

## **Menopause awareness for mental health professionals**

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### **Abstract**

Menopause most commonly occurs in women aged 45-55 and may last for many years. The experience of menopause is a very individual one though many common symptoms are reported such as insomnia, hot flushes, anxiety and poor memory. Many workplaces have no recognition of the disabling effects that menopause can have nor any supportive infrastructure. Nor do workplaces have well informed managers or staff, unsurprising when women themselves often cannot recognise menopause. In addition, symptoms can be interpreted as mental illness. Medical research tends to conceptualise the psychological effects of menopause as psychiatric disorder, but this is not necessarily helpful when treatments for menopause will alleviate experiences rather than the potential inappropriate prescribing of antidepressants for example. Professional awareness is poor generally but there are many actions that can be taken to improve recognition and support; evaluate your services, introduction of specific assessment and information resources for staff and patients and also provide reasonable adjustments. Taking individual responsibility for improving knowledge and skills in this area will mean we can all contribute to a better and more effective environment for women where they feel that their needs are addressed, without having to wait for access to 'specialist' services, if available.

## **Implications for practice**

- The symptoms of menopause may be misinterpreted as mental illness.
- Women's need access to accurate assessment and effective treatments.
- Mental health nurses need to take individual responsibility to improve their knowledge about menopause.
- both staff and patients may be experiencing distress that they do not feel able to talk about due to embarrassment and feelings of shame

## **Why you should read this article.**

- Women are 51% of the population and mental health nurses will come into contact with women experiencing menopause daily.
- Mental health nurses may never ask women about menopause due to the invisibility of the issues when women feel stigmatised and excluded.
- To gain some knowledge that enables mental health nurses to start a conversation about menopause and normalise the issues for women.

## Introduction

The authors of this paper have 70 years of mental health nursing experience between them, in practice, education and research. We are ashamed to say that in that time, neither of us can ever remember asking a woman about experience of menopause. As young women working in mental health services from the late 1980s, we knew that menopause was something that happened to older women, and probably went along with everyday culturally accepted (but actually unacceptable) jokes about it at the time. We now know how debilitating, socially isolating and distressing it can be and how little has changed.

The purpose of this paper therefore is to discuss, educate, advise and provide practical information and resources to enable practitioners in any setting to engage with issues of menopause and mental health with women they meet.. Women are employees, health professionals and patients/service users/consumers, therefore the messages in this paper have wide reaching applicability for all with an interest in menopause in the context of mental health and wellbeing. However, a particular focus on mental health professional issues is emphasised throughout, but with the acknowledgement that these professionals might be women needing support themselves as users of health services, as well as being responsible for accurate assessment of service users in their care.

## Recognition of menopause

In 2020 there were estimated to be 985 million women world wide aged 50 and over (Cano, et al. 2020). Menopause usually happens between ages 45 and 55 (National Institute for Clinical Excellence, NICE 2019) and the average age of onset is 51 years (Baber et al 2016). In the UK 13 million women are perimenopausal or menopausal (51% of the population) and around 25% of these women experience night sweats and hot flushes which adversely affect their quality of life and ability to cope (Griffiths & Hunter 2015). Perimenopause is where the biological change starts to occur eventually resulting in menopause, which is where periods have stopped for more than 12 months (this does not mean that symptoms become less distressing,

though they *may* become milder) (NICE 2019). The lived experience of menopause however, is a very individual one (Sergeant & Rizq, 2017; Banks 2019; Bremer et al 2019), with Sergeant & Rizq (2017) suggesting that it is a unique co-creation between biology and sociocultural circumstance (). However, there are a range of common symptoms generally reported. Table 1 shows data from Griffiths et al (2013) who surveyed 896 women aged 45-55 in work in UK based organisations.

Insert table 1

Recognition of menopause is generally poor. Forty-five per cent of 3275 women over 40 responding to a questionnaire, failed to recognise symptoms such as joint and muscle ache, irregular periods, night sweats, mood swings and poor memory as symptoms of the menopause (Nuffield, 2017). In addition, Nuffield (2017) found that 42% mistakenly believed they were too young or too old for symptoms and 25% put the symptoms down to stress.

The Greene Climacteric scale is a freely available brief measure of menopause symptoms that can be used to assess changes in psychological, physical and vasomotor aspects of menopause. It originates from a 1976 seminal study that appears to have been republished several times. It argues that, based on seven factor analysis papers, the 21 symptoms listed are the common symptoms that will identify menopause (Greene, 2008). It's original intention was to standardise a previously adhoc approach to assessing menopause, however, it's international use appears to have resulted in 'modified' versions(e.g. Australasian menopause society 2016), presumably as authors attempt to update the list to take account of more recent findings such as those shown in table 1. Indeed, in comparison to the research findings of Griffiths et al (2013) shown in table 1, the tool may have significant limitations in current services despite being a recommended tool (NICE, 2019).

In a mental health context, there is also a risk of diagnostic overshadowing. Women are twice as likely to be diagnosed with anxiety disorders (Mental Health Foundation, 2016), however Bremer et al (2019) argued that the 'new onset' experience of anxiety in menopause is a unique syndrome and unlike diagnostic manual descriptions. In addition, the Royal College of Nursing (RCN) guides UK nurses to ask whether low mood is menopause rather than misidentify symptoms as mental illness (RCN, 2019a). Misdiagnosis risks unnecessary treatments being prescribed and potentially inappropriate referral to mental health services.

The issue of diagnosis of menopause in the context of mental health is an important and under researched one. The limited medical research available on databases such as Medline, appear to conceptualise the psychological effects of menopause as psychiatric disorder. Medical treatments focus on physical symptoms, but parity of esteem with the psychological impact of these on mental health is potentially missed if symptoms reported are interpreted as mental illness. This has significant implications for assessment in mental health settings. There is very little research that informs our understanding of the experience of menopause for women with diagnosis of mental illness. Perich et al (2017) conducted interviews with 15 women in Australia aged 40-60 diagnosed with bipolar disorder (BD), exploring how they constructed mood changes during menopause and how this impacted on treatment

decisions. They concluded that women related the experience of mood changes during menopause through the lens of their existing framework of bipolar disorder, with implications for understanding of self and treatment choices.

Although Perich et al (2017) acknowledge cultural and psychosocial influences in the interpretation of mood change for mid-life women, the findings illustrate the confusion and ambiguity in understanding experiences when living with specific mental illness diagnoses. Nine women are described as being diagnosed with BD after age 40 and three after age 50, with five of the women diagnosed with BD during menopause. Although outside the remit of the research, questions about the timing of the BD diagnosis for these women has to be questioned. The women are reported as accepting a biomedical construct of BD and the diagnosis of BD clearly influences their constructions of menopause and mood change. However, it has to be considered, could BD be a misdiagnosis given the life stage it was diagnosed, and could it have been menopause? Could some women just experience more severe mood changes? The DSM5 (APA, 2013) states that the onset of 'manic' symptoms in late midlife or later life should 'prompt consideration of medical conditions e.g. frontotemporal neurocognitive disorder' (p130), though it makes no mention of menopause. Similarly, some psychiatric medications can create confusion when trying to diagnose menopause, for example, periods can stop when taking risperidone or sulpiride (BNF, 2021). Nevertheless, women in the Perich et al (2017) study with a diagnosis of BD and menopause reported more severe mood change, anger, irritability and feeling out of control. The women tended to attribute psychological change to BD and physical change to menopause. Understanding both the potential for diagnostic overshadowing and also engagement with individual constructs of ill health is important for professionals.

#### Professional awareness

General practitioners (GP, primary care physician) are usually the first port of call for women in distress, and one quarter of women who visited a GP, said that the possibility of the symptoms being menopause related is missed (Marlatt et al, 2018). GPs are limited by time and may also be lacking awareness of the wide-ranging symptoms and their impact on women's lives. Women report being prescribed anti-depressants and/or being referred to talking therapies for anxiety and depression. The female GPs who are consulted may themselves be experiencing the same distress and lack of recognition from others, with no support from employers, often being put off seeking help by sexist attitudes (Oppenheim, 2020). Nuffield Health (2017) indicate that in women aged 40-65, (n=3275), 10% seriously considered giving up work due to their symptoms and 18% have taken time off to deal with menopausal symptoms. One in 50 are on long term sick leave and 90% reported being unable to talk to a manager or colleague (Nuffield Health, 2017). In addition, workplaces may not recognise menopause as a cause for absence, with electronic staff records not having sickness absence codes for menopause, with absence statistics hidden in anxiety and stress codes (Banks, 2019). These issues affect women as employees and as service users.

In a recent local scoping exercise (unpublished) with a range of different practitioners working in voluntary and statutory wellbeing and mental health support services (several whom were in menopause themselves), 42 respondents indicated non or little knowledge of menopause and no knowledge of services, resources or

interventions to support women in menopause. There is no reason to suppose it is better anywhere else. It is sixteen years since the RCN first indicated that services need staff to be able to recognise gender-related risk periods such as menopause (RCN, 2005).

Open discussion is needed both professionally and in the public sphere if the needs of women disabled both physically and mentally by experiences of menopause are to be progressed (Griffiths & Hunter, 2015). Menopause has lots of physical symptoms which contribute to poor mental health, but symptoms also include anxiety, stress, tearfulness and irritability, resulting in embarrassment and shame which can be stigmatizing and isolating. Prolonged experiences such as this have significant effects on mental health and wellbeing. Nuffield Health (2017) found (N=3275, aged 40 and 65) that:

- Over 60% of women experience symptoms resulting in behaviour changes.
- One quarter of women will experience severe debilitating symptoms.
- Almost half of menopausal women say they feel depressed.
- A third of women said they experience anxiety.
- Women commonly complain of feeling as if though they are going 'mad'.
- Approximately two thirds of women say there is a general lack of support and understanding.

It has been argued that medicalization of menopause pathologises normal female development and the biomedical model legitimizes ageist, sexist narratives of older women (Sergeant & Rizq, 2017). A feminist sociocultural model focusing on menopause as a natural transition to be embraced is more holistic, recognising the part for example that work, roles, relationships and finance play (Sergeant & Rizq 2017). This may hold the most potential for meaningful development of support services. It is an approach which does not exclude the use of relieving medical interventions such as hormone replacement therapy, but can promote factual information, thus empowering women to make informed choices about their preferred treatments/interventions and adjustments.

What to do?

Although there is a paucity of literature on mental illness and menopause, the literature available suggests that we should be more critical of psychiatric discourse when it comes to assessing the needs of women. However, some more practical approaches are recommended for practitioners:

Evaluate your service and get the conversation started.

Firstly, evaluate your service, perhaps by audit, and consider the following questions:

- Is menopause support being addressed in your service?
- Does your service have a menopause policy for staff?
- Does the manager of your service empower staff to talk about experience of menopause?
- Do performance management processes take account of menopause as the cause of change in performance?
- Do the staff understand how to recognize menopause?

- Is there training available for staff?
- Do you refer to NICE guidance on menopause routinely in your service? Has menopause been considered as a differential diagnosis?
- Are there any service users who might need a diagnosis and/or treatment review with menopause in mind?
- Have the needs of BAME service users and staff been considered in this context?
- Does your service routinely discuss menopause with service users?
- Do you have information about local support organisations or online support resources available in your clinical area?
- Are the needs of men who support women in menopause considered?
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Introduce specific assessment and information.

Introduce key screening questions to any assessment process, to establish menopause status (ie early menopause/perimenopause/menopause /post menopause). This communicates to women that this is a safe space to consider menopause symptoms and experiences, and also lifestyle changes. There are three specific things women and mental health professionals need to consider (NICE 2019):

- Is the woman aged 45-55 years? (for premature menopause in the under 40s consider a blood test).
- Use the Greene Climacteric Scale (a menopause symptoms assessment).
- Ask about menstruation status (ie irregular, heavy, stopped).

Staff should recognise that women in the clinical team may be experiencing menopausal symptoms. We recommend a review of existing service policy to enable the workforce to recognise the impact that menopause can have on some women. This contributes to creating a culture of openness and understanding to ensure a collaborative approach to reasonable adjustments in the workplace.

Information resources should be displayed and promoted, making them accessible (and locally relevant if available), and also free of charge. Create menopause and mental health train the trainer programmes for your workforce, to raise awareness, provide factual information and build confidence to engage in a conversation about menopause with women whether that is with clients/patients or colleagues.

Provide some reasonable adjustments.

The RCN (2019b) document on menopause and work offers ideas for adjustments in relation to hot flushes e.g. use of fans. It also suggests:

- Headaches e.g. use a quiet room/area when possible to take time out.
- Low Mood e.g. identify a 'buddy' for the individual to talk to.
- Loss of Confidence e.g. have agreed protected time to catch up with work.
- Poor Concentration e.g. ensure access to memory-assisting equipment e.g. to do list, notes on phone.
- Anxiety or panic attacks

- Use of guided self-help resources, tools, and relaxation techniques.
- Muscular Aches and Bone and Joint Pain e.g. encourage regular movement and stretching breaks if sitting or static for extended periods of time.

Utilise useful resources.

The following resources may be useful:

Supporting occupational and wellbeing professionals (SOM) Resources for professionals <https://www.som.org.uk/menopause>

Primary Care Women's Health Forum: [www.pcwhf.co.uk](http://www.pcwhf.co.uk)

British Menopause Society: [www.thebms.org.uk](http://www.thebms.org.uk)

NICE Menopause Guidelines

<https://www.nice.org.uk/guidance/ng23/ifp/chapter/Menopause> and

<https://www.nice.org.uk/guidance/ng23/ifp/chapter/Treating-menopausal-symptoms>

[www.menopausematters.co.uk](http://www.menopausematters.co.uk)

[www.menopause-exchange.co.uk](http://www.menopause-exchange.co.uk)

**Greene Climaractic scale** [https://assets.jeanhailes.org.au/Health-professionals/Menopause\\_symptom\\_scale\\_Greene\\_Climacteric.pdf](https://assets.jeanhailes.org.au/Health-professionals/Menopause_symptom_scale_Greene_Climacteric.pdf)

## Conclusion

Two key messages from this paper are firstly, to get a conversation started and second, to take responsibility for recognizing menopause, rather than treat it as an issue for 'specialists. The former can only happen however when practitioners feel confident, informed and supported themselves. An effective service with a vision for practice development should be one of well-informed women and well-informed practitioners, who come together collaboratively. Only then can the views, wishes and concerns of women be explored, and all options considered at this critical time in their life. The following points are particularly important:

- Do not make assumptions.
  - do not assume described experiences or presentations are mental illness.
  - Do not think it is just about older women.
- Be sensitive to women's needs.
- Listen to women, their views, wishes and preferences.
- Learn about what menopause looks like.
- Educate yourself and do not be fearful about having the conversation.

We suggest starting conversations with children, with colleagues, family members and friends.

If everyone who works with women both professionally and clinically educates themselves, then women and clinicians will be empowered to make a difference without having to resort to always referring on to 'specialists. Managers have a key role in setting the tone of a service which can foster empowering environments, provide education and training to meet women's needs, make reasonable adjustments and draw on women's strengths. There is also a clear need for research into menopause in the context of mental illness.

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**Table 1 Most bothersome symptoms (Griffiths et al 2013).**

<b>Problematic symptoms (n=896). (Figures rounded up or down to nearest whole number).</b>
Sleep disturbances 56%
Tiredness 53%
Night sweats 43%
Joint and muscular aches and discomfort 41%
Hot flushes 40%
Feeling low/depressed 39%
Irritability 38%
Poor concentration 35%
Mood swings 35%
Poor memory 42%
Lowered confidence 22%
Anxiety/panic attacks 21%
Weight gain 38%
Frequent visits to the toilet 33%
Changes in skin 27%
Tearfulness 25%
Clumsiness 24%
Heavy periods/flooding 24%
Palpitations/ irregular or racing heart 20%