SECTION CONTENTS

Introduction

Welcome to this edition of the Focus on Women's Mental Health section! As this month's selections highlight, treating serious psychiatric illness with psychotropic medications involves a calculation, or more accurately an estimate, of the risks and benefits of any given treatment option. The risks of not treating must be considered in this matrix. This calculation is even more complex in vulnerable populations.

Atypical antipsychotic medications, or second-generation antipsychotics, are being used increasingly for a range of disorders that occur commonly among women of reproductive age. Tosato and colleagues provide a review of the risks associated with bipolar disorder and schizophrenia in pregnancy outcomes, as well as a review of what is known about the reproductive safety of atypical antipsychotics. This review provides a detailed and elegant context for the decision-making process that occurs for each woman who balances the risks of untreated illness and psychotropic medication exposure.

Liu et al present data on the risk of bipolar disorder diagnosis in women who suffer an index affective episode (depression or anxiety) in the postpartum period. While postpartum psychosis has been long associated with bipolar disorder, the experience of depressive episodes and anxiety has not been clearly linked. Since postpartum affective disorders may represent the onset of an illness whose trajectory may ultimately declare a bipolar diagnosis, it is imperative to understand the risk of bipolar disorder among this population. This is especially important as postpartum women are typically the most likely to be widely screened for depression and are often started on antidepressant medication for postpartum depression and anxiety. While screening for postpartum depression is now commonplace in many health care systems and even mandated in several US states, screening for symptoms or history of bipolarity is not. Liu et al found that women who first received an antidepressant prescription during the postpartum period versus outside the postpartum period had an increased risk of bipolar disorder. Further, the risk of ultimately having a bipolar disorder was substantially higher among women who were treated with both an antidepressant and an anxiolytic in the postpartum.

Also in this issue, Yang and colleagues present a study comparing rates of symptoms consistent with neonatal discontinuation syndrome in women who were taking serotonin reuptake inhibitors (SRIs) during pregnancy, women with no mood disorder and no SRI exposure, and women with affective disorders who did not take psychotropic medication during pregnancy. Women in the SRI group were noted to have a higher risk of preterm birth. Importantly, discontinuation symptoms (as per the Finnegan Scale) were found to be associated with preterm birth, but not with either SRI exposure or a mood disorder diagnosis.

On a very different topic, Baskaran et al studied estrogen replacement and neurocognition in female athletes with oligomenorrhea or amenorrhea. The female hypothalamic-pituitary-gonadal axis can be dysregulated by high levels of exercise, which can then produce states of estrogen depletion. Estrogen depletion has been associated with changes in cognitive processing. In this double-blind, placebo-controlled trial, the investigators found improvements in verbal functioning and executive control in women who received estrogen compared to controls. The investigators discuss the complex relationships between stress (in this case, a heavy burden of exercise), estrogen levels, impact on neurotransmitters, and other mechanisms that impact cognition. This study provides another model by which the impact of estrogen can be studied in hypogonadal states.

We appreciate the contributions of these investigators in enriching the data from which we can draw in future research and clinical work.

For comments or questions about the Focus on Women's Mental Health section, please e-mail me at mfreeman@psychiatrist.com.

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