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By Sandra Neill, MD, MPH, Director of NYU Langone's Center for Gender and Health



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## Beyond the Baby Blues

*Q&A with Dr. Shari Lusskin, Director of NYU Langone's Reproductive Psychiatry Program*

*In her career at NYU Langone Medical Center, Shari Lusskin, MD ('86), has followed in the family tradition and broken new ground. Her father, Ralph Lusskin, MD, is a clinical professor of orthopaedic surgery, and her grandmother Lillian Lusskin, MD, one of the few female orthopaedic surgeons of her day, was an intern at Bellevue Hospital in 1919. Dr. Lusskin, clinical associate professor of psychiatry and obstetrics and gynecology, founded NYU Langone's Reproductive Psychiatry Program in 2003. Last year, the program received an anonymous gift of \$500,000 to expand its clinical and academic program. News & Views spoke with Dr. Lusskin recently about her emerging field.*



Sandra Neill

### Reproductive psychiatry is a relatively new specialty. Why does it deserve to be one?

The field encompasses psychiatric disorders related to a woman's reproductive life cycle. That includes premenstrual mood changes, anything related to pregnancy or postpartum, and psychiatric disorders during the menopausal transition. Managing psychiatric disorders related to pregnancy and postpartum is particularly complex, because whatever happens to the woman will also be experienced, to some extent, by her baby. So if she's pregnant and has to take a medication, the baby will be exposed to the medication. Same thing if she's breast-feeding.

### What drew you to women's mental health?

During medical school in the early 1980s, one of my first patients was a pregnant woman with schizophrenia who was admitted to Bellevue Hospital. We really didn't know what to do with her. Years later at a conference, I met a group of doctors from the University of British Columbia who focused exclusively on women's mental health. I had always been interested in treating psychiatric disorders in patients who also have other medical conditions, but I never knew this subspecialty existed. So this was my lightbulb moment.

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### **How many pregnant women are affected by mood disorders?**

About 14% of pregnant and postpartum women will meet criteria for depression. Pregnancy offers no protection against depression. It also turns out that a woman is more likely to develop depression for the first time postpartum than at other times in her life. What we see is that women are more vulnerable to a mood disorder during times of significant hormonal change.

### **How well do we understand those mechanisms?**

Not very well. We know that hormones such as estrogen and progesterone are neurosteroids—they actually have effects in the brain, on mood and cognition. We don't yet have the equivalent of a "throat culture" for the brain. But the good news is: We're getting closer. We're moving toward rational pharmacotherapy, where we'll eventually be able to check your genotype and tailor treatments to increase their effectiveness and minimize side effects.

### **Doctors used to advise women who planned to become pregnant to step down or discontinue their antidepressants. Is that beginning to change?**

It is changing. Part of our mission is to educate physicians so that they make more informed treatment decisions and recommendations. Not everything is safe. On the other hand, sitting in a hospital severely depressed is not good for the patient or her baby. We know that women with depression can relapse during pregnancy, especially if they reduce or go off their medication. Until the day comes when we can predict with accuracy who can go off their medication safely, we want to be very careful about recommending that patients go off of their medications.

### **How can you distinguish the "baby blues" from clinical postpartum depression?**

The baby blues is a condition that affects between 50 and 90% of women who deliver. It's characterized by mild mood changes—women will be happy one moment, sad the next. They'll experience anxiety and insomnia. But there are no suicidal or obsessional thoughts, and these women generally respond to support and reassurance, improving within a couple of weeks. Clinical postpartum depression means much more pronounced mood changes: sadness that lasts for a week, poor appetite, poor sleep, difficulty bonding with the baby, suicidal thoughts. It's a more severe illness.

### **Many people associate postpartum depression with highly publicized cases, like those of Brooke Shields, the actress and model, and Andrea Yates, who drowned her five children. Did their notoriety help the cause or hinder it?**

Brooke Shields did have postpartum depression, and she actually did a lot to destigmatize the illness. Having someone like her write a book on this topic was a good thing. Andrea Yates is the exception to the rule. She had a true postpartum psychosis. Women with postpartum depression can have obsessive thoughts about hurting the baby, but they are unlikely to act on these kinds of thoughts. Postpartum psychosis occurs in only 1 out of 1,000 pregnancies. Andrea Yates was also chronically mentally ill. Her situation could have been avoided—she was undertreated. Her notoriety made a lot of women scared, more scared than they already were, to admit that they had postpartum depression, because they were afraid that they were either going to become Andrea Yates or be treated like her. Nevertheless, her tragic situation turned a national spotlight on postpartum mental illness, making it easier for people like Brooke Shields to go public.

### **What should a woman with a history of mood disorders do before becoming pregnant?**

She should have a *prepregnancy* consultation with a reproductive psychiatrist to discuss her individual risk factors for relapse during pregnancy and postpartum. If she's on medication, it's best to determine prior to pregnancy what the risks, benefits, and alternatives are, rather than waiting until she's pregnant. A prepregnancy consultation can help you map out a treatment strategy to minimize risk, both during and after pregnancy.

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**With its popular notion of the glowing mom-to-be, our society often portrays pregnancy as a blissful time. How does this expectation affect women who are emotionally vulnerable?**

There's nothing worse for a woman than to see everyone around her excited while she feels a complete lack of connection to the baby growing inside her. In the extreme cases, when someone's psychotic, you might even hear a woman say that she feels like an alien is inside her. If your husband or partner is thrilled that you're pregnant, and your family's thrilled, the contrast is devastating. Women like this suffer tremendously.

**What's your message to a pregnant woman's partner, family, and friends?**

That untreated illness carries its own risks. That if a patient wants to take medication, there's a good likelihood that she really needs it. That it's safer for her to be treated than not to be treated. That depression in male partners, independent of postpartum depression, also has a negative effect on the infant's development. So it's not just all about the mother. It's really about the family. Partners also need to know that they're in a position to be a real advocate for the health and well-being of the mother. They may be the only person who goes out, finds the information, and gets the patient in for treatment.

*For more information about the Reproductive Psychiatry Program, call 212-263-7419.*