“MIDLIFE BLUES” WHY AND HOW TO TREAT?

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What is Midlife?
“Middle aged” truly is our Mid-Life (45-55yrs), meaning that we still have many more years to live and generally spans the menopause transition. “Midlife Crisis” is a universal concept; period of dramatic self-doubt and anxiety felt in "middle years" of life, as a result of sensing the passing of youth and the imminence of old age. There are “Changes in the psychological sense of self” and really just a turning point with psychological transitions due to multiple changes and stressors. Midlife coincides with role changes, sexual and relationship changes, confronting ageing, re-evaluation of goals and expectations, economic changes, hormonal changes, social isolation and personal losses. Midlife should be seen ideally as a period of new opportunities e.g. return to work, increased time for social and leisure activities and improving personal and material relationships.

Midlife is a powerful life stage that brings a challenge…..with “Bouts of Blues” resulting from -

- Fear of aging, change, security and loss
- Grief (loss of parent, unfulfilled dreams, door closing for options, children away)
- Stress due to new responsibilities (grand parenting, ill partner, sandwich generation)
- Losing Self identity & lowered self esteem (loss of passion to work, no longer being “needed”)
- Declining Health, Ability, and fear of Mortality( seeing senior as “who I will be soon”)

One has to give a broader Perspective on what these midlife blues are really all about and how we can best relate to them with insight and some wisdom. Basic aim is to avoid the stress, anxiety and depression that give wrong views about midlife as “Bias Menopause mind set”.

Why do Women suffer from the midlife blues?
Stress, Anxiety, Depression resulting from single or multiple factors -

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

- Precipitating factors
  - Negative mood before menopause
  - Negative attitude toward menopause and aging
  - Smoking, alcohol and drug use
  - Little or no exercise

- Psychological or social conditions –
  - Change in the childbearing role
  - Loss of fertility
  - Empty-nest syndrome
  - Societal value of youth

- High risk –
  - Personal / family h/o major depression
  - Postpartum depression, Premenstrual dysphoria
Window of Vulnerability: Heightened prevalence of psychiatric conditions during periods of intense hormone variability / fluctuations and adverse outcomes resulting from the disruption of hormone milieu have been reported. **Vulnerability Model** [1]

Which symptoms do women report during the Perimenopause?
Vasomotor symptoms – hot flashes and night sweats, Dysphoric Mood – e.g. depressed mood, irritable, tense, Sleep disruption, Sexual concerns or problems, Cognitive changes – e.g. forgetfulness, Vaginal dryness, Urinary incontinence, Somatic/bodily pain symptoms, breast pain and Bleeding symptoms.

**Perimenopause and incidence of depression in midlife women** [2,3]

- Risk factors for depression in midlife women includes- hot flushes, high body mass index, lack of physical exercise, smoking, poor sleep, negative life events, education lower than high school, financial hardship, employment status, age, and race.
- Association between perimenopause and depression in midlife is independent of menopause symptoms. Brain is highly sensitive to sex steroids and endocrine changes may increase risk of depression, so all midlife women should be screened for depression.
- In USA 1.3 million women reach menopause and 20% experience depression. Racial distribution of perimenopausal depression is not known, but countries where older women are highly valued have few symptoms. It is twice common in women than in men (21% v/s 12.7%).
- Higher risk during menopausal transition is reported in PAN ovarian ageing study. [4] Women experience an increased incidence of depressed mood during the late Menopausal transition v/s earlier (Seattle Midlife Women’s Health Study) [5] and risk is smaller when premenopause (SWAN Study). [6] Relevant publication from 3 large studies found that there is a bidirectional association between VMS and depressive symptoms (MDD). [7]

In Indian context with primary care, it is challenging to diagnose depression because of low detection rate (36-56%), low reporting of stressors, high rates of somatic symptoms, less severe depression, short appointments and lack of screening tools. Psychosomatic problems are seen more in urban, while urogenital, body aches and pains are observed both in urban & rural women. [8] The economic and emotional support systems of coping with distressing menopausal symptoms play an important role in severity. Cultural values and attitudes also affect psychosomatic health in Indian perspective. Great Indian diversity (multi cultural, multiethnic, multireligious), rural (72%) urban divide, economic imbalance composition, genetics, end of reproductive life and menstruation, women’s bodily experience, socio-economic problems/status, physical, psychological and, psychosomatic symptoms varies (traditions/modernity), social problems (gender bias, myths, superstitions, taboo) and sexuality, varied life style (women’s work, level of physical activity and environment) and diet, industrialization, western and traditional medicines, use of MHT are the factors which influence mental health. Immigration transition with acculturation stress influence the quality of life in migrated Asian population living in western cultures as reported in (MAHWIS STUDY). [9]
Symptoms are often interconnected because known risk factors for depression commonly occur at menopause. Menopausal symptoms are similar to depression/anxiety symptoms - Sleep disturbance, Palpitations, Sexual dysfunction, Mood changes and Aches and pains. There is definite entity of Co-occurrence of core menopause ‘Brain Syndrome’ related to Midlife Blues. Sleep disturbance at menopause mainly contribute, as 40-60\% of mid-life women have sleep problems which results in to – fatigue, reduced function, emotional liability, depression and anxiety and reduced immune response.

**Evaluation**

“Routine evaluation of depressive symptoms in perimenopausal women is warranted “
- Ask about symptoms - Pervasiveness, duration and severity, Cognitive symptoms (interest, motivation, memory)
- Consider other risk factors - Past history, Major stress, Concurrent physical illness.
- Consider nature of menopause - Surgical, premature or chemo induced may increase risk.

**How to differentiate - Depressive symptoms?**

<table>
<thead>
<tr>
<th>Similar to Menopausal transition symptoms</th>
<th>Discriminating symptoms</th>
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<tbody>
<tr>
<td>Sleep disturbance</td>
<td>Depressed mood, irritable, angry</td>
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<tr>
<td>Weight change</td>
<td>Loss of interest and poor motivation</td>
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<tr>
<td>Fatigue/loss of energy</td>
<td>Sense of hopeless and failure</td>
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<tr>
<td>Concentration difficulties</td>
<td>Indecisiveness</td>
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<tr>
<td>Somatic symptoms; sweating, palpitations</td>
<td>Life not worth it/suicidal ideation</td>
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**Identify: Medications associated with depression**
- Antihypertensives (eg, reserpine, clonidine, thiazides, beat-blockers, hydralazine)
- Sedatives (eg, alcohol, barbiturates, benzodiazepines, chloral hydrate)
- Steroids (eg, corticosteroids, oral contraceptives)
- Dopamine agonists (eg, levodopa, bromocriptine, anantadine)
- Anticonvulsants (eg, phenytoin, carbamazepine)
- Analgesics (eg, ibuprofen, indomethacin, opiates)
- H2-receptor antagonists (eg, cimetidine, ranitidine)
- Stimulant withdrawal (eg, amphetamines, cocaine)

**Management Strategies**
- Treat vasomotor symptoms if they are impacting significantly on sleep and/or quality of life
- Consider HRT if night sweats lined to awakening, may improve mood but is not an antidepressant
- Consider SSRI (fluoxetine, paroxetine & sertraline), SNRI (venlafaxine, desvenlafaxine)
- Antidepressants used for hot flashes may also provide a mood-stabilizing effect.
- Alternative HRT strategies can be employed in women with dysphoric mood, who do not have elevation of their mood with their initial HRT.
- Manage sleep disorder - Take a proper sleep history, Provide information on sleep hygiene.
- Manage mood disorder and menopausal symptoms- Multidisciplinary approach.
- Consider interventions which may improve both Relaxation Exercise and Spiritual Prescriptions ,Stress management,Lifestyle changes (Adequate sleep,Safe alcohol,Good diet) Indian women prefer Meditation and Not Medication!
Assessment and Management of depression in mid-age women

Are depressive symptoms associated with changes in menstrual bleeding. Patterns, vasomotor symptoms and/or vaginal dryness

- Yes → Are there any contraindications to HRT
- No → Trial HRT

Depressive resolved

Are there any contraindications to HRT

- Yes → Psychological therapy e.g. Interpersonal Therapy
- No → Investigate and treat as required

Is this a time of significant role change, losses of stressors

- Yes → Psychological therapy e.g. Interpersonal Therapy
- No → Investigate and treat as required

Are there organic factors which may be contributing to depression – organic illness, medication, alcohol or other substance use

- Yes → Investigate and treat as required
- No → Depressive illness

Is depression secondary to another psychiatry disorder e.g. anxiety, early onset dementia

- Yes → Assess and treat primary disorder
- No → Depressive illness

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Treatment according to severity and risk factors

Perimenopausal Depression

Mild to moderate mood swings

- No history of psychiatric illness; has vasomotor symptoms

Hormone replacement therapy

If no response in 6 weeks, Add an antidepressant

Meets criteria for Major depression

Treat with an antidepressant

Consider adding hormone therapy
Role of Health Care Professional …
- Identify Potential Stressors at Midlife.
- Accurate information about bodily changes.
- Psychological Support
  - Taking time as health professionals to recognize, react to women’s emotional concerns and provide psychological counseling.
- Self help support groups.
- Education / referral resources
- Recognition of the financial and care giving burdens midlife
- Team approach.
- Caregiver supports and services – treatment plan.
- Identify and develop work skills for the second half of their life.

Non pharmacologic methods for coping with stress
- Deep breathing exercises and muscle relaxation training
- Daily exercise (yoga is helpful)
- Healthy diet (plant-based, low-fat, low-caffeine and low-alcohol)
- Sufficient self-care and enjoyable self-nurturing activities (massage)
- Psychological support/therapy (psychotherapy, menopause support group)/Creative outlets that enhance quality of life.
- Finding models for successful aging (Models, literature, locating older women collectives)

Recommendations… [12,13,14]
- Providing balanced information about the menopause to women and their families.
- Discussion of attitudes towards the menopause with reassurance of overly pessimistic beliefs.
- Health promotion sessions focusing upon diet, exercise and smoking.
- Stress management sessions.
- Group discussion of personal, health, and social issues met by women during mid-life.
- Training of gynecologists for early diagnosis and treatment of co-morbid psychiatric disorder with psychotropic medicines.
- Ongoing support
- Early referral to a psychiatric unit, as and when needed.

As per International Menopause society key messages are… [15]
- The prevalence of depressive symptoms are similar before and after the menopause. However, depression risk may be increased during the menopausal transition and the early postmenopause.
- Clinical trial evidence suggests no effect of estrogen therapy on depression in the late postmenopause and has short-term effect at the menopausal transition.
- Large studies should be conducted to further evaluate the potential benefits of estrogen both as monotherapy and as adjunctive treatment for the management of depression in the menopause transition.

Beat the midlife blues:
1. Make your emotional & physical health the priority.
2. Celebrate your accomplishments vs. focusing on past regrets.
3. Establish a new sense of adventure.

After all, research does show that enjoyment of life really begins in the upward trend in the late 40’s and does not peak until 85!
Make a point today to do something positive for yourself emotionally or physically….. Watch those blues fade away.

__________________xxx__________________
Reference:

MCQ

1. For Indian perspective midlife blues all are true, except one –
   a. Peculier to culture
   b. Depend on personal and family circumstances
   c. Early age of menopause
   d. Psychology of aging is different

2. Which of the statement is not true -
   a. Anxiety & depression overall is 2-3 times more common in women than man.
   b. Women experience an increased incidence of depressive mood during early menopausal transition v/s late.
   c. Clinical trial evidence suggest no effect of ERT on depression in late postmenopause but short term positive effect in menopausal transition

3. Low detection rates of depression in Indian women is because of –
   a. Short appointments
   b. Lack of screening tools
   c. Low reporting of stressor & more somatic symptoms
   d. All of the above

4. All these medications can cause depression accept one –
   a. BETA blockers
   b. Alphacalcidol
   c. Benzodiazepines
   d. Corticosteroids
   e. Ibubrufen

5. For treating Perimenopausal depression which of the drug cannot be used –
   a. Clonazepam
   b. SSRI
   c. SNRI
   d. HRT

ANSWER KEY:

1-C  2-B  3-D  4-B  5-A