WHO'S TAKING CARE OF MOMMY?

YOU HAVE MADE IT THROUGH INFERTILITY TREATMENT, BIRTH AND INFANCY. YOUR TODDLER IS SLEEPING MOST NIGHTS BUT YOU ARE NOT. YOU HAVE A SHORT FUSE; CRY EASILY; MAKE UP EXCUSES NOT TO HAVE SEX. YOUR THINKING IS FOGGY. NOTHING INTERESTS YOU. YOU'VE LOST YOUR JOIE DE VIVRE.

By Lee Kyser, Ph.D.

I have seen women like you in my psychotherapy practice. Women usually come to me because they are depressed. They may also come in with their spouse because of conflict in the relationship. Perhaps you, like some of these patients, have already started taking medication for depression but you are just not making much progress. Your family is getting impatient with your being so stressed out. You feel guilty about missing playful times with your little one because you are so tired so often.

A significant part of the problem may be that your hormones are out of balance. In fact, that may have contributed to your earlier infertility, especially if it was related to ovulation irregularities or elevated FSH levels. However, if you are like most infertility patients your focus has been on having a baby and the link to earlier hormone problems may have been lost.

WHAT THE EXPERTS SAY

Professionals in infertility treatment are aware that there is difficulty in identifying and treating these problems. This is different from Post-Partum Depression which occurs immediately after childbirth. Physicians are on the look-out for the severe, more obvious symptoms that accompany this diagnosis.

Dr. Wayne Hudak, a gynecologist, in Atlanta, Georgia, has been working with infertility treatment since 1985. During the past ten years, he has shifted the focus of his practice to treating hormone imbalances in women in perimenopause and menopause. Dr. Hudak says that women requiring ovulation stimulation may have been experiencing a fair amount of hormone deficiency. They may feel better when going through infertility treatment because they are being given medications that stimulate ovulation by increasing their own hormonal production and, thereby, counteracting their deficiency. Their premenstrual symptoms (PMS) may even improve.

The focus of infertility treatment is on getting pregnant, not on monitoring and treating hormone deficiencies to improve quality of life. After achieving the goal of having a baby, symptoms often return, except these women are now further down the time line toward menopause. This is a "crack" where women often get lost, because for many gynecologists, those of child bearing age may not be considered for hormone evaluation and HRT. However, if hormone irregularities occurred prior to infertility treatment, they may become worse with time.

It is important to monitor how patients are feeling and functioning. If there is continuing decline, evaluation for hormone deficiencies is appropriate. Psychotherapists, often the first to notice symptoms, refer clients to Dr. Hudak for medical evaluation. Referral and collaboration with internists, endocrinologists and psychiatrists may also be necessary when thyroid and antidepressant medications are needed. Colleagues in the field echo Dr. Hudak's observations.

Maureen Gallagher Martin, LCSW, a clinical social worker in private practice in Atlanta, consults with infertility clinics that provide evaluation and counseling. She also notes that the goal of infertility treatment is solving the inability to get pregnant. Success is bringing a baby home from the hospital. The infertility clinic releases the patient to her obstetrician to follow her through delivery. No other follow-up treatment is usually advised. Because of her own experience with infertility and symptoms following the birth of her son, Ms. Martin began HRT which she continues today. She cautions women who might be vulnerable to depression after birth to keep in mind why they required infertility treatment in the first place. She urges them to consult with their physicians if they do not seem to be bouncing back in a reasonable amount of time.

Carolyn Kaplan, M.D., is the Director for In Vitro Fertilization (IVF) at Georgia Reproductive Specialists (GRS) in Atlanta, Georgia. Dr. Kaplan believes that the need to assess for hormone imbalances in symptomatic women after childbirth applies to many women in addition to those who seek infertility treatment. Because women are having children later in life, they are closer to the onset of perimenopause. Hormonal fluctuations are normal at this time. Of course, those who do seek infertility treatment are more likely to have hormone deficiencies as a group. And of that group, women who cannot get pregnant because of ovulation problems already have an estrogen deficiency according to Joyce Ball, RNC, the IVF nurse coordinator for GRS. Ms. Ball agrees that infertility patients have tunnel vision. Their main focus in life is to get pregnant. They do not notice that their quality of life may be compromised by symptoms related to insufficient estrogen.

Andy Toledo, M.D., a physician with Reproductive Biology Associates (RBA) in Atlanta, often sees hormone and glandular problems in the initial work-up of his infertility patients. Typically after the first trimester of a women's pregnancy, she is then transferred to her obstetrician (OB) for the duration of her pregnancy and birth. OB's may not be tuned to the need to assess for hormone imbalances. Heightened emotionality may be attributed to hormone fluctuations associated with pregnancy and birth. Dr. Toledo does work with some of his infertility patients after birth to alleviate hormone deficiencies. He says he will take care of his patients "in a heartbeat" should they encounter these problems after birth. Sadly, many do not know to come back to him unless they want to get pregnant again.

The problem gets more complicated because the symptoms of depression may result from different causes at the same time. In psychotherapy, I refer women to be evaluated for medical intervention while continuing to work with them in coping and resolving areas of conflict that are psychological. A woman may suffer from depression as a result of hormone imbalances. But, a secondary psychological problem, like marital conflict, may result from her depression. Psychological stress such as feelings of inadequacy or conflict between career and motherhood may co-exist with hormonal deficiencies as contributors to depression.

I work regularly with psychiatrists who treat depression and anxiety with psychotropic medications, such as Prozac. It is common to see a woman suffering from depression following childbirth treated only with an antidepressant when hormone imbalance may be an underlying contributor to her depression. Sam Brown, M.D., practices in Atlanta as a psychiatrist and psychoanalyst. She has had a special interest in women's health for 25 years. Dr. Brown is keenly aware of the link between childbirth and a lagging hormone imbalance after delivery. "Women who suffer from affective disorders following one reproductive event are at increased risk for recurrences at other reproductive events. Anytime significant shifts in reproductive hormones occur, changes in affective, cognitive, and physiological changes can follow. We often use psychotropics to manage these symptoms i.e. hot flashes, cognitive changes, negative mood states, sleep disturbances. Often psychotropics are not enough to ameliorate symptoms and HRT is also required to completely relieve the symptoms," states Dr. Brown.

Psychotherapy provides an arena for women to digest their physician's recommendations. In addition to helping women sort out their feelings about taking medications, it also provides some information not always emphasized by physicians. Most therapists know that patients taking antidepressants usually require two to four weeks before experiencing any relief from symptoms. However, unless a therapist has consulted with physicians who treat hormone imbalances, they may not know that it can take three to six months at times to achieve therapeutic changes. Women who are suffering need reminding, reassurance, and encouragement to stay the course. Empathy and hand-holding go a long way in helping them tolerate the wait.

THE BIG FEAR OF HRT

Women are afraid that HRT will cause breast cancer. Many of us in the health professions are afraid that a great deal of media coverage of limited research showing some link between HRT and breast cancer is creating more hysteria than warranted and not only in patients. Many gynecologists are pulling women off HRT abruptly. There is controversy and confusion among professionals. Of course, women in treatment are scared.

The media has focused on recent research conducted by the Women's Health Initiative (WHI). The results indicate an increased risk in breast cancer from Prempro, a synthetic estrogen made from horse urine and progestin. Other results from the same study have been reported to negate some of the positive effects HRT is supposed to have on the cardiovascular system. Many women have stopped HRT as a result.

Two articles in the Wall Street Journal, "New Risk in Taking Prempro: Murky Mammograms" and "Makers of Alternative Therapies Question JAMA's (Journal of the American Medical Association) Conclusions, But Most Do So Quietly," June 25, 2003, are the most objective and easily read reviews and critiques of the WHI study I have seen. It puts the study in the perspective it deserves versus the terrorizing headlines often seen in the media. These articles point out two important aspects of this study. Estrogens are different. Some are made from equine estrogen like Premarin. Others are plant based and have the same chemical construction as the estrogen in the female body. A list of the types of estrogen available to women for HRT other than Premarin or PremPro is provided. The second point is that most of the women in the study were over 60 and taking HRT for the first time. In fact, for women between the ages of 45 and 55, the study suggest that the risk of breast cancer caused by HRT is small.

Dr. Kaplan reports that there have been many observational studies that suggest there are benefits of HRT to the heart, bones, brain and quality of life. Nothing has changed her opinion about the truth of these findings. Although WHI is a good source of information about risks and benefits for "older" women who have been "off" hormones for many years, it does not provide information on risks and benefits for "young" women who are using HRT through perimenopause because they are highly symptomatic.

" Women need individualized HRT," says Dr. Hudak. He takes in-depth serum levels in his work-ups and follows women closely after prescribing HRT. There is a broad normal range for estrogen. Levels vary as to how well each woman will feel and function. Dr. Hudak also thinks that both the type of estrogen and the method of delivery i.e. oral or transdermal (patch), make a difference and may vary for individuals.

RECOMMENDATIONS

So, what's a girl to do? If you think you might be depressed seek help now. The sooner depression is treated the better the outcome. You can see a psychotherapist to talk about various concerns as well as get an opinion and referral about seeking medical consultation for treatment of symptoms. I recommend therapists who practice general adult psychotherapy and infertility counseling because they are more likely to be in tune with emotions related to hormone changes. Consider going back to your infertility specialist for evaluation. They work with hormones in more intricate detail than most gynecologists who do not also treat infertility. If your infertility was due to an ovulation problem, there is a higher possibility that you have an estrogen deficiency now. Ask about estrogens that are plant based versus those made from horse urine.

Physicians in obstetrics/gynecology, endocrinology, internal medicine, and family practice will vary in their interest and skill in evaluating and treating hormone imbalances. Psychiatrists are more likely to only treat symptoms of depression with psychotropics. You will probably do best with both psychotropics and HRT if hormone imbalance is a culprit underlying your depression.

Having said that, each woman must make her own decision about HRT considering her individual risk factors for breast cancer and comfort level. If taking HRT will cause an inordinate amount of anxiety for you, it may be counterproductive to any benefit you might receive. You will need to determine if you think a physician is giving you serious consideration for your symptoms related to hormone imbalances. You may be told you are OK because serum levels are within normal range. If so, ask what the normal range is and consider if you are closer to one end. You may also be denied evaluation because you are not the age of most women in perimenopause or menopause. Some physicians do not even acknowledge the existence of perimenopause. If you feel you are being discounted seek another opinion.

Elizabeth Lee Vliet, M.D. is a long-standing women's health advocate. She has written Screaming To Be Heard: Hormone Connections Women Suspect And Doctors Still Ignore. (M. Evans and Company, Inc., New York, 1995 and 2001). The title captures many women's experience when seeking help. The introduction alone is like a group therapy experience. Women identify and realize it is not all in their heads. They are not alone. This is an excellent resource for any woman. After all, it is only a matter of time before many of us knock on a physician's door and ask, "Is this all there is?" Good Luck.

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