Mood and Mood Disorders

Mood Influencers

Some things that cause you stress come from the outside. Things happen, and you have to react. Other "stressors" are internal. They come from the ways you conceptualize your world and yourself, or some are rooted in changes in your physiology. Some stressors have a temporary effect, and others have lasting impact. Someone from your child's school calls and tells you that your child had a bad day. You can simply handle this event, or you can make yourself feel down about it. You are decorating your house for an upcoming party, and you discover that the plumbing in your guest bathroom isn't functioning properly. You have a deadline at work, and your computer's hard disk crashes. You are experiencing conflict over whether you should stay in a long-term, somewhat comfortable relationship with someone you are no longer passionate about. You notice that you are reacting to others in an impatient manner, and you are experiencing "crying jags" when watching a comedy on TV, just before you "get your period." Your doctor suspects that you may be becoming diabetic or you have just found out that your headaches are migraines. All of these stressors can evoke depression or anxiety. How you interpret these occurrences, conflicts, and changes determines the degree to which you become depressed or anxious.

Negative self regard can lead to both depression and anxiety. We develop our sense of ourselves, or our "self concepts," from feedback from important people in our childhood environments. When these people (parents, teachers, older siblings, etc.) are critical of us, make unrealistic demands, or abuse us in any way, we may develop the notion that we are not OK. Then everything that happens around us tends to validate this idea we have of ourselves. If you regard yourself in a negative manner, that is, you think that you are limited, unintelligent, unattractive, weak, etc., you have a tendency not to act self-confidently. This can create a cycle that is sometimes referred to as the "self-fulfilling prophecy." You don't even try to become chair of the committee, and if you do, you act so tentatively that others don't choose you, and that just proves what you already know about yourself—that you are somehow undesirable. Positive self regard, on the other hand, includes knowing and accepting your limitations as well as your strengths. You behave proactively, working toward achievable goals that you have set for yourself. Looking at yourself positively has important implications for avoiding the debilitating effects of depression and anxiety.

> *Carolyn says, "I don't know whether I have PMS or not. Every month I get more depressed and angry. I am screaming at my family. I'm even depressed at work, and it's obvious. My husband thinks that I 'have it.' The last two months, before my period my memory just left me. I forget where I put things. While driving I forget where I'm going." She has been noticing weight gain, feeling bloated, and having breast tenderness just before she gets her period. "Food cravings are a problem in general for me, and before my period I just can't stay away from chocolate and desserts."*

Dolores reports, "I never had problems with PMS before I had my son. It's been getting worse the past few years." She describes having a lot of anxiety, with occasional feelings of panic. She sometimes gets these panic attacks in grocery stores, crossing bridges, and being in open spaces—always when she is by herself. Her impulse is to run in order to get away from these feelings. The attacks are more frequent and more intense just before she gets her periods. She is easily distracted, and she tends to "take things personally" when things happen around her. During the past year she has had a number of hot flushes, for the first time, and her periods are not so regular as they used to be. "My friends tell me that I'm just not like myself any more. They tell me that I am not as outgoing as I have been, and they worry about me."

Harriett had her first child six weeks ago. The delivery was uneventful. She describes herself as being OK during pregnancy, with her moods being stable and positive. Since giving birth, however, she has been experiencing many crying spells and being fearful of hurting the baby or doing something wrong. She worries about whether she will be a good mother. She is not getting enough sleep, since she breast-feeds the child several times during the night. She says, "I feel like my world is caving in. I'm just not able to function. My husband is paying attention to the baby than he is to me. I don't want to go out of the house. I have always been a social person and upbeat. I don't understand what's happening to me."

These three vignettes show that during your ovarian life span there are three times when you are most vulnerable to experiencing difficulties with depression and anxiety. These occur in accordance with ovarian-related conditions—PMS, perimenopause, and postpartum. Two additional ovarian-related conditions—pregnancy and postmenopause—have significantly less chance of bringing on depression and anxiety. Postpartum depression or anxiety, however, is quite prevalent. This is a time when the ovarian hormones can fluctuate rapidly and erratically. The more your ovarian hormones fluctuate the more you are likely to have depression and anxiety interfere with your normal activities.

During PMS, perimenopause, and postpartum, your levels of estrogen, progesterone, and testosterone change both in rate and level. These changes result in corresponding changes in your brain chemistry, affecting your mood, thinking, and behavior. During pregnancy your ovarian hormones are three times higher than normal for you, and during postmenopause they are the lowest, unless you are on hormone-replacement therapy. During both pregnancy and postmenopause your ovarian hormones are the most stable, consistently high or low, and they have the least likelihood of presenting you with mood alterations such as depression or anxiety.

With regard to PMS and perimenopause there are three patterns of experiencing depression or anxiety:

- Your depression and anxiety are not related directly to your menstrual cycle and are present almost all the time. This condition may require that you receive psychotherapeutic and medical treatment. (See Chapter 13.)

- The depression and anxiety symptoms occur in a rhythmic, recurrent fashion during the luteal phase of your cycle. This pattern can appear both during PMS and perimenopause.
- The mood disorder of depression or anxiety becomes exacerbated when the ovarian hormones fluctuate, such as they do in PMS and perimenopause.

The rhythms of the menstrual cycle have a marked connection to your emotional state. The risk for developing mood changes or a mood disorder that requires treatment intensifies as your cycle changes and your ovaries age. PMS symptoms commonly becomes more intensified in the late 30s to mid 40s, often accompanied by new onset of depression and anxiety. The link seems to be related to the instability of ovarian hormone production, which affects brain neurotransmitters, resulting in a destabilization of mood-regulating mechanisms. When the serotonin level lowers within your brain as a result of ovarian-hormone changes during your menstrual cycle, you are more vulnerable to developing depressive and anxiety symptoms. Declining estrogen during mid-life, corresponding to perimenopause, seems to be correlated with higher vulnerability to depression and anxiety disorders among women.

Your experiences during mid-life are likely to be the most stressful of any time in your development other than puberty. During puberty hormones emerge as a significant determiner of your sense of well being, without your having experiences with which to compare this new reality. The appearance of secondary sex characteristics brings excitement, embarrassment, and concerns about beginning womanhood while others may be relating to you as if you were still a child. Being propelled into sexuality, menstruation, and reproductive capability can generate an array of emotional reactions. During your mid 30s to mid 40s the factors that put pressure on you are decidedly different. You may be struggling with teenagers or young children, wondering whether you really want to have children. You may be coping with changes in your relationship with a "significant other." You may be "topped out" in your career or are returning to work or school. It is not uncommon to reflect on your mortality since you are aware of no longer being "bulletproof." In addition, you may be self conscious about changes in your own body, such as wrinkles, sagging, weight gain, loss of stamina, and change in the "youthful look" to one of maturity. When you put this all together, you can see how your vulnerability to anxiety and depression is highest at this age.

What Are Mood Disorders?

Mood disorders, sometimes referred to as affective disorders, are ongoing emotional states that interfere significantly with you daily functioning. Mood disorders are most commonly related to depression or anxiety, and some women experience both. You may be temporarily sad, "down," or tense, but this does not indicate that you would be diagnosed as having a mood disorder.

These mood disorders may or may not be connected to your menstrual cycle. If you are prone to a mood disorder, going through ovarian change may precipitate depression or anxiety to the degree that you need psychotherapeutic assistance. If you are already experiencing a mood disorder, PMS or perimenopause can intensify the condition.

What makes your feelings problematic is when they last for some time and get in the way of your going about your regular routines effectively. A transient feeling may be unpleasant, but it may be nothing more than a feeling of the moment. It could also be a symptom of something else that you have to cope with, such as physical illness, grief over a significant loss, or an indication that you are dreading something undesirable. If you are feeling depressed or anxious for a prolonged period of time, however, you may be suffering from mood disorder, and you may need some form of treatment, such as those discussed in Chapter 13.

Depression

Depression can be considered a mood state, a syndrome, or simply a symptom. How it is considered depends in large part on its severity and the degree to which it is interfering with ordinary functioning. The risk of death from depression is higher than that of breast cancer. So, it is important to consider the seriousness of this disorder. Clinical depression causes difficulty for about one out of every four adults sometime during their lifetimes. If your quality of life is being affected by this condition, you may benefit from treatment, which we describe in Chapter 13.

The most common factors that seem to be found among people who are clinically depressed are prior depressive episodes, a family history of depression, being female, ovarian hormonal fluctuations, and high levels of stress or trauma. Both hysterectomy (removal of the uterus) and tubal ligation (severing the fallopian tubes) cause less blood to flow to the ovaries. This can result in less production of ovarian hormones and bring on depression. Partial oophorectomy, or the removal of one ovary, can also decrease the amount of hormones available and leave the woman open to depression. Complete (bilateral) oophorectomy means that no ovarian hormones will be produced, and this can raise the likelihood of depression, particularly in young women.

There are three major depression syndromes: Major Depressive Disorder, Dysthymic Disorder, and Bipolar Disorder. Each of these clusters of symptoms includes the following:

- Sadness
- A persistent down mood
- Loss of interest in normally pleasurable activities
- Changes in sleep, appetite, and sexual desire
- Poor concentration
- Narrowing of attention span
- Thoughts of suicide
- Feelings of worthlessness and inadequacy
- Hopelessness
- Fatigue

Women who experience these symptoms in an intense and ongoing way, at levels that interfere with social and occupational functioning, are likely to be suffering from depression.

Major Depressive Disorder: Single or Recurrent Episode. This condition exists when your symptoms last two weeks or more. Of people over age 18, about 6% have this disorder at least once in their lives. Most of these are women, since the prevalence of the Major Depressive Disorder is 7% for them, as opposed to only 3% of men. About 2% of people have this disorder last for at least one month. The duration of an untreated major depression is usually 6-9 months, with a 50% chance that it will recur. Having this disorder can be debilitating. You feel "blue" most of the time, your energy level is very low, you may cry uncontrollably, and your interest in what would be normally pleasurable for you is low, and you find yourself being easily irritated and distracted. You tend to "take it out on" other people. You may have thoughts of death, suicide, and what life is all about. You may not feel like eating normally, and you can have trouble falling asleep at night. You may be experiencing significant depression for the first time (single episode), or you may have the condition several times (recurrent episode). Major depression is a serious condition, and it usually requires both psychotherapy and medical attention.

Dysthymic Disorder. This condition represents the persistent experience of the depressive symptoms for two years or more. Women have this disorder more than men do—4% to 2%. Having these symptoms for long periods may be unconscious. You may, however, become aware that something is wrong. You may come to feel that you are alone and "stuck." Everything is a "drag." Life becomes a chore. You may begin to eat compulsively as their only pleasure. Your sexual desire may be very low. Everything is an effort to do. You may think that everyone feels like you. When you get relief through treatment, you may discover that your way of viewing your own life suddenly changes. You may gain an enhanced appreciation of living.

Bipolar Disorder. This condition is sometimes referred to as "manic depressive." Here the person has both depressive and manic symptoms. You might have periods of significant sadness, followed by episodes of having a very high mood. You might be extremely low for a period of time and then notice a rapid acceleration in your general emotional makeup, which persists for another period. Your symptoms may be the opposite of those listed above. This disorder is equally common in women and men (about 1% each) throughout their lifetimes, but women experience rapidly alternating Bipolar Disorder more often than men do.

Depression hits women significantly more than men. This inordinate prevalence among women may be related to numerous factors, such as genetics, stress, socioeconomic status, traumatic events, use of stimulants and hallucinogens, use and abuse of alcohol and drugs, and ovarian hormone makeup and its interaction with neurotransmitters. (Although alcoholism is five times higher among men, women with this affliction often experience much more depression and anxiety.) Any combination of these factors can cause biochemical changes, leading to a depressive condition. Depression can also result from chronic medical conditions, such as complications of hypothyroidism and diabetes.

Sometimes people confuse depression with exhaustion, burnout, or fatigue. You can experience a change in energy level, and it could be temporary or an established pattern. Temporary changes in energy level can be one indicator of depression, but you would have to be experiencing more symptoms in order to be diagnosed as depressed. Your level of energy may drop temporarily from some external event, such as your cat becoming ill, and you feel sad about it. You may "bounce back" without sustaining the mood. If you are experiencing prolonged physical fatigue, you may be suffering primarily from dietary insufficiency, heavy exercise, an external crisis, or a negative physiological condition. Feeling depressed may be a secondary effect of such causes.

Depression is one of over sixty symptoms of the syndrome termed "burnout." You are "burning out" when your capability of functioning is significantly below what is normal for you over a period of time. The most common symptoms are job-related stress, having lots of unfinished business and "loose ends," worry about personal finances, and impatience. Your motivation may get lost, your energy level may drop, and you may lose interest in what is normally interesting to you. As a result, you may be taking away the activities in your life that sustain you. You may be experiencing some aspects of depression, but you may be primarily suffering from the burnout syndrome.

Anxiety

Like depression, anxiety can be considered a mood state, a syndrome, or simply a symptom. If you are experiencing tension, it may come from ordinary events. You may also experience a level of excitement, like "butterflies" or the heady feeling of falling in love. You may feel a temporary rush when you attempt something that you have never done before. Normally women rebound from these feelings quickly. If the emotions are sustained for a long period, they may become troublesome. You are said to be clinically anxious when you are experiencing fear or dread to a degree that interferes with your ability to do your normal activities. Your concern may be general, or "free-floating," or it may be highly specific, as in the various phobias. Your anxiety may come in the form of a "panic attack." Your ovarian-hormone balance can determine the level and duration of your anxiety. In addition, feeling anxious may be a warning sign that you have some medical situation that needs attention.

In ovarian-related conditions in which anxiety is the predominant mood the physiological changes that may occur are follow the sequence below:

- Your estrogen level lowers, as in the premenstrual phase of your cycle.
- The change in estradiol level signals the brain.
- The neurotransmitter serotonin drops, the neurotransmitter norepinephrine increases, and the neuropeptide endorphin drops.
- You may experience anxiety, with such symptoms as tension, irritability, sleep disturbances, sweating or chilling sensations, "butterflies" in the stomach, diarrhea, palpitations, heart pounding, increased heart rate, increased blood pressure, clammy skin, dizziness, feeling out of control, headaches, shortness of breath, worrying, repetitive thoughts, and flashbacks to a traumatic event.

The three most common anxiety disorders are the Generalized Anxiety Disorder, Panic Disorder (with or without Agoraphobia), and Specific or Social Phobia.

Generalized Anxiety Disorder. People who are diagnosed with this disorder have excessive worry that occurs more days than not for at least six months. It may be focused on a number of different activities or events, such as work, school, or home life. People can have a lot of worry in relation to having a history of panic attacks, phobic experiences, physical complaints or serious illness. Anxiety is the most common undesirable reaction to stress. The disorder may be related to the use of prescribed medications or other substance use. This disorder affects women and men equally.

A complex of the following symptoms characterizes this syndrome:

- Excessive anxiety and worry
- Restlessness or feeling "on edge"
- Being easily fatigued
- Having difficulty concentrating or having the mind go blank
- Irritability
- Muscle tension
- Sleep disturbance

Panic Disorder (with or without Agoraphobia). This condition is often missed or misdiagnosed. It can lead to social isolation or phobias. A panic episode occurs in a brief time period, in which one is faced with intense fear or discomfort, coming from a combination of the following symptoms:

- Heart palpitation
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feelings of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, lightheaded, or faint
- Feelings of unreality or being detached of oneself
- Fear of losing control or going crazy
- Fear of dying
- Numbness or tingling sensations
- Chills or hot flushes

The diagnosis requires the presence of fear or discomfort and at least four of the above symptoms. If the person is also experiencing Agoraphobia, feeling that you are in a situation from which you cannot escape or in which you fear having an embarrassing panic attack, the fears involve situations such as the following:

- Being outside the home
- Being in a crowd or standing in a line
- Being on a bridge
- Traveling in a bus, train, or automobile

A person who is prone to a Panic Disorder with Agoraphobia avoids these situations or else endures them with marked distress, or they require the presence of a trusted companion.

Specific or Social Phobia. Both of these types of phobia are marked by persistent, intense fear. Specific phobias are centered on specific objects or situations, such as flying, heights, animals, insects, etc. A social phobia brings on fear of being exposed to social or performance situations in which the person dreads being scrutinized by unfamiliar people. The symptoms are the same as those of the Generalized Anxiety Disorder.

Research on Social Phobia indicates that it may occur in adolescence, associated with parental over-protectiveness. Females and males are equally affected. About 7% of the general population suffer from some phobia, and this is not connected with a history of family mental illness or a history of having the same phobia within the immediate family.

Although we have discussed depression and anxiety separately, they are often part of the total experience of the woman as she copes with life changes and the aging of her ovarian function. There are no simple ways of separating the two intense emotional states, since they can co-exist in response to a great variety of stimuli.

Depression and anxiety can deplete your energy and make life decidedly unpleasant, not only for you but also for the people around you. When you couple these two maladies with PMS or perimenopause, you may be challenged to cope. In Chapter 13 we will discuss several types of treatment that you might consider to work yourself out of these conditions if you develop them. Both depression and anxiety are treatable. When you take personal responsibility for improving your moods, you may improve your ovarian condition as well. You do not have to "suffer through" feeling bad all the time. Advances in psychotherapy, medicine, and alternative treatments offer hope for all women who suffer from these conditions.