Editorial

In the past year, there have been several major health initiatives, accompanied by much public hand wringing, designed to address the American "obesity epidemic." When I hear of these initiatives, I am of two minds. First, I applaud efforts to curb some of our dietary excesses, including our decade-long love affair with "big food." The typical American diet is clearly not great, so these interventions are appropriate. When we combine our diet with a lack of exercise and high levels of stress, we have the makings of a public-health disaster. For these reasons, I strongly support the goals of improving our diet, getting rid of fast food in schools, and encouraging people to exercise.

That being said, I also have some serious concerns about the "war on obesity," which frequently manifests as the "war against fat people." People with higher BMIs are routinely stigmatized, shamed, and discriminated against—especially in healthcare settings. One example is in the terminology itself. When discussing obesity, we've abandoned all pretense of using "person-first" language to describe people with higher BMIs. Instead, we refer to them as "obese women," as if that single trait defines them as human beings. In lactation, our interventions show a similar bias as "obese mothers" are often packed off to special classes, or other interventions, based solely on their BMI.

We fail to recognize that women with higher BMIs do not necessarily eat poorly, or even too much. Recent studies have shown that there are many unexpected factors related to higher BMIs including depression, psychological trauma, and sleep problems (Cappuccio, Strazzullo, D'Ella, & Miller, 2010; Cappuccio et al., 2008; Kendall-Tackett, 2009; Pulkki-Raback et al., 2009). And there are genetic differences; some people are just bigger than others. Finally, women with higher BMIs can actually be more physically fit, according to markers such as blood pressure and lipid profiles, than their thinner counterparts. So it is just insulting to offer unsolicited diet advice, or other "special" interventions, to heavier women without a thorough history and considering whether that advice is even warranted.

So where does breastfeeding fit in? Breastfeeding helps women lose weight postpartum, returning them more quickly to pre-pregnancy weight. Breastfeeding is helpful, but it is unlikely make women with higher BMIs "thin." To my mind, some of breastfeeding's most important effects are on women's lifetime risk of metabolic syndrome, diabetes, and heart disease: the conditions everyone mentions when talking about the health effects of a higher BMI.

Metabolic syndrome is the cluster of symptoms that includes insulin resistance, high triglycerides, high LDL and VLDL cholesterol, and visceral fat. It is the precursor syndrome to both heart disease and diabetes (Haffner & Taegtmeyer, 2003). During pregnancy, levels of triglycerides and LDL cholesterol rise, and there are increases in visceral fat accumulation and insulin resistance. Basically, pregnancy induces a state of temporary metabolic syndrome. Breastfeeding specifically counters that by resetting women's levels of triglycerides, LDL and VLDL cholesterol, and lowering levels of insulin resistance and visceral fat to pre-pregnancy levels (Stuebe & Rich-Edwards, 2009). When women do not breastfeed, these levels remain elevated, thus increasing women's disease risk. This mechanism likely explains the results of several recent studies that have found that breastfeeding lowers women's lifetime risk of heart disease and diabetes (Groer & Kendall-Tackett, 2011; Schwartz et al., 2009; Stuebe et al., 2005).

We obviously want to encourage all women to breastfeed, but we need to recognize that some recent studies have found that heavier women *may* have trouble doing it. As we plan our interventions, we need to tread with caution. We don't want to undermine women's confidence in their ability to breastfeed by suggesting that we anticipate problems–just because of their size. These women may have problems or they may not. It would be terrible if our interventions became self-fulfilling prophecies. It's similar to the mother who has flat nipples. These mothers might also have problems—and we should be aware of that and ready to step in as needed. We just don't want to make an *a priori* judgment and *assume* that they'll have problems, thus undermining their confidence.

In conclusion, breastfeeding is a unique intervention in that it addresses the whole range of factors that put women at risk for metabolic syndrome, diabetes, and heart disease. While breastfeeding may not make all mothers thin, it *will* improve their health and lower their lifetime risk of disease. This will be true for women of all shapes and sizes. And as we work with women with higher BMIs, we should remember that they deserve the same respectful care that we offer all new mothers. [To learn more about how breastfeeding lowers disease risk and protects women's health throughout the lifespan, click here. http://webcasts.ahsc.arizona.edu/people/?id=13058].

To aid you in your efforts in supporting new mothers, I am pleased to present our current issue of *Clinical Lactation*. We have two wonderful articles in this issue that address different aspects of breastfeeding and obesity. In the first, Erica Antsey and Cecilia Jevitt review the research on obesity

and breastfeeding, outlining some of the challenges women with higher BMIs may face. In the second article, Lou Lamb describes the impact of weight-loss surgery on breastfeeding women. Both articles give you the information you need to recognize potential problems, while also encouraging you to pause and assess whether intervention is warranted.

We also feature a three helpful articles that specifically address some of the issues your mothers may face including nipple pain (Véronique Darmangeat), divorce and parenting plans (Kori Martin) , and flat or inverted nipples (Julie Bouchet-Horwitz). Judy Gutowski describes the new taxonomy codes for non-RN, IBCLCs. Vicky Tapia and Diane Powers describe their journey to becoming lactation consultants, and Becky Pockl shares the inspiring story of a mother who breastfed following double mastectomy and reconstructive surgery.

I hope you find the information in this issue to be inspiring and helpful in your practice. As breastfeeding advocates, you have the tools you need to make a real difference in the lives of women. Thank you for all you do for mothers and babies.

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