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Mindful Menopause

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Abstract

Menopause is a part of natural aging process that causes a variety of physiological and psychological changes in the life of women. Various psycho social factors like lifestyle, health, culture, previous mood disorders all impact on menopause transition. Rapid changes in female reproductive hormones are implicated to cause fear, anxiety, depression and mood swings. However, insufficient coping abilities and poor adaptation to stress predisposes vulnerable women to emotional instability. Menopause is an unavoidable stage of life and acceptability of this fact depends on awareness, attitude, practices and health of women. Along with appropriate pharmacological treatment; lifestyle modifications and psycho-social support would go a long way to help women to steer through this phase of life with a sound mind.

Keywords: Menopause; Psycho-social; Anxiety; Depression; Mood disorder.

Introduction

As a woman lives through the 'roller-coaster ride' of life; from childhood to adulthood her body keeps on changing at all times; may it be anatomical, physiological, psychological or hormonal. Menopause is just another phase when ovaries stops producing eggs anymore. Menopause is a Latin word where 'Meno' means month and 'pause' means stop. All women experience menopause regardless of culture, race or social and economical background.[1] Menopause is caused by fluctuation of hormone levels within ovaries[2] and clinical studies suggest average age of cessation is 48–52 years of age.[3] With increase in life expectancy to around 85 years, now a days most women spend one-third of their lives in postmenopausal stage.[4] Despite popular belief, declining estrogen levels is not the sole cause of menstrual cessation; rather many hormones fluctuate to cause this reproductive transition or 'climacteric'.[5] These hormonal fluctuations can occur anywhere from 8-10 years prior to cessation to several years afterwards. The decreased biological and physiological functioning may lead to psycho-social disturbances.[6]

Redefining Menopause

Menopause is a complex three stage reproductive aging transition which can sometimes span multiple decades. 'Menopause' is lack of menstruation for 12 consecutive months and can only be defined in retrospect.[7] 'Perimenopause' refers to period leading up to menopause, this is usually the time when signs or symptoms such as irregular bleeding, hot flashes, insomnia and others may begin.[7] 'Postmenopause' is the point after which a woman has not had a period for 12 months; often this stage is not diagnosed until one to two years of cessation of periods.[7]

However, existing clinical definitions are partial as they focus on physiology only and fail to capture the variability of how women define or experience as they live 'in' an uncertain midlife

reproductive stage. Being 'in' this life stage, dealing with myriad of signs and symptoms on day-to-day basis validates that menopause is not just a retrospect moment or a clinical diagnosis.[8] Biomedical definitions of menopause are often purely negative even pathological9. Health professionals often present menopause as a cluster of symptoms caused by deficiency of reproductive hormones.[10,11] This focus on biology urges doctors to fix women's deteriorating bodies and encourage them to seek medical therapy to replace or restore their hormones.[10-12]

It is important to understand that women's subjective experiences are not always negative. Apart from concerns over physical symptoms, mental instability, sudden signs of aging, diminution of sexuality women may feel neutral or even liberated from menstruation and its nuances, use of contraception and burden of child-bearing. Furthermore, women's previous reproductive experiences prepare them well to handle both expected and unexpected bodily symptoms.

Menopausal Transition and Psycho-social Perspective

Factors like lifestyle, health, culture, previous mood problems and whether menopause onset is natural, surgical or chemotherapy induced; all impact on menopausal symptoms. Increased risk of psychiatric morbidity is seen in women who experience early menopause or surgical menopause.[13] Menopause and mid-life is a time when women's identity shift and their psycho-social transition marks a new stage of life.

Various Psychological factors have an impact on menopause and perimenopause transition.[14]

- Life events, Personality, Coping skills.
- Past experiences of mood disorders.
- Negative attitude to menopause and aging in general report to have more symptoms[15]
- Low self esteem experience more severe menopausal complaints[16]
- Life stressors like poor overall health, unemployment, lack of social support.
- Interpersonal relationships with partner, children, family and friends act as major supports in woman's life with influence on her psychological well-being.

Social factors such as economic status, education and culture have great impact on menopausal symptoms.[14] Few studies have shown rates of depressive symptoms, hot flashes or sweats were significantly lower among Japanese women than females of American and Canadian population.[17] Such variations across cultures reflects differences in

- Social Status of women in the society
- Beliefs regarding menopause and aging
- Sensitivity to specific symptoms
- Biology, Diet and Health behaviour

Low literacy rate in developing nations lead to negative attribute to menopause as the success of woman is considered to be related to production of more children, particularly males.[14]

Psychological Vulnerability in Menopause

Menopause is an endocrine transition which presents myriad challenges which affects the biopsyhcosocial well-being of the woman. Female reproductive hormones and rapid changes in their levels may affect neuro-transmitters in the brain particularly serotonin and Gamma-butyric acid. The greater frequency of symptoms during the years prior to the end of menses and reduction in symptoms once menopause has occurred suggest that emotional symptoms are related to changing hormone levels rather than low hormone levels[18]. Research has shown that fluctuating hormone levels during menopause contribute to mood alterations[19]. Menopause status remains an independent predictor of depressive symptoms[20].

During menopause transition women experience many neuro-pyschiatric symptoms[21] like mood changes, crying spells, cognitive decline and memory loss. A detailed history is important to rule out causes of mood disturbances during menopause transition, such as;

- Untreated vasomotor symptoms
- Recurrence or development of new episode of depression
- Nutritional deficiencies
- Hypothyroidism
- Medications for other illness
- Life stressors
- Adjustment to age related social changes
- Socioeconomic status

Distress in Menopausal Mind

Feeling tense or nervous, feeling blue or depressed, feeling irritable or grouchy has been proposed as symptoms of 'psychologic distress' in menopause.[22] As a direct impact of low estrogen or influence of neurotransmitters and partly due to the psychosocial aspects, menopause may be associated with mood disorders.[23] Vaidya R et al[24] proposed

various theories to explain possible association between menopause and mood.

- Symptom or Domino Hypothesis: Dysphoria caused by vasomotor symptoms.
- Biochemical Hypothesis: Estrogen-decline induced dysregulation of neuro-modulatory systems.
- Psychoanalytic perspective: Loss of reproductive capacity causing emotional disturbance.
- Social aspects: Mid life crisis and its effects.

Estrogen has both neuro tropic and neuro-protective effects on monoamine neurotransmitters of brain that are implicated in pathogenesis of affective disorders. Estrogen replacement therapy improves mood secondary to its effect on serotonin receptor binding.[24]

However, these mood disturbances do not necessarily meet diagnostic criteria listed in Diagnostic and Statistical Manual-5 (DSM-5) or WHO International Classification of Diseases (ICD-10). Current guidelines use the term 'depressive symptoms' to differentiate this condition from depression or major depressive disorders.

Kalra et al[25] proposed use of term 'Menopause distress' as a person-centred, conceptual definition which focuses on 'living with menopause'. Menopause distress is defined as an emotional response characterised by significant, persistent apprehension, discomfort or dejection, due to a perceived inability to cope with the biomedical and psychosocial demands and challenges of living with menopause.

Identify 'Psychological at risk' women

Inefficient coping abilities and poor adaptation to stress predisposes some women to psychiatric disorders. There is emergent unmet need to identify such vulnerable group of women to prevent their further psychological down-troll.

Rosemeier et al[6] classified menopausal women to three groups on basis of severity of menopausal complaints and individual specific perception of menopause.

- The Coper: These women regarded menopause as fairly unproblematic and found to have high degree of self-esteem and composure.
- The Aware: These women reported moderately severe menopausal complaints. They considered menopause as a period of reorientation or a positive challenge and they were working women with highest education level.
- The Sufferer: These women reported most severe complaints hence the name 'sufferer'. Compared to the other two groups they had lowest self-esteem, highest level of loss experience and loss of attractiveness. These women were found to have low level of education, divorced or lived alone. This suggested that the deficits in the quality of life that already exist were reinforced during menopausal transition.

The 'Coper' hardly feels disregard. The 'Aware' is likely to resist social pressure positively. For the 'Sufferer', however, feeling of being written-off reinforces the negative self-image she already has. Such analysis may help us identify psychologically vulnerable women and institute timely psychosocial support as a part of comprehensive menopause care.

Menopause and Psychiatric Morbidity

Symptoms of depression and anxiety are more common in menopausal women. Symptoms of depression may actually be reactions to physiological changes accompanying menopause.[26] For example, night sweats due to fluctuating estrogen levels can interfere with sleep leading to symptoms of fatigue, poor concentration, depressed mood and irritability. Other psychological stressors include;

- Empty Nest Syndrome: Children leaving home
- Loss of partner
- Health problems
- Inability to find new fulfilling roles
- Responsibilities for ailing parents

Depression

Clinically significant depressive symptoms likely to develop in perimenopausal women were twice more common than women who had not yet gone under menopausal transition.[27] Typical symptoms of depression include depressed mood, anhedonia and fatigue for at least 2 weeks, leading to poor social or occupational functioning in absence of substance use.

Anxiety

Although no correlation has been found between hormonal changes during menopause and anxiety disorders symptoms like sweating, palpitations, restlessness, sleep disturbances.

The symptoms of depression and anxiety are different but may overlap and also may present simultaneously. Features that differentiate depression and anxiety are shown in Table 1.

Depression	Anxiety Disorders
Feeling of emptiness, deep sadness or misery, loss of hope	Feeling of fear and apprehension
Slow down of physical movement, lack of energy	Physical feelings of agitation, muscle tension, symptoms of anxiety e.g: heart symptoms, nausea, breathing difficulties etc
Physical body slumped	General sense of being tense and rigid
Loss of interest and ambition, poor performance	May be perfectionist and may be concerned about outcome
Suicidal thoughts present in deep depression	May fear death but not focus on death (suicide thoughts come only when depression is secondary effect of anxiety disorder)

* Adapted from: Psychological and Social Aspects of Menopause - Scientific Figure on ResearchGate. Available from: https://www.researchgate.net/figure/Features-that-differentiate-anxiety-and-depression_fig5_319200366.

Premenstrual Dysphoric Syndrome

A condition where change in mood occurs with changes in hormone levels occurs every month before menstruation. Women report that symptoms worsen with onset of perimenopause and alleviate with menopause.[28]

Trichotillomania

A hair pulling disorder may worsen at perimenopause.[28]

Therapeutic Options in Menopause

Management of biopsychosocial needs of menopausal women could be challenging. It is an art requiring a multi dimensional, empathetic and comprehensive approach providing women necessary solutions and empower them to better deal with this transition.

Lifestyle Modifications

A healthy lifestyle can help to reduce symptoms of menopause.

- Exercise: Physical activity and exercise has beneficial effects on hot flashes, mood, Body Mass Index (BMI), Coronary Heart Disease (CHD) risk.[29] Activities that stimulate brain can help rejuvenate memory such as reading books, puzzles, crossword and longhand mathematics.
- Diet: A nutritious diet reduces fatigue and mood swings. A healthy diet consists of low fats, high fibres with plenty of fruits, veggies and whole grains. Women should ensure enough calcium and Vit D intake on a daily basis. Phytoestrogens are estrogen like substances obtained from some cereals, vegetables, legumes (soy-like) and herbs. They act as weak estrogens and found to alleviate vasomotor perimenopausal symptoms like hot flashes and night sweats. Consumption of 30ms/day of soy isoflavones causes up to 50% reduction of hot flashes.30. Smoking and alcohol consumption is found to worsen the hot flashes. It is advisable to avoid caffeine and spicy food in menopause.

Social Support

Social interactions with family and community, nurturing relationship with partner and healthy emotional support from friends can be very effective means to steer through this life-stage. Misconceptions about midlife changes, embarrassment and stigma around aging, fear and avoidance behaviour in some women need to be addressed with empathy and confidentiality. A professional help from a counsellor and mental health professional is quite effective and should be easily available.

Pharmacotherapy

- *Hormone Replacement Therapy:* HRT lost its charm with reports of increase in risks of breast cancer, heart attacks, strokes and blood clots among menopausal women. However, some studies report use of estrogens and androgens alone or in combination to be effective in improving symptoms in non-clinically depressed perimenopausal and menopausal women[31].
- *Anti-depressants:* Anti-depressants such as SSRIs, TCA are used for depression during perimenopause and menopause. A meta-analysis shows that desvenlafaxine was also associated with reduction in number and severity of hot flashes. However discontinuation rates because of adverse effects such as asthenia, hypertension, anorexia, constipation, diarrhoea, dry mouth, nausea, insomnia, somnolence and mydriasis were very high compared to placebo-treated

women.[32]

Exploring newer therapies

Estrogen's neuro-active role in several brain functions is indisputable. The emerging therapeutic gap has opened up the new horizons for exploring alternatives from other systems of medicine. Neuroscientists, clinical pharmacologists and biomedical scientists are actively engaged in CNS-active medicinal potions.

Managing Menopausal Mind

The psychological experiences of women regarding menopause can greatly vary from person to person. However feelings of anxiety, depression, loneliness and disability are reported with more frequency. Despite all the positive and negative experiences, the fact remains that menopause is an unavoidable natural stage of life for all women and the way they adapt to these natural changes depends on their awareness, attitudes, practices and health both physical and mental. Women with positive attitudes, high self-esteem and family support are those that may better deal with menopause and its symptoms. Deficits in the quality of life during menopause are reinforced in women with low self-esteem, negative attitudes towards menopause and tend to report more severe complaints.

Menopause and perimenopause brings about biopsychosocial changes that women need to navigate on a day-to-day basis. As change can bring uncertainity, coping with uncertainity also becomes part of the everyday experience of reproductive ageing.[33] It is difficult to define the impact of menopause on women in a uniform or standardised way. Asserting women that 'change' and 'uncertainity' are hallmarks of menopausal transition may be uniquely satisfying and validating to every women living through this transition. In fact, acknowledging and welcoming this uncertainty would be a bold and different way of approaching and thriving during this inevitable transition.[8]

Menopause presents as a 'window of vulnerability' but should in fact be viewed as a 'window of opportunity' for self-reflection. The new bodily challenges could be healthy and liberating. Instead of viewing menopausal transition through a biomedical perspective, women should think of this stage of life as a chance to redefine themselves until their body finds a 'new normal'.

We should learn to honour this phase of life as a milestone during which women become free of hormonal shifts and wiser than ever. It is very imperative to help women to demystify and cope with the challenges of menopause and age gracefully. There is a need to glean the positive aspects of menopause by learning strategies that older women have learned over time. Clarity, decisiveness, emotional intelligence, ability to discern the truthfulness of others – all of that tends to ramp up in the fifties. Self- control, emotional resilience, confidence and body acceptance is the Mantra to a 'Mindful Menopause'.

"Menopause ain't a cause to fear;
Life is Beautiful and Age just a number!
Reboot, Rethink, Redefine the Normal-New;
Break the ice, unleash the 'Secret-Star' in you!"

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