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Editorial

Research in the field of perinatal depression continues to evolve and is sufficient for us to make sound clinical decisions. The most recent research challenges our assumptions and shows that the scope of this problem is much broader than we have previously believed. It also shows that depression and posttraumatic stress disorder (PTSD) in pregnancy increase the risk of preterm birth—the number one cause of infant mortality worldwide. Current studies show that birth interventions, such as epidurals, are related to both breastfeeding difficulties and depression. Moreover, depression is a direct threat to breastfeeding. Depressed mothers are significantly less likely to initiate or continue breastfeeding. Therefore, perinatal depression falls squarely within the purview of breastfeeding supporters. It is our problem. Fortunately, when breastfeeding is going well, it actually lowers mothers' risk of depression. This is true even when mothers have histories of significant psychological trauma. Taking action to protect mothers' mental health is crucial to support breastfeeding and, in so doing, give more babies the best possible start in life.

Why “10% to 15% of New Mothers” Is a Misleading Statistic

When discussing perinatal depression, experts often say it affects “10% to 15% of new mothers.” That percentage dramatically underestimates the true incidence. Recent studies have revealed that 10% to 15% describes mostly White middle-class mothers who have entered the mental health system. As such, 10% to 15% is a statistic of privilege and does not reflect true incidence. Unfortunately, most depressed mothers will never see a mental health provider. Yet, their needs are every bit as urgent—if not more so.

What Is the True Incidence?

A study of 1,507 mothers from Australia found that 31% of mothers were depressed in the first 4 years. Risk factors included young maternal age, stressful life events, adversity, intimate partner violence (IPV), and low income (Woolhouse, Gartland, Mensah, & Brown, 2015). In the United Kingdom, a nationally representative sample of more than 86,000 mothers and fathers found that 39% of mothers and 21% of fathers have been depressed in their first 12 years as a parent. Risk of depression is highest in the first year (Davé, Petersen, Sherr, & Nazareth, 2010).

Women in high-risk groups are especially vulnerable and have very high rates of depression. For example, a review of eight Canadian studies found that up to 42% of immigrant, asylum-seeking women were depressed (Collins, Zimmerman, & Howard, 2011). A review of 67 studies found that violence against women during pregnancy increased the risk of depression and PTSD in the postpartum period by 3 times (Howard, Oram, Galley, Trevillion, & Feder, 2013). Similarly, mothers had higher rates of depression if they had been exposed to natural disasters in two different studies from China and the United States (Qu et al., 2012; Xiong et al., 2010).

Depression, Posttraumatic Stress Disorder, and the Number One Cause of Infant Mortality

One of the more alarming recent findings was the relationship between depression, PTSD, and preterm birth. The World Health Organization considers preterm birth to be the number one cause of infant mortality worldwide.

For example, a study of 16,334 women at U.S. Veteran's Administration Hospitals found that the rate of preterm birth was 7.4% for women with no PTSD, 8% if they had previous PTSD, and 9.2% in women with current PTSD (Shaw et al., 2014). Another U.S. study of 2,654 women found that the combination of PTSD and major depression increased the risk of preterm birth by 4 times (Yonkers et al., 2014). Unfortunately, those two conditions often co-occur. It is therefore surprising that we are not routinely screening for both depression and PTSD during pregnancy when it has such an impact on preterm birth and, in turn, infant mortality.

Depression, Breastfeeding Difficulties, and Birth Interventions

Birth interventions can also increase the risk of both depression and breastfeeding difficulties. For example, a study of 5,332 mothers in the United Kingdom found that mothers who had forceps deliveries or unplanned cesareans had more breastfeeding difficulties and depression at 3 months postpartum (Rowlands & Redshaw, 2012). Similarly, a study of 1,280 mothers from Hong Kong found that induction, opioid pain medications, and emergency cesareans were related to

lower rates of both “any” and “exclusive” breastfeeding (Bai, Wu, & Tarrant, 2013).

Epidurals have been particularly controversial. Current evidence suggests that women are less likely to exclusively breastfeed if they had epidurals. A prospective study of 1,280 mothers from Australia found that women who had epidurals were more likely to be partial breastfeeding or have breastfeeding difficulties in the first week postpartum and were twice as likely to stop breastfeeding before 24 weeks (Torvaldsen, Roberts, Simpson, Thompson, & Ellwood, 2006).

In our study of 6,410 new mothers in the first year postpartum, we found that women who had unassisted vaginal deliveries had significantly higher rates of exclusive breastfeeding than women who had any other type of birth. Women who had epidurals had significantly lower rates of exclusive breastfeeding and had higher depressive symptoms, even after controlling for possible confounding variables, including all other birth interventions, history of both depression and sexual assault, and parity (Kendall-Tackett, Cong, & Hale, 2015).

Depression Threatens Breastfeeding, But Breastfeeding Protects Maternal Mood

Not surprisingly, depression, anxiety, and PTSD directly threaten breastfeeding (Mathews, Leerkes, Lovelady, & Labban, 2014). For example, anxiety at 3 months postpartum reduced odds of exclusive breastfeeding by 11% at 6 months (Adedinsawo, Fleming, Steiner, Meaney, & Girard, 2014). A study of 2,400 births in the United States found that a complex pregnancy was associated with 30% lower odds of exclusive breastfeeding. However, supportive hospital practices increased odds of any or exclusive breastfeeding by 2–4 times (Kozhimannil, Jou, Attanasio, Joarnt, & McGovern, 2014).

Fortunately, exclusive breastfeeding lowers the risk of depression. It improves sleep quality and quantity and downregulates the inflammatory response system (Groer & Kendall-Tackett, 2011; Kendall-Tackett, Cong, & Hale, 2011). Even when women have been sexually assaulted, exclusive breastfeeding attenuates the stress response, lessens the impact of trauma, and lowers their risk of depression (Kendall-Tackett, Cong, & Hale, 2013).

Conclusion

These are only a few of the recent findings. As you can see, the field continues to grow and expand. As we learn more, we can continue to improve the services

we provide to new mothers. But first, we need to think differently about depression, realizing how common it is, and help mothers access services they need. Depression in new mothers affects everyone and is within the scope of practice for lactation specialists. Fortunately, there is much we can do.

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