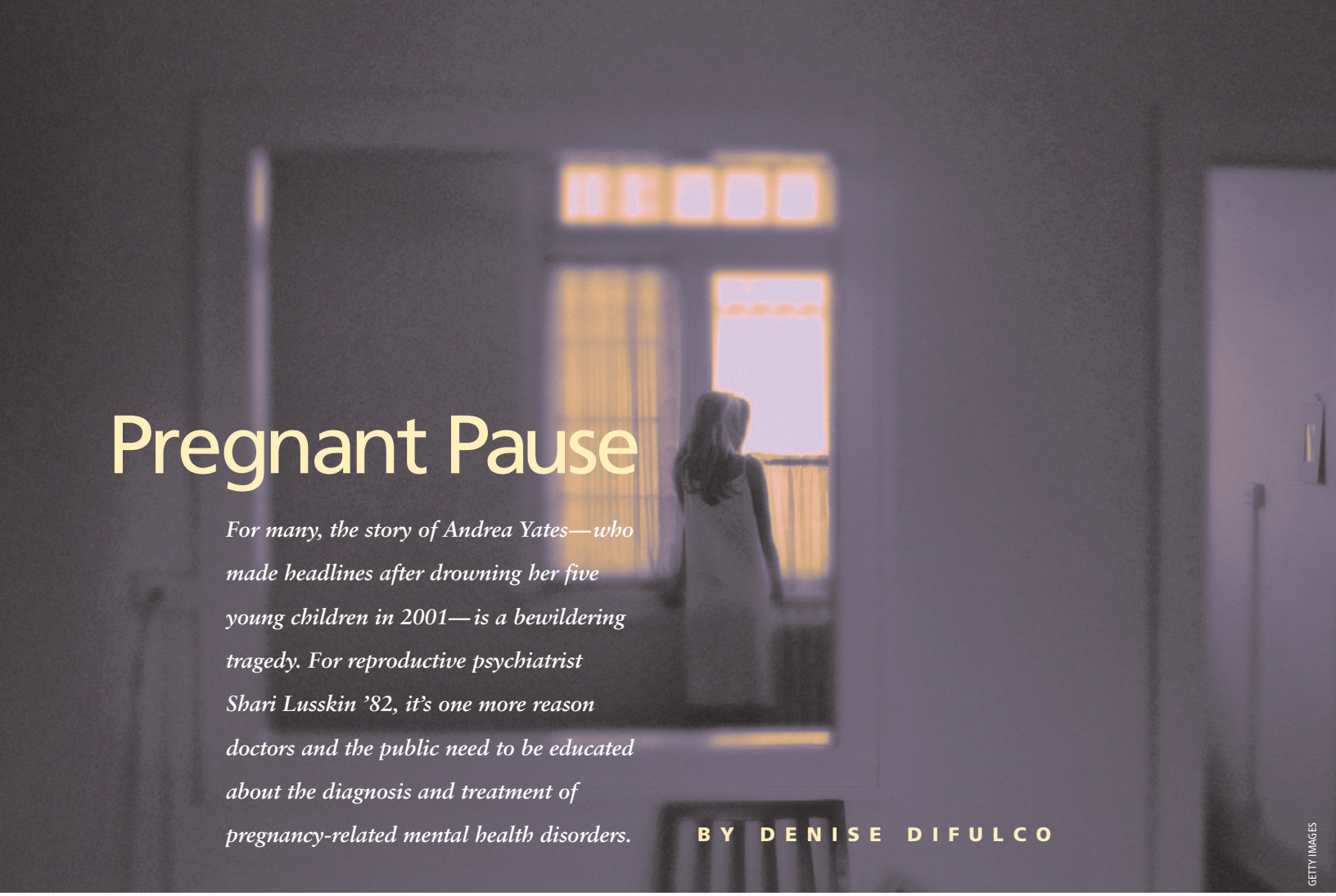

Pregnant Pause

For many, the story of Andrea Yates—who made headlines after drowning her five young children in 2001—is a bewildering tragedy. For reproductive psychiatrist Shari Lusskin '82, it's one more reason doctors and the public need to be educated about the diagnosis and treatment of pregnancy-related mental health disorders.

BY DENISE DIFULCO

GETTY IMAGES

Shari Lusskin '82 was a third-year medical student working in the psychiatry unit at Bellevue Hospital in New York when a young woman with long, unkempt hair and a faraway look in her eyes was admitted. It was clear the woman was expecting a baby. But when doctors asked her about her pregnancy, she gave a different explanation for the size of her stomach: There were snakes in her belly.

The attending physicians, whom Lusskin was observing, diagnosed the woman as schizophrenic and chronically psychotic, and they hospitalized her for the last three months of her pregnancy. No further treatment was offered.

"We didn't give her any medicine because we were afraid of harming the baby," recalls Lusskin. "I look back on that case now, and I hope people know that they can treat these women rather than letting them suffer like that."

That early encounter with pregnancy-related psychosis was formative for Lusskin, who today is one of only a few dozen doctors across the country specializing exclusively in reproductive psychiatry. The specialty treats women from the time they are adolescents experiencing their first period, and possibly suffering from premenstrual syndrome or the more severe and disabling premenstrual dysphoric disorder, to the onset of menopause, when they might have mood changes that require professional counseling or medication. The most vulnerable patients, however, tend to be at the peak of their reproductive lives—pregnant women and new mothers who face the possibility of severe depression or psychosis.

"Our society has an expectation that everything should be fine during pregnancy," Lusskin says. "That your mood will be good, that you'll feel good throughout the whole thing and that anybody who doesn't must be a bad mother."

But in fact, the hormonal shifts women experience both before and after giving birth have a greater impact on a woman's mental state than

JON ROEMER

Shari Lusskin '82 is one of only a few dozen doctors across the country specializing exclusively in reproductive psychiatry.

most people realize. More than 50 percent of women experience postpartum mood changes known as "baby blues," which can last from a few days to two weeks. Ten to 25 percent of new mothers develop postpartum depression—a longer-term, more disabling condition characterized by crying spells, irritability, sadness and fatigue—though researchers suspect that number might be even higher, since many cases are unreported.

Postpartum psychosis is far more serious but far more rare. About one out of every 1,000 new moms develops the condition, in which they can experience delusions and hallucinations, along with severe insomnia, anxiety and delirium.

Doctors are uncertain of the causes of postpartum depression and psychosis, but the women at greatest risk have a personal or family history of depression or stopped taking medication for mood disorders when they became pregnant, Lusskin says. The condition can be aggravated by psychosocial factors, including an unsupportive partner, ambivalence about the pregnancy or any stressful life event.

Few of Lusskin's patients seek psychiatric help on their own. Most often, they are ashamed of their illness—aware of its stigma—and aren't treated until someone close to them intervenes, Lusskin says. Research has shown that fewer than 20 percent of women diagnosed with postpartum depression eight weeks after giving birth had previously told any health care professional about their symptoms. In addition, only 12 percent of obstetricians in the United States inquire about a woman's mental health during pregnancy.

In the most extreme scenario, an untreated woman with postpartum depression or psychosis could attempt to hurt herself or her child. Andrea Yates, the Texas mother who drowned her five young children and made international news headlines in 2001, was convinced she was being tormented by Satan and told investigators that she drowned her children so they could be safe with God.

Mental illness also can have more subtle, long-term effects. Research shows that depression during pregnancy negatively affects both fetuses and newborns, with the impact lasting into childhood. During pregnancy, depression has been associated with low birth weight and premature labor, as well as a mother's cigarette, alcohol or drug abuse; postpartum, it can prevent a woman from bonding with her baby. Other studies link mothers' untreated mental illness to their children's behavioral disturbances, as well as negative changes in IQ.

Reproductive psychiatry has come a long way since Lusskin's Bellevue days. Back then, she says, "We were completely unappreciative of the effects of persistent psychosis on the developing baby and the impairment of maternal-fetal bonding that goes with that."

Today, a woman like the one Lusskin encountered at Bellevue would receive medication and then counseling as she improved.

"It's unadvisable to leave somebody who is medication-responsive without that treatment and safety net," Lusskin says. "Our job is to find the safest medication they can take during pregnancy."

Prescribing drugs for pregnant women is perhaps the most controversial aspect of Lusskin's job, as many obstetricians argue that no drug is entirely safe during pregnancy. But she and her colleagues say—and new research supports the idea—that a woman's untreated mental illness is a

greater threat to the child's development than *in utero* exposure to drugs.

While there are no double-blind, placebo-controlled, long-term studies of the effects of medications—simply because it would be unethical to not treat some of the depressed mothers or expose the fetus to the effects of untreated illness—researchers have followed the development of children exposed to antidepressants both in the womb and while nursing. One report, published in the *New England Journal of Medicine* in 1997, followed children up to age 6 and found no difference in IQ, language development and other developmental milestones between children exposed to antidepressants and those whose mothers were not on medication.

For many of Lusskin's patients, medication is a necessity, but positive results aren't guaranteed. Marcy Levine, a New York City resident who has struggled with depression and bipolar disorder since her teens, says she feared spiraling out of control during her pregnancy if she stopped taking medication. She decided to forego her usual regimen of Depakote, a drug that had been linked to autism and spina bifida, in favor of older, better-researched medications.

Still, Levine became severely depressed during her pregnancy. She recovered postpartum, when she restarted the Depakote.

"What I chose to take was the best-case scenario," says Levine, whose son Benjamin is now 3. "It was the safest we could do under the circumstances."

On a dreary November afternoon Lusskin is spouting acronyms rapid-fire as she lectures a group of second-year residents at Bellevue Hospital Center about which antidepressants are safe to use during pregnancy. As an assistant professor at New York University School of Medicine, which runs the academic program at Bellevue, Lusskin is educating the next generation of practitioners in both psychiatry and obstetrics and gynecology in the treatment of mental illness related to the reproductive cycle.

At NYU Lusskin has been a force behind many recent developments in the field. She convinced the School of Medicine to establish a discipline in reproductive psychiatry—one of only a few in the country—and was named its first director. Shaila Misri, a clinical professor of psychiatry at University of British Columbia in Vancouver, says the program's creation is a milestone. "Starting anything new is fraught with many roadblocks," Misri says. "Shari has been persistent and committed to achieving this."

Lusskin also founded the NYU Medical Center Annual Symposium on Women's Reproductive Mental Health. The symposium is unique in that it's geared toward educating the public, though medical professionals often attend. In its third year in 2003, the conference drew more than 200 doctors, nurses and lay people from as far away as Israel, Belgium and Guyana.

"The public drives physicians to learn more," Lusskin says. "The idea is to have a grass-roots movement in women's mental health, as opposed to a top-down, medically driven specialty."

Lusskin hopes that through public education, more women and doctors will become aware of these conditions and realize that there are safe and effective ways to treat them.

"The good news," she says, "is more and more people are getting interested in [reproductive psychiatry]. It's the kind of specialty that I hope one day will not be a specialty." ■

__Denise DiFulco__ is a free-lance writer based in Cranford, N.J.

ONLINE RESOURCES

New York University School of Medicine
A search of "Shari Lusskin" on the faculty bibliography page returns articles on reproductive psychiatry. Lusskin also maintains a page with links to the 2003 Symposium on Women's Reproductive Mental Health.
library.med.nyu.edu/FacBib and www.med.nyu.edu/people/lussks01.html

The Massachusetts General Hospital Center for Women's Mental Health
The latest information and studies on how certain medications affect fetal and infant health.
www.womensmentalhealth.org

Online PPD Support Group
Forums, research and tips on postpartum depression.
www.ppdsupportpage.com

Depression After Delivery Inc.
A national nonprofit offering support to women suffering from prenatal and postpartum depression.
www.depressionafterdelivery.com

Pregnancy and Depression
Research and articles include the latest medical findings about specific antidepressants and their safety.
www.pregnancyanddepression.com