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Cite this as: *BMJ* 2022;377:e069369
http://dx.doi.org/10.1136/bmj-2021-069369
Published: 15 June 2022

Normalising menopause

Martha Hickey and colleagues argue that social and cultural attitudes contribute to the varied experience of menopause and that medicalisation fuels negative perceptions

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Menopause is a natural event for half of humankind. The term "menopause" denotes the final menstrual period but is often used to describe the menopause transition, starting with changes in the menstrual cycle and finishing one year after the final menstrual period. While media attention in in the UK may give the impression that growing numbers of women are struggling to cope with menopausal symptoms and are seeking hormonal treatment,[1] there is no universal experience and most women prefer not to take medication unless their symptoms are severe.[2] In fact, socioeconomic status, education level, and social and cultural attitudes to menopause act with biological factors such as hormonal changes, smoking, diet, and body mass index to determine the experience of menopause, including the nature and severity of symptoms.

We argue that medicalisation of menopause risks collapsing the wide range of experiences at the average age associated with this natural process into a narrowly defined disease requiring treatment. Medicalisation tends to emphasise the negative aspects of menopause and, while effective treatments are important for those with troublesome symptoms, medicalisation may increase women's anxiety and apprehension about this natural life stage. Changing the narrative by normalising menopause and emphasising positive or neutral aspects such as freedom from menstruation, pregnancy, and contraception, together with information about managing troublesome symptoms might empower women to manage menopause with greater confidence. People with functioning ovaries who do not identify as female will also experience menopause if they do not take cross gender hormones. We use the terms women and women's health to encompass all these individuals.

No universal menopause experience

In high income countries, menopause usually occurs at around age 51 years, although the range is wide (45-55 years). Menopause is often earlier in middle and lower income countries, at 46-48 years on average.[3 4] During the menopause transition women may experience body changes such as vasomotor symptoms (hot flushes and night sweats), sleep difficulties, changes in mood, and aching muscles or joints. These are usually time limited, and their nature and severity vary substantially between women and within the same woman over time. The prevalence of moderate to severe vasomotor symptoms is uncertain but was estimated at 16-40% in a global survey of 11 771 women in 2021, depending on geographical location.[5]

Women with severe vasomotor symptoms often benefit from menopausal hormone therapy, which may also improve sleep.[6] For those who are symptomatic, a cross sectional study of 354 US women reported that their main priorities for treatment were vasomotor symptoms, sleep, concentration, and fatigue.[7]

While the majority of women experience body changes over the menopause transition, most consider this a natural process that is manageable without medical intervention. For example, a US longitudinal survey of 2565 midlife women in the 1980s found that almost half were relieved to be going through menopause (42%) or felt neutral about the experience (35%).[8] An Australian cross sectional survey of midlife women (n=776) in 2001 found that 90% were not troubled by the physical or psychological changes of the menopause transition.[9]

Furthermore, a systematic review of qualitative studies found that menopause is experienced in different ways globally. Specifically, women's expectations and experiences of menopause are strongly influenced by personal, family, and sociocultural factors.[10] Even within countries, social factors modify the experience of menopause. A 2021 international scoping review found that social factors including systemic discrimination, racism, and sexism together with personal factors such as socioeconomic status and beliefs about menopause shaped the experience of menopause in migrant women.[11] In the US, menopause is earlier, and vasomotor symptoms more common and long lasting, in African American than in white American women.[12] The reasons for these disparities are not known but structural racism, inequalities, and ongoing life stressors may contribute.

Cross cultural studies show substantial geographical and ethnic variation in the experience of menopause.[13] Whereas women in high income countries tend to report more vasomotor symptoms,[5]a review of menopausal women in 11 Asian countries found that body and joint pains were the most problematic symptoms, affecting 76% of Korean women and 96% of Vietnamese women.[13] Only 5% of Indonesian women reported hot flushes.

Women's experience of menopause is also strongly influenced by social values around reproduction and ageing, with positive or negative ramifications. For example, women tend to have worse experiences of menopause in countries where their value is predicated on youth and reproductive capacity and ageing is associated with decline.[10] In contrast, in a critical review of midlife embodied change, women identified freedom from menstruation, premenstrual

symptoms, and contraception as positive consequences of menopause.[14] Where menopause marks the end of restrictions such as purdah during menstruation, menopause may bring freedom, elevated social status, and a "second youth."[15] Together, these findings argue against a universal menopause syndrome since women's experiences are strongly influenced by social context and cultural beliefs and expectations.

Medicalisation fuels negative expectations

Negative views about reproductive ageing in women have pervaded the medical literature for centuries. In the 19th century menopause was thought to cause a nervous disorder with multiple physical and psychological manifestations. The ovaries regulated women's identity (femininity) and their physical and mental health were contingent on the balance between ovarian excess or deficiency. This model was clearly articulated in *Feminine Forever* by the gynaecologist Robert Wilson, who recommended oestrogen for all menopausal women to treat their "serious, painful and often crippling disease" and avoid the "untold misery of alcoholism, drug addiction, divorce and broken homes caused by these unstable, oestrogen-starved women."[16]

The message that menopause signals decay and decline, which can potentially be delayed or reversed by hormonal treatments, persists and is reinforced by the media, medical literature, and information for women, often driven by marketing interests. Marketing menopause as a disease is a lucrative business: the industry manufacturing unlicensed "compounded" bioidentical hormones accounts for around 28-68% of all menopausal hormone therapy prescriptions in the US with an estimated worth of around $2bn.[17] Other unregulated treatments are also marketed using the medical model that depicts menopause as a deficiency needing treatment. Women who see this marketing might understandably believe that menopausal hormone therapy is important for maintaining long term health.

This narrative of loss and decline may amplify women's health concerns as they age.[18] Although long term use of menopausal hormone therapy confers some benefits such as reduction in fractures, it also carries risk. In 2017 the US Public Services Task Force recommended against prescribing menopausal hormone therapy for the prevention of chronic disease.[19]

Furthermore, medicalisation and its narrow focus on symptoms may fuel women's negative expectations of menopause and influence what physical and emotional experiences they attribute to menopause.[20] Negative expectations of menopause make for a worse experience. For example, a systematic review found that negative attitudes and expectations before menopause predict the likelihood of distressing menopausal symptoms.[21] In a UK study of 140 women with vasomotor symptoms, those with negative beliefs about menopause were more likely to rate their vasomotor symptoms as "troublesome" and report embarrassment and shame.[22]

Social influences on the experience of menopause are further illustrated by the effects of migration. Women who migrated from India to the UK (n=52) reported similar vasomotor and psychological symptoms to white British women (n=51), while those who remained in India (n=50) reported few or no vasomotor symptoms.[23] Attitudes to ageing also predict sexual activity in postmenopausal women. In a longitudinal study of 602 US women, those who believed sex was important continued to be sexually active regardless of menopause or changes in vaginal lubrication or elasticity.[24] Conversely, in a longitudinal study of 474 Danish women, those who expected menopause to negatively affect sexuality were more likely to experience reduced sexual desire.[25]

A systematic review of factors affecting attitudes towards menopause reported more positive attitudes after menopause compared with before, suggesting that negative socially mediated expectations do not always match the reality of women's experiences.[26] However, the positive aspects of menopause are rarely discussed in the medical literature. A systematic review of standardised menopause questionnaires found only questions asking about negative symptoms and experiences. Hence, there was no opportunity for women to report positive experiences of menopause.[27]

Poor support exacerbates negativity

Population based surveys in the US and Ireland found that most women (65-77%) feel unprepared for menopause and report that they lack important knowledge about what to expect and how to optimise their health.[28 29] Together with limited public discussion and education and shame attached to ageing in women, this may contribute to embarrassment and negative expectations about menopause. Women in the US seeking medical advice at menopause also report wishing to be heard and better supported by their healthcare providers.[30] They prefer to hear that their symptoms are normal and not to take prescribed treatments unless necessary. Unfortunately, some women report feeling dismissed and receiving inaccurate information and ineffective treatments. In a survey of almost 1000 US women approaching menopause who consulted clinicians, patient dissatisfaction was associated with feeling dismissed, being told that their symptoms were not due to perimenopause, receiving inaccurate information, and not receiving helpful advice.[30]

Limited evidence from non-binary and transgender people shows gaps in clinicians' knowledge about menopause, compounded by a lack of culturally safe and appropriate services for these people.[31] Migrant women are another vulnerable group, with a qualitative study in 85 migrant women from 10 low and middle income countries reporting a lack of information about the normal changes at menopause exacerbated by cultural taboos around discussion of symptoms.[14]

Creating more positive experiences of menopause

Understanding the influence of social and cultural factors is critical to reducing negative experiences of menopause. For individual women, it is not possible to reliably predict who will experience troublesome symptoms and for how long. Balanced, evidence based information about the spectrum of normal changes to expect over the menopause transition—in both clinical and community settings—may help women prepare, empower them to manage menopause and instil confidence in navigating this life stage.

For example, perimenopausal and postmenopausal women randomised to a psychoeducational and health promotion programme showed greater knowledge about menopause, more positive attitudes, less discomfort, and greater engagement in healthy habits compared with those who did not participate.[32] Understanding the normal changes of menopause may also help women differentiate menopausal symptoms from other conditions such as depression, which require different management. Other helpful strategies may include taking time to process midlife changes, roles, and responsibilities; challenging overly negative attitudes expressed by others; and using exercise and mindfulness to reduce stress and promote wellbeing.[33] Box 1 provides some evidence based information resources on menopause.

Box 1: Examples of evidence based resources on menopause

- My Meno Plan (https://mymenoplan.org/)

- "What really happens to your body during menopause" (https://www.ted.com/talks/jen_gunter_what_really_happens_to_your_body_during_menopause#t-71391)
- Menopause Whilst Black (https://www.reddskin.co.uk/menopause-whilstblack), recognises the diversity of women's experiences
- Menopause Inclusion Collective (www.menopausecollective.org)
- Queer Menopause (https://www.queermenopause.com) considers how race, neurodivergence, sexual orientation, gender identity, and trauma inform the experience of menopause

Medical education should normalise the physical changes of menopause. Clinicians should provide reassurance about symptoms and their likely time course. Clinicians are also well placed to challenge their own and others' negative views that menopause is a deficiency disease that leads to decline. Women who adopt a medicalised view of reproductive events, including menopause, are more likely to report distress and attribute physical and mental changes to menopause rather than other causes.[2] For women requesting treatment for troublesome symptoms, clinicians should offer effective strategies using a shared decision making approach.

A range of pharmaceutical and non-pharmaceutical approaches are effective for vasomotor symptoms. For example, cognitive behaviour therapy can help by reducing stress, challenging overly negative beliefs about menopause, and improving reactions to vasomotor symptoms, which facilitates coping.[33] Menopause is also an opportunity for clinicians to encourage positive health related behaviours, such as dietary change and physical exercise, which may improve wellbeing, reduce the risk of chronic diseases, and support long term mental and physical health.[34]

Efforts to raise public awareness and reduce stigma around menopause may improve women's experience. In 2021 international guidance brought much needed attention to menopause in the workplace. In an unsupportive workplace, hot flushes and efforts to manage them may cause embarrassment, shame, and potential stigmatisation. These guidelines suggest educating managers and providing practical support such as access to cold drinking water, temperature regulation, and flexible working hours.[35] A more inclusive workplace culture might enable employees to disclose health issues, thereby reducing sources of work related stress.[35]

Medicalisation of menopause as a disease requiring treatment prepares women to expect the worst. Since social meanings and expectations commonly shape women's actual experiences, there is an urgent need to disseminate a more realistic and balanced narrative that challenges stigma around ageing in women, prepares women for expected changes, and recognises menopause as a natural process with both positive and negative aspects.

Normalising ageing in women and celebrating the strength, beauty, and achievements of older women can change the narrative and provide positive role models.[36] In the UK, women who have been through the menopause have raised the profile of menopause through media campaigns and within the workplace.[37] Menopause is now included in the UK high school curriculum, and organisations have developed menopause policies and online resources for employers to better support their employees managing menopausal symptoms.[38] Though outcomes of these policies will need to be carefully tracked, continuing to raise awareness through public health and education campaigns can support women to expect—and enjoy— more positive experiences of menopause.

Key messages

- Menopause is a natural event for half the population, but there is no universal experience
- Experience of menopause is shaped by social, cultural, and biological factors
- The medicalisation of menopause reinforces negative views about reproductive ageing
- Although some women with troublesome menopausal symptoms benefit from menopausal hormone therapy, other effective treatments are available and a narrow focus on symptoms fuels negative expectations
- Challenging gender based ageism, reducing stigma, and providing balanced information about menopause may better equip women to navigate this life stage

This article was updated on 1 November 2022 to correct the provenance statement.

Contributors and sources: MH has clinical and research interests in menopause. MSH has developed a cognitive behavioural intervention for menopausal symptoms and was expert adviser to the NICE guidance on menopause, 2015. NS has been a clinical investigator in menopause and perimenopause for over 35 years. JU has conducted research on midlife, early menopause after cancer, and migrant and refugee women's views of menopause. MH conducted the literature search, drafted the original manuscript, and is the guarantor. MSH, NS, and JU provided input on the content of this article and edited the draft version.

Patient and public involvement: Women in the community who have not yet experienced menopause and those with lived experience were invited to comment on this article, including Nina Coslov who manages the WomenLivingBetter website, Ann Garnier, who manages the LisaHealth APP; and Helen Douglas, co-founder of the Menopause Inclusion Collective. Sarah Williams, founder of Equality Counts, provided advice on gender inclusive language and the care of marginalised groups.

Competing interests: We have read and understood BMJ policy on declaration of interests and declare the following: MH has been an expert witness in 2020 for a public health authority in New South Wales Australia and topic expert for 2022 update of the NICE menopause guidelines. She was site investigator for a study of a non-hormonal agent for vasomotor symptoms after breast cancer funded by Que Oncology and for a trial of a device to treat vaginal dryness funded by Madorra. MSH is author of three books on cognitive behaviour therapy for menopausal symptoms and has a contract with Turning Point UK to develop support for women with menopausal symptoms and received a research grant from Wellbeing of Women to evaluate the MENO-kit, a workplace tool for menopause in the workplace. NS is on the scientific advisory board for Menogenix and Astellas and consultant for Ansh Labs. She has grant support to the University of Colorado from Menopgenix. SH is president of the Society for Reproductive Investigation and on the programme committee of the North American Menopause Society. JU was president of the Society for Menstrual Cycle Research, 2019-2021 and is president of the Australian Society for Psycho-social Obstetrics and Gynaecology.

Provenance and peer review: Commissioned; externally peer reviewed.

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