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On the Other Side of Menopause

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For me it's in the past, a distant memory, that's well behind me. But each generation of women goes through menopause and seems to discover its "horrors" anew. Just recently I came across a new book and a review of a TV series that decry the miseries of menopause and the paucity of attention given to an experience that half the population has to negotiate, suffer, and/or tolerate (McNamara 2019; Steinke, 2019). In 2011, Sandra Tsing Loh wrote:

"During menopause, a woman can feel like the only way she can continue to exist for 10 more seconds inside her crawling, burning skin is to walk screaming into the sea—grandly, epically, and terrifyingly, like a 15-foot-tall Greek tragic figure wearing a giant, pop-eyed wooden mask. Or she may remain in the kitchen and begin hurling objects at her family: telephones, coffee cups, plates. Or, as my mother did in the 1970s, she may just eerily disappear into her bedroom, like a tide washing out—curtains drawn, door locked, dead to the world, for days, weeks, months (some moms went silent for years). Oh, for a tribal cauldron to dive into, a harvest moon to howl at, or even an online service that provides—here's an idea!—demon gypsy lovers. But no, this is 21st-century America, so there is no ancient womyn's (sic) magic for us but rather, as usual for female passages, a stack of medically themed self-help books. . . . Rest assured, though: I'm here to help. Gentle reader, if you are a female of transitional age, which can apparently be anywhere from 35 to 65 these days, let me be your Virgil to the literature of menopause. Long have I wandered through the dry riverbeds, long have I suffered; now I've come back to share my wisdom" (Loh, 2011, paras 1 & 2).

For me, the best explanation of the symptoms that I was experiencing came from a male colleague who did research on sleep disturbances (thanks GMcE). Core body temperature fluctuates with circadian rhythms. During sleep the core body temperature is lowered allowing us to enter the sleep cycle; as morning approaches our core body temperature rises and we wake-up. Temperature dysregulation due to hormonal changes in perimenopause (exhibited in hot flashes and night sweats) causes our core body temperature

to rise at different (arrhythmic) times waking us up in the night. When this occurs repeatedly and chronically, we suffer from sleep loss that ultimately can result in depression (apologies to GMcE for this amateurish description). My symptoms included night sweats, secondary insomnia, mood swings, angst, and dysphoria. Menopause did not occur in isolation for me. Many of my colleagues at our School of Nursing were of a similar age and we went through it more or less together discussing our symptoms, complaining about them, exchanging information on how to handle them, and reassuring each other. In this way we were lucky. According to many authors (including those mentioned above), most women feel very alone in this experience (Loh, 2011; Manguso, 2019; McNamara, 2019; Steinke, 2019).

The words I used to describe my symptoms—angst and dysphoria—were chosen purposely because they connote an unfocused feeling of dread and a generalized state of unease. Using these words with my gynecologist and his female nurse, they both smiled knowingly and told me that I meant anxiety and depression. For me that did not describe my feelings. The same seems to be true of the authors referred to here. Manguso (2019) who is going through a surgical menopause after a pan-hysterectomy says that she doesn't have mood swings, she has one mood—rage. Steinke (2019) is upset with the word "irritability" to define her mood when what she feels also is a "bright ascendant rage." Loh (2011) describes Aunt Carol throwing a leg of lamb out the window and then goes on to say that "throwing the leg of lamb out the window may have been Aunt Carol's outward expression of the process going on within her soul: the reclaiming of self. Perhaps it was her way of saying how tired she was of waiting on her family, of signaling to them that she was past the cook/chauffeur/dishwasher stage of life. For many women, if not most, part of this reclamation process includes getting in touch with anger and, perhaps, blowing up at loved ones for the first time" (para 15).

McNamara (2019) describes a speech given by Belinda in the TV show "Fleabag" and refers also at the end to the freedom that comes with menopause: "... what happens? The menopause comes, the [expletive] menopause comes, and it is the most wonderful [expletive] thing in the world. And yes, your entire pelvic floor crumbles and you get [expletive] hot and no one cares. But then you're free, no

longer a slave, no longer a machine with parts, you're just a person, in business" (Nemenyi, 2019). Obviously a lot of feeling—a lot of emotion and thought—goes into choosing the words to describe what women are going through. And looking at reader reaction to the book by Steinke, many women believe that there is little or nothing written about menopause to which they can relate. As Loh (2011) says the authors who dominate this genre are M.D.'s, Ph.D.'s, and R.N.'s. who write about atrophic vaginitis. Bad news for us!

All of this reminded me of what has gone on in psychiatry and psychiatric/mental health nursing with regard to menopause and mental disorders where menopause may be considered an illness. That history can be tracked partially by looking at succeeding editions of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA). With each edition of the DSM, there has been greater attention paid to gender issues. The DSM I, published in 1952, contained essentially no mention of sex differences in psychiatric illness but included "this disorder" under "Disorders due to disturbances of metabolism, growth, nutrition or endocrine function" (APA, DSM I, 1958, p. 36). The DSM-II (1958) only rarely noted sex differences in disorders but did include the sex-specific disorder "Psychosis with Childbirth" as well as "Involutional Melancholia," which was commonly associated with menopause. The DSM II described Involutional Melancholia as "a disorder occurring in the involutional period and characterized by worry, anxiety, agitation, and severe insomnia. Feelings of guilt and somatic preoccupations are frequently present and may be of delusional proportions (APA, p. 36). DSM II goes on to distinguish this disorder from manic-depressive illness, schizophrenia, and psychotic depressive reaction. Back track a minute—"somatic preoccupations?" I can just hear the authors of the writings cited earlier grinding their teeth over this description!

The DSM III (APA, 1980) added a text section on "Sex Ratios" for each disorder but provided only minimal information such as "more common in women" or stated the information was not available. There were also sporadic comments about gender differences in course and treatment-seeking behavior. Several diagnoses in the DSM III were sex-specific or had different diagnostic criteria for men and women, most of which were in the section on Psychosexual Disorders (pp. 261–284). The other disorder with sex-specific diagnostic criteria in DSM III was Somatoform Disorder, which had a threshold of 14 symptoms (pp. 241–252). Since DSM III and through the current DSM 5, menopause related symptoms have been included under Major Depressive Disorder and Major Depressive Episode (Mood Disorders) when depression is present and under Anxiety Disorders when anxiety is the prominent feature. Also included under Mood Disorders in DSM 5 are Premenstrual Dysphoric Disorder and Mixed Anxiety/Depression.

Loh (2011) describes the professional books written on the physiology and experience of menopause by turns as dry, impersonal, demeaning, unappetizing, and all the same. After explaining the science of perimenopause, these books

go on to explain treatment with hormone replacement (HRT), selective serotonin re-uptake inhibitors (SSRIs), and recommendations for a healthy lifestyle: diet, exercise, drink more water, yoga, cut out alcohol and caffeine, and reduce stress. The occasional book that goes beyond these prescriptions is so long that it will take all of perimenopause to read it. Searching for articles in the professional literature on menopause, I found her descriptions to ring true, even those written by women (see for instance the MGH Center for Women's Mental Health, no date). Santoro, Epperson, and Mathews (2015) (all physicians) published a very comprehensive clinical article on menopause symptoms and their management in 2015. They cover vasomotor symptoms, adverse mood, sleep complaints, vaginal dryness and dyspareunia, cognitive complaints, and the various approaches to treatment in each of these areas.

Their key points are: (1) The late menopause transition (when women begin to experience 60 or more days of amenorrhea) is the point in time when hot flashes, adverse mood, vaginal dryness, and sleep complaints accelerate in prevalence. (2) The duration of hot flashes (vasomotor symptoms) may be longer than previously thought, with newer studies indicating durations of as long as 10 or more years. (3) There are non-estrogenic alternatives that are now approved by the US Food and Drug Administration (FDA) for the treatment of menopause-related vulvovaginal atrophy. (4) Both depression and anxiety increase in prevalence as women traverse the menopause, and the most vulnerable women are those without any prior episodes. And (5) Cognitive changes related to estrogen withdrawal include deficits in verbal and working memory, with almost three-fourths of women having a subjective sense of memory loss (Santoro et al., 2015).

Wow! Pretty much like Loh's (2011) description of the professional literature available for women who are perimenopausal: dry, dispassionate, impersonal and dreadful. A lecture by Marlene Freeman (2010), an Associate Professor at Harvard Medical School and Associate Director of reproductive psychiatry at Massachusetts General Hospital did not have better news. She covered premenstrual mood problems and menopausal symptoms and treatment. For women in the perimenopausal period her conclusions were: women are vulnerable to depressive relapse or new onset depression during the menopausal transition; co-occurring symptoms of menopause (hot flashes, sleep dysregulation, fatigue) are often important targets of treatment to be concurrently addressed; antidepressants are commonly used for menopausal symptoms, particularly as hormonal therapies have demonstrated greater risk and fewer long-term benefits as once believed; and there is no scientific evidence to support the use of alternative therapies as their effects are no better than placebos (Freeman, 2010).

In an article dense with medical terms and a review of scientific evidence on the subject, Parry (2013) discussed the findings of 37 studies on the problems and treatment of symptoms associated with menopause, including the efficacy of the various treatments. Although the other papers mentioned above cover the same topics, Parry's account is to the

point and thorough. Her emphasis is on depression (MDD) and the symptoms that may bring a woman to the attention of health care givers—melancholia, agitation, somatic symptoms, or sleep disturbances. She emphasizes that untreated depression may exacerbate heart disease, diabetes, and osteoporosis; it may also contribute to the risk for suicide and a more debilitating course of the depression that is more refractory to intervention. As a therapy, estrogen alone may reduce hot flashes and improve sleep, but it has not been shown consistently to be effective as monotherapy in MDD. It works well in combination with an SSRI, enhancing treatment outcomes; reducing response time; and obviating the need for increasing the antidepressant dose, with its attendant adverse effects. For vasomotor symptoms in women who cannot tolerate estrogen therapy, paroxetine and venlafaxine are the antidepressants found to have the most evidence for efficacy and tolerability (Parry, 2013). Finally, she cautions against the use of progesterone.

From the articles cited here, the lament of female authors that the milestones of female life are chiefly represented from the view point of medical personnel and outside observers seems well placed. But how about nurses? What have we written? It's true that we may come from a health perspective but we are certainly not outsiders—most of us are women. Are we writing for the audience of women who are drawn to books such as Steinke's (2019) and articles such as Loh's (2011) and Manguso's (2019)? Books/articles with a humanistic perspective that not only discuss hot flashes and mood changes but also the breakdown of our former identity, transition from a reproductive role and what that means to women and how they are perceived in society—the sexual and existential changes that occur. Do any of our writings reflect the freedom that menopause confers or the rebirth of agency that is experienced? Do our writings reflect our shared experience of menopause or only our professional and clinical views?

My initial searches were disappointing. Searching nursing literature and menopause, I found mostly articles that covered the same symptoms and treatments as those written by physicians. The *American Nurse Today* and the *American Journal of Nursing* offer continuing education courses on menopause and perimenopause that focus on common clinical symptoms (hot flashes, mood disturbance, sleep problems, vaginal dryness, etc.) and their treatment alternatives (HRT, SSRIs, sleep medications, vaginal creams, complementary medicine and so forth). Some articles focused exclusively on the use of HRT—its pros and cons. Searching for mental health nursing literature and menopause brought up some of the same references and a few dead ends, e.g., anything that had the word psychiatric nursing in it (programs for psychiatric nurse practitioners) but also surprisingly studies from the 1990s on immigrant women to the U.S. who were depressed. In one more recent immigrant study—2004—depression scores were correlated with age, number of years in the U.S., menopausal status, and support from living in an ethnic enclave (Miller, Sorokin, Wilbur, & Chandler, 2004). Correlations with depression in these studies were significant for most variables related to other

transition experiences such as acculturation and immigration, but not to menopause.

Perhaps the most sustained nursing research on the menopausal transition was the work done by the Seattle Midlife Women's Health Study conducted by researchers at the University of Washington led by Nancy Fugate Woods. This was a longitudinal, population-based study of symptoms women experienced between the late reproductive stage of reproductive aging and the early post menopause (Woods & Mitchell, 2016). Data collection began in 1990 with 508 women ages 35–55 years and continued to 2013. Entry criteria for the study included age, at least one period in past 12 months, uterus intact and at least one ovary. Women were studied for up to 5 years post menopause. Data collection included yearly health questionnaires, health diaries, urinary hormonal assays, menstrual calendars and buccal cell smears. The study was conducted in four phases: Phase 1 (1990–1992, n = 508); Phase 2 (1996–2002, n = 243); Phase 3 (2001–2006, n = 144); Phase 4 (2007–2013; n = 64). Major contributions of these studies included development of a method for staging the menopausal transition and identification of hormonal changes associated with these stages; and identification of naturally occurring clusters of symptoms women experienced during these stages. Similar to other studies noted earlier, the relationship of stress, health status, and social support to symptoms particularly hot flashes, depressed mood, memory problems, and sleep disturbances were examined also (Woods & Mitchell, 2016). Results of the study phases were published from the 1990's to 2016 in journals such as *Climacteric*, *Menopause*, and *Maturitas* in the dispassionate and objective style expected in scientific publication. Finally, I hit on a winning search combination for the kind of study that would describe the feelings of women about the menopause transition in similar terms to those of Loh (2011), Steinke (2019), and Manguso (2019); that combination was: qualitative research and menopause. This search resulted in many studies but not many of these were by nurses. Four studies by nurses using qualitative methods had information that included not only symptoms and treatment but also transition from a reproductive role, perception of menopause in society, freedom and the rebirth of agency (Bertero, 2003; George, 2002; Jeng, Yang, Chang, and Tsao, 2004; Lindh-Astrand Hoffman, Hammar, & Kjellgren, 2007). All of these authors emphasized that menopause was a highly personal and human experience, not just a clinical problem. Of these, the paper by George (2002) offered the most data on women's feelings.

Phenomenology was the study method used for examining the reality and perception of the American woman's experience of the menopausal transition (George, 2002). A multiethnic sample of 15 menopausal American women in Massachusetts was selected from a pool of voluntary participants from Boston and the suburbs (13 white, 2 African American; ages 48–62 years). Immigrant women were excluded because of their many transition experiences confounding the findings of the menopause transition as noted above. Semi-structured interviews were conducted lasting

about one hour; open-ended questions were used throughout the interview. Thematic analysis of the data was conducted using hermeneutic application. Overarching themes were developed from the identified categories of repeated findings or data that recurred frequently throughout the interviews. Three major themes emerged: expectations and realization, sorting things out, and a new life phase.

The categories of expectations and realization included such responses as “totally unaware” of what to expect. Realizations included hot flashes, cognitive changes, and emotional changes—“I’m not myself.” When asked whether their mothers served as role models, women related that their mothers had hidden this information from them. In the category sorting things out, the women said they felt “battered around” by their biology. They had difficulty determining whether their depression was related to hormonal changes or whether they were depressed for some other reason. They also had difficulty deciding whether or not to take HRT given the conflicting messages in the media. The final category was named “a new life phase.” In this category, they experienced the end of an era and most found it a relief. Finally, they saw menopause as a new beginning for themselves unhampered by their former roles (George, 2002).

After their symptoms subsided, the women in George’s (2002) study felt relief and a new beginning. It appears this feeling is not unusual if women are given the support and validation that this feeling is to be expected and embraced. Jeng, Yang, Chang, and Tsao (2004) enrolled 12 perimenopausal women in their study in an exercise program. At the outset of the study, these women felt and labeled themselves as unhealthy. The women continued their exercise program for 6 months or more. After this period of regular exercise, the women reported feeling “empowered” with a decrease in vasomotor symptoms and mood swings. But most importantly these Asian women described themselves as “Health Becoming” with the subcategories of “Releasing Health Crisis,” “Regaining Flowering Life,” and “Self-Fulfilling.”

Lindh-Astrand (a nurse) and her colleagues (two of whom are physicians and the other a nurse) also spoke of empowerment in the menopausal transition (2007). Their study involved semi-structured interviews with 20 women in Sweden. Two main categories were identified from the data including different physical changes with varying symptoms and both positive and negative psychological changes. The menopausal transition was also described as a natural process and as a developmental phase of life. The authors stressed the importance of fostering communication with and in this group of women and supporting them in optimizing their health as they embraced a new life phase (Lindh-Astrand et al., 2007). In another study set in Sweden, Bertero (2003) interviewed 39 women, all 47 years old who spoke of their expectations and/or experiences of menopause. These included physical and psychological changes but also expectations and feelings of freedom. However, the women lacked knowledge about these changes or self-care activities that could prevent problems or mitigate symptoms. Woods and Mitchell (2016) also found that women in Phase

1 of their study described menopause as a period of transition to a new and different life stage, and of uncertainty that elicited mixed feelings; they did not see it as a time of need for health care.

George (2002) notes that in American culture, women often are stereotyped as products of their reproductive systems and hormones. Menstruation means that women are seen as viable objects of desire for men and pregnancy means that women are viable sources of children. While menopause is described in terms of losses—sexuality, fertility, youthfulness, an empty nest. As described by Manguso (2019), “We are culturally prepared to perceive women’s natural aging as unimportant at best, pathological at worst—deserving of dismissal or disgust or both” (p. 71). Maybe someday these images will be replaced in the culture by images of actual women. The women in the four studies recounted here certainly suggest that possibility. And Steinke (2019) makes the case that the inexorable slide away from fertility is a rebirth of agency—that a woman now has the chance, at last, to retake the role of protagonist in her own life.

There are complex interactions among the biologic and psychosocial aspects of menopause that must be seen from a personal perspective and that cannot be addressed within the limits of the biomedical model. The role of nurses and mental health nurses is to facilitate women’s transition through their individualized experience of perimenopause to a promising new stage of life. Since most of us are women, we either will or have gone through this same transition. We can listen to the women who come to us, help them manage symptoms, act as empathetic role models, provide information, and assist them in making decisions. All with the idea that there is a very personal and human side to this that doesn’t fit the stereotype of women at menopause.

Disclosure statement

The author reports no conflict of interest. The author alone is responsible for the content and writing of this paper.

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