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Birth Interventions, Postpartum Depression, and Breastfeeding

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Editorial

Birth interventions, such as epidurals and cesarean sections, are common in the United States and in many other parts of the world. Do these impact breastfeeding and mothers' emotional health? This question has been the focus of fierce debate. By and large, practitioners assure mothers that these interventions, particularly epidurals, have no untoward effects. And some studies support that contention, with results showing little to no impact on early breastfeeding and maternal mental health. In fact, one recent and widely publicized study actually showed that epidurals *decreased* the risk for maternal depression (Ding, Wang, Chen, & Zhu, 2014).

However, other studies reveal drawbacks to these interventions, such as delayed lactogenesis II being more common if a woman has experienced birth interventions. Given that, do these interventions have a negative effect on breastfeeding? Grajeda and Perez-Escamilla (2002) found that highly stressful births increase the stress hormone cortisol, which suppresses prolactin and can delay lactogenesis II by several days. But not every study has found this.

In the current issue is an article that shows, quite clearly, with a large sample, that the type of birth a mother has does influence whether she is exclusively breastfeeding and her risk for depression. Clearly, we cannot say that these interventions are of no consequence when they impact both breastfeeding and maternal mental health.

So what do these findings mean for International Board Certified Lactation Consultants? Lactation consultants, unless they are also obstetricians, labor and delivery nurses, or doulas, are often not there when practitioners decide to use these interventions. During a birth, using these interventions can absolutely be the best decision for both mother and baby. For example, a mother with a prolonged labor may really benefit from an epidural. A baby who is in distress may need to be delivered by cesarean section. As lactation consultants, we often must work with what we have versus what we wished had happened.

That being said, we need to be honest, at least with each other, that mothers may encounter problems in the postpartum period if their births include interventions. In most cases, we should also be circumspect with mothers when talking about the drawbacks of various birth options. Not that we want to "hide" information from mothers. Rather, we should be careful that we do not communicate to them that we think breastfeeding will fail. Perhaps our best option is a state of quiet watchfulness. We do what we can to ensure that mother and baby get off to a good start postpartum and that they have good follow-up in their community. Otherwise, many of these mothers will fall by the wayside.

On the other hand, collectively, we can advocate for births that are both baby-friendly and mother-friendly. Until birth practices are addressed, we are unlikely to see significant increases in exclusive breastfeeding rates. In addition, our rates of postpartum depression are likely to stay the same—or even increase.

Our attitude about birth interventions should be that they can be the right choice in certain situations. But like other types of medical interventions, there are benefits *and* risks. In our study, consequences of birth interventions included lower rates of exclusive breastfeeding over the first year and higher rates of postpartum depression. Let's please get past the idea that these procedures have no negative impact. Out in the wider world, actions have consequences. Why would it be any less true for actions and interventions used during birth?

Kathleen Kendall-Tackett, PhD, IBCLC, RLC, FAPA
Editor-in-Chief

References

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- Grajeda, R., & Perez-Escamilla, R. (2002). Stress during labor and delivery is associated with delayed onset of lactation among urban Guatemalan women. *Journal of Nutrition*, 132, 3055–3060.

Letter to the Editor

Dear Editor:

Last year, *Clinical Lactation* published an article, “Galactosemia and the Continuation of Breastfeeding With Variant Form” (Vol. 4[4], pp. 148–154). The Research Team of the Galactosemia Foundation (GF), the largest support and advocacy group in the world for those affected by all forms of galactosemia (www.galactosemia.org), was pleased to see this article in your journal. However, we wish to address some significant concerns GF has about the authors’ conclusions.

More often than we would like, parents of newborns initially receive an ambiguous diagnosis of galactosemia. Given the potential for a fatal outcome if a galactosemic child continues to consume milk, the primary message ought to be to *stop* breastfeeding immediately following *any* kind of a positive newborn screening result, even when a false positive is suspected.

However, the article says that false positives “should be investigated when making a clinical decision about the

urgency of follow-up and discontinuation (permanent or temporary) of breastfeeding” (suggesting that breastfeeding be continued in the meantime). Instead, the protocol should be to stop breastfeeding immediately and await final test results to a clinical decision about whether breastfeeding *can be resumed*. Many within the galactosemia community are advocates of breastfeeding—for non-galactosemic children—and lactation consultants can play an important role in encouraging lactating mothers to pump and store milk until a definitive diagnosis is made.

We applaud the authors’ effort to educate the larger community of neonatal caregivers about galactosemia. But we wish the article presented a more cautious approach, given the very real risks of a severe, even fatal, outcome. It is critical that those conveying the importance and benefits of breastfeeding know that there are exceptions, and they are very serious indeed.

Thank you,

The Galactosemia Foundation Research Team