

A few theoretical and practical aspects regarding depressive symptoms associated with menopause

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Abstract

Depression and anxiety are strongly influenced, for the majority of people, by circumstances and also by hormonal structures. Researchers found that during menopause, women are more exposed to depression if they have a poor sleep and are less exposed if they have a job. Divorce, the death of the spouse and the loss of job are other factors that contribute to the obvious emergence of depression for menopausal women.

Keywords: *menopause, depression, the role of estrogen, perimenopausal period, comorbidity*

I. INTRODUCTION

Depression has a huge echo in the female existence and the comorbidity situation with menopause is an existential event which inserts itself towards the human continuum. Menopause is defined as a moment of change, of transition from one stage to another of the human existence (Greer, 1993). On the other hand menopause marks the start of a period that refers to a normal course of ontogeny (Baltes, & Schaie, 2013).

Socially expressed attitudes view the understanding of menopause as a decline in both biological and social plan, which in conjunction with the presence of a depressive phenomenology is most often labeled as dysfunctional (Schmidt, & Rubinow, 1991). Depression and anxiety affect several brain structures simultaneously with various symptomatic repercussions: prefrontal cortex - with cognitive disorders; limbic system - the modification of the emotional threshold; basal ganglion – affecting the normality of the movement; hypothalamus - with implication in neurovegetative symptoms that can be somatic and endocrine (Nestler, Barrot, DiLeone, Eisch, Gold, & Monteggia, 2002).

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It was also established that individuals that have too many negative thoughts regarding their problems, are also people who don't have a good opinion about themselves. The fact is significant, because self-esteem is one of the most important elements of mental health: it is more likely that women who believe in themselves come to be assailed by premenopausal doubts and/or menopause or feelings of guilt when they notice they forgot the name of a relative or that they are having a hot flash (Hyde, Nee, Howlett, Drennan, & Butler, 2010).

Assuming responsibility regarding oneself is an important part of maintaining self-esteem during perimenopause (Kittell, & Mansfield, 2000). If commitments are accepted, this does not mean that women should feel imprisoned within them. No matter what problems arise in the lives of individual's, self-pity is the worst possible answer (Kaufert1982).

Keeping close relations with family and friends helps women that are at menopause with comorbid depression. The presence of anxiety-depressive disorders and behavioral polymorphism - are modeled in women, often by the social position and the economical state, by the presence or the lack of children, cultural and spiritual preoccupations, health condition, psychical protection and sexual comfort, elements which constitute themselves in very important items regarding the recognition of the quality and life satisfaction (Chen, Lin, Wei, Gao, & Wu, 2007).

II. TYPES OF TREATMENTS

Regarding the types of treatments used in the depression – menopause complex, in the last 20 years the interest for possible psychoactive properties of estrogen, have outlined two areas: the role of estrogen as a treatment of choice for menopause depression (Sherwin, 2005); provides a method for alleviating mood and life satisfaction for healthy women, without depression (Steiner, Dunn, & Born2003).

In the case of the depressive disorder that accompanies menopause, another option provided by psychiatrists and family physicians is represented by the use of antidepressants (Joffe, Soares, Petrillo, L. Viguera, Somley, Koch, & Cohen, 2007). More recent used drugs, such as serotonin growth inhibitors were praised as being non-harmful and an effective solution (Berendsen, 2000).

Other studies leans towards erasing premenopausal and postmenopausal differences regarding the mood and the presence of affective disorders, considering that menopause is not absolutely associated with an increase of the risk of depression (Lobo, 1994). Within the etiology of the depressive symptoms the family and social foregoing factors seem to be the most important that precedes and continues for the perimenopausal period. On the other hand it was found that the sometimes higher frequency in women compared to men regarding affective disorders, depression and anxiety begins in adolescence and has a correspondent in dysrhythmia or the lack of balance

in the cyclical functionality of the hipotalamo-hipofizo-ovarian axis as opposing to the orchitis, with periods characterized by hormonal sexoid changes where the occurrence of depression is exacerbated - premenstrual, post birth, during lactation, premenopausal and menopausal (Nolen-Hoeksema, 2001).

The existence of the latter entity is present, according to some authors, in 25-50% of women, ambiguity etiological being considered dominant (Manji, Drevets, Charney, & Paykel, 2001). For example, women with surgical menopause (total ovarian failure) and those with preconceived negative ideas about menopause are more exposed to the risk of depression (Avis, Crawford, Stellato, & Longcope, 2001). Menopause is associated with a reduction in the central activity of neurotransmitters and neuropeptides, with consequences on the predisposition and the use of estrogen leads to the amelioration of the situation.

III. CONCLUSIONS

Counseling and psychotherapy in the case of depression associated with menopause aims at individualizing the rediscovery of reality. The effectiveness of psychotherapy must start from perception and individual understanding of depressogenic causes requiring the reconstitution of axiomatic hierarchies for the postmenopausal depressed patient, helped her regain the place and means of communication with other people.

Combining pharmacotherapy with psychotherapy may be more efficient than any of the known methods and clinical protocols recommend a concomitant use of psychotherapy and medications (Kornstein, Schatzberg, Thase, Yonkers, McCullough, Keitner,... & Keller, 2000; Kessler, 2006).

Combating isolation and preserving the dignity of women suffering from menopausal depression requires changing mentalities that proliferate, creating a favorable opinion towards their problems. One way of achieving this goal, inexpensive, without known side effects is education, understood in a broad sense, formatted, that should include important concepts of knowledge regarding depressive symptomatology not only to directly involved specialists, physicians, psychiatrists, psychologists, but also a number of volunteers who want to support the community.

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