Natural and premature menopause

How they affect psychological health

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Menopause can occur naturally or prematurely, either induced or idiopathic. Adverse psychological outcomes can occur and must be dealt with sensitively.

KEY POINTS

- The natural menopause is a normal biological event associated with a range of physical and psychological symptoms.
- Some women may be more vulnerable to depression during the menopausal transition.
- Risk factors for depression include a prior history of depression or premenstrual dysphoric disorder, more prolonged or bothersome vasomotor menopausal symptoms, disturbed sleep and concurrent psychosocial stresses.
- The diagnosis of premature or early menopause often comes as a shock to women, especially if they have not started or completed a family, and is associated with many adverse consequences for physical health and future fertility.
- Many women with premature menopause feel that they are not given enough time and information to help them come to terms with the diagnosis, highlighting the importance of offering return appointments and suitable resources.

Menopause marks the end of a woman's reproductive capacity, and can occur either naturally or prematurely. The natural menopausal transition begins with the onset of menstrual irregularity and ends with the last menstrual period. It is said to have occurred 12 months after the date of the final menstrual period, which occurs at a median age of 51 years.[1] In contrast, premature menopause, which can be induced or idiopathic, encompasses several different conditions that have in common the presence of oestrogen deficiency leading to irregular or absent menstruation and menopausal symptoms. Premature menopause refers to menopause occurring before the age of 40 years, whereas early menopause is defined as the onset of menopause before the age of 45 years.[2] This article discusses some of the psychological implications of naturally occurring and premature menopause.

MedicineToday 2016; 17(5): 41-45

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Physical symptoms of menopause and their relation to psychological health

The menopausal transition is characterised by wide fluctuations in sex steroid hormone levels, and is associated with a range of physical and psychological symptoms. Although most women negotiate this life event without undue distress, some women will seek medical attention for the physical or psychological aspects of menopause.

Vasomotor menopausal symptoms (VMS), vaginal dryness and sleep disturbance are regarded as core menopausal symptoms.[3] There is, however, considerable variation across cultural and ethnic groups as to the most commonly reported physical symptoms. For example, women of Chinese and Japanese backgrounds experience fewer VMS than Caucasian women.[4]

There is only a weak correlation between the frequency of VMS and how much they bother the woman. The extent to which a woman's psychological wellbeing is affected by her VMS is strongly linked to psychosocial factors.[5] These include negative mood and affect, concurrent life stressors, a history of child abuse or neglect and a tendency to focus on somatic symptoms. Women with more negative attitudes towards the menopause and ageing report more symptoms during the menopausal transition.[6]

Vaginal dryness is reported by up to 88% of women aged 55 to 65 years.[7] Women may not raise this concern with their partners or doctor because they feel embarrassed or think that it is just a natural part of growing older.[8] Loss of libido is also commonly reported, and may improve if vaginal dryness responds to local oestrogen therapy.[9,10] Loss of libido, however, is a complex issue that may touch on many factors, ranging from a woman's feelings about her changing body and internalised societal attitudes about sex in midlife to the physical health of her partner.[9]

These issues can have significant adverse impacts on intimate relationships and so clinicians should not shy away from starting a conversation about them. Clinicians may also wish to enquire whether menopausal symptoms are affecting a woman's functioning in the workplace. A recent study conducted in the UK reported that about 50% of menopausal women felt that menopausal symptoms, such as tiredness and hot flushes, made managing work somewhat or very difficult.[11]

Psychological symptoms of menopause

Some studies suggest that the perimenopausal period, when hormonal levels fluctuate the most, is a time of heightened risk for the development of new episodes of depression, especially in women with a prior history of depression.[12] However, other studies suggest a steady decline in depressive symptoms across the menopausal transition.[13] There is no clear evidence that the risk of anxiety disorders increases during the menopausal transition.[14]

Careful questioning is needed to elicit the history of depressive and anxiety symptoms, and their associated features. Table 1 provides some suggestions as to how to ask relevant questions about mood. The clinician should be aware that certain risk factors may increase the risk of depression during the menopausal transition. These include a prior history of depression or premenstrual dysphoric disorder, more prolonged or bothersome VMS, disturbed sleep and concurrent psychosocial stresses. This is made more complicated by the similarity between some physical symptoms of menopause, and those of anxiety and depression. For example, there is overlap between the symptoms of panic attacks and those of hot flushes, whereas sleep disturbance, sexual dysfunction and subjective memory problems are commonly reported by both people with depression and those in the menopausal transition.

Psychological wellbeing and menopause

It is important to balance the concern that the menopausal transition is associated with negative outcomes for women against the more positive aspects of this life transition. For many women, the end of their reproductive life means the end of fears about unwanted pregnancy and the greater independence of children can herald new freedoms.

There is little evidence that menopausal stage and the physical symptoms of menopause have any bearing on positive aspects of wellbeing, such as overall life satisfaction.[15] It seems, rather, that the psychosocial aspects of a woman's life, such as work satisfaction, loneliness, physical activity and attitudes to ageing, are key drivers of wellbeing at this time.[11] Moreover, although some capacities such as muscle strength and working memory may decline with age, others, such as the ability to use experience wisely and to regulate emotion, increase at this time.[16]

Promoting psychological wellbeing

The physical and psychological challenges of the menopausal transition provide numerous opportunities to promote psychological wellbeing during this important but somewhat overlooked period of a woman's life. Some suggestions as to how to address certain key concerns are given in Table 1.

Firstly, there is good evidence for the efficacy of cognitive behavioural therapy (CBT) for the treatment of troublesome VMS.[17] CBT is also likely to be part of treatment for depression, which should take a biopsychosocial approach, and may include prescription of antidepressants.[18]

Secondly, there is a clear role for lifestyle changes, such as weight loss, establishing good sleep patterns, smoking cessation and increasing physical activity. These are likely to have considerable benefits for all aspects of emotional, physical and brain health, as well as specific benefits in reducing the impact of VMS.[17] Social activity has also been shown to have considerable health benefits: people who are more socially engaged not only live longer, but also have a lower risk of health problems.[19] Studies also find that people who are socially engaged in a range of diverse relationships report having better mental health.[20]

TABLE 1. PROMOTION OF PSYCHOLOGICAL WELLBEING DURING THE MENOPAUSAL TRANSITION

Issue	Assessment	Treatments available
Depression	Ask direct questions such as: How long have you felt depressed? Did the symptoms start before your periods became irregular? Is your sleep disturbed by night sweats?	Cognitive behavioural therapy Relaxation, mindfulness, stress management Lifestyle changes, such as weight loss and increasing physical activity
Anxiety	Ask direct questions such as: How long have you felt anxious? Did the symptoms start before your periods became irregular? In what sorts of situations do you feel anxious? Do hot flushes or the fear of having one make you anxious?	Relaxation, mindfulness, stress management Provide an understanding of the relations between thoughts, behaviours and emotions, and physical symptoms of anxiety Help the patient overcome avoidance of situations that provoke anxiety
Vasomotor symptoms and vaginal dryness	Ask direct questions such as: How often do you have hot flushes and night sweats? How much do they bother you? Are you avoiding physical activity or social events because of embarrassment or fear that you will have a hot flush? Are night sweats disturbing your sleep? Is vaginal dryness making it difficult to have sex? Is your libido lower than it used to be? What other factors (e.g. pain, your physical health or your partner's, relationship tensions, body image concerns, not giving enough time to the relationship) could be affecting your sexual relationship?	Provide explanations of biological processes of menopause Provide an understanding of sexuality in midlife Help the patient develop a more positive attitude towards menopause and cultivate self-compassion Physical exercise alone does not reduce VMS but can improve mood and therefore the ability to cope with VMS Cognitive behavioural therapy focused on relaxation and acceptance of VMS, rather than struggling against them
Life stressors	Enquire as to the nature of stressors, and encourage problem-solving approaches if there are practical and realistic solutions to some problems. If feasible solutions are not available, build coping skills	Activity pacing Help the patient develop self-efficacy and control beliefs Lifestyle changes, such as weight loss, increasing physical activity and smoking cessation

Abbreviation: VMS = vasomotor menopausal symptoms.

Finally, menopause coincides with a potentially challenging time when women need resilience in order to cope with pressures from work, ageing parents, teenage children and perhaps the beginnings of health problems in themselves or their partner. One teachable psychological resource that may act as a buffer to life's stresses, and has been shown to weaken the impact of VMS in daily life and be linked to lower depression scores, is self-compassion.[21] This has been defined as a healthy way of dealing with adversity by relating to the self by use of the three elements of self-kindness, a sense of common humanity and mindfulness. Self-compassion enables an individual to acknowledge that stress is a part of life that connects them to others and the human condition, while using mindful awareness to engage with their emotions.[21]

It is beyond the scope of this article to fully consider the role of hormone therapy (HT) in the treatment of women with depression. One recent review concluded that HT alleviates depressive symptoms but not depressive disorder,[22] whereas another review concluded that a role for HT only existed for perimenopausal women who were depressed.[23]

Premature and early menopause

Premature and early menopause can be induced or idiopathic and if induced is most commonly caused by chemotherapy or surgical interventions such as bilateral oophorectomy. Childhood cancer survivors are at heightened risk of developing premature menopause, and as childhood cancer survival rates increase, so too will the number of young women experiencing premature menopause.[24]

Spontaneous menopause is reported to affect about 1% of women under the age of 40 years.[2] The term 'premature ovarian failure' has been criticised for its implication of both the finality of the condition and of individual responsibility for the condition,[25] and the terms 'primary ovarian insufficiency' (POI) or 'primary ovarian dysfunction' are now regarded as preferable alternatives.[2]

Women with premature and early menopause are at increased risk for several physical health conditions, including reduced bone density and its sequelae, and poorer cardiovascular health. Although these physical health issues are important in their own right and may have implications for psychological wellbeing, four other related areas have been identified as being particularly important for psychological wellbeing in this group of women:[26,27]

- communication with health practitioners
- managing symptoms of menopause
- fertility concerns
- psychosocial functioning.

For a discussion of the physical health consequences of premature and early menopause and their management, which is likely to include HT unless a hormone-dependent cancer is present, the reader is referred to a recent review by Faubion et al.[27]

Communication with health practitioners

The issue of effective communication with health practitioners is likely to arise in the earliest stages of diagnosis and management because the diagnosis of premature or early menopause is a potentially devastating one, especially for women who have not yet had children. Guidelines for good practice in the management of women with premature menopause indicate that they need to be informed of the diagnosis sensitively and given sufficient time to ask questions.[28] Follow-up appointments should be made to provide support and further information and resources.

This advice may sound self-evident but it has been found that only 21% of women thought that they had been sensitively informed, were given enough time, had the opportunity to ask questions and received enough information.[26] Almost half the participants in this study did not think they had been given sufficient information. It is therefore crucial that health practitioners offer follow-up appointments, emphasise their availability for further consultations and are able to direct women towards suitable resources. Some examples of these resources are given in Table 2.

Managing symptoms of menopause

About 75% of women with premature menopause have significant fears of developing osteoporosis, weight gain and reduced sexual functioning, whereas around two-thirds have concerns about ageing.[29] VMS are experienced by up to 80% of women with premature menopause.[30]

One of the challenges for women in dealing with these issues is that they will be out of step with most of their peers. Moreover, if the premature or early menopause has been a result of cancer treatments, the onset of symptoms may be more sudden, at a time when the woman is dealing with multiple physical and psychological aspects of cancer diagnosis and treatment.[27] The psychological interventions for managing the symptoms of menopause are similar to those used for women with naturally occurring menopause, with good evidence for the efficacy of CBT for the treatment of VMS.[31]

Fertility concerns

It is obvious that concerns about fertility will be uppermost in many women's minds when they receive a diagnosis of premature menopause, particularly if they are younger, have no or few children and have idiopathic premature menopause.[26] Discussion about options for parenthood will likely require a series of appointments, so that information can be processed and new questions that may arise can be answered.

Ovarian function can be intermittent and unpredictable, and spontaneous pregnancy occurs in 5 to 10% of women diagnosed with POI. Paradoxically, therefore, the need for contraception should also be discussed.[32]

TABLE 2. USEFUL RESOURCES FOR WOMEN WITH PREMATURE AND EARLY MENOPAUSE

Organisation	Website	Resources available
Australasian Menopause Society	www.menopause.org.au	Fact sheets on many aspects of menopause, including premature menopause
Jean Hailes for Women's Health	jeanhailes.org.au	Fact sheets on many aspects of women's health, including premature menopause
The Daisy Network	www.daisynetwork.org.uk	This is a support group for women with premature ovarian insufficiency, registered as a charity in the UK but with members from all over the world.

Counselling will be beneficial for some women who unexpectedly face the prospect of not being able to have children.[27] Feelings about loss of fertility are not restricted to grief and a sense of lost hopes and aspirations, but may be more complex, raising concerns about identity and a sense of incompleteness or inadequacy as a woman. However, it is important for women to express concerns because avoidance of emotions associated with premature menopause has been shown to be detrimental to psychological wellbeing.[33] Referral to mental health practitioners will be indicated for women with persistent or severe distress.

Psychosocial functioning

Most studies report that bilateral oophorectomy is associated with an increased risk for new-onset anxiety and depression, and that POI is associated with an increased risk of depression and anxiety, increased sense of isolation and poorer self-esteem.[2,27] A lower health-related quality of life was found in a sample of women with premature menopause, compared with that found in women who had natural menopause.[26]

There are close interactions between VMS, sleep disturbance, fatigue and depression, and treatment of one component may benefit the others.[34] For example, physical activity and the use of cooling strategies may improve sleep, thereby reducing fatigue and depressive symptoms.

Evidence is emerging that premature menopause has effects on later cognitive functioning; this applies to both women with POI and those with menopause as a consequence of bilateral oophorectomy.[35] Premature menopause is associated with overall enduring decline in cognitive functioning seven years later, with specific deficits in verbal fluency, psychomotor speed and visual memory.[35] It is suggested that these declines should form part of the evaluation of risk and benefit when considering oophorectomy in younger women. This is consistent with recommendations from bodies such as the Royal Australian and New Zealand College of Obstetricians and Gynaecologists that removal of ovaries before the age of 65 years is rarely recommended.[36]

Conclusion

The natural menopausal transition is a hormonally-driven and psychosocially complex life change. Most women cope well with the challenges it presents, and there are effective treatments for those who present with troublesome VMS and symptoms of depression or anxiety. These interventions include CBT, making lifestyle changes and developing psychological assets such as a sense of control, self-compassion and social networks. Midlife is a pivotal time for all women to lay down the foundations of later emotional, cognitive and functional health.

Premature and early menopause are associated with many adverse consequences for physical health and future fertility. It is not surprising that premature and early menopause may give rise to depression, anxiety and a range of complex feelings that include shock, disbelief, grief and feelings of inadequacy as a woman. It is, therefore, important to enquire specifically, but sensitively, about these emotions, even though it may seem that there are more important physical issues to address, and to ensure that sufficient time is given for discussion. Finally, the numerous adverse consequences of premature and early menopause, including the association with cognitive decline, should be taken very seriously when weighing up the costs and benefits of bilateral oophorectomy in younger women. MT

References

A list of references is included in the website version of this article (www.medicinetoday.com.au).

COMPETING INTERESTS: None.

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