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Letters to the Editor

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Comments on “Epidural Analgesia During Labor and Delivery” Article by Chang and Heaman

I am very interested in the article “Epidural Analgesia During Labor and Delivery: Effects on the Initiation and Continuation of Effective Breastfeeding,” which was published in the August 2005 issue of the *JHL*. As I work both in hospitals and in the community, and as the rates of epidural use are skyrocketing, this article is both timely and relevant. I appreciate that the NACS was used to assess babies, and that a standard system (LATCH) was used to assess breastfeeding. It makes such good sense to evaluate babies and breastfeeding using standard and objective systems.

That said, the article leaves me with some big questions. What were the postpartum breastfeeding practices in the facility? In another study, Halpern et al (*Birth*. 1999;26:83-88) found that epidural analgesia did not seem to reduce breastfeeding rates at 6 weeks postpartum and described practices in the study hospital (all babies rooming-in, no nursery for normal infants, no pacifiers, no formula discharge packs, 50 IBCLCs on staff). Perhaps it is the Baby-Friendly style of postpartum practice that really makes the difference, no matter what or if any labor analgesia is used?

I also wonder about the use of the term “effective breastfeeding,” in view of the lovely definitions published by Labbok and Krasovec (exclusive, partial, and token). Why was this new term used? “Any breastfeeding at 4 weeks postpartum” (p. 306) is not the goal of our work; we are aiming for exclusive breastfeeding for about 6 months (AAP).

What happened in the early postpartum? How soon and for how long did babies go to breast immediately after delivery? How many periods of skin-to-skin contact did the babies have? How many babies were supplemented in the hospital? What was the average number of breastfeeds per day?

Answers to these questions will fill in the gaps in this study.

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Response to a Letter to the Editor

Epidural Analgesia During Labor and Delivery: Effects on the Initiation and Continuation of Effective Breastfeeding

Participants for this study were recruited from the Labor, Delivery, Recovery, Postpartum (LDRP) Units of 2 tertiary care teaching hospitals. These LDRP Units have a family-centered approach to childbirth and postpartum care, and they were selected to help control for environmental factors that might affect the initiation of effective breastfeeding. The LDRP Units are supportive of early initiation of breastfeeding by encouraging early mother-infant contact and providing 24-hour rooming-in. Breastfeeding within 1 hour of birth and breastfeeding without restriction are the norms. Both hospitals are participants in the Provincial Baby-Friendly Network. All nurses in the units have received education and training on breastfeeding, as part of orientation and continuing education. Some nursing staff are IBCLCs. Indeed, we agree that a Baby-Friendly style of practice along with having skilled and supportive staff are likely to have an impact on the initiation and continuation of breastfeeding. As we have noted in the article, generalization of the results should be limited to units where early initiation of breastfeeding, rooming-in, and demand-feeding are part of the norm.

Although we recognize the importance of exclusive and sustained breastfeeding, it was the intention of the study to look at the influence of epidural use on infants' ability to breastfeed. Thus, “effective breastfeeding,” defined as either exclusive or partial breastfeeding at 4 weeks postpartum, was used as the outcome measure.

Breastfeeding is highly complex and is influenced by factors related to the mother, the infant, and the environment. This was taken into consideration in the selection of study settings, eligibility criteria for participants, and

decisions regarding data collection. In addition to the results presented in this article, data were collected on postpartum events such as supplementation, breastfeeding frequency, breastfeeding difficulties in the hospital and following discharge, sources of breastfeeding support, and reasons for discontinuing breastfeeding. Given the complexity of our study and the page limit for articles in *JHL*, these data could not all be reported in this article, but they will be presented in another publication, which we hope will answer some of the remaining unanswered questions.

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Water Intake During Lactation

There is often conflicting information given out to breastfeeding mothers. However, the one consistent piece of advice is to drink "a lot" of fluids, preferably water. There is a difference of opinion as to what "a lot" means. Advice ranges from unspecified large quantities of water, to a big glass every time you breastfeed, to 1 glass before you feed, then 1 during and 1 after. There is little information about how big the glass should be. The general population believes at least eight 8-oz glasses of water daily is needed for health. It would then seem that the lactating mother should drink quite a bit more. But is this sound advice?

Several years ago, I had a client who had a dwindling supply at 12 weeks. Her supply was good until the 10th week. The mother was advised by her physician and breastfeeding support community to increase her water intake in order to increase her milk supply. When I was doing my initial history, the mother excused herself 3 times to urinate. She had been dutifully drinking more than 8 glasses of water per day during the initial weeks of lactation. To boost her supply, she had increased her intake to 10 glasses per day. I asked to see the glass. It held 24 ounces! She was consuming 240 oz (3 ¾ gallons) per day of water! She felt sick, was urinating constantly, and was slightly depressed and nauseous. In addition, her supply had continued to diminish. Another woman was drinking more than 1 gallon of water per day to increase her supply, and it was not working. Both women's supply improved as they decreased their water intake to more normal levels. As I began asking about water consumption, I found that many women were

forcing large quantities of water well beyond thirst in an effort to increase milk production. This prompted me to question mothers to understand the relationship between water consumption and milk supply.

Water consumption in lactating women is often addressed by medical personnel and by lay people. Increased water consumption in lactating women is universally promoted. In addition, there is a lack of clarity in what constitutes a "glass of water." Water intake is not the total source of a woman's total fluid consumption, only part of it. A percentage of almost all food is water. Mothers are not counting other foods and beverages in their total fluid count.

There is no evidence to support pushing fluids beyond thirst. Dr Ruth Lawrence, in *Breastfeeding: A Guide for the Medical Profession*, cites several studies that suggest drinking beyond thirst may actually suppress lactation. Dr Lawrence states, "No data support the assumption that increasing fluid intake will increase milk volume."¹ She also states that "restricting fluids has not been shown to decrease milk volume." Her advice is to drink to thirst and to listen to the body's cues to drink. In *Successful Breastfeeding* by the Royal College of Midwives is the statement that "thirst effectively regulates the fluid intake of a lactating woman and the practice of encouraging breastfeeding women to drink large quantities of liquid should be abandoned."² Other sources, including the *Breastfeeding Answer Book*³ and *Core Curriculum for Lactation Consultant Practice*⁴ recommend drinking to thirst. Many women are not getting this advice. I now include questions of what and how much a woman drinks, and I have been astounded to see just how much women are actually forcing themselves to drink.

Many women today are athletic and have exercised regularly before having a baby. They "know" that they need at least 8 glasses (at least 8 oz per glass) of water daily prior to lactation. Therefore, increasing water to 1 gallon or more when lactating makes sense to them.

What is the rationale for 8 glasses a day in the general population? In a review from the *Journal of the American Physiological Society*, the author states that despite an extensive search, he found no scientific evidence to support the claim that we must drink at least 8 glasses of water daily.⁵ Furthermore, the fluid we do drink does not have to be just water to count for fluid intake. All fluids and foods contribute to our fluid intake. He then discussed some of the risks to overly hydrating, especially with water.⁵

In the April, 2005 issue of the *New England Journal of Medicine*,⁶ a case study of a runner in the 2002 Boston Marathon who died of hyponatremia was documented. After this incident, questions were raised about the hydration needed even for long-distance races such as the marathon. The Boston Marathon runner had signs of what was thought to be dehydration and was given intravenous fluids. She died from too much water, which resulted in hyponatremia (an overdilution of her sodium level). In the March 2000 *Medical Surveillance Monthly Report*,⁷ there is an article on overhydration and hyponatremia among active duty soldiers. Cases of hyponatremia secondary to heat stress and excessive water consumption were reported among basic trainees. The general assumption that water can never hurt and the more the better is not accurate or based on evidence but is based on anecdote.

We should be telling lactating women to drink to thirst. This is good advice based on the evidence we have. Lactating women are thirsty. This is the body's own way to increase fluids. Allow mothers to drink fluids other than just water. Nutritious foods such as fruits, juices, and soups have some added benefit in calories and other nutrients. Be on the lookout for those bottles of water lined up at the mother's bedside (especially all the empty ones!). And ask about fluid intake. Your mothers may be very relieved to know that they do not have to drink a gallon of plain water daily to have a copious supply.

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Regarding the Emerging Field of Lactational Psychology

The breastfeeding mother and her nursing are interconnected and interacting human beings, each influenced by personally and culturally based life experiences, behaviors, perceptions, and beliefs; developmental stage; mental health status; interpersonal relationships; learning style; personality; community context; and more.¹⁻¹¹ Therefore, effectively responding to the full humanity of diverse breastfeeding dyads requires a substantial understanding of psychology.

Psychology is "the scientific study of the mind and its methods of working, particularly in relation to behavior."¹² This science is extraordinarily complex and encompasses a variety of specialties, such as those represented in the 50-plus formal divisions of the American Psychological Association (APA).¹³ Many of these specialties, such as counseling, developmental, educational, and social psychology, are applicable to the field of breastfeeding as well as the emerging fields of prenatal and perinatal psychology and infant mental health.

In spite of the numerous psychological aspects of breastfeeding, there is no consensus on the name of the junction of the 2 fields, nor is its existence widely acknowledged. However, a body of research, concepts, and techniques exists that is regularly applied across disciplines by professionals working with breastfeeding mothers. Furthermore, dual professionals are already actively integrating the fields of psychology and lactation. Enough of them exist that in May of 2005, I founded LactPsych, an international e-mail discussion group that serves the needs of health care providers who work multidisciplinary in a variety of settings. The educational backgrounds of LactPsych members include developmental, clinical, and health psychology; psychotherapy; psychiatry; counseling; nursing; psychiatric nursing; and marriage and family therapy. The majority of members are also international board certified lactation consultants. These dual professionals are interested in a variety of issues, including postpartum mood disorders, infant mental health, culturally competent lactation consulting services, the impact of breastfeeding on maternal-child attachment, the impact of sexual abuse on breastfeeding, grief over the loss of breastfeeding, and the impact of traumatic birth experiences on breastfeeding.

I believe that a more formal recognition of the intersection of the fields of lactation and psychology can encourage a greater awareness of its importance, more

interest in the application of integrated knowledge and skills, more educational opportunities, and more research addressing that intersection. Toward these goals, I propose the name "lactational psychology" for the emerging specialty that encompasses the crossroads of the fields of lactation and psychology.

Whatever this important specialty is named, lactation consultants, mental health care providers, other health care providers, and lay breastfeeding counselors have the opportunity to further develop and utilize its concepts and techniques. By so doing, they can better address psychological and breastfeeding issues in their work and can provide or refer mothers to specialized services when they are needed. Participating in the development of an emerging field is exciting and challenging. With this effort comes deep satisfaction at increased knowledge, insight, and skill. Greater collaboration between and integration of the fields of psychology and lactation can yield only more effective care of the breastfeeding dyad.

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Twentieth Anniversary Issue

I so enjoyed the 20th anniversary issue of *JHL*; many thanks to the authors and editors. However, in reading the article "Clinical Lactation Practice: 20 Years of Evidence,"¹ I found a deficit in the information regarding breastfeeding duration. In discussing the factors that influence breastfeeding duration, the authors only briefly mentioned maternal employment. Since 1999, I have been working on legislation requiring workplace accommodation for breastfeeding employees in the state of Oregon. (This year, we did pass a workplace bill; however, because of opposition from the business community, it was weakened from a mandate to a suggestion for Oregon businesses.) Working for better public policy has made me aware of a substantial body of evidence regarding the negative effect of maternal employment on breastfeeding duration. One recent search yielded a number of strong studies that show that return to paid work has a negative impact on breastfeeding duration.²⁻¹⁰ A comprehensive list of studies that show similar results is beyond the scope of a letter to the editor.

In 1998, Minnesota passed a law requiring businesses to accommodate their breastfeeding employees in the workplace.¹¹ From 1998 to 2002, breastfeeding rates at 6 months increased from 20% of Minnesota babies to 45%.¹² For our community of lactation consultants, there are 3 essential lessons in this: first, we must be aware that return to paid employment is a major factor influencing breastfeeding duration. Second, the impact of maternal employment on breastfeeding can be moderated by support within the workplace. Third, public policies that support breastfeeding can make a rapid and impressive difference in outcomes.

In the May 2005 *JHL*, Barbara Wilson-Clay gave a lovely summary of the legislative process at the state level.¹³ I encourage each of you to consider forming, joining, or supporting a state task force that works on public policy in support of breastfeeding. One good law can move us a long way toward our health goals for all mothers and babies.

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