The Women's Health Research Program

Health Bulletin
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Depression and the menopause

The higher prevalence of depression among women than men is one of the most widely documented findings in psychiatric epidemiology with the female-to-male risk ratio approximately 2:1. One in five women will be diagnosed with depression during their lifetime.

Approximately 13 per cent of middle aged Australian women report having had a diagnosis of depression by a doctor, and this is often linked to the menopause.

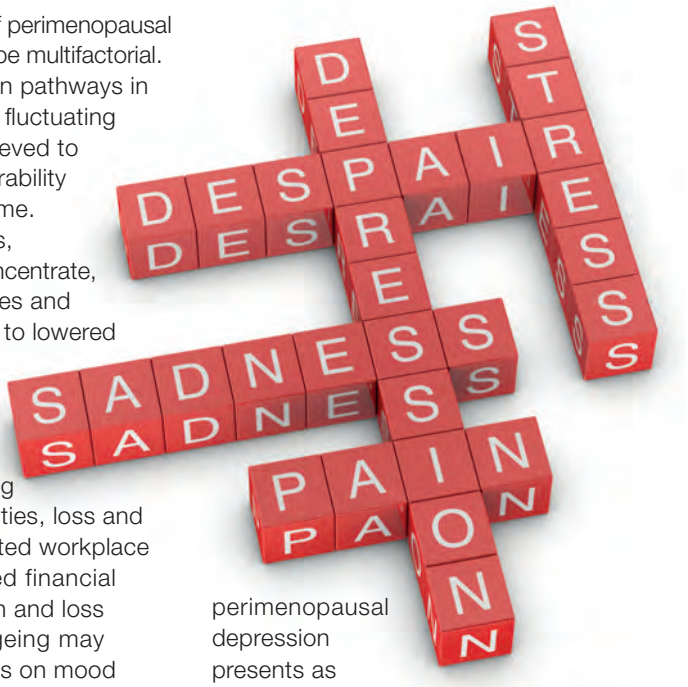
The perimenopause (or menopause transition) is the time from when a woman first experiences irregular periods, or lighter/heavier periods, until 12 months after her very last menstrual bleed. The perimenopause is associated with a higher vulnerability to depression with the risk increasing from early to late perimenopause and decreasing during postmenopause.

- Women with a history of depression are nearly five times as likely to be diagnosed with depression during the perimenopause.
- Women with no history of depression are two and four times more likely to have a diagnosis compared with premenopausal women.
- Premenstrual syndrome has been found to be a strong predictor of perimenopausal depression.

The underlying cause of perimenopausal depression appears to be multifactorial. Interruption of serotonin pathways in the brain secondary to fluctuating oestrogen levels is believed to contribute to the vulnerability to depression at this time. Menopausal symptoms, including inability to concentrate, insomnia and hot flushes and sweats may contribute to lowered mood. Women live in complex situations, with multiple responsibilities. It is believed that competing care-giving responsibilities, loss and bereavement, age-related workplace discrimination, reduced financial autonomy and ill-health and loss of self-esteem with ageing may all have negative effects on mood at this time of life.

Perimenopausal depression is characterised by a different constellation of symptoms from depression emerging at other life stages.

The diagnosis of a major depressive episode requires at least two weeks of depressed mood or loss of interest or pleasure in nearly all activities most of the day, nearly every day, accompanied by at least four of the following symptoms: change in appetite, sleep, fatigue, psychomotor agitation or retardation, feelings of worthlessness, guilt, diminished concentration, or indecisiveness and suicidal ideation. In contrast,



perimenopausal depression presents as flattened mood, characterised by feeling depressed, irritable, hostile, tense or nervous. Clinically it is not unlike the mood changes of premenstrual syndrome, with negative mood, negative self-concept, irritability and less effective coping abilities. A distinguishing feature is that perimenopausal depression is very labile, unlike the persistent low mood seen in major depression.

Perimenopausal depression needs to be differentiated from that of a major depressive episode, or even of straight dysphoria as the correct diagnosis will dictate the best approach to management.

The first line treatment for standard depression is with one of the antidepressants best known as SSRIs (selective serotonin reuptake inhibitors). SSRIs are less effective in the perimenopausal period than at other times.[1,2] Women with perimenopausal depression often respond best to oestrogen therapy and oestrogen therapy is recommended as first-line therapy by the majority of experts if a depressive disorder presents with a first-lifetime onset during the perimenopause and if the depression is mild to moderate in severity. The response rate is in the order of 68–80 per cent with oestrogen compared with 20–22 per cent for placebo therapy, with the effect independent of effects on other menopausal symptoms.[3,4]

Although there is controversy regarding the long term use of oestrogen therapy, compounds with oestrogen-like activity are available that have oestrogen-like effects in some tissues and not others. For example, tibolone is a synthetic compound that has weak oestrogen action in some parts of the body but has weak progesterone-like actions in other parts. It also has some weak androgen action5.

Tibolone effectively treats hot flushes and night sweats, as well as vaginal dryness due to oestrogen deficiency. In many women it improves mood and wellbeing.

Women experiencing depression around the time of menopause should talk to their doctor about treatment options, particularly whether hormone therapy might be best for them.

1. *Cassano P, Soares CN, Cusin C. Antidepressant response and well-being in pre-, peri-, and postmenopausal women with major depressive disorder treated with fluoxetine. Psychotherapy and Psychosomatics 2005;74:362-5.*

2. *Kornstein SG, Schatzberg AF, Thase ME, et al. Gender differences in treatment response to sertraline versus imipramine in chronic depression. American Journal of Psychiatry 2000;157:1445-52.*

3. *Schmidt PJ, Nieman L, Danaceau MA, et al. Estrogen replacement in perimenopause-related depression: A preliminary report. American Journal of Obstetrics and Gynecology 2000;183:414-20.*

4. *Soares CN, Almeida OP, Joffe H, Cohen LS. Efficacy of estradiol for the treatment of depressive disorders in perimenopausal women: A double-blind, randomized, placebo-controlled trial. Archives of General Psychiatry 2001;58:529-34.*

5. *Davis SR. The effects of tibolone on mood and libido. Menopause (New York, NY 2002;9:153-5.*

Get involved in research

Are you aged 55–70 years old and interested in being involved in a study to evaluate if low dose testosterone therapy might enhance learning and memory? To participate you need to be otherwise well and not taking any hormone therapy or antidepressants.

If you would like more information, regarding this and other studies please visit our website: **womenshealth.med.monash.edu** or contact the Women's Health Research Program on 03 9903 0820 or by email on *womens.health@monash.edu*