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Snips from the Journals

Mental health challenges in women: A clinical perspective

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Introduction

Mental health is a core component of overall well-being; yet, its presentation and determinants often differ significantly across genders. In women, biological factors interact with psychological and social factors to shape distinct patterns of vulnerabilities and experiences. Certain mental health conditions, such as those related to the perinatal period and menopause, are unique to women and require specific clinical recognition and management. In addition, women are disproportionately affected by common mental disorders, including depression and anxiety, with significant implications for functioning and quality of life. This article examines these issues from a clinical perspective, highlighting patterns of mental health vulnerability specific to women.

Premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD)

Premenstrual Syndrome (PMS) and Premenstrual Dysphoric Disorder (PMDD) refer to a range of physical, affective, and cognitive symptoms that arise during the late luteal phase of the menstrual cycle and improve after the onset of menstruation, with resolution typically occurring within one week following the onset of menses (1-3).

Premenstrual syndrome (PMS) is not included in current classifications of psychiatric disorders, but premenstrual dysphoric disorder (PMDD) is recognised in both DSM-5 and ICD-11. Both classification systems require that symptoms are confined to the luteal phase and include at least one core emotional symptom: depressed mood, irritability or anger, affective lability, or anxiety. In addition, a range of supporting cognitive and physical symptoms may be present, including poor concentration, lethargy, overeating or specific food cravings, hypersomnia or insomnia, breast tenderness, swelling, and joint pain. DSM-5 further includes decreased interest in usual activities and a sense of being overwhelmed, while ICD-11 describes an additional cognitive symptom of forgetfulness. Both DSM-5 and ICD-11 require that symptoms are associated with clinically significant distress or functional impairment and are not better explained by substance use, medical conditions, or an exacerbation of another mental disorder. DSM-5 additionally specifies that the diagnosis requires the presence of five or more symptoms. A confirmed diagnosis in both systems requires prospective symptom monitoring over at least two menstrual cycles; otherwise, the diagnosis remains provisional (2-4).

The prevalence of PMS among women of reproductive age is estimated to be between 30-40%, while PMDD affects approximately 2% to 6% of women. However, these estimates should be interpreted with caution due to variability in diagnostic methods and study designs (4,5).

Neuroactive metabolites of progesterone, particularly allopregnanolone, which rise sharply during the late luteal phase, have been strongly implicated in the pathophysiology of PMS and PMDD. The interaction of allopregnanolone with gamma-aminobutyric acid type A (GABA-A) receptors in the brain is hypothesised to contribute to the emergence of affective symptoms in a susceptible subset of women (1).

Evidence from multiple randomised controlled trials (RCTs) has demonstrated the effectiveness of selective serotonin reuptake inhibitors (SSRIs) in the treatment of PMDD. The mechanism by which SSRIs act in PMDD appears to differ from their effects in major depressive or anxiety disorders. One hypothesis is that SSRIs modulate the synthesis of allopregnanolone, which may account for the relatively rapid onset of symptom improvement observed in PMDD. Studies have examined continuous dosing, luteal-phase-only dosing, and symptom-onset dosing strategies, with mixed findings; therefore, the optimal dosing regimen remains to be determined. In addition to SSRIs, combined oral contraceptives (COCs), gonadotropin-releasing hormone (GnRH) agonists, and surgical interventions such as ovarian resection have shown benefit in refractory cases. Although some alternative and complementary interventions, including nutraceuticals, acupuncture, and yoga, have demonstrated potential efficacy, heterogeneity in study quality and methodology necessitates cautious interpretation of these findings (1).

Perinatal mental health

The perinatal period extends from pregnancy to 12 months postpartum and represents a phase of heightened vulnerability to mental health disorders in women. During this time, complex biological, psychological and social factors interact to increase the risk of psychiatric morbidity, particularly depressive and anxiety disorders (6).

During pregnancy, psychiatric disorders are most commonly observed in the first and third trimesters. Psychiatric morbidity in the first trimester may be higher due to psychological stress related to unplanned or unwanted pregnancies, miscarriage, ectopic pregnancy, hyperemesis gravidarum, and assisted reproductive treatments, including in vitro fertilisation. In contrast, concerns related to childbirth, fetal well-being, congenital abnormalities, and stillbirth become more prominent in the third trimester and may contribute to increased psychiatric morbidity. Psychiatric morbidity during pregnancy is more likely in women with pre-existing medical or psychiatric conditions, while new-onset psychotic disorders during pregnancy remain relatively uncommon (7).

During the postnatal period, maternal blues are a common and self-limiting condition, affecting approximately 50-70% of women. Symptoms typically emerge within the first few days following delivery, peak around the fourth postpartum day, and resolve spontaneously within two weeks. Affected mothers often present with tearfulness, tension, irritability, and rapid fluctuations in mood, ranging from transient euphoria to misery, without a sustained depressed mood. This condition is thought to result from postpartum hormonal readjustment and is more commonly observed in primiparous women, those who experienced anxiety or depressive symptoms during pregnancy, and women with limited social support (5).

Postnatal psychosis is a rare but severe psychiatric condition, affecting approximately 0.1-0.25% of women. This term is used as an umbrella to describe psychiatric conditions occurring in the postnatal period in which psychotic symptoms are present, including severe depressive episodes with psychotic features, manic episodes with psychosis, schizophrenia, delirium, and other psychotic disorders. Clinical symptoms typically emerge within the first one to two weeks following delivery and may vary according to the underlying diagnosis. Identified risk factors include primiparity, a personal or family history of psychiatric illness, and single motherhood, while obstetric factors do not appear to have a consistent association. With prompt and appropriate treatment, most women recover; however, the prognosis is poorer in women diagnosed with schizophrenia. Recurrence rates in subsequent pregnancies are estimated to be approximately 20% for depressive disorders and 50-90% for bipolar affective disorder (5).

Depression is the most common psychiatric disorder during the perinatal period. Global prevalence estimates range from 10-20%, while Sri Lankan data indicate rates of 8-23% during pregnancy and 7-32% in the postpartum period. Suicidal ideation and self-harm attempts among affected women have been reported at 5.8% and 0.8%, respectively. In Sri Lanka, maternal suicide remains a significant contributor to maternal mortality; available data indicate that 29 maternal deaths occurred in 2020, with underlying depression likely present in 36.8% of cases. Psychological autopsy studies are routinely conducted to better understand maternal suicides and to inform preventive strategies (7).

Risk factors for perinatal depression include a personal or family history of depressive illness, unplanned pregnancy, high neuroticism personality traits, social adversity such as poor family support or domestic violence, and coexisting medical conditions. Perinatal depression is associated with adverse obstetric outcomes, including premature delivery, as well as longer-term consequences for the child, such as emotional and behavioural difficulties, disorganised attachment patterns, depressive symptoms, and impaired intellectual development (8). Many postnatal depressive episodes have their onset during pregnancy and may present with prominent fatigue, irritability, or anxiety rather than a persistent depressed mood. Intrusive thoughts, phobias, and obsessions related to harm to the infant may also occur. In Sri Lanka, postpartum maternal mental health is routinely screened using the Edinburgh Postnatal Depression Scale during Medical Officer of Health (MOH) clinic visits (5).

In addition to depressive disorders, women during the perinatal period may experience anxiety disorders, such as panic disorder, as well as other psychiatric conditions, including obsessive-compulsive disorder and eating disorders. Pseudocyesis is a rare condition in which a woman holds a fixed belief that she is pregnant despite the absence of pregnancy (8).

Management of perinatal mental health conditions should begin with early recognition and timely intervention, as delays in treatment can increase morbidity and adversely affect both the mother and the infant. Careful and ongoing risk assessment is essential, with attention not only to maternal safety but also to the well-being of the infant and the quality of the mother-infant relationship. Wherever possible, treatment should aim to preserve and support this bond, and admission to specialised mother-baby units may be helpful when available. In the postnatal period, prescribing decisions need to take breastfeeding into account, balancing maternal benefit against potential infant exposure. In women with severe or treatment-resistant postpartum illness, particularly when rapid improvement is required, electroconvulsive therapy remains an important treatment option and

should not be unnecessarily delayed. Effective care does not end at discharge and should involve family engagement, as well as collaboration with midwives and public health services to support follow-up and ongoing monitoring.

Mental Health during perimenopause and menopause

Perimenopause refers to the transitional period preceding the cessation of menstrual cycles, during which ovarian hormone production becomes increasingly irregular, resulting in fluctuations in oestrogen and progesterone levels. This phase may begin several years before the final menstrual period. Menopause is defined as the point at which a woman has experienced 12 consecutive months without menstruation, signalling the end of ovarian reproductive functions, and is therefore identified retrospectively. Following menopause, circulating oestrogen levels decline markedly (9). Perimenopause typically begins in the fourth decade of life, while menopause most commonly occurs in the early 50s. The duration and experience of the perimenopausal period vary considerably between individuals, but it generally lasts for approximately five years (10).

Many biopsychosocial changes occur during the perimenopausal period, contributing to increased vulnerability to mood and other psychological symptoms. Fluctuations in oestrogen and progesterone are considered key biological factors underlying these changes. Although oestrogen does not exert a direct effect on mood, it plays an important modulatory role on central neurotransmitter systems, particularly serotonin and noradrenaline. Oestrogen enhances serotonergic activity by increasing serotonin synthesis, upregulating 5-HT_1 receptors, and downregulating 5-HT_2 receptors. Additionally, it increases noradrenergic activity in the brain by reducing neurotransmitter reuptake and degradation through the inhibition of monoamine oxidase and catechol-O-methyltransferase (11).

Alongside these neurobiological changes, this period is often accompanied by significant social and psychological challenges that may further amplify vulnerability to mental health symptoms. Women may be coping with concerns related to fertility, parenting adolescent children, or the transition associated with an empty nest. Additional stressors may include work-related pressures, the emergence of new medical comorbidities, relationship difficulties, and increasing caregiving responsibilities for ageing parents (11).

Within this biological and psychosocial context, many of the core symptoms experienced during the perimenopausal period have important mental health implications. These include vasomotor symptoms such as hot flushes and night sweats; genitourinary symptoms, including vaginal dryness; mood-related symptoms such as low mood and anxiety; musculoskeletal complaints, including joint and muscle pain; and sexual difficulties, most commonly reduced sexual desire (11).

Among the psychiatric conditions associated with this period, depressive disorders are the most extensively described and are estimated to affect approximately 34% of women (12). It is more frequently observed during the perimenopausal period, when ovarian hormone levels fluctuate, rather than after menopause, when hormonal levels are relatively low and stable. The strongest predictors of depressive disorders during this period include a personal history of depression and previous premenstrual or postpartum mood disorders.

There is substantial overlap between depressive symptoms and symptoms associated with perimenopause. Features such as low mood, irritability, anxiety, reduced interest, low energy, impaired concentration, sleep disturbance, reduced libido, and subjective memory difficulties may be present in both conditions. Certain clinical features, however, may help distinguish depressive disorders from perimenopausal symptoms. Suicidal ideation, marked changes in appetite, feelings of guilt, worthlessness, hopelessness, and the presence of psychotic symptoms are more suggestive of a depressive disorder, whereas vasomotor symptoms such as hot flushes and night sweats, menstrual irregularities, and genitourinary features-including vaginal dryness, dyspareunia, itching, and urge incontinence-are more characteristic of perimenopause (9). Depressive symptoms that do not meet diagnostic criteria for a depressive disorder and are closely associated with vasomotor symptoms may respond to hormone replacement therapy (HRT) or psychological interventions such as cognitive behavioural therapy (CBT). Symptoms that meet criteria for a depressive disorder should be managed according to standard treatment guidelines, including the use of pharmacotherapy where indicated.

Insomnia is a common and often debilitating symptom during the perimenopausal period. It may occur as a primary symptom related to declining or fluctuating oestrogen levels, or secondarily as a consequence of vasomotor symptoms such as hot flushes and night sweats. Insomnia may also occur as part of a depressive disorder or, conversely, contribute to the development or exacerbation of depression, anxiety, irritability, and psychological distress (9).

In addition to mood and sleep disturbances, a range of anxiety and severe mental disorders may emerge or worsen during the perimenopausal period. Anxiety-related presentations are particularly prominent, with

some women experiencing a new onset of panic disorder or an exacerbation of previously diagnosed panic symptoms. These symptoms appear to be more commonly observed during perimenopause than in the post-menopausal period and are often characterised by prominent somatic features. Similarly, obsessive-compulsive disorder (OCD) may newly emerge or worsen during this phase, and changes in the pattern or severity of symptoms in pre-existing OCD have been described. Exacerbation of bipolar affective disorder may occur during perimenopause, with depressive episodes reported more frequently than manic episodes. In addition, it has been suggested that the higher prevalence of late-onset schizophrenia in women compared with men may, in some cases, be temporally associated with the menopausal transition, although this relationship remains incompletely understood.

Memory impairment is also a common complaint among women during the menopausal transition. Cognitive difficulties may occur as an intrinsic feature of menopause or be secondary to co-occurring conditions such as depression or mild cognitive impairment. Oestrogen has been recognised for its neuroprotective and neuromodulatory effects, promoting neurogenesis, enhancing synaptic plasticity, and facilitating neurotransmission in brain areas crucial for memory and executive functioning, including the prefrontal cortex and hippocampus. Declining estrogen levels during menopause are associated with reduced serotonergic, cholinergic, and dopaminergic activity, all of which play essential roles in cognitive processing and attention. In addition, oestrogen contributes to cerebral perfusion and glucose metabolism; therefore, reduced oestrogen levels may impair neuronal energy utilisation and synaptic efficiency, resulting in both subjective and objective memory difficulties during menopause (13).

Mental health conditions with female predominance

Beyond reproductive life stages, several psychiatric disorders demonstrate a consistent female predominance across the lifespan. These sex differences reflect a complex interplay of biological vulnerability, psychosocial influences, and gender-related patterns of help-seeking and diagnosis.

Depressive and anxiety disorders are consistently more prevalent in women than in men across the lifespan. Although reproductive transitions influence risk and presentation, as discussed earlier, these sex differences persist beyond such stages. Standard psychiatric epidemiology indicates that rates of major depression are approximately twice as high in women as in men across different cultures, and women also experience a greater non-fatal disease burden, reflected in higher years lived with disability. Anxiety disorders likewise show female predominance, although the magnitude varies by diagnosis, with generalised anxiety disorder, panic disorder, and agoraphobia occurring more frequently in women, while social anxiety disorder shows smaller sex differences between community and clinical samples. Overall, the higher prevalence of depressive and anxiety disorders in women is thought to reflect a multifactorial interplay of biological sensitivity to stress, internalising psychological coping styles, disproportionate exposure to interpersonal and gender-related stressors, and differences in help-seeking behaviour and diagnostic practices (5,14-16).

Eating disorders show one of the most pronounced sex differences in psychiatry, with a clear predominance among women. Anorexia nervosa is particularly more common in females, with female-to-male ratios often reported in the region of 10:1, while bulimia nervosa also shows female predominance, although with a less marked sex difference. The female predominance in eating disorders is thought to reflect a complex interaction of biological vulnerability, psychological traits such as perfectionism and harm avoidance, and sociocultural influences related to body image and weight ideals. From a biological perspective, vulnerability to eating disorders may be influenced by sex differences in how appetite, stress, and reward are regulated, as well as by the effects of gonadal hormones on neural circuits involved in eating behaviour and emotional regulation (5,17).

Certain personality disorders are diagnosed more frequently in women, with borderline personality disorder being the most prominent example in clinical practice. Women are over-represented in clinical samples of borderline personality disorder, while population-based studies suggest that sex differences in prevalence are less pronounced than those observed in treatment settings. This discrepancy highlights the influence of help-seeking behaviour and diagnostic practices, rather than clear differences in underlying vulnerability. Differences in symptom expression may further shape recognition pathways, with women more likely to present with affective instability and self-harm, while men may more often exhibit externalising features such as impulsivity and anger. Higher rates of interpersonal trauma, particularly sexual trauma, alongside gendered patterns of emotional socialisation, are also thought to contribute to observed sex differences in clinical presentation and diagnosis. Histrionic and dependent personality disorders have also been diagnosed more commonly in women in clinical settings, although observed sex differences appear modest and are likely to be strongly influenced by sociocultural expectations and diagnostic practices (18,19).

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