

Psychosomatic Presentation of Menopause

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Abstract

Menopause denotes a point of time in woman's life ending natural reproductive potential labeled retrospectively after a year. The physiological changes affecting quality of life stretch in a period long before and after this time called perimenopause. The changes occur due to declining estrogen level requiring hormone replacement to control both somatic and psychosomatic symptoms. Clinical mislabeling of psychosomatic presentation of menopause appears bothersome in clinical practice at times.

Keywords: Estrogen, Hormone, Menopause, Psychosomatic, Somatization

Introduction

Perimenopause is a key transition in a woman's life cycle due to declining ovarian function and labelled as menopause when there is permanent cessation of menstruation for at least a year. Average age cut-off is around 50 ± 5 years and labelled as premature menopause if it occurs before 40 years and delayed menopause if menstruation persists even after 54 years.¹ Delayed menopause retains estradiol function for a longer period in a woman's life with some protective functions like reproduction, decreasing risk of cardiovascular morbidity, reduced osteoporotic fractures, and stabilizing vasomotor, sleep and mood status. However, the risk of endometrial, ovarian and breast cancers may be increased.² Whereas, the premature menopause invites early somatic and psychosomatic symptoms; this could be idiopathic or due to autoimmune or multifactorial predisposition.³

There are different genetic and environmental factors to influence the menopausal transition. Fluctuating and declining estrogen and progesterone function results in vasomotor, urogenital, physical and psychosomatic changes. Molecular markers would be decreased estradiol and inhibin and increasing follicle stimulating hormone. Sleep disorder, mood swing, unexplained headache and irritability, vasomotor and cardiovascular symptoms, anxiety and depression are commonly encountered somatic and psychosomatic features during perimenopause.^{4,5} Menopause is an important life event ending natural reproductive function due to alteration in hormonal influence. Intricate relationship of sex hormones with non-reproductive bodily function results in multiorgan dysfunction requiring multiple clinical intervention if timely preventive measures are not applied. Individuals with physical symptoms of joint, muscle and bone fracture opt for orthopedic care; palpitation to cardiology care; frequency of urine and incontinence to urology care; pelvic organ prolapse, stress incontinence, vulval pain, vaginal dryness and itching to gynaecological care; and vasomotor, sleep and mood disorder to psychiatric care. Thus, the quality of life during menopausal transition and post menopause depends on both hormonal replacement protocol in early stage and additional geriatric care protocol in late menopause.^{6,7} The psychosomatic presentation puts a dilemma to both patients and physicians for the focused consultation and treatment. There is a risk of under-recognition as well as under-treatment. Psychiatric intervention overshadows the hormonal replacement at times. This risk would be less if somatic symptoms predominate the psychiatric symptoms. There will be systematic variation

in the calculated disease prevalence and disease categorization.⁸

Concept of Psychosomatic Symptoms

Interaction between psychological process and physiological function will be manifested psychosomatically by emotional or psychological and physical symptoms together (Figure 1). Somatization of psychological distress in the form of physical symptoms risks misinterpretation of illness and results in repeated medical care seeking without expected wellbeing. It may even lead to chronicity and disability.⁹ These symptoms arise from hormonal changes and psychological vulnerability, and predominantly present with vasomotor, psychological and physical symptoms. The common vasomotor symptoms are night sweats and hot flushes; psychological symptoms are anxiety, depression, irritability, emotional instability and cognitive difficulties; and somatic symptoms are palpitation, headache, fatigue, joint pain, dizziness and urogenital symptoms.^{10,11}

Biopsychosocial model of describing illness can be applied to interacting factors of menopausal symptoms like hormonal changes as biological or physiological factor; sleep, mood, cognition, stress and coping mechanism as the psychological factors; vasomotor, musculoskeletal and urogenital symptoms as a physical or somatic factor.^{12,13}

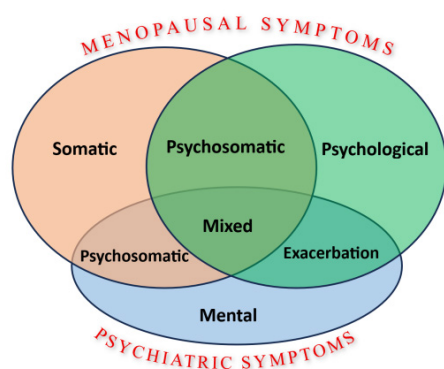


Figure 1: Somatic, psychological and mental presentation at menopause

Prevalence

The commonness of various presentations of menopausal symptoms depends on social context, individual tolerance, symptom awareness and recognition or identification. More than half experience difficulty in daily functioning with vasomotor flush in up to three-fourth, somatic complaints in three-fifths and psychological symptoms in one-third.^{14,15} The Study of Women's health Across the Nation (SWAN) using the Center for Epidemiological Studies Depression Scale (CES-D) found a greater risk of high depressive disorder in women during perimenopause and post menopause. Psychological stress gradually decreases in late menopause. However, the severity of symptoms varies by psychosocial stressors, health status and sociocultural perception.¹⁶

Biological Mechanism

Psychosomatic symptoms in menopause are due to hormonal changes especially the declining serum estrogen level which is responsible for the neurobiological system modulation. The neurotransmitters responsible for mood regulation, emotional stability and cognitive functioning are norepinephrine, dopamine and serotonin which are directly influenced by estrogen. Once its level declines, there will be anxiety, depression and irritability. Estrogen also has a neuroprotective role and, in its deficiency, there will be memory difficulties and loss of concentration.¹⁷⁻¹⁹

There will be changes in hypothalamic thermoregulation in menopause causing night sweats and hot flushes. This change results in episodic sweating and heat sensation due to loss of normal body temperature control mechanism from hypothalamus. These symptoms occur together with psychological distress due to interactive relation between physiological and emotional processes.²⁰ Stress response is regulated by hypothalamic-pituitary-adrenal axis and the estrogen deficiency may alter the cortisol secretion and stress sensitivity that increases the vulnerability to anxiety and psychosomatic symptoms. The chronic stress further dysregulates this axis manifesting as exacerbation of somatic and psychological symptoms.²¹

Psychological Factors: The way a menopausal woman perceive and respond to the menopausal changes may also depend on her psychological factors like stress and life events, personality traits and coping mechanisms, and her past mental health status. During the woman's life cycle, there will be multiple personal and social transitions like career change, familial responsibility, and care giving roles. These are the stressors of one's life and these may intensify the menopausal symptoms and increase the emotional distress as well.²² Neurotic and emotionally blunt woman will have different way of symptom perception and coping strategies, and they are more likely to experience anxiety and somatic features of menopause. In other way, adaptive coping strategies like problem solving, emotional regulation, and social support seeking are better psychological adjustment.²³ The strongest predictor of psychological symptom during menopause is past anxiety or depression like premenstrual dysphoric disorder and postpartum depression.²⁴

Sociocultural Influence: Experience and interpretation of menopausal symptoms are also influenced by cultural beliefs and social attitudes toward menopause.²⁵ In some cultures, menopause is viewed positively as a transition to wisdom, social authority, and freedom from reproductive responsibilities. Women in these cultures often report fewer psychological symptoms. In contrast, cultures that emphasize youthfulness and fertility may associate menopause with aging and loss of femininity. These negative perceptions may contribute to psychological distress and increased reporting of menopausal symptoms.²⁶ Socioeconomic factors such as education, income level, and access to healthcare also influence menopausal experiences. Women with greater access to health information and medical care are more likely to seek treatment and adopt effective coping strategies.²⁷

Psychosomatic Symptom Clusters: Hormonal fluctuations

combined with psychosocial stressors contribute to emotional instability. Thus, the mood swings, irritability, anxiety, and depressive symptoms are frequently reported during the menopausal transition.²⁸ Many women report cognitive complaints such as forgetfulness, difficulty concentrating, and reduced mental clarity. These symptoms are often described as “brain fog” and may be related to estrogen’s role in cognitive processes. Sleep disorders are among the most common complaints during menopause. Night sweats, anxiety, and hormonal fluctuations can disrupt sleep patterns and contribute to daytime fatigue.^{29,30} Musculoskeletal pain, headaches, gastrointestinal discomfort, and palpitations are commonly reported somatic symptoms during menopause. These symptoms often occur in combination with psychological distress.

Quality of Life: Psychosomatic symptoms during menopause can significantly impair women’s quality of life. Severe menopausal symptoms have been associated with decreased work productivity, impaired social relationships, and reduced life satisfaction. Sleep disturbances and chronic fatigue may negatively affect occupational functioning and daily activities. Mood disturbances may also influence family relationships and emotional well-being. Furthermore, untreated psychological symptoms during menopause may increase the risk of long-term mental health disorders, including major depression and anxiety disorders.³¹

Management Approach

Though the root cause of psychosomatic menopausal symptoms is declining hormonal level, its management often requires a multidisciplinary approach addressing both biological and psychological aspects. Vasomotor symptoms will be most effectively addressed by Hormone Replacement Therapy (HRT) and may also improve mood and sleep quality in some women. However, is not appropriate for all individuals due to potential health risks.³²

Psychological therapies such as Cognitive Behavioral Therapy have demonstrated effectiveness in reducing anxiety, improving sleep quality, and helping women cope with menopausal symptoms. Mindfulness-based stress reduction, relaxation therapy, and counseling interventions may also improve psychological well-being.^{33,34} Lifestyle modifications play an important role in managing menopausal symptoms. Recommended interventions include: Regular physical exercise, Healthy diet, Adequate sleep hygiene, Stress management techniques, and Limiting caffeine and alcohol intake. Physical activity has been shown to improve mood, reduce stress, and enhance overall quality of life among menopausal women.³⁵

There is still a clear gap in understanding the psychosomatic presentation of menopause. Many studies focus primarily on biomedical aspects of menopause, while psychological and cultural influences remain underexplored. There is also a lack of longitudinal studies examining long-term psychosomatic symptom especially from developing countries where sociocultural factors may differ significantly. Future research should focus on culturally sensitive interventions

and interdisciplinary approaches that integrate gynecology, psychology, and public health.³⁶

Conclusions

Menopause is a complex biopsychosocial transition characterized by significant hormonal, psychological, and social changes. Psychosomatic symptoms such as mood disturbances, fatigue, sleep disorders, and somatic complaints are common during the menopausal transition and can significantly affect women’s quality of life. The interaction between declining estrogen levels, psychological stress, personality traits, and cultural influences plays a central role in the development of psychosomatic symptoms. Therefore, effective management requires a holistic approach addressing biological, psychological, and social dimensions. Improving awareness, promoting supportive healthcare services, and developing culturally appropriate interventions are essential for enhancing the well-being of women during menopause.

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