
Psychological aspects of menopause management

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The influence of endocrine function on the mood of the menopausal woman continues to be debated and researched. While many women present at the menopause with depression and anxiety, the reasons for these mood disorders cannot be attributed to menopause status alone. The influence of psychological factors, lifestyle, body image, interpersonal relationships, role, and sociocultural factors in predicting levels of depression and anxiety in the menopausal patient cannot be ignored. This chapter discusses the research to date on menopause and depression and anxiety. Included is a discussion of the role of psychosocial factors in the symptomatology of perimenopausal, post-menopausal and prematurely menopausal women. The importance of understanding the individual menopausal experiences of women within the context of their lives while offering support, education, and validation is highlighted. The need for a multidimensional approach to treating the menopausal woman who presents with mood disorders is examined. Finally, this chapter makes it clear that psychosocial aspects of menopause management require further research, particularly on the experiences of women who enter menopause prematurely.

Key words: menopause; psychological factors; lifestyle; relationships; body image; sociocultural influences; management.

The importance of considering menopause within the context of psychological and social factors is increasingly a focus of the research literature today. Clearly, the menopause involves physiological manifestations that result from hormonal changes, and for most women menopause is part of a normal transition. However, menopause does not happen in isolation from the social interpretations and psychological changes that may also occur in a woman's life at the same time. It is important that any understanding of menopause is placed within the context of a woman's life and includes consideration of her psychological state, psychological influences, cultural and social background, and the ageing process. The impact of the timing of menopause for women should also be taken into consideration, particularly when menopause may occur prematurely. Treatment of the menopausal woman should always incorporate a multidimensional approach, including consideration of physiological and psychosocial factors.

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Case studies of two menopausal women to illustrate the role of psychosocial influences

Case one

'Joanne', aged 51 years, presents with hot flushes and vaginal atrophy. She would also like to tell you she feels: depressed, anxious, irritable, fatigued, and not as confident in herself as she once was. Somehow she feels out of control. Her body is doing things which are unpredictable, and she does not know when her next hot flush is coming or how to control the fat which is somehow shifting up towards her waist. Joanne experienced depression after the birth of her first child, but thought it would never return. Her husband is also depressed; she cannot talk to him about menopause because he does not try to understand. Her father has recently died and now she must find a nursing home for her mother. Her children are becoming independent, have either just left home, or have just returned to the family nest after 6 months living away. She knows she has entered another transition in her life. On the one hand she wants to be positive, but Western society does not view ageing women positively. Her roles are changing and there are things she would like to do. She does not know where to start or what to do next; she is depressed and anxious—help.

Case two

Sandra presents with many debilitating menopause symptoms; however, she is only 37 years of age and has experienced menopause prematurely. Sandra's life circumstances are very different, given the developmental time of her life cycle. She has not yet had children; she is not in a relationship and all her friends are having children one after another. She is suffering severe physical and emotional adjustment problems, including extreme mood swings.

The above case studies are two examples of women who have experienced negative reactions to menopause and the timing of menopause: They have been included to illustrate an important point. While it may seem that the menopausal experience can be generalized, it is necessary to understand and account for each woman's individual experience of menopause. At this point it is also important to acknowledge that some women will experience a positive menopause and may see this time in their life as one for new beginnings. Each menopausal patient presents with her own life circumstances and experience. Each woman will have her own psychological history, life events, coping skills, family background, relationship history, body image, roles, social and cultural interpretation of how menopause affects her life. Each woman needs to be given the time to tell her own story.

This chapter considers the latest research and management of menopause, depression and anxiety. The impact and the role of psychosocial factors in the symptomatology of the mood of perimenopausal, post-menopausal, and prematurely menopausal women, along with psychological approaches to treatment, are also discussed.

PSYCHOLOGICAL FACTORS

In general, women have been found to be twice as likely as men to experience an affective disorder and anxiety disorder.^{1,2} Many clinicians are quick to point the finger at

hormones and biological factors, such as menopause in the increased incidence of mood disorders in women. Interestingly, however, researchers have found that the prevalence of depression decreases with age and was experienced more by women in the childbearing years.^{3–5} For example, in a large Australian population study, women aged 18–24 years experienced the highest prevalence of depression at 11%, while 7% of women aged 45–54 years experienced depression.³

It appears that women also believe that hormones account for their experiences of depression and anxiety. Many menopausal women present to their practitioner for the first time with depression and anxiety symptoms in their mid to late forties believing that they are caused by menopause. However, after a thorough history is taken, it is often discovered that the woman has experienced these symptoms previously. It may be that women feel that they can finally report they are depressed and anxious because menopause has legitimized these symptoms.

Depression and the menopause

Biological theories

While some researchers have found an increased incidence of depression in women who have undergone a surgical menopause^{6–8}, physiological links between natural menopause and depression are largely not supported.^{9–11} Theories as to how changing hormone levels are thought to influence mood in menopausal women continue to be debated. Dennerstein and Burrows suggested that changes in hormonal levels might influence the brain through hypothalamic function and/or a change in amine metabolism.¹² Sherwin reported in a summary of studies on neurobiological effects of hormones, that oestrogen and testosterone were present in areas of the brain thought to be relevant to emotional functioning.¹³ Withdrawal of sex hormones at the menopause has been thought to influence neuropeptides and neurotransmitters, resulting in depression, irritability, insomnia and anxiety in women.⁶ Genazzani et al reported that changes in mood of the post-menopausal woman were likely to be related to neuroendocrine dysfunction of the limbic system, generally thought to include the hypothalamus and amygdala.⁶ Recently, Parry and Newton argued that hormones may affect the 'synchrony or coherence between components of the circadian system' (page 102) thus altering timing relationships.² Smith and Studd also reported that oestrogen might work like an antidepressant on neurotransmitters and their receptors.¹⁴ Sherwin found 'estrogen in doses conventionally used to treat menopausal symptoms enhances mood in nondepressed women but is therapeutically ineffective for mood disturbances of a clinical magnitude'¹³ (page 122). More recently, Schmidt et al¹⁵ found that depression decreased in 19 out of 24 women with mild depression, and six of seven women with 'major' depression after 3 weeks of treatment using transdermal oestradiol (0.05 mg/day). Interestingly, the researchers found that, in this small group of women ($n = 34$), the use of HRT for depressive disorder was beneficial regardless of whether women experienced hot flushes, sleep deprivation, or had a previous history of depression.

The role of testosterone in depression is an important focus of current research. One study found that surgically menopausal women who were given androgen had lower depression scores than those given placebos.¹⁶ While other studies have also reported positive effects of testosterone therapy on mood in naturally menopausal women, large longitudinal studies are needed.

Depression and menopausal stage

Little research has been conducted on depression in women who have experienced a premature menopause. Liao, Wood and Conway found that women who had experienced a premature menopause were more likely than women from the general population to report higher levels of depression and stress.¹⁷ The authors suggested that life situation—such as whether the woman already had children, and being in a long-term relationship for example—may also have influenced levels of depression. Case study two (see earlier) illustrated the importance of the timing of this event on mood: Sandra did not have children and was not in a relationship.

Some researchers have reported that psychological symptoms, such as depressed mood, irritability and anxiety, are experienced more severely at the perimenopause rather than post-menopause.¹⁸ It is further suggested, however, that this increase in severity is more likely to be experienced in the perimenopause stage in women who have experienced a prior depression.⁵ Owens and Matthews suggested that women in the transition from perimenopause to post-menopause also experienced increased sleep disturbance, thus affecting negative mood and anxiety.¹⁹

What the research has so far consistently concluded

It appears that the most conclusive finding in regard to menopause and its link with depression is that depressive disorders cannot be predicted by menopausal stage alone; the impact of psychosocial influences on depression must be factored in.²⁰ Recent research has consistently found that depression is predicted by the following psychosocial influences in women's lives rather than menopausal status^{9,21–25}:

- prior depression
- a negative attitude to menopause and ageing
- increased stress and 'daily hassles'
- experience of more severe menopause symptoms
- physical inactivity
- smoking
- dissatisfaction with relationships/or no partner
- low socioeconomic class and/or unemployment

Summary of menopause and depression

Even though many women present to their physician around the time of their menopause with depressed mood, the research which has considered endocrine changes and reports of negative psychological functioning in menopause remains controversial. There is the suggestion that changes in hormone levels may contribute a small percentage towards the variance in accounting for depressed mood. However, it appears that women are more likely to experience depression because of a range of factors, including biological, social and psychological causes. These factors will be discussed more fully in the following sections.

Practice points (depression)

- regardless of whether endocrine changes contribute to negative mood or not, it is important that practitioners assess whether women are experiencing

symptoms of depressive disorders as defined by the DSM-IV (Diagnostic and Statistics Manual)—for example, changes to weight, fatigue and lethargy, increased negative thoughts, thoughts of suicide. Depression may be diagnosed in levels such as mild (low mood that comes and goes) to moderate (persistent low mood with some physical symptoms) to severe and clinical (persistent low mood with increased physical symptoms, increased thoughts of suicide and delusions)

- it is also helpful to ask women to keep a diary over a 3-month period to determine whether they are experiencing symptoms related to menstrual changes and the menopause or whether other factors such as family problems are more responsible for depressed mood
- due to the biopsychosocial nature of depression a multidimensional approach is necessary for effective treatment. Women presenting at the menopause with mild depression may benefit from hormone replacement therapy (HRT).^{13,15,26} It would also be appropriate to consider psychological therapy with this patient, such as cognitive behavioural therapy. Moderate to severe and clinical depression has been found to benefit from antidepressants, in particular selective serotonin re-uptake inhibitors (SSRIs) along with psychological therapy and possibly HRT.¹⁵ It is important to note that if women are also taking HRT they may require a lower dose of antidepressant.²⁰
- treatment of depression should always integrate both biological and psychological modalities

Research agenda (depression)

- many past studies which have considered the link between depression and the menopause are limited by poor design and have failed to account for the confounding effects of age.²⁷ Even though large prospective studies have begun to address these issues, further research into psychosocial influences and treatment modalities is still needed
- further understanding of the combined effects of HRT and antidepressant medication
- more research on mood and women who have experienced a premature menopause
- further investigation of the role of testosterone therapy in mood

Anxiety and the menopause

Anxiety is experienced by most humans in response to everyday life situations. However, when intense anxiety is experienced over an extended period of time and interferes with daily life, then anxiety can be perceived as a problem, which requires both medical and psychological treatment. Anxiety can affect physiological reactions, behaviour, feelings and thoughts.²⁸ Symptoms may include a racing heart, rapid breathing, sweating, hot flushes, shaking, dizziness and nausea.

While many researchers have investigated depression and menopause, less is known about the effects of endocrine function on anxiety in the menopausal woman.

Of the research that has been performed, no definitive correlation with hormone status and anxiety symptoms has been found. In a study of 64 women, Sagsoz et al found that there was no correlation between anxiety and blood follicle stimulating hormone (FSH), leutinising hormone (LH), and estrogen (E2) levels.²⁹ However, many women who are perimenopausal and in the early years of post-menopause do report that they feel more anxious and are aware of the anxiety symptoms of racing heart, rapid breathing and sweaty palms. It may be that some menopausal symptoms are similar to anxiety symptoms such as hot flushes, sweating, awareness of breathing and 'crawling' skin. Freeman et al found that those women who had higher scores on anxiety measures were more likely to report experiencing hot flushes.³⁰ Interestingly, out of 70 perimenopausal women, those taking HRT were more likely to report lower scores on anxiety measures.³¹ Because the severity of their menopausal symptoms had been reduced they also felt less anxious.

There is little known about women who experience menopause prematurely.

Summary of menopause and anxiety

It may be that anxiety is linked to the severity of the menopausal symptoms experienced. Anxiety in the menopausal woman is also likely to be influenced by prior history of anxiety disorder, and psychosocial factors such as relationship status, family problems, socioeconomic status and life style factors such as exercise.

Practice points (anxiety)

- determine the severity of anxiety symptoms, the extent to which they may interfere with daily life (for example, avoidance behaviour) and the length of time they have been present
- a diary is an excellent tool for establishing the true nature of anxiety symptoms while also understanding the menopausal experiences of each individual patient
- as suggested by Boyle and Murrihy, HRT may also lower anxiety levels—perhaps by decreasing the severity of menopausal symptoms such as hot flushes and thus improving overall well-being³¹
- for women diagnosed with an anxiety disorder, both pharmacological and psychological treatment should be used

Research agenda (anxiety)

- due to the focus of past research on depression and menopause there is a real need to perform large prospective studies to explore the anxiety experiences of menopausal women, including premature, peri- and post-menopausal women

PSYCHOLOGICAL AND SOCIAL MECHANISMS AND THEIR ROLE IN MENOPAUSE MANAGEMENT

The following sections discuss the role of psychosocial factors on mood and menopause management. This includes an understanding of personal psychological history and vulnerability, the secondary effects of menopause, lifestyle issues, body image, interpersonal relationships, role and sociocultural influences.

Personal psychological vulnerability

Rather than menopausal status, previous experience of mood disorders, a negative attitude to menopause and ageing, stress and negative life events, coping skills, personality and low self-esteem are more likely to account for the presentation of depression in the menopausal woman.

Past experience of mood disorders

Previous episodes of depression and anxiety have been found to predict depression in the menopause.^{24,32,33} As Joanne from case study one (see earlier) illustrated, she had already experienced depression in her childbearing years. Kuh et al found that poor mental health at the age of 36 years was more likely than menopausal status to predict depression at the menopause.²⁵

Negative attitude to menopause and ageing

Joanne in case study one tried to be positive about midlife; however, she did not like the negative views of society towards ageing women. Women who have a negative attitude to menopause and ageing have been found to have increased reports of depression, particularly in large community studies. Rather than menopausal status, Avis and McKinlay³⁴ found women with a negative attitude to menopause had increased psychological symptoms, while Dennerstein et al³² found that mood was adversely influenced by a negative attitude to ageing.

Life events, personality and coping

Women who have experienced negative life events such as the death of a loved one, illness and marital crises had higher scores on psychological morbidity tests.³³ High levels of stress have also been found to account for negative mood.²⁴ How women cope, and their personality type, are factors which must also be taken into consideration in the menopausal woman who presents with depression and anxiety. While Collins et al found that personality type was a predictor of psychological symptoms in a small sample of patients from a menopause clinic, Ballinger suggested that patients did not cope as well as non-patients with stress and reported increased negative mood as a consequence.^{35,36} Neri et al found that those women with active coping skills had decreased negative mood scores.³⁷

Self-esteem

Women who experience low or unstable self-esteem often experience feelings of depression or anxiety, and are vulnerable to health problems.^{38,39} Self-esteem is the way that we evaluate ourselves, our self-confidence and self-respect. Self-esteem is learned behaviour and in the menopausal woman it may come from the evaluation that is provided by the roles and relationships she has in her life. Body image and depression are closely tied to an evaluation of the self.

Self-esteem contributes a great deal to the way the menopausal woman feels and thinks about herself. Cohen and Lazarus found, for example, that when people with high self-esteem are challenged they believe they have the resources and resilience to cope with extra demands.⁴⁰ When women experience the biological, psychological and social changes that may be occurring in their lives around the transition of menopause,

levels of self-esteem become important to their ability to cope at this time. Bloch found that women who had high scores on self-esteem measures also experienced fewer menopausal symptoms.²¹ It is important to recognize those women who are suffering from low self-esteem in your practice.

Practice points (personal psychological vulnerability)

- ask women about:
 - their previous experience of depression and anxiety
 - their attitude to menopause and ageing
 - any negative life events that may cause them stress
 - how they usually cope with problems
 - how they feel about their self worth
- look for cognitive distortions in your patients such as
 - overgeneralizing
 - minimizing success
 - personalizing blame

Secondary effects of menopause on mood

It appears that negative mood and anxiety are influenced more by the secondary effects of menopause symptoms than by menopausal status. This has also been referred to as the domino effect.⁴¹ Perhaps the physiological changes experienced by women—such as hot flushes and night sweats—result in increased fatigue and feelings of lethargy. It may be that some women mistake the symptoms they experience along with their hot flushes for symptoms of anxiety, or depression when the menopausal woman is feeling fatigued and lacks motivation because of disrupted sleep. It is argued that women who have trouble sleeping and women who experience more hot flushes and night sweats also report increased scores on depressive and psychiatric measures. Sleep disruption during the perimenopausal years has been found to influence reports of anxiety by some researchers.^{9,19,33,42} When women are treated with HRT their menopausal symptoms decrease and their scores on depression and anxiety scales have consequently been found to decrease.

Practice points (secondary effects of menopause on mood)

- assess the severity of menopausal symptoms and their link to symptoms of mood disorder
- assess the role of HRT in the treatment of menopausal symptoms for each individual menopause patient

Lifestyle issues

Those women who exercise and are not smoking have been found to have more positive mood scores. A number of studies have found that women who are physically inactive often report decreased well-being around the time of the menopause.^{23,24,43}

Practice points (lifestyle issues)

- encourage women to exercise and find activities which are physically enjoyable
- ask women to assess negative health practices in their life, such as smoking, and then find appropriate treatment modalities to support positive changes to lifestyle

Body image

Body image is the way women think and feel about their bodies as well as how they visually picture their bodies.^{44,45} Chrisler and Ghiz suggested that the physiological symptoms associated with menopause, such as hot flushes and osteoporosis, may affect a woman's body image—it 'may make a woman feel that her once reliable body is out of control'⁴⁶ (page 70). Changes to the body associated with ageing, such as the physical appearance of wrinkles, may contribute to a woman's negative body image, thus resulting in negative mood.^{44,47}

The most consistent finding of past research into physiological changes to the body as a result of menopausal status is the shift in fat deposits from the lower to the central body without any change in total fat mass.^{48–50} Joanne from case study one (see early in chapter) felt that her body was not in her control and was very negative about the change to her shape. Bellerose and Binik found that body satisfaction was significantly lower for subjects who had undergone an oophorectomy, while in women who had undergone a hysterectomy there was a lower body image satisfaction score than for women who had experienced a natural menopause.⁵¹ Deeks and McCabe found that menopause influenced ratings of fitness and appearance evaluation. Women who were perimenopausal and recently post-menopausal were more likely to rate their levels of fitness and appearance negatively compared to women who were pre-menopausal.⁵² Women who are not satisfied with their appearance have also been found to experience more menopausal symptoms.²¹ It is suggested that the changes to the body as a result of menopause have been found to have an even more negative effect on the body image of women who experience premature menopause.⁵³

A negative body image does appear to be a problem for some women around the time of menopause and midlife. Many of these women are suffering from low self-esteem and are having difficulties in feeling that they are in control of their lives.⁵⁴

Practice points (body image)

- ask women about their view of their body image
- it may be helpful to patients to know that other women also feel as if they have no control over their bodies during the transitions of menopause
- if women experience negative body image that influences self-esteem and depression then referral to a psychologist who specializes in this area will be beneficial

INTERPERSONAL RELATIONSHIPS

Relationship with a partner

Whether women are in a relationship with a partner, heterosexual or homosexual, or whether they are single, widowed or divorced may also influence the experience of menopause. It is not clear whether the quality of a woman's relationship with her partner changes during the menopausal transition, or whether her feelings about her interpersonal relationships influence the experience of menopause.⁵⁵ Very little research has been performed on the influence of relationships and menopause and most of this information has focused on women who are in, or have recently been in, a heterosexual relationship.

Abraham et al found that women were more likely to take HRT if they thought that menopause made relationships with husbands and children more difficult.⁵⁶ Interestingly, those women who were separated from their partner at the time of HRT initiation were more likely to discontinue treatment.⁵⁷ A number of researchers have found that while menopausal stage could not be related to level of depression, marital status was found to influence reports of depression.^{7,58} Widowed, separated and divorced women had higher rates of depression than married women. If a woman perceived that there were 'problems' with her partner she was more likely to report feelings of depression irrespective of menopausal stage.^{24,59}

Relationship with children

Menopause signifies the end of a woman's childbearing years, and it is often the time when her own children may be leaving home. For some women who have not had children, menopause signals to them that this is no longer possible and this can contribute to depressed mood.

Of the research that has been performed on women with children there are inconsistent findings with regard to the impact of children leaving home. Some studies suggested that this event has a negative effect on mood⁶⁰, and other studies reported positive effects or no effects of children leaving home.^{59,61} Researchers have also found that in the first 5 years post-menopause, women were more dissatisfied with the relationship they had with their children and wanted to change the amount of contact they had with their children. Once women had been post-menopausal for longer than 5 years, women were more satisfied with their relationship with their children.⁶² Children seem to be returning to the nest after leaving, and this may also have an impact on the lives of the menopausal woman which needs further research.

Perhaps menopause does signal to women that they have a different role in the lives of their children. After some adjustment, and with the addition of other roles such as that of grandparent, women may be more satisfied with the relationship they have with their children.

Relationship with friends/social support

Those women who are depressed around the time of the menopause may also have fewer friends and social support. Those women who had a social network were found to be more positive about the menopause, and were less likely to be depressed.^{63,64} Not having a confidant has also been found to be a predictor of psychiatric morbidity in the postmenopause.⁶⁵

Practice points (interpersonal relationships)

- ask women about their relationship background, family make-up, and social networks
- ask women how they feel about their relationship with their partner (if there is one) children (if there are any) friends
- it is important to acknowledge that women who experience distress at changes to the family relationship and worry about their partner's problems may be at an increased risk of depression

ROLE, SOCIAL FACTORS, AND CULTURE

Role

Research on the importance of having a role to fulfil for midlife women has provided mixed findings. While multiple roles were associated with higher life satisfaction and well-being it is difficult to know whether more roles resulted in greater satisfaction—or being more satisfied with life made people want to perform more roles.^{66,67} Vandewater et al found that the quality of the role a woman had in midlife, particularly in relation to her family, and her capacity to care for people, predicted higher levels of well-being in later years.⁶⁸

In studies specifically related to menopause, women who were employed reported less discomfort than unemployed women during the menopause; further, those who reported their work role was important to them had better objective health outcomes than women who did not perceive their work role was important to them.^{69,70} Blumel et al found that housewives had worse scores on psychosocial measures of quality of life compared to working women.⁷¹

The role women have in their lives at the time they are going through the menopausal transition and midlife may affect their levels of psychological functioning. As part of the importance of understanding the whole menopausal experience for women, it would seem appropriate for physicians to spend time assessing what roles women have in their life at this time, and how they feel about these roles. Little is known or understood about how role affects the woman who experiences menopause prematurely.

Social factors

The effects of menopause have been found to be mediated by the social class to which a woman belongs. In a large study of the general community, Hunter et al found that being in a lower social class predicted increased feelings of depressed mood and higher levels of anxiety, more than did menopausal status.²⁷ Rather than menopausal status, unemployment was also found to predict higher levels of anxiety, McKinlay et al found that women with only a high school education accounted for more of the variance in higher levels of reports of depression rather than menopausal status.⁷ However, recent research by Dennerstein et al found that education was not an accurate predictor of negative mood.²⁴

Culture

The influence of culture on the experience of menopause has been found by many researchers to be extensive. While it is not possible to cover all of the literature in this chapter, it is important to acknowledge the effects culture may have on the interpretation of menopause, particularly in relation to mood. While women in some cultures may take on more esteemed roles post-menopause, for example, in developing countries⁷², other cultures may devalue the contribution to society by women in post-menopause.⁷³ The attitudes of a particular culture to child-rearing, for instance, will affect a woman when her children leave home and she no longer has to fulfil this role.⁷⁴ If society places great emphasis on being the caretaker then the woman may be regarded as unimportant and insignificant when children leave home.

Practice points (sociocultural factors)

- ask women
 - about the roles they have in their life
 - if they are satisfied with these roles
- encourage them to seek new roles and try something they have always wanted to do—this could be enrolling in an adult education course, performing volunteer work etc.
- assess the social background of your menopausal patient
- ask about the culture a woman comes from and how it might influence her experience of menopause

Research agenda (body image, interpersonal relationships and sociocultural factors)

Further research:

- on the body image of prematurely menopausal women
- on the impact of children returning to the nest
- on menopausal women who are in homosexual relationships
- into the role of self-esteem
- on sociocultural factors such as employment, career changes in the 50s, for example

SUMMARY

It would appear that at the same time women experience changes to their body associated with physiological aspects of menopause it is also important to account for the psychological and social influences on their lives. Endocrine status cannot be used to predict whether women will experience negative psychological functioning; rather psychological morbidity is influenced by many factors and requires a multifaceted approach to its treatment.

Taking time to establish a therapeutic relationship with the woman who is menopausal may help to make her treatment and the experience of menopause more positive. Assess thoughts and feelings about personal psychological vulnerability, body

image, interpersonal relationships, role, social background and culture. Many menopausal women have reported that they want further education and information, support, validation and for someone to take the time to listen to their individual experience.⁷⁵ Some women will need further counselling, and referral to a qualified psychologist in combination with the treatment provided by a physician should be considered as an option.

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