# Marijuana Use and Breastfeeding

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*Marijuana is one of the most widely used recreational substances in the United States, with high rates of use during peak childbearing years. Medical marijuana use is also becoming more widely accepted in the United States, with legalization in 17 states and the District of Columbia. The available literature suggests that maternal marijuana use during breastfeeding is associated with potentially negative outcomes for infants and children. Adverse effects can include feeding difficulty, lethargy, and delayed cognitive and motor development. Mothers considered heavy or chronic users of marijuana are advised to not breastfeed infants. The aim of this article is to examine the prevalence of marijuana use, the potential effects on breastfed infants, and current recommendations from lactation experts.*

**Keywords:** Breastfeeding, marijuana, substance abuse, mothering, infants
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Breastfeeding is the best method of infant nutrition during the first year of life. According to *Healthy People 2020*, new objectives recommend increasing the percentage of infants "ever" breastfed from 75% to 81.9%. Human milk provides superior nutritional and health opportunities, optimizing both maternal and infant health. However, an infant exposed to maternal use of marijuana prenatally or after birth may present with feeding difficulties, withdrawal symptoms, and growth delays (deDios, et al., 2010; Garry et al., 2009; Simmons et al., 2009). Marijuana is a widely used recreational substance in the United States, with the highest rates of use between ages 18 to 25, and greatest increases in use seen in childbearing women (deDios, et al., 2010; Garry et al., 2009). Studies conducted in Europe and the United States from 1980 to 2000 suggest rates between 3% to 30%, with average rates between 10% to 15% (Garry et al., 2009). According to the National Survey on Drug Use and Health, 15.2 million people have used illicit drugs in the past 30 days, with 53.3% of users citing marijuana as the drug of choice (National Institutes on Drug Abuse [NIDA], 2011).

Marijuana grows naturally in most parts of the world and is legal for medicinal uses in 17 of the United States and the District of Columbia. The active ingredient in marijuana is delta-9-tetrahydrocannabinol (THC), which is responsible for the desired effects (NIDA, 2010). (See Table 1.) Accepted medical diagnoses for medical marijuana use include analgesia for acute and chronic pain, migraine, post-traumatic stress, cachexia, nausea, tremor, anxiety, and epilepsy (Garry et al., 2009; Kurtz et al., 2010).

**Table 1. Effects of Marijuana Use**

| Desired Effects | Adverse Effects |
|---|---|
| • Euphoria | • Panic attacks |
| • Increased appetite | • Impaired use of motor vehicle |
| • Altered perception | • Dizziness |
| • Sedation | • Altered perception |
| • Decreased pain | • Possible reduction in prolactin levels |
| • Reduced anxiety | • Increased heart rate |
| • Increased sense of confidence | • Delayed response time |

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Maternal marijuana use during pregnancy and lactation is associated with potentially negative outcomes for infants and children. Hale and Hartman (2006) report using marijuana during lactation can affect brain development of the growing infant. However, as more states legalize medical marijuana, childbearing women need to be advised of the benefits of breastfeeding and the potential negative outcomes of using marijuana while breastfeeding (Garry et al., 2009; Hale & Hartman, 2006; Morrison et al., 2010). Lactation consultants, nurses, and medical providers need to recognize the specialized care of these maternal/infant dyads to promote healthy outcomes. This article examines the prevalence of marijuana use in childbearing and breastfeeding women, the potential effects to infants, and current recommendations for lactation consultants.

## Health Promotion

Under most circumstances, human beings strive to maintain or improve their health. Health-promoting activities can vary based on societal and cultural expectations and how one achieves ideal health in the face of chronic disease (Pender et al., 2011; Sheehan et al., 2010). Individuals using medicinal marijuana to decrease symptoms of chronic illness are striving for health promotion. To have less pain, anxiety, tremor, nausea, post-traumatic stress, and cachexia related to cancer, hepatitis C, or AIDS are powerful attractants to reduce symptoms affecting quality of life. Breastfeeding is another health-promoting activity (AAP, 2012; Healthy People 2020; WHO, 2012). In 2011, Surgeon General Benjamin issued a statement encouraging women to breastfeed as the best way to nourish infants and protect them from disease (Dewey et al., 2003; Hale & Hartman, 2006; Lawrence & Lawrence, 2005).

## Legalized Marijuana in the United States

In the United States, marijuana is still considered a Schedule I drug [high potential for abuse] by the U.S. Drug Enforcement Agency. The possible medicinal effects of marijuana have been the subject of research and debate. Legislative support for legalizing medical marijuana was established under the Compassionate Use Act in 1996 by California Health and Safety Code, Proposition 215 (Office of National Drug Policy [ONDCP], 2003). In several states, patients are allowed to have multiple plants and up to eight ounces of usable marijuana in their possession (Kurtz et al., 2010).

Medicinal marijuana is obtained through medical marijuana distributors. Currently in the United States, 17 states and District of Columbia allow legalized use of medical marijuana with a prescription for several chronic conditions to improve quality of life (see Table 2). Medical providers are required to perform a physical examination and health assessment to determine eligibility for medicinal marijuana, with each state offering specific guidelines. Approved conditions may include cancer, cachexia, epilepsy, glaucoma, chronic

**Table 2. States with Legalized Marijuana**

| | Year Passed | | Year Passed |
|---|---|---|---|
| Alaska | 1998 | Michigan | 2008 |
| Arizona | 2010 | Montana | 2004 |
| California | 1996 | Nevada | 2000 |
| Colorado | 2000 | New Jersey | 2010 |
| Connecticut | 2012 | New Mexico | 2007 |
| District of Columbia (DC) | 2010 | Oregon | 1998 |
| Delaware | 2011 | Rhode Island | 2006 |
| Hawaii | 2000 | Vermont | 2004 |
| Maine | 1999 | Washington | 1998 |

Reference: www.Procon.org

severe pain, migraine, or nausea (Kurtz et al., 2010). Less common uses include insomnia, attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), and anxiety (Garry et al., 2009; Kurtz et al., 2010).

## The Mechanisms and Effects of Marijuana Use

Marijuana is traditionally inhaled using glassware pipes or hand rolled in the form of a cigarette. Once inhaled, marijuana reaches peak effect within 10 minutes, with an expected duration of two to three hours. In marijuana smoke, more than 400 compounds are present with the main hallucinogenic ingredient: delta-9-TetraHydroCannabinol (Djulus et al., 2005; Hale & Hartman, 2006; NIDA, 2011). THC is the "agonist of the cannabinoid receptors located in the nervous system" (Garry et a.l, 2009, p. 2). Cannabinoid receptors (CB) are found in high quantities in specific areas of the brain, including areas influencing thought, concentration, memory, pleasure, perception of time and pain, and finally, cognitive concentration (NIDA, 2010). Cannabinoid receptors also act on brain development during fetal life and play a critical role after birth in the initiation of infant suckling (Garry et al., 2009). The effects of THC manifests on the mesocorticolimbic system and can inhibit gamma-aminobutyric acid (GABA) release resulting in lack of inhibition of dopamiergic neurons (deDios et al., 2010; Garry et al., 2009).

Desired effects for marijuana users include pain relief, altered perception, sedation, euphoria, relaxation, altered mood, delayed response, increased hunger signals, and sense of calm (see Table 1), (deDios et al., 2010; Garry et al., 2009; Hale & Hartman, 2006; Sheih & Kravitz, 2006). Adverse effects include muscle weakness, anxiety, panic attacks, increased heart rate, and increased risk of depressive symptoms in adults (Garry et al., 2009; Hale, 2010). Additional adverse effects from marijuana inhalation or ingestion include poor short-term memory, impaired motor performance, and dizziness (Djulus et al., 2005; Hale & Hartmann, 2006).

Marijuana also can be added to food products, oil infusions, and butters (Chapkis & Webb, 2005). Ingestion of marijuana can take up to an hour to peak, with effects lasting several hours (Chapkis & Webb, 2005). The half-life of THC for an adult is one to 2.3 days and it is metabolized through the kidneys (Hale, 2010). Urine testing for four to six weeks post-inhalation or ingestion is an effective way to determine use in the adult population (Day et al., 2006; Garry et al., 2009; Hansen et al., 2008; Shieh & Kravitz, 2006; Williams & Ross, 2007).

## Prevalence of Marijuana Use

Rates of recreational marijuana use are increasing. According to deDios et al. (2010), young adults ages 18 to 25 have the highest rate of marijuana use, with 16.4% reporting use within the past month. Five percent of childbearing women, ages 15 to 44 years, reported using marijuana in the past 30 days, according to National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2007). Garry et al. (2009) reported that marijuana is the most commonly used recreational drug used during pregnancy, with rates ranging from 3% to 30% percent in studies conducted in Europe and the United States. Recent national estimates in the United States suggest 9.8% of all women, ages 15 to 44 years, and 4% of pregnant women report using illicit drugs in the past month, with marijuana being the most commonly used (Schempf & Strobino, 2008).

According to deDios et al. (2010), complications from the use in young women, ages 18 to 29, have increased from 25% in the 1990s to 32% in 2002. Adverse effects can include increased risky sexual activity, polysubstance abuse, and poor judgment regarding parenting (deDios et al., 2010; Garry et al., 2009; Shieh & Kravitz, 2006). There are no known studies describing the rates of medicinal marijuana use in breastfeeding women. The challenge may be childbearing women are reluctant to report marijuana use because they are afraid of legal consequences and possible interference by child protective services (Garry et al., 2009; Simmons et al., 2009).

## Breastfeeding and Marijuana Use

The benefits of human milk are well known. However, when marijuana is inhaled or ingested by a lactating woman, THC crosses over into the breast milk and can be absorbed by the nursing infant (Academy of Breastfeeding Medicine [ABM], 2009; Astley & Little, 1990; Garry et al., 2009; Perez-Reyes & Wall, 1982). Breastfed infants exposed to THC in the first months of life will metabolize and absorb marijuana compounds at a time when brain development is rapid (Garry et al., 2009). An infant will test positive for marijuana in urine for two to three weeks after ingesting breast milk that contains THC (Garry et al., 2009; Liston, 1998). Infants exposed to THC through breast milk are reported to have increased tremors, poor sucking, slow weight gain,

and poor feeding in the first month of life (see Table 3), (Astley & Little, 1990; Garry et al., 2009).

**Table 3. Adverse Effects on Breastfeeding Infants**

- Increased tremor
- Poor sucking reflex
- Decreased feeding time
- Slow weight gain
- Changes in visual responses
- Delayed motor development

Studies in animals suggest prolactin levels may be reduced with marijuana use and may inhibit milk supply. However, this has not been proven in human populations (Garry et al., 2009; Hale & Hartmann, 2006). With reduction in prolactin levels, milk production may be reduced for the growing infant and can impede normal growth and development (Dewey et al., 2003; Garry et al., 2009; Rasmussen & Kjolhede, 2004). Based on available evidence, infants fed human milk containing marijuana may gain weight more slowly, have ineffective sucking patterns, be at risk for failure to thrive, and have increased risk for sudden infant death syndrome (SIDS) (Astley & Little, 1990; Djulus et al., 2005; Garry et al., 2009).

Fried (1980) studied neonates exposed prenatally to THC and concluded infants of heavy marijuana users were more likely to have a heightened startle reflex and increased jitteriness, consistent with drug withdrawal. A Letter to the Editor in the *New England Journal of Medicine* presented a case study of two breastfeeding mothers: one mother smoked marijuana once a day and the second mother smoked seven times daily (Perez-Reyes & Wall, 1982). Breast milk was analyzed one-hour post inhalation. The breast milk from the mother who smoked seven times a day had TCH levels eight times higher than in her blood levels. Fecal analysis of the infant showed positive metabolites in the baby's stools, suggesting THC in breast milk was metabolized by the infant (Perez-Reyes & Wall, 1982). The mother who smoked only once daily, THC was considered nominal in mother's milk and the infant's urine screen was negative (Pérez-Reyes & Wall, 1982). Limitations of the case study include lack of consistency of amount of time between inhalation of marijuana and infant exposure, and the small sample size.

In 1985, Tennes et al. followed 62 infants in the first year of life. Of the study group, 27 of the mothers reported using marijuana during breastfeeding: 12 smoked once a month or less, nine weekly, and six daily. The results suggested no significant differences in adverse events between the babies of the non-users vs. users of marijuana exposed through breast milk (Tennes et al., 1985). Astley and Little (1990) suggested that infants exposed to marijuana via breast milk were more likely to exhibit adverse effects of THC at one month than they were at three months and one year. Fried and Watkinson (1990) investigated verbal and memory domains in four-year-old children exposed to marijuana prenatally and after birth. At four years, children exposed to maternal marijuana had significantly lower scores in memory and verbal domains.

Studies have shown marijuana can adversely affect infants; however, the evidence is conflicting. Therefore, results need to be considered cautiously regarding sample size, maternal self-reporting integrity, and study type. Another issue may be the differences in potency of plants, levels of THC, or methods of measurements. According to the Office of National Drug Control Policy (2003), marijuana plants today have more THC, with a six-fold increase in potency than plants available 30 years ago.

Another consideration is the ethical challenges of researching women breastfeeding using marijuana. Researchers report potential harm to mother and infant when using marijuana, creating conflict of human protection in health research studies (Djulus et al., 2005; Garry et al., 2009; Sheih & Kravitz, 2006; Simmons et al., 2009). The primary challenge faced by lactation counselors and medical providers is the lack of consistent, current, and evidence-based research for this population (ABM, 2009).

## Implications for Practice

According to the Academy of Breastfeeding Medicine (2009), providing support for a mother who wants to breastfeed and use marijuana, either recreationally or medicinally is challenging. Infants can be at risk for multiple difficulties, both physically and developmentally. However, they can benefit from human milk and breastfeeding. The Academy of Breastfeeding Medicine and International Lactation Consultant Association (ILCA) encourage medical providers and lactation consultants to prepare pregnant women for lactation and postpartum marijuana abstinence to promote advantageous outcomes (ABM, 2009; ILCA, 2009).

 

The Academy of Breastfeeding Medicine (2009), Hale (2010), and the American Academy of Pediatrics (2012) recommend that women avoid breastfeeding if they consistently or heavily use marijuana, either recreationally or medicinally. Further, women who do not receive consistent prenatal care, have a positive urine drug screen at time of delivery, and have no confirmed plan of care at the time of delivery should not breastfeed. When breastfeeding is contraindicated, mothers need information regarding banked human milk and preparation of artificial baby milk. The rationale for this recommendation is clear; the available evidence suggests that THC passes through the breast milk and can potentially adversely affect the breastfed infant (ABM, 2009; Astley & Little, 1990; Garry et al., 2009; Hale, 2010).

Mothers need to be educated to the potential adverse effects related to feeding challenges, delayed growth, and development. Further education for mothers consists of discouraging smoking marijuana around the infant or within the home setting to reduce exposure of second-hand smoke (Garry et al., 2009). Lactation consultants working with mothers who occasionally use medicinal marijuana require careful consideration and education regarding the half-life of THC, amount of exposure to the infant, and follow-up care. Careful observation of the mother and infant, while maintaining an open and trusting relationship with the maternal-infant dyad, will ensure opportunities for education and informed decision making. There are no studies that support breastfeeding and use of marijuana. However, with conflicting results, further studies and case-by-case considerations are warranted in cases of occasional use.

## Conclusion

Medical marijuana is known to offer improvement for symptoms of chronic illness and these benefits have been recognized by voters, state legislation, and medical providers. Conditions such as pain, ADHD, depression, anxiety, nausea, and post-traumatic stress disorder are possible diagnoses for which medical marijuana may be prescribed. The challenge faced by medical providers and lactation consultants is the limited studies with conflicting research results about whether limited use is harmful. Current evidence-based support is lacking regarding these recommendations. Guidelines through the Academy of Breastfeeding Medicine and International Lactation Consultant Association have clearly identified the value of breast milk, and many medications and substances are considered acceptable for women to use during breastfeeding. However, recreational or medical marijuana use is more of a cause for concern and requires individualized assessment, plan of care, and follow-up. Lactation consultants, medical providers, and peer counselors need to carefully consider how to advise women who choose to use marijuana and still offer the best nutrition to their infants.

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## The Affordable Care Act Provides Benefits for Expectant Mothers and Their Newborns

The Affordable Care Act helps make prevention affordable and accessible for all Americans by requiring health plans to cover recommended preventive services without cost sharing. Starting August 2012, the Department of Health and Human Services (HHS) adopted additional Guidelines for Women's Preventive Services that will be covered without cost sharing. These include support for breastfeeding; well-woman visits; screening for gestational diabetes, HIV, and sexually transmitted infections; contraception; and domestic-violence screening.

Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment. One of the barriers for breastfeeding is the cost of purchasing or renting breast pumps and related supplies. The guidelines were based on scientific evidence and were recommended by the independent Institute of Medicine (IOM). To learn more about preventive services for women visit Healthcare.gov.

## Three Midwifery Organizations Issue Consensus Statement

The United States' three midwifery organizations, American College of Nurse-Midwives, Midwives Alliance of North America (MANA), and National Association of Certified Professional Midwives (NACPM), released a historic consensus statement. *Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement* gives maternity care providers, policymakers, and women a succinct summary of the evidence for the benefits of normal physiologic childbirth.