

Menopause – managing psychological symptoms

Evidence brief

August 2024

Rapid evidence checks are based on a simplified review method and may not be entirely exhaustive, but aim to provide a balanced assessment of what is already known about a specific problem or issue. This brief has been reviewed by the members of the Menopause Taskforce. This brief should not be a substitute for individual clinical judgment nor is it an endorsed position of NSW Health.

Evidence brief

Evidence check question

What are the primary considerations and evidence for the assessment and management of psychosocial symptoms in menopause?

Summary

- Multiple systematic reviews found that perimenopausal and postmenopausal women are at elevated risk of experiencing depressive symptoms compared to premenopausal women.¹⁻⁴ Depressive symptoms commonly occurred in combination with other menopause symptoms such as vasomotor symptoms, sleep disturbance and sexual dysfunction.^{1,2}
- Diagnosis involves identification of menopausal stage, assessment of co-occurring and overlapping psychiatric and menopause symptoms (i.e. decreases in sexual functioning), consideration of the psychosocial risk factors common in midlife, differential diagnoses and use of validated screening instruments to aid in disentangling symptoms and determining diagnoses.^{1, 5-7}
- Menopause specific mood disorder scales do not exist; however, several general validated screening measures such as Patient Health Questionnaire-9 (PHQ-9) may be used for categorical determination of mood disorder diagnoses.¹ Validated menopause symptom and health related quality of life scales including the Menopause Rating Scale (MRS), Menopause-specific Quality of Life Questionnaire (MENQOL), Greene Climacteric Scale and Utian Quality of Life Scale include mood items and may be useful in clarifying the contribution of menopause related symptoms.¹
- In menopausal women meeting the criteria for major depressive disorder or experiencing subthreshold depressive symptoms, use of antidepressants was associated with significant improvements in depressive symptoms (2022 systematic review and meta-analysis of seven randomised controlled trials).⁸ Subgroup analysis suggested that:
 - antidepressants were also effective in menopausal women without a diagnosis of major depressive disorder.

- selective serotonin reuptake inhibitors (SSRIs) or serotonin and norepinephrine reuptake inhibitors (SNRIs) significantly improved depressive symptoms relative to those receiving a placebo.⁸
- Hormone replacement therapy is more likely to be effective in reducing depressive symptoms in perimenopausal women who are in their early menopausal transition and with co-occurring physical menopausal symptoms (i.e. hot flashes or vulvovaginal symptoms) than in women in late transition or postmenopausal.⁹
- Cognitive therapy and behaviour therapy (CTBT) is demonstrated to be effective in improving menopausal symptoms such as depression, anxiety, fatigue, as well as quality of life in menopausal women (2022 systematic review of 14 randomised controlled trials).¹⁰
- Other alternative management methods for psychological symptoms include exercise interventions. Evidence suggests that low to moderate exercise intensity reduces depressive symptoms in menopausal women and increases quality of life.¹¹⁻¹³
- In-person or virtual psychosocial interventions, such as health education, web-based decision aids, question prompt lists and app-based symptom monitors, are also found to improve knowledge, patient-physician communication and promote self-care.¹⁴⁻¹⁶

Clinical practice guidelines/guidance

- The National Institute for Care and Excellence (NICE) is currently updating its guidance on diagnosis and management of menopause with an update focus on cognitive behavioural therapy for managing menopausal symptoms.¹⁷ To manage short-term menopausal psychological symptoms, NICE recommends considering:
 - hormone replacement therapy to alleviate low mood that arises as a result of the menopause
 - cognitive behavioural therapy to alleviate low mood or anxiety that arise as a result of the menopause.
- Similar to NICE, the Australasian Menopause Society recommends lifestyle changes as part of a holistic model of care for the management of mood disorders in menopausal women. This includes:
 - low to moderate intensity exercise and cognitive behavioural therapy.¹⁸
 - The use of antidepressants in menopausal women may be indicated for perimenopausal depression, with SSRIs and SNRIs potentially showing improvements in vasomotor symptoms.¹⁸
 - Menopausal hormone therapy is not a first line treatment for depressive disorders, however may be of benefit for mood and sleep quality in women experiencing vasomotor symptoms and can be considered in combination with antidepressants.¹⁸

Background

Menopause transition may be a time of increased mood disturbance and depressive symptoms for women.¹⁻⁴ Risk factors for mood disorders and depressive symptoms and/or disorders during perimenopause included:

- Demographic characteristics (i.e. financial problems, unemployment, ethnicity, <50 years old, low education).
- Somatic symptoms (i.e. vasomotor symptoms, bothersome symptoms, sleep problems)
 - Vasomotor symptoms are associated with depressive symptoms but not major depressive episodes, except potentially in women with first lifetime onset of a depressive episode during the perimenopause.^{1,19,20}

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- Prior health conditions (i.e. prior depression, poor self-rated health, severe premenstrual syndrome, history of psychological disorders).¹
- Medical comorbidities.¹
- Visceral obesity.²¹
- Psychological triggers and factors (i.e. death of significant family members, major stressful life event, limited social support).¹
- Mixed and inconclusive evidence for the association between depressive symptoms and/or disorders and hysterectomy with or without oophorectomy. Some recent longitudinal studies suggested an elevated risk, while earlier studies suggested a reduced risk.¹ The current evidence does not include a randomised controlled comparison, so it is not possible to establish a cause-and-effect relationship¹
- Younger age at menopause and a shorter reproductive period.⁵

Methods

To inform this brief, PubMed and Google searches were conducted using the following search strategy.

PubMed

("menopause"[MeSH Terms] OR "menopaus*" [Title/Abstract] OR "perimenopause*" [Title/Abstract] OR "climacteric" [Title/Abstract]) AND ("depressive disorder"[MeSH Terms] OR "depression"[MeSH Terms] OR "depression" [Title/Abstract] OR "anxiety"[MeSH Terms] OR "anxiety" [Title/Abstract] OR "Bipolar" [Title/Abstract] OR "bipolar disorder"[MeSH Terms] OR "psycho*" [Title/Abstract] OR "psychiatr*" [Title/Abstract]) AND ("systematic review"[Filter] AND "humans"[MeSH Terms] AND "english"[Language] AND 2012/01/01:2022/12/31[Date - Publication])
106 systematic reviews

Google and Google Scholar were searched using terms relating to menopause and psychological symptoms. Only the first five pages of the search results were screened. Studies suggested by Menopause Taskforce members, clinicians and experts were also screened.

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