SCHOOL OF SEXUAL WELLNESS

FREE DIGITAL EDITION



The Midlife Body Guidebook

Symptoms, treatment, desire and coming home to your body

Hope Morrison

FOR WOMEN AND THE PRACTITIONERS WHO CARE FOR THEM



The Midlife Body Guidebook

Symptoms, treatment, desire and coming home to your body

Hope Morrison

SCHOOL OF SEXUAL WELLNESS · FIRST EDITION

The Midlife Body Guidebook
First edition. Free digital edition.

Free to read and share. This digital edition is distributed free by The Midlife Foundation at themidlifefoundation.com/guidebook. You may share this file freely, provided it is unaltered and not sold.

Printed copies, clinic packs and workplace packs: schoolofsexualwellness.com

Written by Hope Morrison.
Published by School of Sexual Wellness Pty Ltd
ACN 702 668 746
ABN 87 702 668 746
Australia

This guidebook is education, not treatment. It does not diagnose, prescribe, treat or cure any condition, and it does not replace care from a qualified health practitioner. Decisions about medicine belong with you and your doctor. Information reflects published guidance at the time of writing and may change.

If anything in this book brings up distress, or memories of harm, stop and reach out to someone you trust or a qualified counsellor. In an emergency, call your local emergency number.

School of Sexual Wellness and The Midlife Foundation are not affiliated with or endorsed by any organisation named in this guidebook.

Copies for clinics, practices and workplace programmes: hello@schoolofsexualwellness.com

© 2026 School of Sexual Wellness Pty Ltd. All rights reserved. No part of this book may be altered, sold or reproduced for sale without written permission. The worksheet pages may be copied for personal or clinical use.

Contents

	A letter before you begin	5
1	How to use this guidebook	6
2	Menopause, the basics	9
3	The symptoms	13
4	Vaginal, vulval and bladder changes	18
5	Desire, arousal and pleasure	22
6	Treatment options	26
7	Bones, heart and the long view	30
8	The HOPE Method	33
9	Talking to your practitioner	37
10	For practitioners	40
11	Your worksheets	44
12	Glossary	54
13	Sources	57

FOREWORD

A letter before you begin

Most women arrive at menopause with almost no information. They have been told about hot flushes. They have not been told about the rest. Not the 3am waking. Not the sudden tears. Not the dryness that turns sex into something to get through, or the quiet disappearance of desire that nobody seems willing to name.

So they wait. They assume it is just age. They assume it is just them. Many never raise it at all, and many of the practitioners who could help never ask.

This book exists to end that silence. It tells you what is happening in your body, plainly. It sets out the treatments that work, and the ones that do not. It gives desire and pleasure the same weight as bones and heart, because they matter just as much to the life you are living.

It is also written for the person on the other side of the desk. If you are a practitioner, this is a way to open the conversation most consultations skip.

Read it in order or go straight to the page you need. Write in it. Take it to your appointment. Hand it to someone who needs it.

You deserve care that includes all of you.

Hope

01

START HERE

How to use this guidebook

This guidebook covers the body, the symptoms and the treatments of menopause. It also covers what most guides leave out: desire, arousal, pleasure and the relationship you have with your own body.

Two readers, one book

If you are a woman in midlife, this book is yours. Read it front to back, or turn to the chapter you need today. Most women start with the chapter that matches what is bothering them most, then go back for the rest.

If you are a practitioner, this book is built to be handed across the desk. Chapter 10 is written for you. It covers how to use the guidebook in a consultation, how to open the conversation about sexual health, and when to refer.

What is in each chapter

CHAPTER	READ IT WHEN
2. The basics	You want to know what menopause is, when it happens and which stage you are in
3. The symptoms	Something has changed and you want to know whether it is menopause
4. Vaginal, vulval and bladder changes	You have dryness, pain with sex, urgency or repeat infections
5. Desire, arousal and pleasure	Your interest in sex has changed, or sex feels different
6. Treatment options	You want to compare what is available before seeing your doctor
7. The long view	You want to protect your bones, heart and brain for the decades ahead
8. The HOPE Method	Treatment has helped your body but you still feel disconnected from it
9. Talking to your practitioner	You have an appointment coming up
10. For practitioners	You care for women in midlife and want to open the conversation
11. Worksheets	You want to track symptoms or plan an appointment
12. Glossary	You meet a word you do not know

Three promises

Three promises run through every page of this book.

1. **Every symptom named here is common, real and worth raising.** You do not need to wait until it is unbearable.
2. **No question about your body is too small or too embarrassing.** Practitioners have heard it before. If they have not, they should have.
3. **You deserve care that includes your sexual health.** Not care that skips it, rushes it or treats it as optional.

> THIS IS EDUCATION, NOT TREATMENT
>
> This guidebook does not diagnose, prescribe or replace care from a qualified health practitioner. Where a decision about medicine is involved, make it with your doctor. Your history, your medicines and your preferences all shape what is right for you.

A word on language

This book uses the word women because most of its readers are women. Menopause also happens to trans men, non binary people and others with ovaries. If that is you, everything in these pages applies to your body too, and your care should be just as complete.

Medical words are explained the first time they appear. Every one of them is also in the glossary in Chapter 12. Where a medical name is long, we write it in full every time, so you can say it to your doctor and be understood.

Write in this book

Underline what applies to you. Fold the corners. Use the worksheets in Chapter 11 to keep a symptom diary for four weeks and to plan your appointment. A book that is written in is a book that gets used.

02

UNDERSTAND THE CHANGE

Menopause, the basics

Menopause is your final menstrual period. It is confirmed after 12 months in a row without a period. The average age is about 51.

Menopause is not one moment. It is a transition that usually runs over several years, with a long run up and a long tail. The hormones that change most are oestrogen and progesterone, made by the ovaries. As the supply of eggs in the ovaries runs low, the hormone signals become irregular, then fall.

Those hormones do far more than run the menstrual cycle. Oestrogen acts on the brain, the blood vessels, the bones, the skin, the joints, the bladder and the vulva and vagina. That is why the changes of menopause can show up almost anywhere in the body.

The stages

STAGE	WHAT IT MEANS	TYPICAL TIMING
Perimenopause	Hormones fluctuate. Cycles change. Symptoms often begin.	Usually starts in the 40s. Often lasts about four years, and can last up to ten.
Menopause	The final period, confirmed after 12 months without one	Average age about 51

STAGE	WHAT IT MEANS	TYPICAL TIMING
Postmenopause	Every year after menopause	The rest of your life
Early menopause	Menopause between 40 and 45	About 1 in 20 women
Premature ovarian insufficiency	The ovaries stop working normally before 40	About 1 in 100 women

Perimenopause: the stage most women miss

Perimenopause is when most symptoms start, and it is the stage most often missed. Periods may still come. They may even look normal for a while. Hormone levels swing from high to low and back again, sometimes within days. That is why a single blood test can look normal on the day and tell you very little.

For most women over 45, perimenopause is recognised from symptoms and the pattern of periods, not from a blood test. Your history usually tells your practitioner more than a test can. Blood tests are more useful when symptoms start before 45, or when something else needs to be ruled out.

EARLY SIGNS THAT ARE EASY TO MISS

- Periods that come closer together, further apart, heavier or lighter
- Waking in the night, often around the same time
- New anxiety, irritability or low mood with no clear cause
- Brain fog and losing words
- Aching joints
- Less interest in sex, or sex that feels different

Induced menopause

Menopause can also be brought on suddenly. Surgery to remove both ovaries, some chemotherapy and radiotherapy, and some hormone treatments for cancer all cause induced menopause. There is no gradual run up, so symptoms are often stronger and arrive all at once. If this is your situation, you deserve specialist advice early, before symptoms take hold.

A hysterectomy that removes the uterus but keeps the ovaries ends periods but does not cause menopause straight away. It can make menopause harder to recognise, because the period pattern is gone. Symptoms become the guide.

Early and premature menopause

Menopause before 45 is not just early. It means more years without oestrogen, which affects bone and heart health. Women with premature ovarian insufficiency are usually advised to take hormone replacement at least until the average age of menopause, unless there is a medical reason not to. This is replacement of what the body would normally make, and it is different from treating symptoms later in life.

If your periods stop before 40, or you have menopausal symptoms before 45, ask your doctor directly about these conditions.

You still need contraception

Pregnancy is still possible in perimenopause. Guidance commonly advises contraception until 12 months after your last period if you are over 50, or two years after your last period if you are under 50. Some hormone treatments for menopause are not contraceptives. Ask which approach suits you.

Every symptom named here is common, real and worth raising.

03

NAME WHAT IS HAPPENING

The symptoms

Most women have symptoms. Around three in four have hot flushes, and for many they last seven years or more. Symptoms vary widely, and none of them means you are failing.

Some women have very few symptoms. Others have many at once. Most sit somewhere in between, with symptoms that come and go over months. The table below sets out the most common ones. The pages after it go deeper.

SYMPTOM	WHAT IT CAN FEEL LIKE	WORTH KNOWING
Hot flushes and night sweats	Sudden heat in the chest, neck and face; sweating; a racing heart	The most common symptom. Very effective treatments exist.
Sleep	Waking at 3am, trouble getting back to sleep	Often driven by night sweats, but not always
Mood	Irritability, low mood, anxiety, tearfulness	The risk of depression rises in perimenopause. Raise it early.
Brain fog	Losing words, poorer focus and memory	Common and usually temporary
Joints and muscles	Aches, stiffness, lost strength	Strength training helps muscle and bone

SYMPTOM	WHAT IT CAN FEEL LIKE	WORTH KNOWING
Skin, hair and weight	Dry skin, thinner hair, weight settling around the middle	Linked to falling oestrogen and ageing together
Periods	Heavier, lighter, closer together or further apart	Very heavy bleeding, or bleeding after menopause, needs checking
Vaginal and bladder changes	Dryness, pain with sex, urgency, repeat infections	Chapter 4. These tend to worsen without treatment.
Desire and arousal	Less interest, slower arousal, harder orgasm	Chapter 5. Common, and treatable.

Hot flushes and night sweats

The medical name is vasomotor symptoms. A hot flush is a sudden wave of heat, usually across the chest, neck and face. It can bring sweating, flushed skin, a racing heart and a feeling of anxiety, followed by chills as the body cools. A flush often lasts a few minutes. Some women have one a week. Others have many an hour.

At night they become night sweats. They wake you, soak your clothes and break your sleep. A broken night repeated for months affects mood, memory, work and patience.

Flushes happen because falling oestrogen changes how the brain's temperature centre works. The range of temperature your body will tolerate narrows, so small rises trigger a full cooling response.

What helps: layers you can take off, a cool bedroom, a fan, breathable bedding, and noticing your own triggers. Common triggers include alcohol, spicy food, hot drinks and stress. For flushes that disrupt your life, the treatments in Chapter 6 work well. You do not need to put up with them.

Sleep

Poor sleep is one of the most common complaints in midlife. Night sweats are one cause. Others include anxiety, needing to pass urine at night, joint pain, and changes in the brain's own sleep patterns. Snoring and sleep apnoea also become more common after menopause and are worth raising, especially if you wake unrefreshed.

What helps: a regular wake time, daylight in the morning, less alcohol, no screens in bed, and a cool, dark room. Cognitive behavioural therapy for insomnia has strong evidence and is often more effective than sleeping tablets over the long term.

Mood, anxiety and low mood

Many women notice new irritability, anxiety, a short fuse or tearfulness in perimenopause, sometimes with no obvious cause. Women with a history of depression, postnatal depression or premenstrual mood changes are more likely to be affected. The risk of a new episode of depression rises during the transition.

If your mood is very low, or you have thoughts of harming yourself, tell your doctor straight away or contact a crisis line in your country. Low mood in midlife is common and treatable.

Hormone treatment can help mood symptoms linked to perimenopause, especially when flushes and poor sleep are part of the picture. Talking therapies and antidepressants remain important treatments for depression itself. The right mix depends on you.

Brain fog

Losing a word mid sentence. Walking into a room and forgetting why. Struggling to hold focus in a meeting. Brain fog is common in perimenopause and early postmenopause, and it frightens many women who fear something more serious.

For most women, the research is reassuring. Memory and thinking tend to steady after the transition. Poor sleep, flushes, stress and low mood all make brain fog worse, so treating them often helps. If memory problems are getting steadily worse, or others are noticing, see your doctor.

Joints, muscles and body changes

Aching joints and stiffness are common and often overlooked. Muscle mass falls with age, and the fall speeds up around menopause. Strength training two or more days a week helps muscle, bone, joints, blood sugar and mood at once.

Weight often moves to the middle in midlife, even without a change in eating. Skin becomes drier and thinner, and hair may thin. These changes are real and can affect how you feel in your body. They are not a personal failure.

Other symptoms

Many other changes are reported, including headaches and migraine changes, palpitations, dry eyes, itchy skin, tingling, tinnitus and changes to body odour. Some are linked to menopause. Others need checking for different causes. If a symptom is new, persistent or worrying, raise it. Palpitations, chest pain and breathlessness always need assessment.

KEEP A SYMPTOM DIARY

Use the worksheets in Chapter 11 for four weeks before an appointment. Note what happens, when, and how much it affects your day, your work and your relationships. A written record helps you be heard.

04

THE CHANGE NOBODY MENTIONS

Vaginal, vulval and bladder changes

The medical name is genitourinary syndrome of menopause. It affects around half of women after menopause, and unlike hot flushes, it usually gets worse over time without treatment.

Falling oestrogen thins and dries the tissue of the vulva, the vagina, the urethra and the bladder. Blood flow drops. Natural lubrication lessens. The tissue becomes less stretchy and more easily irritated. The normal balance of bacteria in the vagina shifts, which can make infections more likely.

These changes are physical. They are not in your head, and they are not a sign that something is wrong with your relationship.

Signs to raise with your practitioner

- [ ] Dryness, burning, itching or irritation
- [ ] Pain, stinging or tearing during sex, or during an internal examination
- [ ] Bleeding or spotting after sex
- [ ] Discharge that is new or different
- [ ] Needing to pass urine urgently or often, day or night
- [ ] Leaking urine
- [ ] Repeated urinary tract infections
- [ ] Discomfort when wearing tight clothes, cycling or sitting for long periods

Many women never mention these symptoms because nobody asks, or because they feel embarrassed. Some stop having sex rather than say it hurts. Some put up with it for years.

Pain is a symptom, not a verdict on you or your relationship.

What helps

OPTION	WHAT IT DOES	HOW IT IS USED
Vaginal moisturiser	Keeps tissue hydrated day to day	Used regularly, two or three times a week, whether or not you are having sex
Lubricant	Reduces friction and pain during sex or touch	Used at the time of sex. A lubricant is not a moisturiser. You may need both.
Low dose vaginal oestrogen	Treats the cause by restoring the tissue	A cream, tablet, gel or ring placed in the vagina. Prescribed by your doctor.
Pelvic floor physiotherapy	Treats pain, tightness, leaking and urgency	Assessment and a programme with a specialist physiotherapist
Gentle care	Reduces irritation	Plain water to wash, no fragrance or douching, cotton underwear

Low dose vaginal oestrogen

Vaginal oestrogen treats the cause rather than the symptom. It thickens the tissue, restores moisture and blood flow, and supports the healthy bacteria of the vagina. It can also reduce urgency and repeat urinary tract infections.

It acts locally. Very little reaches the bloodstream, so it does not carry the same risks as hormone therapy taken as a tablet, patch or gel. Guidance from The Menopause Society supports its use for most women over the long term, including many women who cannot take other hormone treatment. Women with a history of breast cancer should discuss it with their cancer team, but it is not automatically ruled out.

Improvement usually takes a few weeks, with full benefit after about three months. Symptoms tend to return if it is stopped, so most women continue it.

Other local treatments exist in some countries. Ask your doctor what is available where you live.

Choosing a lubricant and moisturiser

- **Water based** lubricants are easy to wash off and safe with condoms and silicone toys.
- **Silicone based** lubricants last longer and suit women with significant dryness. Do not use them with silicone toys.
- **Oil based** products can weaken latex condoms.
- Avoid products with fragrance, warming or tingling agents, glycerine or parabens if you are prone to irritation.
- Choose products made for vaginal use. Some are gentler on tissue than others. A pharmacist can help.

The pelvic floor

The pelvic floor is a sling of muscles that supports the bladder, bowel and uterus. In midlife it can become weak, which causes leaking, or overly tight, which causes pain with sex and difficulty with penetration. Many women have a mix of both.

A pelvic floor physiotherapist can assess what is happening and design a programme. Generic exercises found online can make tightness worse, so an individual assessment is worth having if you have pain.

> **SEXUALLY TRANSMITTED INFECTIONS**
>
> Menopause does not protect you from sexually transmitted infections. Thinner tissue can tear more easily, which may raise the risk. If you have a new partner, condoms and testing still matter.

When to see someone soon

See your doctor promptly about bleeding after menopause, bleeding after sex, a lump, a sore that does not heal, persistent itch with skin changes, or pain that is getting worse. These need assessment. Most causes are treatable.

05

THE CONVERSATION MOST CARE SKIPS

Desire, arousal and pleasure

Low desire is the most common sexual concern women raise in midlife. It is rarely about hormones alone. Body, mind, relationship and history all play a part.

Sexual health is part of health. It affects mood, confidence, closeness and quality of life. It deserves the same attention as sleep or bones, and the same willingness to treat what can be treated.

Desire has two shapes

Spontaneous desire arrives on its own. You think about sex, you want it, and then you seek it out.

Responsive desire arrives after touch or closeness begins. You may feel neutral at the start, then willing, then interested once your body responds.

Both are normal. Many women find desire becomes more responsive with age, with stress or in long relationships. That is not a loss. It means the conditions around sex matter more: time, safety, comfort, the right kind of touch and a body that is not in pain.

No desire is not a problem unless it is a problem to you. The measure is your distress, not a number.

What can lower desire in midlife

FACTOR	HOW IT AFFECTS DESIRE
Pain or dryness	The body learns to expect discomfort, so it stops wanting
Poor sleep and exhaustion	There is nothing left at the end of the day
Low mood, anxiety and stress	The mind cannot settle into the body
Medicines	Some antidepressants, blood pressure tablets and other medicines lower desire or delay orgasm
Body image	Changes in shape, skin or weight can make it hard to feel desirable
Relationship strain	Resentment, unequal load or poor communication dampen desire
A partner's changes	Erection problems or their own low desire change the pattern
Past experiences	The body can carry old harm, shame or silence into the present

Arousal and orgasm change too

Blood flow to the clitoris and vulva falls after menopause. Arousal can take longer. The vulva may feel less sensitive. Orgasm can feel weaker, take longer, or be harder to reach.

What often helps:

- More time before and during sex, without a goal of penetration
- More direct stimulation of the clitoris, by hand, mouth or a vibrator
- A good lubricant, every time
- Treating vaginal dryness, as set out in Chapter 4
- Talking about what feels good now, which may differ from before

When it is a condition

When low desire persists for months and causes you distress, it may be hypoactive sexual desire disorder. It is a recognised condition, and it is treatable.

Good care starts with a full conversation. A practitioner should ask about pain, mood, medicines, relationship, history and what you would like to be different. Treatment then addresses each part. That may mean treating dryness, changing a medicine, sex therapy, couples work or body based work.

For postmenopausal women diagnosed with hypoactive sexual desire disorder, an international consensus statement supports a trial of testosterone at doses that keep levels in the normal female range. It should be prescribed and monitored by a doctor. It is not recommended for low energy, mood or general wellbeing.

Talking with a partner

Many couples stop talking about sex just when talking would help most. One person withdraws. The other feels rejected. Both stay silent.

WAYS TO OPEN THE CONVERSATION

"My body is changing and I want us to work it out together."

"Sex has started to hurt. It is not about you. I am getting it looked at."

"I miss being close. Can we find ways to be close that are not only sex?"

"I need more time to warm up now. Can we slow down?"

Choose a time away from the bedroom. Speak about yourself rather than your partner. Expect it to take more than one conversation. A sex therapist or couples counsellor can help if you are stuck.

Pleasure on your own terms

Pleasure does not depend on a partner. Self touch helps you learn how your body responds now. It brings blood flow to the tissue. It can ease stress and help sleep. For many women it is the first step back into a body that has felt like a stranger.

If self touch brings up shame, fear or old memories, go gently. Chapter 8 offers a slow, consent based way back in.

06

KNOW YOUR CHOICES

Treatment options

You have choices. The right one depends on your symptoms, your history and your preferences. Decide with your doctor.

OPTION	WHO IT SUITS	WHAT TO KNOW
Menopausal hormone therapy	Healthy women under 60, or within 10 years of their final period	The most effective treatment for hot flushes and night sweats. Also protects bone.
Non hormonal medicines	Women who cannot or prefer not to use hormones	Several options reduce hot flushes. Effects are usually smaller than hormone therapy.
Vaginal oestrogen	Women with vaginal and bladder symptoms	Treats them locally. See Chapter 4.
Cognitive behavioural therapy and clinical hypnosis	Women bothered by hot flushes or poor sleep	Good evidence for reducing how much flushes bother you, and for sleep
Lifestyle	Every woman	Will not fix everything, but it matters for symptoms and long term health

Menopausal hormone therapy

Hormone therapy replaces some of the oestrogen the ovaries no longer make. It is the most effective treatment for hot flushes and night sweats. It also helps sleep, mood linked to the transition, vaginal dryness and joint aches for many women. It reduces bone loss and lowers the risk of fracture.

Published guidance from The Menopause Society states that for healthy women under 60, or within 10 years of their final period, the benefits of hormone therapy for troublesome symptoms generally outweigh the risks. The decision is individual. Your age, your health history and your family history all matter.

The parts of hormone therapy

- **Oestrogen** treats the symptoms. It can be taken through the skin as a patch, gel or spray, or by mouth as a tablet.
- **A progestogen** protects the lining of the womb. Women with a uterus need one alongside oestrogen, because oestrogen alone can thicken the lining and raise the risk of womb cancer. It can be a tablet, part of a combined patch, or a hormonal intrauterine device. Micronised progesterone is one option.
- Women who have had a hysterectomy usually take oestrogen alone.

Through the skin or by mouth

Oestrogen through the skin carries a lower risk of blood clots than oestrogen tablets. It is often preferred for women with a higher clot risk, migraine or a higher body weight. Tablets suit some women well. Ask which suits you.

Understanding the risks

CONCERN	WHAT THE EVIDENCE SAYS
Breast cancer	Combined oestrogen and progestogen is linked to a small rise in risk with longer use. Oestrogen alone, for women without a uterus, shows little or no rise.
Blood clots and stroke	Risk rises with oestrogen tablets. Oestrogen through the skin at standard doses carries a lower risk.
Heart disease	Starting before 60, or within 10 years of menopause, does not appear to raise risk. Starting much later may.
Womb cancer	Prevented by taking a progestogen alongside oestrogen if you have a uterus

Hormone therapy may be ruled out, or need specialist advice, if you have had breast cancer or some other cancers, blood clots, a stroke, heart disease, liver disease or unexplained vaginal bleeding.

How long can you take it?

There is no fixed time limit. Guidance supports continuing for as long as the benefits outweigh the risks for you, with a review at least once a year. Some women stop after a few years. Others continue for longer. Symptoms can return when you stop, so stopping is a choice to plan with your doctor.

Non hormonal medicines

Several medicines reduce hot flushes for women who cannot or prefer not to use hormones. They include some antidepressants at low doses, gabapentin, oxybutynin, and newer medicines that act directly on the brain's temperature centre, such as fezolinetant. That newer group needs liver blood tests. Each has its own side effects, and availability differs by country. Your doctor can explain which suits your symptoms and history.

Talking therapies

Cognitive behavioural therapy for menopause helps reduce how much hot flushes and night sweats bother you, and improves sleep and mood. Clinical hypnosis has also been shown to reduce hot flushes. Both are free of medicine side effects and can be used alongside other treatment.

Lifestyle

- Move every day. Aim for at least 150 minutes of moderate activity a week, in line with World Health Organization guidance.
- Do strength training on two or more days a week.
- Drink less alcohol. It worsens flushes, sleep and mood.
- Stop smoking. It brings menopause earlier and worsens flushes.
- Keep the bedroom cool and wear layers.
- Eat plenty of plants, fibre, protein and calcium rich foods.

Be cautious with compounded "bioidentical" hormones sold outside regulated medicines, hormone pellets, and supplements that promise to rebalance hormones. Their dose, purity and safety are not reliably tested. Regulated hormone therapy already includes body identical options, which are tested and prescribed in known doses.

07

INVEST IN THE DECADES AHEAD

Bones, heart and the long view

Menopause is a good moment to look after the decades ahead. Small changes made now pay off for the rest of your life.

AREA	WHY IT MATTERS	WHAT TO DO
Bones	Bone loss speeds up in the first years after menopause. Osteoporosis has no symptoms until a bone breaks.	Weight bearing exercise, strength training, enough calcium and vitamin D, no smoking, less alcohol
Heart	Heart disease is a leading cause of death in women. Risk rises after menopause.	Know your blood pressure, cholesterol and blood sugar. Move daily.
Brain and mood	Wellbeing through midlife and beyond	Sleep, movement, connection and treating low mood
Screening	Finds problems early	Keep up with cervical, breast and bowel screening as advised where you live
Sexual health	Sex can stay good for life	Treat vaginal changes early, talk with a partner, stay curious

Bones

Bone is living tissue, constantly broken down and rebuilt. Oestrogen helps keep that balance. When it falls, bone is lost faster than it is made, especially in the first five years or so after menopause. Over time bones can become thin and fragile. That is osteoporosis. It is silent until a bone breaks, often the wrist, hip or spine.

Ask whether you need a bone density scan, especially if you had early menopause, have a family history of hip fracture, are underweight, smoke, have taken steroid tablets for a long time, or have had a fracture from a minor fall.

Protect your bones

- Weight bearing exercise such as walking, stairs, dancing and jumping, as your joints allow
- Strength training with weights or resistance bands, building up gradually
- Balance work, such as tai chi, to prevent falls
- Calcium from food such as dairy, fortified plant milks, tinned fish with bones, tofu and leafy greens
- Vitamin D from safe sun exposure, or a supplement if your levels are low
- No smoking, and less alcohol

Heart

Before menopause, women tend to develop heart disease later than men. After menopause that gap narrows. Blood pressure, cholesterol and blood sugar often rise in midlife, and fat tends to settle around the middle.

Ask for a heart health check. Know your numbers. Know your family history. Women's heart attack symptoms can differ from men's: breathlessness, nausea, jaw, back or arm pain, and unusual tiredness may come without crushing chest pain. Call for emergency help if you are worried.

Brain and mood

What protects the heart also protects the brain. Regular movement, good sleep, social connection, learning new things, treating hearing loss, controlling blood pressure and not smoking all support long term brain health.

Screening

Midlife is when several screening programmes matter most. Keep up with cervical screening, breast screening and bowel screening as advised where you live. If you have had a hysterectomy, ask whether you still need cervical screening.

Sexual health across the long view

Many women enjoy sex well into later life. Treating vaginal changes early protects the tissue for the long term. Staying curious about your own body, talking with a partner, and seeking help when something changes all help sex stay good for as long as you want it.

YOUR MIDLIFE HEALTH CHECK

- [ ] Blood pressure
- [ ] Cholesterol
- [ ] Blood sugar
- [ ] Weight and waist
- [ ] Bone health risk, and a scan if advised
- [ ] Cervical, breast and bowel screening up to date
- [ ] Mood
- [ ] Sexual health, asked about directly

08

COMING HOME TO YOUR BODY

The HOPE Method

Treatment can fix dryness and hot flushes. It does not always bring back the feeling of being at home in your body. The HOPE Method is the follow through.

Many women describe the same thing. The prescription worked. The flushes stopped. The pain eased. And yet something is still missing. Touch feels distant. The body feels like it belongs to someone else. Desire does not come back on its own.

That is not a failure of treatment. Years of discomfort, silence and disconnection leave a mark. The body learns to brace. Coming back takes more than a medicine. It takes time, safety and practice.

The HOPE Method is a four phase approach to reconnecting with your body. It is taken at your own pace, and only ever by your own consent. Each phase builds on the one before. There is no rush to move on.

This is education, not therapy. You are in charge at every step, and stopping is always allowed. If this work brings up distress or memories of past harm, stop and speak with a qualified, trauma informed counsellor.

H Honour

Meet your body and its history without shame. Name what has changed as a neutral fact, not a failing. Your body has carried you through a great deal. It has adapted to everything asked of it.

Practice. Write three sentences that begin "My body has..." without judgement. For example: "My body has stopped making as much oestrogen." "My body has learned to brace when touched." "My body has kept going." Read them back slowly.

O Orient

Find safety first. Before any work with the body, you need a way to feel steady. Orient is about learning your window of tolerance, the zone where you can feel things without being overwhelmed, and having an anchor that brings you back.

Practice. Sit somewhere warm and private. Look slowly around the room and name five things you can see. Place one hand on your lower belly. Breathe slowly for two minutes. Notice what you feel without trying to change it. That is Orient. Come back to it any time.

P Presence

Come back into contact, gently. Presence is the slow return of attention and touch to parts of the body that have been ignored, braced or numb. Only ever as far as feels right, and only by your consent.

Practice. After a shower, apply moisturiser slowly to your arms, legs and belly. Notice temperature and texture. Notice any urge to hurry. When it feels right, and only then, extend this attention to areas you usually avoid. Stop at any sign of distress and return to Orient.

E Embody

Move from tolerance to tenderness. Embody is living in the body again, with pleasure as a possibility rather than a demand. It includes meeting whatever arises, including "no", and treating that answer with respect.

Practice. Choose one moment each day to do something purely because it feels good in your body. A warm bath. Stretching. Music you move to. Touch without a goal. Notice what your body says yes to. Notice what it says no to. Both are information.

How the phases work together

The phases are not a ladder you climb once. Most women move back and forth. A hard week may send you back to Orient. A good month may bring you into Embody. That is the method working, not failing.

PHASE	THE QUESTION IT ANSWERS	YOU KNOW IT IS WORKING WHEN
Honour	What has happened to my body?	You can describe the changes without blame
Orient	How do I feel safe in my body?	You have an anchor that steadies you
Presence	How do I come back into contact?	Touch feels possible, even interesting
Embody	How do I live here again?	Pleasure feels like a choice you can make

Alongside clinical care

The HOPE Method sits beside medical treatment, not instead of it. If sex is painful, treat the pain first. If mood is very low, get support for it. The method works best when the body is no longer hurting and the mind has room to notice.

Practitioners can use the HOPE Method framework to structure conversations about reconnection. Chapter 10 explains how.

> GO FURTHER
>
> The full method for desire after menopause is taught in The Shift Method at shiftmethodcourse.com. Practitioner training is offered by School of Sexual Wellness.

09

BE HEARD

Talking to your practitioner

Book a longer appointment if you can. Say at the start that you want to talk about menopause. Bring your symptom diary.

Many women leave appointments feeling rushed, dismissed or no further forward. Preparation changes that. A clear list, a written record and the right opening words help you get the care you came for.

Before the appointment

- [ ] Keep the symptom diary in Chapter 11 for four weeks
- [ ] List your current medicines and supplements
- [ ] Note your family history: breast cancer, clots, heart disease, osteoporosis, early menopause
- [ ] Write down the date of your last period and what your cycle has been like
- [ ] Choose your top three concerns
- [ ] Decide what you want from the appointment: information, a test, a referral or treatment

Opening lines that work

> **"I think I am in perimenopause and I would like to talk about my options."**
>
> **"Sex has become painful and I want to understand why."**
>
> **"My desire has changed and it is bothering me."**
>
> **"My sleep and mood have changed in the last year and I want to know whether hormones are part of it."**
>
> **"I have brought a list so I do not forget anything."**

Questions to ask

- [ ] Are my symptoms likely to be perimenopause or menopause?
- [ ] Is hormone therapy right for me? What are my personal benefits and risks?
- [ ] Should I use a patch, gel or tablet? Which progestogen, if I need one?
- [ ] How long can I take it, and how will we review it?
- [ ] What non hormonal options suit me?
- [ ] Could vaginal oestrogen help my dryness, pain or bladder symptoms?
- [ ] Could any of my current medicines be affecting my desire or mood?
- [ ] Do I still need contraception?
- [ ] Do I need a bone density scan or a heart health check?
- [ ] Can you refer me to a pelvic floor physiotherapist, sex therapist or menopause specialist?

During the appointment

Lead with your top concern, not your smallest. Read from your list. Ask the practitioner to write down any medicine names and the plan. If you do not understand something, ask again. It is your appointment.

If you feel dismissed

You are allowed to ask for a second opinion. You are allowed to see a different doctor. You are allowed to ask for a referral to a menopause specialist. Phrases that help:

> **"I would like this recorded in my notes."**
>
> **"What would you need to see before considering treatment?"**
>
> **"Can you refer me to someone who specialises in menopause?"**

After the appointment

Write down what was agreed, while you remember. Book a review, usually after about three months on any new treatment. Keep your diary going so you can see whether things are improving. Use the appointment record in Chapter 11.

10

FOR THE OTHER SIDE OF THE DESK

For practitioners

Most women will not raise sexual concerns unless asked. This guidebook opens the door so the consultation does not have to start from silence.

This chapter is for doctors, nurses, pharmacists, physiotherapists, psychologists, counsellors and workplace health teams. It explains how to use the guidebook in practice and how to hold the conversation that most consultations skip.

Using this guidebook in practice

1. **Hand it over early.** Give it at the first menopause consultation, or leave copies in the waiting room.
2. **Ask her to mark it.** Invite the patient to mark the chapters that apply to her, fill in the symptom diary and bring it back.
3. **Use the worksheets.** The four week diary and the appointment planner turn a vague complaint into a clear record.
4. **Point to Chapter 5.** Naming desire in writing gives permission to raise it.

Ask, every time

One routine question normalises the topic. Asked of every patient, it carries no judgement.

> **"Many women notice changes in sex or desire at this stage. Is that something you would like to talk about?"**
>
> **"Some women find sex becomes uncomfortable after menopause. Has that been the case for you?"**

If she says no, accept it, and let her know the door stays open. Many women answer at the second or third visit.

A process of care

The International Society for the Study of Women's Sexual Health describes a process of care for low desire that suits most sexual concerns in midlife.

STEP	WHAT IT INVOLVES
Ask	Raise the topic routinely and without judgement
Listen	Hear her story, in her words, including what she wants to change
Assess	Pain, genitourinary symptoms, mood, medicines, relationship, history and distress
Educate	Explain what is happening in the body and what is normal
Treat	Address pain and dryness first. Review medicines. Treat mood. Consider specific treatment where indicated.
Refer	When the problem needs skills or time beyond the consultation

Trauma informed care

Some women carry past sexual harm, birth trauma or painful examinations into the consulting room. A trauma informed approach assumes this may be true without requiring disclosure.

- Explain before you examine, and ask permission at each step
- Offer a chaperone and the choice to stop at any time
- Offer control: positions, pace, who inserts the speculum
- Notice signs of distress and pause
- Never assume a reason for avoidance or pain

Refer well

Build a local list before you need it.

REFER TO	FOR
Pelvic floor physiotherapist	Pain with penetration, tightness, leaking, urgency
Sex therapist or counsellor	Low desire, arousal and orgasm concerns, relationship patterns
Menopause specialist	Complex histories, early menopause, treatment not working
Trauma informed psychologist	Distress, past harm, avoidance, anxiety about touch
Gynaecologist	Postmenopausal bleeding, skin conditions of the vulva, masses

Bulk supply and training

Copies are available in packs for clinics, practices and workplace programmes. Contact School of Sexual Wellness at hello@schoolofsexualwellness.com.

HOPE Method Practitioner Training Level One teaches the relational skills behind this guidebook, including how to support women back into contact with their bodies after treatment.

11

TRACK, PLAN AND REMEMBER

Your worksheets

The pages that follow are for you to write on. Copy them as often as you need.

- **Symptom diary, four weeks.** Score each symptom each day: 0 none, 1 mild, 2 moderate, 3 severe.
- **Appointment planner.** Fill it in before you go.
- **Appointment record.** Fill it in straight after.
- **My plan.** What you are trying, and how it is going.
- **Notes.** Anything else.

> TIP
>
> Score at the same time each evening. Note your period days with a P in the bleeding row. At the end of each week, circle the symptom that affected you most.

Symptom diary, week 1

Score 0 none, 1 mild, 2 moderate, 3 severe. Week beginning: _____

SYMPTOM	MON	TUE	WED	THU	FRI	SAT	SUN
Hot flushes							
Night sweats							
Sleep							
Mood or anxiety							
Brain fog							
Joint aches							
Vaginal dryness or pain							
Bladder urgency							
Desire							
Energy							
Bleeding (P for period)							

WHAT AFFECTED ME MOST THIS WEEK

POSSIBLE TRIGGERS I NOTICED

HOW IT AFFECTED WORK, SLEEP OR RELATIONSHIPS

Symptom diary, week 2

Score 0 none, 1 mild, 2 moderate, 3 severe. Week beginning: _____

SYMPTOM	MON	TUE	WED	THU	FRI	SAT	SUN
Hot flushes							
Night sweats							
Sleep							
Mood or anxiety							
Brain fog							
Joint aches							
Vaginal dryness or pain							
Bladder urgency							
Desire							
Energy							
Bleeding (P for period)							

WHAT AFFECTED ME MOST THIS WEEK

POSSIBLE TRIGGERS I NOTICED

HOW IT AFFECTED WORK, SLEEP OR RELATIONSHIPS

Symptom diary, week 3

Score 0 none, 1 mild, 2 moderate, 3 severe. Week beginning: _____

SYMPTOM	MON	TUE	WED	THU	FRI	SAT	SUN
Hot flushes							
Night sweats							
Sleep							
Mood or anxiety							
Brain fog							
Joint aches							
Vaginal dryness or pain							
Bladder urgency							
Desire							
Energy							
Bleeding (P for period)							

WHAT AFFECTED ME MOST THIS WEEK

POSSIBLE TRIGGERS I NOTICED

HOW IT AFFECTED WORK, SLEEP OR RELATIONSHIPS

Symptom diary, week 4

Score 0 none, 1 mild, 2 moderate, 3 severe. Week beginning: _____

SYMPTOM	MON	TUE	WED	THU	FRI	SAT	SUN
Hot flushes							
Night sweats							
Sleep							
Mood or anxiety							
Brain fog							
Joint aches							
Vaginal dryness or pain							
Bladder urgency							
Desire							
Energy							
Bleeding (P for period)							

WHAT AFFECTED ME MOST THIS WEEK

POSSIBLE TRIGGERS I NOTICED

HOW IT AFFECTED WORK, SLEEP OR RELATIONSHIPS

Appointment planner

Fill this in before you go. Take it with you.

DATE AND PRACTITIONER

WHAT I WANT FROM THIS APPOINTMENT

MY TOP THREE CONCERNS

DATE OF MY LAST PERIOD, AND WHAT MY CYCLE HAS BEEN LIKE

CURRENT MEDICINES AND SUPPLEMENTS

FAMILY HISTORY (BREAST CANCER, CLOTS, HEART DISEASE, OSTEOPOROSIS, EARLY MENOPAUSE)

QUESTIONS TO ASK

Appointment record

Fill this in straight after, while you remember.

DATE AND PRACTITIONER

WHAT WE DISCUSSED

TESTS ORDERED

TREATMENT AGREED, INCLUDING NAMES AND HOW TO USE IT

REFERRALS

REVIEW DATE

ANYTHING I STILL WANT TO ASK

My plan

What you are trying, and how it is going. Review it every month.

WHAT I AM TRYING	STARTED	HOW IT IS GOING

ONE THING I WILL DO FOR MY BODY THIS WEEK

ONE THING MY BODY SAID YES TO THIS WEEK

Notes

Notes

12

WORDS EXPLAINED

Glossary

TERM	MEANING
Arousal	The body's response to sexual interest, including blood flow to the genitals and lubrication
Bone density scan	A low dose X ray that measures bone strength
Body identical hormones	Regulated medicines with the same structure as the hormones the body makes
Clitoris	The main organ of sexual pleasure, much larger than the visible part
Cognitive behavioural therapy	A talking therapy that changes unhelpful patterns of thinking and behaviour
Compounded hormones	Hormones mixed by a pharmacy outside regulated medicines; dose and safety not reliably tested
Early menopause	Menopause between 40 and 45
Genitourinary syndrome of menopause	Changes to the vulva, vagina and bladder caused by low oestrogen
Hot flush	A sudden wave of heat, often with sweating and a racing heart
Hypoactive sexual desire disorder	Persistent low desire that causes personal distress

TERM	MEANING
Induced menopause	Menopause caused by surgery, chemotherapy, radiotherapy or medicines
Libido	Another word for sexual desire
Lubricant	A product used during sex to reduce friction
Menopausal hormone therapy	Oestrogen, with a progestogen if you have a uterus, to treat symptoms
Menopause	The final menstrual period, confirmed after 12 months without one
Micronised progesterone	A body identical form of progesterone used to protect the womb lining
Night sweats	Hot flushes during sleep
Oestrogen	The main female sex hormone; levels fall at menopause
Osteoporosis	Thin, fragile bones that break easily
Pelvic floor	The muscles that support the bladder, bowel and uterus
Perimenopause	The years of change leading up to the final period
Postmenopause	Every year after the final period
Premature ovarian insufficiency	Ovaries stop working normally before 40
Progestogen	A hormone that protects the womb lining during oestrogen therapy
Responsive desire	Desire that arrives after closeness or touch begins
Spontaneous desire	Desire that arrives on its own, before any touch

TERM	MEANING
Testosterone	A hormone women make too; sometimes used for low desire after menopause
Trauma informed care	Care that assumes past harm may be present and protects safety and choice
Vaginal moisturiser	A product used regularly to keep vaginal tissue hydrated
Vaginal oestrogen	Low dose oestrogen placed in the vagina to treat local symptoms
Vasomotor symptoms	The medical name for hot flushes and night sweats
Vulva	The external genitals, including the labia and clitoris
Window of tolerance	The zone in which you can feel things without being overwhelmed

13

WHERE THIS COMES FROM

Sources

This guidebook follows the published guidance below. Figures are rounded for readability. Guidance changes over time. Ask your practitioner about the most recent advice where you live.

1. The Menopause Society. The 2022 Hormone Therapy Position Statement.
2. The Menopause Society. The 2020 Genitourinary Syndrome of Menopause Position Statement.
3. The Menopause Society. The 2023 Nonhormone Therapy Position Statement.
4. Davis SR and colleagues. Global Consensus Position Statement on the Use of Testosterone Therapy for Women. 2019.
5. International Society for the Study of Women's Sexual Health. Process of Care for the Management of Hypoactive Sexual Desire Disorder in Women. 2018.
6. Study of Women's Health Across the Nation. Findings on the duration of vasomotor symptoms, mood and cognition across the menopause transition.
7. Faculty of Sexual and Reproductive Healthcare. Contraception for Women Aged over 40 Years.
8. World Health Organization. Guidelines on Physical Activity and Sedentary Behaviour. 2020.
9. Australasian Menopause Society. Patient information sheets.
10. Basson R. The female sexual response: a different model. Journal of Sex and Marital Therapy. 2000.

A NOTE ON SCOPE

This guidebook is education, not treatment. It makes no claim to diagnose, treat or cure any condition. School of Sexual Wellness is not affiliated with or endorsed by any organisation listed above.



The conversation most care skips, written down.

Menopause, explained plainly. Hot flushes, sleep, mood and brain fog. Vaginal and bladder changes. Desire, arousal and pleasure. Treatments that work, and the ones to avoid. Bones, heart and the long view.

One edition for two readers. Women read it to understand what is happening and what to ask for. Practitioners hand it across the desk to open the conversation.

Includes a four week symptom diary, an appointment planner and the HOPE Method for coming home to your body.

School of Sexual Wellness Pty Ltd
schoolofsexualwellness.com · Australia
Education, not treatment.