Sex matters – also in psychosis!

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Sex differences in emotional reactivity to daily life stress in psychosis

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Background A recent study did not find clear-cut sex differences in psychotic symptoms. Studies investigating altered stress reactivity more consistently report differences between the sexes, although the results are contradicting in suggesting either men or women to be more stress-sensitive. We assessed self-reported experiences in the context of real-life to more fully understand the nature of sex differences in psychosis.
Methods We employed the Experience Sampling Method, a structured diary technique, to investigate in real-life:
– symptoms;
– behavior in context;
– underlying mechanisms in 283 healthy controls, 268 subjects at risk for psychosis and 232 patients with psychotic disorder.
Results Multilevel regression analyses revealed no differences in symptom expression between the sexes. Similarly, men and women did not differ in their level of social interaction and overall activity. However, men at increased risk of psychosis were more often alone and were less involved in goal-directed activities compared to women. Finally, women reported more emotional reactivity to daily life stress then men but women also reported more positive affect when pleasant events had happened.
Discussion The data thus suggest only minor differences between men and women in psychotic symptoms and actual behavior. However, whenever differences were apparent, they consistently pointed towards more severe symptoms and more deficiencies in men compared to women. In contrast, increased environmental reactivity in women (to both negative and positive environments) in addition to more social contacts may constitute a protective factor for the development of more severe psychopathology.
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Sex and gender differences in schizophrenic psychoses

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Introduction Sex and gender differences in schizophrenic psychoses have often been described but treatment approaches so far have hardly taken them into account.
Objectives To describe the most important sex and gender differences in schizophrenic psychoses with clinical implications.
Methods Review.
Results Schizophrenic disorders show a later age of onset in women and a slightly better course, especially in young women. As to pathogenesis, there is some evidence that the age difference might be at least partly due to the female sex hormone estradiol being a protective factor. Differences in course might also have to do with this biological factor, but at the same time with the psychosocial advantages of a higher age of onset and other psychosocial factors.
These gender differences have important implications for assessment and therapy. Thus, we have to consider gender differences in coping behaviour as well as psychosocial burdens and needs deriving from differing roles in partnership, family, household and profession, from dependent relationships, potential abuse and violence. Furthermore, there are specific biological risks such as gonadal dysfunction we have to deal with in both sexes differently. Thus, e.g. women with psychosis can also have very special needs regarding fertility, pregnancy and motherhood. Also, around menopause we have to consider special measures such as replacement of physiological 17-b-estradiol.
Conclusions Women, but also men, with schizophrenic psychoses should get a gender-sensitive assessment and treatment.
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Menopause and psychosis

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There has been little research into the effects of menopause on symptoms, social and cognitive functioning in women with schizophrenia, and the results are controversial. The most replicated finding is that late-onset schizophrenia is more prevalent in women than in men and that this fact appears to be related to the diminution of estrogen levels during menopause.
Estrogens have a known protective effect on CNS. Animal research has shown that estrogen has a modulating effect on the dopaminergic, glutamatergic and serotonergic systems.
There are concerns about long-term use of sexual hormone therapy in postmenopausal women with regard to breast cancer risk, and the use of the selective estrogen receptor modulators (SERMS's) can be a better option.
Raloxifene is a SERM that is used in the preventive treatment of postmenopausal osteoporosis and has no effect in the breast and uterus. A number of studies seem to indicate that raloxifene acts on brain dopamine and serotonin systems in a similar way to conjugated estrogens.
In this presentation, I will show the results of some clinical trials that have studied the efficacy of raloxifene as a coadjuvant treatment of patients with schizophrenia. Our team has done two clinical trials that studied the efficacy of 60 mg of raloxifene for the treatment of negative symptoms in postmenopausal women with schizophrenia. Our results showed that raloxifene improved the negative symptoms better than placebo. We concluded that raloxifene seems to be a promising option to treat some patients with schizophrenia.
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Social anxiety disorder – from shyness and blushing to brains and psychotropic drugs

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Recent guidelines for evidence-based pharmacological treatment of social anxiety disorder

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