

# Specific Psychiatric Problems of Women

## Specific disorders

### Neuroses

- women have twice the risk of developing neurotic depression
- interpersonal problems are reported more frequently in women
- anxiety states and obsessional disorders are equally distributed, but anxiety states are more commonly reported by women

### Affective disorders

- risk of developing unipolar depression is increased in women up to the age of 75 (M:F = 3.5:5.8 %)
- risk of developing bipolar psychosis is evenly distributed
- men tend to report more hypochondriacal fears and are more likely to lack insight
- oral contraceptive pill is *not* associated with a higher risk of depression

### Schizophrenia

- lifetime risk is equal in males and females
- increased incidence in:
  - females under 16 compared to males under 16
  - females over 35 compared to males over 35
  - males aged 16-35 compared to females aged 16-35
- process schizophrenia may be more common in men
- schizoaffective disorders may be more common in women

### Suicidal behaviour

- completed suicide is more common in men
- DSH is more common in women
- repeated DSH seems to be slightly more common in men
- use of violent means is more common in men

### Eating Disorders

- AN is more common in females (F:M = 9:1)
- more severe, and with a worse prognosis in males

### Mental handicap

- more common in males (M:F = 4:3)

### Senile dementia

- more common in females, ? due to greater longevity of women

### Criminal behaviour

- adult males are convicted 9 times more commonly than females

- males commit more violent crime

### Alcoholism

- 8 times more common in men

### Premenstrual syndrome

- admission rates to psychiatric wards are higher during premenstrual period, suggesting that patients with pre-existing disorder feel worse at this time
- relationship to mental illness still unclear

### Clinical features

- recurrence of symptoms between ovulation and menstruation – subsidence during menstruation, and absent between menstruation and ovulation

#### 1. Physical symptoms:

- feeling bloated
- weight gain
- tender breasts
- headache
- backache
- cramps

#### 2. Psychological symptoms:

- tension
- irritability
- depression
- tiredness
- forgetfulness

### Epidemiology

- *prevalence* of 20 - 95 % depending on the study
- premenstrual complaint is found more commonly in those with psychiatric ill-health

### Aetiology

- various theories include :
  1. premenstrual decline in circulating  $\beta$ -endorphin
  2. relative deficiency of progesterone
  3. raised prolactin levels
  4. fluid retention
  5. excessive aldosterone
  6. pyridoxine deficiency
  7. raised MAO activity
  8. 'psychological' effect
- More common in:
  - those with a monozygotic twin with premenstrual syndrome
  - those with a mother who has premenstrual syndrome

- women with type-A personality behaviour
- women around 30 years of age
- increasing parity

#### Treatment

- high placebo response is found in all trials
- progesterones (e.g. DYDROGESTERONE)
- oral contraceptive pill
- diuretics
- PYRIDOXINE
- LITHIUM and BROMOCRIPTINE have been tried

## ***Psychological problems in pregnancy***

- the special category of postpartum disorder disappeared after ICD-7 and DSM-I

### **Epidemiology**

- women are less likely to be admitted to a psychiatric ward or to commit suicide during pregnancy than at other times
- 66 % of women have some psychological symptoms during pregnancy, especially in the 1st and last trimesters
- 10 % of women become significantly depressed during pregnancy:
  - usually lasts less than 12 weeks
  - more common in the 1st trimester
  - associated with:
    - previous history of depression
    - previous history of abortion
    - unwanted pregnancy
    - marital conflict
    - anxiety about the foetus
  - characterized by fatigue, irritability, increased neuroticism scores, denial of the pregnancy
  - depression in the last trimester may persist as a postnatal depression

### **Management**

- drug treatment is rarely required and should be avoided in the 1st trimester
- 10-35 % of women take psychotropic drugs at some time during their pregnancy
  - all psychotropics are lipophilic and cross the blood-brain barrier/ placenta
  - higher levels may develop in the foetus

## Puerpal psychosis

- generally held *not* to be a distinct and unitary form of psychosis

### Epidemiology

- psychoses follow 1.5 per 1000 pregnancies
- risk of referral to a psychiatrist in the year following childbirth is five times the background risk
- risk is greatest in the 3 months following delivery
- associated with primigravida status
- history of manic-depressive psychosis predicts 20 % chance of developing puerpal psychosis
- 80 % of patients however, do not have significant risk factors

### Aetiology

1. *Genetic:*
  - a) a family history of major psychiatric disorder predisposes to puerpal psychosis
2. *Biochemical:*
  - a) ? effects of sudden drop in progesterone and oestrogen levels on tryptophan metabolism
  - b) possibility of hypersensitivity of the central D<sub>2</sub> receptors, which may be related to the effects of oestrogen withdrawal on the function of the dopamine systems
  - c) other steroid hormones have also been implicated
3. *Psychodynamic factors:*
  - a) patient's relationship with her own mother
  - b) feelings about responsibilities of motherhood
  - c) reaction to the assertion of her female role
  - d) relationship with husband
  - e) personality of husband (over-passive or over-dominant)
4. *Risk factors:*
  - a) previous psychiatric history
  - b) previous postnatal illness
  - c) family history of affective illness
  - d) Caesarian section

### Clinical features

- most common presentations are:
  1. affective psychoses (70 %)
    - depressive psychosis is more common than both schizophreniform and manic episode
  2. schizophrenia (25 %)
  3. organic psychoses, i.e. delirium (rare in UK)
    - organic psychoses are particularly due to cerebral thrombophlebitis
- evidence for continuum theory:
  1. family history of psychotic disorder is as commonly present as non-puerpal psychosis

2. increased incidence of psychosis before and after the pregnancy and puerpal period also
  3. manic depressives have 10 times the risk of developing puerpal psychosis compared to the general population
  4. the clinical syndrome resembles psychoses occurring at other times
- there may be a distinct clinical picture of puerpal psychosis, consisting of :
    1. a prodromal period, about 2 days after parturition, of insomnia, irritability, restlessness, refusal of food, and depression
    2. rapidly followed by:
      - acute onset of confusion, excitability, overactivity, hallucinations, fatiguability, very labile mood, and preoccupations and delusions concerning the baby – elation, grandiosity, and schizophreniform symptoms are common
      - clouding of consciousness is characteristic
    3. onset is almost always in the first 2

### Management

1. Admission to hospital:
  - admission to hospital is frequently required
  - admission of mother and baby is always advisable -- mothers admitted with their babies tend to stay in hospital for less time and are less disturbed on discharge than mothers admitted without their babies
2. Medication:
  - lithium started on the first postpartum day may prevent the onset of postpartum affective psychosis
  - small doses of neuroleptics (chlorpromazine or haloperidol) are relatively safe if breastfeeding
  - trials of transdermal oestrogen in the prevention of recurrent postpartum psychosis are being done
3. Psychotherapy:
  - marital therapy is frequently needed

### Prognosis

- 70 % recover fully
- risk of future puerpal psychosis = 14-20 %
- risk of future psychosis of any form = 50 %
- poor prognosis with:
  - schizophrenic, rather than affective psychosis
  - positive family history
  - schizophrenia
  - neurotic personality
  - severe marital problems

## Puerpal depression

### Epidemiology

- 10 % of women develop a non-psychotic depressive disorder in the postpartum period
- onset is usually in the 1st month, often on return to home, and usually between day 3 and 14
- associated with:
  - increased age
  - childhood separation from father
  - problems in relationship with mother and father-in-law
  - marital conflict
  - mixed feelings about the baby
  - physical problems in the pregnancy and perinatal period
  - tendency to more neurotic and less extroverted personality

### Aetiology

- ? hormonal effect on tryptophan metabolism
- social and situational changes may make the women particularly vulnerable at this time
- *Risk factors for mild depressive symptoms, dysthymia, and adjustment disorders include:*
  1. youth
  2. being single
  3. recent marriage
  4. social adversity
  5. recent life events
  6. psychiatric history
  7. lack of a female confidante
  8. ambivalence about the baby
  9. previous miscarriage, or termination of pregnancy

### Clinical features

- generally similar to depressive episode outwith pregnancy
- often characterized by worries about ability to cope with baby, fear for own and baby's health, and feeling generally inadequate

### Management

- usually self-limiting, and supportive measures are all that are required
- if depression lasts longer than 1 month, an antidepressant may be indicated
- psychotherapy and marital therapy may also have a role

### Prevention

- some women are started on a prophylactic dose of tricyclic antidepressant following delivery

- modified antenatal classes (to incorporate psychological supports) can reduce the rate of postnatal depression in 'at risk' groups
- early detection is possible using the Edinburgh Postnatal Depression Scale (Cox & Holden, 1987)

### Prognosis

- 90 % last less than 1 month, without treatment
- 4 % of cases last longer than 1 year

## Postpartum 'blues'

### Epidemiology

- 50 % of women have a short lived emotional disturbance commencing on the 3rd day and lasting for 1-2 days
- more common in :
  - primigravidae
  - those who complain of PMT
  - poor social adjustment
  - poor marital relationship
  - high scores on EPI neuroticism scale
  - fear of labour
  - anxious and depressed mood during pregnancy

### Aetiology

- Biochemical:
  - calcium levels
  - monoamines, serum tryptophan, platelet alpha-2 adrenoceptors
- symptoms coincide with sudden weight loss, decreased thirst, and increased urinary sodium secretion

### Clinical features

- episodic weeping
- feeling depressed and irritable
- feeling separate and distant from the baby
- insomnia
- poor concentration

### Management

- simple reassurance and explanation to mother and father

## Manic depressive psychosis

- not at increased risk during pregnancy

- risk of puerpal relapse may be as high as 50 %
  - risk may be higher if the woman has been predominantly manic

### **Chronic schizophrenia**

- less of a risk of worsening of symptoms or relapse than bipolar illness
  - however this risk is only less if medication is continued

### **Termination of pregnancy**

- transient psychological distress (anxiety, grief reactions) is common, but prominent or persistent psychiatric illness is uncommon (< 10 %)
- risk factors :
  - past psychiatric history
  - poor social support
  - young age
  - multiparous
  - sociocultural setting which discourages abortion

### **Miscarriage**

#### **Aetiology**

- Social factors (O'Hare and Creed, 1985):
  - severe life event in the 3 months preceding miscarriage
  - a major social difficulty
  - life events of severe short term threat in the 2 weeks immediately beforehand
  - few social contacts
- Physical causes:
  - foetal abnormality
  - uterine malformation
  - cervical incompetence
  - trauma
  - infection
  - endocrine disorder
  - toxins
  - irradiation
  - immune dysfunction

### **Sterilization and hysterectomy**

- psychiatric symptoms are rare following tubal ligation:

- 71-99 % are completely satisfied
- 2-5 % greatly regret the operation, especially if :
  - aged less than 26
  - small family size
  - under pressure to be sterilized
- incidence of psychiatric symptoms in the 18 months following sterilization is about 1 %, and no higher than general population rate
- sterilization has been shown to improve the mental state, social adjustment, general health, and marital and sexual relationships of the woman
- although originally reported by Barker (1968) that hysterectomy is associated with increased psychiatric illness (especially depression), later studies have discounted the claim

### **Menopause**

- ‘involuntary melancholia’ is likely to be only one presentation of depression in middle age rather than a distinct entity
- risk of depressive illness does not seem to be higher at the menopause than at other times