

HERology transcript—Post Partum Depression and Psychosis

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Postpartum Mental Health Spotlight

Joanne Stone: Welcome to HERology, the podcast from the Mount Sinai Health System dedicated to advancing women's health through the lens of cutting-edge science and compassionate care. I'm your host for today, Dr. Joanne Stone, and our show is brought to you by the Carolyn Rowan Center for Women's Health and Wellness.

Today, we're shining a light on a critical topic that has been receiving a lot of attention from the news media recently, but one that oftentimes is not discussed, the emotional and psychological changes after childbirth. Having a baby is typically portrayed as one of the happiest periods in a woman's life.

For many women, however, the postpartum period can also bring significant emotional and mental health challenges. In this episode of Herology, we're joined by an internationally renowned expert in maternal mental health, Dr. Veerle Bergink, who is the director of Mount Sinai's Women's Mental Health Center.

Along with my co-host, Dr. Anna Barbieri, we explore the spectrum of [00:01:00] postpartum mental health, including postpartum depression and postpartum psychosis.

The Postpartum Care Gap

Joanne Stone: So Veerle, there was a recent article in The New York Times, and it was all about how there's this drop-off of caring for women after childbirth. So during pregnancy, they're just the main focus.

You're seeing them, the doctor or the midwife is seeing them every four weeks, every two weeks, weekly. And then after they deliver, it's like at six weeks they're just done. You know, nobody is taking care of them or looking after them. So given, like, the high rate of mental health and suicide and things like that, what are we doing wrong?

How can we change this, and what should we be focusing on?

Veerle Bergink: Yes, absolutely. Uh, childbirth is a major life event for both parents. It's an emotional, uh, rollercoaster after that, the first weeks, and, um, especially for women who already have mental health disorders, that's very challenging. Um, they sometimes have an increase in depression or anxiety.

But also, uh, mothers are at risk [00:02:00] for having new onset of mental health disorders, and that is easily missed, uh, if women are not seen by, yeah, as you say, basically anyone. So yeah, we need to think of another system and providing better care for parents, especially the mothers, in those, uh, f- first weeks especially, but also after that, right?

In the first months after delivery.

Joanne Stone: Right, and I think, Anna, this is one of the pathways that we have in the Rowan Center that you helped develop, the My Path Moms, where we're not ignoring this, right? We're trying to fill that gap.

Anna Barbieri: Sure. You know, Veerle, just like you said, this is such a profound change in a woman's life.

Actually, in any- new parenthood is a profound change for anybody. But when you mix new parenthood with this profound physiologic, hormonal, psychologic, family systems change, it's, it's really, uh, literally overnight your life changes, right? And women experience this on so many levels, [00:03:00] and that level of change cannot be just handled in a very quick 15-minute, you know, six-week postpartum visit.

So we really try to look at it differently and acknowledge just how massive of a change this is by developing some programs here that address the psychological, the physical, the hormonal, the nutritional change and needs, um, for a woman who recently experienced childbirth.

Hormones Expectations and Early Warning Signs

Joanne Stone: And we know that, as you mentioned, hormonal changes, we know that the estrogen changes, progesterone, all these things, sleep deprivation, all this occurs so immediately after delivery.

So how do we... You know, what are, what are patients at risk for given all these hormonal changes?

Veerle Bergink: I think especially the first few weeks, women are at risk for severe mental illness, and that is rare, but if it happens, then it's severe, and, uh, people should know. Because, as you say, that's the, the free fall in hormones, the immune system [00:04:00] change, and some women get, like, acute mania or psychosis or very severe depression.

Again, it's rare, but, um, it, it occurs specifically in this period of huge physiological changes, and we should detect it if women say, "Oh, I'm really not well. I'm feeling weird." I, uh... If, if they're very depressed, if they lose reality, that should be really reasons to, to check on these, uh, mothers, um, uh, with regards to depression, anxiety.

Yeah, that happens really in, uh, some women already had it during pregnancy, but it happens not specifically in this, uh, uh, very few weeks, but also in the weeks and months after delivery with, yeah, as we discussed, all the major changes. You pointed that out, Anna. In addition to the huge expectations- Sure

people have of mothers. Sure. So it's, it's really the combination of having this, uh, being exhausted, having all these changes, uh, feeling [00:05:00] emotional, and yet at the same time, you're, uh, supposed to be all of a sudden, some people say, "I, I feel like, you know, I have to be the perfect mother" And, and, and people expect you to be, to be, uh, well and, and even to be, uh, over the moon.

Joanne Stone: And it, and- I think your point about the severe depression or s- you know, we'll get into psychosis a little bit later, um, is totally true. And you're right, everybody expects you to be, like, the perfect, doting, loving mother, and yet so many people, what, up to 30%, might experience some degree, even- Yeah ... even the baby blues, right?

Baby Blues vs Depression

Joanne Stone: How do, how do baby blues differ from postpartum depression or, or psychosis or, and how common is that, too?

Veerle Bergink: I think the baby blues, most women have that, honestly. And yeah, you both know because you see all these women. But yeah, um, it's- Baby blues- It's

Joanne Stone: really- ... baby

blacks,

Veerle Bergink: I don't know what

Joanne Stone: I had Or

Veerle Bergink: baby purple, you know.

Yeah, let's say, yeah. But, uh, yeah, this, this emo- yeah, [00:06:00] the emotion, the tears coming really loose and, and then, yeah, the, the fluctuation. That's really the, the first week, and, uh, uh, that, that's very normal, and, uh, that's why it's important if, um, if, if we all think or people think about mental health problems, to see mothers more than once.

Because, yeah, this first week is a period of, uh, emotions, of mood can be low, can be high, and can be all over the place, honestly.

Anna Barbieri: And I think, you know, you make a good point because I think two things can be true. One, I think there is this sort of cultural expectation how motherhood should be celebrated, and it's this fabulous experience, and now, you know, you've met, like, you met your goal, and everything is great from now on.

And I will tell you both, you know, I'm a, I'm a mother.

Veerle Bergink: Yeah.

Anna Barbieri: Um, I also used to deliver babies. I don't anymore. Have seen lots of women go through it. [00:07:00] I had no appreciation just how difficult the s- first few weeks would be, as an obstetrician. And I knew about, you know, falling off of that hormonal cliff, and by the way, as somebody who does hormonal medicine, that is really a hormonal cliff.

You go from your peak estrogen, progesterone levels, all the way down. But the sleep deprivation, your own self expectations of yourself, the cultural expectations of how much we should be able to accomplish. You know, I, I had this dream of, like, furnishing my, you know, bedroom and painting the wall, and breastfeeding, and doing this or that.

It's really a lot to handle. So I think, you know, one, I, I think on one hand we should be able to normalize a little bit of- Anxiety, frustration, disappointment that it's not all, you know, pink clouds and unicorns in those first few weeks. But on the other hand, [00:08:00] we also need to admit that we have a long ways to go in terms of making postpartum care better for women, and really learning how we can discern what's normal and what's kind of the normal misadventures of those first few weeks, versus something that's much more serious that, that needs to be addressed right then.

Joanne Stone: Yeah, but I was just thinking about two things that you said. So one, the huge hormonal shifts. It's almost like a preview to menopause, right? 'Cause the estrogen drops. All of a sudden, you have night sweats, you can't sleep. It's a little bit of a preview- For sure. Yes ... into what menopause is. And then the other thing is, you know, when we talk about breastfeeding, we know how important breastfeeding is, and big advocates for breastfeeding.

It's not for everybody, but I find when I see patients So much of their anxiety is around breastfeeding. For some women- it's easy, and for others, they really struggle, and they feel that.

Veerle Bergink: It

is so stressful for some women. I mean, if it works beautifully, perfect. You know? Some- for [00:09:00] some women, it comes easily.

They enjoy it. They, they feel better. But there's so many women also struggling with breastfeeding, like feeding all the time, 24/7, every few hours, or it being painful, or, you know, they really needed sleep.

So I think there should be more of a balance as well. Like, people should know, of course, you know, it, it's beneficial, especially, by the way, that really first period is best for the immune system, um, uh, of the child.

But, uh, you know, after a few weeks or months or if it's, it's really hard and there is so much pressure to, you know, to keep breastfeeding, or, um, yeah, to keep breastfeeding in full, and there is such judgment for, for, uh, women who, uh, who can't do it, I, I think we should really get rid of it. Yeah. Like, because that makes a huge difference.

I, I see... Again, I see also among the moms with mental health problems, for [00:10:00] some mothers, you know, being anxious, depressed, they tell me like, "Yeah, this is one of the few things that, you know, that I actually like."

So, great. But there are also mothers, uh, who honestly, uh, feel better after they, um, uh, they change from breast to bottle.

It may be physiological, hormonal, but it's also the huge responsibility that you're the only one responsible for the growth of the child, which is carefully monitored- as well, and then the whole wellbeing of the child, that's how women describe it, is on their shoulders, which is a lot, a lot, because everyone is looking at them and- For sure

and when then they stop breastfeeding, sometimes they feel like, yeah, that, that's huge. Also nice for the fathers that they can step in.

Anna Barbieri: You know- Yeah ... many women also have internalized this pressure to be a perfect mother. Yeah. And recently, breastfeeding is sort of associated with being a perfect mother, or if [00:11:00] you're not breastfeeding your baby, you're doing something wrong.

And the reality is, and I would say this from, you know, even my personal experience- Yeah ... and even how we practice, like We all strive to be good parents, and you have to be a good enough mother. Yeah. Oh, it's so happy that you

Veerle Bergink: say it.

Anna Barbieri: Yeah. And sometimes, and sometimes that means that you have to make decisions that may not coincide with what this influencer says, or even with the fact, we, we're not disputing the fact that breastfeeding is really beneficial for the baby.

It is really the perfect food. But if it comes at too much of a cost, psychological, uh, physical, um, it's, it sometimes makes sense to be okay with not breastfeeding. And I think that's what we're saying. Not, not supporting breastfeeding, but really being intentional about how

Veerle Bergink: we look at it. No, because it's, it, the saying, like, happy mother, happy baby is true.

So you should really take care of your self first, of your sleep, of your rest, and that will benefit the [00:12:00] baby as well.

Joanne Stone: I think that's so important, and there's, again, there's so much about, you know, breast is best and all this, and it puts this undue pressure. And

like you said, the fact that you feel the growth of your baby or child is solely respons- you're solely responsible for that is way too much pressure.

And I think not being judgemental and understanding the person and where they are, and like you said, you know, they have to be happy too. So for some women, if you can take that away, that's a source of such stress and anxiety Let them feel it's okay to not necessarily breastfeed- Yeah ... and make them feel-

Anna Barbieri: And it's very-

better ... individual. Some women find it easier to breastfeed, some find it more- Yeah ... difficult. Some babies are harder than others to nurse. Some people have more supply, some people have less supply. So we're all for just really personalizing care and medicine for everyone. Veerle, I have... I'm really curious about [00:13:00] something.

From a hormonal standpoint, if I can go back to that- Yeah, yeah ... because you know I love, I love gynec- You love hormones ... I love hormones. So we know that hormones and mental health, or mental wellbeing, are completely intertwined, right? Hormones, and here I'm talking really about estrogen and progesterone, but of course- Mm

there are other hormones, play a role in the brain. They probably regulate a lot of neurotransmitters. We know of many conditions, you know, uh, premenstrual dysphoric disorder or, or depression before one's period, postpartum mental health issues that we're going to get into. Perimenopausal depression and anxiety are very much related to hormones.

So are there signs, you think, that one could look at in her own life, before pregnancy even, that could be considered kind of, like, warning flags? So if I had depression before periods, like, am I more likely to, um, you know, [00:14:00] encounter certain mental health issues postpartum?

Veerle Bergink: There is some association, yes. If you're, if you're super sensitive for contraceptives or, uh, really having either PMS or even PMDD, yeah, you're a bit more vulnerable for postpartum depression.

But you, it doesn't have to be... Women do not have to be too worried about it, because, yeah, there is an assoc- association, but not, uh, not complete. It's not a guarantee. So there is- Yeah ... we think of it, but there is really a Nobel Prize to be won there, because it hasn't been investigated enough. We do think that there is a subgroup of women with, yeah, endocrine sensitivity to their mood.

W- women who are ex- especially vulnerable for, as you say- fluctuations. Yeah It's not the hormone levels themselves- But the change in itself ... it's really the, the change- Yeah ... that can happen after childbirth, that can happen, um, during the cycle, and of course perimenopause as well. It's

Anna Barbieri: quite

Veerle Bergink: a rollercoaster, yes.

But, but at the same time, it's so unpredictable. So many women with mental health problems, you know, [00:15:00] never had that, and the other way around. I, I think we should figure that out because it might have implications for treatment at the end of the day as well, because now we treat everyone- Yeah ... regardless of whether they had a, a, you know, those

Anna Barbieri: pre- So you're saying-

problems before ... difficult to predict, so Postpartum mental health issues, difficult to predict.

Some association maybe with previous history or previous hormonally related issues, but really everyone should be aware.

Veerle Bergink: Yeah. Well- Right ... I think if you have any, if you had any mental health disorder, then we know that you're at high risk.

So the- Yeah ... the single biggest risk factor to having, uh, mental health disorders after delivery is if you had it before. So that's super simple. That blows away all other risk factors. And other risk factors are, um, also the same as at other times in life. Of course, it's not helpful if you have major stresses in your life or no support system or, um, have, um, a [00:16:00] financial distress, and, and all these things are risk factors as well.

And yeah, and you don't know what kind of delivery you will have- or as you say, what kind of baby, if the baby ends up in the NICU. Of course that is... these are all risk factors as well for mental health, uh, problems. But yeah, we know that especially women who are, who are already vulnerable, um, yeah, are most vulnerable to have it again.

And then in addition, there is a very small group who all out of the blue have severe mental health pr- problems, no no one saw, saw this coming.

Joanne Stone: Yeah.

It, it would be so great if we had better predictors, but like you said, a history, personal history of depression- Yeah ... in the past, if you've had a child and had postpartum depression, or as we talked a little about before, psychosis- Right

really increases that risk later on.

Postpartum Psychosis Risks and Treatment

Joanne Stone: So in the case, you know, we, we've been talking a bit about- Depression and blues, but psychosis is that severe form, [00:17:00] and it, of course, it's been in the news lately- Yeah ... with a recent story out there from, um, from Boston. How do we know who is at much high risk? I mean, my understanding is that if you have a history of bipolar disorder- Yes

let's say-

Veerle Bergink: Bipolar

Joanne Stone: disorder ... bipolar- Yeah ... or if you've had psychosis, of course-

Veerle Bergink: Yeah,

Joanne Stone: before ... before, that's a bit big predictor. But is there any other way that we can say this person is at much high risk for psychosis? And you mentioned a little bit about some of the signs, hallucinations, suicidal ideations, thoughts of harming oneself or, or the child.

How do we get those out there so that people are educated to know what to look for in these patients? Yeah, what the

Veerle Bergink: symptoms are.

Anna Barbieri: And also, is there a difference, you know, when we, especially with, like you mentioned, the recent news, so many people just lump postpartum depression, postpartum psychosis together, and it just rolls off the tongue.

But can you tell us how you distinguish, and does one need to experience postpartum depression always before psychosis, or do you look at them as two [00:18:00] independent

Veerle Bergink: sort of conditions? They're really two very different disorders, as in depression, I think most people know what that is. I mean, it's so common at all times, and especially- Yeah

among women. Low mood, not being able to enjoy, uh, yourself, um, feelings of guilt in this period. It's really often towards, you know, not being a good mother, as we discussed. So people know what the depression is, and it, the onset is already where women depressed during pregnancy or is really the first weeks, months, and it, it gradually gets worse over time.

So postpartum psychosis, uh, can have a way more acute onset. It's earlier in the postpartum period. It's often the first weeks, and, uh, we define it as within 12 weeks, and, uh, the symptoms are more severe. And there are severe mood symptoms, can be depression, but then it's depression with psychotic features, meaning that you're so severely depressed that you lose [00:19:00] reality, think everything is your fault, and really your baby is, uh, the d- the devil, or your baby is better off without you, or thoughts that are not correct.

Or it's mania. The majority of women have mania, which can be, uh, euphoric mania. "I feel great. My do- my doctor is great," you know, "I tr- gonna throw a baby shower for 200 people," like one week after delivery, "and I'm cleaning the house nonstop." That kind of mania, but we often also see mania, which is someone thinking fast and have grandiose idea, but at the same time being super irritable, like angry.

So the mood not being euphoric, but we call it dysphoric, which main- mainly means- Angry, irritable, um, uh, uh, very short-tempered. And those are the most- Yeah ... prominent symptoms. Uh, and then there are psychotic symptoms, as in losing reality, and, uh, [00:20:00] women have a mixture of these. Now, this sounds, might sound a bit complicated, but in, in practice it's often not, because people know if someone is really not themselves, or totally off, or weird.

So I think that is really enough for everyone to know, if you think like, "Okay, this is really strange," uh, you know, this person is off. And especially if the mom describes this herself, "I feel completely numb. I, you know, I don't have any control anymore," and that is over a couple of days, and everyone thinks, like, "This is really weird," then it's, then it's not okay.

Joanne Stone: And it's so important to be able to distinguish between depression and this euphoria, dysphoria- Yeah ... psychosis, because the treatments are so different, right? Yeah. If you treat somebody for psychosis who has, you know, with antidepressants, that can have a

Veerle Bergink: negative effect on them. Yeah. No, that, that, that can have an adverse effect.

And, and we saw this, uh, in the news, but w- uh, [00:21:00] yeah, I've also seen many patients who, who had that. So no, a- as you say, the, the treatment for postpartum psychosis is lithium or electroconvulsion therapy, and, uh, often combined with antipsychotics, which, which work, um, uh, rapid against psychosis and mania. And lithium is, uh, is really the mainstay.

98% of, uh, patients get completely better, so it's a very treatable, uh, condition. But, uh, yeah, the right medication should be started, and, uh, these are not, as you say, antidepressants or, uh, sleep medication.

Joanne Stone: And somebody with a history of postpartum psychosis, do you start them prophylactically, preventively on lithium?

Veerle Bergink: Yes. We, we do this here at Sinai, uh, immediately after delivery, women at high risk. But unfortunately, it's not done enough, which I think is a missed opportunity, because for women at high risk, we have honestly nine months to see [00:22:00] this coming. Sure. For women with bipolar disorder, women who had postpartum psychosis before, they should be informed that if they start medication after delivery, and we know most about lithium, um, uh, but antipsychotics might work as well, we're gonna investigate that, then yeah, then it can be prevented.

And that's, that's important.

Anna Barbieri: And Veerle, so do most... 'Cause you take care of patients- Mm ... with postpartum psychosis. How do they make their way to you? Do they call themselves because they realize something is so wrong that they need help? But then if somebody's really losing touch with reality, they may not even know that.

Or is it their family members that bring them in? And also, how do you think... You know, because we've all had, you know, either these thoughts ourselves, or we've taken care of patients with these, or, or know women with this. You know, it's not unusual for somebody- No ... to say, "I think I'm a terrible

mother," you know, [00:23:00] "I think, you know, maybe this baby would be better off without me."

That doesn't mean I'm suicidal- No, no ... if I have insight into that and I know it's- Right ... kind of this thought. So the women with psychosis- Right ... that you see, do they come in on their own because they know something is wrong? Are they mostly brought in by their families? How, how do you see that?

Veerle Bergink: And- It's about 50/50.

Anna Barbieri: Okay.

Veerle Bergink: So half women really realize, "I'm severely mentally ill, I'm not well." Those are mostly the women with major depressive symptoms as well, depression with psychotic features. Um, but yeah, many women with psychotic features feel like, "Yeah, you know, I can't trust my husband. I'm not even sure if he's- Yeah the father of all my children, and I can't trust anyone, and the rest of the world is, you know, off." Right. "Not me." Right. Or women will feel great, it's like, "Yeah, I mean, uh, you were slow, you were slow, nothing wrong with me." Yeah. Uh, and so half of the women come involuntary, um, [00:24:00] via acute services or so, and, um, are seen by doctors on psychiatric wards.

So I get, uh, calls from either doctors, uh, who see these patients, or, uh, from patients after they had an episode. Um, and then they have, of course, many questions, as in- For sure ... you know, w- will I get, um, how long do I continue this medication? And then I tell them, "Yeah, one year." And- Yeah ... how do I know if I will ever have this again?

And then I tell them that about half of the women- Only have this after childbirth, so that is good news. So it's super severe disorder, but it's very good news that it's very treatable, and that half of women only have this after childbirth. And, um, uh- And the other half? So yeah. And so, and the other half- Mm-hmm

uh, interestingly, uh, women, uh, have mood disorders moving onwards. Even if they were psychotic, very psychotic during the acute phase, they, [00:25:00] they do not have to be worried of getting a psychotic disorder or schizophrenia. So if anything, some women, unfortunately, um, uh, yeah, get bipolar disorder- Mm-hmm ... and then they look back and they say, "Yeah, i- if I look back- There were

Anna Barbieri: signs

Veerle Bergink: there that, that, th- this first episode after childbirth was the start of bipolar disorder." And, uh, for these, uh, women, we advise often to stay on medication or, you know... And women only figure that out when they, after one year, start tapering the medication. And so, yeah, in our research we really would like to, yeah, to figure out- Yeah

whi- which wo- which woman goes on which track.

Joanne Stone: I feel like as an obstetrician who does deliveries- We should be much more informing our patients about signs to look for. And, and not only our patients really, but perhaps their partners who are in the [00:26:00] household, or parents who might be with them helping to care for the children.

'Cause I feel like we don't educate our patients enough about signs to look for. Yes, we do have some screening tools. We do depression screening during pregnancy and postpartum, but we can miss it, right?

Veerle Bergink: Yeah. You know?

Inform Without Fear

Veerle Bergink: I totally agree, but on the other hand, I know that you, you do this in a mindful way, not anxiety-provoking.

But it can also be like, oh, okay, that's another thing I have to worry about in addition to, you know, my delivery being complicated or, uh, you know, all complications I could get, or my child being not healthy. So, so that is the, the trade-off, because it's one out of thousand. So yes, I fully agree, we should inform women like, "Oh, by the way, you know, it's a bit of a sensitive period for severe mental health disorder."

On the other hand, yeah, we got a lot of, uh, or an increase now if it's in the media, uh, pregnant women already being- Right ... [00:27:00] very anxious, many of them, about what to come, and then this could increase anxiety in a way.

Joanne Stone: It's always that balance though, right? Yeah, yeah. Like, so we ha- we, we tend to be able to balance between informing our patients about what to look for, but also saying, "The good news is by knowing this- Yeah

you can prevent it, or you can- Yeah ... this is treatable." Right. So we- Very treatable ... we can, we can- Yeah, yeah ... we can sort of frame it- No, yeah ... in, in, in

Anna Barbieri: the right way. And I think- Yeah ... you know, especially in the practice of obstetrics, and we do this with actually other topics in pregnancy, right? We try to educate patients about what's normal, but also about the things that you must call about it

Veerle Bergink: right away.

Anna Barbieri: Yeah, okay. Right? Like-

Veerle Bergink: Yeah,

Spotting Mental Health Emergencies

Anna Barbieri: okay ... you have bright red vaginal bleeding or hemorrhaging, or you feel the baby has stopped moving, these are emergencies. They're not likely to happen, but just so you know, the, these things cannot wait. To me, this is kind of knowing that difference between what's normal, let's call it baby blues, what's [00:28:00] postpartum depression, and what's an emergency psychological condition like psychosis, that's kind of in that same realm.

This is why- Yeah ... you know, we learn baby CPR, we have, uh, allergy shots at home, like EpiPens just in case somebody needs it. Knowledge about when to- Like how to spot a major health emergency, to me that's in the same realm. Absolutely. That doesn't mean people need to be scared- I, I fully

Veerle Bergink: agree ... but like- And as you say- Yeah

yeah, people g- get this list of other things- Right ... already, and that should be there as well. Yeah. And, and honestly, not only severe, right? Right. People should also know, yeah, because what we hear a lot, and I'm sure you as well, like, "Why did not no one tell me this?" Well, because half the time I didn't know.

Because people feel like we... I, I have that as well. You feel tricked in it a bit. Like, okay, so that's why we're doing this, so that, you know, at least we try to tell. Yeah. Right? So I think that's hugely helpful as well. In addition to, as you

say, yeah, in the list of, yeah, don't be too- Yeah ... worried about [00:29:00] it, but you should know that the, those severe things can happen.

Also prepare women, like, yeah, in a way almost like don't have your expectations- Right ... set too much. But that, that helps, that, that helps a lot. Yeah. If you, uh, and again, if you then are anxious and depressed, it's not, you should not endlessly say, "Yeah, this is normal. I told you so." Exactly. Then it would be miserable.

Exactly. So at some point we should also say, "Well, you know, if you are, you know, so low in mood for weeks, or your anxiety continues to be high," um, we should start treating it. Right. Because, you know, not only postpartum psychosis is very treatable, but postpartum depression is also- And I

Anna Barbieri: think here you're getting-

very treatable ... at a really important point too, because we're not saying, "Oh, let's educate women and their families," because it's on them to identify it in the home and start the course of care. We also need to be better with the way care is delivered on the system level, and [00:30:00] whether that is through education of providers or making that access easier, and making it known to women and their families that we have some really good tools about how to treat- Yeah

a variety of these conditions.

Joanne Stone: Treat, treat and, and, and prevent.

Trauma After Stillbirth

Joanne Stone: I mean, this is, comes up a lot, you know, in this Rainbow clinic, where we take care of patients who've had a history of stillbirth. I mean, these are patients- Mm-hmm ... right, who if they've had a stillbirth are at a way higher risk for depression.

Sure. But what we don't... You know, stillbirth occurs in 1 in 175 pregnancies, way higher than what we're talking about in terms of severe psychosis. Mm-hmm. But it's that fine balance between h- how do you bring up the possibility of stillbirth in a pregnant woman who, like you said- Yeah ... is already anxious- Yeah

about the health of their baby, this and that. Yeah. But yet framing it in a way, like, yes, this can happen, but pay attention to fetal movement, or these are the signs to look out for- Yeah ... and call immediately if you have, you know, bleeding or this issue, you're not feeling your typical movement. But we do see these patients, um, [00:31:00] with a history of stillbirth at much higher risk for depression.

I think you, you see these patients all the time, right?

Veerle Bergink: Yes. We, we, we see, uh, women, yeah. Because they had a traumatic experience, but also the expectations that someone should be happy- Are even higher in this group because they lost a, a child before- Yeah ... so they, they, they feel it even more, and then can, then it can be so confusing also.

Because at the same time, you know, the, the, of course relief that they're, that this child lives is still mixed with the mourning- The grief ... of, or the, the- Yeah ... the grief is, yeah. Uh, yes. The grief of, um-

Joanne Stone: Of what

Veerle Bergink: they lost- That, so I'm so happy- ... and what they should have, right ... yeah, I'm so happy- What they should have had

that there is a, a special attention for these parents. Yeah. And, um-

Joanne Stone: I mean, I, I remember I had a patient who, um, had a prior loss and, and then had a beautiful delivery, full-term, and it was her six-week visit, [00:32:00] typical giving the postpartum depression screen, and she screened it positive. And she was just so ha- like she seemed so happy, and then like in digging down, it was like, what, you know, you screened positive.

What's going on? What, like, why, you know, what are you thinking? And so she's like, "I, I'm just constantly worried that the baby's g- not going to- Yeah ... survive, and I'm in the room every five seconds, you know, seeing if the baby's breathing." Something so unexpected to me, but exactly what you've said, right?

It's like mixed emotion about being h- happy, yet being, you know, bringing up all the trauma of what happened before.

Veerle Bergink: Yeah, and it's constant monitoring- Yeah ... as you mentioned. We see this a lot in, you know, uh, of course, women who are a bit traumatized.

But, uh, I see it in general more and more anyway during the last decades with all technologies.

And yeah, of course, it can be reassuring, but there are big downsides in 24/7 monitoring your baby in terms of constant alertness, an- anxiety, and never [00:33:00] being, uh, off. Whereas, yeah, what we recommend for-

Anna Barbieri: Are you saying I should not look at my grown children's location

Veerle Bergink: on my phone? No, not, not monitor them either.

Not track them. I'm a big fan of, you know, leaving kids a bit independent. Yeah. And that, that really starts with babies- ... because it's, it's good for mothers if they, of course, if they breastfeed, they spend a lot of time with the children. But one of the, uh, first, uh, advices also for depression and anxiety is also to take breaks for the, for the mother, right?

Very simple things. As I said before, so many things work, including going outside every day, either with the baby, but also sometimes being without the baby, doing something with friends without the baby, and letting that go. Don't feel constant- Yeah ... responsible. Um, so all these things work better if you do not feel the need of constantly-

Anna Barbieri: I do think

Veerle Bergink: that-

controlling and checking ... yeah. That helps for obsessive [00:34:00] symptoms. It helps for anxiety and depression.

Anna Barbieri: I would say that hypervigilance and the constant checking, and also the illusion, frankly, that we are in control of the outcome.

Veerle Bergink: Yeah.

Anna Barbieri: Ho- what is this baby going to turn out like? What sort of mother am I going to be?

Some of it, we have to kind of let go of the expectation that we can control outcomes in everything

Joanne Stone: in

Anna Barbieri: life,

Joanne Stone: right? Yeah. It's so hard to do that, though, you know? Because- It's so

Anna Barbieri: hard to

Joanne Stone: do ... so hard to do, 'cause you feel like everything that you do, I, am I gon- am I screwing up this child, is not only, like, in the immediate newborn period, but it can la- last their whole lives, I guess.

Forever. Forever. Um, but yeah, like, they don't come with a, they don't come with a book of instructions and, and knowing and understanding, you know, what does this cry mean? And, and that, to me, also is such a source of anxiety. Sure. Like, I, I don't know what to do and, and do I, you know, burp the baby? Do I have to change the diaper?

Are they hungry? Are

Anna Barbieri: they this, that? And feeling that if I make [00:35:00] the wrong call, it's going to have this tremendous consequences.

Isolation Control and Support

Anna Barbieri: And Veerle, I'm curious- Yeah ... actually, your take on this. So do you think now there is a much different cultural expectation on new parenthood? And also, like, what, how much of a role do you think our societal and cultural change about the care setup for a new baby is?

You know, we used to live in these big families. There were other people around. Lots of women are actually alone at home. Maybe they have a partner, but maybe the partner works. Maybe they live far away from family and friends. Maybe they don't have, uh, financial resources to support help or daycare and all of that.

So it can be a- actually an isolating experience of recovery from a major, again, physiologic, physical, hormonal, [00:36:00] psychological change.

Veerle Bergink: Yeah, I think those are, are major factors, and changing these helps a lot as well because m- many women feel alone, are actually alone the majority of the time, and it really, yeah, it takes a village to raise a child.

And, uh, yeah, people live far away, so we see both, either parents or parents-in-law, you know, not being there, or if they come there, they are 24/7 for weeks, which is usually stressful- That's stressful, too ... as well. So yeah, that, that makes a difference. And I think, yeah, uh, things that help are, uh, ar- arranging this kind of support for yourself, um, in terms of family and friends and, uh...

Yeah, but sometimes it's not there. And, uh, and yeah, the same thing I said before, like, or we discussed before, the step as in, yeah, just do not try to be You know, too controlling on, or on top of it. But sometimes that eas- that's more easily said than done, right? So yeah, women who are very anxious or too [00:37:00] depressed, at some point they say, "Yeah."

I, I mean, and they, they really try hard. And I think that is a moment when we should also switch, switch to other treatments, such as short psychotherapy or medications, antidepressants that work really well in that period.

Joanne Stone: And I think it's a... Well, two things. One, it's important for people not to feel like a failure if they need this medication, right?

Right. It's nothing that they're doing. It's not that they're not a good parent. In fact, they're doing the responsible thing by getting the treatment and taking the medication. So I think that's- Right ... super important. I mean, on a positive note, what I've seen is a lot more of the partners taking, um, paternal or, you know, parental leave.

So I think that's really been a positive step- Yeah ... in terms of our culture. I mean, in other societies, women can be out for a year and, and they're completely financially supported for a year after. But now we see a lot more of the partners taking leave. Is that, do you see that that's helping at all? And-

Veerle Bergink: Yeah, [00:38:00] that's helping a lot, and I think for, for everyone, right?

Because partners also want to be involved. They do. I mean, they don't like the, the model either, so it's not a good model- Right ... for, for both parents. And, uh, yeah, I think we should work towards a system in when some- someone checks at home. We know from other countries, some Scandinavian countries who have that, and that's huge.

It doesn't always have to be a doctor, but it, it really helps if someone visit the mom at home, checking on her health. And yeah, until we're there, it's of, of course good if we-

Anna Barbieri: Yeah ...

Veerle Bergink: yeah, if we have hospital-based- No way ... uh, care. Yeah.

Anna Barbieri: I think, you know, there's so many things we could do differently on like a very individual level.

And this is not medical at all. Right. Like, this is a shout-out to my mother-in-law, who when I had my baby, and she lives about 10, 15 minutes from us, she said, "You ever need to drop this baby off for an hour or two or three, you just drop this baby off, no questions asked." And she also made [00:39:00] meatballs once a week, so I didn't have to cook.

Yeah. That's- Availability of that type of relief from your responsibility, especially if you're exhausted, sleep-deprived. I'll just talk about sleep too. Sleep-deprived, upset, questioning, like how, I, I can't do this anymore because I'm so just physically tired and can't take it, was massive. I- to me, that's a better gift than any onesie or stroller or anything like that.

Two, I do think we need to, like this, this change of culture, partners getting more involved, people becoming more aw- aware, is wonderful, but we also need to change the system. We do need to change the system of how we, how much we know about this. You know, maybe the promise of artificial intelligence is that we're gonna find biomarkers or some sort of a marker that we can predict the risk better, intervene sooner.

How do we change post- the [00:40:00] postpartum journey? We're trying to do that at our center, right? Yeah. To really, and, like, offer better care, more comprehensive, more integrative, more holistic care. And then how do we change the system? Do you think six weeks of maternity leave? I mean, six weeks is nothing. It's just you don't know this is a major identity shift, again, physical, emotional, hormonal, physiologic, and identity.

Six weeks is not enough. Like, I, I would love to see better maternity leave policies and a, a systemic change. I, I, I think most people,

Joanne Stone: what I'm seeing now- Yeah ... it used to be the six week. I'm seeing now most of our, at least our employees, our faculty, our staff, are taking four months off. You know, they combine- Yeah

the maternity leave with FMLA, which is really beneficial for them in terms of getting better, recuperating, things like that. But I'm not even sure if four months is enough time, and I, and I agree with you. Closing the gap and paying attention, having somebody visit, doesn't have to be the physician. It can be even a postpartum doula, right?

Totally. Or [00:41:00] somebody checking in on, on the patient, seeing how they are At six weeks, at 12 weeks, four months- Yeah, that's huge ... eight months-

Veerle Bergink: And as you said, for some- Up to a year ... women, four months is not enough. Other women, yeah, greatly benefit from- Yeah ... especially if they can slowly build it up. They, they go to their work to take some rest, honestly.

So s- for some women, it also works, as in, uh, going back to work. But, uh, yeah, six weeks, everyone agrees that that is ridiculous, right?

Joanne Stone: T- totally. Totally.

Treatments Research and Resources

Joanne Stone: I'm ... I, I don't mean to switch gears, but I do wanna touch on your research that you're doing, because you're really, you know, internationally so well-known in this field of postpartum depression.

Tell me, us a little bit about the research that you're doing here at Mount Sinai.

Veerle Bergink: We're doing research on medication use during pregnancy to help, uh, mothers making the decision, uh, whether they should continue meds during pregnancy or not. Uh, we're doing research on severe mental illness to better be able to predict which mothers, uh, get a relapse [00:42:00] after delivery or not.

And one of the research studies we do is the treatment of, uh, severe postpartum depression. As I said, it's a very- Not

Joanne Stone: psychosis?

Veerle Bergink: Not psychosis. Severe depression. Okay. We do not do, uh, postpartum psychosis, uh, treatment research here, uh, also because we know that, um, yeah, women get better uh, with the current treatments.

Uh, but we do, uh, postpartum depression research with, um, transcranial magnetic stimulation, so very intense week of treatment. You get stimulated, brain gets stimulated, uh, the whole day, and the idea is that, um, uh, it's, it's a rapid treatment for severe depression. So people who have, uh, severe postpartum depression, uh, can, uh, en- enroll in this research.

Anna Barbieri: That is fascinating, especially since treatment of postpartum depression has changed, you know, so much, even in the last 10 or 15 years- Yeah ... and we have new tools. [00:43:00]

Veerle Bergink: Yeah, we do have- That's fantastic. Yeah ... new t- tool. There is also, uh, a medications, uh, specifically for postpartum depression. Uh, but we do need more research there as well- Yeah

because we do not know if this new medication is- Actually better or faster than the medications we have, so we need to do those studies comparing SSRI antidepressants that are well known with, you know, new specific antidepressants, uh-

Joanne Stone: And some, and some of those new treatments- Sure ... you have to be hospitalized for.

Yes. Correct. Right. So, you know, I think it's m- I think that's very important, distinguishing between the efficacy of a, a treatment that for severe depression or people that don't perhaps respond to others, versus other kinds of treatment that can be done as an outpatient because it's very h- it's, it adds extra anxiety if you are separated from your child as well.

Veerle Bergink: Absolutely, and I really want to highlight that severe depression or depression that is difficult to treat, we don't see that that much after delivery. Honestly, [00:44:00] this depression and anxiety- Mm-hmm ... postpartum is often easier to treat. Treat. So that is really reassuring- Yeah ... for women who struggle with this, which is an extra reason to, you know, to have a good care path to, to get women into care who really need it because it's such a treatable condition.

Joanne Stone: This is so, it's such a fascinating topic, and unfortunately, you know, more common than we'd like to s- to, to think. But it's so positive that there are active researchers like you that are doing work on this, that we h- do have treatments that are effective, that we have ways of identifying patients who are at risk or have developing symptoms or showing symptoms of de- baby blues depression or psychosis.

And, and I'm glad that, you know, we're highlighting this in this podcast because I think it's such important information to get out there to, to women, to their fa- and their families as well.

Veerle Bergink: Yeah, absolutely.

Anna Barbieri: And thank you for everything that you do, not only now, but how you're shaping this field, actually.

Veerle Bergink: [00:45:00] So- Yeah. Thank you for having this awesome center.

Joanne Stone: So, Wille, I think it's really important if we can mention to our audience w- where they can turn to in case there are s- severe symptoms that somebody's experiencing or somebody sees that a family member's experiencing. What are some of the resources that they can immediately go to?

Veerle Bergink: Well, if there is, if they have, uh, symptoms like anxiety, depression, there is Postpartum Support International or maternal mental health helplines. If the symptoms are really severe, they should see a doctor that same day or go to the ER or other, uh, otherwise call those, uh, resources.

Joanne Stone: That's all for this episode of Herology.

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