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Mental Health Care for Breastfeeding Mothers with Postpartum Depression

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Up to 20% of women experience postpartum depression (PPD).¹ Up to 88% of these mothers go unrecognized.² Not all primary health care providers realize the importance of repeated and routine screening for PPD for the entire first year postpartum; understand the risks of untreated PPD to mothers, as well as to their children;¹ are familiar with the wide variety of effective treatment options for PPD that exist today; or know how and why to support breastfeeding in the context of PPD. Therefore, they can often more effectively serve a mother coping with PPD by becoming a member of her mental health care team, rather than by trying to be the sole provider of her mental health care. Additionally, not all mental health care practitioners have adequate knowledge about breastfeeding or experience with breastfeeding management in the context of mental health care. Breastfeeding management is particularly important in the context of PPD because symptoms of depression can both contribute to and follow premature weaning.² It is also important because formula fed infants of depressed mothers have a greater risk of negative psychological effects of maternal depression than breastfed infants of depressed mothers.³ When selecting a mental health practitioner, breastfeeding mothers can ask questions to evaluate the practitioner's knowledge and support of breastfeeding, such as:

- How long do you think it is healthy for exclusive (or partial) breastfeeding to continue?
- How do you feel about a mother breastfeeding in your presence during a session?
- What are your views on mothering behaviors that facilitate breastfeeding, such as sleep sharing, baby wearing, and physical closeness between mothers and nurslings?
- How do you protect and support breastfeeding while providing mental health care?
- How often do you recommend weaning or the introduction of artificial substitutes for human milk in order to treat postpartum depression?
- What are the risks to me and my child of weaning and the introduction of artificial substitutes for human milk?
- Do you own and use the current edition of *Medications and Mothers' Milk* by Hale?⁴
- What proportion of your practice consists of breastfeeding mothers?
- What continuing education related to breastfeeding have you completed this year?
- Are you also an International Board Certified Lactation Consultant (IBCLC) or do you specialize in lactational psychology?⁵

If the answers to such questions suggest that the mental health practitioner is not likely to offer care that is compatible with breastfeeding, then the mother may wish to ask her primary health care provider for a referral to a more knowledgeable and experienced practitioner.

Symptoms of PPD overlap—and can co-occur—with those of grief, acute stress disorder, posttraumatic stress disorder, bipolar disorder, and anxiety disorders.^{6,7} The causes of and treatments for these disorders are not identical. Psychotropic medications should never be the only treatment offered to mothers with PPD because symptoms of depression may be caused or worsened by life events and circumstances, chronic pain, sleep deprivation, underlying health problems (e.g., hypothyroidism), nutritional imbalances (e.g., copper/zinc ratio), alcohol and substance abuse, and numerous prescription medications—none of which are cured with

psychotropic medications. However, psychotropic medications can be useful if a mother's symptoms of depression are so severe that they seriously impair her functioning and disable her from engaging in other treatment options, such as psychotherapy. Accurately diagnosing PPD, identifying its causes and contributors, and developing an individualized treatment plan take time and partnership between the primary health care provider, the mental health practitioner, and the mother. A treatment plan that is effective for one mother may not be effective for another. Treatment risks or side effects, such as those associated with psychotropic medications,⁸ may or may not be acceptable or manageable for a particular mother. Effective treatment always begins with ruling out and/or treating underlying health problems that cause or contribute to depression. Additional treatments include dietary changes, nutritional supplements, exercise, help from a postpartum doula, support group participation, various psychotherapies (e.g., cognitive behavioral therapy, interpersonal psychotherapy of depression, solution focused brief therapy), and psychotropic medications.^{1,9,10} If a severely depressed breastfeeding mother requires hospitalization, the hospital can protect breastfeeding by admitting the nursing and mother to the same unit and, if needed, allowing a relative or friend to stay with the mother to ensure the safety of the nursing. If mother-nursing separation is unavoidable (this should *rarely* be the case), the mother should be provided with a hospital grade electric breast pump as well as assistance from an International Board Certified Lactation Consultant in using it. All breastfeeding mothers deserve the opportunity to make informed decisions about their mental health care by being provided with information about a wide variety of effective treatments, the risks and benefits of those options, the risks of weaning or introducing artificial substitutes for human milk, and the risks of not treating PPD. The vast majority of treatment options for PPD, including most psychotropic medications,^{4,11} do *not* contraindicate breastfeeding.

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