

## Mood problems at menopause

Depression is common and affects 1 in 5 women and 1 in 8 men at some stage of their lives ([beyondblue](#)). Depression usually responds well to treatment, but if untreated can be persistent. At least half of those who recover from their first depressive episode will suffer additional episodes and 80% of those who have a history of two episodes of depression, will go on to have a further recurrence <sup>(1)</sup>.

### Mood, depression and the menopause

- Mood disturbance, general symptoms of anxiety and depression are common during the menopause transition <sup>(2)</sup> and this time has been shown to be one of increased risk for both depression and psychosis in some women <sup>(3)</sup>. These symptoms may be more common in those with severe vasomotor symptoms, sleep disturbance and following surgical menopause <sup>(2)</sup>.
- The likelihood of developing depressed mood during menopause may be up to three times that of women in the premenopausal period. There is also a greater likelihood of depression in those women with a history of a depressive illness <sup>(4)</sup>.
- Research has described differing presentations of depression between women of child bearing age and those in the menopause transition. The presentation at menopause appears unique, in that there were lower levels of tension and depressive symptoms, and increased levels of sleep disturbance, anger/hostility and fatigue /inertia in peri-menopausal women compared with those of child-bearing age <sup>(5)</sup>.
- The presenting symptoms of a depressive disorder may be non-specific somatic ones. This makes the diagnosis of depression difficult, particularly in a menopausal woman, where somatic symptoms may overshadow cognitive ones <sup>(6)</sup>. Recent guidelines advise that all women in the menopause transition should be screened for clinically significant depression <sup>(7)</sup> <sup>(6)</sup>.

- Women may present with mood changes and depressive symptoms, but not meet the criteria for a DSM5 diagnosis of depression.
- Differing opinions have been published regarding the link between hormone levels and mood disorders. Judd et al <sup>(8)</sup> claim there are no clear associations between levels or changes in hormones and mood disorders at menopause, while Ryan et al <sup>(9)</sup> state there is a link between the fluctuation of hormones rather than the absolute levels.
- There is no evidence that a first major depressive episode can be precipitated by the menopause <sup>(10)</sup>.

### Symptoms of depression

#### DSM-IV\* Criteria for Major Depressive Disorder (MDD)<sup>(11)</sup>:

- Depressed mood or a loss of interest or pleasure in daily activities for more than two weeks.
- Mood represents a change from the person's baseline.
- Impaired function: social, occupational, educational.
- Specific symptoms, at least 5 of these 9, present nearly every day:
  1. **Depressed mood or irritable** most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful).
  2. **Decreased interest or pleasure** in most activities, most of each day.
  3. **Significant weight change (5%) or change in appetite.**
  4. **Change in sleep:** Insomnia or hypersomnia.
  5. **Change in activity:** Psychomotor agitation or retardation.
  6. **Fatigue or loss of energy.**
  7. **Guilt/worthlessness:** Feelings of worthlessness or excessive or inappropriate guilt.
  8. **Concentration:** Diminished ability to think or concentrate, or more indecisiveness.
  9. **Suicidality:** Thoughts of death or suicide, or has suicide plan.

\* Criteria are unchanged in DSM5



### Risk Factors for depression

#### (based on information from *beyondblue*)

Research suggests that continuing difficulties – long-term unemployment, living in an abusive or uncaring relationship, long-term isolation or loneliness, prolonged exposure to stress at work – are more likely to cause depression than recent life stresses. However, recent events (such as losing a job) or a combination of events can 'trigger' depression in people who are already at risk because of past bad experiences or personal factors.

### Personal factors

- **Family history** – Depression can run in families and some people will be at an increased genetic risk. However, this doesn't mean that a person will automatically experience depression if a parent or close relative has had the illness. Life circumstances and other personal factors are still likely to have an important influence.
- **Personality** – Some people may be more at risk of depression because of their personality, particularly if they have a tendency to worry a lot, have low self-esteem, are perfectionists, are sensitive to personal criticism, or are self-critical and negative.
- **Serious medical illness** – Having a medical illness can trigger depression in two ways. Serious illnesses can bring about depression directly, or can contribute to depression through associated stress and worry, especially if it involves long-term management of the illness and/or chronic pain.
- **Drug and alcohol use** – Drug and alcohol use can both lead to and result from depression. Many people with depression also have drug and alcohol problems. Over 500,000 Australians will experience depression and a substance use disorder at the same time, at some point in their lives.

### Specific risk factors in peri-menopausal women include

- Disturbed sleep, hot flushes, stressful life events, lack of employment, race and age <sup>(4)</sup>.
- Negative attitudes towards menopause, stressful life events and co-morbid health conditions <sup>(12)</sup>.
- Hormonal vulnerability to depression, available social support and coping skills, general wellbeing, and life events<sup>(3)</sup>.

### Treatment for depression

- Management should target menopausal symptoms, deal with psychosocial stressors and exclude clinically significant mood disorders <sup>(2) (3)</sup>.
- A comprehensive approach, including activities which may improve mood (such as exercise), is recommended <sup>(2)</sup>.
- A range of psychological therapies i.e. cognitive behavior therapy (CBT), interpersonal therapy (IT), behavior therapy and mindfulness based cognitive therapy (MBCT) may be utilised (*beyondblue*).
- Moderate to severe depression will require antidepressant medication <sup>(2)</sup>.
- Pharmacotherapies include (*beyondblue*): Selective Serotonin Reuptake Inhibitors (SSRIs), Serotonin and Noradrenalin Reuptake Inhibitors (SNRIs), Reversible Inhibitors of Monoamine oxidase (RIMAs), TriCyclic Antidepressants (TCAs), Noradrenaline-Serotonin Specific Antidepressants (NaSSAs), Noradrenalin Reuptake Inhibitors (NARIs) and Monoamine Oxidase Inhibitors (MAOIs).
- Consider the use of SSRIs or SNRIs as some may alleviate vasomotor symptoms <sup>(2)</sup>.
- There is insufficient evidence to support the use of HRT as a specific modality as prophylaxis or therapy for mood or cognitive dysfunction in peri-menopausal or menopausal women <sup>(6, 13)</sup>. HRT, may however be appropriate therapy for menopausal symptom relief in some women, where depression is also present <sup>(6)</sup>.



### Key points

- Depression is common in women and the time of the menopause transition may be one of greater risk for certain women.
- Women in the menopause transition should be screened for clinically significant depression.
- Management should be comprehensive, and address psychosocial stressors as well as menopausal symptoms.
- Consider psychological therapies, pharmacotherapies and modalities which may improve the feeling of wellbeing and quality of life.

### References

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