The Role of Estrogens in Schizophrenia Gender Differences

by Mary V. Seeman and Marisa Lang

Abstract

The male/female differences that have been described in schizophrenia are important because they may ultimately shed light on factors that mediate the expression of schizophrenic illness. The hypothesis of this article is that estrogens, either directly or indirectly, modify symptom expression and account for many of the observed gender differences. The role of sex hormones is divided into organizational and activational effects. Organizational effects take place during a critical period in fetal life and put a permanent stamp on the developing brain. Activational effects are the direct influences of circulating hormones that appear when hormonal levels rise, and wane when hormonal levels drop. Because levels of sex hormones in adult women fluctuate during the menstrual cycle, cyclic effects of high and low female hormones may induce specific responses by the adult female brain. All these effects have implications for genetic, environmental, pharmacological, neurocognitive, clinical, and epidemiological research in schizophrenia.

This article examines the organizational, activational, and cyclical role of estrogens as major determinants of the gender differences that have been described in schizophrenia. These differences include earlier onset in men (Lewine 1980; Seeman 1981; Bellodi et al. 1982; Loranger 1984), symptom variation (Lewine et al. 1984; Goldstein and Link 1988), family life variation (Seeman and Hauser 1984; Wattie and Kedward 1985; Goldstein and Kreisman 1988), superior treatment response in women (Young and Meltzer 1980; Kolakowska et al. 1985), superior outcome indices in women (Salokangas 1983; Seeman 1986; Goldstein 1988), and differences in aging effects (Seeman 1982; Flor-Henry 1985).

Prenatal Organizational Effects of Sex Hormones

The following is a summary of findings derived mainly from animal studies. The reader is referred to the original references for a comprehensive review of the subject.

Testosterone secretion begins in the male fetus with the development of Leydig cells in the testes. This occurs between fetal weeks 12 and 18 in the human (McEwen 1981) and marks the beginning of testosterone effects, both direct and indirect, on the male brain. Activational effects are the direct influences of circulating hormones that appear when hormonal levels rise, and wane when hormonal levels drop. Because levels of sex hormones in adult women fluctuate during the menstrual cycle, cyclic effects of high and low female hormones may induce specific responses by the adult female brain. All these effects have implications for genetic, environmental, pharmacological, neurocognitive, clinical, and epidemiological research in schizophrenia.

This article examines the organizational, activational, and cyclical role of estrogens as major determinants of the gender differences that have been described in schizophrenia. These differences include earlier onset in men (Lewine 1980; Seeman 1981; Bellodi et al. 1982; Loranger 1984), symptom variation (Lewine et al. 1984; Goldstein and Link 1988), family life variation (Seeman and Hauser 1984; Wattie and Kedward 1985; Goldstein and Kreisman 1988), superior treatment response in women (Young and Meltzer 1980; Kolakowska et al. 1985), superior outcome indices in women (Salokangas 1983; Seeman 1986; Goldstein 1988), and differences in aging effects (Seeman 1982; Flor-Henry 1985).

Reprint requests should be sent to Dr. M.V. Seeman, Dept. of Psychiatry, Mount Sinai Hospital, 600 University Ave., Toronto, Ontario M5G 1X5, Canada.
dependent sex differences in central hormone titers rather than being effects (MacLusky 1988). In other posed to organizational hormonal ef-
to be the result of activational as op-
females, tonicity in males) appears
gonadropin release (cyclicity in
"programmed" from the first.
thalamus for life, converting it into a
thought to masculinize the hypo-
testosterone surge in the male is
zational effect in rodents is the ac-
tation of specific enzymes which, in
plex thus formed encodes genetic in-
structions that result in the produc-
tion of fetal androgens on the
sexual differentiation. These changes are
permanent for the organism, or
organizational." One example of a
powerful sexually dimorphic organi-
zational effect in rodents is the ac-
tion of fetal androgens on the
hypothalamus. The initial fetal
and hormone receptors either directly or
through conversion to dihydrotestos-
terone (Vito et al. 1985; Sholl and
Pomerantz 1986). All the hormone
receptors are similar in that they
bind simultaneously to the hormone
and to deoxyribonucleic acid (DNA)
enhancer sequences within the cell
nucleus (McEwen 1988a). The in-
tracellular hormone-receptor com-
plex thus formed encodes genetic in-
structions that result in the produc-
tion of specific enzymes which, in
turn, catalyze structural and func-
tional change. These changes are
permanent for the organism, or
organizational." One example of a
powerful sexually dimorphic organi-
zational effect in rodents is the ac-
tion of fetal androgens on the
hypothalamus. The initial fetal
testosterone surge in the male is
thought to masculinize the hypo-
thalamus for life, converting it into a
tonic, rather than a cyclic releaser of
anterior pituitary gonadotropins. In
primates, including man, this same
sex difference in the pattern of
gonadotropin release (cyclicity in
females, tonicity in males) appears
to be the result of activational as op-
posed to organizational hormonal ef-
effects (MacLusky 1988). In other
words, it is produced by adolescent
hormone titers rather than being
"programmed" from the first.
Generally in man, hormone-
dependent sex differences in central
nervous system (CNS) function are
less "hard-wired" than in experi-
mental animals (MacLusky 1988).
They are less obligatory and more
susceptible to developmental
variation.
Sexually dimorphic brain nuclei,
however, are known to exist in
drance brains to the same extent
that they do in lower animals
(MacLusky and Naftolin 1981;
Ayoub et al. 1983; Swaab and Fliers
1985). They are present in the
hypothalamus, preoptic area, and
central amygdala, brain areas that
erxert powerful effects on feeding,
play, activity levels, aggression, cer-
tain kinds of learning, neurotrans-
mittel reception, and circadian
rhythms, to say nothing about sex-
ual and reproductive functions. In
adult male and female brains, the
density and distribution of andro-
gen, estrogen, and progesterone rece-
tors in these sexually dimorphic
areas do not, as might intuitively be
anticipated, show sex differences
(Brown et al. 1988). It is possible
that the critical differentiating factors
are sex-related receptor affinity
states rather than receptor numbers
(Seeman and Seeman 1986) or that
critical differences exist only during
critical periods of fetal development.
A review by McEwen (1988a) ex-
plores various possible ways in
which male and female brains can
develop dimorphically despite
essentially identical numbers of the
various sex hormone receptors.
However the sex differences occur,
on a cellular level they may promote
or delay cell death, enhance or
eliminate synaptic connections,
reorganize synaptic networks, affect
dendritic length and branching,
change nuclear or nucleolar size, or
induce the formation of synaptic
vesicles and terminals (McLusky
and Naftolin 1981; Hamburger and
Oppenheim 1982; Toran-Allerand
1984; DeVoogd 1987). Thus, the
functioning of these dimorphic
nuclei in later life may contrast
markedly in the two sexes.
More recent studies in newborn
rhesus monkeys have shown the
presence of estrogen receptors not
only in subcortical but also in cor-
tical areas of the brain (MacLusky
et al. 1987). Aromatase activity (conver-
sion of androgens to estradiol)
has been demonstrated in the hip-
pocampus and neocortex of rodents
and monkeys (MacLusky et al.
1987). Sex differences in the cerebral
cortex may help to explain human
cognitive differences between the
sexes (Kimura and Harshman 1984)
and sexually dimorphic responses to
cortical lesions (Goldman et al. 1974;
Lipsey and Robinson 1986).

Maturation and Birth Trauma. One
of the ways in which male and
female human cortical functions are
known to differ is in the pace of
early development. Female brains in
general show earlier neuronal mye-
linization, earlier establishment of
neuronal connections, and earlier
lateralization of cerebral functions
(Taylor 1969). This results in greater
relative maturity of female brains at
birth and subsequent lesser vulner-
ability to the potential trauma of the
birth process (McMillen 1979).

Birth Trauma and Onset Age. It is
possible that this protection from
perinatal trauma determines the
most salient difference between
males and females in schizophrenia—the onset age of the disorder.
Birth trauma may be the single most
important factor that hastens the
onset of schizophrenia in the
genetically vulnerable (Green et al.
1987; Lewis and Murray 1987). The
greater prevalence of birth sequelae in boys, who, in general, suffer more hypoxia, more infection, more electrolyte imbalance, and lower Apgar scores than girls (Brothwood et al. 1986), may determine the age-of-onset disparity in those who go on to develop schizophrenia.

Onset Age and Outcome. The several year difference in age of onset, occurring as it does during the critical developmental stage of late adolescence, may explain most of the superior outcome seen in schizophrenic women. In other words, discrepancies in levels of gonadal steroids during critical time periods in fetal life may initiate a chain of events that results in gender differences in maturation which, in turn, may account for the greater vulnerability of the male brain at birth and may in this way determine the earlier age of onset in males who are genetically predisposed to schizophrenia. Early age of onset leads to interruption of cognitive and affective development, disruption of interpersonal processes, and insufficient integration of premorbid strengths, all of which result in poorer reintegration after an episode of psychosis and a more turbulent course of illness over time (Seeman 1983b).

Birth Trauma and Structural Abnormalities. Another potential effect of birth trauma may be subsequent abnormalities in brain structure (Weinberger et al. 1980; Andreasen et al. 1982) which have been associated with “defect” or “negative” symptoms, chronicity, and severity of the schizophrenic illness. “Negative” symptoms are much more frequent in schizophrenic males than females (Lewine 1985), and structural abnormalities are also more frequent in schizophrenic males (Andreasen et al. 1990).

Neuroleptic Response Effects. More general male/female differences, presumably also determined early via the organizational effects of prenatal hormones (Bardin and Caterall 1981), may assume significance in schizophrenia in that they determine neuroleptic response differences in the two sexes. Women, for instance, show slower gastric emptying times (DatZ et al. 1987). This delays absorption and, in turn, may make for a more gradual onset of neuroleptic response. Slower absorption may help to explain why women suffer less from acute dystonias following neuroleptic initiation (Swett 1975) and why subsequent compliance with neuroleptic treatment is better in women (Zito et al. 1985). Cerebral blood flow is 15 percent higher in women than in men (Gur et al. 1982), which may result in more efficient neuroleptic distribution to the female brain. Body fat as a percentage of total body weight is about twice as high in women as in men (Frisch 1988). Since neuroleptics are lipophilic, the higher percentage of body fat leads to relatively more neuroleptic storage in women over longer periods of time. This, in turn, may protect women longer than men from schizophrenia relapse during drug-free periods (Seeman 1989). Dopamine receptors have been shown to deteriorate with age more rapidly in men than in women (Wong et al. 1984). This difference may explain the seemingly paradoxical trend toward a greater female/male ratio of neuroleptic need in older age (Seeman 1983a; D'Mello and McNeil 1990), since dopamine receptor density in schizophrenic women may remain high for a decade after schizophrenic men no longer require receptor blockade.

Aging and Outcome. The differential rate of dopamine receptor decay may help to explain why short-term outcome favors schizophrenic women (Salokangas 1983; Seeman 1986; Goldstein 1988) while long-term outcome is indistinguishable between the two sexes (Harding et al. 1987).

Family Effects. The increased burden of families of schizophrenic males (Seeman and Hauser 1984; Goldstein and Kreisman 1988) is determined by multiple factors, and differential effects between the sexes are perhaps best explained by cultural pressures toward higher expectations of male offspring. Nevertheless, the earlier age of onset in males places extra stress on parents, particularly because they blame themselves for the development of their son's illness (Seeman 1983b). Daughters' schizophrenic illnesses most often begin after the young women have left the parental home, and this tends to extend illness attribution to causes other than familial. Men's greater aggressivity and suicidal impulsivity are probably hormonally determined and may be "built in" organizationally during the fetal period. Families of schizophrenic patients find these behaviors especially difficult to live with. They also find the "negative" symptoms of listlessness and affective withdrawal particularly troublesome (Goldstein and Kreisman 1988). As noted previously, these symptoms predominate in males (Lewine 1985) and may be a consequence of birth trauma.
There is evidence from studies of childhood psychopathology that boys are more reactive than girls to stresses and conflicts in the family home (Rutter and Quinton 1984; Earls 1987; Rutter 1987). It is not yet known whether such differential sensitivities between the sexes might be prenatally determined. Whatever the case, they may shed light on the well-known enhanced sensitivity of schizophrenic males to the effect of familial emotionality (Vaughn et al. 1984).

In summary, the organizational effects of prenatal sex hormones create many permanent male/female differences that could influence onset age and outcome measures, symptom expression, family effects, and neuroleptic response in adult schizophrenia.

**Activational Effects of Adolescent Sex Hormones**

Since schizophrenia commonly begins in late adolescence (at least in males), the triggering effects of pubertal sex hormone surges have long been suspected as playing a part in the onset of schizophrenia (Tourney and Hatfield 1972). Gonadal hormones titers may, for instance, have a direct effect on synaptic structure (Olmos et al. 1987). There is, however, no clinical evidence for a direct relationship between hormonal levels and schizophrenia onset. Early puberty has not been associated with early onset in either sex. Estradiol, however, indirectly affects many neurotransmitter systems (Hruska 1986; McEwen 1988a, 1988) so that the effect of a sudden surge of gonadal steroids in either sex may set off a chain of chemical events that may, in the genetically predisposed, culminate in illness. The rapidity of chemical change (without time for homeostasis) may be the crucial factor in precipitating psychosis. This reflects current thinking about the trigger mechanism of post-partum psychosis (Kendell 1985) and may play a part in adolescent-onset schizophrenia. The hypothesis would thus be that puberty, a time of sudden, dramatic hormonal and neurochemical change, is a risk period for the development of schizophrenia which, in females, is made safer by the protective effects of estrogens.

**Protective Effect of High Estrogen Levels.** In experimental animals, estrogens enhance neuroleptic effects such as stereotypy and catalepsy and increase the density of dopamine type 2 (D2) receptors (DiPaolo et al. 1982, 1984; Fields and Gordon 1982; Hruska 1986) as do neuroleptics. Although estradiol has multiple actions on striatal dopamine function in the rat (Hruska 1986; Van Hartesveldt and Joyce 1986), in the human the main effect seems to be neuroleptic-like. Psychosis, clinically, is linked to estrogen decline. One encounters premenstrual (low estrogen) exacerbations of schizophrenia (Endo et al. 1978; Glick and Steward 1980); relative freedom from relapse during pregnancy, a time of increasingly high estrogen levels (McNeil et al. 1984; Chang and Renshaw 1986); and increased vulnerability to psychosis post partum when estrogen levels have precipitously dropped (Mott 1982; Kendall et al. 1987; McNeil 1987) and after menopause when estradiol is low (Seeman 1983a). Together, these clinical observations suggest that high levels of estrogens serve a protective function in schizophrenia.

Through which mechanism such protection is conferred can be speculative only. Sampson and Kimura (1988) have recently reported that cognitive changes in the human female are a function of menstrual phase and sex hormone level. They noted fluctuations in fine motor skills and spatial ability which, in themselves, should have little import for schizophrenia. Nevertheless, other cognitive and affective processes may also be susceptible to the effects of levels of sex hormones mediated through neurotransmitter function.

**Estrogens and Neuroleptic Response.** With respect to neuroleptic responses, women appear to require lower doses than men in the acute stage of illness (Young and Meltzer 1980; Chouinard and Annable 1982; Nedopil et al. 1983; Chouinard et al. 1986) and in the maintenance stage (Seeman 1983a; Dworkin and Adams 1984). Women's lower dosage requirements may be due to the neuroleptic-enhancing properties of estrogen. The effect may be missed clinically because high doses of neuroleptics interfere with the hypothalamic-pituitary-ovarian axis and women given high neuroleptic doses may not be producing estrogens (Flint and Stewart 1983). It is therefore important to determine the endocrine status of women before male/female dose comparisons can be interpreted. In our study (Seeman 1983a), women over 40 required higher neuroleptic maintenance doses than age-matched men. Although their endocrine status was not determined, it is probable that estrogen levels were dropping in this age group.

Anecdotal reports occasionally claim higher neuroleptic dosage requirements in women than in men.
This may be especially true for nonovulating women. It is also possible that neuroleptic regimens that begin with relatively large doses interfere with estrogen secretion before they bring about symptom improvement; thus, women's potential response to low neuroleptic doses may be masked. This is an important research confound and an important clinical treatment issue.

**Estrogens and Outcome.** Improved neuroleptic response leads to relative freedom from unwanted effects, since most neuroleptic side effects are dose-related. When side effects are low, compliance with maintenance regimens is improved (Van Putten et al. 1981), and this may, to a large degree, explain women's better adherence to follow-up programs and subsequent superior middle-range outcome (Salokangas 1983; Watt et al. 1983; Seeman 1986; Goldstein 1988).

Long-range outcome is similar in the two sexes (Ciompi 1980; Harding et al. 1987) not only because of differential rates of dopamine (DA) receptor decay but perhaps also because female subjects in 20-year followup studies are postmenopausal and no longer hormonally advantaged over their male peers.

**Estrogens and Drug Side Effects.** With respect to the timing of neuroleptic-induced extrapyramidal symptoms, women are reported to suffer more parkinsonism and akathisia (Ayd 1961; Keepers et al. 1983) and more tardive dyskinesia (Chouinard et al. 1980; Glazer et al. 1981). The greater susceptibility to parkinsonism and akathisia may be a result of the additive effects of estrogens and neuroleptics on DA blockade.

Tardive dyskinesia (TD), on the other hand, results from mechanisms not fully understood. The syndrome is known to appear clinically when neuroleptic doses are lowered after lengthy periods of dose maintenance. TD often becomes evident clinically in women at the time of menopause, even when neuroleptic doses are maintained. Estrogen drop at this time of life may induce the emergence of TD by relieving DA receptor blockade. The analogy to neuroleptic withdrawal makes this a likely explanation. Studies that report a greater prevalence of TD in women unfortunately do not report endocrine status, although ages are given (Smith and Dunn 1979; Kane and Smith 1982) and support the estrogen withdrawal mechanism.

In summary, the protective direct effects of female estrogens on the brain may help to explain the gender discrepancy in age of onset, superior outcome in women, and discrepant side-effect profiles in men and women. When more is known about direct cognitive and affective effects of sex hormones, symptom differences in men and women may also become attributable to the effects on the brain of diverse levels of distinctive circulating hormones.

**Cyclical Effects of Sex Hormones**

Cyclical effects are the marked changes in hormone levels that occur in the female menstrual cycle. The activational effects of hormones in women are consequently more labile than the corresponding effects in men.

Adult men maintain a tonic release of sex hormones, albeit with diurnal variation, from the testes; female hormones are released with an infradian cyclic pattern from the ovaries, by means of a complex feedback loop that includes the hypothalamus and the pituitary. The resultant fluctuation of female hormone levels may result in sensitized hormone receptors that underrespond or overrespond at different time periods. This may lead to affective lability, ego state fluctuations, and a predisposition to affective disturbance (Weissman and Klerman 1985) and certain personality disorders. When affective lability and ego disturbances are superimposed on schizophrenic illness, they lend a specific coloring to the expression of schizophrenic symptoms in women—more affective symptoms, more paranoid symptoms, and fewer deficit symptoms (Westermeyer and Harrow 1984; Goldstein and Link 1988).

**Cyclicity and Neuroleptic Response.** It is possible that neuroleptic response varies with the menstrual phase in women. Current work in our clinic is attempting to clarify the association of symptoms, menstrual phase, and neuroleptic response. Neuroleptic-induced side effects may also fluctuate over the menstrual cycle. Women's relative protection from acute dystonia (Ayd 1961; Swett 1975) may be explained not only by women's slower gastric emptying but also by homeostatic mechanisms induced by estrogen cyclicility. Acute dystonia is produced by the sudden disruption of the balance between acetylcholine (Ach) and DA that results from DA receptor blockade by neuroleptics. Homeostasis is reestablished over a period of days in men. In women,
such as DDT) exhibit significant chemicals (polychlorinated biphenyls [PCB's] and insecticides Environmental Products.

In summary, symptom expression and variation in neuroleptic response in women may depend in part on changes induced by the cyclic release of female sex hormones.

**Research Implications**

What are the research implications of the putative protective effect of estrogens on the schizophrenic process?

**Genetic Studies.** Given the evidence that milder forms of schizophrenia exist among women than among men, one might expect that affected female relatives of probands would express mild forms. That expectation has implications for linkage studies, since the use of strict criteria to identify affected relatives may miss females with milder forms of illness. Thus, as has been shown in current linkage studies of schizophrenia (e.g., Sherrington et al. 1988), a definition of a broad spectrum of schizophrenia may be important in identifying cases of affected relatives. Age and menstrual status of female probands and female relatives need also to be taken into account in the construction of computerized linkage programs, given the evidence for the effects of estrogens on the expression and severity of psychosis.

**Environmental Products.** Certain chemicals (polychlorinated biphenyls [PCB's] and insecticides such as DDT) exhibit significant estrogenic activity (MacLusky 1988). Cimetidine, an H2 histamine antagonist, is antiandrogenic. Certain antimycotics inhibit aromatase, the enzyme responsible for the aromatization of testosterone to estradiol in the neuron. Similar chemicals are used in agriculture. A number of plants synthesize "phytoestrogens," substances that bear a structural resemblance to estrogens. They are found principally in soybeans, chickpeas, cherries, alfalfa, peas, and beans. They may also accumulate in the form of fungi on grain that has been poorly stored (MacLusky 1988). Whether such substances, which exert weak estrogenic effects, are synergistic or antagonistic to natural hormones is debatable, although some animal studies suggest a net synergistic effect (MacLusky 1988).

Dietary or toxic contributions to schizophrenia severity are complicated variables to study but may be determining factors in, for instance, identical twins who are discordant for schizophrenia. Of significance as well may be the nature of maternal diet or drug ingestion during pregnancies that culminate in genetically at-risk children.

**Drug Studies.** Menstrual phase, fat distribution, and other male/female differences need to be taken into account in outcome studies of drug response (Hamilton and Parry 1983). This is especially true for drugs like neuroleptics which are lipophilic and exert hormonal effects.

The concomitant use of self-prescribed drugs such as alcohol, narcotics, nicotine, amphetamine, or tetrahydrocannabinol, which can alter hormonal output, is an important variable in the evaluation of drug efficacy and side effects.

**Neurocognitive Studies.** The study of cognitive strategies in schizophrenia needs to control for gender effects and for menstrual phase effects in women. This may be particularly important in laterality studies since left-right hemisphere sex differences in estrogen receptor levels have been found in rat cerebral cortex (Sandhu et al. 1986).

**Clinical Studies.** The effects of menstrual phase, contraceptive pills, anovulatory cycles, pregnancy, post-partum period, lactation, and menopause with or without replacement hormones on the severity of symptoms in schizophrenic women need to be documented and assessed. Family studies may need to take the sex of the schizophrenic relative into account when exploring issues of familial precipitants to relapse and family burden.

**Epidemiology.** The incidence of schizophrenia in children of mothers treated with diethylstilbestrol (DES) and in adults suffering from various hormonal anomalies may contribute to the understanding of gonadal hormone effects in schizophrenia.

It must be noted that research which includes the measurement of hormonal levels is very difficult to conduct. Measurements on saliva are less intrusive than frequent blood lettings, but methodological difficulties have not been overcome. Hormones are released in pulses, and it is difficult to compare levels from different time periods in the same individual or among individuals. Steady states are not long in duration and are affected by the time of day, food intake, fatigue, emotion, and other factors. Levels are altered by many drugs, notably...
neuroleptic drugs. It is difficult to study drug-free patients, and most questions that need solutions require daily (at least) knowledge of hormonal levels over several months.

In summary, the organizational and activational (triggering as well as cyclic) effects of gonadal steroids on brain morphology, CNS development, and neurotransmitter systems, in conjunction with the interactive effects of environmental chemicals, open up new areas of research in studies of schizophrenia.

References


Acknowledgments

The authors are indebted to the Canadian Friends of Schizophrenics for support of the Schizophrenia Registry, to Alison Bury and Ron Langevin for continuing collaboration, and to Thelma Law for preparation of several drafts of this article.

The Authors

Mary V. Seeman, M.D., F.R.C.P.(C), is Professor of Psychiatry at the University of Toronto and Psychiatrist-in-Chief at Mount Sinai Hospital, Toronto, Canada. Marisa Lang, B.A., is a Research Assistant in the Department of Psychiatry, Mount Sinai Hospital, Toronto, and the Coordinator of the Schizophrenia Registry.