born addicted to cocaine

- Be born irritated and tremulous
- Face the risk of SIDS
- Face retarded development

If you smoke marijuana,

Your Symptoms:

- Respiratory problems
- Mood problems
- Weight gain

- Other varied psychological problems
- Cancer causing chemicals exposure
- Lack of good hygiene

Your Baby's Symptoms:

- Behavior difficulties
- Nervous system excitation
- Decreased body weight

- Short body length
- Withdrawal symptoms

Also...

If you smoke cigarettes

Your Symptoms:

- Shortness of breath
- Exacerbation of asthma

- Harm to pregnancy
- Increased serum carbon monoxide

Your Baby's Symptoms:

- Increased risk for low birth weight
- Sudden Infant Death Syndrome

- Asthma attacks
- Middle ear infections (ear aches)
- Respiratory infections
4.12 References


**PHYSICIAN’S TOOLKIT 5:**

**Interpersonal Violence**

**Toolkit 5 Contents**

5.1 Introduction
5.2 Interpersonal Violence Research
5.3 The Cycle of Violence
5.4 Types of Abuse
5.5 Physical Effects of Violence
5.6 Psychological Effects of Violence
5.7 Risk Factors for Victimization
5.8 Partner’s Behavioral Signs (Potential for Violence)
5.9 Physician Suggestions
5.10 References

**5.1 Introduction**

"Domestic violence during pregnancy," according to the Pan American Health Organization, an offshoot of the World Health Organization, "is gradually being acknowledged as one of the most severe threats to women's health" (p. 1). The Centers for Disease Control and Prevention (2007) defines domestic violence as, “Physical, sexual, or psychological/emotional violence, or threats of physical or sexual violence that are inflicted on a pregnant woman” (p. 7). Rachelle Drouin (2007) of Women's Web states, “It’s estimated 1 in 5 women will be abused during pregnancy. Even more alarming is the fact that homicide during pregnancy now surpasses automobile accidents and falls as the leading cause of death” (p. 1). One of the suspected causes for increased violence during pregnancy is increased stress level of the father (or male partner) during said pregnancy. This level can increase four-fold if the pregnancy is unplanned or unwanted (Drouin, 2007). Lastly, domestic violence does not only affect adult women during pregnancy. Up to 10% of pregnant 13-17 year olds face violence at the hands of their baby's father (Gessner & Perham-Hester, 1999).

The *ACOG* strongly affirms that domestic violence screening can be conducted by making the following statement---"Because violence is so common in women's lives, and because there is help available for women who are being abused, I now ask every patient about domestic violence"---and by asking these three simple questions:

1. Within the past year----or since you have been pregnant----have you been hit, slapped, kicked, choked, or otherwise physically abused by someone?
2. Are you in a relationship with someone who threatens or physically hurts you?
3. Has anyone forced you to participate in sexual activities that made you feel uncomfortable?
5.2 Interpersonal Violence Research

- Each year approximately 1.5 million women in the U.S. are raped or physically assaulted by an intimate partner. This number includes more than 324,000 women who were pregnant when the violence occurred.¹ ⁶
- 50 – 70% of women abused before pregnancy are abused while pregnant.¹ ⁶
- 26% of pregnant teens reported being physically abused by their baby’s father. Nearly half of them said that the battering began or intensified after the baby’s father learned of the pregnancy.¹ ⁶
- During pregnancy, assaults become focused on the woman’s breasts, abdomen, and genitals.¹ ³
- Assaults on pregnant women can result in placental separation, antepartum hemorrhage, fetal fractures, rupture of the uterus, liver and spleen damage or rupture, and pre-term babies.¹ ³
- Pregnant women who have been abused are at universal risk of having low birth weight babies.¹ ³
- Murder is the 2nd most common cause of injury related death for pregnant women (31%), immediately following automobile accidents.¹ ⁶
- Between 1990 and 2004, more than 1,300 pregnant women were murdered. Most of these women (56%) were shot to death; the rest were stabbed or strangled.¹ ⁶
- 77% of those homicide victims are killed during the first trimester of pregnancy.¹ ⁶
- Women with unintended pregnancies are two to four times more likely to experience physical domestic violence than women with planned pregnancies.¹ ⁶
- Homicide is one of the leading causes of pregnancy associated injury and death.² ⁶
- In four abuse survivor studies, up to 81% of the patients reported that they would like their healthcare providers to ask them privately about domestic violence.² ⁶
- 1 in 4 women are abused by a partner sometime in their lives.² ⁷
- 44 - 47% of women killed by their intimate partners have been seen by a healthcare provider in the year prior to death.² ⁴ ²⁵
- 96% of women in the U.S. who have a live birth receive prenatal care. On average, pregnant women are seen for an average of 12 - 13 visits. Despite this frequent interaction, less than half of reproductive healthcare providers regularly screen patients for intimate partner violence.¹ ⁶

5.3 The Cycle of Violence

Phase One: Tension Building

- The abuser starts to get angry
- The abuser attacks the pregnant woman verbally (insults, profanity, cheating accusations, etc.)
- Minor battering occurs (shoving, shaking, holding down, etc.)
- The woman tries to appease the abuser and tries to anticipate his every whim
• As the tension escalates, the abuser becomes more oppressive, the pregnant woman more passive
• She blames herself for the situation and her lack of control
• Nothing the woman tries works, and she grows increasingly hopeless
• The tension becomes unbearable

Phase Two: Acute Battering Incident

• Violence erupts
• The incident is usually triggered by an external event or by the internal state of the abusive man, rather than the pregnant woman's behavior
• During this stage of battering, the woman is most likely to be sexually or physically assaulted (e.g. kicked in the stomach, punched, choked, bitten). This stage can lead to serious physical injury and even death

Phase Three: The Honeymoon

• The abuser may apologize for his actions
• He may promise that the abuse will never happen again
• The abuser may state that the abuse is all because of something the woman did
• He accepts no fault or blame for his actions
• He may even deny that any abuse ever took place (claiming the woman fell, ran into the door, bruised herself, etc.)

Phase Four: Calm

• In the abuser's mind, nothing happened
• Physical abuse may stop or be greatly reduced
• Some of the abuser's promises made during the honeymoon phase may even be met
• The pregnant victim may hope or fantasize that the abuse is finally over
• The abuser may buy the woman gifts
Figure 1: The Cycle of Violence

Source:
City College of San Francisco, The Cycle of Violence,
http://www.ccsf.edu/Departments/Women_Studies/Project_SURVIVE/4_6.html

Note: The stages of the cycle of violence can last long or short periods of time, and the violence usually gets worse. The “honeymoon” phase will eventually disappear...
Figure 2: Violence Wheel

Tactics of Men Who Batter

- **Power and Control**
  - Using Coercion and Threats
  - Using Economic Abuse
  - Using Male Privilege
  - Using Isolation
  - Using Children
  - Using Intimidation
  - Using Emotional Abuse
  - Using Minimizing, Denying, and Blaming

**Physical Violence**
- Physical violence tactics include threats, control, and isolation.

**Sexual Violence**
- Sexual violence tactics include coercion, control, and emotional abuse.

**Domestic Abuse Intervention Project**
232 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.duluth-model.org
Figure 3: Relationship Equality

NONVIOLENCE

NEGOTIATION AND FAIRNESS
Seeking mutually satisfying resolutions to conflict • accepting change • being willing to compromise.

NON-THREATENING BEHAVIOR
Talking and acting so that she feels safe and comfortable expressing herself and doing things.

ECONOMIC PARTNERSHIP
Making money decisions together • making sure both partners benefit from financial arrangements.

RESPECT
Listening to her non-judgmentally • being emotionally affirming and understanding • valuing opinions.

SHARED RESPONSIBILITY
Mutually agreeing on a fair distribution of work • making family decisions together.

TRUST AND SUPPORT
Supporting her goals in life • respecting her right to her own feelings, friends, activities, and opinions.

RESPONSIBLE PARENTING
Sharing parental responsibilities • being a positive non-violent role model for the children.

HONESTY AND ACCOUNTABILITY
Accepting responsibility for self • acknowledging past use of violence • admitting being wrong • communicating openly and truthfully.

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5.4 Types of Abuse

- Physical 1, 4, 24, 26, 27
- Psychological or emotional 1, 4, 24, 26, 27
- Sexual assault 24, 26
- Isolation 4, 24, 26
- Control of the pregnant victim’s money, shelter, time, food, social contacts 1, 4, 2

5.5 Physical Effects of Violence

- Vaginal/cervical/kidney infections, pelvic pain, and dyspareunia 4, 12, 19, 27
- Contusions, lacerations, fractures, sprains 4, 20
- Injuries to head, neck, chest, breasts, abdomen
- During pregnancy, injuries are especially common to breasts, genitals, abdomen 12, 20
- Abdominal trauma, breast trauma 19
- Vaginal bleeding and hemorrhage 4
- Miscarriage, ruptured membranes 4, 19
- Placental abruption 19
- Insufficient weight gain 19
- Low birth weight 19
- Delayed prenatal care 19
- Exacerbation of chronic illnesses 19
- Fetal bruising, fractures, and hematomas 19
- Death 19

5.6 Psychological Effects of Violence

- Depression 4, 26
- Antisocial behavior 4
- Suicidal behavior in females 4
- Anxiety 4, 26
- Low self-esteem 4, 6
- Fear of intimacy 4
- Inability to trust men 4
- Sleep disorders 12, 26
- Post Traumatic Stress Disorder 12
- Alcohol/Drug abuse 26
- Eating Disorders 26

5.7 Risk Factors for Victimization 4

- Prior history of intimate partner violence
- Being female
- Being young
- Heavy alcohol and/or drug use
- High-risk sexual behaviors
- Witnessing or experiencing violence as a child
- Low level of education
- Unemployment
- Having a higher educational level than intimate partner
• Being Native American, Alaskan Native, or African American
• Having a verbally abusive, jealous, or possessive partner
• Having an unplanned or unwanted pregnancy

5.8 Partner's Behavioral Signs (Potential for Violence)

• Accompanies patient to prenatal office visits, insists on staying close and answers all questions directed toward the woman
• May exhibit intense irrational jealousy or possessiveness in doctor’s presence; or patient may report this to doctor
• The prenatal patient may exhibit signs of stress or could appear to be frightened, ashamed, evasive, or embarrassed
• The woman may be reluctant to speak or disagree in front of her partner

5.9 Physician Suggestions

• The American College of Obstetricians and Gynecologists (ACOG) recommends that physicians screen all patients for intimate partner violence, and that these screenings be conducted in private surroundings, with only the prenatal patient present, at the following times:
  o First prenatal office visit
  o At least once per trimester
  o During the postpartum checkup
• The ACOG strongly affirms that domestic violence screening can be conducted by making the following statement—“Because violence is so common in women's lives, and because there is help available for women who are being abused, I now ask every patient about domestic violence”—and by asking these three simple questions:
  o Within the past year—or since you have been pregnant—have you been hit, slapped, kicked, choked, or otherwise physically abused by someone?
  o Are you in a relationship with someone who threatens or physically hurts you?
  o Has anyone forced you to have sexual activities that made you feel uncomfortable?
• Routinely offer all patients information regarding domestic violence resources and support. Do not mail information to the patient for safety reasons, and let the patient decide if it is safe to take information home.
• Any patient who confirms domestic abuse should be assessed for their immediate safety. If patient is in immediate danger of harm, provide a safe place away from the abuser—encourage her to find a safe place to stay immediately (friends, family, battered women's shelter, etc.). Assist the patient with making important phone calls to domestic hotlines, a crisis center, Abuse Alternatives, the police, etc. You might be saving more than one life by helping.
• Offer every patient a copy of community resources and emergency numbers each office visit.
• Post informative domestic violence posters in the women's bathroom, out of sight of potential abusers.  
• If any patient admits to being abused, do not prescribe tranquilizers or other sedating medicines because these could impair her ability to defend or flee during an attack.  
• The abuse of alcohol and drugs tends to increase after physical or emotional abuse begins. Caution patient that these could not only harm her fetus, but could impair her ability to flee or defend herself during a violent episode.  
• Accurate documentation by professionals is key to helping patients who seek legal action now or in the future.  
• Set up follow-up appointments as needed to help domestic violence victims (and those you suspect are being abused).  
• Establish and furnish safety plans for the abused patient (see 'Patient Handout 1: Victim Personalized Safety Plan’ on following page).  

Handout 1:
Personalized Safety Plan

Below is an eight-step safety plan:

Step 1. Safety during violence.

I can use the following options:

a. If I decide to leave, I can: ____________________________________________
   _____________________________________________________________________

b. I can keep a bag ready and put it ________________________________ so I can
   leave quickly.

c. I can tell ________________________________ about the violence and have them
   call the police when violence erupts.

d. I can teach my children to use the telephone to call the police and the fire
   department.

e. I can use this word code ________________________________ for my children,
   friends, or family to call for help.

f. If I have to leave my home, I can go: _________________________________.
   (Be prepared even if you think you will never have to leave.)

g. I can teach these strategies to my children.

h. When an argument erupts, I can move to a safer room such as _____________.

i. I can use my instincts, intuition, and judgment. I can protect myself and my
   children until we are out of danger.
Step 2. Safety when getting ready to leave.

I can use the following strategies:

a. I can leave money and an extra set of keys with: ___________________________.

b. I can keep important documents and keys at: ________________________________.

c. I can open a savings account by this date _________________________ to increase my independence.

d. Other things I can do to increase my independence are:
_______________________________________________________________________
_______________________________________________________________________


e. The domestic violence hotline is ____________________________.

f. The shelter’s hotline is ____________________________.

g. I can keep change for phone calls with me at ALL times. I know that if I use a telephone credit card, the following month the telephone bill will tell the batterer who I called after I left. I can keep this information confidential by using a prepaid phone card, using a friend’s telephone card, calling collect, or using change.

h. I can check with _________________________ and _________________________ to know who will let me stay with them or who will lend me money.

i. I can leave extra clothes with ________________________________.

j. I can review my safety plan every ___________________ (time frame) in order to plan the safest route.
   I can review the plan with ________________________________ (a friend, counselor or advocate.)

k. I can rehearse the escape plan and practice it with my children.
Step 3. Safety At Home

I can use the following safety methods:

a. I can change the locks on my doors and windows as soon as possible.

b. I can replace wooden doors with steel doors.

c. I can install security systems- i.e. additional locks, window bars, poles to wedge against doors, electrical sensors, etc.

d. I can purchase rope ladders to be used for escape routes from the second floor.

e. I can install smoke detectors and buy fire extinguishers for each floor of my home.

f. I can install an outside lighting system that lights up when someone approaches my home.

I can teach my children how to use the phone to make collect calls to me and to ____________________________ (friend, family member, minister) if my partner tries to take them.

h. I can tell the people who care for my children the specific person(s) who have permission to pick up my children. My partner is NOT allowed to pick them up.

Inform the following people:
School ____________________________
Day Care ____________________________
Babysitter ____________________________
Sunday School ____________________________
Teacher ____________________________
And ____________________________
Others ____________________________

i. I can tell my the following people that my partner no longer lives with me and that they should call the police if he is seen at or near my residence:

Neighbors ____________________________
Church Leaders ____________________________
Friends ____________________________
Others ____________________________
Step 4. Order of Protection

The following steps will help enforce the order of protection:

a. I can keep the protection order ________________ (the location). Always keep it with you.

b. I can give my protection order to police departments in the areas where I visit my friends, family, and where I live and work.

c. I can tell my employer, my church leader, my friends, my family and others that I have a protection order against my abuser.

d. If my protection order gets destroyed, I know I can go to the courthouse and get another copy.

e. If my partner violates the protection order, I can call the police and report it. I can call my lawyer, my advocate, counselor, and/or tell the courts about the violation.

f. If the police do not help, I can call my advocate or my attorney AND I can file a complaint with the Chief of the Police Department.

g. I can file a complaint with the police in the jurisdiction where the violation took place. A domestic violence advocate can help me do this.

Step 5. Job and Public Safety

I can do the following:

a. I can tell my boss, security, and ________________ at work about this situation.

b. I can ask ____________________________ to help screen my phone calls.

c. When leaving work I can do the following:

_______________________________________________________________________

_______________________________________________________________________

d. When I am driving home from work and problems arise, I can

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________
e. If I use public transportation, I can:

_______________________________________________________________________
_______________________________________________________________________

f. I can shop at different grocery stores and shopping malls at different hours than I did when I was with my partner.


g. I can use a different bank and bank at different hours than I did when I was with my partner.

h. I can also do the following:

_______________________________________________________________________

Step 6. Drug and Alcohol Use.

I can enhance my safety if I do the following:

a. If I am tempted to use drugs/alcohol, I can go to a safe place with people who understand the risk of violence and who are committed to my safety and sobriety.

b. I can also:

_______________________________________________________________________

c. If my partner is using, I can:

_______________________________________________________________________

d. I can also:

_______________________________________________________________________

e. To protect my children, I can:

_______________________________________________________________________

Step 7. Emotional Health

I can do the following:

a. If I feel depressed and ready to return to a potentially violent situation/partner, I can tell or call:

_______________________________________________________________________

_______________________________________________________________________
b. When I have to talk to my partner in person or on the phone, I can:
_______________________________________________________________________

c. I can use “I can…” statements and I can be assertive with people.

d. I can tell myself “____________________________________________________”
when I feel people are trying to control or abuse me.

e. I can call the following people and/or places for support: _____________________
_______________________________________________________________________

f. Things I can do to make me feel stronger are: ______________________________
_______________________________________________________________________

Step 8. Checklist of Important Items To Take With You

When I leave I Should Take with Me (items in red are essential):

- Identification for myself
- Children's birth certificates
- My birth certificate
- Social security cards
- School and vaccination records
- Money
- Checkbook/ATM card
- Credit cards
- Keys---house/car/office/safety deposit box
- Driver’s license and registration
- Medications
- Passports
- Green cards
- Welfare identification
- Work permits
- Divorce papers
- Medical records for all family members
- Lease/rental agreement, house deed, mortgage payment book
- Bank books
- Insurance papers---life, car, health
- Car gassed up and working
- Emergency bag with food/water/clothing
- Small sellable items
- Address book
- Pictures
- Jewelry
- Children's favorite toys and/or blankets
- Items of special sentimental value

Source:
Nashville Metro Police Department, Personalized Safety Plan
www.ctcadv.org/Website/personalized_safety_plan__below__htm
Handout 2: Cycle of Violence

Note: Once begun, the Cycle of Violence can continue for many, many years!
Handout 3: Wheel of Violence

Tactics of Men Who Batter

- Using Coercion and Threats
  - Making and/or carrying out threats to do something to hurt her
  - Threatening to leave her
  - To commit suicide, to report her to welfare
  - Making her do illegal things

- Using Economic Abuse
  - Preventing her from getting or keeping a job
  - Making her ask for money
  - Giving her an allowance
  - Taking her money
  - Not letting her know about or have access to family income

- Using Male Privilege
  - Treating her like a servant
  - Making all the big decisions
  - Acting like the "master of the castle"
  - Being the one to define men's and women's roles

- Using Children
  - Making her feel guilty about the children
  - Using the children to relay messages
  - Using the children to harass her
  - Threatening to take the children away

- Using Isolation
  - Controlling what she does, who she sees
  - Telling her what to think
  - Limiting her outside involvement
  - Using jealousy to justify actions

- Using Emotional Abuse
  - Putting her down
  - Making her feel bad about herself
  - Making her feel guilty
  - Insulting her
  - Making her think she's crazy

- Using Intimidation
  - Making her afraid by using looks, actions, gestures
  - Smashing things
  - Destroying her property
  - Abusing pets
  - Displaying weapons

- Minimizing, Denying, and Blaming
  - Making light of the abuse
  - Not taking her concerns about it seriously
  - Saying the abuse didn't happen
  - Shift responsibility for abusive behavior

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Handout 4: Wheel of Non-Violence

- **NEGOTIATION AND FAIRNESS**: Seeking mutually satisfying resolutions to conflict, accepting change, and being willing to compromise.
- **NON-THREATENING BEHAVIOR**: Talking and acting so that she feels safe and comfortable expressing herself and doing things.
- **ECONOMIC PARTNERSHIP**: Making money decisions together, making sure both partners benefit from financial arrangements.
- **RESPECT**: Listening to her non-judgmentally, being unconditionally affirming and understanding, valuing opinions.
- **SHARED RESPONSIBILITY**: Mutually agreeing on a fair distribution of work, making family decisions together.
- **TRUST AND SUPPORT**: Supporting her goals in life, respecting her right to her own feelings, friends, activities and opinions.
- **RESPONSIBLE PARENTING**: Sharing parental responsibilities, being a positive non-violent role model for the children.
- **HONESTY AND ACCOUNTABILITY**: Accepting responsibility for self, acknowledging past use of violence, admitting being wrong, communicating openly and truthfully.
**Handout 5: Indicators of Abusive Relationships**

<table>
<thead>
<tr>
<th>Using Emotional Abuse</th>
<th>Using Privilege</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Putting you down</td>
<td>• Treating you like a servant</td>
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<tr>
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</tr>
<tr>
<td>• Making you think you are crazy</td>
<td>• Being the one to define roles</td>
</tr>
<tr>
<td>• Playing mind games</td>
<td>• Making you feel unimportant</td>
</tr>
<tr>
<td>• Humiliating you</td>
<td>• Punishment for not &quot;obeying&quot;</td>
</tr>
<tr>
<td>• Making you feel guilty</td>
<td>• Ordering you around</td>
</tr>
</tbody>
</table>

<table>
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<tr>
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<tr>
<td>• Preventing you from getting a job</td>
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<td>• Making you ask for money</td>
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</tr>
<tr>
<td>• Giving you an allowance</td>
<td>• Making you drop charges</td>
</tr>
<tr>
<td>• Taking your money</td>
<td>• Making you do illegal things</td>
</tr>
<tr>
<td>• Being secretive about income</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Using Intimidation</th>
<th>Using Children</th>
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<tbody>
<tr>
<td>• Making you afraid (looks, gestures, actions)</td>
<td>• Making you feel guilty about the children</td>
</tr>
<tr>
<td>• Smashing things</td>
<td>• Using the children to relay messages</td>
</tr>
<tr>
<td>• Abusing Pets</td>
<td>• Using visitation to harass you</td>
</tr>
<tr>
<td>• Displaying Weapons</td>
<td>• Threatening to take the children</td>
</tr>
<tr>
<td>• Threatening to expose your &quot;weakness&quot;</td>
<td>• Threatening to hurt you through them</td>
</tr>
<tr>
<td>• Threatening to &quot;tell&quot;</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Using Isolation</th>
<th>Minimizing, Denying, Blaming</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Controlling what you do, who you see and talk to, what you read, &amp; where you go</td>
<td>• Making light of the abuse and not taking your concerns about it seriously</td>
</tr>
<tr>
<td>• Limiting your outside involvement</td>
<td>• Saying the abuse didn’t happen</td>
</tr>
<tr>
<td>• Using jealousy to justify actions</td>
<td>• Shifting responsibility for abusive behavior</td>
</tr>
<tr>
<td>• Destroying your support system</td>
<td></td>
</tr>
</tbody>
</table>

Source: An Abuse, Rape and Domestic Violence Aid and Resource Collection. www.aardvarc.org/dv/p-symptoms.html
5.10 References


PHYSICIAN'S TOOLKIT 6:
Breastfeeding

Toolkit 6 Contents
6.1 Introduction
6.2 Breastfeeding Research
6.3 Benefits of Breastfeeding for the Baby
6.4 Benefits of Breastfeeding for the Mother
6.5 Contraindications
6.6 Possible Reasons Women Stop Breastfeeding
6.7 Characteristics of Women Less Likely to Breastfeed
6.8 Characteristics of Women Likely to Breastfeed
6.9 Perceived Barriers to Breastfeeding
6.10 Physician Suggestions
6.11 References

6.1 Introduction

"Choosing how and what to feed a baby is a personal decision that deserves careful and thorough consideration. Most healthcare professionals recommend breastfeeding for your baby's first year (including the American Academy of Pediatric Nursing Associates and Professionals, World Health Organization, American Academy of Pediatrics, American Medical Association, and American Dietetic Association). Breast milk is the best source of nutrition for the first 6 months of life. It contains appropriate amounts of carbohydrates, protein, minerals, vitamins, and hormones that infants require. Breast milk also contains antibodies from the mother that can help the baby" (The University of Tennessee Medical Center, 2007).

The U.S. Food and Drug Administration (2007) states that, "Both breast milk and infant formula will help a baby grow, but breast milk is the best first food for babies" (p. 1). Experts agree that breastfeeding for even a short period of time is beneficial and, if it is more convenient for the mother to use a pump, the baby will still reap the same health benefits from the breast milk. Though any period of time is beneficial, The American Academy of Pediatrics strongly affirms that babies should be breastfed exclusively for the first 6 months, and that breast feeding should continue until 12 months of age (and beyond) if both mother and baby are willing. It is important to remember that breastfeeding is also beneficial for the mother; in response to the baby's sucking, the mother's body releases a hormone called oxytocin that makes the uterus contract. This is an important post-birth healing response which helps control bleeding. Breastfeeding also provides a contraceptive effect for the mother, as well as improved bone density postpartum, less ovarian cancer, and lower rates of breast cancer following menopause. Breastfeeding also promotes mental health benefits for postpartum mothers, increasing their tolerance to stress and fostering maternal bonding between mother and child."
6.2 Breastfeeding Research

- 95% of African American and 87% of Asian women breastfeed their babies, while only 67% of Caucasian mothers do.
- 78% of mothers ages 30 and older breastfeed their babies, compared to only 46% of mothers ages 29 and younger.
- 90% of mothers who gave up breastfeeding within the first 6 weeks after birth say they would have liked to continued breastfeeding for longer. The most common reasons given for stopping breastfeeding early included rejection by the baby, sore nipples, and insufficient breast milk.
- Formula-fed babies are at an increased risk for ear, chest, kidney infections, gastroenteritis, asthma, obesity, and diabetes.
- Breast milk is the best source of nutrition for the first 6 months of life. It contains appropriate amounts of carbohydrates, protein, minerals, vitamins, and hormones that infants require. Breast milk also contains antibodies from the mother that can help the baby.
- Breastfeeding might help prevent childhood and adult obesity; the National Women's Health Information Center concludes that babies who are breastfed tend to gain less unnecessary weight, which may lead them to gain less weight later as adults.
- Babies who were breastfed exclusively for the first 6 months had I.Q.'s 5 - 10 points higher than babies who were formula-fed.
- Babies who are not exclusively breastfed during the first 6 months tend to have higher rates of infections and hospitalizations.
- Premature babies who are breastfed have better outcomes and higher I.Q. test scores than premature babies who are fed formula.
- Formula-fed babies have a higher rate of SIDS during the first year of life.
- The American Academy of Pediatrics reported that formula-fed babies have increased rates of Type 1 and Type 2 diabetes, lymphoma, leukemia, Hodgkin's disease, obesity, high cholesterol, and asthma.
- The National Institute of Child Health & Human Development has found that a mother's breast milk contains important amino acids, essential building blocks that help a baby's body grow and develop.
- Babies who are breastfed, according to the National Institute of Environmental Health Sciences and the American Academy of Pediatrics, have a 21% lower infant mortality rate between month 1 and month 12, when compared to formula-fed babies.
6.3 Benefits of Breastfeeding for the Baby

Breastfed Babies have:
1. Lower infant mortality rates
2. More complete nutrition
3. Stronger immune systems
4. Fewer infections and allergies
5. Higher I.Q.'s
6. Optimum growth and reduced malocclusion
7. Improved visual acuity and psychomotor development
8. Decreased incidence of SIDS
9. Lower occurrences of ear infections, respiratory infections, intestinal infections, diarrhea, meningitis
10. Better survival rates (especially if born premature)
11. Decreased risk of obesity, diabetes, allergies, and SIDS
12. The vitamins, antibodies, and minerals they need to grow strong and healthy
13. Much lower incidences of sepsis and necrotising enterocolitis when born pre-term, leading to long-term digestive advantages
14. Stronger and healthier teeth during childhood
15. Far fewer incidences of hospitalization
16. Lower risks of developing high blood pressure in child or adulthood

6.4 Benefits of Breastfeeding for the Mother

Mothers who Breastfeed have:
- An easier time losing weight after delivery since breastfeeding uses up excess calories, making it easier to lose pregnancy weight
- A much lower risk of developing breast, ovarian and cervical cancers
- Possible decreased risk of hip fractures and osteoporosis after menopause
- More time for themselves and their babies—getting up, going to the kitchen, mixing, measuring, warming formula and bottle cleaning take up a lot of time!
- Better self-confidence and a special bond with their babies
- More money—formula is expensive, electricity and gas are costly, but breast milk is free and already nice and warm at 98.6 degrees!
- Less postpartum bleeding because breastfeeding releases a hormone (oxytocin) that causes the uterus to contract
- A reduced chance of becoming pregnant soon after delivery because breastfeeding has a contraceptive effect on the mother's body
- Fewer episodes of post-delivery depression
6.5 Contraindications

Women Should **NOT** Breastfeed if:

1. They have AIDS, Hepatitis-C, Tuberculosis, Herpes, or other communicable diseases
2. They take certain types of medications (many are passed on to the baby in breast milk)
3. Drink alcohol or abuse drugs
4. They have had breast surgery in the past for cancer, augmentation, etc. (this may pose difficulties)
5. Their baby has galactosemia (babies with this disorder must be a lactose free diet)

**Note:** Women who smoke can breastfeed, but should be actively encouraged to quit because nicotine is transported to the baby via breast milk. The long-term harmful effects of nicotine on babies is not currently known and it is always better to be safe....

6.6 Possible Reasons Women Stop Breastfeeding

- Breast engorgement
- Anxiety due to the mother’s lack of knowledge concerning how much milk her baby needs at each feeding
- Leaky breasts
- Let-down reflex (other than during breastfeeding)
- Baby has trouble sucking or thrush
- Birth defects with baby’s mouth (such as cleft palate or lip)
- Small size
- Mother or child in weak condition
**Figure 1: Common Problems Associated With Breastfeeding**

### Engorgement:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Potential Causes</th>
<th>Management Strategies for Comfort</th>
<th>Management Strategies for Relief</th>
</tr>
</thead>
</table>
| Three to five days after giving birth, a woman's breasts may become heavy, firm, swollen, and feel warm. With appropriate management, the woman will feel better in one to two days. | • Missed feedings  
• Infrequent feedings  
• Incomplete feedings (due to a sleepy baby)  
• A change in feeding pattern as a result of supplementing or weaning | • Apply warm, moist heat to breasts before nursing or pumping  
• Gently massage breasts  
• Hand express or pump to soften the areola area  
• Apply cold packs or cabbage leaves for 10 minutes after every feeding to reduce swelling (Discontinue when breasts are comfortable)  
• Wear a well-fitting, adjustable and supportive bra  
• Take acetaminophen or ibuprofen | • Frequent feedings (8-12 times every 24 hours)  
• Start feedings on the most engorged side first  
• Encourage vigorous infant suckling by using rhythmic breast compression or gently stroking baby under the chin to keep baby alert and focused  
• Use a variety of nursing positions  
• After feeding or pumping, mothers should examine their breasts. Pay attention to sensitive areas by:  
  — Massaging the breast before and during feeding  
  — Using a nursing position where baby's nose is pointed to the firm area |

### Plugged Ducts:

<table>
<thead>
<tr>
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<th>Management Strategies for Comfort</th>
<th>Management Strategies for Relief</th>
</tr>
</thead>
</table>
| A tender area or a painful lump in the breast may indicate a plugged duct. If the woman also has a fever, she may have mastitis. | • Missed feedings  
• A change in feeding pattern  
• Inadequate milk removal  
• Using a limited number of feeding positions  
• Pressure of a mother’s hand on her breast during feedings  
• A bra or other clothing that places pressure on breast tissue (Underwire bras, Tight sports bras, Wearing a tight-fitting bra during sleep) | • Apply warm, moist heat to the plugged area before nursing  
• Massage the area before and during nursing  
• If the breast does not soften during feeding, pump more milk and save for later use  
• Limit the amount of clothing under the arm during feeding to decrease pressure on the breast  
• Take acetaminophen or ibuprofen to reduce discomfort | • Frequent feeding (8-12 times every 24 hours), allowing baby to feed until full  
• Start on the breast with the plugged duct first  
• Position the infant so baby's nose is pointed toward the plugged area  
• Encourage vigorous infant suckling by using rhythmic breast compression or gently stroking baby under the chin to keep baby alert and focused on feeding  
• Hand express or pump milk instead of skipping or missing feedings  

**Note:** If the tender area or painful lump is not resolved after 24 hours, encourage her to call her lactation consultant or health care provider.
**Sore Nipples:**

**Note:** If not resolved within 48 hours, call lactation consultant.

<table>
<thead>
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<th>Management Strategies for Relief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some nipple tenderness is normal during the early weeks of breastfeeding; however, pain during feeding is not normal and requires follow-up to prevent early weaning. Women with flat or inverted nipples may be at increased risk. Immediately after feeding, nipples should appear moist, pink, rounded, and elongated. It is not normal for nipples to appear: • Blanched • Pinched • Bruised • Blistered • Misshapen • Creased.</td>
<td>• Improper positioning or poor latch • Disorganized suck • A yeast infection (thrush) • Poor tongue extension due to a short frenulum (tongue-tie) Note: Thrush is a common yeast infection that affects mucous membranes in both mothers and babies. If there are white patches in baby’s mouth, it may be thrush and if baby has a diaper rash, it may be a yeast infection. Both mother and baby should be treated.</td>
<td>• Wear breast shells to keep the nipple dry and promote healing • Change nursing pads when they become wet • Avoid plastic-lined pads • Use only water to clean nipples—soap and alcohol are drying agents and may worsen condition • Take acetaminophen or ibuprofen • Put a few drops of colostrum or breastmilk on the areola and nipple after each breastfeeding • Put a small amount of purified lanolin (for breastfeeding mothers) on the damaged nipple or areola tissue after nursing • Discourage the use of other creams, ointments and salves</td>
<td>• Frequent feeding • Review feeding position and latch to ensure baby is breastfeeding and not nipple feeding • Watch for subtle signs of hunger and offer the breast. Delayed feedings may result in baby feeding more vigorously, causing more soreness • If putting baby to breast is too painful, hand express or pump breastmilk at typical feeding times to maintain milk supply and allow healing • Use a variety of feeding positions • If baby falls asleep at the breast or mother needs to interrupt a feeding, break suction by inserting a finger in the corner of baby’s mouth • Limit the use of a pacifier • If baby is grazing or nibbling instead of suckling, encourage vigorous suckling by using rhythmic breast compression or gently stroking baby under the chin. If unsuccessful, break suction and reposition the nipple in baby’s mouth.</td>
</tr>
</tbody>
</table>

**Mastitis:**

**Note:** Referral and antibiotics may be needed: call lactation consultant or health care provider.
When a woman experiences a fever, chills, achy flu-like symptoms, breast tenderness, redness, and swelling, mastitis should be considered.

- Use of some creams, lotions, and salves that introduce pathogens into nipples
- Sometimes, use of a pump may provide pathogen access into breast (this is not the case as long as pump is kept sterile)
- Untreated plugged ducts or cracked nipples
- Infrequent feedings
- Tight clothing
- Teething
- Abrupt weaning
- Low resistance to infection

### Management Strategies for Comfort

- Apply warm packs to affected breast before nursing and cool packs after nursing
- Massage the breast before and during feedings
- Use a variety of feeding positions to promote milk removal from all areas of the breast
- If the breast does not soften enough during feeding, hand express or pump until comfortable
- Take acetaminophen or ibuprofen

### Management Strategies for Relief

- Feed frequently (8-12 times every 24 hours)
- Start feedings on the affected side first
- Go to bed for 24 hours with the baby to promote frequent feeding
- Ask for help with household tasks
- Maintain an adequate diet and fluid intake

**Thrush:**

- Thrush, or yeast, is caused by an overgrowth of the fungal organism *Candida*. A thrush infection can occur on a lactating woman’s nipples, inside an infant’s mouth, and in the infant’s diaper area.

#### Physical signs of thrush in infant:
- White patches in the mouth and on the tongue that cling when attempts are made to wipe them off
- A bright red bumpy diaper rash beginning at the rectum and spreading outward
- General irritability and not breastfeeding well

#### Physical signs of thrush in mother:
- Bright pink, red, white, or shiny nipples
- Complaints of severe burning or shooting pain within the breast or nipple

### Management Strategies

- Treatment by a health care provider is needed for both mother and baby.

The following strategies are recommended for maternal comfort and to decrease the opportunity for yeast to grow:

- Use disposable breastpads and discard after first use (Yeast grows well in a moist warm environment)
- Rinse nipples with warm water or a weak vinegar solution (1-tablespoon per cup of water) and air-dry them after breastfeeding
- Spend a few minutes a day with bra flaps down and nipples exposed to light
- Discourage pacifiers because they can transfer yeast
- Use freshly expressed breastmilk but do not freeze expressed breastmilk for later use—this can reintroduce yeast infection to the baby
- Boil all bottles, bottle nipples, pacifiers and parts of the breast pump once daily for 20 minutes
- Physician may prescribe topical medications for the mother’s nipples, areola, and the infant’s mouth; continue use for the length of time prescribed (typically 10-14 days)
- If thrush persists, consult health care provider
- Good hand-washing techniques, particularly after diaper changes, are critical to prevent cross-infection between mother and baby

Note: Silicone-containing pacifiers and bottle nipples withstand boiling; latex products do not

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### 6.7 Characteristics of Women Less Likely to Breastfeed

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• Under 20 years of age
• Member of a minority group
• Recent immigrant

6.8 Characteristics of Women Who Breastfeed

• First time mothers (74%), compared to only 65% of mothers who have other children
• Older mothers (approximately 78% of those age 30 and over breastfeed)
• Professionally employed
• Completed more education

6.9 Perceived Barriers to Breastfeeding

• The mother's lack of confidence
• The false belief that formula is as good as breast milk
• Physical discomfort

6.10 Physician Suggestions

• Recommend that all mothers breastfeed, except those with communicable diseases (AIDS, Hepatitis-C, Tuberculosis, Herpes, etc.) or those women who have physical disabilities, prior breast cancer surgery, or augmentations that have damaged the breast and preclude breastfeeding. Breastfeeding for the first six months after birth has many benefits for both preemies and full term babies including lower rates of SIDS, antibodies, essential vitamins and minerals, better teeth, optimum growth, fewer infections, etc. 2, 6, 10, 11, 16
• Assess all pregnant women for breastfeeding misconceptions and assure them that, barring a communicable illness or prior breast surgeries, the vast majority of women are able to breastfeed their babies 2
• Assure low income mothers that breastfeeding is far less expensive than formula 16
• Physicians should approach prenatal clients in a non-judgmental manner. Let the pregnant patient know that breastfeeding is, although the preferred choice, not a requirement; let her know that breastfeeding is a personal choice that every new mother has to make for herself 6
• Explain the common problems that she might encounter when breastfeeding her baby: breast engorgement, anxiety concerning how much milk her baby needs at each feeding, leaky breasts, the let-down reflex, etc. These are not so scary when the mother knows beforehand that they are not unusual problems. Educate the patient verbally and via handouts concerning what the common breastfeeding problems are, and let her know that if problems continue, she should seek medical attention 18
• Encourage the prenatal patient early on in her pregnancy to attend a local chapter of the La Leche League. At these meetings, she will learn the basics of breastfeeding from
trained instructors, and will gain insight into making the best choice for her and her baby.

- Provide accurate information about the benefits of breastfeeding compared to formula, and address these facts before conception (or soon after at each prenatal visit) to insure that the prenatal patient has all the facts needed to make an informed choice.
- Elicit family medical history (diabetes, obesity, cancers, etc.) to help demonstrate the importance of breastfeeding when considering the baby’s future health risks.
- Elicit any risk factors for potential breastfeeding problems/contraindications to lactation; provide education and support.
- Encourage the prenatal patient’s support person(s) to participate in the decision to breastfeed, and educate them accordingly.
- Provide the patient with local support services/resources that can offer important support and educational services. It is important to keep handouts of these resources/support agencies in your office.
- Warn patient about medicines, alcohol, illicit drugs, nicotine that could harm her baby via breast milk.
- Provide culturally sensitive breastfeeding posters, pictures, handouts, and brochures in your office.
- Encourage your patient to ask for support from her friends and family concerning breastfeeding.

Note: The National Institute of Health assures that, under advisement of a physician, engorgement, hardening of the breast, breast abscess, fever, and the use of pain medications and antibiotics are not reasons to stop breastfeeding.
Handout: Breastfeeding

Mom, here’s why it’s so important to breastfeed your baby:

Breast Milk:

• Is the best source of nutrition for the first 6 months of your baby’s life. It contains the right amounts of carbohydrates, protein, minerals, vitamins, and hormones that your baby needs. Breast milk also contains antibodies that help your baby grow strong and healthy
• Will give your baby a stronger immune system
• Helps your baby have fewer allergies
• Helps your baby avoid childhood obesity, high blood pressure, and Type II diabetes
• Gives your baby a higher I.Q.
• Ensures that your baby has the best eyesight possible
• Helps ensure that your baby has good hand-eye coordination
• Will greatly decrease the chance your baby will suffer SIDS (sudden infant death syndrome)
• Will decrease the number of sinus, ear, throat, lung, and intestinal infections that your baby will get. Also, breastfeeding ensures that your baby will have fewer cases of diarrhea, and helps him or her avoid contracting meningitis

Also, Mom...

• You will have an easier time losing weight after delivery since breastfeeding uses up excess calories, making it easier to lose pregnancy weight
• After menopause, you will have a lower risk of hip fractures, breast cancer, and osteoporosis
• Breastfeeding gives you more time for yourself (remember it takes time to get up, clean bottles, mix and warm formula—breast milk is always the right temperature and already mixed to perfection!)
• Breastfeeding increases a woman’s self-esteem and helps form a special bond between you and your baby
• Breastfeeding will save you money (formula is expensive, and needs electricity or gas to be warmed—breast milk is free, and is already nice and warm at 98.6 degrees!)
• You will have less postpartum bleeding because breastfeeding releases a hormone called oxytocin that causes the uterus to contract
• Breastfeeding has a contraceptive effect on a woman’s body, reducing the chance of conceiving while nursing
• Women who breastfeed have far fewer episodes of Postpartum Depression than women who choose to feed their babies with formula

However, even though breastfeeding is the ideal choice nutritionally for the baby and physically for the mom, formula is a good alternative for those moms who choose not to breastfeed, are unable to breastfeed because of a communicable disease, or who have had a prior breast surgery that has damaged the breast's feeding ability. You will still be able to bond with your baby, and formula, as overseen by the Federal Food and Drug Administration, contains all the known vitamins and minerals your baby needs to grow up healthy. Studies have found that Formula Manufacturers are getting closer all the time to matching the necessary vitamins and minerals contained in breast milk. The basic difference between your milk and formula lies in the Manufacturer's inability to match or manufacture unique, complex substances found only in a mother's milk.

Reasons You Might **Not** Be Able to Breastfeed Your Baby:

- **X** If you have:
  - active HIV
  - Tuberculosis
  - Herpes lesions on your breasts
- **X** If you use illicit drugs or drink alcohol
- **X** If you have certain chronic illnesses (especially diabetes), you should consult your physician before starting to breastfeed
- **X** When taking medications, or before beginning medications, always consult with your physician first. Certain medications can pass through your milk and may harm your baby (especially some mood stabilizers, migraine medications)
- **X** If you have had breast surgery for cancer or augmentation in the past, you may have difficulty breastfeeding your baby

**Note:** if you have breast problems such as engorgement, breast hardening, a breast abscess, a fever, or use antibiotics or pain relievers for said fever, then usually you can still breastfeed. The key is to consult with your physician first, before breastfeeding your baby. The doctor can advise you about the medicines you are using, or the condition that is giving you problems and, in many instances, can give you suggestions or home remedies to help relieve your discomforts.

**Remember:** don't hesitate to call your doctor or local expert (La Leche, etc.) if you have any problems, concerns, or questions about health conditions, medications, or over-the-counter supplements. Last, remember---breastfeeding is a choice---not a requirement. You decide what is best for you and your baby.
Handout 2: Sore Nipples

Sore Nipples

To avoid soreness, make sure that your baby is attached and positioned correctly on your breast. If it hurts, take the baby off and try again.

Bring your baby in close to you—her chest to your chest. Her nose and chin should be touching your breast. Her mouth should cover much of the dark area around your nipple - slightly more of the area below the nipple than above.

 TICKLE YOUR BABY’S LIPS WITH YOUR NIPPLE UNTIL SHE OPENS HER MOUTH VERY WIDE, LIKE A YAWN.

When removing your baby from your breast, place your little finger in the corner of the baby’s mouth, between the gums to break the suction; then gently move the baby away from the breast.

If your nipples are sore, try nursing in different positions.

Cross-cradle hold

Cloth position

Lying down

❤ Begin breastfeeding on the side that is less sore.
❤ If both breasts are sore, massage your breasts before breastfeeding until the milk begins to flow.
❤ After feeding, wash your hands and express a few drops of your milk and rub it into the sore skin; warm water may also be helpful.
❤ If soreness doesn’t improve within 1 to 2 days, consult a breastfeeding counselor.

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Source: South Los Angeles Health Projects WIC Program,
www.breastfeedingtaskforla.org/resources/breastfeeding-public-education.htm
Handout 3: Feeding Decisions

Feeding Decisions

You know "breast is best"—
but you may be wondering:

❤ Will I produce enough milk for my baby?
❤ How will I feed my baby when I'm out in public?
❤ How will I return to work or school or attend appointments?

Here are some ideas:

Breastfeed often to make the milk your baby needs.

Wear an oversized blouse, or cover up with a receiving blanket for privacy when you are out in public.

Pump your milk and leave it with your baby's caretaker when you are at work or at school.

What will happen if I give my baby formula?

❤ Using formula will decrease your milk supply and can make breastfeeding difficult.
❤ Babies who receive formula get more ear infections and diarrhea.
❤ Babies who receive formula are more likely to get serious infections, diabetes, and certain cancers when they are older.

Babies who receive only breast milk grow to be the healthiest and smartest they can be.

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Source:
Handout 4

Getting a Strong Start with Breastfeeding

Before the Baby Comes:
- I want to breastfeed my baby.
- Learn about breastfeeding—attend classes, speak with other mothers.
- Tell your family, doctor and nurse you want to breastfeed.

At the Hospital:
- Start breastfeeding within an hour after birth, if possible.
- Tell the staff you want your baby to only have breast milk.
- Keep your baby in the room with you day and night.
- Learn to recognize when your baby is hungry.
- Ask for help if you have any questions.

The First Feedings at the Breast:
- Your very first milk, colostrum, is just right for your baby and will protect her against disease.
- Newborns may be sleepy from their mother’s medication during labor—have patience and keep trying.
- The first feedings are practice for you and your baby.
- Let your baby breastfeed as often and for as long as she wants.
- It is common for newborns to have very closely spaced feedings at certain times of the day and night.

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Source:
Breastfed Babies Don’t Need Formula!
You can produce all the milk your baby needs

Avoid Bottles
The first 2 to 3 days you will have thick yellowish milk called colostrum. It is all your baby needs at the beginning.

Breastfeed Correctly
Hold your baby close to you, facing your breast. Your baby’s mouth should cover much of the dark area around your nipple — slightly more of the area below the nipple than above.

Breastfeed Frequently
Breastfeed your baby at least 8 to 12 times in 24 hours, including night-time feedings. Babies sometimes nurse more often at night. To feel rested, sleep when your baby sleeps.

What to Expect

♥ First days after birth:
- 1-3 wet diapers per day.

♥ After day four:
- At least 4 poops per day, plus additional wet diapers.
- Poops will be soft and a mustard-like yellow.

♥ After the first month:
- At least one poop per day.

♥ After 6 weeks:
- Some babies poop only every few days.
- Don’t worry! Your baby is not constipated.

Important Tips:

♥ If your newborn has been sleeping more than 2 hours during the day or 3 hours at night, wake him up and breastfeed.

♥ Your baby will have periods when he wants to breastfeed more often than usual. These are times of rapid growth and usually last a couple of days. To produce all the milk your growing baby needs, breastfeed more often during these periods.

The WIC Program is an equal opportunity provider and employer

Source:
6.11 References


PHYSICIAN’S TOOLKIT 7: Miscellaneous Handouts

Toolkit 7 Contents

- Relaxation Handout
- Healthy Smile Handout
- Healthy Body Image Handout
- Skin, Hair, and Nails
- Eating Disorders
- Things to Avoid when Pregnant
- Chronic Stress Handout
- Anger Management
Handout: Relaxation

Mom...

There are many ways to ease stress and relax!

• Find a quiet place and meditate --- can you hum ‘aaaahhhmmmm’

• Set aside time to read your favorite book

• Get out and enjoy the sun

• Listen to soothing music

• Turn down the lights and take a warm, enjoyable bath
• Rent a funny video and have a good ole’ laugh
• Have your partner give you a massage
• Start a journal... write down your worries and concerns
• Get creative... paint, doodle, get crafty
• Take a stroll in the park... notice birds, flowers, bees, changing leaves
• Get a hug --- give a hug
• Walk or pet your dog or cat
• Go for a relaxing drive in the country
• Just do nothing, watch children play, and listen to your thoughts
Handout: Healthy Smile

Steps for a Healthy Smile During Pregnancy

- Have regular dental checkups and cleanings to prevent gingivitis
- Brush teeth at least twice daily using fluoride toothpaste
  and a soft bristle toothbrush and don’t forget to brush your tongue to remove bacteria!
- Floss daily
- Rinse your mouth with warm water, and use an anti-microbial mouthwash

- Limit your amount of sugary desserts and drinks (see Figure 2 for healthy alternatives)
- Eat a well-balanced diet
- Take your prenatal vitamins as prescribed by your doctor
- Don’t crunch ice cubes with your teeth
- If you grit your teeth while sleeping, ask your doctor for help with protecting the biting surfaces of your teeth
Figure 1: Healthy Snacks For a Healthy Smile

Pick a variety of foods from these groups:

Fresh fruits and raw vegetables
- berries
- oranges
- grapefruit
- melons
- pineapple
- pears
- tangerines
- broccoli
- celery
- carrots
- cucumbers
- tomatoes
- unsweetened fruit and vegetable juices

Grains
- bread
- plain bagels
- unsweetened cereals
- unbuttered popcorn
- tortilla chips (baked, not fried)
- pretzels (low-salt)
- pasta
- plain crackers

Milk and dairy products
- low or non-fat milk
- low or non-fat yogurt
- low or non-fat cheese
- low or non-fat cottage cheese
Meat, nuts and seeds

- chicken
- turkey
- sliced meats
- pumpkin seeds
- sunflower seeds
- nuts

Others (these snacks combine foods from the different groups)

- pizza
- tacos

Remember to...

- limit (or avoid) sugary foods
- avoid sweets between meals
- eat a variety of low or non-fat foods from the basic groups
- brush your teeth with fluoride toothpaste after snacks and meals
Exercise---as a means of staying fit, not to lose weight; when you are pregnant you should gain 25 – 37 pounds (if you are at a healthy starting weight) as your baby grows. Also, exercising while pregnant helps you relax, sleep better, and makes your clothes fit better. Further, exercise may make your pregnancy more comfortable for you, can shorten your labor, and can reduce the need for obstetric interventions. Simply, exercise can help you to have less pain while delivering, and can help you get back into your jeans sooner after your baby is born. (Ask your doctor before beginning any exercise program)

Nutrition---don’t make the mistake of eating for two! Eat when you’re hungry, and stop when you’re not…avoid snacks, and if you must snack, choose healthy foods (carrot, celery, or other veggie sticks, non-processed fruits)

The Mirror---don’t let the mirror rule your life! Pregnancy is a beautiful state of being, and you should not spend hours in front of the mirror obsessing about negative thoughts. Okay, you’ve gained weight, your regular clothes don’t fit, and your stomach sticks out…that’s completely natural for this stage in your life---impending motherhood! When you feel the urge to look in the mirror, pamper yourself: go to the salon, have a facial, get a massage! or whatever it takes to help you feel better!
Clothing---wear what is comfortable and allows you to move, sit, and lie comfortably. Choose comfortable shoes because your feet are likely to swell. Also, make sure those shoes have low heels to prevent strains, sprains, pain, and falls.

Socializing---Seek out uplifting people---

Examples are friends, family, church groups, Lamaze classes, and La Leche League breastfeeding classes. The possibilities are endless. You'll feel better about yourself, and will enjoy the conversation. Likewise, try to avoid negative people who bring you down.
As a Way to Improve My Body Image, I Agree To...

- Spend less time in front of the mirror criticizing my looks
- Exercise to stay fit, not to lose weight
- Wear clothing that is comfortable and flattering
- Eat nutritious foods that will keep me and my baby healthy, and to avoid dieting and sugary fattening snacks and sodas
- Not compare myself to anyone else. I am unique and special just as I am
- Focus on what I like most about what I see in the mirror. When I'm feeling negative, I will limit the time I spend looking at myself
- Wear clothing that lets me move freely and rest comfortably
- Pamper myself---put on my makeup, do my nails, get facials, back massages, foot massages---the works
- Go for walks, enjoy the sun, children's laughter, exercise, pet my dog and/or cat
- Manage my stress through things like: seeking out friends, attending social events, shopping, painting, calling people I love, going for country drives
- Take naps and rest when I need them
- Keep regular dental appointments for the whitest smile possible
- See the beauty that is me—The MOM TO BE!
### Handout: Skin, Hair, and Nails

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
<th>Duration</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pruritic Urticarial</strong></td>
<td>This is the most common skin condition during pregnancy, and can appear during any of the three trimesters. Pruritic Urticarial can be slightly itchy with mild discomfort, and appears as small red bumps or hives located on the breasts, thighs, buttocks, or arms.</td>
<td>Disappears soon after delivery.</td>
<td>Ask your Physician about anti-itching cream, antihistamines, or topical cortisteroids to relieve the itching. Note: do not take any medications without consulting your doctor first!</td>
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<tr>
<td><strong>Acne</strong></td>
<td>Acne is caused by elevated hormones associated with pregnancy.</td>
<td>Usually lasts only a few months, and gradually goes away when hormone levels return to normal after you’ve had your baby.</td>
<td>Usually, no treatment is necessary. Do not take any over the counter medications for acne. Instead, consult your physician/Dermatologist about the appropriate treatment for you.</td>
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<tr>
<td><strong>Mask of Pregnancy</strong></td>
<td>50 - 70% of women get the mask of pregnancy; this problem occurs when the skin’s pigmentation causes the forehead, upper lip, and cheeks to take on a pink flush or brown splotches.</td>
<td>Usually disappears after the birth of your baby.</td>
<td>The mask of pregnancy is caused by sun exposure. Ask your Physician about sunscreens, or simply wear a hat when out of doors during the day.</td>
</tr>
<tr>
<td><strong>Moles</strong></td>
<td>Some moles may get larger and become darker during pregnancy.</td>
<td></td>
<td>Notify your Physician if any mole changes shape, or bleeds—if so, you may need referral to a Dermatologist.</td>
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<tr>
<td><strong>Stretch Marks</strong></td>
<td>Pink or purple bands usually found on the abdomen, breasts, or thighs. 50 - 90% of women report getting stretch marks during their pregnancy.</td>
<td>Usually caused by too rapid or too much weight gain during pregnancy.</td>
<td>Try not to over eat. Eating a well balanced diet and exercise helps. Note, be sure to get your Doctor’s approval before purchasing any lotions or creams for your skin. Also, keeping your body well hydrated helps.</td>
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<tr>
<td>Condition</td>
<td>Description</td>
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<tr>
<td><strong>Skin Tags</strong></td>
<td>Small, benign skin colored growths commonly found in the armpit, on the eyelids, and on the breasts.</td>
<td>If they don't go away after your baby's birth, your doctor can easily remove them.</td>
<td></td>
</tr>
<tr>
<td><strong>Worsening of Pre-existing Skin Conditions</strong></td>
<td>If you have an existing skin condition prior to becoming pregnant, then pregnancy worsen them somewhat.</td>
<td>If any skin condition gets worse during your pregnancy, contact your primary care physician/dermatologist.</td>
<td></td>
</tr>
<tr>
<td><strong>Linea Nigra</strong></td>
<td>This is the dark line that runs from the middle of your abdomen to your pubic bone, and occurs in the 4th - 5th month of pregnancy.</td>
<td>This line has always been on your abdomen; it just gets darker as your pregnancy develops.</td>
<td></td>
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<tr>
<td><strong>Pregnancy Glow</strong></td>
<td>Facial flushing caused by blood circulation and oil glands working overtime during your pregnancy. This condition is normal, and is caused by hormones released during pregnancy.</td>
<td>There's nothing you or your Physician can do for this condition; however, it quickly fades after delivery.</td>
<td></td>
</tr>
<tr>
<td><strong>Growth of Unwanted Body Hair</strong></td>
<td>Sometimes during pregnancy, women get unwanted hair on their cheeks, upper lips, chin, chest. This is caused by hormonal changes in the endocrine system.</td>
<td>If your skin's too oily, you can use oil-free soaps, cleansers, and makeup.</td>
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<tr>
<td><strong>Spider Veins</strong></td>
<td>Reddish, tiny blood vessels that branch outward underneath the skin. Spider veins are caused by the rise in blood circulation during pregnancy. They can appear on the face, neck, upper chest, arms, and occur mainly in Caucasian women due to heredity.</td>
<td>Don't cross your legs after delivery, and if they don't go away, laser treatment can remove them.</td>
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<tr>
<td>Issue</td>
<td>Description</td>
<td>Recommendations</td>
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</table>
| Varicose Veins| Bulky, bluish veins that appear on the legs during pregnancy, and are due to increased blood flow to the baby. They are sometimes painful and can be hereditary. | * Avoid standing in place for long periods of time.  
* Walk as much as possible.  
* Prop feet up while sitting.  
* Avoid sitting for long periods  
* Wear support stockings  
* Avoid gaining excessive weight during pregnancy |
| Nails         | Some expectant mothers complain of weak, split nails. Others state that their nails not only grow faster, but become stronger. | Changes in the nails during pregnancy are not permanent.  
If you have weak or splitting nails, keep them trimmed and avoid nail polish until after your baby is born. |
| Hair          | Some pregnant women complain of oily, thinning hair, while others say their hair grows thicker. | Changes in hair are due to changes in hormone levels during pregnancy and are not permanent.  
After delivery, you may lose a lot of hair. Don’t worry; as hormone levels balance out, your hair will gradually return to normal. |
Pregnancy and motherhood require a great amount of physical and psychological strength. During pregnancy, the growing baby receives all nourishment from the mother. When stores of carbohydrates, proteins, fats, vitamins, minerals and other nutrients are low, a woman’s body will drain them to support the growth and development of the baby. If reserves are not sufficiently restored through healthy eating, the mother can become severely malnourished, and this can lead to depression, exhaustion and many other serious health complications.

The average woman gains between 25-37 pounds during pregnancy. While this amount is required for a healthy pregnancy, for women with eating disorders, gaining this amount can be very frightening. Some women with disordered eating are able to more easily cope with weight gain during pregnancy because they see it as a sacrifice for an important cause. But others may plunge into a deep depression as they struggle with the idea of weight gain and body image issues.

The Relationship between Specific Eating Disorders and Pregnancy:

Women with anorexia nervosa are underweight and may not gain enough weight during pregnancy. They risk having a baby with abnormally low birth weight and related health problems. Women with bulimia nervosa who continue to purge may suffer dehydration, chemical imbalances or even cardiac irregularities. Pregnancy heightens these health risks. Women who are overweight due to binge eating are at greater risk of developing high blood pressure, gestational diabetes and overgrown babies.
**Risks for the Mother:** Poor nutrition, dehydration, cardiac irregularities, gestational diabetes, severe depression during pregnancy, premature births, labor complications, difficulties nursing, post-partum depression.

**Risks for the Baby:** Poor development, premature birth, low birth weight for age, respiratory distress, other perinatal complications, and feeding difficulties.

Professionals recommend that women with eating disorders do their best to resolve eating disorder related weight and behavior problems before they attempt to get pregnant. It is important to consult with your physician, counselors and/or a registered dietician before attempting to get pregnant. Women with eating disorders who become pregnant are advised to seek specialized medical and psychological help. Pregnant women with eating disorders should inform their obstetricians about these problems and may require “high risk” obstetrical care.

**REMEMBER:** Eat healthy, well-balanced meals and maintain a healthy weight for several months before conceiving and throughout pregnancy to protect the health of yourself and your baby!
What if I Become Pregnant while Struggling with an Eating Disorder?

Though having an eating disorder may decrease the chances of pregnancy, sometimes women with anorexia or bulimia do become pregnant. When this happens, steps should be taken to protect the health of the mother and the baby. Professionals can address specific needs related to pregnancy and disordered eating only if you are willing to be completely honest with them about your struggles.

If you are pregnant and struggling with disordered eating...

- Be HONEST with your prenatal health provider regarding past or present struggles with an eating disorder.
- Extra appointments with your prenatal health provider may be necessary to more closely track the growth and development of your baby.
- Consult a nutritionist with expertise in eating disorders before or immediately after becoming pregnant. Work with the nutritionist throughout the pregnancy to create a plan for healthy eating and weight gain. Continue these visits post-partum. The nutritionist can help you return to a normal weight through healthy means.
• Individual counseling during and after pregnancy can help you cope with your concerns and fears regarding food, weight gain, body image and the new role of mothering.

• Attend a support group for people with eating disorders.

• If your doctor approves, attend a prenatal exercise class. It can help you practice healthy limits to exercising.

• Other classes on pregnancy, childbirth, child development and parenting skills can also be helpful in preparing to become a mother.

• Allow your prenatal health provider to weigh you. This information is essential to track the health of your baby. If you would prefer not to monitor your weight gain, ask your doctor about standing on the scale backwards.

• Under certain circumstances, for example if you suffer from severe depression or obsessive-compulsive problems, you may require medications for these conditions even during pregnancy.

The skills of a multidisciplinary team of health care providers and the support of family and friends can help you deliver a healthy baby and protect yourself.

Source:
Pregnancy and Body Image

For some women, body image is a huge concern, especially during pregnancy. Some women welcome their pregnant bodies, while others are in complete shock about the different changes. Naturally, your body is going to be different than it was before you were pregnant. Hormone fluctuations will cause your uterus to expand, your breasts to grow, your feet to enlarge, and your skin to break out. You may suffer increased fatigue and incredible food cravings. Not to mention varicose veins and mood swings!

Loving your body before pregnancy can help you get through the physical and emotional changes during pregnancy. Changing your body image while you are pregnant is a pretty tough thing to do, especially if it was already low to begin with.
Here are some ideas to try that will help you love and accept your pregnant body:

- Concentrate on your baby. Your body is changing in order to help your baby grow and develop. It is a natural process.
- Express your feelings. Talk with your partner, family, or friends about how you are feeling. Keeping your feelings bottled up will only make you feel worse.
- Try to get out for some enjoyable exercise. A light swim or walk can help you clear your mind and get the focus off your body.
- Take up prenatal yoga. Yoga focuses not on how your body looks, but on the link between your body and your mind.
- Practice self-massage. Touching your own body will help you become more familiar and accepting of it.
- Learn as much as you can about pregnancy. By educating yourself, you will know what to expect and feel more in control.
- If you are really having serious issues, seek out mental health counseling.

My pre-baby body is gone ... for good!

Don’t worry new moms! After your baby is born, your body has to adjust and return to a non-pregnant body. Your stomach may seem more of a pooch rather than the toned abs you are use to. Don’t expect a flat belly after your delivery. Remember, your body has been through a lot and needs time to recover. Give yourself some time to rest and catch up on some sleep.

The American Pregnancy Association suggests exercising as a way to help you get your pre-pregnancy body back. Join a gym that offers childcare or load up your stroller and walk through the neighborhood. This will also help get you out of the house so you can feel refreshed.
Pregnancy and Eating Disorders

Having an eating disorder can increase your chances of never being able to get pregnant. The longer you have an eating disorder, the higher the risk that you will face some type of fertility problems. There are basically two types of eating disorders: anorexia and bulimia. Anorexia involves starving oneself and avoiding appropriate food intake. Bulimia involves binge eating and then purging by vomiting, using laxatives, or over-exercising to rid the body of excess calories. Both types of eating disorders affect the reproductive process, pregnancy, and health of the baby.

Eating disorders affect pregnancy negatively in a number of ways. The following complications are associated with eating disorders during pregnancy:

- Premature labor
- Low birth weight
- Stillbirth or feta death
- Intrauterine growth retardation
- Likelihood of caesarean birth
- Delayed fetal growth
- Respiratory problems
- Gestational diabetes
- Low amniotic fluid
- Preeclampsia

Source:
U.S. Department of Health and Human Services, www.4woman.gov/bodyimage/pregnancy
**Handout:**

**Things to Avoid when Pregnant**

*Cigarettes* Can Harm Your Baby

**If you smoke while pregnant:**

- You have an increased risk of miscarriage.
- Your baby is more likely to be born early and underweight (both of which pose serious health risks).
- Your baby may develop physical and mental defects.

There are many community services to help pregnant women quit smoking—ask your doctor for a list. It’s never too late to quit.

*Alcohol* Can Damage Your Baby’s Brain

- Any alcohol you consume passes through the placenta to your baby. When you drink alcohol, so does your baby.
- Fetal alcohol syndrome, the result of alcohol exposure in the womb, can cause your baby serious mental and physical defects.

Because there is no known safe amount of alcohol consumption during pregnancy, it is best to avoid alcohol completely. If you need assistance with changing your alcohol consumption behaviours, ask your doctor or look for support and treatment centres under Community Resources. It’s never too late to quit.
Dangers of Illegal Drugs

- Marijuana contains tar, which produces carbon monoxide and threatens the health of your baby in the same way cigarettes do.
- Street drugs such as cocaine, heroine, methamphetamines, ecstasy, and others, pose dangerous threats to your health and the health of your baby.

Women who use street drugs should talk to a doctor about how they can make lifestyle changes. There are many support resources that can help with detox, treatment, and counselling.

Other Drugs

- Stop taking oral birth control if you suspect you may be pregnant.
- It is best to limit caffeine consumption while pregnant. A developing baby cannot process caffeine, especially in large amounts.
- Talk to your doctor or midwife about the safety of any prescription and over-the-counter drugs.
- Ask a dietitian about the safety of any nutritional supplements or herbal remedies you use.

Did you know...

Drinking alcohol while you are pregnant can cause your baby brain damage and create severe mental and emotional difficulties that will last the rest of your child’s life? The effects of alcohol on a fetus vary, depending on the amount and frequency of the pregnant woman’s drinking and the fetus’s stage of development.

A woman who stops drinking alcohol at any time during her pregnancy will help her baby. It’s not too late.

Source: Vancouver Island Health Authority www.viha.ca/children/pregnancy/growing_healthy_baby/ things_to_avoid.htm
Foods

- Fish (due to mercury contamination in larger, older fish)
  - Swordfish
  - Shark
  - King Mackerel
  - Tilefish
  - Fish from lakes and rivers

Note: eat no more than two meals (12 ounces) per week of:
  - Shrimp
  - Canned Light Tuna
  - Salmon
  - Pollock
  - Catfish

- Meat, Poultry, Raw Eggs, Raw Fish, Raw Shellfish (can contain bacteria or Listeriosis---a serious food-borne illness)

During Pregnancy, changes in your metabolism and circulation may increase the risk of bacterial food poisoning. To prevent illness, fully cook eggs and all meats until juices run clear (check with a thermometer). Don’t eat medium or rare burgers or sausages, heat or cook until steaming. Cook hotdogs and heat deli meats until steaming hot—or avoid them completely.

- Dairy Products

Skim milk, mozzarella cheese, or cottage cheese can be a healthy part of your diet--as long as they’ve been pasteurized.

Unless these soft cheeses are clearly labeled as being made with pasteurized milk, don’t eat them.
  - Brie
  - Feta
  - Camembert
  - Blue cheese
  - Mexican-style cheeses

- Caffeine---During pregnancy, drink no more than two or three cups of coffee each day (avoid caffeine if at all possible).
• **Herbal Tea**—Don't use any herbal tea, even those marketed for pregnant women, without asking your doctor first. Some teas, especially Red Raspberry Leaf, can cause contractions!

• **Alcohol**—No amount of alcohol is safe for your baby! Even tiny amounts can cause your baby to suffer from Fetal Alcohol Syndrome after birth (a lifelong disability).

• **X-rays**—only if necessary, and notify your technician before any x-rays are taken.

• **Lead**—lead exposure should be limited. Any lead-based paints in your home should be removed (by someone other than you). Also, in houses built before 1978, use cold water to cook because the pipes could contain lead.

• **Well Water**—have well water tested for nitrate and coliform bacteria.

• **Saunas, Hot Tubs, and Steam Rooms**—should be avoided by all pregnant women! The heat, 120 degrees or higher, can damage your unborn baby's brain, spinal cord, and nervous system!

• **Cat Litter Boxes**—should be changed by someone else in the home while you are pregnant; cat feces can contain parasites that could harm your baby.

• **Gardening Gloves**—should be worn while working with soil; also, unwashed vegetables and fruits should be washed to prevent Toxoplasmosis, a bacteria that can contaminate the soil where they are grown.

• **Avoid Exposure**—to anyone who has Hepatitis B, Chicken Pox, Influenza, German Measles, Herpes, Cytomegalovirus, or Fifth Disease. If exposed to any of these diseases, or if you have any symptoms associated with one of them (fever, breaking out, etc.), call your physician immediately.
Handout: Staying Healthy
During Pregnancy

Mom, be sure to...

- Get enough sleep
- Eat Nutritious foods
- Take your prenatal vitamins as prescribed by your physician
- Get plenty of regular exercise
  (ask your physician before beginning exercise)
- Take 400 micrograms of folic acid daily (ask your doctor the best ways to get your daily allowance)

Don’t...

- Use illegal drugs
- Take prescription drugs without prior physician approval
- Smoke or use tobacco products
- Drink alcohol
- Eat raw or half-cooked meat, fish, or eggs
- Eat unwashed vegetables or fruit, or do gardening without leather gloves
- Change kitty litter due to parasites
- Have unnecessary x-rays (always notify the x-ray tech that you are pregnant)
- Douche
- Take hot baths, use saunas, hot tubs, or steam rooms
- Use chemicals
- Eat Swordfish, Shark, King Mackerel, Tilefish (because of mercury content)—See page 132 for more information
Handout: Determining Chronic Stress During Pregnancy

Name: __________________________
Score: _________________________
Date: _________________________

The number of boxes you check, the higher your chronic stress levels.

- Do you always feel tired? Even when you get up in the morning?
- As your pregnancy progresses, do you find yourself becoming cynical and resentful?
- Do you find yourself rigid and inflexible when trying to maintain control of any situation?
- Have you lost contact with family or friends since the beginning of your pregnancy?
- Found yourself having flare-ups of stress-related illnesses such as:
  - Asthma
  - Psoriasis
  - Irritable bowel syndrome
  - Ulcers
  - Headaches
- Find that you always feel depressed, down or anxious since becoming pregnant?
- Have you found that your weight has changed, since the beginning of your pregnancy, due to excessive overeating or loss of appetite?
- Find that you are plagued by chronic muscle aches resulting from built up tension?

*Note: If three or more boxes are checked, you should seek advice about chronic stress relief from your physician*
Handout: Anger Management

How to Cope During Pregnancy

When you feel angry:

✓ Try to find the real reason you are angry
✓ Determine what or who triggered your anger
✓ Look at your current circumstances (bills, pregnancy complaints, etc.)
✓ Analyze what your inner voice is saying to you
✓ Ask yourself, "Is it worth being angry about?"
✓ Say to yourself, "Others' opinions have worth, and should not make me mad."
✓ Think, "Difficult people can't make me angry anymore. Only I can choose to be angry, and I am taking control of my temper!"
✓ Choose mental "time-outs" instead of moving to instant anger
✓ Choose not to vent anger on innocent bystanders
✓ Choose when, where, and how you allow yourself to express your anger

When others are angry:

1. Listen to what they are saying, instead of letting your anger verbalize itself at the same time
2. Ask the person, "Why/what made you mad at me?"
3. Let the angry person know that you take their grievance/anger seriously
4. Try to take the other person's point of view as a means to understand what made them angry
5. Reply to the angry person's anger calmly, with an even tone of voice and non-threatening body posture
6. Let them know that you are listening, but still have your own opinion about the grievance
7. Use "I" statements instead of "You" when discussing differences of opinion
8. Avoid lecturing the other person
9. Be open minded (within reason) concerning other's perspectives
10. Be balanced, not overly obsessed with "one way" or nothing at all
8.1 Abuse Resource Numbers

Abuse Alternatives
423-652-9093
Hotline- 423-764-2287

Crisis Center Hotline
276-466-2312

National Domestic Violence Hotline
1-800-799-SAFE

Tennessee Domestic Violence Hotline
1-800-356-6767

Local Domestic Violence Hotline
1-423-926-8901

Sexual Assault Response Center
1-423-928-8522

Child Advocacy Center
276-645-5867

Child Abuse
KPT-1-423-224-1900
BLVT-1-423-323-2044
### 8.2 Breast Feeding Support & Information

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Feeding Essentials</td>
<td>423-239-5885</td>
</tr>
<tr>
<td>Breast Feeding Hotline</td>
<td>1-800-994-9662</td>
</tr>
<tr>
<td>Breast Feeding Counselor @ Health Department</td>
<td>423-279-2861 or 423-224-1624</td>
</tr>
<tr>
<td>LA Leche League-Breast Feeding Counseling and Information</td>
<td>423-764-1548</td>
</tr>
<tr>
<td>Breast Feeding Support</td>
<td>423-279-2861-BLVT 423-224-1624-KPT</td>
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</table>

### 8.3 Childbirth & Parenting Classes

<table>
<thead>
<tr>
<th>Class</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indian Path Medical Center</td>
<td>1-423-857-7240</td>
</tr>
<tr>
<td>Holston Valley Medical Center</td>
<td>1-423-224-6370</td>
</tr>
<tr>
<td>Prepared Natural Childbirth Class Prenatal Education</td>
<td>1-423-723-6877 or 1-877-230-NURSE</td>
</tr>
<tr>
<td>Tennessee Infant Parent Services</td>
<td>Information and support to families of children (0-3yrs) who have developmental delays. 423-926-4388</td>
</tr>
<tr>
<td>Baby Care Basics</td>
<td>1-877-230-NURSE</td>
</tr>
<tr>
<td>Baby Sense Class</td>
<td>Wellcare at Fort Henry Mall 1-423-723-6877</td>
</tr>
<tr>
<td>Tennessee Early Intervention System</td>
<td>423-434-4401</td>
</tr>
<tr>
<td>AGAPE Women Services</td>
<td>423-926-3788 24 hr. Hotline- 423-928-2273</td>
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### 8.4 Departments of Human Services

<table>
<thead>
<tr>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingsport, TN-DHS</td>
<td>423-224-1900</td>
</tr>
<tr>
<td>Bristol/Blountville TN-DHS</td>
<td>423-279-9164</td>
</tr>
<tr>
<td>Johnson City, TN-DHS</td>
<td>423-929-0171 423-434-6953</td>
</tr>
<tr>
<td>Carter County, TN-DHS</td>
<td>423-543-3189</td>
</tr>
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</table>
### 8.5 Emergency Food Resources

<table>
<thead>
<tr>
<th>Location</th>
<th>Organization</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elizabethton, TN</td>
<td>Second Harvest Food Bank</td>
<td>423-477-4053</td>
</tr>
<tr>
<td>423-542-5121</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haven of Mercy Ministries, Inc.</td>
<td>Johnson City, TN</td>
<td>276-628-9266</td>
</tr>
<tr>
<td>423-9261965</td>
<td>American Red Cross</td>
<td></td>
</tr>
<tr>
<td>Share Food Program</td>
<td>Central Baptist Church</td>
<td></td>
</tr>
<tr>
<td>Blountville, TN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>423-354-0280</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bristol Food Pantry</td>
<td>Colonial Heights Christian Church</td>
<td></td>
</tr>
<tr>
<td>Bristol, VA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>276-466-2312</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Baptist Church of Blountville</td>
<td>Blountville, TN</td>
<td>423-239-2513</td>
</tr>
<tr>
<td>423-323-8033</td>
<td>Crossroads United Methodist Church</td>
<td></td>
</tr>
<tr>
<td>Department of Human Services</td>
<td>Blountville, TN</td>
<td>423-239-2500</td>
</tr>
<tr>
<td>423-279-9164</td>
<td>First Broad Street United Methodist Church</td>
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<tr>
<td>American Red Cross</td>
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<td></td>
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<tr>
<td>Bristol, VA</td>
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<td></td>
</tr>
<tr>
<td>276-645-6650</td>
<td>First Christian Church</td>
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<tr>
<td>Glad Tidings</td>
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<tr>
<td>Bristol, TN</td>
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<tr>
<td>423-764-3854</td>
<td>Department Of Human Services</td>
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<tr>
<td>King Benevolent Fund</td>
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<tr>
<td>Bristol, VA</td>
<td></td>
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<tr>
<td>276-466-3014</td>
<td>Full Gospel Mission Kitchen Of Hope</td>
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<tr>
<td>Neighborhood Service Food Bank</td>
<td>Bristol, TN</td>
<td>423-246-1735</td>
</tr>
<tr>
<td>423-968-3951</td>
<td>Help and Hope Ministries</td>
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</tr>
<tr>
<td>Salvation Army</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bristol, TN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>423-764-6156</td>
<td></td>
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<tr>
<td>Department Of Human Services</td>
<td>Kingsport, TN</td>
<td>423-224-1900</td>
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<tr>
<td>American Red Cross</td>
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<tr>
<td>Kingsport, TN</td>
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<tr>
<td>423-378-8700</td>
<td></td>
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<tr>
<td>King Benevolent Fund</td>
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<td>Bristol, VA</td>
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<tr>
<td>276-466-3014</td>
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<td>Neighborhood Service Food Bank</td>
<td>Kingsport, TN</td>
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<tr>
<td>423-968-3951</td>
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<tr>
<td>Salvation Army</td>
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<tr>
<td>Bristol, TN</td>
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<td></td>
</tr>
<tr>
<td>423-764-6156</td>
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</table>
Higher Ground Baptist Church
Kingsport, TN

Hunger First
Tri-Cities, TN/VA
423-392-0012

Indian Springs Community Mission
Kingsport, TN
423-288-4341

Salvation Army
Kingsport, TN
423-246-6671

St. Paul’s Episcopal Church
Kingsport, TN
423-245-5187

Waverly Road Presbyterian Church
Kingsport, TN
423-247-5121

Salvation Army
Johnson, City
423-926-2101

Carter County Department of Social Services
Elizabethton, TN
423-543-3189

Good Samaritan
Johnson City, TN
423-928-0288

Neighborhood Service Center
423-246-6180

Haven of Rest Rescue Mission, Inc.
423-968-2011
8.6 Local Health Departments

Johnson County Health Department
Mountain City, TN
423-727-9731

Sullivan County Health Department
Blountville, TN
423-279-2776

Washington County Health Department
Johnson city, TN
423-975-2200

Health Department Services

TennCare Outreach

Home Visit Nurse - for infants at risk for medical or developmental problems

Referral for prenatal care

Full prenatal care at some Departments

(CSS) Children’s Special Services - assists children (through age twenty-one) that have special medical needs that the family is financially unable to provide for. (Sometimes hearing and speech services are offered).

(WIC) Women, Infants, and Children - Vouchers for nutritious foods (cheese, milk, cereal, etc.) are issued to women who are pregnant or are breast feeding or have children under the age of five, with the risk of poor growth,

Nutritional Classes

Child Health Care - Well child check-ups (physical, exams, screening tests, and immunizations.)

Primary Care - Treats acute and chronic illnesses, diagnostic testing, and health counseling as needed.

Immunization Shots - Immunizations against polio, diphtheria, whooping cough, tetanus (lockjaw), measles, mumps, rubella (German measles), hemophilus (meningitis), and hepatitis B are provided for children. Flu and pneumonia immunizations, tetanus-diphtheria boosters, and hepatitis B vaccines are also available to adults for lasting protection against these diseases.
8.7 Support Groups

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Bristol Alcohol Anonymous</td>
<td>Bristol, TN</td>
<td>423-968-2020</td>
</tr>
<tr>
<td>Kingsport Alcohol Anonymous</td>
<td>Kingsport, TN</td>
<td>423-245-1440</td>
</tr>
<tr>
<td>American Cancer Society</td>
<td>1-800-227-2345</td>
<td></td>
</tr>
<tr>
<td>American Diabetes Association</td>
<td>1-800-556-3405</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding Essentials</td>
<td>Kingsport, TN</td>
<td>423-239-5885</td>
</tr>
<tr>
<td>La Leche League</td>
<td>1-800-525-3245</td>
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</tr>
<tr>
<td>Alcoholics Anonymous</td>
<td>Johnson City, TN</td>
<td>423-926-0144</td>
</tr>
<tr>
<td>Weight Watchers Meetings</td>
<td>Bristol, TN and Kingsport, TN</td>
<td>423-723-6877</td>
</tr>
<tr>
<td>Tri-Cities Mothers of Twins and More</td>
<td></td>
<td>423-239-0028</td>
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<tr>
<td>Moms-R-US</td>
<td>Bristol, TN</td>
<td>423-968-9444</td>
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<tr>
<td>Tobacco Cessation</td>
<td>Kingsport, TN</td>
<td>423-224-2356</td>
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<tr>
<td>Moms-R-US</td>
<td>Bristol, TN</td>
<td>423-968-9444</td>
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8.8 Temporary Housing Resources

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<tr>
<th>Organization</th>
<th>Location</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Housing Authorities</td>
<td>423-378-3050</td>
<td></td>
</tr>
<tr>
<td>Haven Home for Single Women and Women with children</td>
<td>423-968-7216</td>
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</tr>
<tr>
<td>Haven of Rest</td>
<td>Bristol, TN</td>
<td>423-968-2011</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>Bristol, TN</td>
<td>423-764-6156</td>
</tr>
<tr>
<td>Hope Haven for Women and Children</td>
<td>Kingsport, TN</td>
<td>423-246-7843</td>
</tr>
<tr>
<td>Hope House for Young Pregnant Women</td>
<td>Kingsport, TN</td>
<td>423-239-7994</td>
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<tr>
<td>Inter-faith Hospitality Network</td>
<td>Kingsport, TN</td>
<td>423-246-6500</td>
</tr>
<tr>
<td>Safe House for Victims of Domestic Violence</td>
<td>Kingsport, TN</td>
<td>423-246-2273</td>
</tr>
</tbody>
</table>
Salvation Army
Kingsport, TN
423-246-6671

Shepherd Inn (Domestic Violence)
Elizabethton, TN
423-542-0180

Abuse Alternatives
Bristol TN
423-764-2287

Safe Passage (Domestic Violence)
JC\Washington County, TN
423-542-0180

Chips Family Violence Shelter
Erwin\Unicoi county Area
423-743-0022
Hotline- 423-388-8281

8.9 Utilities

Bristol Neighborhood Services Center
Bristol, TN
423-968-3951

Kingsport Neighborhood Service Center
Kingsport, TN
423-247-5149

KCMC
423-378-3722

St. Vincent DePaul Society
423-288-8222

Bristol Faith In Action
Bristol, VA
423-968-8292

Neighborhood Service Center
Elizabethton, TN
423-542-5121