Hadassah Magazine Presents – Menopause: New Truths, Old Myths

[00:00:00] **Lauren Tetenbaum:** And studies show that up to 70% of women experience an emotional rollercoaster, that doesn't mean that they're meeting the criteria for a mood disorder like major depression. But they deserve support. If they're not feeling good, if they're not feeling like themselves, if they're snapping at their loved ones and yelling at their children and feeling like they can't be at work anymore because they don't recognize themselves, they deserve support.

[00:00:25] **Lauren Tetenbaum:** Women don't need to be suffering to get support.

[00:00:33] **Libby Barnea:** Hello and welcome to Hadassah Magazine Presents. I'm your guest host. Libby Barnea, the Deputy Editor of *Hadassah Magazine*.

[00:00:42] **Leah Finkelshteyn:** and I'm your other guest host, Leah Finkelstein, senior editor of *Hadassah Magazine*.

[00:00:47] **Libby Barnea:** We're thrilled to be talking today with three women who are leaders in reframing the conversation and treatment around menopause.

[00:00:54] **Libby Barnea:** Joining us are Joanna Strober, Lauren Tenenbaum, and Sheryl Kingsberg. Here in the United States, Around 1.3 million women enter menopause every year and around 2 million enter perimenopause. Menopause, which is defined by a year without menstruation, occurs on average at age 52. Perimenopause denotes a roughly five to 10 year phase immediately

preceding menopause, but often this entire transition to a woman's post reproductive life is referred to as menopause.

[00:01:26] **Libby Barnea:** All these definitions are of course familiar to our three esteemed panelists who we would like to introduce now.

[00:01:33] **Leah Finkelshteyn:** Joanna Strober is the co-founder and CEO of MIDI Health, a virtual care platform for women in perimenopause and menopause. Before midi, Joanna founded Kurbo, the first digital therapeutic for childhood obesity, which she sold to Weight Watchers.

[00:01:49] **Leah Finkelshteyn:** Previously, Joanna spent more than 20 years in direct private equity and venture capital. Joanna is the author of the book Getting to 50 50, A primer around how women can Succeed at work and at home. She was named to the Forbes 50 over 50 list of top innovators, the CNBC change Maker 2025 and Time 100 healthcare leaders.

[00:02:11] **Leah Finkelshteyn:** Lauren Tenenbaum, author of *Millennial Menopause: Preparing for Perimenopause, Menopause, and Life's Next Period* is an advocate and therapist who supports millennial and young women through life's transitions As both a lawyer and a social worker, Lauren specializes in professional and personal identity shifts, including the perinatal period and perimenopause.

[00:02:33] **Leah Finkelshteyn:** Lauren's go-to Resource for Women Seeking Counsel, empowerment and Connection. Sheryl Kingsburg is the chief of the Division of Behavioral Medicine at McDonald Women's Hospital, university Hospital's, Cleveland Medical Center, and a professor at Case Western Reserve University. Her areas of clinical specialization include female sexual disorders, menopause, pregnancy and postpartum mood disorders, and psychological aspects of infertility.

[00:03:02] **Leah Finkelshteyn:** She is a past president of the Menopause Society and the International Society for the Study of Women's Sexual Health, and she currently serves as the advocacy committee chair for the Menopause Society. Welcome everyone, and let's start the conversation with just a quick note that of course, women should always plan individualized discussions with their medical professionals regarding their own care.

[00:03:26] **Leah Finkelshteyn:** With menopause suddenly everywhere from news reports to memes on social media to pop culture. Do you think it's fair to say that menopause is having a moment? And if so, what's driving this new

visibility for something women have always experienced? Joanna, do you wanna start?

[00:03:44] **Joanna Strober:** It's really nice to be here.

[00:03:45] **Joanna Strober:** You know, I gotta tell you, I'm not entirely sure what's creating it. I have some theories. What I'd like to believe is that younger women are coming into perimenopause and unwilling to accept the status quo, and so they are much louder about wanting to feel better. So they're looking for answers. They're not willing to just say, okay, I'm willing to not feel good.

[00:04:08] **Joanna Strober:** Instead, they're looking for better answers, and that is what's driving a lot of this. I do believe, you know, some of it is the celebrities, but I actually think a lot of it is just that women, younger women are saying they deserve better, and I'm really proud of them for that.

[00:04:21] **Leah Finkelshteyn:** Lauren, do you have anything to add to that?

[00:04:24] **Lauren Tetenbaum:** Yes, and we couldn't do what we're doing by demanding more information and resources without the women who came before us. So thank you to everyone here on this call. I think millennials who technically were born between 1981 and 1996 have become accustomed to talking about tough topics, whether it's fertility struggles, the struggles of motherhood.

[00:04:49] **Lauren Tetenbaum:** Postpartum issues. Mental health in general. We share a lot. We grew up with social media and fortunately we have had rights that were hard won over the years. That we are demanding, we maintain and that we can access better healthcare. I hope that our generation, my generation of millennials and all of us continue to demand better for our reproductive health.

[00:05:15] **Sheryl Kingsberg:** On the practitioner side, menopause is also having a moment, and I love that you called it having a moment, because by definition, menopause is actually one moment. Mm-hmm. It is by definition, 12 months after your last menstrual period, or if you have a surgical menopause, it's. That moment. I think it's confusing for women 'cause they say, am I perimenopausal?

[00:05:36] **Sheryl Kingsberg:** When am I done with menopause? You're never done with menopause. It is the rest of your life, whether it's at 40, 50, 60, uh. But practitioners are also embracing menopause. We still haven't gone far

enough yet, though we still don't have education in OB GYN, uh, training or in primary care. We now have 12,000 members of the Menopause Society that is up from.

[00:06:03] **Sheryl Kingsberg:** 2000 just a few years ago. So practitioners are catching on that. Millennials and Gen z Xs and baby boomers are demanding better healthcare.

[00:06:16] **Libby Barnea:** Great answers. Thank you, Sheryl. This is, um, something I'm gonna direct to you. We would love to get a sense of the latest thinking around hormone therapy, which earned a bit of a bad rap about 20 years ago after an abruptly halted women's health initiative study.

[00:06:31] **Libby Barnea:** So what has changed in the medical understanding of these drugs and how they might be seen as beneficial?

[00:06:37] **Sheryl Kingsberg:** Sure. When you're talking about drugs, you're talking about hormones and hormone therapy, so that's estrogen. Um, and a progestogen or progesterone is the general term. If you have a uterus and you are taking estrogen for menopause symptoms, you will need to take progestin or progestogen in order to protect your uterus and the uterine lining.

[00:06:59] **Sheryl Kingsberg:** So those are the, uh, the old or initial treatments that we were looking at in the Women's Health Initiative, which was stopped in 2002 because of some data that came out that gave the sense that while this study was supposed to look at whether menopause hormone therapy prevented heart disease, that was the goal.

[00:07:21] **Sheryl Kingsberg:** It looked like there was an increase in breast cancer risk in the group that was taking both estrogen and. Progesterone, and it was a particular estrogen, and it was a particular progestogen in the estrogen only arm. There was no increase. In fact, there was a slight decrease. There was improvement in prevention of colorectal cancer.

[00:07:40] **Sheryl Kingsberg:** Certainly we know it's helpful for osteoporosis, but regardless, the press was all over it and within minutes practically. Everybody came off their estrogen or their hormone therapy. Uh, physicians were frightened to prescribe it, and it took another 18 years before people then reanalyze that data to show while there is a slight increase in breast cancer in that estrogen progesterone group, it was about eight breast cancers per 10,000.

[00:08:14] **Sheryl Kingsberg:** And so they were promoting the idea that there was a, you know, a huge risk, but the real risk is very small. And again, in the estrogen only arm, there was no increased risk. So the Menopause Society put out a hormone position statement in 2022, which you can get to if you go to the Menopause Society. Um, it's long and it's complicated.

[00:08:36] **Sheryl Kingsberg:** So if you don't want to sort of read the details, it says it is first line treatment. If you are a candidate for hormone therapy, if you have symptoms, hot flashes, night sweats, joint pain. We'll talk about vaginal dryness in a minute. My favorite topic, brain fog. Um mm-hmm. There are many symptoms of menopause that hormone therapy is very helpful for, and the fear of hormones has gone away.

[00:09:02] **Sheryl Kingsberg:** Now it has gone. In the other direction. Now there's been misinformation that we have data, that it prevents breast cancer, that it prevents heart disease, that it prevents dementia. It may, we don't have that data yet. We know that it probably doesn't increase the risks. And let me ask one more, uh, add one more thing to the, the Women's Health Initiative.

[00:09:24] **Sheryl Kingsberg:** Mm-hmm. The women in that trial were older. And one of the reasons why the data looked the way it did was that the women coming into this trial were often in their sixties and not at the average age of onset of menopause, which is 51 or 52. So that changed everything. So that is why that misinformation went out there.

[00:09:44] **Sheryl Kingsberg:** We now have better data, which is why estrogen, the uh, black box label has been removed for both vaginal and systemic estrogens. We need to be careful. It is helpful. It is good for symptom relief, but it is not necessarily for prevention. It is not a panacea. It is not the fountain of youth, and I'm sure Joan and Lauren hopefully Will, will second and third.

[00:10:09] **Leah Finkelshteyn:** Thank you, Sheryl. Lauren, you'd mentioned millennials and perimenopause a little bit earlier, and you have said in the past that millennials have a chance to be proactive rather than reactive about midlife health. What does that look like in practice? What do younger women just approaching perimenopause need to be thinking about?

[00:10:28] **Lauren Tetenbaum:** Knowledge is power, and it was my goal through writing my book and through supporting women through my psychotherapy practice and meetings like this, these gatherings like these. To educate women, they often don't even recognize perimenopause symptoms. We know that women tend to feel unlike themselves as they enter the menopause

transition, and those emotional symptoms are usually among the first of perimenopause.

[00:10:57] **Lauren Tetenbaum:** But we're not taught anything about this, and women can really suffer and they can really suffer for many years. So educating yourself, knowing what perimenopause is, knowing what treatment options might be available, knowing how to talk to providers about what's troubling you and how to get access to resources is really important.

[00:11:19] **Lauren Tetenbaum:** Knowing yourself and when anything is new and different, knowing how to speak up about it. Also, lifestyle changes. And of course the wide range of medical options ranging from hormone therapy to other psychotropic medications. And again, I wanna emphasize lifestyle, good sleep, good nutrition, good social connection.

[00:11:39] **Lauren Tetenbaum:** Those can't be understated.

[00:11:42] **Leah Finkelshteyn:** Lauren, you mentioned speaking up and advocacy. We wanted to ask about that. Drive. You clearly have to advocate on behalf of other women and whether you connect that drive to your support for other causes, perhaps Jewish causes.

[00:11:55] **Lauren Tetenbaum:** Yes, I proudly do. Very proud to be here with Hadassah tonight and with this community.

[00:12:03] **Lauren Tetenbaum:** It's certainly been an interesting time to be publicly Jewish, to be a Zionist, but I am proud to be. I wear my high necklace in my author photo, and I speak at various JCCs and other community centers. And honestly, being a Jewish woman is so much a part of my identity that. I see my. Role as if not now when?

[00:12:28] **Lauren Tetenbaum:** Right. It's up to me with the education and privilege that I have to speak up on behalf of women everywhere and to continue to have empathy and really operate under the principle of tko, no la Right. Making the world a better place. Absolutely.

[00:12:44] **Libby Barnea:** Thank you for that, Lauren, and staying with that Jewish angle for just a minute, for Jewish women approaching menopause, there are actually some specific and special considerations, including the heightened incidents of BRCA mutations in the Ashkenazi Jewish population.

[00:12:58] **Libby Barnea:** Joanna, we understand that there are lots of MIDI clients who might carry the BRCA mutation. Can you speak a little bit about what hormone therapy and medical interventions might mean to women who carry such a mutation?

[00:13:11] **Joanna Strober:** We do have the BRCA mutation in our family, so I've spent a lot of time looking at this.

[00:13:16] **Joanna Strober:** In addition, our chief clinical officer at MIDI as a woman named Dr. Mindy Goldman, she is one of the pioneers in survivorship care and basically helping women who had cancer. To figure out what they can do post menopause and what treatments they can use and what treatments they can't use. And then that interest of hers actually also got her into understanding women who had brca, because often they have their ovaries removed.

[00:13:45] **Joanna Strober:** Right? And so when they have their ovaries removed, they actually go into early menopause. A lot of doctors don't give them hormone therapy, and so they go into early menopause and they don't have the right treatments. We're actually working with cancer doctors all over the country to make sure that when women do have their ovaries removed, they immediately get sent to get.

[00:14:06] **Joanna Strober:** Hormones so that they don't have to go into immediate early menopause. In addition, there's actually a lot of research that shows that women who um, have the BRCA gene can absolutely take hormones. So we've been doing a lot of research on this. We actually are tracking all of our BRCA patients and we're starting an entire part of our business so that we can make sure those women are well supported.

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[00:15:23] **Leah Finkelshteyn:** Joanna. There's nothing like the tech sector to disrupt standard modes of doing business or perhaps standard doctor appointments. What gave you the idea that there was a high tech solution to increase access to menopause care?

[00:15:37] **Joanna Strober:** Yeah, so part of it is a high tech solution, and part of it was actually government changes. So I had a really hard time getting menopause treatment for myself. I live in Palo Alto, California. You would think I would have some well educated providers here, but. I ended up going to a primary care doctor.

[00:15:53] **Joanna Strober:** That primary care doctor told me that I should go on an SSRI for my anxiety. They sent me to a sleep specialist because I wasn't sleeping and marriage therapy. Um uh, I was really sent on a terrible wild goose chase. Honestly in the marriage therapy every week, you know, no one ever brought up vaginal estrogen.

[00:16:14] **Joanna Strober:** How can, I'm looking at Dr. Ling Springs about this. Can you imagine like every week? Every week, they never said, oh, have you thought about vaginal estrogen? And that was for quite a long time of therapy. So I've learned how woefully undereducated, really the clinical community is on menopause. They don't look at a woman and say, oh.

[00:16:37] **Joanna Strober:** Let's start with hormones. Instead, they say, oh, anxiety, SSRI. Oh, not sleeping sleep, doctor. So eventually I had to drive an hour. I went to San Francisco. I found this great doctor and she sat down with me. She gave me three simple medications. She gave me estrogen, progesterone, and testosterone, and wow. My whole life changed in a very short period of time.

[00:17:02] **Joanna Strober:** I was also getting back to what we were saying earlier. I was in perimenopause. I was still having my period, so, mm-hmm. I wasn't even thinking about menopause 'cause I didn't even know what perimenopause was. So what happened was I very quickly got to feel better very quickly, and I was very grateful. And then I got pretty angry and I got pretty angry at the doctors who had given me the wrong care and at the system that made me have to go pay a thousand dollars to get access to this because I couldn't find any insurance.

[00:17:31] **Joanna Strober:** Covered care anywhere near where I live. As you mentioned, I was working at Weight Watchers. I had been doing some research for them on the intersection of menopause and weight, and I had this revelation that basically this was during COVID. The COVID laws were changing, and so for the first time, you could actually use technology to take this great doctor that I was going to and scale her care nationally and get it covered by insurance.

[00:17:58] **Joanna Strober:** And that was just this. I was like, wow. Like I can take her information and I can then put FA hundreds of doctors on a platform and I can use her protocols and expand those protocols out to, to lots and lots of women. And because the laws had changed, we could get insurance coverage. It was really a combination of laws changing and technology.

[00:18:19] **Joanna Strober:** Now we have about 500 providers on our platform. We're taking care of over 25,000 women a week. We are able to scale this really effectively because we have a combination, as I said, of the laws changing and really good technology.

[00:18:33] **Libby Barnea:** Looking beyond some of that medical care, maybe looking beyond hormone therapy for a minute.

[00:18:37] **Libby Barnea:** Lauren, what supports do you think are essential for women navigating the menopause transition from a mental health perspective? What emotional and psychological shifts during perimenopause and menopause do you think women are least prepared for?

[00:18:53] **Lauren Tetenbaum:** Probably the rage and the irritability that I hear a lot about midlife is.

[00:18:59] **Lauren Tetenbaum:** Often, just by nature of midlife, a stressful time. And not everything is hormonal or related to perimenopause, certainly, but a lot of women tend to lose their coping mechanisms that they've developed or they get new anxiety or depressive symptoms, and studies show that up to 70% of women experience an emotional rollercoaster.

[00:19:22] **Lauren Tetenbaum:** That doesn't mean that they're meeting the criteria for a mood disorder like major depression. But they deserve support. If they're not feeling good, if they're not feeling like themselves, if they're snapping at their loved ones and yelling at their children and feeling like they can't be at work anymore because they don't recognize themselves.

[00:19:42] **Lauren Tetenbaum:** They deserve support. Women don't need to be suffering to get support. So I think it goes back to knowing yourself, building support systems. If you've had a previous episode of depression, you are at higher risk of another episode during perimenopause, and that might sound scary. But again, knowledge is power.

[00:20:02] **Lauren Tetenbaum:** If you know the risks and the risk factors, you can set yourself up for success and you can build a support team with loved ones, with professionals, with various resources like support groups, and it doesn't have to be this doom and gloom time of your life.

[00:20:21] **Sheryl Kingsberg:** Can I ask, Joanna, since you got put on estrogen and progesterone and you said, why didn't anybody ask me about vaginal estrogen?

[00:20:30] **Sheryl Kingsberg:** I hope they added in vaginal estrogen as well. 'cause you know, I'm gonna wanna talk about sex, but you know, speaking of BRCA women, we just published a paper on the impact of hormone therapy on women who've had risk reducing ectomy. And the reality is that estrogen. Because oftentimes they don't have uterus or they always don't.

[00:20:55] **Sheryl Kingsberg:** Estrogen is not enough for many women when it comes to sexual dysfunction and GSM, and there is a disconnect. We need to teach clinicians that while systemic hormones, estrogen, for example, will help with hot flashes, perimenopausal mood issues, it is often not enough. To address vaginal dryness, pain with sexual activity, and what they really need added in, it's not just enough, is a vaginal estrogen or vaginal DHEA or US biafine.

[00:21:27] **Sheryl Kingsberg:** There are many options and for women who are not able to take hormone therapy, we actually, besides the SSRIs, which often have side effects or SNRIs, which often have side effects, we now have two approved non-hormonal treatments. For vasomotor symptoms that can probably also help with sleep. 'cause we didn't talk about insomnia, but that is a huge problem for per and postmenopausal women.

[00:21:53] **Sheryl Kingsberg:** And it's not just due to hot flashes. The loss of estrogen absolutely impacts our sleep cycle. And so many women will have what we call waySo waking after sleep onset. So it's not about falling asleep, it's not about early morning awakening. It is. Waking up at two or three, not just because you have to pee and not just because you're having a hot flash.

[00:22:12] **Sheryl Kingsberg:** It is an insomnia issue anyway, we really don't talk enough, um, about those other options. There's one called Lin, and there's another one called bza. Those are non-hormonal treatments. They work on. Receptors in the brain that are related to hot flashes, and I just wanna throw that out there for women who may not know that those treatments exist.

[00:22:36] **Sheryl Kingsberg:** So they should be asking their healthcare professionals about those two.

[00:22:40] **Leah Finkelshteyn:** Sheryl, that's actually a perfect segue for my next question. You know, what's coming among your many specialties is menopausal and post-menopausal sexual health. What do you think women should be more aware of in addition to vaginal dryness?

[00:22:54] **Leah Finkelshteyn:** And the couple of things that you mentioned regarding their sexual health in perimenopause, menopause, post menopause,

[00:23:02] **Sheryl Kingsberg:** all

[00:23:02] **Leah Finkelshteyn:** pauses.

[00:23:03] **Sheryl Kingsberg:** Right. So, um, you know, Lauren was talking about how women in millennial women are not afraid to talk about menopause. Everybody is still afraid to talk about sex no matter what their age.

[00:23:14] **Sheryl Kingsberg:** They're still uncomfortable and so. One, give yourself permission to accept the fact that you are entitled to a healthy sexual life, whether you are 40, whether you are 50, whether you are 60, whether you are 80. You are entitled to a healthy sexual life. And so you should be asking your healthcare professional about your sexual concerns.

[00:23:35] **Sheryl Kingsberg:** And if they're uncomfortable, 'cause some are, find somebody else who isn't. And to Joanna's point, the only silver lining for COVID has been telehealth. And so we do have sexual health experts that can provide care. Uh, I'm licensed in 42 states, so there are practitioners. If you can't find one in Palo Alto or.

[00:23:56] **Sheryl Kingsberg:** Cleveland, Ohio, which we do. You can find them, whether it's at MIDI or various places. Women should pay attention to the fact that there are four categories of sexual concerns. One is sexual desire. Many women will talk about their loss of desire, their loss of drive at midlife. We know that it is not specific to menopause, right?

[00:24:18] **Sheryl Kingsberg:** We have data, and Susan Davis just published on this, that it is not menopause per se, that causes what we call hypoactive sexual desire disorder. It is an aging process, but it often is noticeable at midlife, so, so for many midlife women, they'll notice. If they don't have the appetite for sex the way they used to, or they may have trouble with arousal, which is genital sensation, or they may have trouble reaching orgasm or with genital urinary syndrome of menopause Without estrogen, the whole urogenital tract starts to become thin, dry, kind of atrophies a little bit.

[00:24:57] **Sheryl Kingsberg:** We've changed the terminology from vulvovaginal atrophy 'cause who wants to know that they're atrophying to genital urinary syndrome? Because it's not just the vagina, it is also the vulva and is also the urinary tract so that women may often notice they're having more UTIs or pain with urination. So it's very important that they can think about using vaginal estrogen.

[00:25:20] **Sheryl Kingsberg:** And to Joanna's point about why the heck she was in marriage counseling and nobody talked to her about pain, it is very easily treated now that will take care of the pain. Sometimes women will then develop anxiety if they've had pain. So don't forget cognitive behavioral psychology and CBT cognitive behavioral therapy can be very helpful to help reduce the impact of hot flashes to help regain comfort with sexuality again.

[00:25:46] **Sheryl Kingsberg:** To address low desire when it's a relationship issue, I always say it's not necessarily the age of people in the relationship. It's the age of the relationship, right? Because after 10, 20, 30 years, you have to work harder to build up passion and excitement and romance. And women actually get bored more quickly than men do because men can rely on testosterone to push their drive.

[00:26:14] **Sheryl Kingsberg:** And women need a little bit more, you know, romance and novelty and excitement. Which then brings me to the topic of testosterone. So people wanna know, we know vaginal estrogen for GSM. What about desire? So yes, cognitive behavior therapy. Yes, for some women testosterone, particularly if you are low in your premenopausal, if it's dropped below what your premenopausal levels are, we have no way to measure it.

[00:26:43] **Sheryl Kingsberg:** It is not on label it. There's no approved testosterone treatment for women. We have a published guideline of how practitioners should use testosterone with women. So please, whoever's out there, no pellets, no pellets, no pellets. We use, uh, we use FDA approved male

gels and we use about one 10th of a daily dose for women that would be using for men.

[00:27:10] **Sheryl Kingsberg:** It's a little topical gel they can put on the back of their calf. And what we're trying to do for women who respond to testosterone is bring them to their premenopausal levels, right? Not super levels, just what they were in their thirties and their forties. There's also a drug called Adi, A-D-D-Y-I, which.

[00:27:28] **Sheryl Kingsberg:** After 10 years on the market. Finally, finally, the FDA approved in postmenopausal women. For some reason, there was this assumption that women were two species free and post. This is a non-hormonal treatment and it is now approved in postmenopausal women. Yay, first and only treatment for postmenopausal women with sexual dysfunction.

[00:27:50] **Sheryl Kingsberg:** There's another drug called vii, which is an injectable that has not yet been studied in postmenopausal women. And there is Sildenafil or topical Viagra called Dare to Play that is now available for women with arousal disorders. Just saying there are treatments out there besides cognitive behavior therapy.

[00:28:11] **Sheryl Kingsberg:** Please ask and come to the Is Wish website or the Menopause Society website or go to mini, make sure that you ask for help because you certainly deserve it and we can treat sexual concerns.

[00:28:23] **Joanna Strober:** Um, MIDI is the largest provider in the country of most of these things, which is both good and bad, right. Women have a really hard time getting excess and we prescribe a lot of them.

[00:28:33] **Joanna Strober:** So every one of those medications that she was talking about, we are actively prescribing every day, quite honestly, along with erotica and vibrators. It doesn't have to be medication. There are other, uh, we have a lot of other tips and tricks of things that can work. We have an entire protocol of, mm-hmm.

[00:28:50] **Joanna Strober:** Of lots of different things that women can try. So there are a lot of medications, but there are other cognitive behavioral therapy, but other things as well that we recommend.

[00:28:58] **Libby Barnea:** That's great. Sheryl, as a follow-up, I understand that as a clinician and as past president of the Menopause Society, you use what you've called a bio-psychosocial approach when you treat patients.

[00:29:09] **Libby Barnea:** Can you explain what the bio-psychosocial approach?

[00:29:12] **Sheryl Kingsberg:** Sure. My down followed big words, right? GSM and bio-psychosocial. Really, it's looking at the fact that when we think about sexual concerns, we think about that there are many factors that can contribute. It could be. Neurochemical that is, for example, lack of dopamine, or if you're on an SSRI, so many women will have, and men too will have sexual side effects of being on an SSRI or an SNRI, right?

[00:29:39] **Sheryl Kingsberg:** Either problems with desire, problems with orgasm, so hormones can have an effect either causing GSM and general health issues. That's the bio part of bio-psychosocial. Psychological aspects can contribute. And Lauren was talking about this so, so eloquently talking about all the psychological factors that can contribute to midlife stressors, right?

[00:30:01] **Sheryl Kingsberg:** So it could be relationship issues, it could be depression, it could be anxiety, could be having little kids, could be taking care of elderly par. There are many psychological factors. Sociocultural factors. There are many people who have religious and cultural factors that contribute to sexual concerns.

[00:30:19] **Sheryl Kingsberg:** For example, I see lots of women who have vaginismus, which is the involuntary tightening that makes wanted penetration impossible because they've grown up with such religious fears that, oh, nope, can't, can't touch down there, and certainly wait until marriage if you are going to get married. To have penetrative sex.

[00:30:40] **Sheryl Kingsberg:** So sociocultural factors, and then interpersonal, the quality of a relationship. You could have all the biologic drive, but if you don't like your partner, you're not gonna wanna have sex with that person, right? And so we look at all those factors. It could be one, it could be two, it could be all of them, and they could be combined.

[00:30:58] **Sheryl Kingsberg:** So when a woman comes into my office, I ask her what's going on for her so that I can then plan a treatment. That's going to be appropriate for her 'cause it's not a one size fits all. Some women will benefit from medicine, some women from lifestyle changes, some women from cognitive behavior therapy, some from some combination.

[00:31:19] **Sheryl Kingsberg:** But a clinician will figure out which factors are contributing to her symptoms and then that guides treatment. So it is not a one size fits all, and we have many options. We just need to talk about it.

[00:31:32] **Lauren Tetenbaum:** I think the point of this conversation is that there is a community, there are resources available and we've given many, and MIDI is, has such a robust website, for example.

[00:31:44] **Lauren Tetenbaum:** There are so many ways to feel better, so if you're not feeling good, please seek out options that you deserve.

[00:31:52] **Joanna Strober:** There's so much misinformation out there. And I know that's really hard to navigate and, and it's also hard because a lot of the misinformation is coming from your doctors. I wanna just acknowledge that because there are lots of doctors that we trust who are not up to date on the most recent information all day long.

[00:32:11] **Joanna Strober:** I've been told I'm too old for hormones. You're not too old for hormones, especially not vaginal, estrogen. We put it on 85-year-old ladies because it presents UTIs like. You are most definitely not too old for a lot of these medications like, and just because you had stopped having your period doesn't mean you still don't need to be treated for menopause.

[00:32:30] **Joanna Strober:** As Sheryl said earlier, menopause may be a one day thing, but it goes on for the rest of your life. But I think the really hard thing for me is how many doctors will tell you go on an SSRI for depression, for example. Okay. SSRIs have a lot of side effects. They're also addictive. So we see many women come to us and they've been in an SSRI for five to 10 years because they were in perimenopause and they were put on one, and then we have to get them off of it in order to even try to see whether there's other things that we can do.

[00:33:01] **Joanna Strober:** I'm not saying all SSRIs are bad, but what I'm saying is if you're in your forties and you're feeling the rage that Lauren is talking about, because that is the number one reason come people come to us. Mood disorders. It is rage and anxiety. It's actually bigger than the hot flashes. I think women are willing to deal with the hot flashes.

[00:33:20] **Joanna Strober:** Like it's okay. I'll have the hot flashes. The things they're having a hard time dealing with or their hor their rage and their, their mood changes are probably the number one thing that really gets them. And

what happens is they go to the primary care doctor and they give them an SSRI instead of giving them the right medication.

[00:33:36] **Joanna Strober:** So don't think you're too old. Do your research. There is really good research out there. You know, you have to talk to a doctor who's really educated, whether it's from the Menopause Society, that's a good place to start. Or the MIDI website, like we do the research we have. A lot of researchers doing all this research.

[00:33:52] **Joanna Strober:** I just had all day people asking me like, I've been told my mother had cancer, so I can't use hormones. That's just false. There is no reason why if your mother had cancer, you are, you can't take hormones. Like there's so many falsehoods out there, and I think we gotta figure out how to overcome a lot of these falsehoods so that women are getting the right care.

[00:34:12] **Sheryl Kingsberg:** One little caveat there. Age does matter with hormone. Oh

[00:34:16] **Joanna Strober:** it does, absolutely. It

[00:34:18] **Sheryl Kingsberg:** does matter. So when you say you're not too old, you know, the Menopause Society guidelines would say within 10 years of onset of menopause or by age 60, it doesn't mean that there aren't exceptions, but we have lots seeing, we have

[00:34:33] **Joanna Strober:** lot of patients who are a, they did, they get a calcium artery score and then they are able to take hormones.

[00:34:38] **Joanna Strober:** But we have, there's protocols, there's lots of updated protocols.

[00:34:41] **Sheryl Kingsberg:** I just don't want the misinformation that went out a few months ago. Um, that said everybody, because now you talk about the social media. Now women in their seventies and eighties are coming in saying, did I miss the boat? Because I was, you know, I went through menopause during the Women's Health Initiative and so now I see that it's the Fountain of Youth and what can I go on?

[00:35:05] **Sheryl Kingsberg:** And for the most part, it's an individual in that over 60. But really be very careful and don't assume that you're never too old to start systemic hormones. You are never too old to start vaginal estrogen. And

these other drugs are certainly possible and SSRIs may be difficult to come off of. They are not technically addictive.

[00:35:27] **Sheryl Kingsberg:** They're difficult

[00:35:28] **Joanna Strober:** to come off of. We're taking, we are having a lot of issues right now trying to

[00:35:31] **Sheryl Kingsberg:** get women off. They, they are, they are, but they are, by definition, they're not addicted.

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[00:36:30] **Libby Barnea:** Somebody has a question about connection between gut health and menopause. They feel like their gut digestion has slowed down immensely with perimenopause and menopause. I can't eat many foods now, IB slike symptoms. Can one of you speak about a correlation between gut health motility and menopause?

[00:36:48] **Joanna Strober:** Women don't get enough fiber. I'll just say fiber. There is definitely a connection

[00:36:54] **Sheryl Kingsberg:** and it may be more age related than specific

[00:36:58] **Joanna Strober:** to menopause. Mm-hmm. But it's complicated.

[00:36:59] **Libby Barnea:** Okay. This is a question I, I myself have had, actually, I know many women have had this question. How do you get accurate

results from hormone tests when you get your blood drawn one time, you know, it's a snapshot of, of you on one day.

[00:37:11] **Libby Barnea:** Since hormone levels change over the course of a month, don't we need readings more frequently? And since everybody's different, how do I know that my normal pre perimenopause levels were where they should be?

[00:37:24] **Lauren Tetenbaum:** You don't.

[00:37:26] **Sheryl Kingsberg:** Good point, good point. Yes. It, it is hard to know. It's a snapshot and one, and by definition, perimenopause are the fluctuations of hormones, which is why you have more symptoms, right.

[00:37:39] **Sheryl Kingsberg:** Margaret Mead coined the term postmenopausal zest. Many women, once they're through that transition. Can really now sort of shine. So do not assume that menopause means the end of your brilliance, your creativity, your growth. It, it perimenopause is the harder part. So keep in mind postmenopausal zes, but the question to the hormone testing, you know, if your FSH level is above 30 nanograms per deciliter and it stays consistently, and yes, you should have it tested more than once, but a high.

[00:38:14] **Sheryl Kingsberg:** FSH follicular stimulating hormone, that is pretty much a sign of menopause. But you know, I get lots of questions about testosterone and there is no great accurate testing for testosterone levels in women. It requires fancy lab, and so you're trying to get a total testosterone, which will give you sort of a snapshot, and even time of day does determine that, and it doesn't tell you whether.

[00:38:39] **Sheryl Kingsberg:** Testosterone will help you. It doesn't tell you whether you have hypoactive sexual desire disorder, and we only use it for sexual desire. We don't have data that it does other things. So again, if people think it's gonna give me the Fountain of Youth, we have data on desire and it's an empirical use of testosterone, meaning.

[00:39:01] **Sheryl Kingsberg:** You can measure it. It won't tell you whether you have a problem and it won't tell you if it'll help. Mm-hmm. We use it, we measure to make sure we haven't put you into a really high range, and then we see whether it helps.

[00:39:12] **Leah Finkelshteyn:** I absolutely love Sheryl the postmenopausal zest.

[00:39:16] **Libby Barnea:** Yeah.

[00:39:17] **Sheryl Kingsberg:** That's

[00:39:18] **Libby Barnea:** very optimistic, isn't it?

[00:39:19] **Libby Barnea:** Yeah. People are asking about weight gain, which is common during menopause and somebody's wondering if, if GLP one would be.

[00:39:28] **Sheryl Kingsberg:** I'm so glad you asked and I'm sure Joanna's gonna jump in because there's just a recent study showing the combination of hormone therapy and GLP one works better in weight loss in per and postmenopausal women than GLP ones alone.

[00:39:44] **Joanna Strober:** Huge fan. Yes. Okay. We recommend them, we prescribe them. And the combination of hormones and weight loss and GLP ones is a very effective solution.

[00:39:54] **Sheryl Kingsberg:** Although GLP ones carry their own risks, side effects, and. Talk about hard to come off of. You can't really, and for many women who just want it to lose some weight, that extra 10, 20 pounds, you know, unfortunately, once you stop, your hunger tends to come back and your metabolism is affected by it.

[00:40:14] **Sheryl Kingsberg:** And many people will note weight gain. It is a game changer, and I'm not against them. I just wanna make sure there's full disclosure of pros and cons.

[00:40:26] **Leah Finkelshteyn:** These are all fantastic questions and all of our panelists have discussed information and misinformation, so we're throwing this out to all of you. If there's one myth about menopause that you would most want to retire, what is it?

[00:40:42] **Lauren Tetenbaum:** So I am 40 and I continue to get looks of astonishment when I say that. I wrote a book about menopause, people think, oh my god, menopause. You're so far away from that. And they assume it's an old lady issue and it's not. Menopause of course, as we've learned, can start in one's late thirties, early forties, and that's spontaneous menopause transition.

[00:41:07] **Lauren Tetenbaum:** I'm not even talking about surgical or induced menopause. And it a time in our life that can last for several years with several

symptoms. So knowledge is power. The more that we know it's never too early to. Get prepared and I think that women deserve information and access to care and bodily autonomy.

[00:41:31] **Leah Finkelshteyn:** Joanna.

[00:41:32] **Joanna Strober:** I think you don't need to suffer. Don't just grin and bear it. I'm probably more aggressive than Sheryl in my desire to get women access to things and let them try them and see how they feel, but I believe really strongly that you should try. Whatever you can that is legal and safe to help you feel better.

[00:41:52] **Joanna Strober:** And you should experiment and, and be open-minded to different things and whether it's nutraceuticals or whether it's weight loss medications, or whether it's hormones, like, be open-minded and realize you don't need to suffer. You can get at, you can feel great and, and you should be proactive in trying to do that.

[00:42:09] **Sheryl Kingsberg:** Sheryl. I'm not gonna disagree with the women shouldn't suffer. I think the biggest myth is that it's a natural part of aging and therefore you should learn to live with it. And that is not true. Our hair turns gray. We don't live with that, and we certainly can have many, many treatments that can be helpful.

[00:42:27] **Sheryl Kingsberg:** I don't know that I am. Not wanting women to try things, I, I just want to make sure they're evidence-based and that it's shared decision making with patients and their practitioners so they know the pros and the cons and, you know, the Menopause Society will talk about evidence-based medicines. You know, at university hospitals, we've developed a midlife women's health program that has many of the same things that MIDI has in that.

[00:42:53] **Sheryl Kingsberg:** We have not just primary care and OBGYNs, but just to the point and to, to Lauren's point about is it going, being sent for, you know, SSRIs or therapy? If it is a sleep problem, we have sleep medicine. If it is a weight problem, then we have endocrinologists who are obesity specialists. We have rheumatology.

[00:43:13] **Sheryl Kingsberg:** We have a whole list of every subspecialty and a practitioner who is interested in midlife women. With those problems so that they don't get shunted off to, oh, it must be depression. Take an SSRI. They recognize that we're starting with midlife and, uh, midlife women, and it's not always just a menopause symptoms, but it is about midlife and we wanna make

sure that women have healthy lives well into their eighties, nineties, and beyond.

[00:43:43] **Leah Finkelshteyn:** That's a very good node to end on. Thank you, Joanna, Lauren and Sheryl for being with us for this important discussion.

[00:43:51] **Libby Barnea:** We would like to thank the magazine's digital editor, Ariel Kaplan, who both promoted and produced this event, and we'd like to give a shout out to our partners in the engagement division and the marketing and communications division of Hadassah, who always play an important role in making these events happen.

[00:44:12] **Lisa Hostein:** Thanks for joining us today. If you like this episode of Hadassah Magazine Presents, please follow the podcast on Apple, Spotify, or wherever you listen to podcasts. And please, please rate and review us to help bolster our audience. You can find this and other Hadassah podcast@hadassah.org on the podcast page where you can also sign up for new episode alerts.

[00:44:35] **Lisa Hostein:** Check out the show notes for further resources, and if you'd like to watch a video recording of this interview, you can find that@hadassahmagazine.org. I'll be back soon with another enlightening and engaging episode. Thanks again for joining us. Until next time. Goodbye.