

SPECIAL ARTICLE

FIGO best practice recommendations for the mental health of women at menopausal age

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Abstract

Mental health during the menopausal transition requires focused attention to ensure supportive experiences for women. This review presents the International Federation of Gynecology and Obstetrics (FIGO) recommendations and summarizes the evidence, addressing 13 key questions framed by members of the FIGO Committee on Women at Menopausal Age. Although the literature on mental health during menopause is extensive, a gap exists in consolidated best practice recommendations. The FIGO committee members assessed the evidence quality and recommendation strength using a 5-point Likert scale. Over 70% of the experts agreed with a strong recommendation level (score of 5) for eight questions, while five questions were agreed with high and moderate recommendations. Symptoms of anxiety and depression are prevalent during the perimenopause. Menopause-related mental health issues are often overlooked in low- and middle-income countries. Mental health issues impact quality of life, necessitating psychological support during menopause care. Early detection requires training primary care providers to identify symptoms. Treatment should be individualized and may include lifestyle changes, cognitive-behavioral therapy, and hormone therapy. Transdermal estradiol is preferred for managing mood swings, particularly in women with metabolic risks. Escitalopram and venlafaxine effectively manage depressive symptoms and vasomotor instability in patients with major depressive disorder. Non-pharmacological interventions, such as lifestyle changes, therapy, mindfulness, and exercise have shown benefits. Partner and family support helps reduce the stigma associated with mental health issues during menopause. Advocacy is required for policies that support menopause awareness and mental health.

KEYWORDS

anxiety, clinical tools, cognitive behavioral therapy, depression, lifestyle changes, menopausal hormone therapy, menopause, mental health, mood, quality of life, recommendations

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1 | BACKGROUND

By 2030, WHO anticipates that the number of women experiencing menopause or postmenopause worldwide will exceed 1.2 billion.¹ Understanding the link between menopause and mental health is crucial for addressing women's difficulties during this phase. Menopause occurs at a variable age, typically marked by changes in menstrual patterns, culminating in the final menstrual period (FMP). This event, marked by the end of menstruation and reduced ovarian function, affects quality of life (QoL).²⁻⁴ Women spend approximately 30% of their lives in menopause. Menopause-related symptoms affect approximately 50%–80% of middle-aged women.^{5,6} Hormonal shifts during menopause affect physical, emotional, mental, and social well-being.⁴ Sex steroid hormone fluctuations during the perimenopause can also affect mental health.⁷ The neurobiological basis of depression is yet to be explored in detail but it is thought to involve many neurotransmitter pathways that are strictly interrelated, including serotonin, dopamine, adrenaline/noradrenaline, γ -aminobutyric acid (GABA), and neurosteroids (e.g. allopregnanolone).⁸ In healthy individuals, dopaminergic neurons in the mesolimbic pathway regulate motivation, rewards, and pleasure. Many dopaminergic pathways are modulated by serotonergic neurons.⁹ Most of these pathways are strongly affected by estrogen and progesterone levels; thus, changes in their balance during menopause transition can have important implications for mood stability.⁸

Evidence links vitamin D deficiency to adverse mental health outcomes, including depression, anxiety, cognitive symptoms, and reduced psychological well-being. Studies have shown that low serum vitamin D levels correlate with increased depression and anxiety risk, with vitamin D's neuromodulatory, antioxidant, and anti-inflammatory properties potentially underlying these effects.¹⁰ Vitamin D deficiency has been linked to cognitive difficulties and psychotic features in mentally-ill adolescents.^{11,12} Although studies indicate that vitamin D supplementation improves anxiety more than depression, evidence supports a significant relationship between vitamin D deficiency and adverse mental health outcomes.^{10,13}

Women experience menopausal symptoms, including vasomotor symptoms such as hot flashes and night sweats, as reported in 265 studies involving 349 608 middle-aged women. These are the main symptoms, along with anxiety, sleep disturbances, mood swings, depression, and cognitive changes.⁵ Considering the effects of menopause on mental health, it is imperative for healthcare professionals

to provide compassionate care when addressing associated concerns. Currently, no standardized guidelines exist for managing the mental health of menopausal women. Studies have explored mental health during menopause and have proposed management strategies. This review presents evidence-based recommendations for addressing mental health challenges in menopausal women to enhance patient care. This narrative review provides a summary of studies on 13 pertinent questions, with a quality evaluation.¹⁴ The International Federation of Gynecology and Obstetrics (FIGO) committee members convened to review the evidence on menopause and mental health, addressing symptoms, impact, vulnerability, experiences, and management strategies through collaboration with authors. Practice recommendations are evaluated based on available evidence. A survey on practice recommendations was conducted to evaluate the strength of the recommendations using a 5-point Likert scale and was interpreted based on the survey responses. Typically, members are asked to indicate their level of disagreement or agreement regarding the stated opinion on a 5-point response key ranging from "strongly disagree," "disagree," "neither disagree or agree," "agree," and "strongly agree".¹⁵

2 | EVIDENCE SYNTHESIS ADDRESSING KEY QUESTIONS ON MENTAL HEALTH IN MENOPAUSE

2.1 | How common are mental symptoms in perimenopause or during the menopause transition?

Midlife women experience mood swings and psychological changes, including irritability, anxiety, and depression.¹⁶⁻¹⁹ Studies show that 45%–68% of women experience heightened depressive symptoms during perimenopause, with symptoms 1.4 times more likely than during premenopause.^{5,20,21} The Australian Longitudinal Study on Women's Health found that most women had stable depressive symptoms during menopausal transition, with only 9% reporting increasing symptoms linked to perimenopause, oophorectomy, and to the initiation or discontinuation of hormone therapy.^{22,23} US studies indicate depressive symptoms are five times higher during menopause than premenopause.²⁴ A Chinese prospective community-based cohort study found that depressive symptoms peaked at 20% in early postmenopausal women.²⁵ Women without

lifetime major depressive disorder (MDD) have a lower risk of developing MDD during midlife than those with a history of MDD (28% vs 59%).¹⁹ MDD differs from general depressive mood in terms of its persistence and severity.²⁶ In general, evidence suggests that there is no universally increased risk for MDD or subthreshold depressive symptoms, but that specific subgroups are vulnerable to depressive symptoms during menopause transition.²⁷ Risk factors can be either related to menopause or psychosocial. Depressive symptoms in midlife are associated with menopause symptoms (vasomotor symptoms, sleep disturbances, sexual changes),^{15,28} comorbid chronic health conditions,²⁰ current life stressors,^{29,30} and a history of depression. Some of these risk factors are modifiable.²² The Penn study showed that women with prior depression had 13-fold more symptoms during perimenopause.³¹ Menopause attitudes, aging status, and stigma may contribute to symptoms.^{32,33} Prevalence varies by race and ethnicity, with 27% of black women and 22% of white women experiencing symptoms in a SWAN study.³⁴ Globally, the prevalence is 43%, with the highest in Cambodia at 82%.⁵ Physical fatigue is the most common symptom (64.13%), followed by anxiety (50.53%), mood swings (49.03%), and sexual issues (45.45%).⁵ The high prevalence of depressive symptoms highlights the importance of routine screening for depression during menopause.

2.2 | What is the prevalence of mental health issues during menopause in low- and middle-income countries (LMICs)?

Research in LMICs shows that psychological symptoms, such as depression, anxiety, and sleep disturbances, among postmenopausal women are in the range of 10%–38%. In the Indian context, depression was observed in 45% of the population, anxiety in 10%, and overall psychological symptoms in 32.2%–38.7% of postmenopausal women.³⁵ However, the exact prevalence rates for specific mental health disorders (such as depression and anxiety) during menopause in LMICs are still not well-established due to limited nationally representative data and inconsistent study methodologies.³⁶

A study of 41 LMICs showed that vasomotor symptoms (VMS; e.g. hot flashes, night sweats), joint pain, and sexual concerns match those of high-income countries, but their severity remains under-researched. VMS prevalence was lower in Asian (hot flashes in 51%, night sweats in 50%) and Middle Eastern regions (hot flashes in 65%, night sweats in 58%) than in Latin American (hot flashes in 57%, night sweats in 70%) and African countries (hot flashes in 66%, night sweats in 78%). Sexual problems predominated in the African and Asian regions.³¹

2.3 | How does menopause-related mental distress impact QoL?

Menopause brings about significant changes that can greatly affect many women's QoL, largely due to the psychological and

physical transformations it triggers. Mental challenges linked to menopause may include depression, anxiety, psychological distress, loss of libido, mood fluctuations, and memory issues, all of which can reduce overall life satisfaction and well-being. Studies have shown that menopausal symptoms, such as vasomotor issues, hot flashes, fatigue, and alterations in body composition, contribute to psychological distress. These symptoms negatively affect mental health, leading to conditions such as anxiety and depression, which are common among women in the peri- and postmenopausal stages.³⁷ The intensity of these psychological symptoms is associated with negative perceptions of menopause, which can further intensify distress and lower QoL.³² Moreover, studies have shown that the severity of menopausal symptoms, whether psychological or somato-vegetative, is linked to a reduction in mental health and QoL in postmenopausal women. This impact persists into menopause, affecting conditions such as depression, sleep difficulties, and a decrease in social roles and activities.^{38–40}

2.4 | Are there any tools or scales designed to evaluate mental health disturbances in menopausal women?

Various scales have been used to assess mental health disturbances in specific contexts and populations. The Menopause Rating Scale (MRS) evaluates menopausal symptoms, including psychological, somatic, and urogenital symptoms, to assess their impact on the QoL of women.⁴¹ The Patient Health Questionnaire–9 (PHQ-9) is a validated nine-item tool designed to assess the severity of depression.⁴² MENQOL is a validated tool,⁴³ and the Steiner Premenstrual Tension Self-Rating Scale (PMTS) evaluates psychiatric symptoms in perimenopausal women.⁴⁴ The Center for Epidemiological Studies Depression Scale (CES-D) assesses depressive symptoms in the general population,⁴⁵ while the Mental Health Quotient (MHQ) evaluates psychiatric disorders and mental function.⁴⁶ Internet-based mental health measurement platforms compare mental health outcomes before and during the COVID-19 pandemic by assessing their psychological distress and resilience.⁴⁷ The Sukoon Psychosocial Illness Scale (SPIS) comprises six subscales: emotional, sexual, religious, social, spiritual, and professional.⁴⁸ These tools support assessment and intervention planning.

2.5 | How can psychological disturbances associated with the menopausal transition be distinguished from overt pathological depression, and what validated tools are available to aid in this differentiation?

Differentiating psychological disturbances during menopause transition from overt pathological mental disorders requires recognizing

that hormonal fluctuations, particularly decline in estrogen and progesterone levels, can cause anxiety, depressive mood, and distress often accompanied by vasomotor symptoms and fatigue, which are common but usually reflect physiological changes rather than clinical disorders. Pathological mental disorders have specific diagnostic criteria that are independent of menopause. Not all women experiencing menopause show the same psychological distress, and studies show that menopausal transition alone does not universally increase risk of affective disorders.^{49,50} However, predisposed women are at significant risk of mood disorders: these symptoms often remain subthreshold, but sometimes criteria for the diagnosis of a pathological mental disorder are satisfied. Differentiating between mood symptoms and pathological mental disorders is important, as they may require different therapeutic approaches. Risk factors for mood symptoms can be menopause-related (e.g. severe vasomotor symptoms or sleep disturbances, sensitivity to estrogen changes, early or surgical menopause) or related to psychosocial conditions (e.g. history of mental disorders, psychosocial stressors).^{18,50,51} Clinical tools, such as the Composite International Diagnostic Interview for Women (CIDI-VENUS), assess mental disorders by considering women's reproductive milestones and differentiating between physical and psychological menopausal symptoms.⁵² Clinical evaluation must differentiate between menopausal symptoms and pathological disorders by evaluating the timing, severity, history, and risk factors to determine the appropriate interventions.

2.6 | How should we approach hormonal and pathological depression?

Depression during the menopausal transition is increasingly recognized as a multifactorial condition, influenced by both hormonal fluctuations and underlying psychiatric vulnerability. Appropriate clinical tools should be used to differentiate hormonal and pathological depression. When mood disturbances are accompanied by vasomotor symptoms and sleep disruption, it suggests a hormonal contribution to depressive states.⁵³ However, major depressive disorder may also emerge or recur during this period, independent of hormonal changes, highlighting the importance of distinguishing pathological depression from hormonally mediated mood symptoms.⁵⁴ Women with a prior history of depression, adverse psychosocial stressors, or significant co-morbidities are at greater risk of developing clinically significant depressive episodes.^{54,55} Management therefore requires an integrated approach. Menopausal hormone therapy (MHT) may alleviate mood symptoms linked to estrogen deficiency, especially in perimenopausal women, while standard psychiatric treatments such as selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), and cognitive behavioral therapy remain essential for pathological depression.^{53,54} A comprehensive, individualized assessment that considers hormonal status, psychiatric history, and psychosocial context is critical to ensure appropriate

treatment and to avoid both under-recognition and overtreatment of depression in midlife women.^{54,55}

2.7 | When should mental health issues related to menopause be addressed? Are there any specific criteria?

The management of mental health issues during menopause necessitates a comprehensive approach owing to the complexity of symptoms associated with hormonal fluctuations. The menopausal transition is characterized by significant physical and psychological symptoms, particularly in individuals with pre-existing mental health conditions.⁵⁶ Early identification of mental health deterioration during this phase is crucial for ensuring the well-being of women.⁵⁷ The criteria for addressing menopausal mental health concerns include the recognition of symptoms such as anxiety, depression, and negative emotional impact, which are prevalent during perimenopause.⁵⁴ Symptom severity is a critical determinant of mental health outcomes in menopausal women. Severe past menopausal symptoms are significantly associated with depression, sleep disturbances, and a negative impact on QoL.³³ Overall, careful monitoring and personalized treatment strategies are essential, given the diverse experiences and potential long-term effects of menopausal symptoms on mental health.⁵⁸ Severe symptoms like suicidal tendencies should be managed by a multidisciplinary team led by psychiatrist.

2.8 | What is the first-line treatment approach for addressing mental health issues during menopause?

According to FIGO, MHT is the first-line treatment for menopausal symptoms. The MHT type and duration should be customized according to the patient's history, age, and health status to ensure that the benefits outweigh the risks.⁵⁹ Organizations such as the International Menopause Society, American College of Obstetricians and Gynecologists (ACOG), National Institute for Health and Care Excellence (NICE), and US Preventive Services Task Force (USPSTF) have their recommendations on the application of MHT in clinical practice.⁵⁰ Other treatment options for menopause-related depression include antidepressants and cognitive behavioral therapy (CBT). The European Menopause and Andropause Society (EMAS) recommend antidepressants, psychosocial therapies, and lifestyle changes for mild depression during the menopausal transition. NICE guidelines advocate the use of SSRIs for moderate-to-severe cases and recommend the use of antidepressants, psychosocial therapies, and lifestyle modifications with supportive strategies for mild depression, noting their efficacy irrespective of baseline severity (NICE NG23).⁶⁰ The combination of antidepressant agents with MHT appears to offer the best therapeutic potential in terms of efficacy, speed of improvement, and sustained remission in women with depression during the menopausal period.⁵² CBT has shown particular

benefit for menopause-related insomnia and is specifically recommended by NICE guidelines for depressed mood during menopause.^{27,61} The 2019 guidelines from the “Expert Opinion on Pharmacotherapy” suggest that SSRIs and SNRIs should be the primary medications prescribed for MDD during menopause.⁶² The Canadian Network for Mood and Anxiety Treatments (CANMAT) recommend the utilization of transdermal estrogens as second-line treatment options for perimenopausal women experiencing depression.^{63,64}

Management involves lifestyle measures, exercise, and MHT, which can significantly improve well-being, QoL, and alleviate mental and physical health issues associated with menopause.^{56,57}

2.9 | Which MHT molecules are used to treat perimenopausal mental health issues? What dose and route of administration are preferred for managing mental health issues in perimenopausal/menopausal women?

MHT addresses mental health concerns by mitigating the effects of the drop in sex hormones. The efficacy of MHT is contingent on factors such as dosage, route of administration, and individual patient characteristics. It effectively alleviates mood swings, anxiety, and depression associated with reduced estrogen levels. Estrogens enhance mood by modulating brain neurotransmitters.^{65,66} Low-dose MHT has been shown to effectively relieve symptoms in younger women.^{67,68} Ultra-low dose of combined estradiol 0.5 mg/dydrogesterone 2.5 mg was well tolerated across a multi-ethnic population of postmenopausal women.⁶⁹ Transdermal MHT (patch, gel, spray, dose range is 14–100 µg/day) presents a lower thrombotic risk compared to oral administration.^{70,71} Oral micronized progesterone and dydrogesterone both protect the endometrium during estradiol replacement therapy in women with a uterus, without increasing risk of breast cancer. Conjugated equine estrogens or 17B estradiol are equally effective, but the latter has less load on the liver; the dose depends on age, symptom severity, route of administration, and overall health profile.⁷² According to available Indian and international guidelines for menopausal hormone therapy, estradiol doses have been summarized in Table 1.^{71–74}

2.10 | Which antidepressants are commonly used to manage depression during menopause?

Depression management in menopausal women involves the use of antidepressants, hormone therapy, or both, based on the patient profile and severity. SNRIs effectively treat both affective disorders and vasomotor symptoms associated with menopause.^{45,50} Common examples include escitalopram, fluoxetine, sertraline, paroxetine, and venlafaxine. Among these, low-dose paroxetine is specifically FDA-approved for vasomotor symptoms (such as hot flashes) related to menopause; however, all of the above can be considered for vasomotor and mood symptoms, especially when MHT is unsuitable. In clinical practice, SSRIs and SNRIs (notably escitalopram, venlafaxine, and desvenlafaxine) are the most well-supported antidepressants for managing depression during menopause, with robust evidence from high-quality studies. Careful individualization of therapy, considering both mood and menopausal symptoms, is recommended.⁷⁵ Both paroxetine and venlafaxine reduce hot flashes and depressive symptoms and effectively improve the QoL; thus, they may represent an alternative to MHT when it is not suitable or can be added when symptom control is not complete.⁷⁶ Treatment choices should consider symptoms, history, and menopausal status, with combined approaches to optimize patient outcomes.

2.11 | What are the recommended non-pharmacological strategies, such as dietary modifications, exercise routines, and lifestyle changes, to address mental health issues during menopause?

Non-pharmacological strategies effectively manage mental health during menopause, particularly in women who prefer non-medical treatments. CBT addresses symptoms through cognitive and behavioral strategies as an alternative to medications such as MHT or SSRIs.⁷⁷ Regular physical activity enhances mood and QoL during menopause by reducing symptoms and improving cardiorespiratory fitness.^{78,79} A review of 27 studies showed that resistance training, aerobics, walking, pilates, and aquatic exercises improve physical and mental health in postmenopausal women, with nine studies reporting positive effects on depression.⁸⁰ Mindfulness-based therapy improves menopause-specific QoL and reduces

TABLE 1 Systemic menopausal hormone therapy (MHT), which may alleviate menopausal symptoms.

Formulation	Typical starting dose	Maintenance range	Targeting symptoms
Oral estradiol	1–2 mg daily	0.5–2 mg daily	Moderate to severe vasomotor symptom (hot flashes and night sweats)
Transdermal estradiol patch	0.025–0.05 mg/day	Up to 0.1 mg/day	Anxiety, depression, hot flashes, night sweats
Transdermal estradiol gel/spray	0.25–1.25 mg/day	Adjusted based on response	Moderate to severe vasomotor symptom (hot flashes and night sweats)
Estradiol acetate vaginal ring (Femring)	0.05–0.1 mg/day	Every 90 days	Moderate to severe vasomotor symptom Moderate to severe vulvar and vaginal atrophy

anxiety, depression, and stress in randomized controlled trials, although some effects require further validation.^{81,82} The North American Menopause Society supports dietary supplements and lifestyle changes, despite evidence of inconsistent efficacy. Sleep quality management and techniques such as clinical hypnosis can reduce vasomotor symptoms.^{83,84} Research suggests that gut related microbiota management “may help alleviate mental health and menopausal symptoms”.⁸⁵ CBT, mindfulness practices, and exercise offer substantial evidence-based relief (Table 2) from psychological challenges during menopause. Tailored interventions, often involving multiple strategies, may provide effective support for women experiencing menopausal transitions.

Addressing mental health issues during menopause requires dietary modifications, exercise, and lifestyle adjustments.

Several studies have suggested that a diet rich in vegetables and fruits is correlated with reduced menopausal symptoms, including mental health issues.⁸⁷ Omega 3 fatty acids, vitamin D, vitamin B12, vitamin B6, and folate have been studied widely in mental well-being, but the results are inconsistent.⁸⁸ An inverse relationship between omega 3 intake and depression was observed in some studies, although after adjusting for other lifestyle confounders the relationship was no longer significant, suggesting that the relation between depressed mood and omega 3 fatty acids intake may reflect a wider association between depressed mood and lifestyle.^{89,90} Conversely, other cross-sectional studies have reported a significant association between omega 3 fatty acid deficiency and an increased risk of depressive symptoms.^{91,92}

TABLE 2 Assessment of quality of clinical evidence.

Clinical question	Comments	Type of evidence	Quality of evidence
1. How common are mental symptoms in menopause?	Mental fatigue, anxiety and depressive symptoms, mood swings, sexual issues, major depressive disorder are common ⁵	Systematic review and meta-analysis (n=2)	Level 4, low
	Incidence of schizophrenia and other psychoses ⁸⁶	Systematic review and meta-analyses	Level 4, low
	Mood and other psychological changes, including irritability ^{12,13}	Observational studies (n=3) and longitudinal or prospective cohort study (n=1)	Level 3, moderate
	Increased suicidal ideation ⁸⁶	Cross-sectional study	Level 3 or 4, low to moderate
2. The impact of mental health and QOL	The intensity of menopausal symptoms has a profound impact on the emotional and cognitive well-being of women in midlife, which can negatively influence their QoL ^{30,31}	Observational studies (n=2)	Level 3 or 4, low to moderate
	Postmenopausal women with depression had a significantly lower HRQoL ³²	Cross-sectional study	Level 3 or 4, low to moderate
3. Treatment approach for addressing mental health issues during menopause	Menopausal hormone therapy recommended for menopause symptoms namely vasomotor and urogenital ⁴⁹	FIGO recommendations	Level 1- high
	The antidepressants, psychosocial therapies, and lifestyle changes for mild depression recommended options during menopausal transition	The European Menopause and Andropause Society (EMAS) recommendation ⁸⁶	Level 1-high
		RCTs and meta-analysis on SSRIs (e.g., escitalopram, sertraline, paroxetine), ⁶⁷ and SNRIs (e.g., venlafaxine, desvenlafaxine) ⁸⁶	Level 1-high
4. Non-pharmacological management strategies for mental health during menopause	Mood, anxiety, and overall psychological well-being during menopause	RCTs and meta-analysis on CBT	Level 1-high
		RCTs and some meta-analysis on MBIs and meditation	Level 1 to 2, high to moderate
	Multiple RCTs and systematic reviews support the positive effect of physical activity and exercise (Including walking, yoga) on mood and QoL ^{75,77}	RCTs and systematic reviews	Level 1 to 2, high to moderate
	Less evidence for lifestyle and counseling	Cohort studies Expert opinion	Level 5, Low

Abbreviations: CBT, cognitive behavioral therapy; HRQoL, health-related QoL; LOE, Level of evidence; MBIs, mindfulness-based therapy; QoL, quality-of-life; RCT, Randomized-controlled trials; SNRIs, serotonin-norepinephrine reuptake inhibitors; SSRIs, selective serotonin reuptake inhibitors.

Dietary habits involving high consumption of mayonnaise, vegetable liquid oils, sweets, and fats are associated with increased symptoms.⁸⁴ Weight management through proper nutrition is essential, as menopause-related weight gain can increase psychological distress in women.⁹³ Regular physical activity, especially walking and yoga, has been shown to improve mood during menopause.⁷⁹ Smoking cessation and stress reduction are crucial because poor sleep increases mental health risks. Mindfulness techniques support mental well-being.^{94,95} Health education on menopause improves coping strategies and self-care.⁹⁶ Alternative therapies, such as aromatherapy and acupuncture, show promise in treating psychological symptoms, although further research is needed.⁹⁷ A holistic approach that combines diet, exercise, and lifestyle changes effectively manages mental health during menopause.

2.12 | What is the role of counseling and role of spouse and family in addressing mental issues associated with menopause

Counseling is essential for managing menopause-related mental health challenges. Menopause can cause hot flashes, sleep disturbances, depression, anxiety, and diminished self-esteem, thereby affecting mental health and QoL. Counseling allows women to discuss their symptoms and receive guidance.^{52,54} Healthcare practitioners provide counseling for menopause management, MHT evaluation, and lifestyle modifications. Counseling helps assess symptoms and enables treatment decisions. Menopause transition affects women differently based on their personal history and health conditions, requiring personalized counseling.⁵⁴ Women experiencing cognitive changes or "brain fog" can benefit from counseling that provides education and reassurance, helps manage symptoms, and reduces anxiety about cognitive disorders.⁹⁸

Counseling addresses menopausal stigma, particularly for women with autism, and supports healthcare providers and health literacy.⁹⁹ Counseling plays a crucial role in assisting women during menopause by providing information, addressing mental health issues, and enhancing QoL. This highlights the need to tailor care for each woman during this stage of life.⁷⁴

Spousal support plays a significant role in mental health during menopause and contributes to improved QoL through emotional assistance.¹⁰⁰ Supportive relationships help women manage mental health challenges more effectively,¹⁰¹ and living with a spouse is associated with healthier lifestyle habits among middle-aged adults.¹⁰² Such support can also help reduce anxiety and depression.¹⁰³ More broadly, family support is linked to better mental health outcomes,¹⁰⁴ although cultural factors can influence family roles and their impact on mental well-being.¹⁰⁵

2.13 | What is the influence of legislation on the mental health of menopausal women?

The interplay between legislation and women's mental health during menopause involves awareness and access to treatment and intervention. Many women face difficulties in accessing appropriate care, highlighting the need for enhanced healthcare services.⁵² Racially and ethnically minoritized women experience unique challenges, with depression being common and influenced by social and structural factors.¹⁰⁶ Legislation that recognizes the challenges of menopause and enshrines supportive policies, reasonable accommodations, and anti-discrimination measures can substantially improve mental health outcomes for menopausal women. Where such supports are lacking, women face greater risk of anxiety, depression, stigma, and career or social setbacks.^{54,107,108}

According to the Mental Healthcare Act (MHCA) of 2017, mental health care is established as a fundamental right for all individuals in India, with anticipated improvements in the treatment of individuals with mental illness (PMI). The right to access mental health care (Section 18) ensures access to affordable mental health services, without discrimination. The right to equality and non-discrimination (Section 21) prohibits discrimination based on gender, age, or reproductive status when seeking mental healthcare services. The right to informed consent and autonomy (Sections 4, 5, and 22) ensures that women can make informed decisions regarding mental health treatment, including menopause-related symptoms. The right to confidentiality (Section 23) protects all mental health information, whereas the right to community-based care (Section 19) supports care in the least restrictive environment, particularly for midlife women.⁸⁶

Mental health stigma and discrimination intersect with gender inequality, compounding women's psychological burden. The cumulative impact of gender-based and other forms of discrimination necessitates a rights-based approach to address these issues. International frameworks, such as the UN Convention on the Rights of Persons with Disabilities (UN-CRPD), have emphasized dignity, autonomy, and inclusive access to mental health care for women and girls.

3 | PRACTICE RECOMMENDATIONS AND STRENGTH OF RECOMMENDATION

FIGO members shared their practical recommendations and responses were graded using a 5-point Likert scale. A response with a high Likert score suggests that the recommendation is viewed favorably and is likely to be effective.⁹

Recommendations were graded using the structured scale, with each grade reflecting the strength of the recommendation and the certainty of supporting evidence, as follows: 5=highly effective (strongly agree/excellent); 4=effective (agree/good); 3=moderately effective (neutral/fair); 2=ineffective (disagree/poor); and 1=highly ineffective (strongly disagree/very poor).

4 | SUMMARY OF RECOMMENDATIONS

Recommendations	Recommendation score (survey respondents %)	Interpretation
1. Mental symptoms are common in perimenopause or during the menopause transition - Women in the perimenopause face a higher risk of mental symptoms than premenopausal women, particularly those with severe vasomotor symptoms. - Women with a history of MDD showed a higher midlife recurrence (59%) than those without (28%). - Anxiety, mood swings, and depression are common during perimenopause, particularly in patients with severe vasomotor symptoms or a history of depression. - Routine mental health screening, using tools such as the Patient Health Questionnaire-9 (PHQ-9), should be a part of standard midlife care.	Score 5 (strongly agree, $\geq 50\%$)	High recommendation
2. Prevalence of mental health during menopause in low- and middle-income countries - Although the number of postmenopausal women is increasing, the data remain inconsistent. Menopause is not widely acknowledged in low- and middle-income countries. In these countries, menopause and its mental health impact remain under-recognized in public health agendas. - Ensuring timely, affordable, and continuous access to treatment is essential, particularly in healthcare systems where menopausal care is not universally accessible. A significant barrier to sustaining treatment is the cost of medications, such as MHT or antidepressants, or the lack of public provision, which frequently leads to the premature cessation of care. This underscores the need for health systems and policy-level initiatives to guarantee sustainable access, regardless of educational background or legislative developments. - Cultural stigma and limited access to mental health services can lead to underdiagnosis. - There is a need for locally relevant data and culturally validated screening tools for evaluation of mental health during menopause. - It is essential to understand the most distressing menopausal symptoms and their health effects across different populations to provide suitable support and care for the patients.	Score 5 (strongly agree, $\geq 70\%$)	Strong recommendation
3. How does menopause-related mental distress impact the QoL of patients? - Menopause-related symptoms, including mental health issues, can significantly affect a woman's QoL especially during perimenopause. - Integrating psychological assessment and support into menopause care should be prioritized.	Score 5 (strongly agree, $\geq 70\%$)	Strong recommendation level
4. Are there any tools or scales designed to evaluate mental health disturbances in menopausal women? - Healthcare professionals should use validated screening tools to identify women at risk of mental health conditions. - Commonly used tools include the MRS, PHQ-9, MENQOL, CES-D, DASS-21, ISI, Steiner PMTS, MHQ, and SPIS. - Existing scales are useful, but most have been validated only in English-speaking populations. - Cross-cultural adaptation and validation are required for broader global applications.	Score 5 (strongly agree, $\geq 70\%$)	Strong recommendation level
5. Distinguishing tools between the psychological disturbances associated with menopause and MDD - Evaluating the timing, severity, history, and risk factors will help in diagnosing MDD. - This distinction is often clinical rather than one purely based on scales. The CIDI-VENUS is promising but has not yet been widely implemented in practice.	Score 4 (strongly agree, $\leq 50\%$)	Moderate recommendation level
6. How should we approach hormonal and pathological depression? - Clinicians should use patient history, symptoms, hormone tests, and clinical judgment to differentiate between these conditions. Differentiation is crucial to avoid overtreatment with antidepressants. - Management differs in treating hormonal imbalances in hormonal depression vs using psychotherapy or antidepressants for major depression. - Depression that follows hormonal patterns and resolves with hormonal correction suggests a hormonal cause, whereas persistent depression unresponsive to hormonal treatment likely indicates pathological depression. - Collaborative management involving gynecologists, psychiatrists, and endocrinologists is important to distinguish hormonally driven mood changes from major depressive disorders and to tailor appropriate treatments.	Score 5 (strongly agree, $\geq 50\%$)	High recommendation

Recommendations	Recommendation score (survey respondents %)	Interpretation
7. When should mental health issues related to menopause be addressed? Are there any specific criteria? • Women at risk should be identified by screening at perimenopause. • Women with moderate-to-severe symptoms that affect QOL should be treated promptly. • Suicidal tendencies must be taken seriously, and a multidisciplinary team, including psychiatrists, should lead the management. • Early screening during the perimenopause is essential. • Primary care providers should be trained to recognize initial psychological symptoms and refer patients as needed.	Score 5 (strongly agree, $\geq 70\%$)	Strong recommendation level
8. The first-line treatment approach for addressing mental health issues during menopause. • Evidence on first-line treatments for mental health concerns during menopause is inconsistent, highlighting the need for an individualized approach. • An individualized approach combining lifestyle modifications, CBT, and hormonal therapy, when indicated, is the best. • Cognitive behavioral therapy is particularly effective in managing insomnia and other menopause-related symptoms. • Perimenopausal women experiencing menopausal symptoms, including mild depression, that significantly affects their QoL, may benefit from menopausal hormonal therapy (MHT). • Patients with mild depressive symptoms may also benefit from psychosocial therapies, physical exercise, and lifestyle modifications. • Major depressive disorder and suicidal ideation require urgent attention and should be managed by a multidisciplinary team, including psychiatrists, using antidepressants and other appropriate psychiatric treatments.	Score 4 (strongly agree, $\geq 50\%$)	High recommendation level
9. Which MHT molecules are used to treat perimenopausal mental health issues? What dose, and route of administration are preferred for managing mental health issues in perimenopausal/menopausal women? • The dose depends on the age, symptom severity, route of administration, and overall health profile. • The lowest effective dose should be given as long as the patient needs, with periodic reassessment (see Table 1 for dosage schedule). • Transdermal estradiol has demonstrated good efficacy for mood symptoms and is preferred in women with metabolic or thrombotic risk.	Score 4 (strongly agree, $\leq 50\%$)	Moderate recommendation level
10. Which antidepressants are commonly used to manage depression during menopause especially when MHT is contraindicated? • For women experiencing depressive symptoms related to menopause, SSRIs and SNRIs may be recommended, particularly when MHT is contraindicated or inappropriate (patients who have survived breast or endometrial cancer and often experience severe mood disturbances). • Venlafaxine (37.5–75 mg/day) and paroxetine (20–50 mg/day) have demonstrated both antidepressant effects and the ability to reduce the frequency and severity of hot flashes, thereby improving the overall QoL. • Escitalopram (5–10 mg/day) is also effective and tends to be associated with fewer side effects, making it a suitable option for some patients. • Treatment should always be tailored to the individual, considering both mood symptoms and menopausal complaints of the patient. • Clinicians should consider potential drug-hormone interactions and initiate treatment with the lowest effective dose. • Individualization is essential, especially in settings where access to MHT is limited.	Score 5 (strongly agree, $\geq 70\%$)	Strong recommendation level
11. What are the recommended non-pharmacological strategies to address mental health issues during menopause? • A holistic approach, including diet, physical activity, mind-body practices, and psychological support, can help manage mental health during menopause. • CBT reduces symptoms of depression, anxiety, and insomnia during menopausal transition. • Psychological counseling and stress-management techniques, such as mindfulness, support emotional regulation. • Dietary interventions include omega-3 fatty acids, vitamin D, vitamin B6, vitamin B12, and folate; however, evidence of their efficacy remains inconclusive. • Exercise, including aerobic activity and yoga, may improve mood and reduce anxiety levels. • A fiber-rich, plant-based diet supporting the gut microbiome may influence mood regulation; however, more research is needed on this. • Lifestyle interventions, CBT, mindfulness, and physical activity show consistent benefits, while evidence on dietary supplements remains mixed but promising.	Score 5 (strongly agree, $\geq 70\%$)	Strong recommendation level

Recommendations	Recommendation score (survey respondents %)	Interpretation
12. What is the role of counseling and role of spouse and family in addressing mental issues associated with menopause? • When addressing mental health concerns, counseling should be provided to spouses and family members. • Education of partners and families reduces stigma and supports treatment adherence in community-based menopause programs. • Partner, family involvement, and social connect provides emotional support and reduces the stigma associated with mental illness.	Score 5 (strongly agree, $\geq 70\%$)	Strong recommendation level
13. What is the influence of legislation on menopausal women's mental health? • Every country should have legislation emphasizing dignity, autonomy, and access to mental health care for women to prevent gender-based discrimination. • Advocating for legislation and workplace policies that support menopause awareness and mental health care ensures dignity and access to services. • Policies should protect women's rights to mental health care and workplace adaptation during menopause.	Score 5 (strongly agree, $\geq 70\%$)	Strong recommendation level

Abbreviations: CBT, cognitive behavioral therapy; CES, Center for Epidemiologic Studies Depression Scale; CIDI-VENUS, Composite International Diagnostic Interview for Women; DASS-21, Depression Anxiety Stress Scale; ISI, Insomnia Severity Index; MDD, major depressive disorder; MENQOL, Menopause-Specific Quality of Life Questionnaire; MHQ, Mental Health Quotient; MHT, menopausal hormone therapy; MRS, Menopause Rating Scale; PHQ-9, Patient Health Questionnaire-9; PMTS, Premenstrual Tension Self-Rating Scale; QoL, quality of life; SNRI, serotonin-norepinephrine reuptake inhibitor; SPIS, Sukoon Psychosocial Illness Scale; SSRI, selective serotonin reuptake inhibitor.

BOX 1 Summary of key points

- Mental health symptoms, including depression, anxiety, and mood swings, are prevalent during perimenopause, affecting 40%–60% of women, peaking in early perimenopause. These symptoms often coincide with vasomotor disturbances and sleep disruptions, diminishing quality of life.
- The prevalence of mental health disorders during menopause in low- and middle-income countries varies due to limited data, cultural influences, and heterogeneity of studies. National data are scarce in low-income countries.
- Timely and affordable access to treatment is imperative, especially in regions where menopausal care is not universally available.
- Locally relevant data and culturally validated screening tools are needed to assess mental health during the menopause.
- Healthcare professionals should use validated screening tools to identify at-risk women.
- Clinicians should use patient history, symptoms, hormone assays, and clinical judgment to differentiate between conditions and prevent overtreatment with antidepressants.
- Suicidal tendencies require immediate attention from mental health professionals.
- Early screening during perimenopause is essential.
- Treatment should include lifestyle modifications, cognitive behavioral therapy, and hormonal therapy when indicated.
- A holistic approach, including diet, physical activity, mind-body practices, and psychological support, can help manage mental health during menopause.
- Counseling should include the spouses and family members.
- Nations should enact legislation that emphasizes dignity, autonomy, and access to mental healthcare for women to prevent gender-based discrimination.
- Adopting these FIGO best practice recommendations may potentially reduce the burden of mental health in peri- and menopausal women.

Out of 13 questions, over 70% of the FIGO committee members strongly recommended (score of 5) eight questions, while five questions received high and moderate recommendations.

5 | CONCLUSION

These practice recommendations are both comprehensive and timely (Box 1). Their successful implementation, particularly in LMICs, will require integrating mental health screening into primary care, training

healthcare professionals, and promoting public awareness to reduce stigma and improve access to care. Although not all women experience mood symptoms during the menopausal transition, vulnerable individuals, especially those with a history of affective disorders or severe vasomotor symptoms, are at increased risk for developing clinically significant mood disturbances. This risk must be carefully considered during clinical evaluation. MHT, when not contraindicated, should be offered to improve QoL, stabilize hormonal fluctuations, and support mood and anxiety regulation. When psychiatric conditions are identified, evidence-based psychiatric interventions complemented

by non-pharmacological strategies should be integrated into care to ensure comprehensive support, particularly when MHT is contraindicated. In addition to managing symptoms in the short term, recent studies suggest that starting MHT soon after menopause may offer protective effects for the brain, potentially lowering the long-term risks of cardiovascular issues, neurodegenerative diseases, and bone deterioration. It is crucial to understand that mood changes linked to menopause differ from those associated with psychiatric disorders. Healthcare professionals and policymakers must urgently address the mental health challenges associated with menopause. Implementing FIGO best practice recommendations could offer potential clinical benefits to women during the perimenopausal and menopausal stages.

5.1 | Limitations

This narrative non-systematic design and the variability in evidence quality across different regions, such as LMICs, could enhance balance. Implementing several recommendations may be challenging in low-resource settings. The differences between these settings were recognized appropriately. The availability and validation of screening tools differ significantly – access to MHT and psychotherapy varies greatly across health systems – and recommendations may require adaptation based on the capacity of the health system.

AUTHOR CONTRIBUTIONS

SK formulated the concept. SK, HD, CB, AG, and GD acquired the available data from published literature, critically analyzed it, and formulated the initial draft. SK, DR, EA, GD, MH, ALDF, EH, and MB edited the draft. All authors reviewed and approved the final version of the manuscript.

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The authors have no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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