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Mental Health During Menopausal Transition

Mini review
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Minireview

Like for the other reproductive periods of women's life, there is not enough knowledge about menopausal transition and its influence on mental health. Menopausal transition is defined as a period known as Stage-2 (early) and Stage -1 (late) according to the Stages of Reproductive Aging Workshop (STRAW) [1]. This period is also known as perimenopause and it's characterized by variable menstrual cycle length and later skipped cycles of amenorrhea longer than 60 days. According to literature symptoms of CNS can be present even 5 years before vasomotor symptoms or other somatic symptoms.

Most frequently psychological dysfunction during this period is related to mood disturbances (mood swings, depression, irritability, anxiety, suicidality), cognitive impairment (verbal memory, concentration, working memory, attention) [2], sleep disorders (insomnia, hypersomnia, problems with quality of sleep) [3] or sexual dysfunction (loss of libido, inability for sexual arrousal or orgazam) with more other symptoms as loss of self confidence, fatigue, brain fog etc. During perimenopause almost 80% of women will have some symptoms, 2/3 of these women will have vasomotor symptoms (night sweat, hot flashes) accompanied with some of the earlier listed psychological symptoms.

Etiology for the psychological issues during menopausal transition is not completely understood. It is known that hormonal disturbances can contribute to this symptoms (not only fall in estrogen and progesterone levels, but in testosterone also) [4], melatonin fall during this period, vasomotor symptoms (insomnia, depression), accompanied somatic diseases (e.g. fibromyalgia, hypertension, hypo/hyperthyroidism), drugs (e.g. corticosteroids, β blockators, antidepressants), vulvovaginal atrophy (leading to dispareunia, loss of self satisfaction, anxiety or depression). Many psychosocial risk factors can be related with psychological symptoms [5]. Empty nest syndrome, care for adolescents vs. old parents, stressful life experience, culturally conditioned life style, loss of partner or sexual problems of the partner all can lead to complex psychological symptoms in menopausal women.

Treatment is complex and multidisciplinary, but needs to be personalised, also. Psychoeducation, behavioral changes, psychotherapy (Cognitive Behavioural Therapy, CBT), marital counseling should be the first line treatment for women with mild symptoms. If there are moderate or severe symptoms pharmacotherapy should be introduced. There is not enough relevant data for Hormonal Substitution Therapy (HST) in treatment of cognitive impairment during menopausal transition. While there is no established effective treatment option, off-label use could be tried with HST (for vasomotor symptoms) [6], atomoxetine or clonidine (transdermal patch). Also, if there is any psychiatric disorder diagnosed it should be treated to try to control cognitive symptoms (as treatment of pseudodementia in depression). Antidepressants stay the first line treatment for moderate to severe depression during menopausal transition. Serotonin Selective Reuptake Inhibitors (SSRI e.g. escitalopram, citalopram, fluoxetine, paroxetine), serotonin norepinephrine reuptake inhibitors (SNRI e.g. venlafaxine, desvenlafaxine, duloxetine) or mirtazapine, agomelatine should be tried.

Pregabalin can be used as a mood stabilizer. Some alternatives could be helpful as black cohosh, soy/isoflavonoides or red clover. The second line therapy (as adjuvant) could be HST applied. If there is a sexual dysfunction, applied therapy should be assessed as SSRI which could cause these problems. Treatment is to correct therapy, HST, vaginal estrogen, lubricants, testosteron. Menopausal transition is a physiological state with mental health consequences, usually mild and transient but if leading to the general or professional dysfunction should be recognised and treated to help women go to this phase with the less possible problems.

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