Women’s Mental Health Across the Reproductive Lifespan: From Menarche to Menopause

Emily C. Dossett, MD, MTS
Los Angeles County + University of Southern California Obstetrical and Gynecological Assembly of Southern California
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Objectives

- Understand significance of women’s mental health
- Discuss periods of vulnerability: menses, perinatal period, perimenopause
- Understand presentation and assessment
- Learn latest evidence-based treatment

Windows of Vulnerability

- Menses
- Pregnancy / Postpartum
- Perimenopause
- Other issues:
  - Infertility
  - Pregnancy Loss
  - Female-specific Cancers

Women and Depression

- Lifetime prevalence rates in women: 20%
- Higher rates for every anxiety diagnosis except OCD
- Women have twice the rates as men
- Rates start to differ at menarche
- Return to men’s rates in menopause


Theories as to WHY

- Neurobiologic Theory
- Domino Theory
- Psychosocial Theory

The Neurobiologic Theory

- Estrogen and serotonin work closely together
- The brain is an “estrogen sensitive organ”
- As estrogen levels shift, serotonin function is impacted
- Some women are particularly vulnerable to these shifts: genetic predisposition
- The result? Mood and anxiety symptoms

Mood and the Menstrual Cycle

Key Point: Assessing for mood symptoms around the menstrual cycle should be a part of every woman’s assessment.

Prevalence of PMS and PMDD

- PMS: >50%
- PMDD: 2-8%
- Premenstrual exacerbation of symptoms

Premenstrual Dysphoric Disorder (PMDD)

- In most cycles for the past year, during the days prior to onset of menses.
- Must have one of the following:
  - Marked depressed mood, hopelessness
  - Marked anxiety, tension
  - Marked affective lability
  - Marked anger or irritability


PMDD DSM-V con’t:

Other symptoms can include (need a total of 5 for diagnosis):

- Decreased interest in activities
- Concentration difficulties
- Marked lethargy or lack of energy
- Change in appetite, overeating, or food cravings
- Hypersomnia or insomnia
- Feeling overwhelmed or out of control
- Physical symptoms: bloating, breast tenderness

How to tell the difference? PMS v. PMDD v. MDD

Adapted from Burt VK.

PMDD: Evidence-Based Treatments

- SSRIs: standard of care, intermittent dosing
  - Sertraline (Zoloft): 25-100 mg
  - Fluoxetine (Prozac): 10-20 mg
  - Paroxetine (Paxil): 10-20 mg
- COCs: some positive data (drospirenone plus ethinyl estradiol)
- Calcium carbonate: 1200 mg/day
- Lifestyle modifications


Perinatal Mood and Anxiety Disorders (PMADs)

Myth of Pregnancy

Myth of New Motherhood

How Common Are PMADs?
- 10-15% during pregnancy and the postpartum
- Three times more new cases in postpartum than controls
- Much higher in ethnic minority women: closer to 30-40%

Risk Factors for PMADs
- “History repeats itself”
- Physically hard pregnancy or postpartum
- Unplanned pregnancy
- Infertility history / high expectations
- Lack of social support
- Financial, physical, or emotional stress
- Intimate partner violence

Key Point: Untreated depression in pregnancy increases risk of PPD by 50-80%


Why Do PMADs Matter?

- Risks to Mother
- Risks to Fetus
- Risks to Infant and Child
- Risks to Family

Risks to Mother

- Infrequent and late-entry prenatal care
- Appetite disruptions, poor weight gain
- Sleep disturbances, fatigue
- Increased risk of substance use
- Increased risk of smoking
- Suicidal thoughts and/or actions


Risks to Neonate

- Pre-term delivery
- Low birth weight
- Lower Apgar scores
- Elevated “stress hormones”


Risks to Infant

- Increased crying and irritability
- Increased risk of child abuse and neglect
- Poor attachment to mother
- Decreased duration of breastfeeding


Risks to Child

- Cognitive
- Emotional
- Behavioral
- Family Life


“The Baby Blues”

- Over 80% of women
- Tearfulness, mood swings, feeling overwhelmed
- Occurs in first two to three weeks
- Resolves on its own
What’s Different Perinatally When a Woman Has a PMAD?

- Multiple or severe physical complaints
- Pronounced anxiety
- Tearfulness
- Severe low mood/hopelessness
- Lack of connection to the infant


What’s Different Postpartum?

Key difference: “If you could have 8 hours to yourself, in a nice, quiet, clean bed, would you be able to sleep?” If no, then consider PMAD.

“Exposure always occurs, be it to treatment or illness.”

Stowe, Z et al. CNS Spectrums, Vol 6, No 2, February 2001

Risk of Relapse

- Asymptomatic women who quit their antidepressants in pregnancy: 68% relapsed
- Half of these relapsed in first trimester
- In other words: pregnancy does NOT protect against depression


Risks of Medication in Pregnancy

- First trimester considerations
- Congenital malformations?
- Pregnancy loss?
- Perinatal complications
- Long-term effects


Perinatal Antidepressant Use: Guidelines

- Use only when necessary and appropriate
- Do not avoid if woman truly needs
- Minimize number of exposures
- Use lowest possible EFFECTIVE dose
- Consider breastfeeding early and often

Breastfeeding

- Major concern for many new moms - plan from the beginning
- Emphasize sleep, flexibility, and health
- Sertraline, paroxetine and nor tripryline are undetectable in infant’s serum


Additional Treatment Approaches

- Psychotherapy
- Support groups
- Partner education
- Dietary supplements (e.g., fish oil)
- Sleep (5 hrs), diet, exercise

A Brief Look at Perimenopause and Mood

The Stats

- Average age of menopause is 52
- Most women have symptoms for at least 8 years previously
- Women now living over a third of their lives in menopause

Peri/Menopausal Symptoms

- Affective
  - Sad mood, pessimistic
  - No pleasure / joy (anhedonia)
- Anxious
  - Tension, persistent worry
  - Irritability
- Cognitive
  - Lack of concentration
  - Poor memory
Is perimenopause an independent risk factor for depression?

- Generally thought yes, though controversial
- Diagnosis of depression 2.5 times more likely
- Postmenopause: rates are equal to men’s rates


How to help? Treatment Options

- Psychotherapy
- Antidepressants
- Hormone replacement therapy?

Antidepressants

- Is one better than another?
- Start with what worked best in the past; if not, then:
- Start with an SSRI or SNRI (venlafaxine, desvenlafaxine, or duloxetine)
- Equivalent efficacy in perimenopause
- SNRIs may be better in postmenopause


Hormone Replacement Therapy for Depression?

- If falling estrogen levels lead to depression, shouldn’t replacing them help mood?
- Seems to be a “mental tonic” for well women
- May be helpful for depressed women, but data mixed
- General health concerns may limit use
- LOWEST dose for SHORTEST duration


CONCLUSIONS

- Women’s mental health focuses on vulnerability and wellness at times of reproductive change
- Evidence-based, effective treatments are available
- Proactive assessment of symptoms increases chances of health overall
- Women will come to you first – be ready!