



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Women's Health and Well-Being During Midlife and Menopause:

Recommendations to Improve Access to and Quality
of Medical and Mental Health Care

APA PRESIDENTIAL TASK FORCE ON WOMEN'S HEALTH AND WELL-BEING DURING MIDLIFE AND MENOPAUSE



APPROVED BY APA COUNCIL OF REPRESENTATIVES, AUGUST 2026

Copyright © 2026 by the American Psychological Association. This material may be reproduced and distributed without permission provided that acknowledgment is given to the American Psychological Association. This material may not be reprinted, translated, or distributed electronically without prior permission in writing from the publisher. For permission, contact APA, Rights and Permissions, 750 First Street, NE, Washington, DC 20002-4242.

Suggested Citation

American Psychological Association, Presidential Task Force on Women's Health and Well-Being During Midlife and Menopause. (2026). *Women's Health and Well-Being During Midlife and Menopause: Recommendations to Improve Access to and Quality of Medical and Mental Health Care*. Retrieved from <https://www.apa.org/pubs/reports/midlife-and-menopause.pdf>.



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Women's Health and Well-Being During Midlife and Menopause:

Recommendations to Improve Access to and Quality
of Medical and Mental Health Care

**APA PRESIDENTIAL TASK FORCE ON WOMEN'S HEALTH AND WELL-BEING
DURING MIDLIFE AND MENOPAUSE**

APPROVED BY APA COUNCIL OF REPRESENTATIVES, AUGUST 2026

Abbey Kruper, PsyD, ABPP

Nicole Hollingshead, PhD, PMH-C

Carolyn Gibson, PhD, MPH, MSCP

Sheryl A. Kingsberg, PhD

Sara L. Kornfield, PhD

Angela Bethea-Walsh, PhD

Helen L. Coons, PhD, ABPP

***Rebecca C. Thurston, PhD,
FABMR, FSBSM, FAHA***

APA Staff Liaison

Raquel Halfond, PhD

TABLE OF CONTENTS

Executive Summary	2
Women’s Health and Well-Being During Midlife and Menopause: The Imperative to Improve Access to and Quality of Medical and Mental Health Care	3
The Charge of the Task Force and the Current Report	4
The Imperative to Improve Clinical Care in Midlife and Menopause	4
Midlife and Menopause: Common Symptoms and Biopsychosocial Assessment	6
Evidence-Informed Health and Mental Health Treatment in Midlife and Menopause	7
Clinical Care Models for Women in Midlife and Menopause	9
Improving Access to Quality Care Services for Women in Midlife and Menopause	10
Education for Medical, Nursing and Mental Health Professionals	11
Supporting Consumer Knowledge and Accessing High-Quality Information on Midlife and Menopause	12
References	13
Table 1: Common Menopause Symptoms	16
Table 2: Risk Versus Protective Factors for Psychological Health During the Menopause Transition	17
Table 3: Behavioral Targets for Health Promotion in Midlife & Menopause	17
Figure 1: Interaction Between Physical and Psychological Symptoms	20

INTENDED USE OF THIS REPORT

This report is intended to provide information drawn from professional literature and clinical experience and to improve understanding of women's health and well-being during midlife and the menopause transition, including medical and mental health care considerations. It is not intended to create a requirement for practice. It is not meant to restrict scope of practice in licensing laws for psychologists or other independently licensed professionals, nor limit coverage for reimbursement by third-party payers. The report is also not intended to be used within a legal or judicial context to imply that psychologists or other independently licensed professionals are required to comply with any of its recommendations.

This report is not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation. It is not definitive and not intended to take precedence over the judgment of psychologists.

The panel members based their recommendations on the professional literature and Task Force consensus but did not conduct or formally evaluate systematic reviews of the literature for this report. Readers are encouraged to consider the companion research report written by this Task Force, *APA Presidential Task Force Report on Women's Health and Well-Being During Midlife and Menopause: Research Gaps and Recommendations*.

Clinicians are also encouraged to consider the report from the APA Presidential Task Force on Evidence-Based Practice (2006), *Evidence-Based Practice in Psychology*, and APA's (2021) *Professional Practice Guidelines on Evidence-Based Psychological Practice in Health Care*, both of which emphasize the integration of best available research to date with patient characteristics, culture, and preferences, and clinical expertise, when making treatment decisions. Ultimately, when clinicians are developing treatment plans, they are encouraged to do so in a shared decision-making process with the patient in which all relevant information about options is presented to help inform the process.

Executive Summary

Midlife, including the menopause transition, is a developmental period marked by profound biological, psychological, and social changes. However, the needs of women¹ during this time remain widely underacknowledged and insufficiently addressed by scientific and clinical communities. Despite midlife and menopause affecting nearly 50% of the population and up to half of their lifetime, medical and mental health care during this period are often lacking. Many women must navigate impairing symptoms without high-quality, personalized clinical guidance or effective support. Significant gaps in education and training, research, treatment interventions, and access to physical and mental health care can result in increased risk of chronic medical conditions, reduced quality of life, impaired work productivity, increased mental health burden, and long-term morbidity and mortality. Addressing midlife and menopause needs is consequently a clinical priority and public health imperative.

This American Psychological Association (APA) 2025 Presidential Task Force report highlights necessary actions to help women receive comprehensive, evidence-informed, culturally tailored and trauma-informed care in midlife and menopause. Consistent with the World Health Organization (WHO)'s definition of health, we include the spectrum of physical, social, and mental health issues during midlife and menopause. The task force advances broad recommendations to strive towards for key stakeholders, including federal research and healthcare agencies, women's health advocacy groups, professional societies, academic researchers, healthcare systems, the spectrum of clinical care providers across disciplines, community organizations, and philanthropists focused on women's health to improve midlife and menopause care. The evidence-informed recommendations, developed by a panel of experts across the United States, emphasize the imperative to improve access to and the quality of women's physical and mental health care across midlife to prioritize health promotion and prevention initiatives in our country.

PRIMARY RECOMMENDATIONS²—STRIVE TO:

1. Acknowledge the challenges women face during midlife and menopause while also appreciating the positive aspects of this developmental stage, which is influenced by medical, mental health, psychosocial, sociocultural, cognitive, sexual, interpersonal, and occupational factors.
2. Expand access to evidence-informed, comprehensive, personalized, and culturally relevant ongoing physical and mental health care during midlife and menopause, with an emphasis on early intervention, health promotion, and disease prevention.
3. Tailor screening, assessment, treatment, and prevention strategies for all women with special consideration for at-risk populations, including women who experience early-onset, medically induced, or surgically induced menopause.
4. Implement interdisciplinary, integrated care models for women in midlife and menopause across public and private primary and specialty settings using tailored service delivery modalities to address the complex interplay of medical, mental health, and psychosocial challenges.
5. Improve access to care for all women during midlife and menopause using a range of community-based, trauma-informed, and telehealth care delivery models, including promoting access for urban, rural, coastal, and frontier communities and for persons from underserved populations or facing systemic barriers to healthcare.
6. Expand education and training of clinical providers across all disciplines and increase workforce representation from underserved communities to enhance expertise in midlife and menopause care.
7. Encourage widespread access to high-quality information and public education about midlife and menopause across populations and communities.

1 Although we primarily use the term "women" in this report, the APA recognizes the need for more inclusive language, classifications, and recommendations to highlight understanding and respect for intersecting gender diversity of persons who receive care and participate in research in traditional women's health settings. ACOG Inclusive Language (2023); APA Psychology Inclusive Language (2023).

2 The panel members based their recommendations on the professional literature and expert consensus but did not conduct or formally evaluate systematic reviews of the literature for this report.

Women's Health and Well-Being During Midlife and Menopause: The Imperative to Improve Access to and Quality of Medical and Mental Health Care

OVERVIEW OF MIDLIFE AND MENOPAUSE

Midlife, often defined as the age range from 40 to 65, is a major phase of life for women³ and includes the menopause transition. This developmental period is marked by significant shifts in physical health, social transitions, and affected by viewpoints on aging and mortality, all of which may impact mental health and well-being. The menopause transition encompasses several stages. Perimenopause, often beginning between ages 40 and 50, follows a woman's late reproductive years and is a time of fluctuations in reproductive hormones, menstrual cycle irregularity, and the potential onset of menopausal physical, sexual, cognitive, and mood symptoms (The Menopause Society, 2014). Postmenopause begins 12 months following a woman's final menstrual period and is the stage a woman remains in for the rest of her life (Harlow et al., 2012).

Women spend nearly half of their lives in peri- and postmenopausal years. As of 2024, approximately 52 million women in the United States are in midlife (U.S. Census Bureau, 2024). An estimated 6,000 women enter menopause each day for a total of over two million women each year (Whiteley et al., 2013). Midlife and the menopause transition are pivotal times to optimize health and well-being for women to prepare for aging and to take active steps to prevent chronic physical health conditions that can develop later in life, such as cardiovascular disease, diabetes, osteoporosis, dementia, cancer, and disability. Early intervention and informed, comprehensive treatment can mitigate negative effects on mental health and well-being, quality of life, and morbidity and mortality for women.

Expertise in the evaluation, treatment, and prevention of adverse physical and mental health outcomes is vital for women's health, but training in midlife and menopause is limited (Allen et al., 2023). Moreover, women from many communities face significant barriers to evidence-informed, culturally relevant, and trauma-informed physical and mental health care from providers across all health and behavioral health disciplines (Cortés & Marginean, 2022; Peate et al., 2024; Thurston et al., 2025; Troutman et al., 2025). This task

force report offers recommendations aimed at improving the quality of midlife and menopause health and mental health care for women across communities using tailored, personalized approaches. Consistent with the World Health Organization (WHO) definition of health, we include the spectrum of physical, social, and mental health issues during midlife and menopause. The Task Force advances broad recommendations for key stakeholders, including federal research and healthcare agencies, women's health advocacy groups, professional societies, academic researchers, healthcare systems, the spectrum of clinical care providers, community organizations, and philanthropists focused on women's health, to improve midlife and menopause care.

The sections include:

1. The Imperative to Improve Clinical Care in Midlife and Menopause
2. Midlife and Menopause Common Symptoms and Biopsychosocial Assessment
3. Evidence-Informed Health and Mental Health Treatment in Midlife and Menopause
4. Clinical Care Models for Women in Midlife and Menopause
5. Improving Access to Quality Care Services for Women in Midlife and Menopause
6. Education & Training for Health and Mental Health Professionals on Midlife and Menopause
7. Supporting Consumer Knowledge and Accessing High-Quality Information on Midlife and Menopause

3 Although we primarily use the term "women" in this report, the APA recognizes the need for more inclusive language, classifications, and recommendations to highlight understanding and respect for intersecting gender diversity of persons who receive care and participate in research in traditional women's health settings. ACOG Inclusive Language (2023); APA Psychology Inclusive Language (2023).

The Charge of the Task Force and the Current Report

The 2025 APA Presidential Task Force on Midlife and Menopause Health and Wellness was appointed by the 2025 APA president, Dr. Debra M. Kawahara. The charge of the Task Force was to address research gaps and recommendations, clinical care, education and training, as well as advocacy and policy matters necessary to improve outcomes among midlife women and persons experiencing menopause. The Task Force membership included colleagues across disciplines and settings with expertise in biomedical, psychological, behavioral, cognitive, sexual, lifespan, and sociocultural aspects of midlife and menopause health and wellness, with a specific focus on research and clinical care in diverse individuals, communities, and populations.

Dr. Kawahara appointed cochairs to lead the Task Force: Rebecca C. Thurston, PhD, FAMBR, FSBSM, FAHA, to lead the research workgroup, and Abbey Kruper, PsyD, ABPP, and Helen L. Coons, PhD, ABPP, to lead the clinical care workgroup. The cochairs invited interested psychologists with relevant expertise to share their input. The cochairs, together with Dr. Kawahara, reviewed the range of expertise for interested psychologists and Dr. Kawahara made final appointments to the Task Force. The Task Force was divided into research and

clinical care workgroups. The full Task Force and the individual workgroups each held regular meetings. Task Force members and the APA Science Knowledge & Expertise unit conducted informal literature searches to identify relevant publications. The panel members based their research and clinical care recommendations on the professional literature and consensus but did not conduct or formally evaluate systematic reviews of the literature for the two reports. Recommendations were formed by consensus via discussion over a series of calls and working drafts. Task Force members wrote two final reports with research and clinical care recommendations with multiple opportunities to review and share any feedback among the Task Force members. They also shared drafts with selected content experts outside the Task Force as well as staff from APA's Office of General Counsel. Feedback was addressed and/or incorporated before the reports were finalized in spring of 2026. The 2025 APA Presidential Task Force Reports on Women's Health and Well-Being During Midlife and Menopause include *Research Gaps and Recommendations* and *Recommendations to Improve Access to and Quality of Medical and Mental Health Care*.

The Imperative to Improve Clinical Care in Midlife and Menopause

Despite the universality of midlife and the menopause transition for women, symptoms are often underrecognized and untreated (Bevry et al., 2024; Kapoor et al., 2025). High-quality information for health and mental health professionals to meet the needs of women in midlife and menopause is lacking. Research, education, and clinical guidance across all medical and mental health disciplines is typically insufficient to meet the treatment needs of women in midlife. Despite menopause symptoms being an indicator for long-term health (Andrews et al., 2024), a 2021 analysis of United States healthcare for midlife women suggests only 20% to 25% receive indicated medical treatment, with even fewer women receiving menopause hormone therapy (MHT) (Carter, 2025).

Additionally, social and cultural factors, such as low income,

chronic stress, and discrimination also contribute to wide disparities in access to care and disease burden. For example, despite often experiencing severe menopausal symptoms, Hispanic and non-Hispanic Black women received menopause hormone treatment at less than half the rate of non-Hispanic White women (2.7%, 2.5%, and 6.3% respectively; Carter, 2025).

Nonbinary individuals endorse greater isolation and gender dysphoria during the menopause transition, though research on their experiences and inclusive treatment approaches remain extremely limited (Sobel et al., 2024; Westwood, 2025).

Importantly, early onset of the menopause transition—caused by medical or surgical interventions or occurring spontaneously—is often accompanied by more severe symp-

toms and increased risk of chronic health conditions, especially without proper medical management (Carter, 2025). With increasing rates of breast and colon cancers in young women in the United States, medical and surgical treatments may lead to a rise in the number of women experiencing early menopause and the associated physical, sexual, mental health, and other challenges that may persist for a significant proportion of their lives (CDC, 2025; Shiels et al., 2025; ACS, 2025).

The menopause transition also has implications for women's work productivity, status, and advancement. Approximately 30% of women in the U.S. labor force are in midlife and may be at their peak career status while experiencing menopause. A comprehensive analysis estimated the annual economic cost of menopause symptoms at \$5.4 billion in lost productivity due to absenteeism, reduced work productivity, and increased healthcare utilization (Heissel et al., 2025). Economic losses are particularly prominent for women experiencing severe vasomotor symptoms; those working in manual, routine-intensive, and caregiving roles; and women without a college degree (Heissel et al., 2025).

The meaning and impact of menopause is also shaped by cultural attitudes toward aging, gender, and productivity, which in the United States are often viewed negatively (Thomas et al., 2024; Dahlgren et al., 2023; Levy et al., 2020). However, the menopause transition is not a pathological condition; it is a natural life event that involves a complex interrelationship among physical, psychological, and social factors. Symptom expression is variable across women, and many women desire guidance to improve their well-being. Implementing early, comprehensive, and personalized physical, sexual, and mental health, as well as interpersonal and occupational approaches, can help reduce stigma and improve physical and mental health outcomes for women.

- Promote access to medical and mental health care by addressing inequities for all women, including in rural communities, and among high-risk and underserved women.
- Support specific populations, such as women experiencing early onset menopause or chronic physical or mental health conditions, to receive tailored, personalized interventions during menopause.
- Provide early and ongoing communication to women on midlife and menopause as a normative developmental and reproductive stage in which medical and mental health interventions may be indicated and effective to improve health and well-being.
- Use communication strategies to reduce the stigma and negative association of midlife and menopause changes by balancing the significant physical and mental health challenges present for women with the potential positive aspects, such as cessation of heavy and irregular menstruation and/or positive changes in life satisfaction and self-confidence.
- Dedicate initiatives aimed at improving workplace population health by raising awareness and implementing supportive interventions for women in midlife and during the menopause transition, including modifications to work policies and benefit plans, the physical environment, and the workplace culture.

RECOMMENDATIONS—STRIVE TO:

- Recognize the systemic factors that contribute to gaps in women's health research, education, and care, including longstanding funding limitations, workforce shortages, institutional priorities, and insurance and reimbursement policies that can affect the availability and sustainability of comprehensive women's health services.
- Fund research on clinical care models and treatment interventions to enhance long-term physical and mental health outcomes for women in midlife and menopause.
- Advance educational initiatives across all health and mental health professions to increase expertise in assessment, diagnosis, and treatment for women in midlife and menopause.

Midlife and Menopause: Common Symptoms and Biopsychosocial Assessment

In late reproductive years and early perimenopause, women commonly note changes in mood, sleep, and cognition as initial symptoms. These symptoms can persist over the menopause transition and contribute to it being a time of vulnerability for women's mental health (Harlow et al., 2020; Greendale et al., 2009). Additional prevalent physical symptoms include vasomotor symptoms (e.g., hot flashes, night sweats), genitourinary symptoms (e.g., vaginal and vulvar changes, urinary and pelvic floor symptoms), and changes in sexual health (see Table 1). Many women experience symptoms that significantly affect and diminish their overall health and quality of life, while others experience few symptoms or feel relieved when menses end.

Importantly, some women are particularly vulnerable to a high burden of physical, cognitive, or mental health symptoms. Black women may experience more frequent, severe, and persistent vasomotor symptoms (Thurston & Joffe, 2011). Additionally, women with a history of trauma, many psychosocial stressors (e.g., socioeconomic strain), underlying mental health comorbidities, hormone-sensitive mental health conditions, and transgender or nonbinary individuals may be at increased risk for higher symptom burden.

Ideally, all health and behavioral health care professionals will consider personal and family physical and mental health history as well as evaluation of menstrual patterns and additional symptoms that may be indicative of aging or menopausal changes. Suboptimal or insufficient assessment may lead to missed or delayed diagnosis, dismissal of concerns, and untreated symptoms that further worsen health and quality of life for women. Clinical assessment is best done through a personalized, comprehensive, biopsychosocial, and trauma-informed approach recognizing the interplay of biological, psychological, and sociocultural factors that shape midlife and menopause. Table 2 contrasts risk and protective factors for mental health during the menopause transition.

Physical conditions can be determined based on laboratory findings and medical history. Mental health professionals should consider a woman's medical status and medical and reproductive history such as pregnancy history, gynecological conditions, medications, and other medical diagnoses and treatment history (Lumsden et al., 2025). Although women may request hormone testing to understand their symptoms, the variability of levels during perimenopause may limit meaningful interpretation for staging

or treatment. Due to the variability in sex hormones during perimenopause, blood work to assess hormonal lab values is not routinely recommended for menopause staging unless indicated by a medical professional based on individualized symptoms, medical history, and age (Harlow et al., 2012; The Menopause Society, 2014). The stage of postmenopause may be confirmed through persistent elevation in follicle-stimulating hormone (Harlow et al., 2012). STRAW-10 provides a standardized framework to classify reproductive aging for women (Harlow et al., 2012). Finally, assessment of health behaviors such as sleep, nutrition, physical activity, social support, substance use, and stress management (see Table 3) are also necessary targets of assessment to inform diagnostic impressions.

All health and mental behavioral health professionals across disciplines can use brief, evidence-informed screening tools appropriate to clinical concerns and the population being treated. During perimenopause, many symptoms co-occur and influence one another (see Figure 1). Additionally, biopsychosocial changes in midlife and menopause, (e.g., sleep disturbances or vasomotor symptoms), may exacerbate pre-existing mental health conditions, such as mood and anxiety disorders, attention deficit hyperactivity disorder (ADHD), and posttraumatic stress disorder (PTSD). See the *APA Presidential Task Force Report on Women's Health and Well-Being During Midlife and Menopause: Research Gaps and Recommendations* for additional discussion of these concerns. Using a comprehensive assessment and differential diagnosis approach can discern whether psychological symptoms represent a recurrence of an existing mental health diagnosis, new onset symptoms accompanying menopause, or other medical or mental health conditions.

RECOMMENDATIONS—STRIVE TO:

- Recognize, evaluate, and address midlife and menopause concerns related to physical, mental health, psychosocial, sociocultural, cognitive, sexual, interpersonal, and professional experiences for women at routine and problem-focused health and mental health care visits.
- Promote personalized, comprehensive, and ongoing biopsychosocial assessment, specifically evaluating mental health symptoms during prior reproductive phases (such as related to menarche, menstruation, and, if applicable, perinatal periods). Differentiate menopause-related and

nonmenopause factors in the etiology of presenting physical and mental health concerns.

- Assess menopause stage (e.g., premenopause, perimenopause, or postmenopause) by relying on menstrual cycle characteristics, which may be supported by age and additional symptoms including vasomotor symptoms (VMS), genitourinary syndrome of menopause (GSM), sleep disturbances, mood, or cognitive changes. Assess patients' level of distress and the impact of symptoms, treatment interventions, and treatment responses. Special consideration in assessment of menopause will need to be given to women with histories of irregular cycles, premature ovarian insufficiency (POI), or medical/surgical onset of early menopause.
- Use high-quality validated measures that are tailored and normed for the specific population to assess mood

symptoms, health-related quality of life, and menopause-specific symptoms. Consider additional measures based on mental health symptoms, such as mania, post-traumatic stress disorder, eating disorders, or other psychiatric conditions.

- Assess sexual health related to desire, arousal, orgasm, pain, relationship context, medical history and medications, trauma history, and cultural attitudes. Universal, open-ended prompts and tailored sexual health screening measures can be used.
- To minimize risk for under, missed or delayed diagnosis and treatment, consider whether symptoms are related to menopause, aging, life stressors, interpersonal factors, or other primary medical or mental health conditions and discern the interrelationship between physical and mental health symptoms.

Evidence-Informed Health and Mental Health Treatment⁴ in Midlife and Menopause

Both pharmacological and nonpharmacological approaches may be effective to address physical and mental health symptoms in midlife and menopause. Psychological interventions can offer valuable education, insight, support, and practical strategies to address a wide range of biopsychosocial concerns in midlife and menopause. Some estimates indicate that half of women will experience mental health (e.g., depressive, anxious) symptoms during midlife and the menopause transition (Thurston et al., 2025; Maki et al., 2018). Despite the burden of mental health symptoms, too few women in midlife seek needed and effective care. According to the Kaiser Family Foundation, less than one third of U.S. women aged 45–64 who thought they needed treatment received mental health services in 2022 (Diep et al., 2022). Comprehensive, personalized, and interdisciplinary treatment interventions support healthy aging and reduce the effects of disease and illness for women. In addition to individualized care, population-health interventions in midlife and menopause will promote long-term health and well-being for all individuals (see Psychology's Role in Advancing Population Health; APA, 2022).

MENTAL HEALTH

Limited research has examined the efficacy of non-pharmacological interventions to manage psychological symptoms and diagnoses that are common for women in midlife and menopause. Clinicians can consider evidence-informed interventions that have demonstrated efficacy across the lifespan (e.g., cognitive behavioral therapy (CBT), behavioral activation, interpersonal psychotherapy, mindfulness-based interventions, and trauma-focused treatments; Rukure & Husted, 2025). A small literature suggests benefit of CBT and mindfulness-based interventions for depressive symptoms and anxiety among women in midlife and/or the menopause transition (Rukure & Husted, 2025; Wang et al., 2025), with assumed efficacy of other evidence-informed approaches in and after the menopause transition. While research specific to self-compassion interventions in midlife and menopause is needed, some literature suggests there are benefits from these practices in modifying negative appraisals and attitudes related to aging and health and improving general well-being (Brown et al., 2019; Othman et al., 2025).

Pharmacological approaches that have been specifically examined in peri- and postmenopausal women with demon-

⁴ The panel members based their recommendations on the professional literature and expert consensus but did not conduct or formally evaluate systematic reviews of the literature for this report.

strated benefit for mood symptoms include selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs; Maki et al., 2019). Menopause hormone therapy may improve depression for women in perimenopause with little evidence of benefit for women in postmenopause in the absence of vasomotor symptoms (Maki et al., 2019; Lebin et al., 2025). Although menopause hormone therapy may improve hormone-sensitive mood disturbances, its routine use to improve clinical depression in perimenopause and menopause is not recommended, particularly in the absence of other physical symptoms of menopause (Lumsden et al., 2025).

VASOMOTOR SYMPTOMS

Menopause hormone therapy is a first-line treatment for bothersome vasomotor symptoms. Nonhormonal pharmacological treatment options such as SSRIs, SNRIs, gabapentin, pregabalin, oxybutynin, and neurokinin receptor antagonists (Huang et al., 2025) are also available and may be helpful for some women. Two validated CBT protocols (CBT-MENO and MENOS) effectively reduce vasomotor symptom bother and interference in symptomatic perimenopausal and postmenopausal women, though typically not vasomotor symptom frequency (Green et al., 2019; Ayers et al., 2012). Research on group-based CBT-MENO, which contains separate modules for multiple symptoms and mood concerns common in the menopause transition, has shown improvement in depressive symptoms, insomnia, and sexual concerns (Green et al., 2019; Ayers et al., 2012). Clinical hypnosis, which can be self- or therapist-delivered, is effective for reducing vasomotor symptoms and improving sleep (Ott et al., 2020) and sexual function among peri- and postmenopausal women (Johnson et al., 2019). A small and mixed literature suggests that mindfulness-based stress reduction (MBSR)—a manualized, group-based intervention involving eight weekly sessions lasting 2 to 2.5 hours, a silent retreat, and daily meditation practice designed to train individuals on cultivating and incorporating mindfulness practice in daily life—may decrease vasomotor symptom bother, increase self-reported sleep quality, decrease depressive symptoms and anxiety, and increase quality of life among women during and after the menopause transition (Wang et al., 2025).

SLEEP DISTURBANCES

CBT for insomnia (CBT-I) is an effective and well-regarded nonpharmacological treatment approach to chronic sleep disturbance and insomnia with effectiveness equivalent or superior to pharmacotherapy and has shown efficacy for women in midlife and menopause with sleep disruption (Zhang et al., 2022). In a randomized controlled trial of women in midlife with moderate insomnia and comorbid vasomotor symptoms at baseline, the majority no longer met criteria

for clinically significant insomnia at the completion of the 8-week CBT-I protocol (McCurry et al., 2016). Additionally, women in the active arm reported significant improvement in vasomotor symptoms interference and negative mood. Data supports the efficacy of both individual and group-based CBT-I (Rukure & Husted, 2025).

The evidence for the efficacy of mindfulness-based and mind-body interventions to improve sleep specifically in midlife women or during menopause is limited and of low quality. However, some studies suggest positive effects on sleep among this population (Thurston et al., 2025).

SEXUAL HEALTH

Interventions to improve sexual health in midlife and menopause address sexual anxiety and negative cognitions about aging, enhance attentional focus on sexual stimuli, and improve sexual function and satisfaction (Simon et al., 2018). Behavioral strategies include directed masturbation exercises, psychoeducation on clitoral anatomy and stimulation, communication training, structured exposure, and expansion of the sexual repertoire to include pleasurable, pain-free activities. Pelvic floor muscle training (Jorge et al., 2024), optimizing partner support, and mindfulness exercises can enhance desire, arousal, and orgasmic capacity (Toledo et al., 2026).

Pharmacologic medication and topical options for female sexual interest and arousal disorder are available. For genitourinary syndrome of menopause and sexual pain, multidisciplinary treatment may include vaginal hormonal therapies, dilator use, cognitive-behavioral interventions, pelvic floor physical therapy (Kaufman et al., 2025) as well as collaboration with sexual medicine specialists.

HEALTH BEHAVIOR

Interventions to promote healthy behaviors can be implemented at individual and population-health levels. Focused efforts to improve physical activity, sleep, nutrition, weight management, limited substance use, social support, and stress management (see Table 3) can help women improve their overall physical and mental well-being, manage menopause symptoms, and avoid some negative side effects of pharmacotherapies. Behavioral interventions, such as motivational interviewing, which can increase readiness for change, improve adherence, and sustain long-term self-management, show potential benefits for improving health behaviors and quality of life for midlife women, but larger trials are needed for women in midlife and menopause (Orhan & Yağmur, 2025). Mental health professionals are especially qualified to implement a variety of evidence-informed interventions (e.g., motivational interviewing, goal-setting, self-monitoring, and problem-solving) to help modify harmful behaviors and increase healthy habits for women in midlife and menopause.

RECOMMENDATIONS—STRIVE TO:

- Provide all women with anticipatory and ongoing guidance and tailored education beginning by age 35 and throughout the late reproductive years that addresses the importance of health behaviors for midlife and the menopause transition related to physical symptom management, mood stability, and prevention of long-term chronic medical or mental health conditions.
- Consider specific populations at increased risk during midlife and menopause who would benefit from early physical and mental health prevention and treatment interventions to promote long-term health and well-being.
- Implement population-health education and interventions to address physical activity, sleep, nutrition, and stress management for health prevention and promotion for women in midlife and menopause.
- Use evidence-informed psychological and behavioral interventions for women in midlife and menopause, which may include cognitive behavioral therapy, mindfulness and compassion-focused therapies, and evidence-informed trauma interventions. Provide psychological treatments aimed at tailored, personalized care that considers co-occurring symptoms.
- Use evidence-informed prevention and treatment interventions to address health and lifestyle behaviors that may have significant long-term health implications (e.g., smoking, physical inactivity, suboptimal nutrition, substance use, etc.).
- Identify consultation or specialty care needed, including mental health professionals, physical and pelvic floor therapists, nutritionists, or other specialists (e.g., endocrinology, gynecology, sleep medicine, sexual medicine/therapy) based on individualized patient assessment.
- Implement interdisciplinary care with active and ongoing communication and collaboration with patients grounded in a holistic and comprehensive approach.
- Implement person-centered and culturally responsive interventions tailored to the specific needs of women in midlife and menopause. Consider how cultural factors and gender identity intersect with health behaviors and use shared decision-making regarding individualized treatment needs and goals.

Clinical Care Models for Women in Midlife and Menopause

INTEGRATED CARE

Providers across healthcare disciplines can address the complex and interacting effects of midlife and menopause and meaningfully promote physical and mental health with evidence-informed, multi-modal, multidisciplinary, and integrated care treatment. Models of care, including co-located, collaborative care, warm hand-offs, and clear referral pathways support collaboration among primary, specialty, and mental health professionals. For further guidance on integrated in women's primary and specialty obstetrics & gynecology settings, see Caudle & Coons (2024).

CARE MODALITIES

Clinical providers across disciplines can further enhance midlife and menopause care for women by considering and implementing a range of care delivery modalities. In addition to integrated care approaches, telehealth has been shown to be effective for women's health and mental health visits

and treatment protocols (ACOG, 2025; Goldstein et al., 2025). Additionally, group care models with shared visits among interprofessional providers can provide ease of access for women in midlife and menopause. Moreover, evidence-informed group treatment interventions can help normalize women's experiences in midlife and provide social support. Guided self-help options may also enhance patient self-efficacy and empowerment (Hunter, 2021).

TRAUMA-INFORMED CARE

It is essential that comprehensive midlife and menopause physical and mental health care for women is trauma-informed (SAMHSA, 2026). An estimated 40% of women in the United States have experienced interpersonal trauma in their lifetime, which can contribute increased risk during midlife for posttraumatic stress, depression, anxiety, changes to sexual health, chronic pain, and cardiovascular disease risk as well as menopause symptom burden (Thurston et al.,

2025). Trauma history across the lifespan can also affect an individual's sense of trust and safety and health care engagement, especially with sensitive topics or treatment interventions, such as physical and pelvic exams and other invasive procedures.

CLINICAL CARE RESEARCH

More studies are needed to develop and test efficacy and comparative efficacy of treatments and care models tailored to the needs of women in midlife and menopause. See the *APA Presidential Task Force Report on Women's Health and Well-Being During Midlife and Menopause: Research Gaps and Recommendations* for review of current literature and future directions related treatment approaches and clinical care models for midlife and menopause mental health care.

RECOMMENDATIONS—STRIVE TO:

- Implement midlife and menopause physical and mental health care across public and private primary and specialty clinical settings, including federally qualified health centers (FQHC), Indian Health Service (IHS), private community practices, and hospital-based practices.
- Provide midlife and menopause care across the continuum of women's primary and specialty settings within obstetrics and gynecology settings, including general gynecology, urogynecology, sexual medicine, and menopause practices; internal and family medicine, cardiology; neurology; psychiatry; and surgical and medical oncology practices that include women experiencing early menopause.
- Offer comprehensive midlife and menopause care with integrated, interprofessional care models with providers across disciplines collaboratively using evidence-informed, multimodal approaches.
- Offer a variety of care delivery modalities, including telehealth, group medical visits, group-based physical and mental health interventions, and guided self-help.
- Apply trauma-informed care principles in all care settings, delivery modalities, and treatment approaches for midlife and menopause care.
- Increase research on the effectiveness, scalability, and generalizability of clinical care models for women in midlife and menopause.

Improving Access to Quality Care Services for Women in Midlife and Menopause

Women face complex and unique barriers to physical and mental health care in midlife and during the menopause transition. Across diverse communities, women encounter persistent upstream systemic inequities that contribute to downstream barriers to care and affect health equity and outcomes.

Socioeconomic disparities in income, education, race, health insurance, and employment status significantly affect access to quality midlife and menopause care (Cortés & Marginean, 2022; Peate et al., 2024; Zahn et al., 2024). Geographic inequities limit availability of access to quality care, particularly in rural, frontier, coastal, and other underserved regions. Individual and social factors for women in midlife and menopause, including mental health, low self-esteem, competing demands from work, and caregiving responsibilities can contribute to less care-seeking and delayed attention to health. Women in midlife and menopause also have risks associated with intimate partner violence that can contribute to increased menopausal symptoms as well as barriers within healthcare settings related

to disclosure and receiving needed treatment (Mann et al., 2025).

In addition, racial and ethnic minority individuals may be disproportionately affected by structural racism as well as social stigma that impacts the discussion of and attention to midlife and menopause physical and mental health care (Lewis Johnson et al., 2024). Prior adverse experiences (i.e., implicit bias, microaggressions, and discrimination) from healthcare providers contribute to reluctance to seek care (Campbell, 2025; Hamed et al., 2022). The lack of racial or ethnic similarity between patients and healthcare providers may also contribute to negative healthcare experiences (Ye & Yi, 2023). A 2023 survey found that 63% of the healthcare workforce self-identified as White, in contrast to 58% of the U.S. population in the same year (Hill et al., 2025). When care is sought, treatment, such as menopause hormone therapy, is less likely for racial and ethnic minority women and women of low socioeconomic status (Blanken et al., 2022; Christmas et al., 2022).

Furthermore, sexual minorities and nonbinary people who

are in midlife or menopause may feel excluded when accessing care in a heteronormative healthcare system. The lack of inclusive, tailored care options and prior negative healthcare experiences for gender diverse individuals can contribute to avoidance of seeking needed care (Toze & Westwood, 2025). Lastly, the presence of neurocognitive impairments and other severe or chronic physical conditions may also impact the ability for some individuals to receive needed treatment.

Given the complex and interacting barriers to care faced by individuals in midlife and during the menopause transition, strategies to improve access, timeliness, and quality treatment are essential.

RECOMMENDATIONS—STRIVE TO:

- Strengthen upstream investments in the social determinants of health, such as community infrastructure, access to healthy food, reliable transportation, and other essential resources, through coordinated public and private sector partnerships, recognizing that equitable access started in early life and sustained across the lifespan can improve long-term health outcomes and quality of care for women.
- Ensure population health initiatives across diverse communities and locations are available for women in midlife and menopause, such as culturally tailored health educa-

tion, safe spaces for physical activity, access to healthy food sources, and transportation to care to improve health outcomes.

- Promote training in culturally responsive, trauma-informed, and gender-diverse inclusive care for all health and mental health professionals providing midlife and menopause care.
- Commit to population health communication for women in midlife and menopause, including accurate and culturally tailored information on physical and mental health symptoms and availability of evidence-informed treatments to counter the stigma associated with midlife, aging, and menopause in some communities.
- Increase access to the continuum of midlife and menopause physical and mental health care for women from at-risk, minoritized, and geographically isolated communities (specifically coastal, rural, and frontier) through telehealth treatment options and expanded provider networks.
- Recognize that meaningful access extends beyond the availability of services and requires insurance coverage and reimbursement structures that adequately support evidence-informed medical, mental health, preventive, interdisciplinary, and community-based care, enabling services to be sustainably delivered.

Education for Medical, Nursing and Mental Health Professionals

Education and clinical training on midlife and the menopause transition are not routinely included in medical and mental health graduate, intern, or residency disciplines. Estimates indicate that only 31% of obstetrics and gynecology residency programs reported having a menopause curriculum and 83% agreed that their programs need more menopause educational resources (Allen et al., 2023). The extent of midlife and menopause curriculum in other medical, nursing, and particularly mental health training programs is unknown. Without consistent training, health and behavioral health care professionals may lack the knowledge and skills to address menopause-related concerns. This knowledge and skills gap can contribute to individuals feeling misunderstood and/or dismissed, and it can affect patient trust, especially for persons from diverse communities (Aninye et al., 2021).

RECOMMENDATIONS—STRIVE TO:

- Expand education and training, including continuing education, on midlife and menopause across health and mental

health disciplines throughout the continuum of medical, nursing, and graduate school; residency, internship, fellowship; and continuing education or licensed professionals.

- Include curriculum on midlife and menopause health and mental health care for accreditation of medical, nursing, and mental health graduate programs through inclusion of coursework, training blocks, and clinical rotations.
- Include curriculum related to the stages of menopause, common symptoms during each stage, early or premature menopause, sexual health, mental health, and high-quality, evidence-based treatment and prevention interventions, including pharmacological and nonpharmacological approaches.
- Promote education on midlife and menopause that includes knowledge of screening and assessment tools, prevention, and management of common symptoms for women.

- Emphasize patient awareness, education, and empowerment in coursework and clinical placements.
- Establish partnerships between training directors and medical and mental health clinicians providing midlife and menopause care to expand access to and the depth of clinical training.
- Offer clinical rotations in interprofessional and integrated care settings that specialize in pharmacological and non-pharmacological interventions for midlife and menopause care.
- Expand education in midlife and menopause across all health and behavioral health disciplines to include reliable web-based and self-paced opportunities when possible.

Supporting Consumer Knowledge and Accessing High-Quality Information on Midlife and Menopause

Many women want to feel informed and empowered about their health, yet feel that they lack sufficient and reliable information, including information about menopause. As technology advances, women are relying more frequently on online and nonscientific sources for information about health. For example, in a 2022 UK government survey, women identified family/friends and online searches as their most common sources of health information, ahead of healthcare professionals (Department of Health & Social Care, 2022). These sources may provide information that is misleading or false, including conveying false claims and low or exaggerated risks, undermining evidence-based guidance, or recommending alternative treatment interventions that conflict with recommended care, and women may not verify the source or reliability of information (John et al., 2025).

Misinformation can affect policy development, physical and mental health treatment interventions, direct health care, and patient-provider communications and trust. In some cases, it may result in harm to the patient's health. Continued funding for evidence-based research, education, and training for health and mental health professionals is necessary to reduce the prevalence of misinformation that impacts lifelong health and well-being of women (see Using Psychological Science to Understand and Fight Health Misinformation: An APA Consensus Statement; van der Linden et al., 2025).

RECOMMENDATIONS—STRIVE TO:

- Use primary prevention strategies and population-health interventions to provide high-quality information on midlife and menopause to all women beginning in late reproductive years to increase the likelihood that they are informed prior to onset of symptoms.
- Use evidence-based, high-quality, and current data on midlife and menopause care in all assessment, education, prevention, and treatment interventions for women in midlife and during the menopause transition.
- Review online information regularly and prepare evidence-informed guidance for the public to address effects of misinformation. Provide education on how to verify the source and credibility of information to know if it is of high quality.
- Encourage individuals to obtain evidence-based health information from medical societies and reputable organizations.
- Promote online educational platforms to translate high-quality menopause information for consumer knowledge to advance their informed understanding and address misinformation.
- Assess individual factors, such as health literacy, sociocultural factors, gender identity, or other considerations, that may influence health beliefs and/or health information is sought or used.
- Use patient-centered communication to promote empowerment and self-advocacy, while ensuring individuals demonstrate informed decision-making of health-related information, including risks and benefits of treatment. Prioritize treatment relationships so that persons are feeling heard and understood while health-related information, especially misinformation, is clearly addressed.

References

- American College of Obstetricians and Gynecologists. (2026). *Menopause: What your ob-gyn wants you to know*. <https://www.acog.org/store/products/patient-education/books/menopause-what-your-ob-gyn-wants-you-to-know>
- Allen, J. T., Laks, S., Zahler-Miller, C., Rungruang, B. J., Braun, K., Goldstein, S. R., & Schnatz, P. F. (2023). Needs assessment of menopause education in United States obstetrics and gynecology residency training programs. *Menopause*, 30(10), 1002-1005.
- Andrews, R., Lacey, A., Bache, K., & Kidd, E. J. (2024). The role of menopausal symptoms on future health and longevity: A systematic scoping review of longitudinal evidence. *Maturitas*, 190, 108130. <https://doi.org/10.1016/j.maturitas.2024.108130>
- Aninye, I. O., Laitner, M. H., & Chinnappan, S. (2021). Menopause preparedness: Perspectives for patient, provider, and policymaker consideration. *Menopause*, 28(10), 1186-1191.
- American Cancer Society. (2025). *Cancer incidence rate for women under 50 rises above men's*. American Cancer Society Research News. <https://www.cancer.org/research/acs-research-news/cancer-incidence-rate-for-women-under-50-rises-above-mens.html>
- American College of Obstetricians and Gynecologists. (2025). Committee statement no. 20: Ethical considerations with telehealth in obstetrics and gynecology. *Obstetrics & Gynecology*, 146(4), 572-582.
- American Psychological Association. (2022). *Psychology's role in advancing population health*. <https://www.apa.org/about/policy/population-health-statement.pdf>
- American Psychological Association. (2023). *Using psychological science to understand and fight health misinformation (APA Consensus Statement)*. <https://www.apa.org/pubs/reports/misinformation-consensus-statement.pdf>
- Ayers, B., Smith, M., Hellier, J., Mann, E., & Hunter, M. S. (2012). Effectiveness of group and self-help cognitive behavior therapy in reducing problematic menopausal hot flashes and night sweats (MENOS 2): A randomized controlled trial. *Menopause*, 19(7), 749-759.
- Bevry, M. L., Stogdill, E. R., Lea, C. M., Taylor, K. R., Lovaas, A. M., Bailey, K. J., Mara, K. C., Dierkhising, R. A., Chaudhry, R., Faubion, S. S., & Kapoor, E. (2024). Addressing menopause symptoms in the primary care setting: opportunity to bridge care delivery gaps. *Menopause*, 31(12), 1044-1048.
- Blanken, A., Gibson, C. J., Li, Y., Huang, A. J., Byers, A. L., Maguen, S., Inslicht, S., & Seal, K. (2022). Racial/ethnic disparities in the diagnosis and management of menopause symptoms among midlife women veterans. *Menopause*, 29(7), 877-882.
- Brown, L., Huffman, J. C., & Bryant, C. (2019). Self-compassionate aging: A systematic review. *The Gerontologist*, 59(4), e311-e324.
- Carter, B. (2025). *Women in menopause often go untreated*. AARP Public Policy Institute. <https://doi.org/10.26419/ppi.00362.001>
- Caudle, M. R., & Coons, H. L. (2024). Foreword: Integrating mental health care in obstetrical and gynecology practice. *Clinical Obstetrics and Gynecology*, 67(1), 115-116.
- Campbell, C. N. (2025). Healthcare inequities and healthcare providers: We are part of the problem. *International Journal for Equity in Health*, 24, 97. <https://doi.org/10.1186/s12939-025-02464-9>
- Centers for Disease Control and Prevention. (2025). *Breast cancer among women younger than 45 years*. U.S. Department of Health & Human Services. <https://www.cdc.gov/united-states-cancer-statistics/publications/breast-cancer-among-young-women.html>
- Christmas, M., Janssen, I., Joffe, H., Upchurch, D., Santoro, N., & Kravitz, H. M. (2022). Menopause hormone therapy and complementary alternative medicine, quality of life, and racial/ethnic differences: The Study of Women's Health Across the Nation (SWAN). *Menopause*, 29(12), 1357-1364.
- Cortés, Y. I., & Marginean, V. (2022). *Key factors in menopause health disparities and inequities: Beyond race and ethnicity*. *Current Opinion in Endocrine and Metabolic Research*, 26, 100389.
- Dahlgren, M. K., Kosereisoglu, D., Smith, R. T., Sagar, K. A., Lambros, A. M., El-Abboud, C., & Gruber, S. A. (2023). Identifying variables associated with menopause-related shame and stigma: Results from a national survey study. *Journal of Women's Health*, 32(11), 1182-1191.
- Department of Health & Social Care [United Kingdom]. (2022). *Results of the "Women's health – Let's talk about it" Survey*. DHSC. <https://www.gov.uk/government/calls-for-evidence/womens-health-strategy-call-for-evidence/outcome/results-of-the-womens-health-lets-talk-about-it-survey#contents>
- Diep, K., Frederiksen, B., Long, M., Ranji, U., Salganicoff, A. (2022). *Access and coverage for mental health care: Findings from the 2022 KFF Women's Health Survey*. Kaiser Family Foundation. <https://www.kff.org/mental-health/access-and-coverage-for-mental-health-care-findings-from-the-2022-kff-womens-health-survey/>
- Goldstein, K. M., Rushton, S., Lewinski, A. A., Shapiro, A., Lanford-Davey, T., Coleman, J. N., Chawla, N., Patel, D. B., Van Loon, K., Shepherd-Banigan, M., Sims, C., Cantrell, S., Alton Dailey, S., & Gierisch, J. M. (2025). Experiences receiving and delivering virtual health care for women: Qualitative evidence synthesis. *Journal of Medical Internet Research*, 27, e68314.
- Green, S. M., Donegan, E., Frey, B. N., Fedorkow, D. M., Key, B. L., Streiner, D. L., & McCabe, R. E. (2019). Cognitive behavior therapy for menopausal symptoms (CBT-Meno): A randomized controlled trial. *Menopause*, 26(9), 972-980.
- Greendale, G. A., Huang, M. H., Wight, R. G., Seeman, T., Luetters, C., Avis, N. E., Johnston, J., & Karlamangla, A. S. (2009). Effects of the menopause transition and hormone use on cognitive performance in midlife women. *Neurology*, 72(21), 1850-1857.
- Hamed, S., Bradby, H., Ahlberg, B. M., & Thapar-Björkert, S. (2022). Racism in healthcare: A scoping review. *BMC Public Health*, 22, 988. <https://doi.org/10.1186/s12889-022-13122-y>

- Harlow, S. D., Elliott, M. R., Thurston, R. C., & Jackson, E. A. (2020). Monthly variation of hot flashes, night sweats, and trouble sleeping: Effect of season and proximity to the final menstrual period in the Study of Women's Health Across the Nation. *Menopause*, 27(1), 5-13.
- Harlow, S. D., Gass, M., Hall, J. E., Lobo, R., Maki, P., Rebar, R. W., Sherman, S., Sluss, P. M., De Villiers, T. J., & for the STRAW + 10 Collaborative Group. (2012). Executive summary of the stages of reproductive aging workshop + 10: Addressing the unfinished agenda of staging reproductive aging. *The Journal of Clinical Endocrinology & Metabolism*, 97(4), 1159-1168.
- Hill, L., Lo, J., Artiga, S., Pestaina, K. (2025). *Physician workforce diversity by race and ethnicity*. Kaiser Family Foundation. <https://www.kff.org/racial-equity-and-health-policy/physician-workforce-diversity-by-race-and-ethnicity/>
- Heissel, J. A., Donofry, S. D., Bonheur, A., Shinnick, D., Rollison, J., & Troxel, W.M. (2025). *The economic impacts of menopause in the United States*. RAND. https://www.rand.org/pubs/research_reports/RRA4292-1.html
- Huang, A. J., Faubion, S., & Grady, D. (2025). Nonhormonal treatment of menopausal vasomotor symptoms. *JAMA Internal Medicine*, 185(7), 874-875.
- Hunter M. S. (2021). *Cognitive behavioral therapy for menopausal symptoms*. *Climacteric*, 24(1), 51-56.
- John, J. N., Gorman, S., Scales, D., & Gorman, J. (2025). Online misleading information about women's reproductive health: a narrative review. *Journal of General Internal Medicine*, 40(5), 1123-1131.
- Johnson, A., Roberts, L., & Elkins, G. (2019). Complementary and alternative medicine for menopause. *Journal of Evidence-Based Integrative Medicine*, 24, 2515690X19829380.
- Jorge, C. H., Bø, K., Chiazuto Catai, C., Oliveira Brito, L. G., Driusso, P., Kolberg Tennfjord, M. (2024, July). Pelvic floor muscle training as treatment for female sexual dysfunction: A systematic review and meta-analysis. *American Journal of Obstetrics and Gynecology*, 231(1), 51-66. doi: 10.1016/j.ajog.2024.01.001.
- Kapoor, E., Safwan, N., Chaudhry, R., Griffin, J. M., Kling, J. M., Shufelt, C. L., Cole, K. C., Enders, F. T., & Faubion, S. S. (2025). Addressing menopause symptoms: Barriers and opportunities for improvement. *Mayo Clinic Proceedings*, 100(11), 1897-1907.
- Kaufman, M. R., Ackerman, L. A., Amin, K. A., Coffey, M., Faubion, S. S., Goldstein, I., & Wilson, T. S. (2025). The AUA/SUFU/AUGS guideline on genitourinary syndrome of menopause. *The Journal of Urology* 214(3), 242-250. <https://doi.org/10.1097/JU.0000000000004589>
- Lebin, L. G., Blissett, G., Patel, K., & Metcalf, C. A. (2025). The role of menopause hormone therapy in psychiatric symptoms and disorders: A review of evidence. *Current Treatment Options in Psychiatry*, 12, Article 19. <https://doi.org/10.1007/s40501-025-00351-2>
- Levy, B. R., Slade, M. D., Chang, E., Kanno, S., & Wang, S. Y. (2020). Ageism amplifies cost and prevalence of health conditions. *The Gerontologist*, 60(1), 174-181.
- Lewis Johnson, T., Rowland, L. M., Ashraf, M. S., Clark, C. T., Dotson, V. M., Livinski, A. A., & Simon, M. (2024). Key findings from mental health research during the menopause transition for racially and ethnically minoritized women living in the United States: a scoping review. *Journal of Women's Health*, 33(2), 113-131.
- Lumsden, M. A., Dekkers, O. M., Faubion, S. S., Lindén Hirschberg, A., Jayasena, C. N., Lambrinoudaki, I., Louwers, Y., Pinkerton, J. V., Sojat, A. S., & van Hulsteijn, L. (2025). European Society of Endocrinology clinical practice guideline for evaluation and management of menopause and the perimenopause. *European Journal of Endocrinology*, 193(4), G49-G81. <https://doi.org/10.1093/ejendo/lvaf206>
- Maki, P. M., Kornstein, S. G., Joffe, H., Bromberger, J. T., Freeman, E. W., Athappilly, G., Bobo, W. V., Rubin, L. H., Koleva, H. K., Cohen, L. S., & Soares, C. N., on behalf of the Board of Trustees for The North American Menopause Society and the Women and Mood Disorders Task Force of the National Network of Depression Centers. (2019). Guidelines for the evaluation and treatment of perimenopausal depression: summary and recommendations. *Journal of Women's Health*, 28(2), 117-134. <https://doi.org/10.1089/jwh.2018.27099>.
- mensoecrec
- Mann, C., Hinsliff-Smith, K., & Olewe-Richards, S. (2025). The intersection of domestic abuse and menopause: a scoping review. *BMC Women's Health*, 25(1), 624. <https://doi.org/10.1186/s12905-025-04161-9>
- McCurry, S. M., Guthrie, K. A., Morin, C. M., Woods, N. F., Landis, C. A., Ensrud, K. E., Larson, J. C., Joffe, H., Cohen, L. S., Hunt, J. R., Newton, K. M., Otte, J. L., Reed, S. D., Sternfeld, B., Tinker, L. F., & LaCroix, A. Z. (2016). Telephone-delivered cognitive-behavior therapy for insomnia in midlife women with vasomotor symptoms: An MsFLASH randomized trial. *JAMA Internal Medicine*, 176(7), 913-920.
- Orhan, İ., & Yağmur, Y. (2025). The effect of motivational interviewing on healthy lifestyle behaviors and quality of life in menopausal women: A pilot randomized controlled trial. *BMC Women's Health*, 25, 306. <https://doi.org/10.1186/s12905-025-03807-y>.
- Othman, S., Steen, M., & Abdelnasser, N. (2025). Self-compassion education for older adults' mental health and wellbeing: a mixed methods systematic review. *Aging & Mental Health*, 29(7), 1166-1178.
- Otte, J. L., Carpenter, J. S., Roberts, L., & Elkins, G. R. (2020). Self-hypnosis for sleep disturbances in menopausal women. *Journal of Women's Health*, 29(3), 461-463.
- Peate, M., Johnson, T. L., Avis, N. E., & Hickey, M. (2024). Addressing sociodemographic, socioeconomic, and gendered disparities for equity in menopause care. *Cell Reports Medicine*, 5(6).
- Rukure, H., & Husted, M. (2025). Cognitive behavioural therapy for menopausal symptoms: a systematic review of efficacy in improving quality of life. *BMC Women's Health*, 26(1), 58.
- Shiels, M. S., Haque, A. T., Berrington de González, A., Camargo, M. C., Clarke, M. A., Davis Lynn, B. C., Engels, E. A., Freedman, N. D., Gierach, G. L., Hofmann, J. N., Jones, R. R., Lofffield, E., Sinha, R., Morton, L. M., & Chanock, S. J. (2025). Trends in cancer incidence and mortality rates in early-onset and older-onset age groups in the United States, 2010-2019. *Cancer Discovery*, 15(7), 1363-1376.
- Simon, J. A., Davis, S. R., Althof, S. E., Chedraui, P., Clayton, A. H., Kingsberg, S. A., Nappi, R. E., Parish, S. J., & Wolfman, W. (2018). Sexual well-being after menopause: An International Menopause Society white paper. *Climacteric*, 21(5), 415-427. <https://doi.org/10.1080/13697137.2018.1482647>

- Sobel, T., Derakshani, D., & Vencill, J. A. (2024). Menopause experiences in sexual minority women and non-binary people. *Maturitas*, 185, 108007.
- Substance Abuse and Mental Health Services Administration. (2026). *Trauma-informed approaches and programs*. <https://www.samhsa.gov/mental-health/trauma-violence/trauma-informed-approaches-programs>
- The Menopause Society. (2014). *Menopause practice: A clinician's guide* (6th ed.).
- Thomas, S. L., Randle, M., & White, S. (2024). (Re)framing menopause: A comprehensive public health approach. *Health Promotion International*, 39(3), daae052.
- Thurston, R. C., & Joffe, H. (2011). Vasomotor symptoms and menopause: findings from the Study of Women's Health Across the Nation. *Obstetrics and Gynecology Clinics of North America*, 38(3), 489–501.
- Thurston, R. C., Thomas, H. N., Castle, A. J., & Gibson, C. J. (2025). Menopause as a biological and psychological transition. *Nature Reviews Psychology*, 4(8), 530–543.
- Toledo, R. G., Winkelman, W. D., Reyes-Gonzalez, D., Bergeron, S., Fladger, A., Hacker, M. R., & Anand, M. (2026, January). Female sexual desire, arousal, and orgasmic dysfunctions: A systematic review and meta-analysis of treatment options. *Journal of Minimally Invasive Gynecology*, 33(1), 16–33. doi: 10.1016/j.jmig.2025.06.004.
- Toze, M., & Westwood, S. (2025). Experiences of menopause among non-binary and trans people. *International Journal of Transgender Health*, 26(2), 447–458.
- Troutman, A., Are, F., Okoye, A., Chiang, S., Craig, D., Akande, A., & Stafford, I. (2025). *Breaking the silence: A scoping literature review on trauma-informed care for Black women navigating sexual health-related trauma*. *International Journal of Environmental Research and Public Health*, 22(10), 1484.
- U.S. Census Bureau. (2024). *National population totals and components of change: 2020–2023*. <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-national-detail.html>
- van der Linden, S., Albarracín, D., Fazio, L., Freelon, D., Roozenbeek, J., Swire-Thompson, B., & Van Bavel, J. J. (2025). Using psychological science to understand and fight health misinformation: An APA consensus statement. *American Psychologist*, 81(5), 685–701. <https://doi.org/10.1037/amp0001598>
- Wang, H., Wang, H., Kwok, J. Y. Y., Tang, S., & Sun, M. (2025). The effectiveness of mindfulness-based interventions on menopausal symptoms: A systematic review and meta-analysis of randomized controlled trials. *Journal of Affective Disorders*, 381, 337–349.
- Westwood, S. (2025). Lesbian, gay, bisexual, transgender and queer (LGBTQ+) menopause: Literature review, knowledge gaps and research agenda. *Health*, 29(4), 468–488.
- Whiteley, J., DiBonaventura, M. D., Wagner, J. S., Alvir, J., & Shah, S. (2013). The impact of menopausal symptoms on quality of life, productivity, and economic outcomes. *Journal of Women's Health*, 22(11), 983–990.
- Ye, H., & Yi, J. (2023). Patient–physician race concordance, physician decisions, and patient outcomes. *Review of Economics and Statistics*, 105(4), 766–779. https://doi.org/10.1162/rest_a_01236
- Zahn, K., Pittman, A., Conklin, J., Knittel, A., & Neal-Perry, G. (2024). Disparities in menopausal care in the United States: A systematic review. *Maturitas*, 186, 108021. <https://doi.org/10.1016/j.maturitas.2024.108021>
- Zhang, Y., Ren, R., Yang, L., Zhang, H., Shi, Y., Shi, J., Sanford, L. D., Lu, L., Vitiello, M. V., & Tang, X. (2022). Comparative efficacy and acceptability of psychotherapies, pharmacotherapies, and their combination for the treatment of adult insomnia: A systematic review and network meta-analysis. *Sleep Medicine Reviews*, 65, 101687.

TABLE 1

Common Menopause Symptoms

	Description
Vasomotor Symptoms (VMS)	Hot flashes or night sweats, collectively termed VMS, are one of the hallmark menopausal symptoms and most frequently occur during the late perimenopause and early postmenopausal years. Symptoms may be experienced as sudden sensations of heat in the face, neck, or chest, and typically last several minutes. Other associated symptoms may include chills, irritability, anxiety, nausea, sleep disruption, and palpitations.
Genitourinary Syndrome of Menopause (GSM)	GSM refers to physical symptoms and changes in vaginal or vulva health, as well as urinary tract or pelvic floor. Symptoms may include vaginal dryness, discharge, burning, itching, and painful intercourse, or urinary frequency and urgency. Anatomic changes in the genital tissues can occur. Symptoms can impact quality of life, self-esteem, and sexual intimacy.
Mood and Other Psychological Symptoms	Common symptoms include mood swings, irritability, depression, and anxiety. Depressive symptoms are often subclinical, yet women with prior history of depression are most at risk of major depressive disorder. Anxiety, including worry, tension, difficulties relaxing, as well as irritability are also common and need further study in the menopause transition. A variety of factors influence mental health symptoms, including but not limited to burden of physical symptoms, sleep problems, sex hormone changes, social support and caregiving strain, relationship transitions, professional changes, financial concerns, and presence of stressful life events.
Cognition	Common cognitive symptoms include forgetfulness, trouble focusing, and difficulty with multitasking. Some refer to these symptoms as “brain fog.” They are most prevalent during perimenopause and early postmenopause. Changes in cognitive performance on neuropsychological testing, particularly declines in verbal learning and memory, are common during the menopause transition. For most women, cognition remains within normal ranges, yet these cognitive changes can be a source of considerable concern to women.
Sleep	Sleep disruption refers to difficulties falling asleep, staying asleep, or waking early, and may be associated with daytime impairment. Sleep issues are linked to vasomotor symptoms, sexual health changes, and mental health, yet can occur in the absence of these symptoms. Obstructive sleep apnea is also increasingly common over midlife and underdiagnosed in women.
Sexual	Concerns with sexual health are classified by problems with desire, arousal, orgasm, or pain, with clinical diagnosis requiring distress and persistence of symptoms. Sexual health is impacted by interplay of physical health, hormonal changes, psychological health, interpersonal relationships, and sociocultural factors.

TABLE 2

Risk Versus Protective Factors for Psychological Health During the Menopause Transition

Risk Factors	Protective Factors
Chronic stress	Stress management/resilience
Stressful life events	Self-worth
History of trauma/Adverse childhood experiences	Perceived social support
Vasomotor symptoms	Positive attitude toward aging
Socioeconomic strain	Health behaviors (physical activity, sleep, nutrition)
Poor social support	
Prior mental health history	
Menopausal factors (surgical menopause, early menopause, highly symptomatic menopause, or prolonged menopausal transition)	
Health behaviors (smoking, disrupted sleep, sedentary behavior)	

TABLE 3

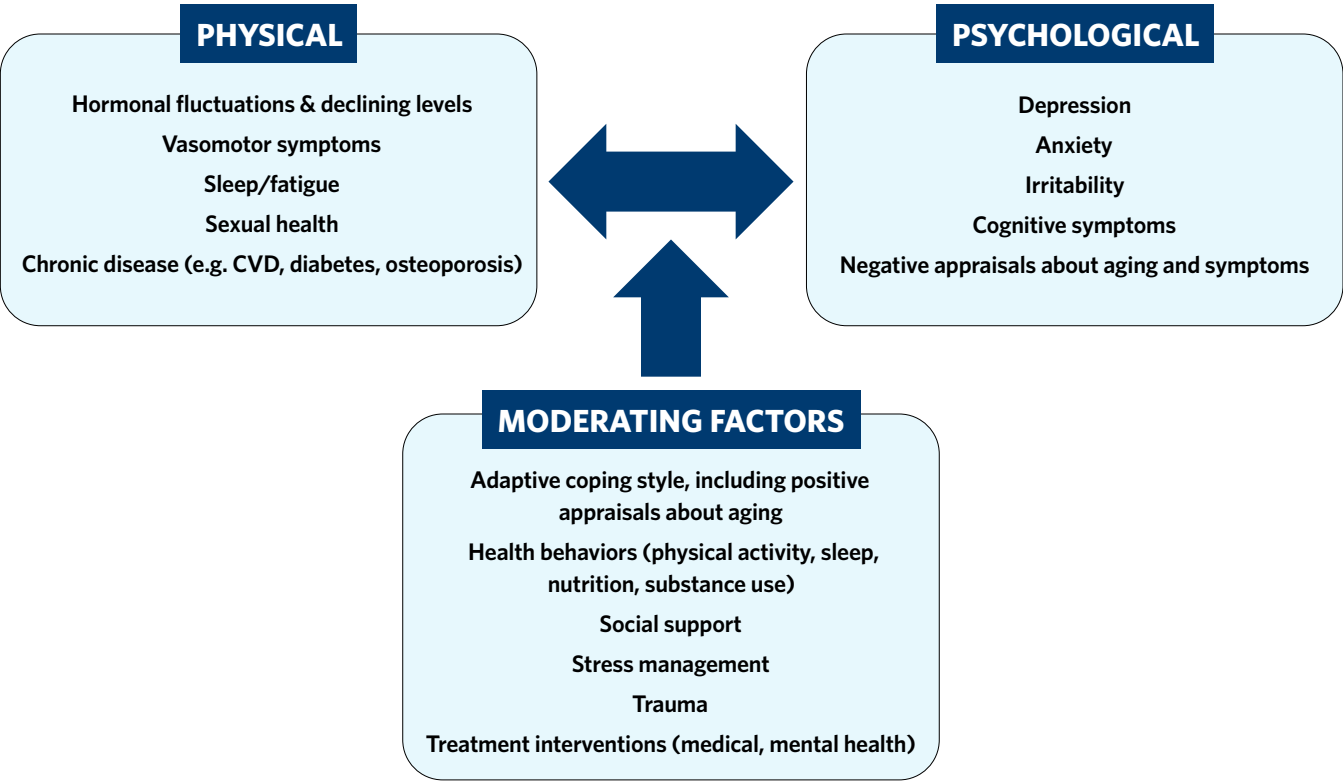
Behavioral Targets for Health Promotion in Midlife & Menopause

	Background	Healthcare Recommendations—Strive To:
Physical Activity	<p>There is robust data to support the benefits of exercise for women in midlife and menopause on physical and mental health, sleep, and weight management.</p> <p>Benefits can include improvements in mood as well as positive changes in body image and physical abilities.</p> <p>Regular exercise may help preserve and slow the loss of muscle mass with age, and supports bone, cardiovascular, and brain health.</p>	<ul style="list-style-type: none"> Recognize the inherent barriers for physical activity for women in midlife related to time, finances, caregiving demands, work responsibilities, and other factors. Educate women on the benefits of even light movement for physical and mental health symptoms. Suggest they identify enjoyable, sustainable activities (e.g., group classes, online or app-based options, or walking with friends). Work with women to set small, realistic goals to promote consistency. Provide evidence-informed goals of 30–60 minutes of moderate physical activity 3–5 days/week. Use evidence-based interventions, such as Motivational Interviewing, to promote behavior change.

	Background	Healthcare Recommendations—Strive To:
Weight Management	<p>Weight gain and redistribution of fat (e.g., increased visceral and abdominal fat) are common in midlife and the menopause transition. Even women who are weight stable may experience a change in body composition with a relative increase in fat mass and decrease in lean mass.</p> <p>Changes in weight are often related to age-related metabolic slowing, with some weight composition changes due to menopausal factors.</p>	<ul style="list-style-type: none"> ▪ Educate women early on potential weight changes to proactively support adoption of healthy lifestyle changes. ▪ Validate the emotional experience and challenges related to changes in weight distribution and body image, supporting positive body image. ▪ Assess specific, individual contributing factors (such as medications, medical conditions, health behaviors, or psychological disorders that can impact weight). ▪ Weight loss, when medically indicated, may aid in reducing VMS in some cases, specifically early in the menopause transition.
Nutrition	<p>Higher intake of fruits, vegetables, protein, fiber, and whole grains is recommended for women in the menopause transition.</p> <p>Nutrient-dense foods support cardiovascular, metabolic, and bone health.</p>	<ul style="list-style-type: none"> ▪ Encourage women to consume a balanced diet, including fruits, vegetables, whole grains, and lean protein. ▪ Encourage adequate intake of protein, fiber, and hydration for their personal health needs. ▪ Discuss potential effects of spicy foods related to VMS and caffeine related to VMS, anxiety, or sleep, if concerns are present. ▪ Consider referral to dietitian or nutritionist for individualized nutrition guidance.
Substance Use	<p>Substance use, specifically nicotine and excessive alcohol use, increases the risk of chronic health conditions.</p> <p>Smoking is associated with earlier onset of menopause (~2 years) and more severe VMS.</p> <p>There is limited data on the use of cannabis during midlife and menopause. There is potential for effects due to its impact on the endocannabinoid system; however, more research is needed.</p>	<ul style="list-style-type: none"> ▪ Screen all women and refer to substance use treatment programs when indicated. ▪ Provide education on risks of smoking in midlife and menopause. ▪ Offer smoking cessation support and pharmacologic aids if appropriate. ▪ Reinforce benefits of smoking cessation for menopause symptom relief and long-term health. ▪ Encourage abstinence from marijuana use given the limited data. ▪ Provide education on healthy alcohol use and encourage treatment interventions if problematic or excessive use is present.

	Background	Healthcare Recommendations—Strive To:
Social Support	<p>The presence of social support is a protective factor for overall health and stress resilience. Greater levels of perceived support positively influence mood, coping, and well-being.</p> <p>Changes in interpersonal relationships, impact on workplace functioning, and potential increased burden of caregiving can have a negative impact on perceived support contributing to physical and mental health concerns for women in midlife and during menopause transition.</p>	<ul style="list-style-type: none"> ▪ Encourage women to prioritize quality time and practice open communication to strengthen their established relationships. ▪ Recognize the need for additional support services or resources for women in midlife to limit impact of caregiving responsibilities. ▪ Help women brainstorm opportunities, spaces, hobbies/interests, and values to foster social connections. ▪ Encourage women to connect with local community organizations or interest groups. ▪ Establish group-based health and mental health interventions for women in midlife and during menopause.
Stress Management	<p>Presence of emotion regulation skills, self-compassion, and positive appraisals of midlife and menopause have been shown to improve overall quality of life and well-being, including during the menopause transition.</p> <p>Meaningful activities that promote a healthy mindset and mitigate effects of stress can support physical and psychological health, as well as improve the impact of menopause symptoms.</p>	<ul style="list-style-type: none"> ▪ Provide information and resources on mind-body practices, such as relaxation, meditation, or yoga. ▪ Encourage development of a self-compassion and/or gratitude practice as is aligned with a woman's goals and preferences. ▪ Discuss the benefits of cognitive therapy skills related to modifying thoughts and developing perspective taking skills. ▪ Recommend referrals for psychotherapy for evidence-based treatment interventions to foster healthy physical and psychological behaviors.

FIGURE 1
Interaction Between Physical and Psychological Symptoms





AMERICAN
PSYCHOLOGICAL
ASSOCIATION