Women’s Mental Health

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Prevalence of Mood Disorders by Gender

[Bar chart showing the prevalence of mood disorders (MDE, DD, SAD, PMDD, BPD) by gender (Female, Male).]
Depression in Women: Contributing Factors

- Psychosocial Stressors
- Biological Vulnerability
- Reproductive Factors

Psychosocial Risk Factors

- Stressful life events
- Relationship status
- Lack of social support
- Care of young children (< 6 years old)
- Work/education status
- History of abuse/victimization
Reproductive Events Related to Psychiatric Disorders in Women

- Premenstrual Period
- Pregnancy
- Postpartum Period
- Menopausal Transition/Perimenopause
- Hormonal Therapies
- Infertility

Premenstrual Dysphoric Disorder

- Normal or a disorder?
- Severity issues
- Biology is unclear
- Good treatments exist
Is Pregnancy a Time of Emotional Well-being in Women?

- Up to 20% of women suffer from mood or anxiety disorders during pregnancy.
- In one study, nearly 50% of women who discontinued antidepressant therapy to avoid fetal exposure experienced symptoms severe enough to re-institute treatment.
- 50% of women with bipolar disorder will experience an exacerbation of their illness during pregnancy.

Depression in Pregnancy
Common but Rarely Treated

- 3472 pregnant women (> 18 years of age) screened with CES-D in obstetric setting.
- 20% (n = 689) scored > 16 on the CES-D.
- Depression during pregnancy associated with:
  - Past history of depression, poorer overall health, greater alcohol use, smoking, being unmarried, unemployment, and lower education level.
- Only 13.8% of those women reported current formal treatment.
Weighing the Risks

- Risks of untreated psychiatric illness must be considered
  - Impaired self-care
  - Failure to follow prenatal guidelines
  - Suicidal behavior, impulsivity
- Many women discontinue or avoid pharmacologic treatment during pregnancy.
- Women with histories of psychiatric illness who discontinue treatment during pregnancy are especially vulnerable to recurrent illness.

Treatment Options During Pregnancy

- Psychotherapy
- Psychotropic medications
- Light Therapy
Non-Pharmacologic Treatments

Psychotherapy
- Effective in mild to moderate illness, or in conjunction with medication in more severe illness

Light Therapy
- Found to significantly decrease depressive symptoms (reduction of HAM-D score by 50%)

Psychotropic Medications During Pregnancy: Are They Safe?

- All medications diffuse readily across the placenta.
- No psychotropic drug has yet been approved by the FDA for use during pregnancy.
- Many women discontinue or avoid pharmacologic treatment during pregnancy.
Risks of Medication Exposure During Pregnancy

- Teratogenesis
  - Baseline incidence in U.S. is 2-4%
  - An estimated 500-600 exposures must be collected to demonstrate a two-fold risk
- Neonatal Toxicity/Perinatal Syndromes
  - May be associated with exposure to or withdrawal from medications
- Long-term Neurobehavioral Effects
  - Cognitive or behavioral problems later in development

The Postpartum Period

- Postpartum Blues
- Postpartum Depression
- Postpartum Psychosis
Postpartum Blues

- Occurs in 50-85% of women
- Characterized by mood lability, tearfulness, anxiety and irritability
- Symptoms peak at day 4-5
- May last a few hours to several days
- Symptoms do not interfere with functioning
- Reassurance rather than treatment
- If symptoms persist > 2 weeks, patient should be evaluated for a more serious mood disorder

Postpartum Psychosis

- Rare event occurring in 1-2 per 1000 women after childbirth
- Onset as early as 48-72 hours after delivery
- Symptoms resemble those of a rapidly evolving manic (or mixed) episode
- Earliest signs are restlessness, irritability and insomnia
- Evolves to include a rapidly shifting depressed or elated mood, disorientation or confusion, and erratic or disorganized behavior
- Delusions are common, and often center on the infant
- Risk for suicide and/or infanticide is high
Postpartum Depression (PPD): An Overview

• Clinically indistinguishable from any major depressive episode
• Typically emerges over first 2-3 months after delivery
• Sometimes heralded by the onset of milder depressive symptoms during pregnancy
• Milder cases are often difficult to diagnose
• Co-morbid anxiety symptoms may occur
• Increased risk is associated with a history of major depression, bipolar disorder and PPD
• Woman with PPD are at risk for recurrent depression unrelated to pregnancy or childbirth

Postpartum Depression (PPD): Diagnosis I

Symptoms:
• Depressed mood
• Tearfulness
• Loss of interest in usual activities
• Feelings of guilt
• feelings of worthlessness or incompetence
• Fatigue
• Sleep disturbance
• Change in appetite
• Poor concentration
• Suicidal thoughts
Postpartum Depression (PPD): Diagnosis II

- Milder cases are difficult to distinguish from non-depressed postpartum women experiencing sleep and appetite disturbances and fatigue.

- Edinburgh Postnatal Depression Scale
  - 10-item questionnaire
  - Score of > 12 or affirmative answer to item 10 asking about suicidal thoughts indicates a need for a more extensive psychiatric assessment.

Postpartum Depression (PPD): Risk Factors

- All women are at risk regardless of age, marital status, education level or socioeconomic status.
- Previous episode of PPD.
- Depression during pregnancy.
- History of depression or bipolar disorder.
- Recent stressful life events.
- Inadequate social supports.
- Marital problems.
Postpartum Depression (PPD): Treatment I

- Type of treatment selected depends on severity and type of symptoms present
- Non-pharmacological interventions alone may be offered for women who are reluctant to use medications, or with less severe forms of PPD
- Pharmacological approaches are indicated for more severe forms of PPD, and may be combined with psychotherapy

Postpartum Depression (PPD): Treatment II

Psychotherapy
- CBT found to be as effective as fluoxetine
- IPT found to be effective in women with mild to moderate depression
- Longer-term therapies may be indicated when comorbid personality disorders are present
- Management should include increasing social supports, help with child care
- Couples therapy may be useful
- Group therapy may be useful
- Parent-Infant interventions may be useful
Postpartum Depression (PPD): Treatment III

• Conventional antidepressant treatments have shown efficacy in the treatment of PPD
• Standard doses are effective and well-tolerated
• Choice is guided by prior treatment response
• SSRI’s are first-line agents: anxiolytic, non-sedating and well tolerated
• TCA’s are more sedating, and may be useful when insomnia is prominent
• Benzodiazepines may be helpful if anxiety is prominent

Psychotropic Medications and Breast-feeding

• All psychotropic medications are secreted into breast milk
• Concentrations in breast milk vary widely
• Peak concentrations are attained at 6-8 hours
• Infant exposure varies
• Infant toxicity depends on exposure and hepatic metabolism
• Relationship between infant serum concentrations and infant physiology, behavior and development is unknown
• Carefully monitor breast fed infants
**Depression and Menopausal Transition**

- No increase in first onset depression during menopause
- Slight increase in recurrence of depression among women 45-54 years old
- A history of other reproductive-related depression places women at greater risk
- Mild mood symptoms are not uncommon in perimenopausal women
- Estrogen replacement therapy often relieves minor depressive symptoms, but not major depression

**Psychiatric Conditions and Infertility**

- Women with infertility have higher rates of mood and anxiety disorders
- Studies show that 40-50% of women undergoing infertility treatment are affected
- Major depressive disorder, dysthymic disorder and GAD are most common
- Suicidal ideation is common
- Hormonal therapy may play a role
Hormone Therapy and Depressive Symptoms

• Depressive Symptoms may be associated with
  – Hormonal Contraceptives
  – Hormone Replacement Therapy
  – Infertility treatment
• Inconclusive evidence to support a causal relationship
• Hormone therapies may influence diagnosis and treatment of depressive disorders

Comorbid Psychiatric Conditions in Women with Depression

• Anxiety disorders
• Eating disorders
• Substance abuse
  - Alcohol, prescription drugs, tobacco, illicit substance
Comorbid General Medical Conditions in Women with Depression

- Chronic pain
- Migraines
- Chronic fatigue syndrome
- Endometriosis
- Fibromyalgia
- Thyroid disorders

Medication Treatment and Side Effects

- Sexual Dysfunction
- Weight Gain
- ? Suicidality
Conclusions

- Women have higher rates of mood disorders and associated psychiatric conditions
- These disorders are more likely to occur during the reproductive years in women
- Reproductive and psychosocial factors are especially important influences on mood and other psychiatric disorders in women
- Women often present with comorbid psychiatric disorders and/or medical conditions
- Diagnosis and treatment approach should incorporate known gender differences