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Menopause, Mood, and Relationships: A Psychotherapeutic and Communication-Focused Review

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Narrative Clinical Review

Abstract—The menopausal transition can coincide with vasomotor symptoms, disrupted sleep, cognitive complaints, sexual changes, altered self-understanding, and increased vulnerability to depressive symptoms in some women. It also occurs during a period often crowded by work, caregiving, illness, bereavement, and changes in intimate relationships. Neither a purely hormonal story nor a purely psychological one is adequate. This narrative clinical review considers evidence available through 30 May 2024 and develops a psychotherapeutic and communication-focused approach. Assessment should establish reproductive stage, symptom timing, severity, functional impact, psychiatric history, sleep, physical health, medication, substances, and social context. Transition-associated symptoms must be distinguished from independent mood, anxiety, sleep, trauma-related, bipolar, substance-related, and medical conditions without assuming that one excludes the other. Cognitive-behavioral interventions have evidence for reducing how problematic hot flushes and night sweats feel and for treating insomnia; broader psychosocial and mindfulness findings are promising but heterogeneous. Therapy can also support direct communication with partners, clinicians, and workplaces, including discussion of sexuality and accommodations. Hormone and nonhormone treatments require individualized medical prescribing; psychotherapy should complement rather than obstruct informed medical care. A credible formulation respects biological change, social inequality, personal meaning, and the woman's own priorities while refusing both dismissal and diagnostic overreach.

Index Terms—menopause, perimenopause, psychotherapy, depression, sleep, relationships, sexual health

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I. INTRODUCTION

A woman who becomes tearful, forgetful, wakeful, or less interested in sex during midlife may be offered two unsatisfactory explanations. One attributes nearly everything to hormones; the other treats menopause as incidental and applies a psychiatric label without examining bodily change. Both can miss what she is living through. Menopause is a reproductive transition with biological effects, but its experience is shaped by prior mental health, sleep, relationships, work, culture, health, and the meaning attached to ageing and fertility.

The transition is not a uniform syndrome. Some women have few troublesome symptoms, while others experience hot flushes, night sweats, sleep disruption, mood change, genitourinary symptoms, pain, cognitive complaints, or impaired functioning. Global review shows substantial variation in symptom patterns and duration (Monteleone et al., 2018). A professional response begins by asking what changed, when, and with what consequence rather than treating a culturally prominent symptom list as a diagnostic checklist.

Psychotherapy has several legitimate roles. It can treat a depressive, anxiety, insomnia, or trauma-related disorder using an indicated method; reduce the distress and interference associated with vasomotor symptoms; address shame, identity, relationship cycles, and workplace strain; and help a patient communicate with medical clinicians. It cannot determine hormone-treatment suitability, exclude physical disease, or make a structurally inflexible workplace supportive through coping alone.

The communication task is equally important. Women report dismissal, uncertainty, stigma, and fragmented advice, while clinicians report knowledge gaps and limited consultation time (Davis et al., 2021; Barber & Charles, 2023). Better dialogue does not require declaring that every complaint is caused by menopause. It requires taking the

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account seriously, holding more than one hypothesis, explaining the basis and limits of conclusions, and coordinating care when expertise lies elsewhere.

II. SCOPE AND REVIEW METHOD

This narrative clinical review considered evidence publicly available through 30 May 2024, one month before the nominal issue date. It prioritized staging consensus, professional position statements available by that date, longitudinal studies, systematic reviews and meta-analyses, randomized trials of psychosocial interventions, and qualitative or occupational research relevant to communication, sexuality, and work. Complete online-first publications available by the cutoff were eligible. No new meta-analysis was conducted.

The review concerns adults undergoing natural or treatment-induced menopausal transitions, while recognizing that much evidence concerns cisgender women in higher-income countries. People who menstruate or experience gonadal hormone change may use different gender language. A clinician should follow the patient's terms and avoid assuming fertility wishes, sexual orientation, partner status, or gender identity. Surgical menopause, premature ovarian insufficiency, cancer treatment, and gender-affirming care involve distinct medical questions that require appropriate specialist coordination.

Evidence is uneven. Vasomotor symptoms and hormone therapy have a large medical literature; psychotherapy studies are fewer, use varied outcomes, and often recruit volunteers with problematic symptoms. Relationship, sexuality, workplace, and culturally diverse experiences are frequently studied qualitatively or cross-sectionally. Such research is indispensable for understanding meaning and barriers, but it does not estimate treatment effects.

This article is not prescribing guidance. Statements about menopausal hormone therapy and nonhormone medication summarize cutoff-eligible professional positions and indicate when a prescriber should be involved. Individual decisions depend on symptom target, reproductive stage, age, time since menopause, personal and family history, contraindications, interactions, preferences, and local licensing. A psychotherapist should neither recommend a specific regimen outside scope nor portray medical treatment as avoidance of psychological work.

Clinical reviews describe vasomotor, sleep, mood, genitourinary, and other symptoms as overlapping but differently treatable domains (Santoro et al., 2015). That domain-based approach informs this review. It allows one complaint to receive medical treatment, another to receive psychotherapy, and a third to be monitored, without requiring a single totalizing explanation.

III. STAGE, LANGUAGE, AND CLINICAL TIMING

The final menstrual period can be identified only retrospectively after twelve months of amenorrhea when no other cause is present. The STRAW+10 framework describes reproductive, menopausal-transition, and postmenopausal stages using bleeding patterns and selected endocrine markers, while noting limits in particular populations (Harlow et al., 2012). In clinical conversation, perimenopause commonly refers to the transition and early period around the final menstrual period. Precise usage matters when timing is part of a causal hypothesis.

Symptoms do not begin or end on a single date. Cycle variability, vasomotor symptoms, sleep disturbance, and mood vulnerability may appear before menstruation stops, and some symptoms persist after it. A timeline is more informative than the label alone. It places menstrual changes, symptom onset, psychiatric episodes, childbirth and reproductive history, medications, illness, losses, relationship events, and work demands on the same page.

Menopause is physiologic, but “natural” does not mean clinically trivial. Childbirth, pain, and ageing are also ordinary biological processes that can require care. Conversely, the presence of a transition does not make every distressing experience a disorder. The patient and clinician can distinguish expected variation, symptoms that deserve targeted support, and syndromes meeting criteria for psychiatric or medical treatment.

Language carries history. “Change of life” may suggest loss to one person and freedom to another. Some welcome the end of menstruation or pregnancy risk; some grieve fertility, youth, bodily familiarity, or a hoped-for child. Cultural silence can make symptoms frightening, whereas strongly medicalized public narratives can make ordinary lapses appear ominous. Therapy should elicit the person's meaning before offering a preferred story.

Early or treatment-induced menopause may have different health and identity implications from natural menopause at the usual age. Symptoms following oophorectomy or cancer therapy can be abrupt, and hormone options may be constrained. These situations warrant medical review and often require attention to grief, sexuality, body image, and decisions made under pressure. General advice derived from natural menopause should not be transferred without qualification.

IV. ASSESSMENT AND DIFFERENTIAL FORMULATION

Assessment begins with the patient's priorities. A list of possible symptoms can help recognition, but it should not replace the account of which changes are most disruptive. The clinician asks about timing, pattern, severity, daily

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interference, and what improves or worsens each problem. Tracking bleeding, vasomotor symptoms, sleep, mood, and medication for a bounded period can reveal sequence without turning life into continuous monitoring.

Psychiatric history changes interpretation. Prior depression, anxiety, trauma, premenstrual dysphoric disorder, postpartum illness, bipolar disorder, substance problems, and response to earlier treatments all matter. Most midlife women with a major depressive episode during perimenopause have a prior depressive history, although first-onset episodes occur (Maki et al., 2018). Reduced sleep need with increased energy, activation, or risk taking requires assessment for bipolar-spectrum illness rather than being assigned automatically to menopause.

Physical and treatment factors can mimic or amplify symptoms. Thyroid disease, anemia, sleep apnea, pain, infection, medication effects, alcohol, stimulants, sedatives, and chronic medical illness may affect mood, cognition, temperature regulation, or sleep. Abnormal bleeding, new neurological symptoms, chest symptoms, severe pain, or other concerning signs require medical assessment. A therapist should state clearly when the formulation exceeds psychotherapy's diagnostic reach.

Context is part of differential diagnosis. Midlife may bring care of children and parents, bereavement, relationship change, discrimination, financial pressure, and insecure work. These are not noise around a hormone effect. They can cause or sustain distress, interact with sleep and vasomotor symptoms, and determine which intervention is usable. The formulation should allow several causes to be active without forcing one winner.

Risk assessment remains direct. Hopelessness, self-harm, suicidality, domestic abuse, substance-related harm, severe functional decline, psychosis, and inability to care for oneself require the same seriousness as at any age. Attributing danger to hormones can delay care; dismissing the transition can also lose a relevant precipitant. Safety planning and urgent referral follow need and local pathways, not the clinician's preferred causal narrative.

Table 1. Differentiating overlapping midlife presentations

Presentation	Questions that clarify	Do not assume	Possible next step
Low mood or irritability	Episode duration, anhedonia, history, cycle and stress timing	All mood change is hormonal	Assess depressive disorder, risk, sleep, and context
Night waking	Night sweats, apnea risk, pain, schedule, substances	Every awakening is insomnia or a hot flush	Sleep diary; medical and sleep assessment as indicated
Memory or concentration complaint	Onset, fluctuation, sleep, mood, medication, function	A complaint proves neurodegeneration	Address contributors; investigate progressive or focal change
Reduced sexual interest or pain	Desire, arousal, comfort, relationship, medication, trauma	Hormone level alone explains sexuality	Medical assessment for pain/GSM; relational and sexual formulation
Work difficulty	Symptoms, task demands, temperature, flexibility, discrimination	The worker lacks resilience	Consider treatment, accommodations, and occupational support

V. MOOD ACROSS THE TRANSITION

Longitudinal studies support a window of increased vulnerability to depressive symptoms and episodes for a subset of women during the menopausal transition. In the Penn Ovarian Aging Study, changes in menopausal status and hormones were associated with depressive symptoms, and a prospective study of women without previous lifetime major depression found increased risk of new onset during the transition (Freeman et al., 2004; Cohen et al., 2006). These findings establish vulnerability, not inevitability.

The pathway is rarely singular. Hormonal fluctuation may interact with prior reproductive sensitivity, genetic vulnerability, sleep disruption, vasomotor symptoms, health, and adversity. Reviews emphasize that social stress, relationship quality, financial hardship, prior depression, and physical symptoms contribute alongside reproductive biology (Bromberger & Epperson, 2018). Therapy should therefore avoid telling a patient that her experience is “just hormones” or, conversely, that recognition of hormones undermines psychological meaning.

A major depressive episode remains a major depressive episode when it occurs in perimenopause. Assessment considers pervasive low mood or loss of interest, cognition, guilt, psychomotor change, appetite, sleep, function, duration, and risk. Treatment should be based on severity, history, preference, comorbidity, and evidence for depression. The menopause context may influence choice and sequencing, but it should not lower the standard of psychiatric care (Maki et al., 2018).

Subthreshold symptoms can still impair relationships and work. A patient may feel less emotionally resilient when repeated night sweats erode sleep, while conflict then increases arousal and further disrupts rest. A formulation can identify this loop without claiming that any one element is the original cause. Initial steps might include sleep treatment, symptom education, direct partner communication, reduction of alcohol, medical review, and psychotherapy for rumination or conflict.

Mood monitoring should be proportionate. Weekly measures can show trend during treatment, while a brief daily record may clarify cycle or symptom coupling. Continuous

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checking may increase threat and self-surveillance. Measures support, rather than replace, the patient's account of vitality, pleasure, concentration, connection, and function. Improvement in hot flush interference does not necessarily mean that an independent depression has remitted.

VI. SLEEP, AROUSAL, AND THE NEXT DAY

Sleep difficulty during the menopausal transition may involve night sweats, insomnia, sleep-disordered breathing, restless legs, pain, mood disorder, medication, substance use, caregiving, or ordinary environmental disruption. Reviews describe a changing sleep landscape rather than one menopausal sleep disorder (Baker et al., 2018). Asking only about hours slept misses timing, awakenings, temperature, worry, breathing symptoms, and next-day impairment.

A reciprocal loop can develop. A nocturnal hot flush produces awakening; concern about another episode increases arousal; more time awake strengthens the association between bed and vigilance; fatigue then worsens concentration, emotional regulation, and conflict. Cognitive-behavioral therapy for insomnia targets the conditioned and behavioral components even when the first awakening has a physiological trigger. It does not require denying the hot flush.

A randomized MsFLASH trial found that telephone-delivered CBT-I improved insomnia more than menopause education among perimenopausal and postmenopausal women with vasomotor symptoms, with gains maintained at twenty-four weeks; hot-flush frequency did not differ, although interference improved (McCurry et al., 2016). The distinction is clinically valuable. A treatment can restore sleep and reduce burden without changing every bodily event.

Sleep restriction components require judgment when bipolar risk, seizure disorder, severe sleepiness, hazardous driving, shift work, or medical instability is present. Suspected sleep apnea warrants assessment, especially when snoring, witnessed breathing pauses, morning headache, or daytime somnolence occurs. Advice to accept poor sleep is not mindfulness, and sedating medication is not a substitute for determining what is waking the patient.

Partners may become part of the sleep system through different temperature needs, worry, touch, snoring, or resentment about disrupted nights. A practical conversation can address room temperature, bedding, sleeping arrangements, and how temporary changes will be interpreted. Sleeping separately for a period can be a collaborative health decision rather than evidence of relational withdrawal, provided intimacy and meaning are discussed rather than assumed.

VII. COGNITION, IDENTITY, AND SELF-TRUST

Word-finding difficulty, forgetfulness, and reduced concentration are commonly reported in midlife, especially under poor sleep and high demand. Subjective cognitive change deserves attention without immediate catastrophe. The clinician asks whether the difficulty fluctuates, which tasks are affected, whether others have noticed progressive decline, and how sleep, mood, pain, medication, alcohol, and workload contribute. Focal neurological change or progressive functional loss requires medical assessment.

The meaning of a lapse often intensifies its impact. A missed word can be interpreted as incompetence, ageing, loss of professional identity, or the beginning of dementia. Anxiety then consumes working attention and increases further lapses. Therapy can separate event from prediction, develop compensatory strategies, and test whether performance changes with sleep, context, or reduced multitasking. Reassurance should not outrun assessment.

Identity may shift in contradictory ways. The end of fertility can bring grief, relief, ambiguity, or no particular reaction. Changes in appearance, sexual response, family role, or perceived social visibility may unsettle earlier assumptions. A therapeutic conversation does not need to force empowerment or loss. It can make room for both, including meanings shaped by infertility, pregnancy history, gender identity, culture, or a life that did not follow expected stages.

Self-trust can be damaged by repeated dismissal. If a patient has been told that symptoms are imaginary, inevitable, or too vague, she may arrive with an exhaustive dossier or difficulty tolerating uncertainty. The clinician can validate that change is real while remaining precise about what is known. “I believe that this is affecting you; several causes may be contributing, and we can investigate them” is more credible than certainty offered to compensate for earlier invalidation.

Practical supports reduce cognitive load: one calendar, written medical questions, protected focus periods, reminders, and recovery after poor sleep. These are not proof of decline and need not become a complex self-optimization project. The objective is to preserve valued function while assessment and treatment proceed.

VIII. PARTNER COMMUNICATION AND RELATIONAL LOOPS

A partner may see withdrawal, irritability, reduced sexual contact, or changed sleep without understanding the experience behind it. The woman may fear being dismissed, blamed, aged, or pressured, and therefore disclose little until strain is high. The partner may then guess incorrectly or treat every disagreement as a symptom. Menopause becomes a third participant in the relationship, invoked either to explain everything or forbidden as an explanation at all.

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A more useful conversation separates experience, interpretation, and request. “I wake hot and then cannot return to sleep” describes experience; “you do not care” is an interpretation; “could we try separate duvets and talk on Saturday about how this is affecting us?” is a request. The partner can describe impact without diagnosing motive. Both remain accountable for behavior even when symptoms lower tolerance.

Psychoeducation can reduce personalization but should not recruit the partner as monitor or prescriber. The woman retains privacy and decision-making. A partner can ask what support is wanted, attend a consultation with consent, or help with practical changes. Repeated unsolicited advice, tracking, jokes, or pressure to use or avoid hormone therapy can become another source of strain.

Relationship difficulties may predate the transition. Menopause can expose an unequal division of labor, neglected intimacy, coercion, or longstanding communication problems; it does not cause them all. Couple work is appropriate when both want it and the relationship is safe. Where coercive control or abuse is present, conjoint sessions can increase danger, and individual safety assessment takes priority.

A partner conversation that preserves agency

- Choose a time outside an argument or severely disrupted night.
- Describe one change and its effect before offering a cause.
- Ask what the other person has noticed; correct guesses without ridicule.
- Make one specific, time-limited request about sleep, touch, workload, or support.
- Keep medical choices with the patient and qualified prescriber.
- Review whether the arrangement helped rather than treating it as a permanent verdict.

IX. SEXUALITY, COMFORT, AND INTIMACY

Sexuality at midlife is shaped by desire, arousal, genital comfort, body image, mood, medication, partner availability and health, relationship quality, privacy, culture, and prior sexual experience. Longitudinal SWAN data show changes in aspects of sexual functioning across the transition, but menopause stage is only part of the account (Avis et al., 2009). A biopsychosocial formulation is more accurate than reducing desire to estrogen or to relationship satisfaction alone (Thomas & Thurston, 2016).

Genitourinary syndrome of menopause can include vaginal dryness, irritation, urinary symptoms, and pain with sexual activity. Pain should not be reframed as avoidance or treated through encouragement to continue penetration. Medical assessment is indicated, and the 2020 NAMS position statement describes hormonal and nonhormonal options whose suitability depends on symptoms, history, and preference (The North American Menopause Society, 2020). Psychotherapy can address anticipation, communication, trauma, and relational consequences while physical treatment proceeds.

Desire discrepancy needs language without blame. One partner's wish for sex does not create an obligation, and reduced interest is not proof of lost love. Conversation can distinguish spontaneous from responsive desire, affection from sexual initiation, and kinds of touch that are welcome, uncertain, or painful. Couples may broaden intimacy, change timing, use lubrication or other aids after suitable advice, and renegotiate what closeness means. No adaptation is required if the woman does not want sexual activity.

Medication effects should be considered, including sexual effects of some antidepressants and other drugs. Stopping or changing medication without a prescriber can create harm. The psychotherapist can help the patient prepare a specific account—onset, domain affected, distress, relationship context, and treatment priorities—for the prescribing consultation. Embarrassment decreases when the clinician introduces sexual health routinely and uses inclusive, non-assumptive language.

Past trauma may become salient during examinations, bodily change, pain, or perceived loss of control. Trauma-informed care explains procedures, obtains ongoing consent, and allows stopping. The presence of trauma does not make a physical symptom psychogenic. Both physical and psychological contributors can be addressed without requiring the patient to prove which came first.

X. WORK, CAREGIVING, AND SOCIAL CONTEXT

Work can magnify symptoms through heat, uniforms, public speaking, shift schedules, limited bathroom access, and little control over breaks. Symptoms can in turn affect confidence, attendance, and concentration. A workplace account that focuses only on individual coping misses job design and stigma. Reviews identify a limited intervention literature and call for organizational as well as individual responses (Jack et al., 2021; Rodrigo et al., 2023).

The MENOS@Work randomized trial found that a self-help CBT intervention reduced how problematic hot flushes and night sweats were and improved some work and social outcomes compared with a waitlist, in a selected sample of working women (Hardy et al., 2018). This supports a practical option; it does not show that a booklet can correct inflexible schedules, harassment, poor ventilation, or discriminatory promotion decisions.

A clinical work plan identifies the functional problem and the smallest useful accommodation. Flexible start time after disrupted sleep, access to cooler space or water, breathable uniform options, predictable breaks, remote work for a bounded period, or reduced exposure to a specific trigger may help. Disclosure should be limited to what is necessary and chosen. Occupational health can translate clinical needs without requiring intimate detail to be shared with a line manager.

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Caregiving load often sits beside paid work. A woman may be supporting children, parents, a partner, and colleagues while sleep and energy change. Therapy that adds an elaborate wellness program can become another demand. Mapping responsibilities, identifying negotiable labor, and preparing direct requests may produce more benefit than teaching private endurance. When others refuse reasonable redistribution, the limitation is relational or structural, not a failure of coping skill.

Social class, racism, migration, disability, rural access, and health literacy shape who receives information and treatment. Public discussion often centers professionally employed, partnered, White women and can leave other experiences invisible. Clinicians should ask about access, language, cost, community meanings, and previous health-care encounters rather than assuming that low help-seeking indicates low need.

XI. COMMUNICATING WITH CLINICIANS

A productive consultation needs enough structure to hold complexity. The patient can be helped to identify the two or three most impairing changes, their timeline, menstrual or treatment context, current medication, relevant history, and the decision she hopes to make. A symptom diary can support this account when brief and purposeful. It should not be required as proof that a woman's report is credible.

Clinicians should explain their reasoning. If symptoms are thought likely to be transition-associated, the basis and alternatives should be stated. If a psychiatric disorder is diagnosed, the clinician should describe which criteria and impairments support it and how menopause changes, or does not change, the plan. When uncertainty remains, naming what will be observed and when review will occur is better than a vague reassurance.

Qualitative research identifies barriers at the patient, clinician, and service levels, including stigma, prior dismissal, variable knowledge, time pressure, and limited confidence in treatment (Davis et al., 2021; Barber & Charles, 2023). Communication training cannot create appointment capacity, but it can prevent a short consultation from becoming adversarial. Summarizing the account, offering options with benefits and harms, and documenting a follow-up decision are concrete acts.

The psychotherapist can support preparation and reflection without becoming an informal prescriber. After a consultation, therapy may examine what was understood, what remained unanswered, and whether the patient felt able to express preferences. If the medical plan appears unclear or concerning, the response is to encourage clarification, second opinion, or specialist referral rather than to advise discontinuation.

An earlier JPPC article on atypical depression illustrates the archive's longstanding interest in differentiating mood presentations and in the role of therapeutic communication, although its printed volume conflicts with the archive folder label (Haverkampf, 2018). The present task is broader: not to place menopause into a depression subtype, but to prevent bodily transition, psychiatric syndrome, and personal meaning from being collapsed into one another.

XII. PSYCHOTHERAPEUTIC INTERVENTIONS

Psychotherapy should be matched to the target. A woman with major depression may need an evidence-based depression treatment; one with insomnia may benefit from CBT-I; one distressed by hot-flush interference may choose menopause-specific CBT; another may want work on grief, body image, trauma, relationship conflict, or assertive communication. A generic package labeled “menopause therapy” can obscure these distinctions.

In MENOS2, group and self-help CBT reduced ratings of how problematic hot flushes and night sweats were compared with usual care, with effects on perceived burden more consistent than elimination of the bodily events (Ayers et al., 2012). The intervention includes psychoeducation, paced breathing or relaxation, and work with attention, beliefs, stress, and sleep. Its clinical promise lies partly in restoring agency without claiming voluntary control over physiology.

A 2024 meta-analysis of thirty randomized trials reported small improvements in depression and anxiety with CBT and mindfulness-based interventions and broader improvements in quality of life, but studies were heterogeneous and menopausal stage was not consistently captured (Spector et al., 2024). A separate mindfulness meta-analysis found reduced stress but nonsignificant pooled effects for anxiety and depression, illustrating how conclusions depend on included studies and outcomes (Liu et al., 2023). Mindfulness should be offered as a practice with uncertain domain-specific effects, not a cure or a test of acceptance.

Interpersonal and psychodynamic work may address changing roles, loss, dependency, anger, sexuality, and meanings of ageing, but menopause-specific trial evidence for these approaches is sparse. Their use can still be justified when they address an established clinical formulation or disorder. The therapist should distinguish general psychotherapy evidence and reasoned adaptation from direct evidence that an approach treats menopausal symptoms.

Treatment progress is best measured across the chosen domains. A compact dashboard might include symptom interference, sleep, mood or anxiety, one relationship or work outcome, and adverse effects or burden. Frequency of hot flushes may remain similar while distress and function improve; conversely, a physical treatment may reduce flushes while depression persists. Separate measures preserve clinically important mixed change.

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Table 2. Matching psychotherapy to the primary treatment target

Primary target	Relevant approach	Evidence boundary	Useful outcome
Hot-flush/night-sweat interference	Menopause-specific CBT	Better support for problem rating than complete symptom removal	Interference, coping, sleep, valued activity
Persistent insomnia	CBT-I with appropriate safety screening	Treats insomnia processes even when vasomotor triggers remain	Insomnia severity, efficiency, daytime function
Depressive or anxiety disorder	Disorder-specific evidence-based psychotherapy	Menopause context does not replace diagnosis	Symptoms, risk, function, recurrence plan
Stress and reactivity	Mindfulness or acceptance-based work if preferred	Heterogeneous findings; not a universal mood treatment	Stress, practice burden, valued participation
Relationship, identity, or grief	Individual or couple formulation when safe	Direct menopause-specific trial evidence is limited	Communication, agency, intimacy, chosen goals

XIII. COORDINATING HORMONE AND NONHORMONE CARE

Menopausal hormone therapy is the most effective treatment for vasomotor symptoms and can prevent bone loss, but benefit-risk varies by formulation, route, timing, and individual history (The North American Menopause Society, 2022). It is not one medication and cannot be responsibly discussed through slogans. The prescriber assesses uterine status, bleeding, cardiovascular and thromboembolic risk, cancers, liver disease, migraine and other relevant factors, current medication, and patient preference.

Evidence concerning mood needs precision. Expert guidance supports standard treatments for perimenopausal depression and considers estrogen therapy in selected circumstances, while not treating hormone therapy as a proven antidepressant for all women (Maki et al., 2018). A randomized prevention trial found fewer clinically significant depressive symptoms with transdermal estradiol plus intermittent micronized progesterone than placebo in selected euthymic women, but this does not establish routine prevention or treatment for every patient (Gordon et al., 2018).

Nonhormone prescription options can target vasomotor symptoms when hormone therapy is unsuitable or unwanted. The 2023 NAMS statement evaluates agents including certain SSRIs or SNRIs, gabapentin, fezolinetant, and oxybutynin, with differing evidence and adverse-effect profiles (The North American Menopause Society, 2023). Licensing and availability vary. A psychotherapist should be alert to mood, sleep, sexual, cognitive, and withdrawal effects while leaving selection and dose management to a qualified prescriber.

Genitourinary symptoms may respond to lubricants, moisturizers, pelvic health input, or local prescription therapies depending on presentation and history (The North American Menopause Society, 2020). Painful sex should prompt assessment rather than exposure through pain. For patients with a history of hormone-sensitive cancer or complex medical risk, coordination with relevant specialists is particularly important.

Professional positions emphasize individualized decisions and periodic review rather than a fixed duration for everyone (Baber et al., 2016; The North American Menopause Society, 2022). Psychotherapy can help a patient weigh fears, values, uncertainty, and previous experiences, but it should not turn decisional support into persuasion. Choosing hormone therapy is not psychological avoidance; declining it is not denial.

Table 3. Psychotherapy-medical coordination without scope drift

Issue	Psychotherapist contribution	Prescriber or specialist contribution	Shared review
Vasomotor symptoms	Assess distress, sleep, behavior, and treatment preferences	Diagnose, review contraindications, offer licensed options	Frequency, interference, adverse effects, function
Depression or anxiety	Diagnostic formulation, risk assessment, psychotherapy	Medication and hormone suitability; physical differential	Track psychiatric and transition symptoms separately
Insomnia	CBT-I when suitable; sleep and arousal formulation	Assess apnea, restless legs, medical causes, medication	Sleep, daytime safety, activation, tolerability
Pain or genitourinary symptoms	Address fear, trauma, communication, relational effects	Examination and physical treatment with consent	Comfort, urinary symptoms, intimacy goals
Treatment uncertainty	Clarify values and questions; support agency	Explain benefits, harms, alternatives, and local evidence	Document decision and planned reassessment

XIV. SAFETY, FOLLOW-UP, AND CHANGING FORMULATIONS

Follow-up should be planned rather than left to worsening. The interval depends on severity, risk, treatment change, and access. A review asks what changed in the target symptoms, what changed elsewhere, what adverse effects or burdens appeared, and whether the original formulation still fits. It also checks whether the patient could obtain the medical or workplace support discussed.

Mixed outcomes are expected. Better sleep may reveal a persistent depression; reduced vasomotor symptoms may improve patience without resolving a coercive relationship; an antidepressant may improve mood while worsening sexual function. A single global rating can obscure these trade-offs. The patient and clinicians need permission to say that a treatment helped one domain and harmed another.

Longitudinal review is most useful when it tests a stated formulation. Patient and clinician can identify the expected sequence—for example, whether fewer night sweats should

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precede better sleep, and whether improved sleep should alter concentration or mood—and follow two or three patient-prioritized outcomes. Timing and covariation cannot prove causation, but they can make competing explanations more or less plausible. Persistently low mood after vasomotor symptoms and sleep improve should prompt renewed assessment for an independent depressive disorder or continuing psychosocial stress (Maki et al., 2018).

Interpretation becomes harder when several changes begin at once. Hormone therapy, an antidepressant, CBT-I, reduced alcohol use, workplace accommodation, and a partner's practical support may all be appropriate, yet simultaneous starts can conceal both benefit and harm. When severity and safety permit, the team can document start dates, agreed targets, and likely adverse effects, then stagger changes enough to learn from them. This is a reasoning aid, not a rule: urgent symptoms should never wait for a tidier experiment. Evidence that CBT-I can improve menopausal insomnia illustrates why domain-specific outcomes matter even when broader symptoms coexist (McCurry et al., 2016). Prescribing decisions and monitoring remain with an appropriately qualified clinician (NAMS, 2022).

With the patient's consent, a partner's observations may clarify chronology, but they should not determine what counts as real. The review can compare what each person noticed, how each interpreted it, and which interaction changed. For example, less conflict after sleep improves is useful information; attributing every disagreement to hormones is not. Clinicians should use the same discipline when documenting uncertainty: record a working differential and the findings that would prompt medical or psychiatric reassessment.

Urgent review is warranted for suicidal intent, psychosis, severe agitation, marked functional collapse, mania-like activation, concerning bleeding, neurological change, chest symptoms, or other acute medical signs. The list is not exhaustive and does not ask psychotherapists to diagnose physical emergencies. It asks them to notice when ordinary scheduled coordination is no longer enough.

Complementary and over-the-counter products should be asked about neutrally because patients may not consider them medication. Evidence, purity, interactions, and regulation vary. A dismissive response may end disclosure; uncritical endorsement can create harm. The appropriate route is accurate recording, evidence-based discussion within scope, and pharmacist or prescriber review where interactions or risk are possible.

A changing formulation is a strength. If symptoms do not respond as expected, the clinician rechecks stage, diagnosis, sleep, physical health, medication, substance use, trauma, relationship safety, workload, and what the patient actually wanted from care. Neither hormones nor psychology should become an unfalsifiable explanation.

XV. LIMITATIONS OF THE EVIDENCE

The menopause literature is extensive but does not answer every psychotherapeutic question. Definitions of stage, symptom burden, depression, and menopause-specific treatment vary. Many studies combine perimenopausal and postmenopausal participants, use self-selected samples, or follow outcomes briefly. The 2024 psychosocial meta-analysis could not identify optimal timing because menopausal status was not consistently collected (Spector et al., 2024).

Psychosocial trials often compare treatment with waitlist, usual care, or education rather than another credible therapy. Blinding is difficult, and outcomes such as problem rating are necessarily subjective. Subjective improvement is clinically important, but it should not be represented as a proven physiological mechanism. Long-term effects, adverse events, and differential benefit by psychiatric history remain underexamined.

Relationship and workplace evidence is frequently qualitative, cross-sectional, and concentrated in Western settings. Sexuality studies may assume heterosexual partnership and underrepresent disabled, queer, transgender, racially minoritized, low-income, surgically menopausal, and unpartnered people. The language of empowerment can itself become culturally narrow when it assumes access to choice, money, and responsive services (Hickey et al., 2024).

Hormone and nonhormone guidance changes as evidence and products develop. This review is bounded to 30 May 2024 and cannot serve as current prescribing guidance after that date. Future research should integrate reproductive staging, psychiatric diagnosis, sleep, relationships, work, adverse effects, patient-prioritized outcomes, and longer follow-up. It should test care pathways, not only isolated interventions.

XVI. CONCLUSION

Menopause can alter mood, sleep, cognition, bodily comfort, sexuality, and daily function, but it does not supply a complete explanation for a person's distress. Assessment requires timing and reproductive stage alongside psychiatric history, physical health, medication, substances, relationships, work, culture, and safety. Independent disorders and transition-associated symptoms can coexist.

Psychotherapy is useful when it has a defined target. Menopause-specific CBT can reduce the burden of hot flushes and night sweats, CBT-I can treat persistent insomnia, and disorder-specific therapy should be offered when a psychiatric disorder is present. Relational work can support communication, identity, sexuality, grief, and practical

negotiation, although direct trial evidence is thinner in these domains.

Good care is coordinated rather than territorial. Prescribers assess hormone and nonhormone options; psychotherapists help patients describe experience, examine meaning, change maintainable loops, and make informed choices. Partners and workplaces may need to change too. The governing stance is neither dismissal nor certainty: believe the impact, investigate the causes, explain the limits, and keep the woman's priorities at the center of the plan.

The clinically useful unit of assessment is not the hormone, symptom, or relationship in isolation, but the changing system linking bodily transition, prior vulnerability, social context, and communication. Care is most credible when that formulation remains open to revision as medical and relational evidence changes.

XVII. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT). Where CFT is discussed, it is presented as a formulation perspective and not as a substitute for established assessment, evidence-based treatment, or independent replication. No other conflict of interest was reported.

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Patient material—No identifiable patient material is presented. Any brief examples are generic composites created to illustrate clinical reasoning and are not case reports.

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