The Psychology of Infancy
A quarterly publication for those interested in the development of all babies & children

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When my first baby was born, I was dumbstruck with how absolutely beautiful he was. I couldn’t believe that our genes could produce such a perfectly gorgeous, handsome, stunningly attractive and good-looking baby. I would look at my friends’ babies, and could see that they were pretty good looking and rather cute… in their own way, but nothing and no-one really compared to my son. I even contemplated putting him in a baby show so that others could share his beauty.

After a while, it became somewhat obvious that other people did not share my passion and my perception. They obviously thought he was OK, but unlike me, they COULD tear their eyes away to look at other children, especially their own babies.

People who work with mothers and babies have long noticed this “maternal obsession”, that love is blind. Just look at any pictures in any parenting magazine and you will see it everywhere – an adoring mother gazing at a small bundle, who may or may not be gazing back at her.

The selfless parent/mother love/obsession has a pragmatic side that is in our genes and also helps the survival of our species. When parents (especially mothers) are so obsessed with their babies, and they can’t take their eyes off them, the babies tend to stay safe. When babies are safe, they are more likely to pass on their genes to the next generation. A similar thing happens with sexual partners. Their “blind” passion could be explained in terms of the “selfish” gene. If love is blind, there is more likely to be mating, and the genes of those two people are more likely to be passed on to their babies.

When I look back at photos of my newborn oldest son, I know that I loved him at first sight, but honestly, he wasn’t all those perfect things that I thought at the time. We mothers have a hormone called oxytocin, which is sometimes called the love hormone. When it flows through our bodies, we lose all perspective and just blindly love the baby in front of us. We would like to think we are being dispassionate and objective, but we’re not. That doesn’t detract from the love that flows from mothers to their babies. Sometimes however, if the hormone is not released for some reason, we may feel like something is wrong with us because that immediate loving feeling isn’t there. Not at all; after a while, the oxytocin hormone level goes down, and we just love our babies in a more rational way. If you don’t feel immediate obsessive love for your baby, there’s nothing wrong with you, except perhaps in the hormone department. Just give it some time and your baby’s innate attractiveness will hook you in.

PS. By the time babies 2 and 3 were born, I recognised my obsession for what is was – an adaptive form of rose-coloured glasses that I didn’t take quite so seriously the second and third time around.

Carol Newnham PhD
The number of overweight children has increased to an alarming extent. In the USA, overweight in 6-11 year-olds has doubled, in 12-17 year-olds, it has tripled, in 6-23-month-olds it has gone from 7-12%. In 2000, more than 10% of 2-5 year-olds (more than 2 million children) were obese.

Definitions

The most convenient way to work out body fat is by calculating the Body Mass Index (BMI). BMI is the ratio of kilograms of body weight to the square of height in meters. So if you weigh 100 kilograms and you are 1.5 meters tall your BMI would be 100/2.25=44 (normal BMI is <25).

What causes obesity?

There are many contributions to childhood obesity. One of the most potent predictors is parental obesity. The influences included here are genes plus the child’s birthweight and temperament, plus environmental factors such as parental control of feeding, parental dieting and binging, breastfeeding, dietary intake, physical activity and sleep patterns. It is in the last 7 factors that involve the child’s environment, that prevention is possible.

Prenatal Health

Environmental influences begin very early in life. Maternal smoking, under- and over-eating, diabetes, prematurity and birthweight all have an influence. Both high and low birthweight increase a baby’s risk for obesity.

Birthweight

Extremes in birthweight may change a baby’s physiology in ways that create conditions for later weight gain. Birthweight extremes also change the way parents feed their children. If babies are small parents may overfeed their children. If babies are large they may restrict food intake. Either way, parents unwittingly use abnormal feeding patterns that disrupt the development of normal self-regulating feeding behaviour.

Breastfeeding

Breastfeeding is associated with a lower risk of the child becoming overweight and the longer the child is breastfed, the lower the chance of him or her becoming overweight. Breast-fed babies grow well with lower energy (calorie) intakes compared with formula-fed babies. The energy requirements of breast-fed babies are 17-22% lower for babies from birth to 12 months of age.

Eating Patterns

Current guidelines about nutritional needs are based on the age of the baby, food groups and the prevention of nutrient deficiencies. However, the fact is that very few babies or toddlers in developed countries fail to get their necessary nutrients. Over the past 20 years, the dietary quality of infant diets has improved, while the intake of sugar and excess juice has worsened. Even children of the lowest weight groups have adequate nutrients. Western-country children are eating more fruits and vegetables and fewer calories from fat compared with 40 years ago. Portion sizes for toddlers have remained about the same for 20 years. What HAS changed is energy intake – the number of calories consumed daily. Little children eat more sugars and carbohydrate than they did 20 years ago. Despite this, parents are still concerned about nutritional adequacy of the food they give their children. 78% of parents of premies were concerned about the quality of their child’s diet at 2-3 years, with 51% using food as a reward to increase intake and 69% coercing their child to eat. This perception of inadequate food intake persists in parents of premies.

When should a parent be concerned?

Problems that should be addressed include difficulty chewing or swallowing, weight loss not associated with an infection or change in diet (weaning from the breast) that persists longer than 2 months, growth rate lower than normal for more than 2 months or lack of food resources in the home.

Feeding practices

Children who are not controlled or coerced to eat learn to self-regulate their intake. Self-regulation may be the key to preventing obesity by creating eating patterns that balance energy input with energy output. As children get older and are more in control of their own diet, there is a decrease in the quality of their diet and an increase in BMI and obesity. Meddling with self-regulation can backfire, as in the overweight child who is put on a diet or the thin child who is given high calorie supplements.
The ideal role for parents in relation to their child’s eating is to model good eating habits. Mothers with high fruit and vegetable consumption had daughters who ate more fruit and vegetables. When mothers pressured their daughter to eat fruit and vegetables, they ate less. However the modelling works the other way as well – when parents’ eating is disordered (overeating or dieting) children are less able to regulate their own intake.

Another role for parents is to provide appropriate food and oversee the where, when, the with whom of eating and then let their children decide what and how much to eat. The “what” can even include “unhealthy” food such as biscuits or chips, but presented in moderate amounts. Thus foods are not omitted but parents help children learn moderation.

Developing food preferences

Withheld foods (because they are “bad”) become desirable and “pushed” foods (because they are “good”) become less desirable. Foods that are presented without value judgements allow the child to experience all foods, which helps with the development of preferences and self-regulation.

Setting conditions for eating may also help. Children eat better when they eat with other people. They accept new food better if others are eating the same food. Eating together as a family improves feeding competence and is associated with less fat, sweet drinks, fried food intake and more fruit and vegetable consumption in adolescents. The more times a child experiences a new food the more likely they are to accept it. Food likes and dislikes should only be judged after multiple chances (at least 10) to try it. Children also do better when meals and snacks are not taken in front of the TV. Family meals should begin as soon as the baby is able to sit in a high chair.

Increasing energy output

While energy input has increased in the last 20 years, energy output has not. Promoting an active lifestyle should start as soon as infants begin to walk. In children and adolescents, more than 2 hours of TV watching per day correlates with obesity and higher BMIs. Walking with toddlers (instead of relying on the pusher) and the opportunity to play outside are also helpful. The amount of sleep each night gives a clue as to whether toddlers get enough activity. Fewer hours of sleep is a risk factor for obesity and active children sleep longer.

WHAT OTHER FACTORS MIGHT CONTRIBUTE TO FEEDING PROBLEMS?

Early mother-baby interactions are likely to set a pattern and to be repeated into the future. When a mother and her baby have success, this success feeds on itself (forgive the pun) and fuels a growing sense of competence. The mother realises that “I can do this and my baby is feeding well and I don’t have to worry about him gaining weight.” For the babies, when they have success at feeding, feed times become a time of hunger-satisfied, of pleasure and of love of being with their mother. If something in this time is awry, then feed times, that obviously have to occur, cause anxiety and displeasure. Mothers and babies need to have early success and their confidence boosted from the beginning. When feeding is not going well, mothers need support and guidance from experts, who will help them in non-threatening, non-critical ways.

Sometimes mothers are not sensitive to babies’ hunger and satiety (fullness) cues. Sometimes babies have problems such as breathing difficulties or heart-rate irregularities that make the suck-swallow-breathe tasks difficult. When problems exist and persist, it is helpful, if possible, to consult a team of professionals that may include a lactation consultant, a psychologist and a speech pathologist. The baby’s weight and food intake need to be monitored so that each new approach can be assessed. Parents may need to be helped with watching for typical baby signals.

**Embedding activity and nutrition into each day**

What we want to do with babies and toddlers is not to do with special, once-off programs, but to develop healthy habits that become second-nature to the child.

- Babies and toddlers need a daily balance between energy output (burning up calories) and input (the number of calories consumed)
- Daily nutrition helps organise the body’s growth patterns and body weight
- Early patterns and preferences influence later ones
- Routines give young children a sense of security and trust because their most basic needs are being met in a consistent, dependable way
- Routines are also part of the child’s daily learning environment. Routines provide scheduled times for physical activity and for learning about what and how to eat. Patterns are repeated day after day and become internalised. Patterns increase the likelihood that good habits will continue

**Physical activity and motor development**

Maturation of a child’s body does not guarantee that motor skills will develop (remember the images of the orphaned babies who were kept in cots all day and subsequently became delayed in all areas of development). Babies and toddlers need the opportunity and motivation to practise skills to become proficient in them. There are 3 broad areas in which motor skills and the joy of being active can develop. Children need the opportunity and the motivation to do these things.

First, babies and children need to learn to move through space – to roll, crawl, walk, run, hop, skip etc. Secondly, babies and children need to be able to change and move their center of gravity – to balance on one foot, to turn, to push up from a sitting or lying position, to reach out and stretch for something. These two are sometimes called gross or large muscle motor skills. Finally, babies and children need to be able to rely on their body’s strength and balance in order to manipulate hands and legs to achieve goals – catching, grasping, throwing, hitting, kicking, writing etc. These skills are sometimes called fine motor skills and they often also need eye-hand (or foot) coordination.

*We don’t want special one-off programs with babies, but rather to develop healthy habits that become second nature.*
Each of these skill areas develop at once, and each one helps development in the other areas. Most babies and toddlers develop their fundamental motor skills in an unstructured environment that is able to leave them free to move while keeping them safe. A baby who can push up on his stomach then learns to roll over and then stretch and then has the skills required to reach for a toy. The toy may be the final motivation to extend and use the skills and it also provides the reward for the baby to do it again and again until he is really proficient and can try the next difficult thing. However parents can “structure” dedicated time to physical activities that promote skills and motivation. It’s called PLAY. For example:

Birth – 9 months (mostly stationary babies)
• During nappy changes, massage hands, arms, legs and feet. Gently stretch them to help range of motion
• Talking and singing with movements and facial expressions
• Use squeaky toys and rattles and make up games like moving only to the squeak and stopping for the rattle
• Tummy time – provide toys to encourage looking and touching and stretching to one side (baby has to transfer weight to one side in order to stretch to the other)
• Put bells on wrists and ankles, buy socks with animal puppets on them. These will encourage your baby to keep moving their arms and legs.
• When sitting up, put toys out of reach so that the baby has to bend, balance and use trunk muscles to control balance.
• Provide toys that are different from each other – different shapes, sizes, weights, textures, with different noises. Give and take the toys with your baby so they learn to grasp and release their grasp.

8-18 months (mobile babies)
• Babies will be captivated by what they see and their motor skills will develop because of all the possibilities of doing things in their world
• Skills need to be used over and over again and then progressively challenged to try new, more difficult things
• The challenges will be in most babies’ environments but you can provide some of them. They will include taking your baby to different environments such as the park, outside in the backyard, or to the beach. They will encourage your toddler to keep moving for longer and to use different skills.
Why did God Make Mothers?
• She’s the only one who knows where the sticky tape is
• Mostly to clean the house
• To help us out of there when we were getting born

How did God make mothers?
• He used dirt, just like for the rest of us
• Magic plus super powers and a lot of stirring
• God made my Mum just the same like he made me, just bigger parts

What ingredients are mothers made of?
• Clouds, angel hair and one dab of mean
• They had to get their start from men’s bones, then they mostly used string

Why did God give you your mother and not some other mum?
• We’re related
• God knew she likes me a lot more than other people’s mums like me

What kind of little girl was your mum?
• My mum has always been my mum and none of that other stuff
• I don’t know because I wasn’t there, but my guess would be pretty bossy
• They say she used to be nice

What did mum need to know about dad before she married him?
• His last name
• She had to know his background. Like is he a crook? Does he get drunk on beer?
• Does he make at least $800 a year? Did he say NO to drugs and YES to chores?

Why did your mum marry your dad?
• My dad makes the best spaghetti in the world. And my mum eats a lot
• She got too old to do anything else with him
• My grandma says that mum didn’t have her thinking cap on

Who’s the boss at your house?
• My mum doesn’t want to be boss, but she has to because dad’s such a goof ball
• Mum. You can tell by room inspection. She sees the stuff under the bed
• I guess mum is, but only because she has a lot more to do than dad

What’s the difference between mums and dads?
• Mums work at work and work at home and dads go to work at work
• Mums know how to talk to teachers without scaring them
• Dads are taller and stronger, but mums have all the real power ’cause that’s who you got to ask if you want to sleep over at your friend’s
• Mums have magic, they make you feel better without medicine

What does your mum do in her spare time?
• Mothers don’t do spare time
• To hear her tell it, she pays bills all day long

What would it take to make your mum perfect?
• On the inside she’s already perfect. Outside, I think some kind of plastic surgery
• Diet. You know, her hair. I’d diet, maybe blue

If you could change one thing about your mum, what would it be?
• She has this weird thing about me keeping my room clean. I’d get rid of that
• I’d make my mum smarter. Then she would know it was my sister who did it and not me
• I would like for her to get rid of those invisible eyes on the back of her head
There has been a rapid increase in obesity in children and the problem seems to start in the preschool years. Some children have a genetic disposition towards having obesity, but the predisposition alone does not cause obesity - the child also has to have a certain kind of environment to become obese.

The regulation (control) of eating

It is ideal if children are able to “regulate” their eating – to be able to adjust their eating to match the energy needs of their body. One early study found that children who were allowed to select their own diet grew well and were healthy. When given nutritious choices, 2-5 year-olds can select an adequate diet without adult supervision, and they spontaneously make adjustments to their diets to meet changed energy needs (they eat more when they need more and eat less when they need less).

Other studies have found that parents can interfere with this internal regulatory ability. In one study, children were allowed to eat in accordance with their feelings of hunger and satiety (“fullness”). In this situation, the children were able to adjust their food intake, even if the food they were offered sometimes had high calories (the children ate less), and sometimes had low calories (the children ate more). Children who ate a high calorie first course ate less later and children who ate a low calorie first course ate more later. In another study, they were rewarded for the amount of food they ate during a meal. When this happened all responsiveness to the energy content of food disappeared and the children increased the amount of food they ate significantly. The take-home message for us parents is not to reward children for eating.

Parents who reported a high amount of control over what and how much their children ate had children who were not able to regulate their food intake based on their feelings of fullness. A high amount of parental control was connected with low self-control in children. This was especially so with overweight children. When the mother tried to restrict the amount of food children ate, they (the children) lost their ability to control their eating even more.

Development of regulation

Between 6 months and 3 years of age babies become more independent both physically and emotionally. As the baby becomes more physically competent, daily meals can be a tussle between the baby’s need for autonomy and dependency between the mother and the baby. For example, there may be a battle of wills over who will hold the spoon that delivers food into the baby’s mouth.

In addition to mastering self-feeding, the baby must also learn to tell the difference between internal sensations of hunger and fullness and their emotional needs – for affection, feelings of their anger and frustration. Parents should offer food when the baby is hungry but not when the baby is upset and needs affection or calming. Likewise, they should allow the baby to finish the meal when full, and not try to force in just a bit more. If parents “respect” and act on the baby’s signal that they are hungry or full, they are supporting the baby’s own internal regulation of eating. The baby will become attuned to these internal sensations and also be able to tell them apart from others such as anger, sadness and pleasure. If parents have responded to their baby’s emotional needs by feeding them, they will start to confuse hunger with emotions such as being sad, lonely, frustrated or angry. They learn that eating can alleviate negative feelings and generate positive feelings. It may even be that some children, who are born with some strong negative emotional reactions may tend to overeat.

Ideally babies will give clear hunger and fullness signals. If babies give poor hunger cues, and parents become anxious about getting adequate food into their baby, they may try to override the baby’s food refusal. If toddlers are overweight, and they give strong hunger signals but poor fullness signals, parents may try to limit the child’s eating, thinking that they are overeating.

Studies suggest that babies and young children have an in-born capacity to regulate their food intake according to the energy their body needs. Parents can interfere with this innate regulation of eating.
One answer (not a magic bullet)

Parents need to help their children learn internal regulation – to eat when they are hungry and to stop when they feel full. They already do this very well with feelings of thirst and when the thirst is quenched by water. Parents also need to help their young children to handle strong emotions without trying to minimize that emotional reaction by using food. Food can be offered regularly (say every 3-4 hours) and the child is not offered food between these meal and snack times. During these eating times, the child is offered small portions of food but is allowed to ask for additional helpings until he or she has had enough. Allowing the child to stop eating is critical. Parents are encouraged not to praise or criticize their child for how much or how little they ate.

In terms of eating the “right” foods, banning appealing foods focuses children’s attention on that appealing food and increases their desire to eat it. Researchers suggest that these “bad” foods are sometimes offered, but not often and in small quantities.
Like many unexpected experiences, spending all or part of your Christmas Day in a NICU can be unexpectedly enjoyable. Nurses and doctors (who often would like to be somewhere else themselves) usually make great efforts to "lighten" the atmosphere—with an attitude that says something like if we have to be here at all, at least let's make this time a celebration and different. Nurseries have lots of Christmas decorations that have been stored away during the year and they are brought out to make the place look very festive. At the nursery I visit most, they always have a real Christmas tree in the foyer, and therefore at every visit we get that lovely Christmas tree smell that is so evocative of Christmases past.

So what can you do for yourself, to help lift your own spirits?

• Buy or make your baby a gift. It sounds so simple, but means so much (to you). It can be anything from a special keepsake to a piece of clothing that you plan to bring them home in.

• Buy or make a special decoration for your baby’s living space. You may want to buy something you can keep forever. Every Christmas I bring out the decorations that my children made when they were toddlers and they mean a great deal to me—much more than the beautiful bought decorations. You might choose a decoration that you bring out for years to come, and will be able to tell your children (and maybe even their own children) about its history and its meaning to you.

• Buy or make gifts for your baby’s nurses and doctors. These can be small or large, individual or for the group. Food is always good.

Have you noticed the common theme here—giving. Planning a present for someone else, then making or buying it puts your mind into another place. That other place is a positive one—full of the future and thankfulness. This, in turn, is a present for yourself. Have you ever noticed that when you are anxious, your mind seems to obsessively go round and round the same stuff, just a like a stuck record. If you can do something—anything—to break that groove of thinking, your mind lightens and even when you go back to the thing that is worrisome, it’s not quite as awful as before.

• Give yourself permission to have some time away from your baby to celebrate Christmas with the rest of your family.

• Take lots of photos or videos in the nursery and at home (or wherever you are) so that later you can show your child pictures and messages from their family on their first Christmas. Just because they are stuck in hospital doesn’t mean they are not still part of your family and close to everyone’s hearts and thoughts.
Publisher- Allen and Unwin

Rosie is a little hare who can’t wait until her baby brother is born. She thought about how she would teach him to hop and leap and run, just like her. However, she didn’t have to wait long for little Bobby to be born, because he was born prematurely and he was “the smallest, weakest little hare ever”. Rosie became frightened when Bobby was born and when her mother asked whether she would like to hold him, she said no. As time went by, Bobby became bigger and stronger, but still Rosie was frightened and did not want to do anything with her little brother. Finally, one day her dad took Rosie aside and told her a story about a hare and a tortoise (no not the one you know). The hare and the tortoise had spent the day together in the forest, but became separated just when it was getting dark and it was time to go home. So Tortoise plodded on home, saying to himself “Slow and steady will get me safely home”. Hare had run on ahead, but came to meet Tortoise with a lantern. That day Rosie began to realise that her little brother was slowly and steadily getting bigger and stronger, and she began to be less frightened of her little brother and could finally start to do things with him.
OBESE FAMILY AND FRIENDS CAUSE KIDS TO MISTAKE THEIR OWN OVERWEIGHT STATUS

For many of us, perceiving that we are overweight acts as a powerful impetus to take action to lose a few kilos. However, children and teenagers who are surrounded by overweight peers and parents are less likely to be aware of their own extra kilos. Their own (over)weight status may seem quite normal when they are surrounded by others who are overweight. Further, children and teenagers may start to think that overweight is normal. Younger children are even more vulnerable to under-evaluating their weight. The every-day environments of children – their home, school and playground can influence health in many ways. At a time when obesity is increasing at alarming rates, it may be important to help children perceive what is normal, what is underweight and what is overweight. If children and teenagers perceive themselves to be overweight or obese, they are more likely to adopt a healthy lifestyle, and this is more easily adopted in the younger years.


EATING UNTIL FULL AND EATING QUICKLY MAY TRIPLE THE RISK FOR BECOMING OVERWEIGHT

How a person eats may be just as important as what he or she is eating. Eating quickly, gorging and binge eating have all been associated with not being able to feel fullness. People who eat quickly tend to have a higher body mass index (BMI). A study of 3287 found that adults who ate until they felt full (51% of the men and 58% of the women) and who ate quickly (45% of the men and 36% of the women) ate more and were more overweight.


BREASTFEEDING AND (LOWER) CHILDHOOD OBESITY

Breastfeeding has many positive health benefits, including preventing ear infections and allergies, lowering the risk of the child developing respiratory problems and preventing obesity later in life! Some of the reasons why breastfeeding might help these things are unknown. In an effort to find the link with (no) obesity, a researcher compared the feeding habits of mothers who breastfed and mothers who bottlefed their babies, and also the eating habits of their other children. They found that breastfed children could more easily determine when they were full. Children who were bottle-fed with pumped breast milk were less able to tell when they were full. Children who had a lower response to fullness had a higher body mass index (BMI).

It seems that children who were breastfed were perhaps able to pull away and stop feeding when they were full, while children who had been bottle fed were expected by their mothers to eat a set number of ounces a day. If babies stopped their bottle feed (because they were full) mothers may have been more likely to try to get them to finish the bottle. When babies are breastfed, mothers are not able to measure how much the baby has taken in, and therefore they have to trust their babies’ “full” signals. Mothers who bottle feed their babies are encouraged to focus more on their babies’ signals. Babies may take in more at some feeds and on some days than on others.

FLAXSEED OIL AND PRETERM BIRTH

A study has found that the risks of a premature birth quadruple if flaxseed oil is consumed in the last two trimesters of pregnancy. Many women try to use “natural” health products during their pregnancies. They believe them to be safe because they are natural, yet in reality they are also chemical products. 3354 pregnant Canadian women were studied. Ten percent of them used “natural health products” although about 1/3 of them also stopped using the products during the pregnancy. 19% used chamomile, 17% used green tea, 12% used peppermint tea and 12% used flaxseed oil.

In the general population the rate of premature births is 2-3%. But for women consuming flaxseed oil in the last 2 trimesters, 12% gave birth prematurely. Women who consumed the actual flax seeds themselves were not at added risk to have a premature delivery. Chamomile, green tea and peppermint tea did not change the incidence of prematurity.

REFERENCE: Pregnant women consuming flaxseed oil have high risk of premature birth. Science Daily, 2008

PREGNANCY DEPRESSION DOUBLES RISK OF PRETERM DELIVERY

Pregnant women with symptoms of depression have an increased risk of preterm delivery, and the risk grows with the severity of the depressive symptoms. In addition, other social and reproductive risk factors, obesity and stressful events may strengthen the depression-preterm delivery link.


BIRTHMARKS AND LOW BIRTHWEIGHT

Hemangiomas (birthmarks) are benign tumours composed of blood vessels. There has been a dramatic increase in the number of babies presenting for the care of hemangiomas. Factors such as being female, Caucasian, premature AND low birthweight are risk factors for hemangiomas. For every 1.1 pound decrease in birthweight, the risk of hemangiomas increased nine-fold. Based on low birthweight statistics, the incidence of hemangiomas may have increased by 40% in the last 20 years. Other risk factors that have been identified are maternal age, maternal history of infertility and assisted reproductive technologies. Children born to women who have had a miscarriage are also more likely to develop hemangiomas. While hemangiomas are a most common birthmark, their cause is not known. Infantile hemangiomas are not visible at birth but become so within a few weeks.

REFERENCE: Medical College of Wisconsin (2008). Increased rate of common birthmarks linked to rise in number of low birth weight infants in U.S. Science Daily.
WHY HAVE A PP EDITION ABOUT CHILDHOOD OBESITY FOR PARENTS OF PREMIES?

There is a connection between nutrition of the fetus and the patterns of adult adipose (fat) cells. A higher amount of obesity is found in individuals who had either low or high birth weight. While people who were small as babies tend to have a lower BMI, they also tend to have more abdominal fat, reduced muscle mass and high overall body fat despite their lower BMI. This "central" obesity is connected with several other medical problems that are associated with insulin resistance and/or metabolic syndrome. Babies who were born small for dates or small for gestational age are also more likely to become overweight than babies who put on the normal amount of weight during gestation.

Reduced nutrient supply in early pregnancy as occurred during the Dutch Winter Famine in 1944-5 resulted in increased body weight, BMI and waist circumference in the offspring when they were 50 years old.

CLINIC FOR PREMATURE BABIES AND THEIR PARENTS

Our services now include:

* Individual counselling
  Like anyone who has an ongoing, stressful experience, parents of premature babies may develop anxieties and other mood changes which do not seem to get better over time. Our psychologists offer information and help with behavioural and cognitive skills that assist the emotional recovery of parents. Counselling fees are based on a sliding fee scale according to the family’s annual income.

* Individual assessments
  Individual assessments of your infant’s care and developmental needs by our neonatal developmental specialists. Fees are based on a sliding scale according to your family’s annual income. You may also be able to claim some fees through Medicare.

Location: Heidelberg Repatriation Hospital
Level 1, Centaur Building
Banksia Street, Heidelberg Heights, VIC 3081
Telephone: (03) 9496 4496 Fax: (03) 9496 4148
Email: elizabeth.barbante@austin.org.au

Premiepress Editions for 2008

March - Special Edition - When a baby Dies
- When a baby dies
- What are the chances of surviving?
- Making the decision to stop life support
- What happens when a baby dies in hospital?
- Premieparents- Between two eternities. Saul’s story

June
- Breastfeeding - the influence of the significant other
- Scientific myths of 2007
- Early sociability in babies
- Premieparents - Kylie’s story

September
- Preparing for a premie
- Infant mental health
- Setting priorities
- Premieparents - Yvonne’s story

December - Special Edition - Childhood obesity can start in infancy
- Preventing childhood obesity
- What contributes to feeding problems?
- Appetite regulation
- Christmas in the NICU
- Something to make you laugh
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Contact Merran on 0419 534 805 or 9504-3711
or email playgroup@featherweightclub.com

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