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Reprint of The Manitoba Project: a re-examination of the link between menopause and depression

Patricia A. Kaufert, Penny Gilbert and Robert Tate

Faculty of Medicine, Department of Community Health Services, University of Manitoba, 750 Bannatyne Avenue, Winnipeg, Manitoba (Canada)

This paper re-examines the association between menopause and depression using data from a study in which 477 women were interviewed 6 times over a 3-year period. Menopause is examined as one of a series of factors which may increase the risk of depression for women in middle age, such as children leaving home, the death and illness of family members, the stresses of daily living, health and the onset of chronic disease. Rather than hormonal changes, it seems to be her health coupled with the shifts and stresses of family life in a woman's menopausal years which may trigger her depression.

Key words: menopause; depression; methodology

Introduction

The assumption that the menopausal woman will be depressed, irritable and anxious is pervasive and persistent. A manufacturer of HRT preparations included anxiety and irritability among the list of menopausal symptoms featured in an advertising campaign launched in Canada in 1990. A 1983 survey in a Canadian city reported that over 90% of a general population sample agreed with the statement that 'many women become depressed and irritable at menopause' [1]. A study among British general practitioners in the late 1970s found that they described the menopausal woman as 'neurotic, depressed, unable to cope with emotional crises' [2]. Clinical researchers have been working with checklists of menopausal symptoms which included depression and irritability since the early 1950s [3]. Indeed, the conviction that oestrogen deprivation was the root cause of menopausal depression led many researchers in the 1960s and 1970s into expecting (and sometimes finding) an improvement in psychological well-being after hormone treatment [4].

This assumption has survived, despite a lack of strong supporting evidence. Research to test the existence of an association between menopause and depression has been constant, but marred by methodological problems. Until the 1980s, general-population-based surveys were quite rare. Most research was done with small samples, selected from clinical populations, often from among women who

Correspondence to: P.A. Kaufert, Faculty of Medicine, Department of Community Health Services, University of Manitoba, 750 Bannatyne Avenue, Winnipeg, Mannitoba R3E 0W3, Canada.

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had undergone a surgical rather than a natural menopause [5]. The measurement of depression was methodologically naïve, the usual practice being to work with the handful of symptoms in the Blatt Menopausal Index [6]. Only a few studies used one of the standard measures of psychological morbidity current in the psychological and epidemiological literature [3]. Most studies were cross-sectional in design. Unless selecting for post-surgical patients, relatively few women in most study populations were in the immediately post-menopausal phase or experiencing the changes of the peri-menopause. Furthermore, because the data were cross-sectional, researchers could not determine whether a woman's depression was recent or a long-term condition, predating the hormonal changes of menopause. Finally, much of this research drew on a very narrow conceptual base. Focused on menopause, researchers rarely controlled for other factors with a potential link to depression. Insofar as there was an underlying explanation of why women should be depressed, other than in response to the decline in oestrogen, researchers borrowed from Freudian theory and linked depression with the loss of fertility and the end of mothering.

Menopause research improved dramatically during the 1980s, becoming more sophisticated both conceptually and methodologically. This issue of *Maturitas* brings together papers from a new generation of studies, based on large samples of women, selected from the general population, and followed over time. Rather than the Blatt Menopausal Index [5], the authors used measures of psychological complaints which were developed by researchers in psychological epidemiology. These instruments have been tested for reliability and validity, carefully calibrated to measure psychological distress, and evaluated for use in community-based rather than clinical populations. Their use marks a critical advance on past efforts to examine the relationship between menopause and depression.

Equally important, however, is the fact that these new studies draw on a broader literature. Although still concerned with the impact of hormonal changes, they also looked for explanations of depression in the wider context of women's lives. The classic Freudian model has been replaced by theories drawn from the sociopsychology of depression, which emphasize role loss rather than lost fertility. In role loss theory, it is where the lost role linked the individual into a network of relationships and social support that women are most vulnerable to depression, particularly if the role was also a source of self-esteem and validation of self. One researcher comments:

'If one does not know who one is (in a social sense), or if one loses a valued identity, then one simply does not know how to behave. Not only may a profound sense of depression and anxiety be experienced, but severely disorganized behaviour may result' [7].

Midlife is seen as a time when women must redefine their roles as daughters, wives and mothers. Parents die. Husbands become ill. Children grow into autonomous adults. In the terms of this theory, late middle age (the menopausal stage) sets women at risk for depression because they are losing the roles in which they had invested most highly and in which they had found their primary identities. At the same time, the body starts to falter. Women not only stop menstruating, but often face the first signs of deteriorating health and the onset of conditions they will carry into old age.

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