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Psychological and Social Aspects of Menopause

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Abstract

Menopause is one of the age-related phases of physiological transition of females. There is robust research and information regarding its biological aspects specially its endocrine base, yet the psychosocial aspect is quite interesting and debatable due to its variability among different cultures and climates. There are certain subthreshold response in form fear and loss of reproductive life to no more ability to reproduce and a feeling of loss of femininity. The period of menstruation simulated to reproductive age or fertility is around half of their lives; therefore, loss of fertility or reproductive life may be a source of stress specially among tribes where long reproductive age period is desired on the cultural belief that this will lead to a large family size that is considered as a symbol of success. Psychological factors such personal or inter-psychic (personality, self-esteem, and coping skills) and intrapsychic (relationship issues and social support) may contribute in the onset, course, and repose to perimenopausal period. There are certain psychiatric conditions such as anxiety, depressive disorder, and premenstrual dysphoric syndrome related to premenopausal period that must be screened. Before embarking on pharmacological treatment, psychosocial intervention especially lifestyle modifications must be offered to avoid complications.

Keywords: menopause, psychosocial, women, depression, anxiety

1. Introduction

As female grows old with passing years, she undergoes different phases of life, from childhood to adulthood. Her body keeps on changing at all levels; may it be anatomical, physiological, and hormonal with the years of aging. Menopause is just another phase of life like puberty. It is the time when ovaries stop producing eggs any more.

Menopause is a Latin word where “*Meno*” means month and “*pause*” means to stop. Various terms have been used for menopause in different languages as “*Haiz ka band hona*” in Urdu, “*alssnn yas*” in Arabic.

It is neither a disease, an illness, a pathology, nor a state of being not well but just a normal physiological phenomenon of aging among females from transition of reproductive life to no more ability to reproduce. It has no impact on sexuality of a female. This transition occurs with some changes in hormones of female endocrine system predominantly estrogen leading to menopausal symptoms.

For women, the menopausal period is considered the climacterium, the middle adulthood; a period in life characterized by decreased biological and physiological functioning and may lead to psychosocial disturbance in form of interpersonal relationships [1]. It may start anywhere from the 40s to the early 50s but generally occurs between 47 and 53 years [1].

Considering the onset of menopausal age, one must keep in mind the difference between days per year in various calendars such as a lunar year of 354 days used by Muslims as compared to the solar year of 365 despite the fact that the later also known as Gregorian calendar is widely in use, but ancient calendars are also used by a significant number of peoples who belong to certain regions and religions, in the form of the Julian calendar, the Islamic calendar, etc.

The menopausal condition has been analog in men as andropause. For men, the climacterium has no clear demarcation; male hormones stay fairly constant through the 40s and 50s and then begin to decline [1].

All women will not experience menopause in the same way in terms of their onset and symptoms. Apart from a normal response or may be a positive feeling in the form of relief from pain or at least the burden of the management of menstruation each month, many premenopausal women have concerns that they will experience mental instability, sudden signs of aging, and diminution of sexuality at this time. Culture, health, previous experience of mood problems, lifestyle, and whether menopause onset is a natural, surgical, or chemotherapy-induced, will all impact on menopausal symptoms. Increased risk for psychiatric morbidity is seen in women who experienced early menopause or surgical menopause [2]. According to study of Bernice Neugarten, the famous American psychologist who is specialized in adult development and the psychology of aging, more than 50% of females described menopause as an unpleasant experience, some believed that their lives had not changed in any significant way, and many women experienced no adverse effects while some reports feeling sexually free after menopause of any worry of becoming pregnant.

2. Psychological factors

2.1. Personal psychological vulnerability

Large epidemiological studies have shown that the years usually associated with natural menopause, that is 45–55, are not associated with increased psychiatric morbidity or more utilization of health services by women [2–5]. Various personal factors of an individual female may affect her menopausal experience. Such as follows:

- Past experience of mood disorders.
- Negative attitude to menopause and aging: women with more negative attitudes toward the menopause in general report more symptoms during the menopausal transition [6].
- Life events, personality, and coping.
- Self-esteem: women with a low self-esteem used to have more severe menopausal complaints [7].

2.2. Life stressors

They may include the following:

- Lack of social support
- Unemployment
- Surgical menopause
- Poor overall health status

2.3. Interpersonal relationships

Social interpersonal relationships also have their impact on a person's life and general well-being. They constitute a major social support in a woman's life and help her in managing stressors and problems in life with influential effect on psychological health. They may include the following:

- Relationship with a partner
- Relationship with children
- Relationship with friends/social support

Menopause could be a stressful transition due to various beliefs related to fertility and a gradual diminishing role or role shifts in society. Depression at menopause has been attributed to the *Empty Nest Syndrome*. A phenomenon observed with depression that occurs in some men and women when their youngest child is about to leave home. Many women, however, report an enhanced sense of well-being and enjoy opportunities to pursue goals postponed because of child rearing [1].

3. Social factors

Education and socioeconomic statuses are also important factors found to influence the intensity and symptoms of menopause [8]. The influence of psychological factors, lifestyle, body image, interpersonal relationships, role, and sociocultural factors in predicting levels of depression and anxiety in the menopause cannot be ignored.

Role, social factors, and culture have a great impact on menopausal symptoms, as few studies have shown rates of depressive symptoms and hot flashes or sweats were significantly lower among Japanese women than females of American and Canadian population [9]. Such variations across cultures may reflect differences in

- Beliefs and expectations regarding menopause and aging
- Status and roles of women in a particular society
- Sensitivity to specific symptoms
- Biology, diet, and health behaviors

In developing countries where there is low literacy rate, it has been observed that females expect conception even after menopause, and this may be because the success of woman was considered to be related to production of more children, particularly males.

The factors that must be considered while dealing with menopausal women are the following:

1. The variation in reproductive period, i.e., from onset of menses (also termed “menarche”) to menopause.
2. Variation in life expectancy among different countries, e.g., life expectancy of woman is as low as 50.8 years in Sierra Leone and as high as 86.8 years in Japan.

As reproductive life could vary significantly among the various countries, we may consider average menarche age as 13 years and age of menopause as 51 years, and on calculating the reproductive period of women in developing country with average life expectancy of 50 years, they would have reproductive life that is 74% of their total life in comparison to women of developed country with life expectancy of 86 years who would have reproductive life constituting only 44% of their life from birth.

With the above fact, the period of menstruation is simulated to reproductive age or fertility is around half of their lives; therefore, loss of fertility or reproductive life may be a source of stress specially among tribes, where long reproductive age period is desired on the cultural belief that this will lead to a large family size that is considered as a symbol of success.

4. Secondary effects on mood/psychiatric morbidity and menopause

Popular psychiatric nosology such as the WHO International Classification of Diseases (ICD-10) and Diagnostic and Statistical Manual of Mental *Disorders* (DSM-5) is also ambiguous about this condition; therefore, insurance for its management need to be addressed. ICD-10 has a variety of coding for menopause and related menopausal disorders as shown in **Figure 1**.

Menopause is not a time of high risk for psychiatric illness but may be a time of psychological stress for women. Some women will experience psychological symptoms during the perimenopausal years [10]. Since mild emotional symptoms occur in many women during

N95	Menopausal and other perimenopausal disorders
	<i>Excl.:</i> excessive bleeding in the premenopausal period (N92.4) postmenopausal: <ul style="list-style-type: none"> • osteoporosis (M81.0) • osteoporosis <ul style="list-style-type: none"> ◦ with pathological fracture (M80.0) • urethritis (N34.2) premature menopause NOS (E28.3)
N95.0	Postmenopausal bleeding <i>Excl.:</i> that associated with artificial menopause (N95.3)
N95.1	Menopausal and female climacteric states Symptoms such as flushing, sleeplessness, headache, lack of concentration, associated with menopause <i>Excl.:</i> those associated with artificial menopause (N95.3)
N95.2	Postmenopausal atrophic vaginitis Senile (atrophic) vaginitis <i>Excl.:</i> that associated with artificial menopause (N95.3)
N95.3	States associated with artificial menopause Post-artificial-menopause syndrome
N95.8	Other specified menopausal and perimenopausal disorders
N95.9	Menopausal and perimenopausal disorder, unspecified

Figure 1. ICD-10 coding for menopause and related disorders.

the perimenopausal years, it is important to establish whether the symptoms are of sufficient severity and duration to constitute major depression, generalized anxiety disorder, or panic disorder. Psychological distress is usually seen more in females with disturbed sleep [11]. Sleep could be disturbed in midlife due to psychosocial stressors of life or as a result of symptoms of menopause like hot flushes (also termed as “flashes”) and night sweats. Female reproductive hormones and rapid changes in their levels may influence neurotransmitters in the brain, particularly the serotonin and gamma amino butyric acid systems. Estrogen modulates serotonin to increase serotonin presynaptic reuptake, modulates norepinephrine levels, decreases monoamine oxidase levels, affects dopamine turnover, increases brain excitability, affects endorphin levels, and possibly interacts with gamma amino butyric acid [12]. Progesterone is found to increase monoamine oxidase levels. In high doses, progesterone has an anesthetic effect and may decrease brain excitability through an interaction with the gamma amino butyric acid system [12]. The drop in estrogen levels during perimenopause and menopause can lead to hot flashes that disturb sleep. This can lead to anxiety, fears, and mood swings [1].

The greater frequency of symptoms during the years prior to the end of the menses and the reduction of symptoms once menopause has occurred suggest that emotional symptoms are related to changing hormone levels rather than low hormone levels [12].

Research has shown that reproductive hormones produced during menopause contribute to mood alterations, such as depression [13]. Menopausal status, however, remains an independent predictor of depressive symptoms [14]. Some women experience anxiety and depression, but women who have a history of poor adaptation to stress are more predisposed to the menopausal syndrome [1].

The two most common psychiatric conditions are anxiety and depression. Therefore, all the general physicians and gynecologists must ask two screening questions for each of these conditions from women of perimenopausal age, as suggested by experts, given in **Figures 2 and 3** (*in Urdu—for developing countries where Urdu language is medium of communication).

Screening Depression in Suspected cases

- Use following 2 screening questions case
- 1. Over the past 2 weeks, have you felt down, depressed, or hopeless? (Udaas, Na-umeed, Mayoos)*
- 2. Over the past 2 weeks, have you felt little interest or pleasure in doing things? (Shouk, Dīchaspi, Khushi/Lazat)*

If whether of these is present, then ask additional questions

Ref: David Goldberg, Prescribing anti-depressants in primary care and hospital practice; Depression in medical specialties; WPA Bulletin on Depression; Facing, understanding and managing Depression Vol.7 No.26, 2003

Figure 2. Screening questions for depression among perimenopausal cases (Urdu).

Identification: anxiety

Consider asking:

Over the last two weeks, how often have you been bothered by the following problems?

- Feeling nervous, anxious or on edge
- Not being able to stop or control worrying

GAD-2 is the first two questions of the GAD-7 scale

The GAD-7 tool was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

Figure 3. Screening questions for anxiety among perimenopausal cases.

4.1. Depression and the menopause

The changes that occur in hormone levels along with general health, shifts, and stresses of family life in a woman's menopausal years as a whole effect the onset of depression among them [15]. According to a study at Harvard on Moods and Cycles constituting premenopausal women aged 36–44 years with no history of major depression with a follow-up of these women for 9 years to detect new onsets of major depression. Clinically significant depressive symptoms likely to develop among perimenopausal women were twice as common than women who had not yet gone under menopausal transition [16].

Typical symptoms of depression include depressed mood, anhedonia, and fatigue. Reaching diagnosis of Depressive Disorder, two internationally recognized criteria are of ICD-10 and DSM-5. Symptoms should be there for at least 2 weeks and leading to poor social or occupational functioning and condition should not be due to any substance use. Presence of at least two typical expressions with two common symptoms constitutes the criteria of Major Depressive Disorder (F32) according to International Classification of Diseases version 10 (ICD-10), while presence of at least one typical and five or more common symptoms constitute criteria to diagnose Depressive Disorder in Diagnostic and Statistical Manual (DSM). List of Symptoms is shown in **Figure 4**.

4.2. Anxiety and the menopause

Women who are more anxious experience greater extent of menopausal symptoms. Many of the symptoms of anxiety and menopause coincide like sweating, palpitations (increased heart rate), restlessness, sleep disturbance, which may confuse some. But no correlations have been found in between hormonal changes during menopause with incidence of anxiety disorder. Other psychosocial factors may contribute in development of anxiety among females of midlife.

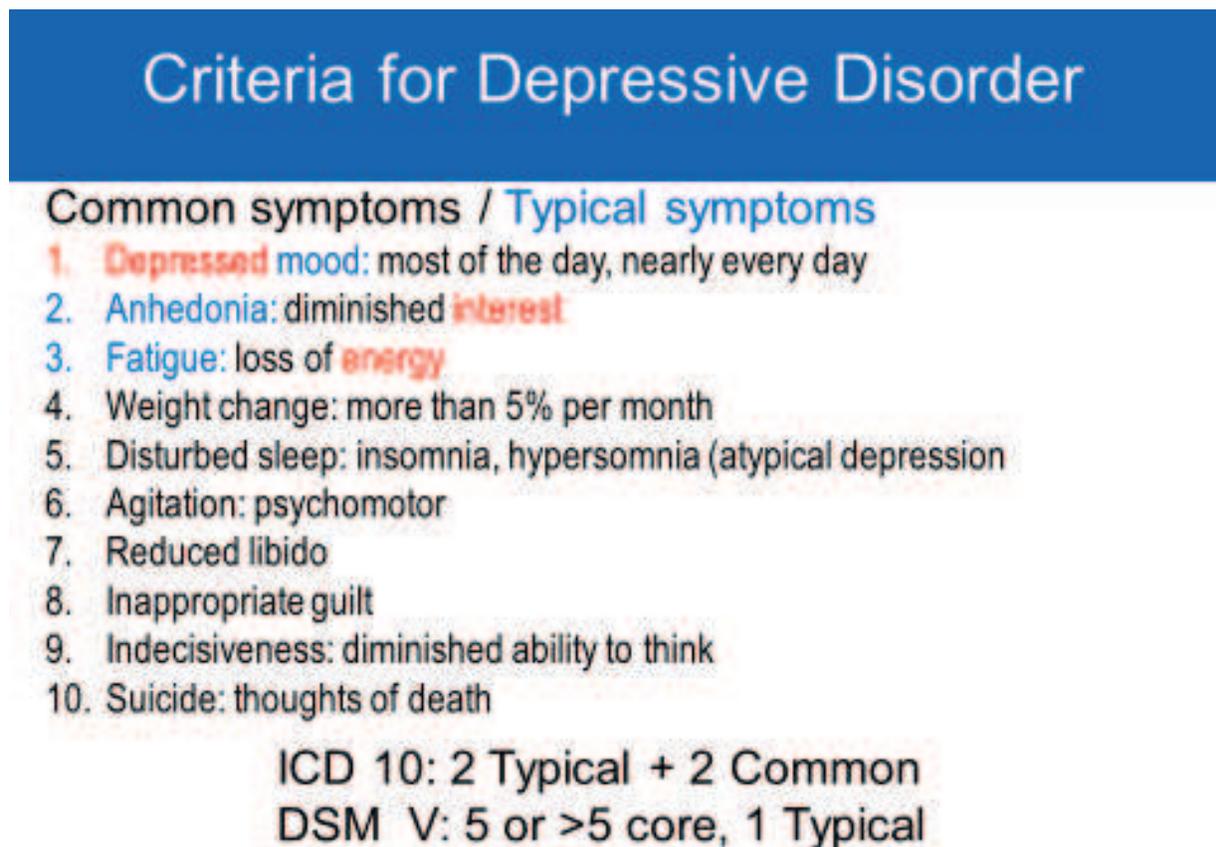


Figure 4. ICD-10 and DSM diagnostic criteria for depressive disorder.

Symptoms of anxiety include the following:

- apprehension
- irritability
- impatience
- fearfulness
- restlessness
- difficulty concentrating
- trouble falling asleep
- increased frequency of urination
- hyperventilation
- sweating, especially in the palms
- muscle tension

The symptoms of anxiety and depression may sometimes coincide and may be present simultaneously so if asked what are the defining symptoms of anxiety and depression? The clear difference and presentation of symptoms have been described in **Figure 5** with various differences and the similarities of anxiety and depressive disorder.

Anxiety & Anxiety Disorder	Depression
Feeling of fear, apprehension and excessive anxiety energy	Feeling of emptiness, deep sadness or misery, loss of hope
Physical feelings of agitation, muscle tension and symptoms of anxiety eg. heart symptoms, nausea, dissociation, diarrhoea, breathing difficulties etc	Slowing down of physical movement and lack of physical energy
General sense of being tense and rigid	Physical body slumped
May be a perfectionist and is concerned about the results of activities (can lead to poor performance)	Loss of interest and ambition (can lead to poor performance)
May fear death but not focused on suicide (Suicide thoughts come only when Depression is a secondary effect of anxiety disorder)	Suicidal thoughts present in deep depression

Figure 5. Features that differentiate anxiety and depression.

4.3. Other psychiatric conditions

Apart from anxiety and depressive disorder, the other psychiatric conditions that have been linked to menopause are premenstrual dysphoric syndrome and surprisingly a rare condition Trichotillomania discussed as under.

Premenstrual dysphoric syndrome: it is a condition of changing mood with changes in hormone levels every month before menstruations.

Anecdotally, many cases as they approach to menopause report that their symptoms of premenstrual dysphoric syndrome worsen at onset of perimenopause and alleviate with menopause [17].

Trichotillomania (hair-pulling disorder) symptoms may worsen at perimenopause [17].

5. Biopsychosocial aspects in management of symptoms of menopause

The art of assessing menopausal symptoms and menses may be threatening in some culture; therefore, reaching this condition needs proper working and skills which are less cumbersome because in general females are sensitive about aging process and loss of fertility.

5.1. Pharmacological interventions

5.1.1. Hormone replacement therapy

Estrogen and androgen alone or in combination of both is found to be more effective in improving symptoms in nonclinically depressed perimenopausal and menopausal women according to meta-analysis [18] of various studies on effects of hormone replacement therapies on mood. Progesterone had a much smaller effect, and when combined with estrogen, reduced the positive effects of the estrogen. The most robust effect was noted with androgen, either alone or in combination with estrogen.

Studies have shown that combined estrogen-progestin drugs (e.g., premarin) cause small increases in breast cancer, heart attack, stroke, and blood clots among menopausal women. Studies of the effects of estrogen alone in women who have had hysterectomies (because estrogen alone increases the risk for uterine cancer) are ongoing [1].

5.1.2. Antidepressants

Depression during perimenopause and menopause is treated in much the same way as depression that strikes at any other time.

Although symptoms of depression are relieved by a majority of antidepressants including SSRIs such as Fluoxetine, Paroxetine, SNRIs, e.g., venlafaxine, des-venlafaxine, and TCA as amitriptyline, but desvenlafaxine (the dual serotonin and norepinephrine reuptake inhibitor)

is used popularly, off label, for symptoms of depression with menopause despite the fact that the US Food and Drug Administration (FDA) has denied an application for its use for the treatment of moderate-to-severe vasomotor symptoms such as hot flashes associated with menopause.

A meta-analysis shows that desvenlafaxine was associated with a statistically significant reduction in the number and severity of daily moderate-to-severe hot flashes. The number of nighttime awakenings because of hot flashes was also significantly decreased. However, the rate of desvenlafaxine treatment discontinuation because of adverse events was significantly higher than placebo-treated women and the risk ratios of adverse events such as asthenia, hypertension, anorexia, constipation, diarrhea, dry mouth, nausea, dizziness, insomnia, somnolence, and *mydriasis* (the dilation of the pupil) were very high [19].

5.2. Nonpharmacological interventions

5.2.1. Lifestyle modifications

A healthy lifestyle can help to reduce symptoms of menopause

1. Exercise

- Being physically active helps with hot flashes, stress, and mood
- Exercise has beneficial effects on hot flashes, well-being, Body Mass Index (BMI) and Coronary Heart Diseases risks [20]
- Activities that stimulate the brain can help rejuvenate memory such as doing crossword puzzles, longhand mathematics, and reading books.

2. Diet

- A nutritious diet helps with fatigue and moodiness.
- A healthy diet, low in fat, high in fiber, with plenty of fruits, vegetables, and whole-grain foods.
- Intake of foods with phytoestrogen.

Phytoestrogens are estrogen-like substances found in some cereals, vegetables, legumes (including soy), and herbs. They might work in the body like a weak form of estrogen. The first widely attributed health benefit of phytoestrogen consumption was relief from vasomotor perimenopausal symptoms, including hot flashes and night sweats. Moderation is a likely key and the incorporation of real foods, as opposed to supplements or processed foods to which soy protein is added, is probably essential for maximizing health benefits [21]. Consumption of 30 mg/day of soy isoflavones reduces hot flashes by up to 50% [22].

- Ensure enough calcium and vitamin D intake on regular basis

- Avoid smoking and alcohol, as it is known to make hot flushes worse
- Foods that should be avoided in menopause
 - Caffeine
 - Spicy foods

5.2.2. *Social support*

- Social interactions with family and community, nurturing relationship, and healthy emotional support from friends are very effective means. A professional help from a counselor and mental health professional is quite effective and must be readily available. Misconception as described by individuals as potentially difficult, embarrassing, and stigmatized leading to fear and avoidance in some individuals at developing countries must be addressed.

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