The Breast is Best paradigm and Maternal Mental Health: Best Practices in Psychotherapy and Lactation
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Session Objectives

- Describe the relationship between breast-feeding and maternal mood and anxiety disorders, including birth trauma PTSD.
- List the symptoms of Dysphoric Milk Ejection-Reflex (DME-R) and its potential impact on nursing and maternal mental health.
- Describe the fundamentals of being a breast-feeding friendly psychotherapist and a mental health friendly lactation specialist.
- Discuss concrete interventions in lactation and psychotherapy supportive of sound maternal mental-health and breast-feeding.
- Share resources with clients and colleagues for further support.

Defining the issue:

Perinatal Mood and Anxiety Disorders and Breastfeeding

Why is it relevant to lactation specialists and psychotherapists?
Know what you’re working with!
Base knowledge in psychotherapy and lactation

- Recall high risk of suicidality (passive vs. active)
- All diagnoses, not just PPD
- Better she looks, may be increased concern
- Set personal biases aside
- Ask the right questions
- Understand principles of infant feeding, palate issues etc.

Perinatal Mood and Anxiety Disorders
Pregnancy and the First year Postpartum

- Psychosis - Thought Disorder or Episode
- Major Depressive Disorder
- Bi-Polar Disorder
- Generalized Anxiety
- Panic Disorder
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder

Perinatal Depression ~ 10-25%

Both General and Perinatally
- Agitated depression
- Disinterest in activities for self
- Hopelessness
- Guilt
- Tearfulness
- Irritability
- Anger/rage
- Insomnia

Perinatally Specific
- Usually an anxious component
- Anhedonia usually not regarding infant and children
- Looks “too good”
- Often highly functional
- Hidden illness
- Intense shame
- Passive/Active suicidal ideation
PTSD or Depression? Or Both?

Signs of post-traumatic stress disorder, or PTSD, differ from postpartum depression, and can be severe.

PTSD
- The person experiences intense fear, helplessness, or horror.
- Persistent anxiety and re-experiencing trauma.
- Avoidance or numbing of emotional responsiveness.
- Hyperarousal.

Postpartum depression
- Diminished interest in activities.
- Feeling hopeless or worthless.
- Trouble concentrating.
- Trouble sleeping or eating.
- Feelings of guilt.

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Postpartum Depression and Breastfeeding: The Impact

- Significantly more likely to discontinue breastfeeding between 4 and 16 weeks postpartum (Field 2008; Ystrom 2012).
- More likely to give infants water, cereal, and juice during that time.
- More likely to experience feeding difficulties.
- More likely to report being “unsatisfied” with breastfeeding and lower rates of self-efficacy.
- PPD and low support leads to early weaning (Mathews et al JHL 30(4) 480-487).

Impact of Sx on Rates of Exclusive Breastfeeding:

- Anxiety at 3 months reduced odds of Ex BF by 11% at 6 mos (Adedinsewo et al JHL 2014 30(3) 102-109).
- Complex pregnancy ~ greater than 30% lower odds of EBF.
- Supportive hospital increased the odds by 2-4 times.
- Birth interventions matter.
- Elective cesarean increased depression and anxiety.
- Planned cesarean is higher than emergency and nearly double unplanned.

Source: NIMH Postpartum Depression, American Psychiatric Association, Dept. of Psychiatry University of California Medical School of San Diego.
Impact of birth trauma on breast-feeding: a tale of two pathways.
Cheryl Tatano Beck, Sue Watson

(a) Proving oneself as a mother: sheer determination to succeed
(b) Making up for an awful arrival: atonement to the baby
(c) Helping to heal mentally: time-out from the pain in one’s head
(d) Just one more thing to be violated: mothers’ breasts
(e) Enduring the physical pain: seeming at times an insurmountable ordeal
(f) Dangerous mix: birth trauma and insufficient milk supply
(g) Intruding flashbacks: stealing anticipated joy
(h) Disturbing detachment: an empty affair

Because of their illness women will hear...

- "If you choose not to breastfeed...you’re not a good mother"
- "If you have difficulties breastfeeding, you’re doing something wrong."
- "If you don’t enjoy breastfeeding, your maternal instincts are impaired in some way."
- "If the breastfeeding relationship does not go along smoothly you are unable to do what comes naturally to all other women."
- "If you quit breastfeeding, you will continue to fail as a mother." (Kleinman, Karen 2007)

What does it mean to say to a mother “Breast is Best?”

- Oftentimes nursing is the one thing going well or the one thing a mother feels she has the ability to “do right”.
- If women seek medical tx they may be told they must discontinue this one area of efficacy = grief and loss
- Beware judgment!
- Beware depressive self-talk & nursing experiences
- Anxious self-talk can begin a vicious physiological and psychological cycle
- Flexibility in thinking is the therapeutic goal!
Hormones, Inflammation, and Breastfeeding: Friend or Foe?

Inflammation and PPD: The new etiology paradigm

- Psychoneuroimmunology (PNI) = new insights
- Once seen as one risk factor; now seen as THE risk factor underlying all others
- Depression associated with inflammation manifested by pro-inflammatory cytokines
- Cytokines normally increase in third trimester: ↑ vulnerability
- Explains why stress increases risk
- Psychosocial, Behavioral & Physical
- Prevention and treatment to ↓ maternal stress & inflammation (Kendall-Tackett 2015)

Pro-Inflammatory Cytokines

- ↑ Third Trimester
- ↑ Risk
- ↑ Pre-term Birth
- ↑ Preeclampsia
Protective Benefits of Breastfeeding

- Attenuates stress
- Modulates inflammatory response
- Protective affect on the neural development of infants

Dennis & McQueen, (2009), Hale (2007)
Kendall-Tackett, Cogig & Hale, (2010)
Kendall-Tackett (2015)

Potential Negative Impact of Nursing on Depressed Mothers

- PNI research suggests that the natural inflammatory response on pregnancy, combined with inflammatory process such as stress and pain, i.e.: nipple pain, can increase risk and severity of symptoms.
- When nursing is going well = protective.
- When nursing is very stressful and/or painful = increased risk.

Kendall-Tackett (2015)

New evidence on breastfeeding and postpartum depression: the importance of understanding women’s intentions. Maternal Child Health J. 2015 Apr;19(4):897-907
Borra C1, Iacovou M, Sevilla A.

"The estimated effect of breastfeeding on PPD differed according to whether women had planned to breastfeed their babies, and by whether they had shown signs of depression during pregnancy. For mothers who were not depressed during pregnancy, the lowest risk of PPD was found among women who had planned to breastfeed, and who had actually breastfed their babies, while the highest risk was found among women who had planned to breastfeed and had not gone on to breastfeed. We conclude that the effect of breastfeeding on maternal depression is extremely heterogeneous, being mediated both by breastfeeding intentions during pregnancy and by mothers’ mental health during pregnancy."

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D-MER

Dysphoric Milk Ejection Reflex

- Dysphoric Milk Ejection Reflex (D-MER) is an anomaly of the milk release mechanism in lactating women. A lactating woman who has D-MER experiences a brief dysphoria just prior to the milk ejection reflex.
- These emotions usually fall under three categories, including despondency, anxiety and aggression.
- Physiological, not psychological
- Not a PMAD
- Majority of mothers with D-MER report no other mood disorders
- Can be co-morbid with PMADs

D-MER

Dysphoric Milk Ejection Reflex

- Hollow feelings in the stomach
- Anxiety
- Sadness
- Dread
- Introspectiveness
- Nervousness
- Anxiousness
- Nervousness
- Anxiousness
- Emotional upset
- Angst
- Irritability
- Hopelessness
- Something in the pit of the stomach.

D-MER Treatment

- Awareness, understanding, and education
- Decreases likelihood of early weaning
- Supporting dopamine levels
- Nutrition
- Herbs
- Medication
D-MER Resources

- D-MER.org
- Healing Breastfeeding Grief: How mothers feel and heal when breastfeeding does not go as hoped. (2016 Jacobson, Hilary)
- https://www.facebook.com/DMERORG/?fref=ts

Principles of Lactation

- Feed on cue
- Give only breastmilk and prescribed medications/vitamins until 6 months of age
- Continue breastfeeding until 1 year of age in conjunction with complimentary foods
- Continue breastfeeding after 1 year for as long as mom and baby desire

American Academy of Pediatrics 2016

Principles of Pumping

Separation Cases

- Pumping if mom and baby are separated should begin within 6 hours of giving birth
  - Ideally at birth done as hand expression
  - Maximum colostrum
- Hand expression is better than the pump for the first few days until full milk "comes in"
- Pumping should be done on a similar schedule to feeding
  - But at night take a break!!!!!!!
- Pumping with hand expression should be used
- Hands on Pumping
- Frequent non-pumping expression will maximize production

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**Principles of Pumping Not Separated**

- Pumping should be delayed for 2-3 weeks if mom and baby are together and feeding is going well
- Hand expression and spoon/cup/syringe feeds if medically necessary
- Hands on Pumping any time mom is expressing after the full milk is established
- Jane Morton from Stanford
  - [http://newborns.stanford.edu/Breastfeeding/MaxProduction.html](http://newborns.stanford.edu/Breastfeeding/MaxProduction.html)

**Feeding Baby Expressed Milk**

Try everything to avoid a bottle for the first 2-3 weeks

- Spoon feed
- Cup feed
- Syringe feed
- SNS- supplemental nursing system

**How Do you Balance Mental Health and Lactation**

- Good Support is key!
  - Making sure support knows your lactation goals
- Work with partner, family and friends to allow them to help with feeding
  - Night feeds
  - Take care of other chores so mom can just feed the baby and sleep
- When appropriate let mom sleep
  - If pumping only, skip the middle of the night pumping
  - 1st morning pump yields the most milk
Coping Skills and Mindfulness are Key

- Sore nipples
- Low Milk Supply
- Plugged ducts and mastitis
- DMER
- Fussy at the breast
- Colic and Reflux

Can these all be anxiety related?

What can professionals do to address the potentially conflicting needs of mother and baby?

Not an “either/or” proposition: We can provide support, relief, choices, and address underlying causes of difficult nursing relationships by addressing maternal mental health.

Fundamentals from lactation and mental health

- Familiarity with screening tools
- Understanding psychotropic medication and nursing
- Know where in your community to refer for good lactation support
SCREENING – What Tool?

- Edinburgh Postnatal Depression Scale (EPDS)
  - (Cox, Holden & Sagovsky, 1987)
  - 10 item self-screen
  - Pre & postnatal use
  - Copyright-free
  - Not a diagnostic tool
  - Not to override clinical assessment
  - Available in 23 languages
- Postpartum Depression Screening Scale (PDSS)
  - (Beck & Gable, 2000)
- Patient Health Questionnaire (PHQ-9)

PSYCHOTROPIC MEDICATIONS IN PREGNANCY & LACTATION

Why Many Women Don’t Seek Treatment

- Afraid they will be told to stop breastfeeding
- Most women know that breastfeeding is best for their infant
- Rather “get through it” than give up nursing
- Afraid of impact on neonate
- Stigma
- Are not given:
  - Adequate information about risks/benefits
  - Chance to discuss it with others
  - Authority to make final decision

The BF Friendly Psychotherapist:

- Invites babies to sessions!
- Provides a nursing pillow, blankets, quilt, baby toys
- Asks non-judgmental assessment questions:
  - “How are you feeding your baby?”
- Holds space for and explores each mother’s feeding story
- Facilitates and honors significance of grief around losses related to feeding
- Takes note of inflammatory processes related to feeding and works to mediate them
Ruling Out Other Causes

- PTSD
- Birthing Trauma
- Undisclosed trauma or abuse
- Thyroid or pituitary imbalance
- Anemia
- Side effects of other medicines
- Alcohol or drug use
- Hormone imbalance
- Adrenal Fatigue

The PMAD Friendly Lactation Specialist:

- Notices mothers emotional cues
- Looks for excessive worry or control structures
- Explores moms beliefs about how often, how long etc
- Asks about sleep
- May administer the EPDS and/or provide extras
- Knows about PMADs and offers education, resources and support
- Knows who to refer to in the community (Groups, counseling etc)

The PMAD Feeding Experience: Look for Rigid Thinking Styles

<table>
<thead>
<tr>
<th>Going well</th>
<th>Not going well</th>
</tr>
</thead>
<tbody>
<tr>
<td>I'm a good mother because I can nurse</td>
<td>I'm a terrible mother and a failure</td>
</tr>
<tr>
<td>Breastfeeding is the most important thing</td>
<td>My body doesn't work</td>
</tr>
<tr>
<td>My sleep can wait</td>
<td>Everyone else can but me</td>
</tr>
<tr>
<td>I have to keep this up or something bad will happen</td>
<td>I have to make this up to my baby</td>
</tr>
<tr>
<td>There is one right way to feed my baby</td>
<td>I can't tell anyone</td>
</tr>
<tr>
<td></td>
<td>I can't handle not knowing how much she's getting</td>
</tr>
</tbody>
</table>
Breastfeeding, Anxiety & Perfectionism—"The Good Mother"

Flexible suggestions:
- If this position doesn't work, there are others.
- There's nothing wrong with your nipples or breasts.
- Your body is just right for your baby.
- You're both learning.
- The first 6 weeks are all learning.

Positive reframes:
- Your body needs rest to make milk.
- Your baby is so lucky.
- You're doing your best.
- This isn't easy for anyone.
- It's ok to take a break.
- Look for general signs rather than obsessive recording.

Help Manage Internal and External Pressures

Internal:
- Fear that she is the only one able to care for baby.
- Unrealistic expectations of others helping.
- Inability to rest.

External:
- Support persons not appropriately helping.
- Societal expectations.
- Not enough medical leave.

Everyone's all like "Look at my garden, made-from-scratch cake, and respectful children." I'm over here like "We're breathing."
CULTURAL CONSIDERATIONS

- Beliefs/traditions re: pregnancy, childbirth, postpartum, and nursing
- Concepts of “mental health”
- Concepts of best feeding practices
- Seeking help outside of the family
- Beliefs re: “paths to wellness”
- Variation among individuals
- Degree of acculturation
- Your own cultural biases

(Munoz & Mendelson, 2005)

Concrete Interventions- Wellness planning in therapy and lactation

- Sleep
- Nutrition
- Omega-3
- Walk
- Baby breaks
- Adult time
- Liquids
- Laughter

See www.utahmhc.com

Let’s put the kids to bed early tonight, turn on some music, and sleep like crazy.

somemom.com
Lactation Issue!

Maternal Mood Disorders and Lactation are NOT incompatible

Lactation can help with healing if addressed with sensitivity

“There are several ways to feed a baby but only one YOU.”

Infant Feeding

- Weaning - especially early and abrupt can be related to and increase in sx
- Dramatic decrease in prolactin and oxytocin
- Beware the hormone sensitive brain!
“Babies were born to be breastfed”  
(U.S. Dept. of Health and Human Services 2004)  
OR  
“Babies were born to be loved by a mother who felt supported”  
(letter to the editor, Herald-Sun by William Meyer, Associate clinical professor in Dept. of Psychiatry at Duke University Medical Center)

Infant Feeding in summary:  
- Mothers' tx will be impacted by every interaction with medical professionals  
- The decision to nurse or not must not be made for her.  
- Ignorance about medication and nursing abounds.  
- More women nurse exclusively when their sx are caught early and treated appropriately

We must balance what we know to be optimal nutrition for babies with what we now know to be optimal for the survival of mothers and the well-being of the family:

Sound Maternal Mental Health
Scenarios - What Would You Do?

1: A mom is referred to the lactation clinic because she has “severe” pain with letdown. She says that she BF her first baby without any issues but this time it really hurts when with each letdown during every feeding. Upon assessment you find that the latch is excellent, mom has a good milk supply, baby has no tongue or palate issues, the nipple tissue is normal color and intact. Baby has normal stools and urination pattern, is gaining weight and is content after a feeding. You notice that although mom says her pain is at a 7-8 on the pain scale, she is showing no signs of distress while feeding. During the evaluation you find out that dad just got relocated to another state and is home every other weekend for three days. How do you counsel this patient?

Scenarios - Continued

2: Mom is experiencing severe PPD and PPOCD. She is being treated with medication and counseling. She wants to continue breastfeeding more than anything. She has been told that her symptoms will get better and she will recover more quickly if she quits. What do you tell her?

Scenarios - continued

3: Mom has been feeling unlike herself since her baby was three weeks old and is unable to sleep. She finds that just as she starts to fall asleep she has a panic attack and wakes up. She is afraid to fall asleep for fear that she will miss out on her baby's cries and he will starve to death. What should be done? How do we help her?

4: Mom has been told by her physician that she cannot continue breastfeeding due to her medications. What are the options?
What will YOU do in your scope of practice to support mothers around infant feeding?

Additional Resources

The following slides are for additional information for help and support.

Recommended books for professionals:

- Healing Breastfeeding Grief: How mothers feel and heal when breastfeeding does not go as hoped. (2016 Jacobson, Hilary)
- A Breastfeeding-Friendly Approach to Postpartum Depression (2016 Kathleen Kendall-Tackett)
- Breastfeeding Made Simple (Nancy Mohrbacher)
+ Lactation Resources

- www.kellymom.com
  Information and practical skills
- www.kathleenkendall-tackett.com
  Research and information
- www.unpitysciencechick.com
  Research and resources

+ PMAD resources

- www.utahmhc.com - Utah Maternal Mental Health
  Collaborative. Interagency networking, resource and policy
devolution. See website for many resources, free support
groups, etc.
  3202mom partner and largest perinatal support organization.
  Resources and training for providers and families. Free
  support groups, phone, and email support in every state and
  most countries.
- http://www.mnhcoalition.com - National Coalition for
  Maternal Mental Health- Social Media Awareness Campaign,
  ACOG, private & non-profit.

+ PSI Support for Families

- PSI Support Coordinator Network
  www.postpartum.net/Get-Help.aspx
  Every state and more than 40 countries
  Specialized Support: military, dads, legal,
  psychosis
  PSI Facebook Group

- Toll-free Helpline 800-944-4PPD support to
  women and families in English & Spanish

- Free Telephone Chat with an Expert
PSI Chat with an Expert

- Every Wednesday for Moms
- First Mondays for Dads
- New Chats in development
- Spanish-speaking
- Lesbian Moms

PSI Membership

- [www.postpartum.net/Join-Us/Become-a-Member.aspx](http://www.postpartum.net/Join-Us/Become-a-Member.aspx)
- Discounts on trainings and products
- Professional and Volunteer training and connection
- PSI Chapter development
- Members-only section of website
- List your practice or group, find others
- Conference Presentations
- Worldwide networking
- Professional Membership Listservs
  - PSI Care Providers International Repro Psych Group
- Special student membership discount
- Serve on PSI Committees

PSI Public Awareness Posters

- "You are not alone"
- [http://postpartum.net/Resources/PSI-Awareness-Poster.aspx](http://postpartum.net/Resources/PSI-Awareness-Poster.aspx)
PSI Educational Brochures
English & Spanish
www.postpartum.net/Resources/PSI-Brochure.aspx

PSI Educational DVDs

Healthy Mom, Happy Family
13 minute DVD
Information, Real Stories, Hope
1-800-944-4773
www.postpartum.net/Resources

Support for Fathers

- Chat with an Expert for Dads: First Mondays
- Dads Website www.postpartumdads.org
- Fathers Respond DVD 8 minutes

Contact psioffice@postpartum.net to purchase DVD
+ Provider Resources

- www.postpartum.net - Postpartum Support International, national partner and largest perinatal support organization. Resources and training for providers and families. Free support groups, phone, and email support in every state and most countries.
- www.womensmentalhealth.org MGH Center for Women’s Mental Health: Reproductive Psychiatry Resource and Information Center. Harvard Medical School.
- www.motherisk.org Medication safety and resources.