Beyond Hormones: Reframing Menopause as a Psychological Developmental Stage

Recognising the psychological dimensions in clinical care.

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Menopause is typically conceptualised as a physiological or neuroendocrinological transition. However, clinical presentations and qualitative research consistently indicate that it constitutes a developmental life stage in some ways comparable to adolescence or matrescence given it is also characterised by disruption to identity, relational roles, and systems of meaning. Individuals frequently report a disconnection from their prior sense of self, often stating they "no longer recognise themselves."

CLINICAL OBSERVATIONS

In therapy and clinical care, women rarely present with a single issue. Instead, they bring a constellation of experiences:

Burnout & Exhaustion

Often pre-existing, driven by over-functioning, caregiving, poor sleep, and cognitive fatigue.

Mood Disorders

Episodic or fluctuating depression, anxiety, irritability, and apathy often with no previous mental health history.

Cognitive Disruption

Memory lapses, word-finding issues, brain fog is frequently mistaken for early dementia or ADHD.

Trauma Reactivation

Perimenopause is a 'second wave' of trauma triggers, particularly around motherhood, sexuality, and power.

Late Diagnosed ADHD / Autism

Masking becomes unsustainable, leading to collapse and identity crisis.

Self-Silencing & Identity Loss

Deep gendered conditioning around being good, selfless, and agreeable begins to unravel.

Relational Disruption

Divorce, estrangement, or shifts in caregiving roles coincide with increased emotional distress.

"Not Feeling Like Myself"

A phenomenological marker of existential disruption.

RESEARCH FINDINGS

Studies confirm what clinicians observe. Menopause is consistently associated with **identity disruption** and **narrative fracture**, where women report invisibility, alienation and loss of coherence. Researchers highlight the need for meaning-making, drawing parallels with **bereavement** and the **reconstruction of self** after symbolic loss.

Sociocultural pressures, particularly gendered expectations of productivity, selflessness and compliance, intensify distress, while negative age beliefs exacerbate **mood disturbance.** Conversely, **positive age beliefs** protect wellbeing and support resilience.

Menopause is also a time of **re-embodiment**: women may experience body shame and sexual strain, yet many describe this stage as a gateway to freedom, where old scripts are resisted and **autonomy is reclaimed**. **Role transitions** are central, encompassing the empty nest, workplace invisibility, shifting friendships and intimate relationships. For many, **unresolved trauma** resurfaces, while others confront mortality and reassess values, purpose and legacy. **Neurodivergence** is increasingly recognised at this stage, with women identifying **ADHD** or **autism** for the first time as long-standing coping strategies collapse.

CORE DEVELOPMENTAL TASKS OF MENOPAUSE

Analogous to other key life-stage transitions such as adolescence and matrescence, the menopausal transition is a complex biopsychosocial process involving disruption to established identity, roles, and meaning systems. **Attending to the developmental tasks inherent to this period is critical for affect regulation, psychological resilience, narrative coherence, and successful adjustment to the evolving demands of midlife.**

Identity Re-formation - Dismantling socially conditioned or historically embedded identities and reconstructing a more integrated, self-determined sense of self.

Clarification of Meaning and Values - Re-evaluating core beliefs, priorities, and existential frameworks in light of changing life circumstances and internal shifts.

Reclaiming Power and Boundaries - Strengthening intrapersonal authority and establishing psychologically safe and developmentally appropriate boundaries in relational and occupational domains.

Relational Recalibration - Re-assessing patterns of relational over-functioning, emotional labour, and attachment dynamics to promote reciprocity and authenticity.

Embodiment and Presence - Re-establishing connection with the body as a source of wisdom and vitality, moving from performative regulation to integrated, embodied awareness.

Desire and Self-Expression - Reclaiming and redefining personal desires—including creative, sexual, emotional, and vocational expression—previously suppressed by sociocultural or developmental constraints.

Integration and Flourishing - Consolidating identity shifts, psychological insights, and behavioural changes into a coherent self-narrative, with an orientation toward meaning-making, vitality, and post-transition growth.

Key Message

Menopause is not only a physiological transition.
It is a developmental life stage in which identity is dismantled and reconstructed.
Recognising and supporting the significance of this transition, is integral to psychological adjustment and wellbeing during perimenopause and beyond.

PSYCHOLOGICAL INTERVENTION: MODEL FOR THE MENOPAUSAL DEVELOPMENTAL TRANSITION

Phase 0: Assessment and Orientation

A comprehensive biopsychosocial assessment identifies presenting concerns, risk factors (e.g., trauma history, neurodivergence, mood disturbance), and contextual stressors.

Clinician stance and focus: The clinician builds rapport, ensures safety, and conducts a thorough exploration of psychological, physiological, relational, and historical factors contributing to the woman's presentation.

Phase 1: Disruption

Psychological disequilibrium emerges through symptoms such as anxiety, low mood, irritability, cognitive disruption, and relational strain.

Clinician stance and focus: Clinicians validate the woman's experience as a significant psychological shift, not merely hormonal "symptomatology." Clinicians provide strategies to support women manage biopsychosocial challenges and begin to gently name the underlying cracks in identity, roles, and schemas that may be surfacing.

Phase 2: Disintegration

As established roles, schemas, and expectations break down, women frequently experience a loss of coherence in identity.

Clinician stance and focus: The clinician holds space for identity fragmentation and emotional vulnerability, affirming that these experiences represent a necessary deconstruction. Schema therapy and feminist-informed practice are used to uncover internalised roles, inherited beliefs, and patterns of self-silencing or over-functioning.

Phase 3: Reconstruction

Therapeutic engagement focuses on meaning-making, values clarification, and narrative repair. Through modalities such as schema-informed therapy, narrative therapy, EMDR, and feminist practice, women begin to re-author their identities, reclaim autonomy, and redefine relational patterns.

Clinician stance and focus: Clinicians actively support clients to explore new ways of being that are grounded in agency, integrity, and self-defined values.

Phase 4: Integration

Psychological consolidation occurs as new insights, behaviours, and self-concepts align. The woman's capacity to manage the impacts of peri/menopause symptoms improve and she reports a marked increase in self-trust, agency, vitality, and congruence between inner experience and external expression.

Clinician stance and focus: Clinicians support the woman to anchor her redefined identity into daily life, relationships, and decision-making.

IMPLICATIONS FOR COLLABORATIVE CARE

For **medical providers**, this means recognising psychological disruption as an integral feature of menopause, not a psychiatric disorder in and of itself. For **mental health practitioners**, the work involves equipping women with tools to enhance their ability to cope with symptoms, narrative reframing, grief integration and supporting identity reconstruction. **Allied health professionals** and **workplaces** also play a role in addressing embodied, relational and systemic needs.