

Mood and the menopause

Key points

- Mental illness is prevalent in all age groups and for women this manifests as affective and anxiety disorders. The menopausal transition is a time of increased risk.
- The presentation of mood disturbance in the menopause transition appears unique with less sadness, increased anger, irritability and fluctuation in severity of symptoms. Assessment of psychosocial stressors, menopausal symptoms and mood is necessary.
- Most women will benefit from education about the menopause transition and are likely to respond to treatment, if needed.

In the 2007 National Survey of Mental Health and Wellbeing almost half of all respondents aged 18-65 had a mental health problem at some time in their lives. One in five Australians experience a mental illness in any year. The most common illnesses are related to anxiety, then affective and substance use disorders. Women have a higher prevalence of anxiety and depressive disorders (1).

The menopausal transition is a time of increased risk of mood disturbance. Even women with no previous history of depression, particularly those with history of vasomotor symptoms (VMS) or adverse life events are at increased risk of depressive symptoms compared to premenopausal women (2). The risk of a major depressive episode (MDE) is also higher in the peri-menopause compared to the pre-menopause in women with a history of Major Depressive Disorder (MDD) (2).

Women with hysterectomy and ovarian preservation have a 20% higher risk and women with hysterectomy without ovarian conservation have a 44% higher risk of depression (3). Premature ovarian insufficiency is associated with a 20% higher prevalence of depression than the general population (4).

Risk factors for depressive symptoms/disorders are multiple and include VMS, previous mood disorders including prior MDD, reproductive related mood disturbance (severe premenstrual syndrome (PMS) or postpartum depression), other health factors, psychological and socioeconomic factors, and hormonal changes such as variability in FSH and oestradiol.

The clinical presentation of **depression/mood disturbance at the menopause transition may be unique**, with less sadness, increased anger, irritability and paranoia which can fluctuate in severity compared to younger women. Many symptoms

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overlap; difficulties with sleep, concentration, energy and libido could be attributed to classic depressive symptoms or, equally, to mood disturbance related to the menopausal transition.

Furthermore, it has been reported that women describe an “on-off” phenomenon with sadness or irritability which may last for minutes to hours and spontaneously resolve, similar to what can be seen with PMS (5), making it harder to establish a temporal association between the psychological and physical symptoms. However, a unique presentation at the menopause has not been shown in research, which is likely contributed to by a lack of menopause-specific screening tools to assess mood disturbance.

Validated tools exist to assess the severity of depressive symptoms (eg Patient Health Questionnaire-9) and menopause related quality of life questionnaires (eg Greene Climacteric Scale). Additionally, although anxiety disorders are the most common mental health disorders (2) and anxiety and affective disorders have a separate DSMIV/ICD10 criteria, these are not assessed separately, nor consistently, in studies looking at either depression or anxiety (6) in the menopause making menopausal depression an umbrella term. More recently, a questionnaire, Meno-D, developed by Kulkarni et al. (7) has been validated as a screening questionnaire to rate the severity of symptoms related to depression in the perimenopause to be used by clinicians, in research and as a [self-assessment tool](#) (www.maprc.org.au/sites/www.maprc.org.au/files/MENO-D_0.pdf). Using 12 items, graded from 0-4, it identifies five subcategories: somatic, cognitive, self, sleep and sexual function.

Management

An individualized approach and comprehensive discussion about treatment options is recommended for each patient.

Lifestyle changes which may modify mood should be implemented as part of a holistic model of care. A meta-analysis found that low- moderate intensity exercise reduces depressive symptoms in midlife and older women (8).

Psychological therapy may be helpful. Clinical trials have demonstrated the benefit of cognitive behavioural therapy (9).

Antidepressants may be indicated for perimenopausal depression. Selective serotonin reuptake inhibitors and serotonin noradrenaline reuptake inhibitors have also been shown to improve VMS. It should be noted that some SSRI/SNRIs can cause sweating. While SSRIs are generally considered first line, desvenlafaxine has been shown to be efficacious in two randomised, double blind placebo-controlled trials in peri- and post-menopausal women (2). Of note, the SSRIs and SNRIs have side effects that may result in sexual dysfunction.

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Use of SSRIs in women with breast cancer using tamoxifen. There have been concerns that certain SSRIs (paroxetine and fluoxetine) may reduce the active metabolite of tamoxifen.

Menopausal hormone therapy (MHT) may help women who have symptoms of low mood related to perimenopause or menopause (10). However, MHT is not currently recommended as a first line treatment for major depression (2). MHT may be of particular benefit for mood and sleep quality in women experiencing VMS and can be considered in combination with antidepressants. Evidence from RCTs suggests oestrogen is as effective as antidepressants in *perimenopausal* women but is ineffective in *post-menopausal* women (2) suggesting a window of opportunity for its use in the perimenopause. Some evidence exists for the efficacy of MHT in the prevention of the onset of depression in euthymic perimenopausal women; at present there is insufficient evidence to recommend prescribing MHT for prevention of depression.

References:

1. Australian Bureau of Statistics (2009). National Survey of Mental Health and Well-being: Summary of Results, 2007. ABS:Canberra.
2. Maki, PM et al. Guidelines for the evaluation and treatment of perimenopausal depression: Summary and Recommendations. *J Women's health* 2019;28:117-134
3. Wilson L et al. Hysterectomy and incidence of depressive symptoms in midlife women: the Australian Longitudinal Study on Women's Health. *Epidemiol Psychiatr Sci.* 2017: 1-12
4. Schmidt PJ et al. Depression in women with spontaneous 46, XX primary ovarian insufficiency. *J Clin Endocrinol Metab.* 2011: 96:E 278-E287
5. Worsley, R et al. The association between vasomotor symptoms and depression during the perimenopause: a systematic review. *Maturitas* 2012;77:111-117
6. Bryant, C, Judd FK, Hickey, M. Anxiety during the menopausal transition: A systematic review. *J J Affect Disord* 2012 Jul;139(2):141-8.
7. Kulkarni, J et al. Development and validation of a new rating scale for perimenopausal depression - the Menopause-D. *Transl Psychiatry* 2018;8:123-131
8. Perez FR et al. Health outcomes systematic analyses project, effects of programmed exercise on depressive symptoms in midlife and older women: a meta-analysis of randomized controlled trials. *Maturitas* . 106(2017) 38- 47.
9. Khoshbooi R et al. Effectiveness of Group Cognitive Behavioural therapy on Depression among Iranian Women around menopause. *Australian Journal of Basic and Applied Sciences.* 2011;5: 991-995.
10. National Institute for Health and Care Excellence. (2015, updated 2019). Menopause: diagnosis and management. (NICE Guideline No. 23.) www.nice.org.uk/guidance/ng23

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