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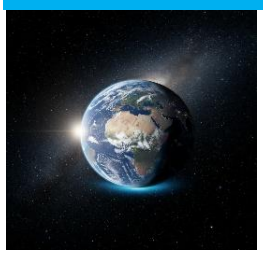

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Breastfeeding and postpartum depression mechanisms and care

Michalina Janiszewska

https://orcid.org/0009-0002-1621-8293

michalinalazik@gmail.com

Provincial Specialist Hospital Mikolaj Pirogow, Lodz, Poland

Maciej Sobkowiak

https://orcid.org/0009-0006-1976-5531

maciejsobkowiak1996@live.com

Poznan University of Medical Sciences, Poznan, Poland

Paulina Sobkowiak
https://orcid.org/0000-0003-1702-4239
paurat97@gmail.com
Karol Jonscher Clinical Hospital, Poznan, Poland

Justyna Jusiak
https://orcid.org/0009-0006-6992-9303
justynajusiak98@gmail.com
Hospital The Monument of the Baptism of Poland, Gniezno, Poland

Janusz Łuczak
https://orcid.org/0009-0004-5557-7074
janusz.luczak21@gmail.com
Polish Mother's Memorial Hospital-Research Institute, Lodz, Poland

Justyna Dżumaga
https://orcid.org/0009-0004-5833-4377
justynadzumaga@gmail.com
Pomeranian Medical University in Szczecin, Poland

Jeremi Łuczak
https://orcid.org/0009-0004-6141-7771
jeremi.luczak@gmail.com
Karol Jonscher Clinical Hospital, Poznan, Poland

Maria Łazik
https://orcid.org/0009-0005-6584-3177
marysia.lazik5@gmail.com
Wroclaw Medical University named after the Piasts of Silesia Wrocław, Poland

Roksana Dybowska
https://orcid.org/0009-0000-4432-294X
dybowskaroksana@gmail.com
Karol Jonscher Clinical Hospital, Poznan

Marta Walaszek
https://orcid.org/0009-0003-4252-5841
marta.walaszek18@gmail.com
Medical University in Lodz, Poland

Corresponding Author
Michalina Janiszewska, michalinalazik@gmail.com

Abstract

Objective: To synthesize evidence on the association between breastfeeding and postpartum depression, emphasizing bidirectionality, proposed mechanisms, key modifiers (self-efficacy, stress and social support), and integrated intervention strategies.

Methods: Narrative review of the peer-reviewed literature provided by the author, prioritizing meta-analyses, systematic reviews, randomized trials, and large observational or qualitative studies.

Results: Across settings, postpartum depressive symptoms are associated with reduced breastfeeding initiation, exclusivity, and duration. Early cessation and negative breastfeeding experiences are also associated with higher depressive symptom burden in some populations. Self-efficacy and social support consistently correlate with both mood and feeding outcomes, and stress appears to amplify risk. Interventions spanning pregnancy through the postpartum period and combining lactation support with psychosocial care show the most consistent promise.

Conclusions: Because breastfeeding and postpartum depression influence one another and share modifiable determinants, clinical pathways should integrate screening, individualized feeding support, and stepped mental health care.

Keywords:
Breastfeeding, postpartum depression

Background

Breastfeeding is a foundational early-life exposure with implications for nutrition, immune development, and longer-term health. Beyond macronutrients, human milk contains bioactive factors that shape infant immune maturation and microbial colonization, which may contribute to reduced risk of infections and other outcomes later in life.[9,26]

Postpartum depression is common and clinically consequential. It can affect motivation, decision-making, perceived competence, and the ability to persist with demanding health behaviors during the early postpartum period. In addition, postpartum depression frequently co-occurs with anxiety and sleep disturbance, and can influence mother–infant bonding, with downstream effects on family wellbeing and health care use.[5,8,10,24]

Meta-analytic and systematic evidence supports an association between breastfeeding and postpartum depression, but heterogeneity across studies suggests the effect is context- and timing-sensitive and may be bidirectional. Two practical interpretations follow: (I) depressive symptoms may reduce breastfeeding initiation, exclusivity, or duration; and (II) breastfeeding experiences—particularly pain, insufficient support, or early cessation—may affect depressive symptom trajectories in vulnerable women.[1,2,12,14,15]

Methods

This narrative review is based on the studies and guidelines provided by the author. Evidence was prioritized as follows: (a) systematic reviews and meta-analyses; (b) randomized controlled trials; (c) large observational studies; and (d) qualitative research. Key outcomes included exclusive breastfeeding, breastfeeding duration/cessation, breastfeeding self-efficacy, perceived social support, stress, and postpartum depression or anxiety. Where available, studies

addressing special populations (prematurity, infant hospitalization, pandemic conditions) were used to illustrate context sensitivity.

Bidirectional evidence

Meta-analyses report a significant association between breastfeeding and postpartum depression, with variation by setting and methods. Across pooled samples, breastfeeding is generally associated with lower odds of postpartum depressive symptoms, although the magnitude differs by measurement tool, time window, and study design.[21]

A systematic review and meta-analysis indicates that antepartum and postpartum depressive symptoms are associated with reduced exclusive breastfeeding, supporting the possibility that mood symptoms may precede and shape feeding outcomes.[12]

Additional observational studies suggest that breastfeeding practices may also influence postpartum mood. For example, early cessation, recurrent breastfeeding problems, and stressful feeding experiences have been linked with higher depressive symptom burden. These findings align with a feedback model in which distress can impair breastfeeding persistence, and breastfeeding difficulties can intensify distress.[1,6,19,28,30,31]

Community data identify overlapping risk factors for postpartum depression and breastfeeding disruption—such as psychosocial stressors and limited support—suggesting shared vulnerabilities that can confound causal interpretation if not carefully addressed.[8,14,21]

Routine screening during pediatric well-child visits can identify postpartum depression risk and underscores the feasibility of embedding maternal mental health assessment into infant care pathways. In these settings, breastfeeding status can act as a visible marker of potential distress or reduced support.[32]

Mechanisms

Mechanistic explanations span biological, psychophysiological, and psychosocial pathways. Lactation involves neuroendocrine processes that may influence stress regulation and affiliative behaviors, potentially supporting emotional wellbeing in some women. However, the same period is characterized by fragmented sleep, physical recovery from birth, and heightened daily demands, which can offset any protective effects.[1,2,5,6,11]

Stress physiology provides one biologically plausible bridge between feeding mode and mood. Evidence indicates that feeding mode is associated with patterns of HPA-axis regulation that relate to postpartum depression and anxiety symptoms. These findings support the idea that breastfeeding may interact with stress reactivity, but they do not establish that breastfeeding itself is causal; rather, physiological differences may reflect underlying stress exposure, sleep, or support.[20]

From a psychosocial perspective, perceived success or failure with breastfeeding can influence self-worth, perceived competence, and stress. Qualitative accounts describe feelings of guilt, shame, or inadequacy when breastfeeding goals are not met, while supportive counseling and realistic goal-setting can reduce distress.[3,16]

Nutritional factors have also been discussed in postpartum depression prevention and management. Reviews propose possible roles for micronutrients and dietary supplements; however, evidence quality varies, and clinical decisions should be individualized and integrated with broader mental health treatment plans.[1,15]

Modifiers

Breastfeeding self-efficacy is one of the most consistent correlates across studies. A systematic review and meta-analysis reports that postpartum depression is associated with lower breastfeeding self-efficacy, suggesting that confidence may be both a determinant and an outcome of feeding experiences.[3]

Cross-sectional studies similarly show inverse relationships between depression scores and breastfeeding self-efficacy, and positive relationships between self-efficacy, breastfeeding attitudes, and perceived social support. These findings are clinically important because self-efficacy can be strengthened through practical coaching, early troubleshooting, and supportive feedback.[4,18,23,27]

Social support and stress repeatedly emerge as modifiers. Evidence suggests that higher stress and lower social support strengthen the association between early exclusive breastfeeding cessation and postpartum depressive symptoms. This implies that breastfeeding support without attention to context may be insufficient in higher-risk families.[8,30]

Context-sensitive risk is evident in special populations. Mothers of premature or hospitalized infants may experience limited feeding opportunities, separation, and heightened anxiety; pandemic-related restrictions may further reduce support. These contexts can shape both breastfeeding experience and mood symptoms and should inform tailoring of interventions.[17,21,28]

Table 1. Evidence summary and actionable implications

Domain	Key findings (high-level)	Representative references
Association	Breastfeeding and postpartum depression are associated; effects vary by context and timing.	1, 2, 12, 14, 15
Self-efficacy	Lower self-efficacy correlates with higher depressive symptoms and less favorable feeding outcomes.	3, 4, 18, 23, 27
Stress/support	Higher stress and lower support strengthen the cessation–depression relationship.	8, 21, 30
Interventions	Perinatal, individualized programs integrating lactation and psychosocial support show dual benefits.	7, 22, 29, 25
Clinical care	Screening plus stepped care; individualized medication decisions during breastfeeding.	5, 10, 13

Interventions and management

Systematic evidence supports integrated approaches that address breastfeeding challenges and maternal mental health together. Interventions are more likely to improve both breastfeeding outcomes and maternal mental health when they span pregnancy through postpartum, provide individualized support, and are delivered by trained staff or multidisciplinary teams.[22,25]

Randomized trials evaluating midwife-led group breastfeeding support and structured psychoeducational programs suggest potential reductions in postpartum depressive symptoms alongside improved breastfeeding outcomes. Such programs may work by increasing self-efficacy, normalizing challenges, and strengthening social connection.[7,29]

Clinical management guidance emphasizes routine screening, stepped-care approaches, and shared decision-making regarding psychotherapy and pharmacotherapy during pregnancy and postpartum, including considerations relevant to breastfeeding. Importantly, effective treatment of postpartum depression can be compatible with breastfeeding when medication choices, dosing, and monitoring are individualized.[5,10]

Consensus recommendations for pharmacological management in breastfeeding women stress individualized risk–benefit assessment and infant monitoring. These recommendations can help clinicians support maternal treatment goals while reducing unnecessary discontinuation of breastfeeding driven by uncertainty.[13]

Practice implications for interdisciplinary health care include: (I) pairing lactation support with mental health screening at early postpartum contacts; (II) using brief self-efficacy–building strategies (goal-setting, coaching, troubleshooting); (III) actively mobilizing partner and family support; and (IV) embedding screening and referral pathways into pediatric well-child care to reduce access barriers.[3,6,32]

Discussion

Current evidence supports a bidirectional, context-sensitive association between breastfeeding and postpartum depression. Self-efficacy, social support, and stress are modifiable determinants with direct clinical relevance. However, several limitations constrain inference. Many studies are cross-sectional, use different definitions of exclusive breastfeeding, and rely on screening tools rather than diagnostic interviews. Confounding by socioeconomic status, prior mental health history, and support environments can bias estimates. Future research should prioritize longitudinal designs that capture symptom trajectories and feeding experiences over time, identify subgroups most likely to benefit from targeted support, and evaluate pragmatic integrated models in routine care.[1,2,8,12,22]

From an exercise and health science perspective, postpartum depression and breastfeeding trajectories may influence engagement in physical activity and other recovery behaviors. Low mood, fatigue, and disrupted sleep can reduce readiness for gradual return to activity, while successful, supported feeding routines may reduce stress and improve perceived control. Integrating brief lifestyle counseling (sleep hygiene, gentle activity planning, and stress-management strategies) into lactation and mental health contacts may therefore yield synergistic benefits. These components should be framed in a nonjudgmental way and adapted to medical recovery and individual preference, ensuring that breastfeeding goals do not override mental health safety.[5,6,10,31]

Summary

Breastfeeding is promoted worldwide because it supports infant development and maternal health. At the same time, mood disorders after childbirth are common and can disrupt daily functioning, sleep, and the early parent–infant relationship. Over the last decade, research has increasingly treated breastfeeding and postpartum depression as interconnected outcomes rather than separate clinical problems.

Here we show that the association between breastfeeding and postpartum depression is best described as bidirectional and context dependent. Depressive symptoms during pregnancy and the postpartum period are associated with lower likelihood of exclusive breastfeeding and shorter breastfeeding duration. Conversely, early cessation and distressing feeding experiences are linked with higher depressive symptom burden in some women, particularly when stress is high and support is limited. Evidence also points to consistent psychological correlates, especially breastfeeding self-efficacy and perceived social support, which may both shape and reflect mood and feeding trajectories.

Taken together, these findings argue for integrated postpartum care. Routine mental health screening should be paired with early, practical feeding support and strategies that strengthen confidence and social support. Such approaches may reduce avoidable breastfeeding discontinuation, improve maternal wellbeing, and support healthier outcomes for infants and families.

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Author Contribution Statement

Conceptualization: Michalina Janiszewska, Paulina Sobkowiak

Methodology: Paulina Sobkowiak, Maciej Sobkowiak

Software: Maciej Sobkowiak

Check: Justyna Jusiak

Formal analysis: Janusz Łuczak

Investigation: Justyna Dżumaga, Paulina Sobkowiak, Michalina Janiszewska

Resources: Michalina Janiszewska, Jeremi Łuczak

Data curation: Maria Łazik, Maciej Sobkowiak

Writing - rough preparation: Janusz Łuczak, Michalina Janiszewska

Writing - review and editing: Paulina Sobkowiak, Justyna Jusiak

Visualization: Roksana Dybowska, Paulina Sobkowiak

Supervision: Marta Walaszek, Janusz Łuczak

Project administration: Michalina Janiszewska

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