MENOPAUSE SCIENCE

THE PLAYBOOK

If You're Reading This

The science of what she's going through.
The playbook for what you do next.

wtfismenopause.com

Early Reader Praise for The Playbook

Catch my breath

"This is the first time I've read something that I can actually relate to. It's only been a couple of weeks but I feel better placed to understand my wife and what she's going through, it's helped me catch a breath and not engage in an argument that no one will win. Genuinely life changing and I told my buddies about this over our weekly coffee catch up. Thank you for changing my family's lives."

Mike H., 47
Hoboken, New Jersey

No longer taking it personally

"I've read it twice now - and will read it again. It's evidence backed, yet concise. It gives the theory, yet puts it into practice. It's good; I really enjoyed it, and it helped me realize what I do well and where I fail. I think most importantly, it helped me reframe my mind away from: "it's me", as I tend to take things personally."

Anonymous, 50
UK

Before You Start

If you're reading this

You've probably had a fight you didn't see coming.

You've probably said something that landed wrong, in a tone you didn't mean to use.

You've probably felt like you're walking on eggshells in a house that used to be yours, too.

You've also probably googled something you didn't tell anyone you googled. Is my partner having an affair? Will perimenopause end my marriage? Why doesn't she touch me anymore? You closed the tab and went back to whatever you were pretending to do.

You're not the only one. There are thousands of guys with the same browser history tonight.

Most of them have nobody to talk to about it. You don't either, probably. The men in your life don't have language for this. Your father didn't get a guide. Your friends don't bring it up. Your partner is too tired to teach you, and you wouldn't ask if she had the energy.

You bought this because something at home isn't working and you want to fix it without making it worse. That instinct is the right one. Most men don't even get that far.

You don't need to read this front to back. You don't need to memorize anything. You don't need to prove you've done your homework. This guide is designed to give you a basic understanding of what a woman’s body is going through and the mental tax it can have too.

How to use this guide

This is a reference, not a textbook. You will not retain everything on the first read. You are not supposed to.

There are nine chapters in three parts. Part 1, Know: what is happening to her. Part 2, Cope: what this is doing to you, and how to stay steady. Part 3, Act: the doctor visit, the treatments, and the playbook at home.

Read it through once. Bookmark the playbook protocols. Pull the doctor visit pages out before her next appointment. Keep the B.A.S.I.C.S. card in your phone if you think it will help.

WHERE TO START IF YOU'RE DESPERATE

If something is on fire today, jump straight to: Chapter 07 for doctor visits, Chapter 09 for the Bad Night Protocol, the Hot Flash Response, and the Apology Template. If you are at the end of your own rope, head to Chapter 04 first.

This guide is for educational purposes. It is not medical advice and does not replace consultation with a qualified healthcare provider. Treatment decisions, including hormone therapy, belong to her and her doctor.

Straight through

Start at page 01. Each chapter builds on the last.

Triage mode

Chapter 07 and 09 first. Then come back.

Reference use

Resources and sources begin on page 95.

FROM THE AUTHOR

Why I wrote this

We all learned about puberty. Most of us got a version of sex ed. What nobody taught us was what happens after, later in life. The second hormonal chapter that affects all of us differently. The one that can take a decade. The one that every man with a woman in his life will eventually watch unfold, with no idea what he's seeing.

In 2002, I was 16, mid-puberty, running on pure hormonal chaos. My mother was in perimenopause, running on her own version of it. I had no idea what was happening to her. Neither did my father. Neither did she. Menopause wasn't something anyone talked about, not at school, not at home, certainly not among men. We were living with my grandmother at the time, who figured she hadn't gone through menopause because she felt no symptoms.

Nobody taught us in school about perimenopause, or about what happens when our own testosterone starts to decline, because it wasn't happening to us. But it was happening at home. That gap hasn't closed much since.

Nine years later, I was diagnosed with Type 1 Diabetes. Living with a condition where hormones set your day teaches you something most people never have to learn: what it is to have how you feel dictated by something invisible you can't argue with. That's what I'm bringing to this guide. Men and women have the same hormones, in different quantities and ratios. We cover the basics in Chapter 1. If you understand your own body, you're one step closer to understanding hers than you think.

Roughly one in three women receives an incorrect diagnosis before someone connects her symptoms to hormones. Most men miss perimenopausal symptoms for the same reason most doctors do: nobody taught us what it looked like. Health class ended at puberty. Menopause got a sentence in a textbook. The ten years between, the years that test every relationship, went unmentioned. Just one percent of healthcare research and innovation goes to female-specific conditions outside oncology. That's why 5% of sales from this guide go toward supporting women's health initiatives, specifically menopause research.

While working on a separate women's health venture, what stood out most was how often men asked how to support the women in their lives going through menopause. Women need the support; that isn't in question. But the men trying to help need support too, and most have nowhere to turn. That's why I wrote this: a plain read on what's happening to her, and what actually helps.

If you finish this guide and think "I never knew that" more than once, it did its job.

Jordan Smith
Toronto, Canada

wtfismenopause.com

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PART 1

Know: Education & Empathy

What is happening: the science, the symptoms, and the load she is carrying.

MENOPAUSE SCIENCE

01

CHAPTER 1

The Invisible Transition

What is happening to her body, and why nobody warned you.

What Is Perimenopause?

Perimenopause is the hormonal transition leading up to menopause. It starts, on average, in a woman's early-to-mid 40s and lasts anywhere from 4 to 10 years.[1] During this time, estrogen and progesterone production becomes irregular. Her body is phasing out its reproductive cycle.

Menopause is a point in time, identified retrospectively. Perimenopause is the years of hormonal transition before it. Postmenopause is after. But symptoms often don't respect that boundary, which is the part that matters for relationships.

Most of the symptoms you're seeing now are very likely perimenopausal.

1 in 2	4–10	51
Women experience significant symptoms	Years perimenopause typically lasts	Average age of menopause (US)[2]

KEY DISTINCTION

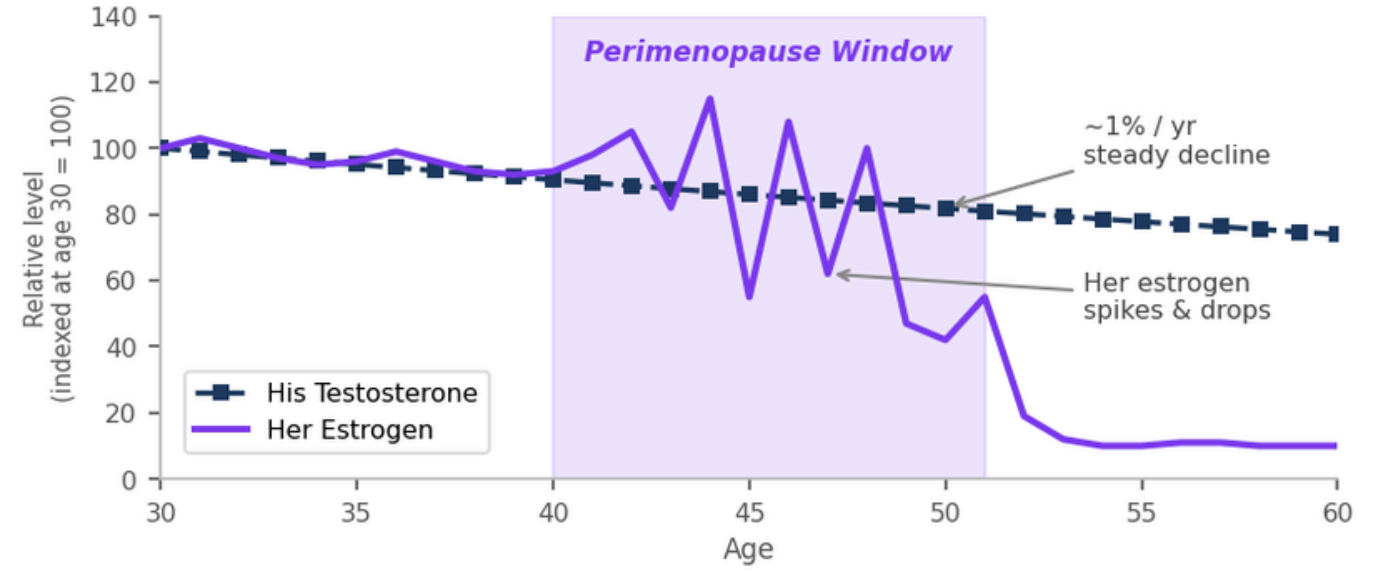
Perimenopause is not a disease. It is a biological phase, the same as puberty, only in reverse. The symptoms are real and often disabling. The cause is hormonal, not psychological.

Remember: nothing she is experiencing is made up. If a doctor ever suggests that, get a second opinion.

The Hormonal Parallel

Here is the most direct path to understanding what she is going through: you are going through something related at the same time.

Estrogen can become unpredictable in her early 40s before it eventually drops sharply. Your testosterone has been declining at roughly 1% per year since your early 30s.[3] The window overlaps. The biology is different, but a hormonal shift is happening in both of you simultaneously. That shared context changes the conversation.



HER ESTROGEN

Can fluctuate 5–10× within a single cycle during perimenopause, then falls to roughly 20% of peak by menopause.

HIS TESTOSTERONE

Declines gradually by ~1% per year from age 30. By the time she enters perimenopause, he has already lost 10–15% of his baseline.[3]

WHAT THIS MEANS FOR YOU

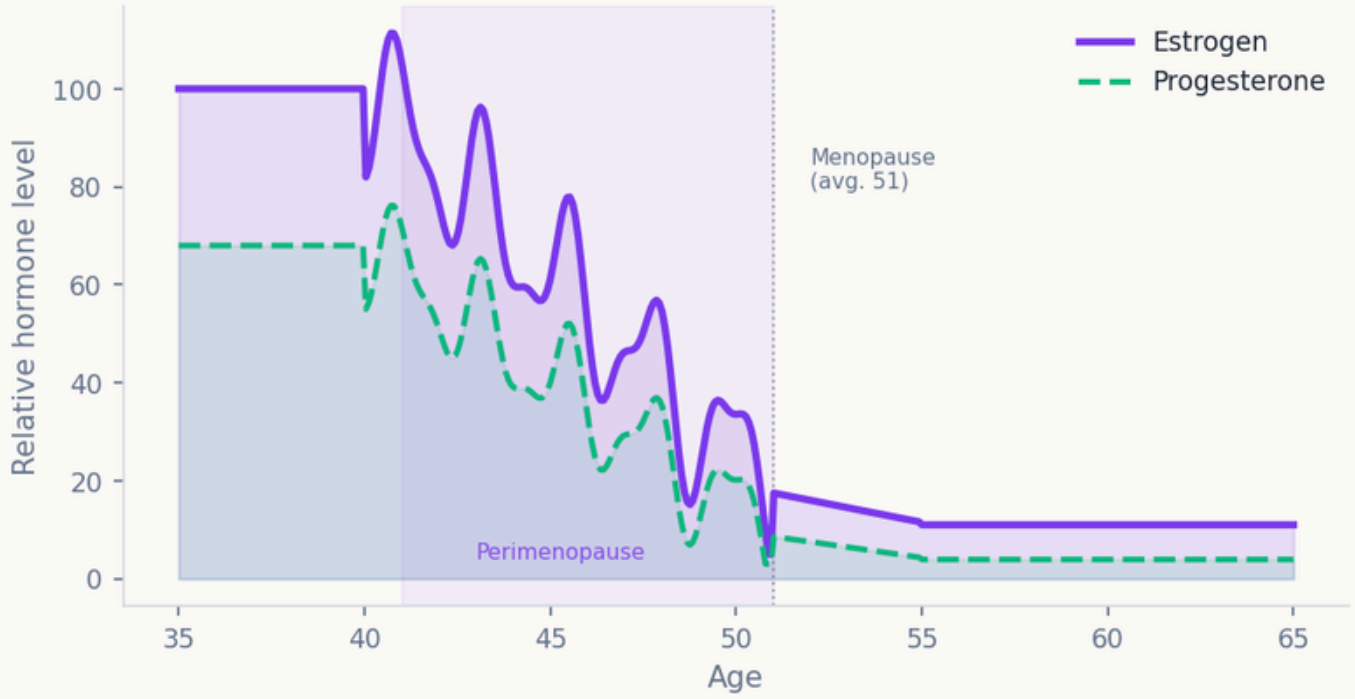
Neither of you is exempt from hormonal change in midlife. Hers is faster, more disruptive, and more visible. But the parallel is real. If your own energy, mood, or libido has shifted in ways you have not fully explained, the hormonal picture is worth examining. A doctor can run a simple testosterone panel. The point is not to compare experiences. It is to understand that this is biology, not choice, not weakness, for either of you.

[3] Feldman HA, et al. Age trends in the level of serum testosterone and other hormones in middle-aged men. J Clin Endocrinol Metab. 2002;87(2):589–598. PMC1502324

Graph above: Illustrative, based on published patterns of estradiol variability during the transition and age-related testosterone decline. Individual variation is large.

What her hormones are doing

Estrogen and progesterone don't decline in a straight line like testosterone does in a male after the age of 30.[4] They fluctuate wildly before the long-term drop begins. This is why she can feel fine on Monday and completely undone by Thursday.



The shaded band is perimenopause: the transition phase before her final period. The irregular spikes in that window are not anomalies. They're normal. The sharp drop after menopause (around age 51) stabilizes to a lower, consistent baseline.

Note: these are relative levels. Individual variation is significant.

Why unpredictability is the point

Her good days are not evidence it's over. Her bad days are not permanent. Both are part of the same hormonal pattern. Consistency from you matters more during the swings than during the calm.

What she may be experiencing

Perimenopause has over ***30 documented symptoms***.[5] Not all women experience all of them. Most women experience at least several. Below are the most common.

Hot flashes and night sweats

Sudden heat surges, often at night. Can soak sheets. Disrupts sleep.

Sleep disruption

Difficulty falling asleep, waking at 3 AM, non-restorative sleep.[6]

Brain fog

Slowed thinking, poor word recall, difficulty concentrating.[7]

Mood changes

Irritability, anxiety, low mood. Often cyclical or unpredictable.[8]

Physical changes

Joint pain, weight redistribution, changes in libido and vaginal health.

You're not imagining it

The research gap in women's health is not a small problem. Women are 51% of the US population. Yet women's health research receives under 8% of the NIH budget, and menopause specifically receives less than 1% of that, roughly $56 million a year against a $47 billion NIH budget.

For decades, medical research excluded women of reproductive age from clinical trials, citing hormonal complexity as a confounding variable. The long-term result is a knowledge deficit that affects every woman who goes through menopause.

42%

of women who sought help for symptoms received no treatment advice from their doctor

1 in 3

women who sought GP help for symptoms were not adequately diagnosed or treated

Here is what that failure has done to households. She was told her symptoms were anxiety, stress, or just aging. So at some point she may have stopped explaining them, because explaining them got her nowhere. That means the first place you noticed a change may not have been a conversation. It may have been the relationship itself: the distance, the shorter fuse, the sense that something was off. No one gave her a framework. No one gave you one either. So you did what anyone would do without information. You took it personally.

This is not her fault. It is not your fault. It is a structural failure that predates all of us.

The practical implication: she has probably been told, at some point, that what she is experiencing is not that bad, is anxiety, or is just aging and she may have started to believe it.

YOUR ROLE

Believe how her body is treating her. That is the foundation everything else is built on.

She is not
falling apart.

CHAPTER 01 — TAKEAWAYS

What to remember

1 Perimenopause is not menopause

Perimenopause is the transition. It lasts years. Menopause is the so called finish line, defined as 12 months without a period.

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2 Female hormones don't decline linearly like males

They spike, drop, and spike again. Her good days don't mean it's over. Her bad days don't mean it's permanent.

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3 The research gap is real

Women's health has been underfunded for decades. Her difficulty getting answers reflects a system failure, not a personal one.

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4 Belief is the baseline

Everything else in this guide depends on whether you believe what she is telling you about her experience. Start there.

MENOPAUSE SCIENCE

02

CHAPTER 2

The B.A.S.I.C.S.

Six symptoms. What they are, what causes them, what they feel like from the inside.

B is for Body Changes

Falling estrogen alters how her body stores fat, builds muscle, and maintains collagen.

Metabolism slows. Joints stiffen. Skin loses firmness.

WHAT YOU'LL NOTICE

She may say her workouts don't work the same. Clothes fit differently even at the same weight. She might mention feeling puffy or that her body feels foreign.

PLAYBOOK TIP

Focus on health together, not on her weight. Train. Eat protein. Drink less. Lead by example, not instruction. The single fastest way to make this worse is to comment on her body. Think of this as an opportunity to adopt a healthier lifestyle that could benefit both of you.

5–8 lbs

Average weight gain during perimenopause, mostly abdominal

Source: Office on Women's Health, 2025

A is for Arousal

Falling estrogen and testosterone reduce blood flow and natural lubrication.

Arousal slows. Sex can become uncomfortable. Emotional closeness may still feel strong, but physical desire often drops.

WHAT YOU'LL NOTICE

Sex happens less often. She may avoid it because it hurts. She may seem detached even when emotionally connected. She may not bring it up because it hasn't felt safe to, or because she has been managing it alone long enough that she doesn't know how to start.

PLAYBOOK TIP

Do not take it personally. Do not push for frequency. Keep affection on the table without sex attached to it. If she mentions pain or dryness, encourage her to ask her doctor about local estrogen and lubricants. Both are highly effective and dramatically underprescribed.

58%

Of women report changes in sexual desire or comfort during perimenopause

Source: Khani S, Azizi M, et al. 2021

S is for Sleep Disruption

Estrogen and progesterone help regulate body temperature and the circadian rhythm.

As they fall, night sweats jolt her awake.[9] Lower progesterone, a natural sedative, makes it harder to fall back asleep.

WHAT YOU'LL NOTICE

She is up between 2 and 4 a.m. and can't get back. She is short on patience by 7 a.m. She may start sleeping in another room just to stay cool. None of that is about you.

PLAYBOOK TIP

Cool the room to 65°F or 18°C. Switch to breathable bedding. Take morning duties for a stretch so she can sleep in. Protect her sleep like an asset. One bad night magnifies every other symptom on this list.

40 – 60%

Of women in perimenopause report sleep disturbance

Source: Baker FC, et al. Nat Sci Sleep, 2018

I is for Irregular Periods

As ovulation becomes inconsistent, cycles shorten, lengthen, or skip.

Flow can change. Heavier, lighter, or much longer than before.

WHAT YOU'LL NOTICE

She might mention that her period feels unpredictable. Heavy months (my mother's last period was 143 days, which is not typical but does happen). Skipped months. Embarrassment when it catches her off guard. Anxiety about whether something is wrong.

PLAYBOOK TIP

Keep supplies at home and in the car. Offer to handle laundry or errands when she is tired. Know the red flags: bleeding that lasts more than 14 days, soaking through a pad or tampon every hour for several hours, or any bleeding after menopause all need medical evaluation. These are examples, not the full list. If a bleeding change worries her, that alone is reason to see a doctor. Remember, this is educational only, not medical advice.

100%

Menstrual cycle change is not a side effect of perimenopause. It is the definition. The transition is diagnosed by cycles that vary by 7+ days, then by skipped periods.

Source: STRAW+10 staging system (Harlow et al., Menopause, 2012)

C is for Cognitive (Brain Fog & Mood)

Estrogen supports the neurotransmitters that drive focus, memory, and emotional regulation.

When estrogen swings, so do attention, word recall, and mood. Many women describe it as not feeling like myself.

WHAT YOU'LL NOTICE

She is distracted. She forgets things mid-sentence. Tasks she handled easily feel overwhelming. Small frustrations trigger outsized reactions, often followed by guilt or tears.

PLAYBOOK TIP

Do not correct her. Do not tell her to relax. Offer practical structure: a shared calendar, written reminders. Mood changes during perimenopause are neurological in origin, not character, not a choice. They are distinct from clinical depression, but both can occur.[10] If her low mood is persistent and not cyclical, that warrants clinical evaluation, not more patience.[11]

60%+

Report problems with memory, focus, or mood during perimenopause

Source: SWAN Study (Freeman et al. 2014); Maki PM, et al. Climacteric, 2019

S is for Sweats & Hot Flashes

Falling estrogen throws off the brain's thermostat in the hypothalamus.

It misreads normal body temperature as too hot and triggers a full cooling response. Flushed skin, racing heart, sudden sweat. Day or night.

WHAT YOU'LL NOTICE

She might suddenly strip off layers, fan herself, or wake drenched. Sleep gets disrupted for days. Mood and patience erode in step.

PLAYBOOK TIP

Stay calm. Help her cool down without making it a thing. Lower the bedroom temperature. Skip the comments about it being just a hot flash. It is not trivial. It is her hypothalamus malfunctioning under hormone pressure she cannot will away.[12] [13] Frequent hot flashes are also increasingly linked to cardiometabolic risk markers, including insulin resistance.[14]

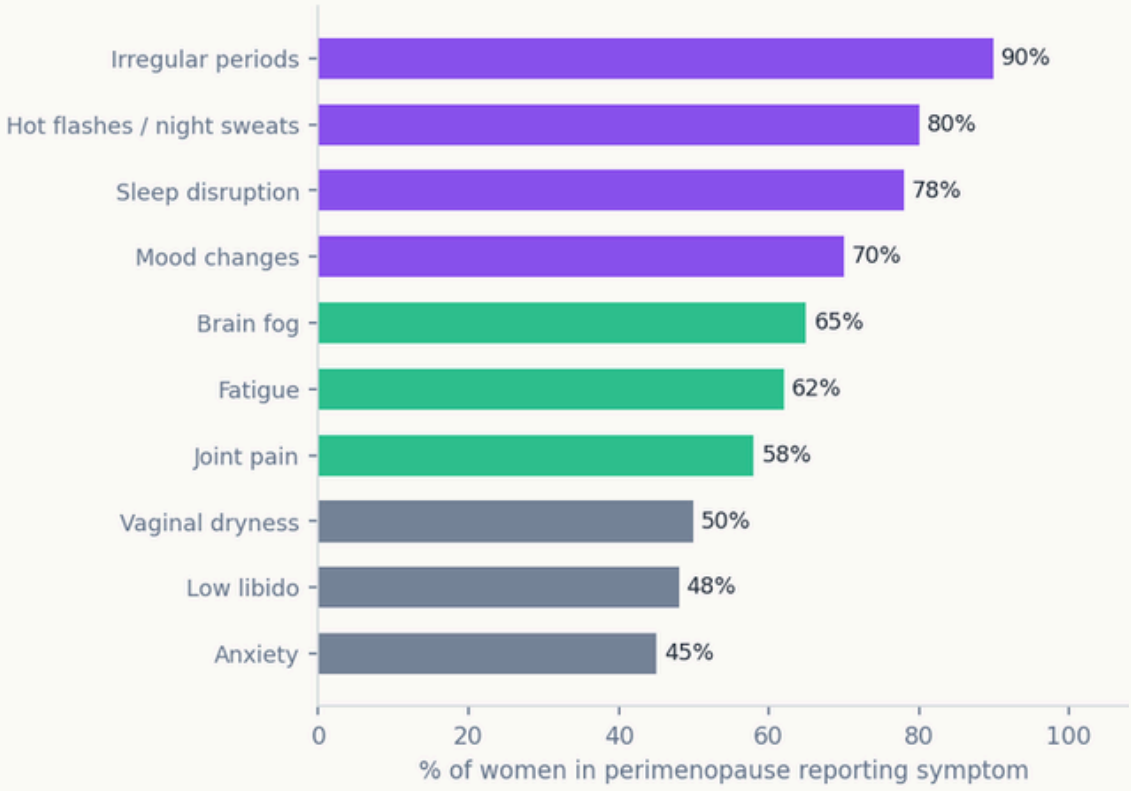
75%

Of women experience hot flashes or night sweats; over half experience them for 7+ years

Source: Avis NE, et al. JAMA Intern Med, 2015

How common is each symptom?

Survey data across multiple studies on women in the perimenopausal transition.[5]



These are not edge cases. Every symptom on this chart affects the majority of women going through this transition.

Sources: Freeman et al. 2014, SWAN Study data, Shifren et al. 2008.[5] [15]

Surgical menopause

If she has had her ovaries removed (oophorectomy), either as a standalone procedure or as part of a hysterectomy, she has experienced surgical menopause.

What makes surgical menopause different

Natural perimenopause unfolds over years. Surgical menopause is immediate: hormones drop to postmenopausal levels within days of surgery. Symptoms can be sudden and severe. The psychological adjustment is also faster and often harder, particularly for women who were not expecting it or who had the surgery for a reason other than menopause.

If she has been through surgical menopause and is not on hormone therapy, she may be managing a full hormonal cliff without support. This is worth raising with her doctor.

Surgical menopause before age 45 is associated with increased risks of cardiovascular disease, osteoporosis, and cognitive decline in the long term, independent of the condition that required surgery.

HRT is especially well-supported for women who undergo surgical menopause. The benefit-risk profile is strongly positive when started in the early postoperative window.

If her ovaries were removed before 45

This is the group where the abrupt hormonal drop carries the most long-term risk, and where HRT is most clearly the standard of care. If she is not on it and has no medical reason to avoid it, that is worth understanding. Bring it up as a question for her doctor, not a pressure on her.

Source: Rocca et al., Mayo Clinic Study of Aging; Faubion et al., Menopause Society guidance on surgical menopause

B.A.S.I.C.S.

Quick reference card

B

Body changes

Weight, joints, skin, hair. Average 5–8 lbs gain during perimenopause.

A

Arousal

Libido drop, dryness, discomfort. Often undertreated. Highly treatable.

S

Sleep disruption

Waking 2–4 a.m., night sweats. Compounds every other symptom.

I

Irregular periods

Heavier, lighter, missed. 90%+ experience noticeable cycle changes.

C

Cognitive

Brain fog, memory slips, mood shifts. Biological, not character.

S

Sweats

Hot flashes day or night. 75% of women experience them.

MENOPAUSE SCIENCE

03

CHAPTER 3

The Cognitive Load

What she is carrying. How to take real parts of it off her plate.

Her brain is doing more

Before the hormonal symptoms started, she was probably already carrying a disproportionate share of the household's mental load. Most women in heterosexual partnerships carry more of it. The research on household labor is consistent on this.

Now add disrupted sleep, brain fog, joint pain, and unpredictable mood. Add a medical system that frequently dismisses her. Add the ongoing management of her own symptoms while continuing to manage everything else.

The cognitive load did not increase because perimenopause started. Perimenopause made the existing load harder to carry.

Was already doing

- Track the family schedule
- Manage appointments
- Anticipate needs
- Monitor emotional climate
- Remember every deadline
- Hold the mental map of the household

Now also doing

- Continue working at full capacity
- Navigate the medical system
- Manager her own symtoms
- Manage others' perception of her
- Research her symptoms
- Protect you from the full picture

What you see vs. what you don’t

Most men don't see it until it stops.

The items on the left are visible. You probably notice them. The items on the right are invisible. You probably don't.

Visible Work	Invisible Work
✓ Cooked dinner	→ Remembered the permission slip
✓ Did the laundry	→ Tracked everyone's appointments
✓ Ran school drop-off	→ Noticed the milk before it ran out
✓ Paid the bills	→ Managed the emotional temperature
✓ Went grocery shopping	→ Planned her mother's birthday
	→ Worried about money at 3 AM
	→ Held the mental load for the family

The invisible column is not a list of complaints. It is the operating system of the household. It runs in the background, all the time, and she is the only one who can see it.

> **THE POINT**
>
> The goal is not to thank her for it. The goal is to take pieces of it permanently.

Own something permanently

Helping is not the same as owning. Helping means she asks, you do it. Owning means it never leaves your list. Here are five to choose from:

Book medical appointments

She shouldn't spend cognitive energy managing logistics on top of symptoms.

Run school logistics and extracurriculars

Forms, pickups, who needs to be where. Hold the schedule so she doesn't have to worry.

Manage grocery restocking

Don't wait to be asked. Notice something is low? Restock.

Handle family communications

Birthdays, RSVPs, group texts, reminders. Become the one who remembers.

Managing finances and bills

Due dates, statements, the annual renewals. She stops being the one who tracks what's due. You take over.

Pick two. Own them completely, starting now. Not as a favor, and not for credit. The goal is that she feels the load get lighter without having to ask. That is what she will remember.

The workplace is part of this

The cognitive load doesn't stop at the front door. She is managing symptoms at work too.

Brain fog in a meeting she needs to perform in. A hot flash during a presentation. Exhaustion that makes a full day feel like two. The mental calculation of whether to tell anyone, and what it will cost her if she does.

Most women do not disclose perimenopausal symptoms at work. The professional consequences of being perceived as less capable or emotionally unstable are real and well-documented.[16]

1 in 4 women say perimenopausal symptoms have negatively affected their career performance or progression[17]. Most never told anyone at work.

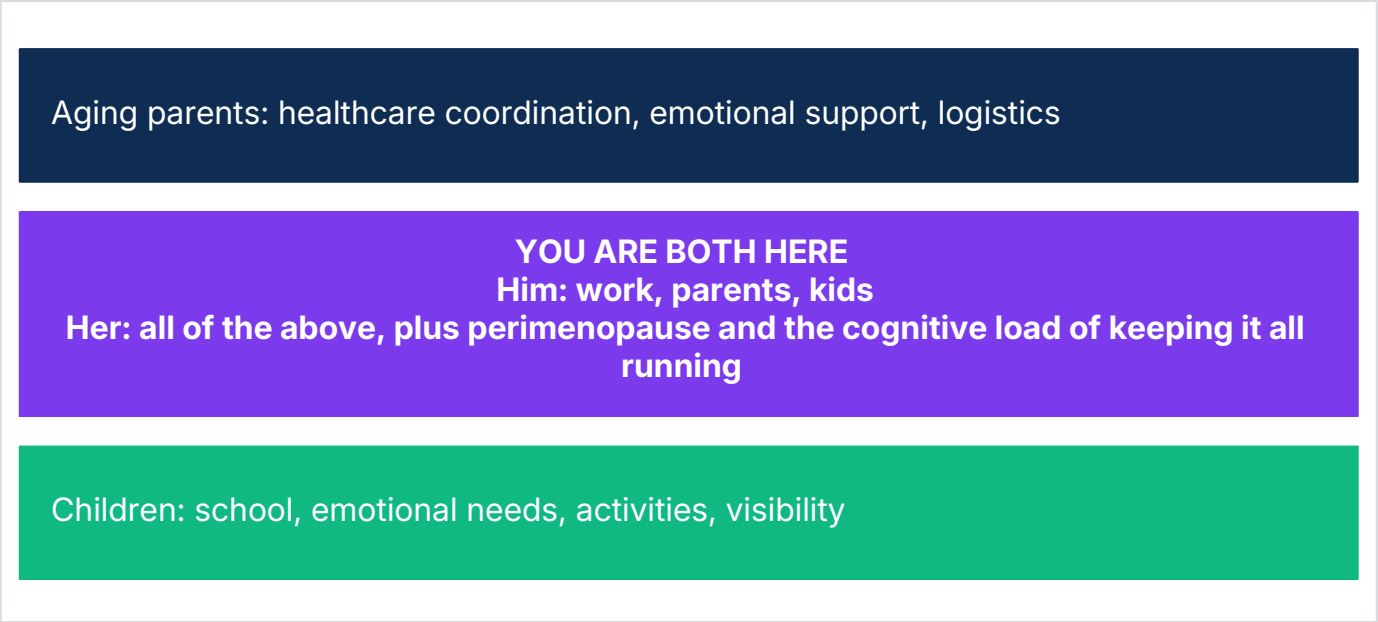
What you can do with this: be aware that she's managing two jobs simultaneously, and that the job she's doing at home has a direct effect on her capacity at work. Reducing the home cognitive load is not just a domestic gesture. It frees up capacity she needs at work while she manages these symptoms.

The sandwich generation

Many midlife men and women going through perimenopause are simultaneously managing children at home and aging parents who need increasing support. This is called the sandwich generation: squeezed from both sides at once.

The average age of perimenopause onset (mid 40s) aligns almost exactly with the age at which parents begin to need care management, and children are in the most demanding phases of school and adolescence.

This is not a coincidence of timing. It is a structural reality for many in midlife.



You are in this squeeze together. The difference is she is also managing the mental load of it, and doing it through symptoms you do not have. You cannot remove her parents' or your children's needs. You can carry more of the coordination, so the squeeze is not hers to hold alone.

The reallocation

This is not about doing more chores. It is about restructuring which cognitive tasks live in whose head.

Was: She tracks the fridge

Now: You track the fridge. You don't ask if something is low. You check. You restock.

Was: She manages the calendar

Now: You have full visibility of the calendar. You enter events. You flag conflicts.

Was: She coordinates care

Now: If there are children or aging parents, you take a named domain. Fully.

Was: She manages her appointments

Now: She manages her own medical calendar. You take everything else.

Was: She absorbs household tension

Now: You notice tension in the household and address it before she has to.

Own something.

CHAPTER 03 — TAKEAWAYS

What to remember

1 The cognitive load was already there

Perimenopause didn't create it. It made the existing load harder to carry with less sleep, less cognitive bandwidth, and more to manage medically.

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2 Invisible work is real work

The mental operating system of the household is labor. Not acknowledging it is not the same as it not existing.

---

3 Own, don't help

Helping means she asks. Owning means it never reaches her. Pick domains and take them off her list permanently.

---

4 She may be sandwiched

Children, aging parents, work, her own body. The most useful thing is removing tasks, not adding support.

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2

PART 2

Cope: Navigation & Resilience

What this is doing to you, and how to stay steady while it does.

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04

CHAPTER 4

The Toll

What this is doing to you, and why saying so is not a betrayal of her.

It's happening to you too

Part 1 was about her. Part 3 is about what to do. This part is the bridge, and it is about you. It is here for a practical reason: you cannot show up steady for someone while you are coming apart and acting like you are fine. Most men try exactly that. It works for a while, then it stops working, usually at a bad moment.

BOTH ARE REAL

What she is living through is real. What you are living through is real. They are two sides of the same transition, and they do not compete for the same space. You have probably spent years being told, directly or otherwise, that your side doesn't count right now. This guide is not going to tell you that.

You do not have to earn this by suffering quietly first. The next three chapters are about your side of it. What this does to you, why it is hard, and how to adapt without dropping the ball. Get your footing here, then you can actually show up for her.

You are not the anomaly

Most men going through this assume they are the only one finding it hard. The data says otherwise.

In the MATE survey, a 2019 study of 450 US men with partners in the menopause transition, 63% said their partner's symptoms affected them. Of those, 77% said the impact on them was negative, and more than half said it was straining the relationship.[18]

What the numbers say

In the follow-up survey, nearly half of men said their own aging made their partner's transition harder to navigate, and frustration was the most commonly reported feeling.[19]

What they mean

If this chapter reads like your house, you are in the majority, not the minority. The feelings on the next pages are the norm for men in your position. Almost none of them say so out loud.

That silence is the problem this section solves. You cannot deal with a feeling you have not named.

No study has measured the loneliness or grief of male partners. The numbers prove how common the impact is. The next pages give it some language.

What it looks like from the inside

1

Invisible

How you are doing stopped being a question anyone asks. Her situation always felt more urgent, so yours got filed as trivial, then as nothing. When someone does ask, you answer with an update on her. Most men start to do this without noticing.

2

Eggshell fatigue

You read her tone before you speak. You check the emotional weather when you walk in. You run the same calculation before asking for anything: does she have room tonight, or does it wait? Running like this all day for years produces a tiredness that more sleep will not fix.

3

The vertigo

What was fine yesterday is a problem today. What she needed this morning is the wrong move tonight. After enough rounds you stop trusting your own read. Her hormones swing within a single cycle. You are riding that same instability just from the outside.

4

Unwanted

Not only the sex. The hand on your back. Being kissed goodbye like it means something. When casual touch goes quiet long enough, you notice you are being handled like a housemate. Chapter 02 covers why it is physiology, not a verdict on you.

The heavier four

5 Resentment, and the guilt under it

You watch your words, handle the logistics, extend grace daily, and much of it lands as if you did nothing. Resentment builds. Guilt follows, because you are supposed to be the steady one. Left alone, it leaks out as coldness or a short fuse.

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6 Loneliness

Your person is in the house and you are alone. The one you used to debrief the day with is the one you can no longer debrief the day with. Almost no one warns men about this part. Most men report it as the heaviest.

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7 Grief

You are grieving a partner who has not left. The version of the relationship you planned on is suspended, and no one can tell you for how long. Feeling it is not disloyal. It is the normal response to something you love changing without your consent.

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8 Helplessness

More chores did not fix it. Patience did not fix it. Raising treatments the wrong way made it worse. You are wired to solve, and this does not respond to solving on your timeline. The next chapter covers what helplessness turns into when it goes unattended.

The two feelings men don't admit

These two get their own page because they are the reason everything else in this chapter goes unsaid.

Fear
Is she done with me. Is this the beginning of the end. Would she be happier without me. You have run one of these at 2am. Almost every man has. Almost none say it. Unsaid fear becomes Chapter 05.

Shame
Shame that you resent her while she is suffering. Shame that you miss sex. Shame that you have imagined a simpler life, then felt worse for it. None of it makes you a bad partner.

IF YOU ONLY REMEMBER ONE THING

NFeeling this is allowed. Handing it to her is not. This chapter is for understanding your own side of it, on your own. The rest of the guide is for what you do about it. Keep those separate. Blur them and you become one more thing she has to manage.

The standard advice says park your needs. Parked needs do not disappear. They leak out, usually at her. ***Needs do not get parked. They find a way out****. Chapter 6 is about choosing which way.*

MENOPAUSE SCIENCE

05

CHAPTER 5

The Trap

The moves that feel like relief and cost you the relationship.

Four moves that feel like coping

1

Withdrawal

Bury yourself in work, spend all your time in the garage, on the phone. Technically present, functionally gone. It feels like self-protection. But you disappear during the window she can feel alone, and your consistency matters most during her swings. To her it can read as one more person dismissing.

2

Scorekeeping

The ledger feels like fairness, but it is rigged. It records your deposits and none of hers, because her load is mostly invisible to you. The math always says you are owed. And the list eventually gets read out loud, mid-fight. It has never once improved one.

3

Ego defense

Her lost libido becomes a verdict on you. Her sharpness becomes an attack. But these changes are physiology, not her assessment of you. Ego defense converts a medical fact into a personal wound she now has to manage on top of her symptoms.

4

Helplessness into anger

The one most men will not admit to. When you cannot fix it and cannot get seen, helplessness converts to anger, usually at night, when the fuse is short. One bad night can undo months of steady showing up.

CHAPTER 05 — THE TRAP

The fifth move, and what ties them together

There is a fifth move that hides inside the other four, and a single thread that connects all of them.

The quiet fifth: martyrdom

Suffering visibly while never stating a need. The heavy sigh. 'I'm fine.' The request never gets made, so it never gets answered.The tell: you make sure she sees the effort, and never say what you actually want.

The common thread

All four moves are attempts to feel something other than helpless. The helplessness is not the problem. What you do to escape it is. Each move hands her a feeling she did not cause and cannot fix.

Chapter 06 is the one exit that does not route through her.

Each move works for about an hour. Each one makes the next month worse.

MENOPAUSE SCIENCE

06

CHAPTER 6

The Outlet

Where the feeling goes, so you can come back steadier.

CHAPTER 06 — THE OUTLET

Somewhere that is not her

You need an outlet that is not her. This is not optional and it is not weakness. If she is your only outlet for what this transition is doing to you, she is now responsible for both sides of it, hers and yours. She cannot carry that, and the attempt is what produces every move in the last chapter.

Where it goes
A friend, told plainly: 'Home is hard right now and I need someone to say that to.' A men's group. A therapist. A community of men in the same phase. What matters: it exists, and it is not her.

Your own body first
Broken sleep, no movement, and arriving home running on empty lose you moments you would otherwise handle. A regulated body is the difference between responding and reacting.

What does not work: drinking as a nightly routine, the coworker who really listens, the affair you have decided you would never have. Those are exits, not outlets. You already know this. I'm just confirming it for you.

Most men have nobody to ask and nowhere to go. That is not a personal failing. It is a hole in how men are supported through midlife. Finding your outlet is part of the work. The resources section at the back is where to start. Some health insurance plans will help cover costs associated with mental health. Worth taking a look at your benefits if you have them.

The one conversation you're allowed to have with her

Everything in this section says your feelings get handled somewhere that is not her. That stands. But there is a difference between unloading on her and letting her know you exist.

Once, on a calm day, at a neutral moment, never during or after a fight, you are allowed to say something like:

“I know you're carrying a lot right now. I'm not asking you to fix anything. I just need you to know I'm finding this hard too, and I miss you. That's all. Nothing to solve.”

Then stop talking. No examples. No ledger. No negotiation.

Said once, without an agenda, this does two things. It keeps you from disappearing in your own house. And it offers her something she may want more than you realize: five minutes of being a partner instead of a patient.

If she cannot receive it that day, do not take it back and do not repeat it that week. Trust that she heard it.

Both things are true

Your feelings are real. They are also not her fault, and they are not her bill to pay. Both are true at the same time, and holding both is the job. Men who drop the first half turn into martyrs and eventually detonate. Men who drop the second half turn into one more thing she has to manage, at the moment she has the least left to manage with.

None of this means going quiet. Talking about your day, your work, the things you are worried about is not a burden on her, that's part of a relationship. Asking for what you need is not a burden either. The thing to avoid is narrower than it sounds: making her responsible for how you feel, at the point where managing how she feels is already taking everything she has.

A woman who wrote in has been on HRT for two years with no improvement. She still makes sure her husband gets hugs and small touches every day, and tells him she loves and respects him. "None of this is his fault," she said. Her story is on page 82. Menopause is not a one-way arrangement, and she knows it better than you do.

You feel it, you take it somewhere useful, you ask for what you need, and you stay.

Say it. Don't make it hers to fix.

That is the whole loop. You do not come back with a speech about your week. You come back steady, and you carry your share. Chapter 9 is on how you do that.

What remains is Part 3: the doctor visit, the treatments, the protocols at home. You will run all of it better for having read these three chapters, because steadiness is easier to fake for a week than for a decade, and she can tell the difference. This section is what makes the steadiness real.

READER STORY

Therapy date night

A story from Geoff in Toronto, Ontario. Shared as submitted, edited only for spelling, with his permission.

It was 1.5 years since my wife and I were last intimate. I also initiated the majority of the affection and was constantly being rejected and even pushed away for giving a gentle hug or peck on her cheek. I felt a growing discomfort and dread with how my wife and I were growing too far apart. Somehow we were really good roommates and able to effectively navigate domestic and life things really well, but our relationship was suffering greatly.

For me, the “rock bottom” moment was when I asked my wife out on a date night – a simple dinner and theater date. Her response, “Why? We don't do stuff together anymore. I'm too busy and I've filled up my time doing other things now.” Yikes.

Before this there were other signs beyond a dead bedroom and date night resistance. She insisted on waking up early at 5am to go to the gym and, therefore, needed to go to bed early – except that she would regularly go out with friends and return home at 11:30pm many times each week. Date night with hubby was a firm “Why” but date night with friends was always a yes. She also said perplexing things like, “You're not kind” and “You're too independent” and, my favorite, “Are you getting a handjob from your chiropractor?” I felt that logic and reasoning wasn't going to get us out of this rut. We needed help and a different perspective.

WHAT HE RAN

What you just read is Move 2, *Scorekeeping,* from Chapter 05.
Watch what he does with it.

The talk, and the ask

One evening I asked her if we could talk. I told her things like, “I'm concerned we are growing apart... I miss spending time with you... I loved it when we would spend time with one another... I deeply miss affection and sex... I'm very concerned that we will have nothing to do with one another when our son leaves for university...” I kept the focus on how I was feeling rather than what she was (not) doing.

Although we agreed to things such as “weekly date nights,” weekly “let's talk” touchpoints to talk about relationship things, and she would reduce her evening commitments that took her out of the home so often, our habits were very slow to change.

“I think we need to see a couples therapist together,” I said.

“Oh. I didn't think we had a broken relationship,” she replied.

“We don't have a broken relationship, yet, but I feel we're headed in that direction. You have every right to be happy, fulfilled, and healthy, but I'm a part of that being in your life. I don't know what to do.”

Fast forward to our first “therapy date night,” as I came to call it. She wasn't amused and dreaded it every time we went. She was terrified that we were going to “open the flood gates.” “Good, better out than in,” I said as I held her hand walking into the office. I was just excited that we were finally doing something meaningful to help our relationship.

Inside the sessions

The first few meetings with our psychologist were to cover intros and “getting to know you” sort of things. We had a “What do you want to get out of couples therapy?” intro talk, then she and I met with her separately for 1:1s to answer her questions about our upbringing, relationships with our parents, what we thought was working / not working about our relationship, etc.

Our therapist stressed that “I'm focusing on your 'relationship' but not any of you specifically. One week we might chat a little more about hubby and another week we might chat more about the wifey. I'm just trying to work with both of you on the issues you face.” I appreciated this perspective, as did my wife.

Importantly, our therapist also asked us, “What do you want to accomplish? Do you want to get a divorce and figure out how to navigate it effectively? Do you want to stay together? Or are you not sure and want to figure out what you want to do?” My wife said she wanted to stay together. I said, “I prefer to stay together, but only if my wife will be happy.”

Throughout the therapy sessions, we talked about the usual stresses in marriage: kids, finances, domestic life, careers, family relationships, etc. Overall, therapy was beneficial because we both assumed positive intent and were able to understand where we were each coming from. Furthermore, the understanding was being facilitated by an independent, impartial third party, which made the learnings and resolutions more digestible (i.e. rather than me “telling” my wife “You need to do X more,” it was much better having the therapist tell her that).

READER STORY

What changed

My wife's “I do all the domestic work around the house” turned into, “My husband does the majority of domestic work and he 'leaves stuff' because he simply needs a break at the end of the day.” She learned strategies for accepting and communicating her needs / wants / concerns without her feeling she was being negative. I learned that a very negative romantic relationship she had when she was a teenager meant that I was inadvertently triggering these memories / worries in some of my actions. I also learned strategies to be a better empathetic listener.

We continue to practice our new behaviours even today. We both have a lot to learn / practice to “get it right” still. Overall, therapy helped us change how we framed one another's actions in a more neutral/positive light. Therapy has provided us with a stronger, more empathetic foundation for us to “work on” other aspects of our relationship in the future. Although I would strongly recommend couples therapy to any couple at any time, I view it as a critical part of helping a couple navigate the menopause phase of life.

WHAT HE RAN

He owned his side without blaming her. He kept the ledger shut instead of reading it out mid-fight. He took the problem to a third party instead of putting it on her. Then he stayed. The order matters: the conversation came first, the therapist second, the scorecard never.

MENOPAUSE SCIENCE

3

PART 3

Act

What to actually do: the doctor, the treatments, the playbook at home.

MENOPAUSE SCIENCE

07

CHAPTER 7

The Doctor Visit

Why the system fails her. How to navigate it anyway.

The system fails women

The medical system is not designed well for perimenopausal women. This is documented, not an opinion.

Average GP appointment: 15 minutes

Not enough time to describe complex, multi-system symptoms that have developed over years.

Menopause training in medical school

A 2023 survey of US OB/GYN residency programs found only 31% had any menopause curriculum. This is the specialty meant to lead on women's health. Only 6.8% of residents across specialties felt prepared to manage menopause.

Symptom attribution bias

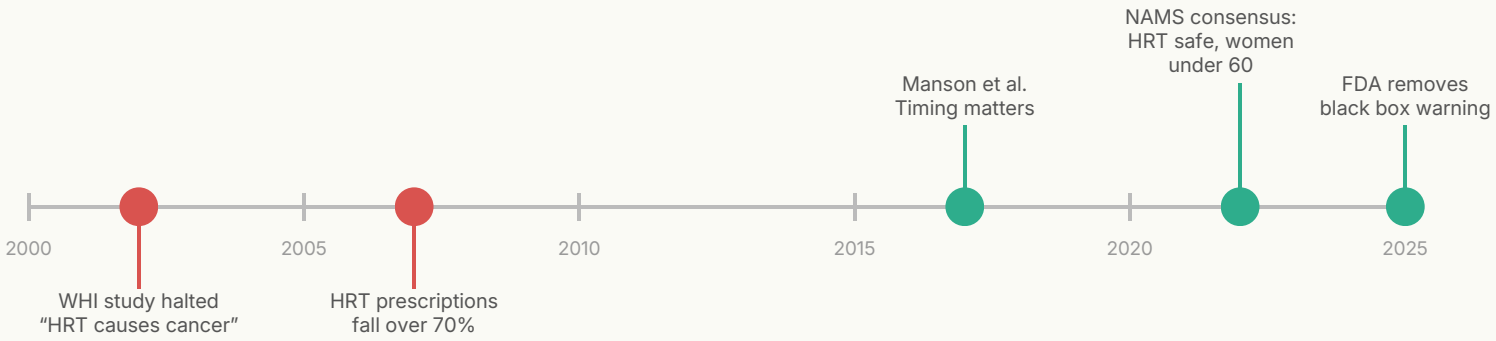
Mood symptoms are frequently attributed to depression or anxiety, not hormones. Women are prescribed antidepressants instead of HRT or other forms of treatment.

The WHI shadow

A flawed 2002 study scared a generation of doctors off prescribing HRT. Many still practice under those assumptions.

The WHI study and what it actually found

In 2002, the Women's Health Initiative (WHI) published results showing that combined estrogen-progestin therapy increased the risk of breast cancer and cardiovascular disease. HRT prescriptions dropped over 70% within two years. That overreaction was based on an overgeneralization of the data.[20]



The WHI study was conducted on women with an average age of 63. Most were a decade or more past menopause.[21] The "timing hypothesis" now shows that HRT started within 10 years of menopause (or before age 60) has a profoundly different, and substantially more favorable, risk profile.[22] [23] [24]

Manson's 2017 reanalysis (JAMA) found that among women who started hormone therapy between 50 and 59, mortality outcomes were more favorable than for women who started in their 70s. During the treatment years, the younger group's all-cause mortality was about 31% lower (HR 0.69), though over the full 18-year follow-up that gap narrowed. The age pattern is the point: when you start matters.

What the evidence actually says

Claim: HRT causes breast cancer

Evidence: Combined HRT (estrogen + progestin) is associated with a small increased risk after 5+ years of use. Estrogen-only HRT (for women without a uterus) is associated with a reduced breast cancer risk.[26] Transdermal HRT carries lower clot risk than oral.[26]

Claim: HRT causes heart attacks

Evidence: The WHI result applied to older women. Started within 10 years of menopause, HRT is cardioprotective in most women with no pre-existing cardiovascular disease.[25]

Claim: Natural menopause is safer

Evidence: Untreated menopause carries its own risks: bone loss, cardiovascular risk, cognitive decline, and reduced quality of life. These are not trivial.[27]

Claim: HRT should only be short-term

Evidence: NAMS 2022 states there is no mandated limit on HRT duration for women who are benefiting. Duration is a shared decision with an informed clinician.[25]

4 questions she can ask her doctor

You can share these with her if she wants them as a starting point for the appointment. But don't push.

1 **Is what I'm experiencing consistent with perimenopause?**

Opens the diagnostic door. Forces the doctor to engage with the hormonal frame.

2 **What are the treatment options, including hormone therapy?**

Ensures HRT is part of the conversation, not excluded before the consultation starts.

3 **Are you familiar with the NAMS 2022 guidance on HRT safety?**

Screens the doctor. An informed menopause specialist will know this document.

4 **If you're not recommending treatment, what is the clinical basis for that?**

Requires the doctor to justify inaction. Normalizes evidence-based pushback.

Bone health: ask whether a bone density scan (DEXA) is indicated. Bone loss accelerates significantly during perimenopause and the first years post-menopause.[28]

When she gets dismissed

She may come back from a doctor's appointment with nothing. No diagnosis. No treatment plan. A suggestion to "try mindfulness" or a prescription for antidepressants she didn't ask for.

This happens. It is common. It is not the end.

WHAT SHE NEEDS FROM YOU

Not outrage on her behalf (unless she wants it). Not an immediate fix-it plan. Acknowledgment that she was not heard and that it is not her fault. Ask her what she needs next.

WHAT COMES NEXT

She can request a referral to a menopause specialist (often an OB-GYN or endocrinologist). She can see a different GP. She can go directly to a specialist who focuses on menopause. She does not have to accept the first answer she was given.

WHAT YOU CAN DO

Offer to help research a menopause specialist in your area. Offer to come to the next appointment if she wants company. Do not take over the appointment or speak on her behalf unless she asks. Offer to take notes during the appointment or advocate on her behalf if she is continuing to not be heard. Together, you can make a plan before the visit. Check out the Doctor appointment prep sheet on page 49.

How to find a menopause specialist

A general practitioner is not always the right starting point. A menopause specialist is a clinician who has specific training and experience in managing perimenopausal and menopausal symptoms.

1 **Check the NAMS provider directory**

The North American Menopause Society maintains a searchable directory of certified menopause practitioners (menopause.org).

2 **Look for NCMP or MSCP certification**

NAMS Certified Menopause Practitioner (NCMP) and Menopause Society Certified Practitioner (MSCP) are the relevant credentials.

3 **Telehealth options exist**

Platforms specializing in women's hormonal health have made specialist access significantly more accessible. A provider can often be seen within days, not months.

4 **Ask directly about HRT experience**

In an intake call or first appointment, ask how many patients they currently have on HRT and what protocols they follow. This surfaces competence fast.

Doctor Appointment Prep Sheet

Share this page with her, or tear it out

SYMPTOMS I'M EXPERIENCING (WITH DURATION)

HOW SYMPTOMS ARE AFFECTING DAILY LIFE

WHAT I WANT FROM THIS APPOINTMENT

QUESTIONS I WANT ANSWERED

REMINDER

She doesn't owe anyone an explanation for wanting to feel better. These symptoms are real and treatment options exists.

MENOPAUSE SCIENCE

08

CHAPTER 8

Treatments and Tools

What the evidence says about HRT, non-hormonal options, and lifestyle.

Three treatment buckets

There is no single treatment for perimenopause. There are three categories, which can be used individually or in combination.

Hormonal therapy

Replaces or supplements estrogen and/or progesterone. The most effective treatment for the core symptoms, especially hot flashes, sleep, bone health, and night sweats..

Non-hormonal options

Medications (SSRIs, SNRIs, gabapentin) and non-pharmaceutical approaches (Cognitive Behaviorial Therapy or CBT, CBT-I or Cognitive Behavioral Therapy for Insomnia) that address specific symptoms without hormones.

Lifestyle interventions

Sleep hygiene, exercise, nutrition, stress management, alcohol reduction. Modify symptom severity. Rarely sufficient alone for significant symptoms, but always relevant.

HRT explained

Hormone Replacement Therapy (HRT) replaces the hormones the ovaries are no longer producing reliably. It comes in several forms.

Estrogen-only

For women without a uterus. Patch, gel, or oral.

Combined (E+P)

Estrogen plus progestogen (synthetic or bioidentical). For women with a uterus. Protects the uterine lining.

Bioidentical HRT

Hormones chemically identical to the body's own. Can be FDA-regulated or compounded. Regulated options are preferred for safety monitoring.[29]

Transdermal (patch/gel)

Applied to skin. Applied to skin. Bypasses the liver, which is why it carries lower clot risk than oral. Preferred for women with clot risk factors.

Local estrogen

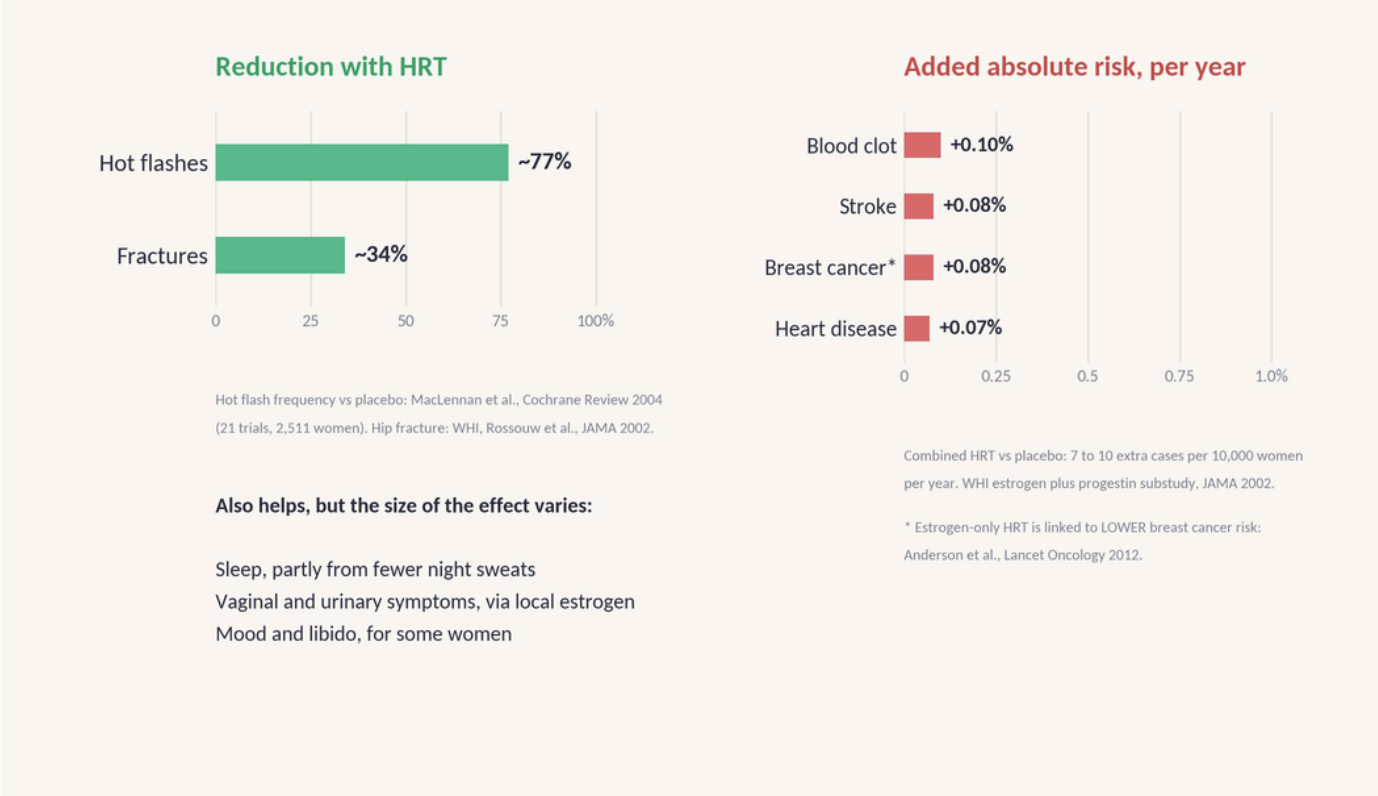
Vaginal cream, ring, or tablet. Targets vaginal dryness, irritation, and urinary symptoms. Very low systemic absorption. Does not require progestogen.

Testosterone (off-label)

Endorsed by 10 international medical societies for hypoactive sexual desire disorder (HSDD) in postmenopausal women.[30] Prescribed at physiological doses. Not FDA-approved for women in the US, widely used internationally by menopause specialists.

The risk-benefit picture

The evidence base for HRT has been substantially updated since 2002. This is what the current data shows.[25]



The added risks on the right are fractions of a percent: roughly seven to ten extra cases per 10,000 women each year. The benefits on the left are meaningful improvements in daily life.

Transdermal HRT carries lower blood clot and stroke risk than oral. Estrogen-only HRT does not carry the breast cancer signal that combined HRT does, and is linked to lower breast cancer risk.

The FDA update

November 2025

In November 2025, the FDA removed the boxed warning from estrogen-containing hormone therapy products, including patches, gels, oral estrogen, and low-dose vaginal estrogen. The Menopause Society backed the decision for vaginal estrogen, noting the warning "may have been a deterrent to the use of the low-dose vaginal estrogen," which it called a safe and effective therapy for a condition most menopausal women experience. Important: the removal was broad, but the clinical picture is not. Vaginal estrogen and systemic estrogen have different risk profiles. The Menopause Society and ACOG both cautioned that systemic estrogen still carries risks for some women and should be an individual conversation with her doctor.

Why this matters: local vaginal estrogen for GSM, vaginal dryness, discomfort, painful sex, is one of the most underprescribed menopause treatments. If her doctor has been hesitant, the specific warning that may have been the barrier is gone. For systemic HRT the label changed, but the clinical standard did not. The NAMS 2022 guidance below still applies.

THE NAMS 2022 POSITION

"For women who are younger than 60 years or who are within 10 years of menopause onset and have no contraindications, the benefit-risk ratio is favorable for treatment of bothersome vasomotor symptoms and for those at elevated risk for bone loss or fracture." — North American Menopause Society, 2022[25]

How to bring up HRT

Only do this if she has not already researched it herself. Many women have. Check before you educate.

If she brings it up

Listen. Ask what she's found. Ask what's stopping her. Don't immediately solve. She may need to think out loud more than she needs information.

If you want to bring it up first

"I've been reading about HRT and the updated evidence. I don't want to tell you what to do, but I wanted to make sure you'd seen it. Do you want to talk about it?" Then stop. Let her respond.

What not to say: "You should be on HRT." "Why haven't you asked your doctor about this?" "My friend's partner started it and she's completely different now." All three position her as the problem.

Introduce the information once. Leave the door open. Do not return to it unless she does.

A NOTE ON YOUR HORMONES

If you've been told your testosterone is low, that's worth its own conversation with your doctor. It has its own criteria and needs proper diagnosis, so it isn't a matter of doing what she's doing. But the timing is worth noticing. You may both be dealing with hormonal change at the same point in your lives, which makes this less her problem and more something you're both in. Raise yours separately, though. Not as part of this one.

If she doesn't want HRT

She may have decided not to pursue HRT. She may have reasons you don't know about: a personal or family history of breast cancer, a previous experience with hormonal medication, a deep distrust of pharmaceutical intervention, or a belief system that prioritizes non-medical approaches.

Some of those are clinical, some are personal. You don't have to find all of them persuasive. She's the one making decisions about her own body.

WHAT TO SAY

"I trust you to make the decision that's right for you. What can I do to make this easier?"

Non-hormonal options are real and useful. They're on the next pages. Work within her preferences, not against them.

You've given her the information once. What she does with it is hers.

The goal is not to get her on HRT. The goal is to reduce her suffering with whatever tools she's willing to use.

Vaginal dryness and painful sex

This chapter names it directly because most guides don't. Genitourinary Syndrome of Menopause (GSM) is the clinical term.[31] It affects roughly half of postmenopausal women, and unlike hot flashes it does not resolve on its own. It gets more common with age, and it is the reason sex can become painful or something she avoids.[32]

Vaginal tissue becomes thinner and less lubricated as estrogen declines. This is a physical change, not a choice. It is not an indication of how she feels about you.

Local estrogen (vaginal)

Cream, ring, or tablet applied vaginally. Highly effective. Very low systemic absorption. Does not require adding progestogen. Can often be used by women who cannot take systemic HRT, though a history of breast cancer needs a conversation with her oncologist.[25]

Vaginal moisturizers

Non-hormonal. Used regularly (not just during sex). Revaree and Replens are common brands. Reduce dryness over time.

Lubricants (during sex)

Water-based or silicone-based. Address discomfort in the moment. Not a long-term treatment for tissue atrophy, but useful short-term.

Ospemifene

Prescription oral tablet, a SERM rather than an estrogen. Approved for moderate to severe dryness and painful sex. Carries a boxed warning for endometrial cancer and cardiovascular risk, so it needs a full conversation with her doctor. Not a casual alternative to the options above.

Non-hormonal options

For women who can't or won't use HRT, several evidence-based alternatives exist.[33]

SSRIs / SNRIs

Paroxetine (FDA-approved for hot flashes), venlafaxine, escitalopram. Reduce vasomotor symptoms 40 to 60%. Also help mood and anxiety. Venlafaxine is preferred for women with a history of breast cancer, since paroxetine can interfere with tamoxifen.

Gabapentin

Reduces night sweats and hot flashes, particularly effective for nighttime symptoms. Side effect profile includes sedation.

CBT-I

Cognitive Behavioral Therapy for Insomnia. Strong evidence for sleep disruption specifically. Works independently of hormones.

Fezolinetant

NK3 receptor antagonist. FDA-approved in 2023 for hot flashes. Non-hormonal. Shows 50%+ reduction in vasomotor symptoms in trials. Carries a boxed warning for rare but serious liver injury, and requires liver blood tests before starting and periodically after.[34]

Lifestyle interventions

None of these will substitute for hormone therapy in a woman with significant symptoms. But they reduce the load in real ways, and some of them matter more for the long term than for the symptoms themselves.

Exercise	Strong evidence for bone density, mood, sleep, and cardiovascular health. Strength training is particularly valuable through perimenopause for preserving bone and muscle. Some evidence that resistance training specifically may reduce hot flash frequency.[37] Broader evidence for exercise and yoga is inconclusive.[35] [36]
Alcohol	A common self-reported hot flash trigger and a well-established sleep disruptor. Cutting back tends to improve night sweats and morning fatigue.
Sleep hygiene	Cool bedroom, consistent schedule, no screens before bed. Pairs well with CBT-I. Reduces the compounding effect of poor sleep on all other symptoms.
Stress management	Chronic stress worsens hot flashes, mood, and sleep. Meditation, breathwork, and therapy all show symptom reduction in trials.
Nutrition	Soy isoflavones are not recommended by The Menopause Society.[39] Cochrane found that extracts high in genistein reduced hot flash frequency in four small trials, but placebo response in this literature runs 20 to 66%, which is why the guidelines have not moved.[40] Mediterranean diet supports cardiovascular and bone health. Calcium and Vitamin D are essential for bone protection.

The cost reality

Access to menopause care is not equal. Insurance coverage varies widely. Specialist wait times can run months. Compounded bioidentical hormones are often out-of-pocket. Figures below are US cash-price estimates as of July 2026.[41]

Treatment	Cost range	Notes
Standard HRT (generic)	**$20–$60/month**	Covered by most insurance. Estradiol patch or gel. Estrogen only. Add $30 to $80 if she needs progesterone, which she will if she has a uterus.
Bioidentical compounded HRT	**$80–$250/month**	Usually out-of-pocket. Not FDA-monitored for consistency.
Telehealth menopause platforms	**$30–$100/visit**	If you're looking for a second opinion, telehealth is often fastest.
Menopause specialist visit	**$200–$500+**	Out-of-pocket if specialist is out-of-network. Worth it for complex cases.
Local estrogen (vaginal)	**$40–$80/month**	Generic options exist. Coverage varies. Highly effective for GSM specifically.
Fezolinetant (Veozah)	**$550–$765/month**	Non-hormonal prescription. Coverage inconsistent. Manufacturer savings programs may apply.

Insurance coverage changes frequently. Check your specific plan before assuming out-of-pocket costs. Costs reflect the US market; Canadian pricing and coverage vary by province. If her doctor won't prescribe HRT, a telehealth menopause platform is often the fastest path to access.

Supplements

The supplement market for menopause is large, largely unregulated, and full of overstated claims. The Menopause Society does not recommend supplements for hot flashes. Individual trials in menopausal women do show effects for specific ingredients at specific doses, which is what is below, along with what each one is not supported for.

Soy isoflavones

Evidence: Mixed • Extracts high in genistein, above 30mg daily

Four small trials each pointed to fewer hot flashes, though they were too different to combine into a single result. Broader soy preparations and dietary soy did not. Placebo response in this literature runs 20 to 66%, which is why guidelines have not moved.

Black cohosh

Evidence: Mixed • 20–40mg/day

Some trials show hot flash reduction, inconsistent across studies. Rare reports of serious liver injury have led regulators in Australia and elsewhere to require warning labels. Stop and see a doctor for yellowing skin or eyes, dark urine, or unusual fatigue.

Magnesium

Evidence: Limited • 300–400mg/day

Supports sleep, bone health, and normal glucose regulation. Cheap, well tolerated, and worth it for general adequacy rather than symptom relief.

Creatine

Evidence: Emerging • 5g/day

Well established for muscle preservation, which matters through perimenopause. Cognitive evidence is early and mostly outside menopausal populations. Low risk.

MENOPAUSE SCIENCE

09

CHAPTER 9

At Home

What to do, what to say, and what to stop doing.

Will this break us?

This is the question underneath all the others.

Data from the MATE Survey, a small 2019 cross-sectional study of 450 men with perimenopausal partners, found that 63% said their partner's symptoms affected them. Among those men, 56% said it had affected the relationship.[18] The risk to relationships is real, but it is not inevitable.

What breaks couples

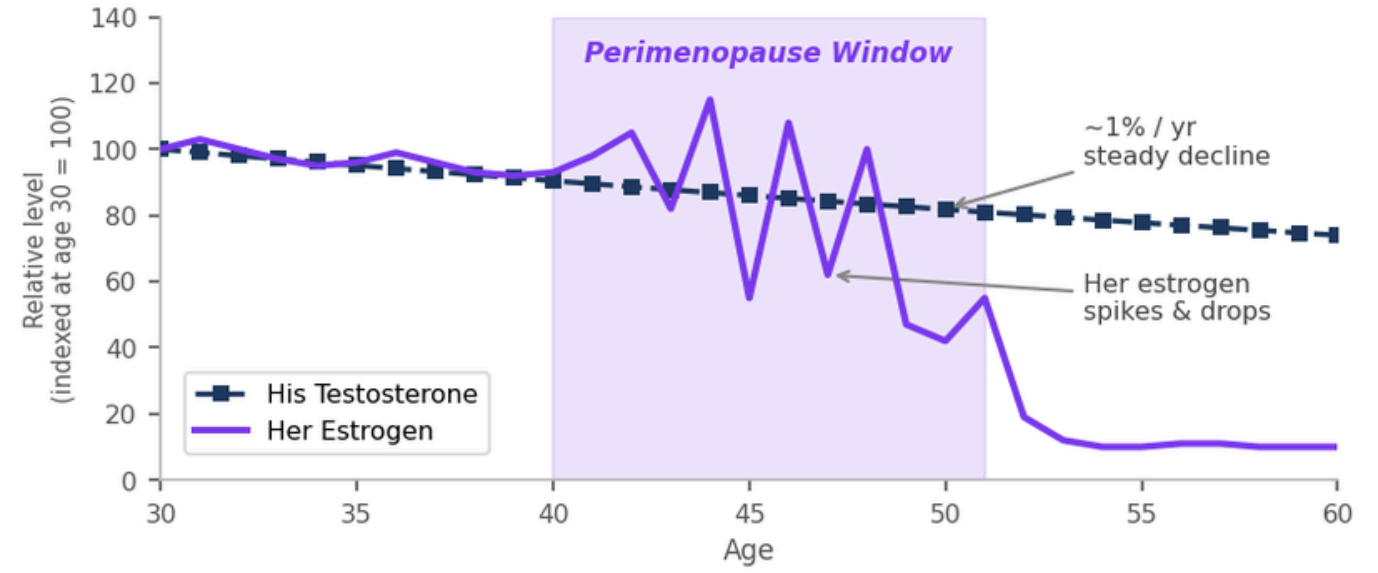
Withdrawal. Dismissal. Partner interpreting her symptoms as directed at him. No information. No framework.

What keeps them together

A partner who stays in the room. Who asks instead of assumes. Who reduces load without being asked. Who doesn't make it about himself.

You are reading this guide. That already puts you ahead of most.

This chapter is the practical side: what to do, what to say, and what to stop doing.



Illustrative, based on published patterns of estradiol variability during the transition and age-related testosterone decline. Individual variation is large.

Three couples

Composite stories drawn from real patterns. No one here is a specific person.

Mark & Anna — **Still married. Almost weren't.**

Mark googled 'is my partner having an affair' before he googled 'perimenopause.' He read for three hours on the kitchen floor at 2 a.m. after Anna left to sleep at her sister's. He took the dishes the next day. He took the kids' pediatrician the next week. He took her hand before he started the conversation.

David & Priya — **Stronger than before**

David noticed at 41. He read up before Priya raised it. He sent her one article, then waited. When she was ready, he was already informed. He came to the appointment with the prep sheet. Priya said the appointment was the first time in years she felt like she had a teammate at the doctor's office.

Rob & Jen — **Divorced**

Rob waited it out. He told himself it was a phase. He stopped touching her shoulder when he passed her. He stopped texting in the middle of the day. The sex stopped first, then the affection, then the conversation. He just didn't show up.

The Anti-Hover Rule

When I was diagnosed with Type 1 Diabetes at 25, I lived at home with my parents.

They were not helicopter parents. But out of love, they hovered. Is your blood sugar stable? When did you last test? Do you need to sit down? Did you bring your dextrose tablets?

Hovering creates emotional work. It feels like care to the person doing it. It feels like added pressure to the person receiving it.

The same applies to menopause.

HOW HOVERING SHOWS UP

Asking 'are you okay?' on loop · Asking if she's too hot instead of turning the thermostat down · Standing there watching her struggle · Waiting for instructions before doing anything · Doing half a task and looking for praise · Following her around with solutions she did not ask for

The Rule

Anticipate, do not interrogate. Act, do not announce.

Hovering makes you feel useful but it makes her feel monitored. The goal is the same: she gets through this. The method is different: you prepare and then stay out of the way.

The 4 Home Fronts

Perimenopause affects four areas of home life. Each one has a specific set of things you can do. The next four pages go into each.

01

Sleep

Sleep is one of the first things to go, and poor sleep makes every other symptom worse. Protecting it is the highest-leverage thing you can do at home.

02

Chores

Rebalancing the domestic load. What to own. What to remove from her awareness entirely.

03

Lifestyle

Exercise, alcohol, social life, nutrition. Practical adjustments that reduce symptom load.

04

Sex

Intimacy when her body has changed. How to stay close. How to talk about it.

Sleep

Sleep disruption is the compounding symptom. Everything else gets worse when she doesn't sleep.

1. Keep the bedroom cool. If she needs it colder than you do, that is not negotiable. Get a better duvet for yourself.

2. When she wakes at 3 AM, don't turn on a light or start asking questions. That extends the wake window. If she's distressed rather than just awake, that's different. Say something.

3. If she needs a separate sleep environment on bad nights, that's not rejection. It's sleep management.

4. Take the morning. If she finally gets deep sleep before dawn, protect it. You handle the logistics.

5. Don't reference her tiredness in a way that sounds like complaint. She knows she's tired. She's been awake.

If this outlasts the bad week, CBT-I is the best-evidenced treatment for insomnia. Find the options. She decides.

Chores

This is not about pitching in more. It is about taking things off her cognitive list permanently. Start with the two that touch her most.

Groceries

Own the grocery run. Build the list yourself from what you observe in the house. Don't ask her to write it.

Cooking

Cook at least 4 nights per week. On the nights she cooks, stay out of the kitchen and don't critique what she makes.

Laundry

Run it. Fold it. Put it away. All three steps. Leaving clean laundry in a pile transfers the final cognitive step back to her.

Calendar management

Own the shared calendar. Know what's coming without being told, and put your own commitments in it yourself. She stops being the one who remembers.

Morning logistics

If there are children, own the morning. She should be able to sleep without worrying about what's not getting done.

Lifestyle

Small changes to how you both live won't fix her symptoms, but they reduce the load around them.

Exercise together	If she wants company, go. If she wants solitude, protect it. Morning walks, strength sessions, whatever she prefers. Make yourself available.
Alcohol	Alcohol is a common trigger and a well-established sleep disruptor. You don't need to stop drinking. But drinking heavily around her, on school nights, while she's dealing with broken sleep, is not neutral.
Social events	She may not be able to predict her good and bad days. Be flexible with social commitments. Don't resent canceled plans.
Food environment	If she's eating differently, lower sugar, more protein, whatever it is, don't make it a topic. Buy what she's using. Don't stock the house with the things she's trying to avoid.
Her downtime	She may need more unstructured recovery time than before. Don't fill it. Don't have an opinion about it. She is not being lazy.

Sex

Sex may have changed. Her desire may be lower. Physical intimacy may be uncomfortable. She may want closeness without sex, or sex without the pressure of performance, or none of it right now.

Don't interpret withdrawal as rejection of you

She is managing pain, low desire, or emotional exhaustion. None of that is a verdict on you. Making her responsible for reassuring you during this is the wrong direction.

Initiate differently

Physical affection that has no agenda. Touching that doesn't lead anywhere. She needs to trust that you can be close without it becoming a negotiation.

Ask what feels good

Once, simply, not as a recurring topic. Ask on a calm day, not in bed and not after she's said no. "I want to understand what works for you right now." Then adjust. Don't ask again for a while. The fuller version of this conversation is Protocol 05.

Lubricant is not optional

If she's experiencing vaginal dryness, have good lubricant available as a default. Don't make it a production. Have it. Use it when relevant. It helps in the moment, but it isn't a treatment for the underlying tissue change. The treatments for that are in Chapter 8.

Closeness still counts. Sitting close, a hand on her back, going to bed at the same time. Offer it without it being a step toward something else.

CHAPTER 09 — PROTOCOL 01

The Bad Night Protocol

This is for the nights she's awake and struggling, not the nights she's just awake. If she's asleep or settling, leave her alone.

LOWER THE TEMPERATURE

Adjust the thermostat. Open a window. Offer a cold cloth without being asked.

READ THE ROOM

Silent means give space. Restless means check in. Crying means sit down and stay.

DON'T TRY TO FIX IT

Say: 'I'm here.' Silence from you is not failure. Resist the urge to explain or solve.

GET THE BASICS

Water. Phone charging. Whatever she keeps on the nightstand. Small acts beat grand gestures.

CHECK IN TOMORROW

Once she's up, a text or coffee shows the night didn't change how you see her.

CHAPTER 09 — PROTOCOL 02

The Hot Flash Response

It looks like a brief inconvenience. To her, it's her body doing something she can't control.

DO	DON'T
Hand her water without making it a moment.	Don't say 'is this another one?'
Step toward the AC, fan, or open window.	Don't laugh. Don't joke. Don't comment.
Lower the volume in the room. Less stimulation helps.	Don't try to determine the trigger out loud.
If you're driving, ask if she wants the air on.	Don't bring it up later in front of others.
If with friends, casually move to a cooler space.	Don't suggest she 'try meditation' in the moment.

AT NIGHT

Night sweats follow the same rules as Protocol 01:

- Don't turn on a bright light
- Water on the nightstand
- Lower the temperature
- Replace the pillow or the sheets, or strip them in the morning so she doesn't wake up to a chore

CHAPTER 09 — PROTOCOL 03

Romance, not sex

Sex tends to slow down during perimenopause. Affection should not.

Most men, when sex declines, quietly pull back the rest. Hand on her hip. Coffee in bed. The text in the middle of the day. The slow dance in the kitchen. They do it without realizing. The relationship loses temperature on both ends at once.

Touch her like you're not trying to start something. That's the move.

Walk together, no agenda.

20 minutes after dinner. No phones. No problem-solving.

Hand on her shoulder when you pass her.

Brief contact, no ask. Costs nothing. Reads as 'I see you.'

The 30-second hug.

Long enough to feel her shoulders drop. Most men let go before that. Hold longer.

The midday text.

Not a question. A statement. 'Thinking of you.' 'Hope today's easing up.'

Make her something.

Tea. Toast. A reservation. The food is not the point. The unprompted action is.

CHAPTER 09 — PROTOCOL 04

The Forgetfulness Protocol

Brain fog is a physical symptom, not carelessness. She is more frustrated by it than you are.

MOVE TO SHARED SYSTEMS

Shared family calendar. Shared notes app. Get it out of her head so she isn't the one holding it.

DON'T CORRECT HER IN FRONT OF OTHERS

If she misremembers a detail in conversation, let it go. Bring it up later if it actually matters. Usually it does not.

REPEAT BACK, DON'T QUIZ BACK

Instead of 'didn't I tell you that yesterday?' try 'just to confirm, the appointment is at 3 on Thursday, right?'

OWN THE APPOINTMENTS

If you can be the one who books, reminds, and drives, do it. One less domain in her head.

PRE-WRITE WHAT SHE NEEDS TO REMEMBER

Sticky note on the door. Calendar reminder pushed to her phone. Make recall someone else's job.

CHAPTER 09 — PROTOCOL 05

The Libido Conversation

Most men avoid this conversation because they don't know how to start it without making it about themselves. Here is one way to start. Have it on a calm day. Not in bed, not after sex has been declined, not during a fight.

OPEN

“I want to talk about something. It’s not a complaint and it’s not pressure. I just want to make sure I’m not making this harder than it needs to be.”

NAME IT

“I read that during perimenopause libido and physical comfort can shift, sometimes a lot. I don’t want either of us to feel like that’s about us, because it isn’t. It’s biology.”

ASK

“What would help right now? More space, more affection that isn’t about sex, talking to your doctor about it, something else?”

LISTEN

Then stop talking. Whatever she says, don't argue with it or try to fix it in the same conversation.

CLOSE

“Thanks for telling me. I love you. Nothing about how I see you changes here.”

CHAPTER 09 — PROTOCOL 06

When she won't talk about it

Sometimes the partner who shuts down the conversation is her, not you.

She's exhausted. She's been dismissed. She's tired of explaining her own body. She doesn't want one more conversation about something that already lives in her head 24/7. That's not personal. It's depletion.

Don't make her teach you.

Read the guide. Read what her doctor gives her. Show up already informed. Conversations are easier when you're not asking her to be the professor.

Lower the stakes of the question.

Instead of 'we need to talk about this' (terrifying), try 'I read something that made me think of you. Can I leave it on the counter?'

Drop and walk.

One article, once. Then leave it alone. Pressure shuts her down. Patience opens the door.

Lead with action, not words.

Take the dishes. Take the morning. Cool the room. Show you understood without saying it. Many women would rather be supported in silence than coached into a conversation.

If the wall is permanent, pick a moment.

If she has refused for months, pick one calm Sunday. One sentence: 'I want you to know I'm here when you're ready.' Then drop it again. this is the one exception to the rule in Chapter 8

CHAPTER 09 — PROTOCOL 07

The Apology Template

You will say the wrong thing. Everyone does. What separates a useful partner from a useless one is the repair.

1 **Name what you did**

Specific. “When you told me about the night sweats, I made a joke.” Not: “I’m sorry I upset you.”

2 **Name the impact**

What it actually did to her. “It made you feel like I wasn’t taking it seriously.”

3 **Skip the explanation**

No 'I just' or 'I didn't mean to.' Excuses dilute repair. Skip them entirely.

4 **Commit to specific change**

Not 'I'll do better.' Try: 'Next time you tell me something physical is happening, I'll ask one question instead of joking.'

5 **Stop talking**

Let her respond. Or not. Don't fish for forgiveness. If she doesn't accept it, don't apologize again. She heard it.

ONE PHRASE THAT NEVER WORKS

“I’m sorry you feel that way.” That is not an apology. It’s a deflection. Strike it from your vocabulary.

Phrases that work. Phrases that don't.

Effective phrases give her agency and remove yourself from the center. Ineffective phrases either minimize her experience or make the moment about your discomfort.

PHRASES TO USE	PHRASES TO RETIRE
What would help right now?	Are you on your period?
I'm here. I'm not going anywhere.	You're being dramatic.
Tell me what you need from me this week.	Just calm down.
I read about this. Anything I've got wrong?	Have you tried yoga?
Want me to come to the appointment?	I'm sorry you feel that way.
I've got dinner. I've got the kids. Sleep.	At least it's not as bad as...

PROTOCOL 08 — THE OUT OF 100 CHECK-IN

Borrowed from Brené Brown. Ask: 'Where are you out of 100 today?' Then: 'I'm at ___. Here is what I'm picking up today.' This allows us to quantify the invisible, makes the load shareable and it removes blame. Takes 30 seconds.

A few more things

PATTERN LOG

If you notice patterns (certain triggers, certain times of month, certain situations that consistently go better or worse), write them down. Not to track her. To get better at reading the room.

Better when: _____ Harder when: _____

THIS DOES END

Symptoms don't last forever, but they last longer than most people expect. Hot flashes and night sweats can run 4 - 8 years, often continuing several years past her final period.[38] Some symptoms, like vaginal dryness, need treatment rather than time. She will find a new baseline. The goal is to get there with your relationship intact.

THE SUNDAY REVIEW

Fifteen minutes, once a week. Five questions:

What did I take off her plate this week?

Where did I keep score?

Did anything of mine go somewhere that was not her?

What am I avoiding saying or doing?

What does next week need from me?

MENOPAUSE
SCIENCE

Where to go next

Reader stories, AI Prompts, Resources

What readers said

I asked men who had been through this to describe their lowest point, the turning point, and what actually worked. These four pages are their answers, condensed from their own words. First names and locations shown where contributors chose to share them. Everything else withheld. Shared with each contributor's permission.

READ THEM TOGETHER

The stories disagree with each other. One man turned things by leaning in and forcing the conversation. Another by stepping back and building his own life. One is still waiting for the turn. That is the honest picture: there is no single move that works. There is feeling it, taking it somewhere useful, and staying.

Stepping back into your own life is not the same as withdrawing from her. Chapter 5 covers the difference.

Several stories mention hormone therapy as a turning point. That is their experience, not medical advice, and not a promise. Treatment decisions belong to her and her doctor.

READER STORIES

She had already seen an attorney

“My wife had told me she was leaving. She'd seen an attorney. We were planning an apartment we'd alternate weeks in: one week in the house with the kids, one week in the apartment. She lived in the guest room for six months, going out most nights and coming home straight to her room.”

The turning point

“Our kids talked to her. They told her she didn't seem like their mom anymore. My youngest said, 'I don't say my mom. I just say her.' She made the decision to get help and try again with us.”

What worked

“I stopped worrying about her. I went to the gym daily. Completed projects on the house. Focused on our boys. Pleasant, cordial, and no 'us' talk. What didn't work: talking about us and asking her for anything at all.”

What he wishes someone had told him at the start: “You cannot change this. You need to be here and be strong and let every one of her big emotions go through you to the ground.”

Where it is now: “Fantastic. Better than it's ever been, no joke.”

Anonymous, 54, Kansas City.

READER STORIES

Pressure didn’t work

“Every cycle was two weeks of her being irritated and two weeks of neutral, and a 'why bother' withdrawal from my side. No sex, little intimacy. At best, a reasonable feeling of collaboration. I pushed her to look into HRT for one to two years and waited for the storm to pass. It didn't.”

The turning point

“She started HRT and I drew a clear boundary about us seeing a therapist.”

What worked

“I got a therapist of my own. Learning to speak up for myself is what made the difference.”

What he wishes he'd had at the start: more conversations with older men who had been through it. There was nowhere to find them.

Not every story ends resolved. His hasn't yet. He is still in it.

Anonymous, mid-40s.

Two years of pushing moved nothing. Chapter 8 covers why: raise it once, then leave it with her. His marriage also wasn't at the attorney stage. Earlier in, stepping back reads as leaving.

READER STORIES

From 95 percent gone to 5

“She was seeing someone else. I knew, and she knew I knew. I wasn't allowed to touch her shoulder. We stayed civil and slept in the same bed every night while she texted him from it. I was mostly invisible to her.”

The turning point

“She planned a trip with the other man. I told her that if the kids asked where she was, I would not lie to cover her. She sat in silence, then burst into tears. She declined the trip.”

What worked

“HRT made a massive difference over 18 months: from 95 percent sure of divorce down to 5. That, and not being needy: concentrating on myself and the kids.”

What he wishes someone had told him: “Menopause is much more than hot flashes. It completely changes some women into unrecognizable versions of themselves. She even says that now herself. It has gotten dramatically better since.”

Anonymous.

Remember: She is not a different person. The symptoms are real and they can be treated. What he describes is how it felt at the worst of it, not where it ended. Her affair was not a symptom, and this guide does not claim otherwise.

READER STORIES

Her side of the bed

One story arrived from the other side of the transition. A woman, 58, two years into HRT that has not worked yet, married to a man living every chapter of this guide.

“Sex hurts like sandpaper. Lube has done nothing. My libido is completely dead and has been for some time. I've been on HRT for two years and have seen no real changes.”

The turning point

Him telling her he isn't going anywhere is the only thing that has shifted so far. "Other than this, we have no problems. We still laugh and have the best times. Just not sexy times."

What worked

“We lived like roommates for a long while. But I make sure he gets hugs, cuddles, and small touches every day, and I tell him how much I love and respect him. None of this is his fault.”

Jill, 58, Georgia.

Systemic HRT does not always resolve genitourinary symptoms. Local estrogen is a separate treatment, and Chapter 8 covers it. Her experience is not a reason to expect nothing from treatment, and it is not a reason to promise everything.

Prompts that can help with the work

The rest of this guide gives you the knowledge. These 40 prompts put it to work in Claude, ChatGPT, or whichever AI tool you use. Copy a prompt, replace anything in [brackets] with your details, and use one prompt per conversation.

FOUR BEST PRACTICES TO REMEMBER:

One: never paste identifying details about your partner into an AI tool. No names, no workplace, no medical records.

Two: AI is a research and thinking tool, not a doctor. Her treatment decisions belong to her and her doctor.

Three: Be specific about symptoms and situations, not about her identity. "She's had night sweats for eight months, and her doctor dismissed it" is useful. Her name and workplace are not.

Four: Ask for sources every time. Add "cite sources" to any prompt that gives you a number, a percentage, or a claim about what the research says. Then check that the source exists and says what the answer claims it says.

The first six pages are research about her: the science, the symptoms, the treatments, and the medical system.

The last five pages are for you: what you are feeling, what to do with it, and how to say things out loud.

Explore the basics

01 — The three phases

“Explain the difference between perimenopause, menopause, and postmenopause. Include timelines, what causes each phase, and why symptoms can start in her early 40s while her periods are still regular. Use plain language.”

02 — Crash course for partners

“Give me a crash course on perimenopause written for husbands or partners. Plain language, evidence-based, about 10 minutes of reading. End with the five most common mistakes men make and what to do instead.”

03 — The full symptom map

“List the documented symptoms of perimenopause beyond hot flashes. Group them by category: sleep, mood, memory, joints, skin, heart, digestion, periods. For each one, explain the cause in one line and how common it is.”

04 — Why fluctuation matters

“Explain why hormones fluctuating matters more than hormones declining. Why can she feel fine for two weeks and then not? What does this mean for how I should read her good days and bad days?”

Understand the symptoms

05 — What it feels like

“Explain what [a hot flash / brain fog / a 3am wake-up] feels like from the inside, written in first person. Then tell me what a partner can do in that moment that helps, and what makes it worse.”

06 — Her symptoms, sorted

“My partner's main symptoms are [list them]. Which are commonly linked to perimenopause? Which could be something else worth ruling out and what could be worth raising with her doctor?”

07 — What broken sleep does

“Explain what disrupted sleep does to her: mood, patience, memory, pain tolerance. I want to understand why everything gets worse when she is not sleeping.”

Understand the symptoms, continued

08 — Brain fog and her fear

“Explain brain fog in perimenopause. Is it permanent? What does research say about memory and thinking after the transition ends? She is worried it is early dementia. What do studies actually show and what, if anything, improves it?”

09 — Desire and comfort

What happens to sexual desire and physical comfort during perimenopause? Explain the physiology so I understand it is not about me. What is treatable, and what does the evidence say about how well those treatments work? Cite sources."

10 — GSM, explained

"Explain genitourinary syndrome of menopause (GSM) in plain terms. What is it, how common is it and in which group, and is it undertreated? What are the treatment options, and what does the evidence say about the safety of local vaginal estrogen? Cite sources."

Research treatments and evidence

11 — The WHI study

“Summarize the 2002 WHI study on hormone therapy. What did it claim, what was wrong with how it was reported, and where does medical consensus stand now? Use absolute risk numbers, not relative. Cite sources.”

12 — HRT evidence

“Summarize the current evidence on hormone therapy for a healthy woman under 60. Cover benefits, risks, timing, and types. Write it so I can understand it, not so I can lecture her. Her decisions belong to her and her doctor. Cite sources.”

13 — Non-hormonal options

"What are the evidence-based non-hormonal options for [hot flashes / sleep problems / mood changes]? Separate what has real trial support from what is marketing. Include what The Menopause Society's 2023 nonhormone position statement recommends and does not recommend. Cite sources."

14 — Check a supplement

"What does the evidence say about [supplement name] for menopause symptoms? Cover study quality, the doses used in trials, safety, and drug interactions. Does The Menopause Society recommend it? Cite sources."

Navigate the medical system

15 — Why doctors dismiss her

“Why do so many women get dismissed by doctors during perimenopause? Explain the research gap in women's health and how little menopause training most doctors get. What does a menopause-certified practitioner do differently?”

16 — Find the right doctor

“How do I find a menopause-informed doctor in [city or country]? Which directories are legitimate? What questions show whether a doctor takes this seriously?”

17 — Prep the appointment

"My partner has a doctor's appointment in [timeframe] and previous ones went nowhere. What makes these appointments go badly, and what actually helps? If a symptom log would help, describe what a useful one looks like so I can offer it. Then tell me what my role is, and where my role ends."

Understand her daily reality

18 — What work costs her

“Explain what perimenopause is like at work: how symptoms affect meetings, presentations, and performance, and why most women tell no one. I want to understand what she might be managing that I never see.”

19 — Her other conditions

“How does perimenopause interact with [her existing condition: migraines, endometriosis, anxiety, diabetes]? What does the evidence say about symptoms getting better or worse and what does that mean for treatment decisions she may need to discuss with her doctor? Cite sources.”

20 — What she may not say out loud

"Beyond symptoms, what changes during perimenopause in how a woman sees herself: her body, her appearance, her sense of aging, her confidence, her place at work and socially? What do women say about this that they rarely tell their partners? Cite sources where research exists, and be clear where you are describing common reports rather than studies."

21 — The load she's carrying

"Explain the concept of cognitive or mental load in a household, and how perimenopause symptoms interact with it. What does the research say about how this is typically divided, and what specifically gets harder when someone is running that load on broken sleep?"

Name what you're feeling

22— Say it once

“My wife is going through perimenopause and it is affecting me in ways I have not said out loud. Ask me questions, one at a time, to help me name what I am feeling. Do not give advice yet.”

23 — Invisible

“I feel invisible at home. How I am doing stopped being a question anyone asks. Help me sort this into three buckets: what is the situation, what is my own pattern, and what needs to change.”

24 — Coming off high alert

“I have been on alert for years: reading her tone, bracing before I walk in the door. Explain what long-term hypervigilance does to a person, and give me a realistic plan to come off high alert without checking out. Tell me where this is something to work through on my own and where it warrants talking to someone."

25 — Grieving something that isn't gone

"I think I am grieving the version of my marriage I planned on, even though my partner is right here. Help me understand that feeling without treating the marriage as already over. What is the difference between grieving a phase and giving up on the relationship, and what does the second one look like from the outside?"

26 — Evidence versus fear

“I am afraid my marriage is ending. Ask me questions, one at a time, that help me separate evidence from fear. Then tell me honestly what the evidence supports.”

Handle resentment and anger

27— Resentment and the guilt

“I resent my wife and I feel guilty about it, because she is the one suffering. Explain resentment in caregiving relationships: what it means, what it does not mean about me, and what to do with it that is not venting at her or swallowing it.”

28 — The scorecard audit

“I have been keeping score of everything I do and everything I do not get back: [list it]. Challenge me. What would her list say that I cannot see? Then tell me what to do with mine besides bringing it up in a fight.”

29 — Anger at night

“When I cannot fix something and cannot get heard, I get angry, usually at night. Help me map the pattern: when it happens, what my warning signs are, and what to do in that moment instead. Tell me where this is something to work on my own and where it warrants talking to someone.”

30 — The morning after

“I handled something badly last night: [what happened]. Be blunt. Walk me through what happened step by step, where I could have exited, and what repair looks like in the next 24 hours.”

31 — Going cold

"I stopped reaching out. Less touching, fewer texts, less conversation, and I told myself I was giving her space. Help me work out whether that is genuinely what she needs right now or whether I am withdrawing and calling it something else. Ask me questions first, then be direct with me."

Talk to her

32 — Plan the conversation

“Help me plan a conversation with my wife about [topic]. Rules: I speak only about my side, I do not list what she has done, and I talk for under two minutes. Draft it, then role-play her three most likely responses and coach my replies.”

33 — Practice on the AI

"Play my partner. She is exhausted, irritable, and expecting this conversation to be a criticism. I want to practice raising [topic] without getting defensive when she pushes back. Stay in character for three exchanges, then tell me where I got defensive and what I missed."

34 — Say you're struggling

"Help me tell my partner I am struggling too, without making it her problem to solve. Using the script in Chapter 6 as the model, write three versions, each under 30 seconds, each ending with 'nothing to solve.' Then tell me when to say it and when not to."

35 — Rebuild touch

"Physical affection has disappeared from our marriage: no hand on the back, no kiss goodbye. Help me understand why it went and what actually rebuilds it. I do not want a schedule or a program, I want to understand what makes small contact feel safe again rather than like an opening move. Include what to do when a gesture gets turned down."

Find support

36 — Find one person

"I have no one to talk to about my marriage. List my realistic options from easiest to hardest: what to say to a friend, how to find a therapist, and which types of men's groups or online communities exist and how to evaluate whether one is real and worth joining. Do not name specific groups unless you can point me to a source I can verify. Then draft the opening message for the easiest one."

37 — Start therapy

“I want to start therapy but I have never done it. Explain what individual therapy looks like for a man in my situation: how to choose someone, what the first session covers, and what progress looks like after three months.”

38 — Audit your week

“Here is my typical week: [work hours, workouts, kids, evenings]. Review it. Where is the time for processing my own stress that is not late at night? Suggest one realistic change.”

Your own health, and the weekly review

39 — Your own midlife

“I am [age] and my own body is changing: energy, recovery, sleep, drive. Explain the evidence on male midlife hormonal change. What is real, what is marketing, and what baseline tests are worth discussing with my doctor? Cite sources.”

40 — The drinking habit

"I want to stop drinking my way through the evenings. Help me understand what the evening drink is actually doing for me and what could do the same job. If anything I describe suggests this is more than a habit, say so directly and tell me who to talk to instead of building me a plan."

41 — The Sunday review

“Act as my Sunday 15-minute review. Ask me one question at a time: What did I take off her plate this week? Where did I keep score? Did I process my own stress somewhere that was not her? What am I avoiding saying or doing? What does next week need from me? Push back if my answers are vague.”

RESOURCES

Canadian Resources

Menopause Foundation of Canada
menopausefoundationcanada.ca

Canada's primary menopause non-profit. Includes a physician finder, symptom resources, and a guide specifically for partners. Bilingual English and French.

Blair Health
blairhealth.ca

Virtual menopause clinic available across Canada (all provinces except Quebec). OB/GYN-led, no referral needed, HSA eligible.

Coven Health
covenhealth.com

OBGYN-led virtual clinic in Ontario. Multidisciplinary team including nurse practitioner, dietitian, and psychotherapist. Extended benefits eligible.

RESOURCES

American Resources

TheMenopause Society

menopause.org

Clinical guidelines and a certified practitioner directory. If she needs a specialist and her GP isn't cutting it, start here.

National Menopause Foundation

nationalmenopausefoundation.org

Education and peer community built for women navigating menopause. The symptom checklist is useful context before a doctor visit.

Midi Health

joinmidi.com

Virtual menopause clinic available in all 50 states, covered by most major insurance plans. No referral needed.

RESOURCES

The Menopause Science Ecosystem

WTF Is Menopause
wtfismenopause.com

The Substack that feeds this guide. New issues on the research, the policy, and the practical side of perimenopause. Written for both women and the men in their lives.

r/WTFisMenopause
reddit.com/r/WTFisMenopause

The community for people navigating this together. A place to ask questions you wouldn't ask anyone else, men and women in the same conversation.

Have an idea or suggestion?

Email us at support@menopausescience.co

A note on language

Perimenopause affects anyone with ovaries. Non-binary people experience it. Transgender women may experience related hormonal transitions. Same-sex partnerships navigate this too.

The clinical content in this guide is applicable across these contexts. The relational framing is written in the language of heterosexual partnership because that is the context where the gap between the person experiencing symptoms and the person least likely to have information about them is most consistent.

If you are reading this as a woman supporting a partner, as a same-sex couple, or as anyone other than the specific demographic this guide addresses: the information still holds. The underlying principles (believe her, reduce load, stay in the room) don't require a specific pronoun.

The research gap affects everyone. The guide acknowledges the narrowness of its framing while recognizing that narrowness has practical utility for the largest underserved audience.

Feedback on future editions is welcome at jordan@menopausescience.co.

About the author

Jordan Smith is the founder of Menopause Science, an evidence-based content brand focused on the perimenopausal transition.

He is also the author of WTF Is Menopause, a Substack publication covering menopause research, policy, and relationships. The publication is read by both women in perimenopause and the men who love them.

MENOPAUSE SCIENCE

Evidence-first content on the perimenopausal transition. Research explained in plain language, with sources you can check. 5% of sales of this guide goes toward funding menopause research.

WTF IS MENOPAUSE

The Substack at the intersection of menopause research and the people it affects. Direct, evidence-first, and written for anyone who needs a clearer map.

JOIN OUR REDDIT COMMUNITY

You're not the only man reading something like this at midnight trying to understand what's happening at home. The r/WTFisMenopause Reddit community exists for exactly that, a place to ask questions you wouldn't ask anyone else, hear from people further along, and stop guessing alone. reddit.com/r/WTFisMenopause

wtfismenopause.com

You've finished the guide.

Now the work starts.

Reading this guide is not the same as showing up differently. The gap between knowing and doing is where most partners get stuck.

1. Pick one thing from Chapter 6 to implement this week. Not all of it. One.

2. Share this guide with her if you think it would help. Ask first.

3. Read the WTF Is Menopause Substack. New issues come out regularly. The research moves fast.

4. Review the supplement evidence in Chapter 5 and consider whether it's relevant to her situation.

If this helped, tell another man about it.

The more men who read this, the smaller the gap.

ENDNOTES

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MENOPAUSE SCIENCE

THE PLAYBOOK

If You're Reading This

AI Use Disclaimer

Artificial intelligence tools were used to support the research, organization, and editing of this guide. AI was used as an assistive tool, not as a substitute for human judgment or qualified medical expertise. Medical and scientific claims were reviewed against credible sources where possible, but AI generated content can contain errors, omit important context, or become outdated as new evidence emerges. This guide is for educational purposes only and is not medical advice. It should not be used to diagnose, treat, or make healthcare decisions. Readers should consult a qualified healthcare professional for advice specific to their circumstances.

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