Perinatal Depression: Searching for Specific Tools for a Closer Look at This Window

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The management of psychiatric conditions during pregnancy constitutes a challenge to physicians, patients, and their families. Health professionals engaged in women's health care quite often struggle with the decision on how to balance the obstetric and neurobehavioral risks inherent to an untreated depression during pregnancy with the potential risks (eg, teratogenic, obstetric) related to the use of psychotropic agents during this period in a woman's life.[1] As physicians and academic psychiatrists actively engaged in clinical care and solely devoted to women's mental health issues, we constantly witness the difficulty that most patients face to accept any help (pharmacologic or not) for the treatment of depression during pregnancy; they fear the stigma, they share a sense of "moral failure," and they quite often are hesitant to accept the fact that, in reality, this time in life might not necessarily be "all right" and that psychiatric intervention might be needed.

One could argue that even among the medical community there seems to be a certain ambiguity in acknowledging the existence of "windows of greater vulnerability"[2] for mood disorders across the female life cycle; after all, little is known about the underlying mechanisms that render some women to be at heightened risk for developing mood, anxiety, or psychotic symptoms during periods of hormone instability such as the postpartum. The argument that depression during female-specific critical times occurs due to environmental changes and stressors (eg, changes in family or professional roles during the perinatal period) rather than due to hormonal fluctuations does not contradict the "critical window" hypothesis. Instead, it would be plausible to consider the occurrence of mood disorders during "windows of risk" as a result of complex, modulatory effects of both reproductive hormones *and* environmental stressors under vulnerable conditions.[3] In addition, earlier exposure to stressful events (eg, childhood trauma, abuse, or neglect) and presence of psychiatric history could characterize a *continuum* of risk for some subpopulations, leading some women to be at even greater risk for developing depression while facing critical milestones in life.

It has become evident that standard diagnostic interviews do not provide detailed information on specific characteristics of women's reproductive years, making it very difficult to relate psychopathological syndromes and their course to core female-specific issues, such as the menstrual cycle, pregnancy, postpartum, and menopause. To address this obvious deficit, an international working group has examined the suitability for developing a female-specific diagnostic assessment tool. A systematic and comprehensive approach to current female-specific core questions in mental disorders and psychopathological research is now provided through the Composite International Diagnostic Interview for Women (CIDI-VENUS).[4] The CIDI-VENUS allows a reliable examination of a wide range of mental disorders with embedded modular additions of women-specific conditions and factors (menstruation, pregnancy, postpartum, or menopause).

The existing challenges, however, extend beyond a proper diagnosis. It seems imperative that we search for a better understanding of the role of sex hormones, genetics, and reproductive staging for the development and/or susceptibility of psychiatric disorders. It is hoped that physicians and researchers will eventually be able to disentangle the biologic, psychological, and neurochemical aspects of perinatal depression to better tailor treatment strategies.

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