

DEPRESSION DURING THE TRANSITION TO MENOPAUSE: A Guide for Patients and Families

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It is a common myth that as women enter the menopausal years, it is “normal” to feel depressed. Serious depression, however, should never be viewed as a “normal” event, and women who suffer from it at any time in life should receive the same attention as for any other medical illness. This guide is intended to answer commonly asked questions about depression that occurs around menopause.

Depression affects up to 25% of women at some point in their lives, a far higher proportion than is seen among men. Depression can be a debilitating disease, limiting daily activity as much as severe arthritis or heart disease. Large-scale research studies have shown that most problems with depression begin when women are in their 20s or younger. It is actually unusual for depression to appear for the first time after menopause, when all menstruation has ceased. However, there is a transitional time in mid-life known as perimenopause when women become somewhat more vulnerable to depression. This is the time when menstrual periods gradually lighten and become less frequent. The transition to complete menopause may last anywhere from a few months to a few years.

Minor mood problems, insomnia, and hot flashes are common during perimenopause. In some women, these symptoms progress to a more severe mood disorder known as major depression. The risk for major depression is greatest in women who have a history of depression in the past or who had depression after childbirth (postpartum depression). Women who have had problems with depressed mood around the time of their menstrual periods (premenstrual dysphoric disorder) may also be at higher risk

for major depression in perimenopause. And some women do become depressed for the first time in their lives during perimenopause.

Several theories have been proposed to explain the increase in depression during perimenopause. A traditional psychological view is that the “empty nest syndrome” or other aspects of middle age lead to feelings of loss and sadness. More recently, scientists have focused on the biological effects of hormonal fluctuations on mood, since this is a time when the ovaries begin to make less estrogen. Estrogen interacts with chemicals in the brain that can affect mood. In some women, the decrease in estrogen during perimenopause may lead to depression. Hot flashes and insomnia during this transition may also cause emotional distress.

Many treatments for depression during perimenopause have been suggested, but most have not yet been evaluated in scientific studies. We therefore recently surveyed 36 leading experts in this field about the treatment of major depression in relation to menopause. The recommendations described in this article are based on the results of this survey.

What is Major Depression?

Major depression is a kind of illness called a mood disorder that affects a person’s ability to experience normal mood states. Mood disorders are biological illnesses believed to be caused by changes in brain chemistry, and the tendency to depression is sometimes inherited genetically. Physical or emotional stress can trigger the biological changes that occur in depression, and the hormonal changes leading up to menopause may also trigger such changes, especially in women who may be prone to depression because of underlying brain chemistry or family history.

The symptoms of major depression include:

- Depressed mood most of the day, nearly every day for 2 weeks or longer and/or
- Loss of interest or pleasure in activities that the person usually enjoys.

Other symptoms can include:

- Fatigue or lack of energy
- Restlessness or feeling slowed down
- Feelings of guilt or worthlessness
- Difficulty concentrating
- Trouble sleeping or sleeping too much
- Recurrent thoughts of death or suicide.

Mood disorders like major depression are not the fault of the person suffering from them or the result of a “weak” or unstable personality. Rather, they are treatable medical illnesses for which there are specific medications and psychotherapy approaches that help most people.

How is depression assessed in a woman nearing menopause?

A woman who feels depressed and thinks she also may be entering menopause should be evaluated by a gynecologist to determine whether her symptoms could be related to the hormonal transition. She should also see a psychiatrist or other mental health professional, especially if her depression is severe or if she has been depressed in the past. As part of the evaluation, the doctor will:

- Take a careful history of current and past symptoms, both emotional and physical
- Perform a physical exam and do blood tests to evaluate the function of the woman’s ovaries (if she is still having some menstrual periods) and thyroid gland (which may cause depression when underactive)
- Ask about life stressors that may be affecting the woman.

Treatments

Treatment recommendations for major depression that occurs in association with menopause depend on how severe the woman's symptoms are and whether she has had previous episodes of depression.

Whenever symptoms are severe, the experts recommend treatment with antidepressant medication, generally in combination with hormone replacement therapy (usually estrogen plus progesterone, or occasionally estrogen alone). The combination of an antidepressant and hormones is advised whether or not the woman has had depression in the past.

If the woman's symptoms are relatively mild and she has never been depressed before, experts do not agree on a single best strategy but suggest trying hormones or antidepressants, one at a time. Hormone replacement therapy by itself will usually relieve physical symptoms such as hot flashes and will sometimes improve mood significantly. On the other hand, some women prefer to avoid hormones, especially if they have few physical symptoms, and may do better with an antidepressant.

In women who are clearly in menopause rather than transition, the experts believe that antidepressant medication is more likely to relieve depression than hormone replacement. However, many women should consider hormone replacement for its other health benefits.

In all of these situations, experts also recommend the use of psychotherapy along with whatever medication is chosen. Just working with a psychotherapist, however, is unlikely to help severe depression unless medication is used as well.

Antidepressant medication

Many types of antidepressants are available, with different chemical mechanisms of action and potential side effects. For women with depression associated with menopause, the experts prefer a type of antidepressant that affects a brain chemical

called serotonin. These medications are called selective serotonin reuptake inhibitors (SSRIs). Among these, the expert panel prefers fluoxetine (Prozac), sertraline (Zoloft), and paroxetine (Paxil) as first choices, with citalopram (Celexa) an alternative.

SSRIs can have the following side effects: nervousness, insomnia, restlessness, nausea, diarrhea, and sexual problems. Side effects differ from 1 person to another. Also, what may be a side effect for one person (e.g., drowsiness) may benefit someone else (e.g., a woman with insomnia). Fortunately, most women with depression do not have many problems with side effects from the SSRIs. To try to reduce the risk of side effects, many doctors start with a low dose and increase it slowly. If you are having problems with side effects, tell your doctor right away. If side effects persist, your doctor may lower the dose or suggest trying a different SSRI.

Hormonal Treatments

While antidepressants are the most appropriate treatment for severe major depression in perimenopausal women, estrogen may also be appropriate for mild to moderate symptoms, particularly if the woman has never been depressed before. Studies are underway to compare estrogen and antidepressants and to determine for which patients estrogen may be preferred. Estrogen can be given either as a pill (e.g., Premarin, Estrace, and Estratab) or through the skin by a patch. The woman should discuss the benefits and risks of each formulation with her doctor. There is no doubt that estrogen controls the physical symptoms of menopause, especially hot flashes. There is controversy over how long it should be taken and whether its other general health benefits, such as keeping bones strong and possibly preventing memory problems and heart disease, may be outweighed by risks of breast cancer and stroke.

Progesterone, the other major female hormone, does not by itself treat or prevent perimenopausal depression or physical symptoms. However, it is often combined with estrogen (except in women who have had a hysterectomy) to ensure that excessive buildup of the uterus does not occur, which may lead to a risk of cancer. The major disadvantage of progesterone can be uncomfortable side effects such as bloating,

headaches, and even mood changes. Should side effects occur, different forms and dose schedules of progesterone may help.

Depression is sometimes a side effect of hormone replacement therapy, for reasons that are not understood. (It may also occur in some younger women who take birth control pills.) When this happens in a woman who has never been depressed before, it may help to try a different hormone preparation. However, in women who have significant histories of depression and become depressed again when starting hormone replacement therapy, the experts usually advise treating with antidepressant medication and/or stopping hormones altogether.

Psychotherapy

Two types of psychotherapy are highly recommended for depression related to menopause. Interpersonal therapy focuses on understanding how changing human relationships may contribute to, or relieve, depression. Cognitive-behavioral therapy focuses on identifying and changing the pessimistic thoughts and beliefs that accompany depression. When used alone, psychotherapy usually works more gradually than medication, taking 2 months or more to show its full effects. However, the benefits may be long-lasting. Psychotherapy is usually combined with medication in major depression. It is unlikely to help severe depression if used by itself.

What if the first treatment isn't helping?

It is important to give each treatment strategy enough time to work before considering another. If hormones are tried first, a response should be seen within 2-4 weeks. If the response is not satisfactory, the experts strongly suggest adding an antidepressant. If an antidepressant is used first, it must be adjusted to a high enough dose, and then given for at least 1-2 months to tell if it will help. If an SSRI antidepressant does not work in this time frame or produces intolerable side effects and has to be stopped sooner, the experts strongly recommend switching to a second SSRI. The doctor may also suggest combining the SSRI with a second medication,

which could be either another kind of antidepressant, or hormone replacement therapy if not already in use.

FOR MORE INFORMATION

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