Mood Disorders
Throughout a Woman's Life Cycle

Dr. Yanuck in her new office at the Yanuck Center for Life and Health.

Premenstrual Syndrome, Post-Partum & Perimenopausal Depression

By Cheryl Yanuck, MD

Fluctuations in mood are known to occur at times of hormonal shifts in women. Most mood disorders start around the time of puberty in girls. Before puberty, the rate of depression is equal between boys and girls. After puberty, girls are twice as likely to be depressed as boys.

Premenstrual Syndrome, commonly known as PMS but referred to as Premenstrual Dysphoric Disorder (PMDD) in the medical world, is a well-known disorder where women become irritable, upset, bloated, and crave sweets during the two weeks before their periods start. These symptoms can range from mild to severe; in fact, PMDD has been used as a defense in murder trials!

The months after giving birth are another high-risk time for women to become depressed. Since many women are nursing their infants at this time, skillful treatment has to consider the needs of both mother and child.

Finally, the years around menopause cause a jump in the rate of depression for at-risk women. However, menopause does not increase the rate of depression in women without any prior history of depression; by their 40s and 50s, the women who are prone to depression have already experienced previous episodes.

A common element in the treatment of hormonally-related mood disorders is the neurotransmitter serotonin. Serotonin helps the brain be less affected by hormonal changes, so having adequate serotonin makes it easier to manage hormonal changes without getting mood changes. Drugs that increase serotonin levels in the brain (Prozac, Zoloft, Celexa, Lexapro, and others) are likely to make women feel better at times of hormonal flux. It is important to know how to administer these medications at each stage of life for maximum benefit. Medications are best prescribed in combination with other treatment modalities, such as psychotherapy and nutritional counseling.

CASE 1: PMS

B is a 30-year-old graphic designer who came to my office stating: "My husband told me to do something about my terrible PMS." During the 10 days before her period, B became edgy, tearful, tense, and more prone to starting arguments. She also experienced breast tenderness and cravings for chocolate. Her mood returned to normal around the second day of her period, and she was fine for the next 2-3 weeks. Her symptoms were clear enough that we didn't need to use mood graphs to clarify the timing of her symptoms.

I started B on a low dose of Zoloft during the last two weeks of her cycle. She stops the medicine once her period starts, then resumes it two weeks later. We also discussed stress management techniques to calm herself when flooded with strong emotion, and role-played ways she could communicate better with her husband if she was upset. In addition, B started taking a multivitamin, reduced her caffeine and alcohol intake, and increased her exercise frequency to offset irritability and anxiety. Over the next two months, her PMS symptoms went from severe to mild and manageable. She has continued taking Zoloft two weeks per month for the last several years without relapse.

For some women, keeping a chart of emotional changes for several months makes it easier to determine if mood symptoms are indeed linked to the menstrual cycle. There is a mood chart on my website that can be used for this purpose (www.yanuckcenter.com/node/30—click on Mood Graph). This can be done before going to the doctor, to save time before treatment is initiated.

Some women suffer from depression throughout the month, with an exacerbation during the PMS time. These women can increase their dose of antidepressant during the last two weeks of their cycle if necessary.

CASE 2: POST-PARTUM DEPRESSION

M was referred to me by her gynecologist after her six-week post-partum check-up. She described feeling overwhelmed, tearful, anxious, unable to sleep even when her baby was asleep, with disturbing thoughts of leaving her family "because they'd be better off without me." She was not actively suicidal, but sometimes wished she could cease to exist. Her family was concerned, but too occupied with their own lives to be of much help. Her husband worked two jobs to make ends meet, since M had quit her job to stay home with the baby. M's mother lived far away, and was sole caregiver for her own elderly mother. M had had an unhappy childhood, in a household full of tension about her father's drinking. She now felt unprepared to raise her child, isolated, and unsupported, as she had been as a child.

We started meeting weekly for psychotherapy sessions. M usually brought the baby with her and we were able to get her husband to come in on two occasions to discuss specific issues. M started on a low dose of Prozac, a drug considered safe during breast feeding. We focused our therapy sessions on understanding the old emotional wounds that were being reopened by her current situation. We did internal resource work, strengthening M's ability to care for her own inner child as competently as she did her actual child on her best days. We also discussed concrete parenting issues, such as how to respond to the baby when she cried. M joined a new mother's group, where she made friends that became a support network for her. She managed to go for regular walks with her new friends and their babies. She increased the amount of protein and vegetables in her diet, reduced her intake of simple carbohydrates (white bread, cookies, candy), and eliminated hydrogenated oils and fast food. M's mood and sleep improved within a month, and after a year she was able to taper off Prozac and end therapy. She knows she is at risk for postpartum depression after future pregnancies and plans to come in if necessary in the future.

CASE 3: PERI-MENOPAUSE

L is a 50-year-old-writer who, over the last six months, has become depressed and irritable, with disrupted sleep due to hot flashes. Her periods are becoming irregular. She prefers natural methods of improving her health and had declined hormone replacement therapy at her gynecologist's office due to concerns about breast cancer and a preference for avoiding pharmaceutical drugs. I started L on a supplement called 5-HTP, a precursor (building block) of serotonin, as well as the vitamins needed for her body to convert 5-HTP to serotonin. Her blood level of vitamin D was low, so she started taking a daily vitamin D3 supplement. In addition, she took black cohosh and vitamin E for hot flashes, and valerian root extract as needed for insomnia. She improved her diet in the same way described for M (*above*) and started exercising more regularly. Over time, L's mood and sleep improved, and she was able to reduce the number of supplements that she took.

Depression rates increase during the perimenopausal period up to five years before women stop menstruating, and decrease two years after periods stop. The risk is highest in women with a prior history of depression. In addition to the natural methods described, SSRI antidepressants can be effective at relieving not only mood symptoms of menopause, but also hot flashes.

Each of the women described above found relief by addressing the specific pattern of factors driving her depression. My goal in treating women with depression is to identify and address the unique pattern of factors driving their depression to provide the best possible level of relief and resolution. h&h

Cheryl Yanuck, MD, is a psychiatrist who works with adults and older adolescents. She uses a variety of psychotherapy techniques as indicated for each individual patient, and has received years of advanced training in the treatment of trauma and dissociation. Dr. Yanuck uses elements of supportive psychotherapy, insight-oriented psychotherapy, cognitive-behavioral psychotherapy, interpersonal psychotherapy, art therapy, and guided imagery. On the biological side, Dr. Yanuck is skilled at prescribing psychiatric medications and, in appropriate cases, incorporates nutritional supplements into the regimens she prescribes. Relaxation techniques and other mind-body techniques are also recommended when appropriate.

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