THE AGONY AND, YES, THE ECSTASY OF MENOPAUSE

A DIFFERENT KIND OF COMING-OF-AGE STORY.

WHEN I WAS 48, I JOINED a new book club. At my first meeting, talk turned to an ex-member who'd been having a hard time with hot flashes. One evening, the women said, things got especially bad for her. She shifted uncomfortably all through the book talk, until finally she had to peel off her sweater for relief. When that wasn't enough, she tore off her blouse. When *that* wasn't enough, off came her tank top, too—until there she sat, red-faced and dripping, in just her bra.

Back then, the prospect of hot flashes terrified me; my mother's had been ferocious. If you haven't yet reached menopause, you might be terrified, too—and not just by the idea of turning into the incredible flaming woman, stripped to her skivvies in someone else's living room. There are the hot flashes, the night sweats, the brain fog, the mood swings, the free-range rage, the bloating, the weight gain.

And on top of those miseries is the loss they're supposed to portend: of sexiness, of fertility, of the best and juiciest part of your life, of femininity, of—if you take it far enough—your very womanness. You will become shriveled and uninteresting, the story goes, a dried-up, barren husk of your former self, an old hag that no one lusts after anymore. And then you'll die.

Here's the truth: You probably will sweat the physical stuff. And possibly the mood stuff. Maybe a lot. Perhaps a ton. You will likely—sometimes astonishingly—encounter bodily changes no one ever told you about. You might be frustrated and, yes, enraged by modern medicine's incomplete understanding of what is happening to you and by the cultural sexism that underlies that failure.

But. You may also make a significant discovery—something grand and important. You might even call it the discovery of a lifetime: that menopause, far from being the tragic end of the best part of a woman's existence, can actually be a threshold, a gateway, the passage to the you you've been waiting your whole life to become.

BY ROBIN MARANTZ HENIG / ILLUSTRATIONS BY EMILIANO PONZI

BEGINNING WITH THE FIRST period, at about age 12, to be female is to experience a decades-long cycle in which two powerful sex hormones, estrogen and progesterone, rise and fall, triggering the rhythms of menstruation. Estrogen, secreted by the ovaries as an egg matures, reaches its highest level during week 2 of a typical four-week cycle. Progesterone, secreted after the egg follicle ruptures during ovulation, peaks between weeks 3 and 4. These two hormones are primarily responsible for getting a woman's body ready, month after month, to achieve and maintain a pregnancy.

As the ovaries age in the four-to-ten-year lead-up to menopause known as perimenopause, which usually begins in the mid- to late 40s (see "Get Firm on the Terms," below), they don't reliably release an egg every month. And whenever a cycle takes place without ovulation, there's no empty egg follicle and no progesterone is produced. So that month there's an imbalance—too much estrogen, too little progesterone—and maybe the same is true two months later when again there's no ovulation, and a month or two after that. It can all lead to roiling hormonal swings that are a lot like puberty. Except worse. Because these inner storms happen while you're up to your eyeballs in the trappings of responsible adulthood.

"My perimenopausal patients are in the middle of very busy lives," says JoAnn Pinkerton, MD, a professor of obstetrics and gynecology at the University of Virginia and executive director emeritus of the North American Menopause Society (NAMS). They're juggling their jobs (and might be at the height of their careers, or trying to reboot after being downsized, or stressing over ageism in the workplace), their kids (who might be hormonally charged teens themselves), their aging parents (with their increasing care needs), their other health issues (which could include chronic conditions like hypertension, arthritis, and diabetes), and their love lives (which could be affected by all manner of factors, from divorce to romantic malaise to partners facing health issues of their own). "All of these make the process of perimenopause much more difficult even than puberty was," Pinkerton says.

Yet when it comes to navigating that process, women are, to a stunning degree, left to their own devices. "Every girl gets the period talk, but almost no woman gets a talk about what's happening on the other end," says Stephanie S. Faubion, MD, medical director of NAMS and director of the Mayo Clinic Center for Women's Health. "That's really a shame. And as a result, we have women coming to the clinic in a panic. They can't sleep, they're having heart palpitations, they're forgetting things, their hair is thinning, they're anxious—and they literally think they're dying when, in fact, they're just in perimenopause."

If there were such a thing as the menopause talk, it would make sense for doctors to initiate it. But by and large, medical training doesn't equip them to do so.

If there were such a thing as the menopause talk, it would make sense for doctors to initiate it. But by and large, medical training doesn't equip them to do so. In a 2019 study in which researchers surveyed 177 residents in family medicine, internal medicine, and ob/gyn, 20 percent received *zero* menopause lectures during their residency; less than 7 percent said they felt prepared to manage the care of women in the various stages of menopause. The knowledge gap reflected in those numbers may explain why, in another survey, only 7 percent of midlife women with urogenital changes (like vaginal dryness, pain during sex, urinary incontinence) said they had doctors who broached the subject of such changes with them. Instead, many women complain of doctors who minimize their concerns with, essentially, a pat on the head and a shrug of the shoulders and a reminder that menopause is just part of life.

You could argue that that attitude represents progress. In her new book, *The Slow Moon Climbs: The Science, History, and Meaning of Menopause,* Susan Mattern, a professor of history at the University of Georgia, notes that the author of the first American textbook on menopause, from 1897, compared its effects "to epilepsy, hysterical attacks, and the paroxysms of malaria." Thus began a trend of pathologizing a natural phenomenon experienced by half the human population. With the advent of hormone therapy—pioneered in the 1930s, first available in the U.S. in 1942—the trend became the rule. In the 1950s, a decade that loved its gender norms, the femininity fearmongers joined in, beating the drum of diminished sexuality and youthfulness. And in 1966, a Brooklyn gynecologist named Robert Wilson published a runaway bestseller, *Feminine Forever,* whose sexist attitudes linger today. Wilson was the Pied Piper of plying menopausal women with estrogen—for the rest of their lives. With estrogen, he promised, they could look forward to eternal youth and attractiveness (and menstruation!—on Wilson's plan, women could expect to have five to seven periods per year, indefinitely). Without estrogen, they were fated to live as "sexual neuters" suffering from a "serious, painful, and often crippling disease" that made long life "an unnatural burden." Wilson wasn't speaking

GET FIRM ON THE TERMS

Even health experts sometimes jumble the words that apply to women in midlife. Let's sort things out....

PERIMENOPAUSE. This transitional phase, which typically begins in a woman's 40s (but could start as early as the mid-30s), is the precursor to menopause. Ovarian function declines, and levels of the sex hormones estrogen and progesterone rise and fall unevenly.

MENOPAUSE. Your ovaries are no longer producing estrogen or progesterone. Because there's no definitive way to pinpoint when they stopped, menopause is defined, in hindsight, as 12 consecutive months without having a period. The average age of reaching menopause in America is 51.

POSTMENOPAUSE. While some people say they're "in menopause" for the rest of their life, this term brooks no confusion: Your periods are gone and aren't coming back.

ROLLER COASTER: HENNIE HAWORTH. ICONS, ALL FROM THE NOUN PROJECT: FLAME: IEJANK. DROPLETS: ADNEN KADRI. CACTUS: BAKUNETSU KAITO. DEVIL: DEEMAK DAKSINA. AWAKE: MATT WASSER. FORGET: ANDREW FORRESTER.

Is This *Normal*?

SHORT ANSWER: PROBABLY YES. BUT HORMONAL HIGHS AND LOWS CAN MAKE PERIMENOPAUSE A PRETTY WILD RIDE. **BY CORRIE PIKUL**

WTF?	WHAT'S GOING ON?	WHAT TO DO
PERSONAL INFERNOS And clothes-drenching sweats. One minute you're calm and cool; the next you feel like you've been zipped into a down parka and locked in a sauna.	One of the most common symptoms of menopause, hot flashes (see "You're Getting Warmer," page 120, for the full story) are sudden waves of heat in the face, neck, and chest accompanied by sometimes-profuse sweating, flushing, and a racing heartbeat. (Night sweats are hot flashes that occur while you're asleep.) As many as **75 percent of North American women will flash during perimenopause,** and while some are hardly bothered, nearly a quarter are miserable enough to seek relief from clinicians.	Hormone therapy (HT)—estrogen, or estrogen plus progesterone—is the most effective way to ease hot flashes and night sweats. Beyond hormones: A study of 187 symptomatic postmenopausal women found that clinical hypnosis was associated with a 74 percent reduction in hot flashes. Antidepressants called selective serotonin reuptake inhibitors (SSRIs) have also been effective in women who don't have depression; other antidepressants, certain blood pressure drugs, and gabapentin, a drug used to treat epilepsy and migraines, may also help. Disappointingly, studies on herbal remedies have been inconclusive.
CRIME-SCENE-LEVEL BLEEDING There will be blood. So much blood. And clots like you've never seen.	Before their periods finally stop, about 90 percent of women experience four to eight years of menstrual cycle changes due to erratic hormone production. According to a 2014 study, during perimenopause, **77 percent of women will have at least three episodes of prolonged periods lasting ten days or more** (with at least three of those days involving heavy bleeding).	Low-dose birth control pills can minimize and regulate bleeding (though they're not an option if you smoke). But if you're bleeding more often than every three weeks or if the amount is interfering with your daily life, talk to your doctor about treatment options, as well as to rule out other causes.
SEARINGLY PAINFUL, DESERT-DRY SEX Bring on the women's luberation movement.	Decreasing levels of estrogen can cause the vagina to become narrower, drier, and possibly inflamed or irritated. **Approximately one-third of midlife and older women suffer from dryness and pain during intercourse**—yet they often hesitate to speak to their doctors about this and other symptoms of genitourinary syndrome (which also includes leaking urine).	Low-dose vaginal estrogen (available in creams, the ring, and a tablet) is highly effective at treating dryness. OTC water- or silicone-based lubricants can ease friction during sex, and vaginal moisturizers can help keep tissues more supple. Once things get more comfortable, regular sexual activity, which promotes blood flow to the area, can help keep the problem from getting worse!
FIRE-STARTER RAGE Like you just want to burn it all down.	Emotions, especially anger or sadness, can feel very intense. This is likely due to fluctuating levels of estrogen, as well as the neurotransmitter serotonin. Approximately **one in four peri- and postmenopausal women will feel irritable, depressed, or anxious,** contributing to a sense that things are out of whack.	Do what you realistically can to minimize stress, which makes mood issues worse: Exercise several times a week, start a regular yoga practice, get good rest, try meditation and deep-breathing exercises, treat yourself to a massage now and then. To keep some peace at home, talk to your family about what you're going through so they know it's not them (well, not always), it's (mostly) you.
INTOLERABLE INSOMNIA You'll wonder if you'll ever sleep again.	**About 40 to 50 percent of women will have sleep problems during the transition,** sometimes due to waking up from night sweats but also because of naturally decreasing levels of the hormones estrogen, progesterone, and melatonin. (Other things in your life could also be keeping you on edge: stress, anxiety, depression, an increased need to urinate at night, and more.)	Sleep hacks matter like never before (no caffeine past midafternoon, a cool–if not frigid–bedroom, no screens in bed). Many women turn to alcohol to help them wind down, but unfortunately, this is almost guaranteed to disrupt slumber later in the night. If night sweats are your nemesis, hormone therapy can help.
MEMORY PROB– Wait, what were we talking about?	The brain blur of forgetfulness and loss of focus–which gynecologist Tara Allmen, MD, author of *Menopause Confidential,* calls menofog–is very real, and it affects up to 60 percent of women, particularly during perimenopause. **The good news: Research shows that cognition tends to stabilize postmenopause.** Brain fog is *not* the onset of Alzheimer's; it's linked to estrogen decline, and your cognitive system should adapt.	Regular aerobic exercise has been shown to help memory and cognition in general–it's one of the best things anyone can do for an aging brain. Sleep is also crucial to cognitive performance. Following a Mediterranean diet may also help protect the brain. Some women who are prescribed HT for hot flashes, night sweats, and vaginal dryness have reported an improvement in cognition. Just remember: You have options.

LIGHT: HENNIE HAWORTH.

metaphorically when he said menopause could and should be cured.

We surely don't want to go back to that kind of thinking. But as we make our way through perimenopause and menopause, we deserve to be able to function in our lives and in the world—comfortably and with dignity. That menopause isn't something to be cured shouldn't mean our only option is to grin and bear it (or gin-and-tonic and bear it while standing in front of an open freezer fanning ourselves). We aren't asked to do so with menstrual cramps or childbirth, other natural processes. Men aren't asked to do so with erectile dysfunction. (ED, by the way, is the male equivalent of hot flashes in the sense that each is the most problematic symptom of the decline of a signature hormone. Yet as Amy M. Miller, PhD, president and CEO of the Society for Women's Health Research, notes with some frustration, at this point treating ED is so commonplace, it can be done with generic drugs.) In the pecking order of American society, men still outrank women, and menopausal women often seem hardly to rank at all, not just in the media, or in Hollywood, or on Tinder, but in all the places where we tend to become invisible as we age—and in biomedical research, which for years has left midlife women in the lurch.

Happily, that's changing. Though you're still likely to kill a conversation by making mention of your hot flashes (*you* may not be embarrassed, but other people will be, on your behalf), the menopausal transition is coming out of the shadows. Someday we may look back on 2019 as the year Darcey Steinke invented a new publishing category, the menopause tell-all, with her *Flash Count Diary: Menopause and the Vindication of Natural Life*. Certainly it should go down in history as the year the Emmy-nominated dramedy *Fleabag* featured Kristin Scott Thomas soliloquizing majestically about "the menopause...the fucking *menopause*" (more on this later). And let's not forget that in the UK, the University of Leicester has adopted an official, first-of-its-kind menopause policy designed to normalize the experience—inviting the women and men of its faculty and staff to monthly menopause cafés and exhorting them simply to speak the word "menopause" three times daily. (Want to try this yourself? You might start on October 18: World Menopause Day.)

As more women assume leadership roles in science and medicine, we're also seeing new data about what happens in our 40s and 50s. (And using more dignified terminology to discuss it: In 2014, for instance, the condition crushingly known as vaginal atrophy was renamed genitourinary syndrome of menopause.) One major source of this data is the Study of Women Across the Nation (SWAN), now in its 23rd year. SWAN's origin story is instructive. Back in the 1990s, Sherry Sherman, an endocrinologist with the National Institute on Aging then in her 40s, suspected a serious lack of scientific knowledge about midlife women. "She was determined to do something about it," says Susan Johnson, an emerita professor of ob-gyn and epidemiology at the University of Iowa and SWAN's current study chair.

That menopause isn't something to be cured shouldn't mean our only option is to grin and bear it (or gin-and-tonic and bear it).

So Sherman organized a conference at the National Institutes of Health to gather what was understood about menopause at the time. It confirmed that the pool of knowledge was shallow indeed, at which point Sherman went out and secured funding to sponsor a network of seven clinical sites to start collecting data from thousands of women then aged 42 to 52. The study has generated a slew of reports—close to 500 journal articles to date—that reveal menopause to be normal, natural, sometimes difficult, but eminently survivable; it was SWAN that really focused new attention on perimenopause, helping establish it as a pivotal point when a woman's lifestyle choices can have a profound effect on her future health. (For more on this, see "Do This in Your 40s, Thank Yourself in Your 60s," page 121.) Sherman died in 2014, but SWAN, her legacy, is potent proof of what scientific research can achieve when the people asking and answering the questions are women, as seven of SWAN's ten principal investigators are.

That same lesson was borne out by a groundbreaking 2016 study from Johns Hopkins—the work of two female Hopkins ob-gyns, Wen Shen, MD, and Mindy Christianson, MD, who, a few years earlier, had surveyed hundreds of ob-gyn residents across the U.S. to see whether they'd had adequate instruction on menopause, and, finding that they hadn't, devised a two-year

HORMONE THERAPY: WHERE ARE WE AND HOW DID WE GET HERE?

1993
The Women's Health Initiative (WHI) hormone therapy (HT) trials are designed to test the effects of postmenopausal hormone therapy on women's risk for coronary heart disease, bone fractures, and breast cancer. The trials include 27,347 women ages 50 to 79.

2002
The trial of estrogen-plus-progestin is stopped three years early because of increased risk of breast cancer, heart disease, stroke, and blood clots.

2003
The FDA slaps a "black-box" warning on estrogen products—they should not be used to prevent cardiovascular disease—and recommends, for symptoms like hot flashes, night sweats, and vaginal dryness, the lowest effective dose for the shortest duration.

2004
The trial of estrogen alone is stopped one year early because of increased risk of stroke and no overall benefit. Doctors grow wary of recommending HT; prescriptions for the two most common forms in the U.S., Premarin and Prempro, decline to 21 million (from 61 million in 2001).

2005
Following the publication of Suzanne Somers's book *The Sexy Years,* in which she touts the benefits of "bioidentical" HT, more women turn to these unregulated, non-FDA-approved formulations obtained from compounding pharmacies.

2006
New WHI data emerges, showing that younger women (between ages 50 and 59) actually *don't* face the same alarming risks from HT as postmenopausal women over age 60.

2012
The North American Menopause Society (NAMS) issues a position statement supporting the use of HT to treat disruptive menopausal symptoms like hot flashes, night sweats, and vaginal dryness, but recommends against using estrogen plus progesterone beyond three to five years.

2017
Based on further research from the WHI and other trials, NAMS updates its position statement to say that for the majority of healthy women under age 60 who are within ten years of menopause and want relief from their symptoms, the benefits of HT outweigh the risks. And that's where we stand today. **–C.P.**

menopause-medicine curriculum to see if it made a difference. Did it ever: Before the curriculum, 76 percent of residents felt "barely comfortable" managing the care of menopause patients; 8.4 percent felt "not at all comfortable." After the curriculum, the cohort of "comfortable/very comfortable" had swelled to 86 percent. Wen and Christianson are now menopause education evangelists; they've put their lectures on CDs that they send free to other ob-gyn programs, and Wen has even developed an app to answer practitioners' treatment questions.

NAMS has similarly invested in boosting practitioner know-how, by offering a certification program in menopausal health. Any licensed healthcare provider—physician, nurse, naturopath, physician's assistant, pharmacist, social worker, psychologist—can sit for the exam, which consists of 100 multiple-choice questions that test knowledge on everything from the hypothalamic-pituitary-ovarian axis to bone-mineral density tests to the use of isoflavones and herbs as alternative therapies. Currently, 1,131 practitioners are certified; the NAMS website, menopause.org, has a handy tool to help you find one near you.

I COULD HAVE BENEFITED from seeing such a practitioner myself. Like many women, I was surprised to find that as my ovaries wound down, my periods aggressively ramped up. I bled like crazy—heavily, unpredictably, sometimes in clots so thick it felt like a vampire cleanse. I went to business meetings, dinners, movies massively pre-padded. The only thing that stanched the flow was going back on the birth control pill in my late 40s—a treatment not without risks, but risks I was willing to take.

I never did get the hot flashes that plagued my mother. It turns out that your menopause doesn't necessarily mimic your mother's. Nor does it have any obvious connection to your own reproductive history—whether you had easy pregnancies, tough ones, or none at all. Scientists do know that women who've ever suffered a major depressive episode have a 59 percent greater chance of experiencing another one in perimenopause. They've also found suggestive links between childhood trauma and the severity of menopause symptoms, and there are hints that women who had PMS will experience more mood issues. But experts are still teasing out all these relationships, which are multilayered and complex.

In my early 50s I went off the pill to see if things had settled down; they had. Eventually,

You're Getting Warmer

WHAT'S HAPPENING WHEN YOU FLASH.

Experts aren't certain about the exact mechanism driving hot flashes, flushing, and night sweats. But we have an idea, thanks in large part to women scientists like Rebecca Thurston, PhD, at the University of Pittsburgh; Pauline Maki, PhD, at the University of Illinois at Chicago; and Naomi Rance, MD, PhD, at the University of Arizona—not to mention a cadre of overheated rodents (Rance has worked with lab rats to identify which neurons are involved when their tail skin vasodilates, their version of a hot flash). Here's what we know:

Starting in perimenopause, your **INTERNAL THERMOSTAT** goes on the fritz. The part of your brain responsible for sensing and controlling body heat overreacts to even slight changes in core body temp. This is likely due in part to estrogen withdrawal, Thurston says, but could also be due to extreme estrogen fluctuations. (The neurotransmitters norepinephrine and serotonin play a role, as do special neurons in the hypothalamus—but more research is required to know exactly how they factor in.)

Most women report noticing **TRIGGERS** that make them flash—for example, spicy food, stress, or red wine. However, Thurston and her team haven't been able to manipulate these possible culprits to induce hot flashes in the lab. "We've tried to warm women up with special heating pads, stress them out by asking them to, say, perform difficult math tasks, but they're just as likely to flash while sitting calmly." (Thurston would know: She monitors participants' brain, heart, and blood vessels so she can measure when they're flashing even when they don't realize they are.)

Neurons in the brain are activated, and the hypothalamus sends out the signal that the body needs to cool down. In response, you experience **VASODILATION** (widening of your veins, arteries, and capillaries to increase blood flow and dissipate heat) as well as the cursed sweating. You may be oversensitive to drops in body temperature, too, which is why clamminess, shivering, and chills often follow hot flashes.

The hot flash can last from one to 15 minutes (usually closer to five) before your **BODY TEMPERATURE** returns to the "comfortable" range. The process can continue for seven to nine years—that's the mean duration, although a third of women flash for longer. It's not uncommon to have hot flashes into your 70s or beyond. Scientists are working on finding a reliable predictor of when they will stop.

The problem with not fully understanding how and why flashes happen is that it limits the development of new treatments. **HORMONE THERAPY** can be very effective, but it's not the best option for every woman, and other treatments come with side effects and caveats, too.

But some explosive new findings could change everything: Thanks to Thurston and other scientists, it's now believed that hot flashes may be associated with increased risk of **CARDIOVASCULAR DISEASE**, the number one killer of women, says Stephanie Faubion of NAMS. Adds Thurston: "We've seen that women with more, and more frequent, hot flashes—upward of four in a day—often have signs of underlying vascular dysfunction that can put them at risk for future cardiovascular issues. We don't think hot flashes *cause* the dysfunction—they just help identify women who have it." Showing the connection isn't meant to scare women, says Faubion. On the contrary, it could be the thing that saves them, by directing public interest—and all-important research dollars—into this hot-button menopausal symptom. **–C.P.**

THIS PAGE: WEIGHT LIFTER: HENNIE HAWORTH. ICONS, ALL FROM THE NOUN PROJECT: SLEEP: DYM DESIGN. MEDITATION: CHANUT IS INDUSTRIES. CARROT: ALFAFEHAH. BONE: SARAH. SCALE: ALEKSANDR VECTOR. NO SMOKING SIGN: VECTORS MARKET. PREVIOUS PAGE: BURNER: HENNIE HAWORTH. THERMOSTAT: PROSYMBOLS. TNT: JON TESTA. BRAIN: SVELTE UX. HOURGLASS: SMA RITZ. PULSE: NIKITA KOZIN.

DO THIS IN YOUR 40s, THANK YOURSELF IN YOUR 60s

You'll never drop dead of a hot flash, but flashes—and other perimenopausal symptoms—are red flags telling you it's time to get serious about your health, says Tara Allmen, MD, a board-certified gynecologist in New York City. The great news is that you already know how: Just follow the advice your doctor has been repeating for years. "They give you all this information about healthy habits in your 20s or 30s, but women that age often shrug it off," says Siobán Harlow, PhD, a professor of epidemiology and global public health at the University of Michigan School of Public Health. Then you hit midlife, and your body stops bouncing back the way it used to. Is it ironic that we finally have to take healthy living seriously just when so many of us are feeling too stressed and sluggish to do so? Yes! But think of these lifestyle changes as a gift to your fabulous future self.

PRACTICE GOOD SLEEP HYGIENE. It seems like a cruel joke to suggest that women plagued by night sweats and insomnia need to sleep better, but doing so is vital to your well-being, now and forever. When you're rested, you're more likely to make healthier food choices and to exercise, be in a better mood, and have sharper cognition. So make sleep hygiene your religion (thou shalt not drink alcohol after dinner or binge on Netflix until 1 a.m.). And if the Goddess of Zzz's still forsakes you, speak to a psychologist about insomnia or a sleep specialist about apnea.

LOWER YOUR STRESS. It can take a serious toll on your physical and mental health. Research shows benefits from regular exercise and meditation, but also consider talking to a therapist—especially if you're prone to depression (which can put you at greater risk of having a depressive episode in perimenopause). And don't forget your friends: Social interaction is a known mood booster.

GET HEART SMART. Talk to your doc about cardiovascular risk factors like high blood pressure, elevated cholesterol, and diabetes. Eat healthy (more plants, whole grains, poultry and fish; less saturated fat, sodium, red meat, and processed foods) and commit to aerobic workouts (at least 150 minutes a week of moderate-intensity activity). If you've been prescribed heart meds, take them. And note that as frequent hot flashes during perimenopause may be associated with increased cardiovascular disease risk, all of this advice is *crucial* for flashers.

(RE)BUILD STRONG BONES. A decrease in estrogen can accelerate the natural loss of bone. Make sure you're getting enough vitamin D, doing weight-bearing exercises like running, jumping rope, and squat-jumps (they help build bone in addition to growing muscle) and practicing yoga, which can help reinforce bones while improving balance.

MAINTAIN A HEALTHY WEIGHT. With age, we lose muscle mass and our metabolism slows, both of which can lead to weight gain. On average, midlife women gain one and a half pounds per year, which often shows up in the midsection as a result of decreasing estrogen levels. Fat in the abdominal area can increase the risk of serious conditions including diabetes, breast cancer, and cardiovascular disease. Following all the above advice will help ward off weight gain—as will lifting weights to build calorie-burning muscle.

QUIT SMOKING! It makes every other health issue worse. **–C.P.**

after a year without bleeding, I was diagnosed as having gone through menopause.

I was done. And that was a relief. I was glad to say goodbye to periods, glad to be liberated from the emergency fortifications I'd grown used to carting around, glad to no longer be ruled by a cycle and instead be able to focus on myself and my own idiosyncratically shifting needs. A lot of work goes into being a woman of childbearing age; mine was finished. And I'd had it relatively easy! My husband had a vasectomy when we were in our 30s, so I'd already enjoyed years of not needing to give one single thought to birth control. Plus, I'd never faced the risks that fertility brings for women and girls in so many parts of the world. (The UN Population Fund [UNFPA] has reported that every two minutes, a woman dies from pregnancy- or childbirth-related causes. Depending on where you live, menstruation-based discrimination can lead to shunning, harassment, lost school days, lost wages, and, according to UNFPA, "transactional sex to pay for menstrual supplies.") For me, a lucky middle-class American, getting to menopause was a new kind of freedom. For other women, it is salvation.

I did wonder, though: What's the point of menopause in evolutionary terms? What's the advantage of a trait that makes reproduction impossible? In almost every other animal species (not counting killer whales, short-finned pilot whales, belugas, and narwhals), females can bear young until nearly their dying day, yet women lose that ability and then go on to live another *third* of their life. Paleoanthropologists have suggested that, far from being merely an aberration among humans, menopause is what *made* us human. The so-called Grandmother Hypothesis, which gained traction in the 1990s thanks to field data gathered by anthropologist Kristen Hawkes of the University of Utah, posits that menopause gave our forebears the chance to evolve some of our most salient, beneficial traits. As the theory goes, early humans lived in multigeneration kinship groups, and the postmenopausal women in these groups, lacking young children of their own, played a critical role in aiding the survival of their offspring's children—who, living to adulthood, were able to procreate and pass on their grandmothers' longevity genes. This in turn allowed for the evolution of more complex brains and the development of cooperation and sociability. Nicely done, cave ladies.

Scientists may still be years away from obliterating hot flashes. Even female scientists

Your Bag of Tricks

THE CHANGE IS GONNA COME.
WITH THESE SUPPLIES, YOU'LL BE READY.

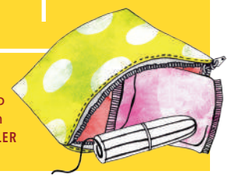
LEAK-PROOF UNDERWEAR In bikini and French cuts, and fetching rose and periwinkle shades, Speax by Thinx undies may not look like they can hold up to eight teaspoons of urine. But they can—and they eliminate odor, too. (From $28 per pair; shethinx.com)

PORTABLE FAN Behold one of civilization's great achievements: the rechargeable W Fan. You wear it around your neck, position the two fan heads to your liking, and blast away hot flashes with cool, cool air. At the highest of the three speeds, you can almost achieve lift-off. ($37; wfanusa.com)

SLEEP SUPPLEMENTS Hope for the middle-aged and the restless: Preliminary research suggests that CBD may help with sleep. Try Plant People's Drops+ Sleep (from $79; plantpeople.co)—but check with your doctor first, as CBD can affect certain meds.

BETTER BEDDING The next best thing to snoozing on ice, Sheex Performance sheets are made of a moisture-wicking polyester-spandex fabric (from $179; sheex.com). You may sweat, but you won't stay wet.

VAJAYJAY MOISTURIZER AND LUBE Keep hydrated down there by applying a moisturizing lotion every few days—like the gyno-recommended Replens Long-Lasting Vaginal Moisturizer ($16; replens.com for stores). And using lube before sex—like Pink Silicone ($23; pinksensuals.com) or Good Clean Love's water-based Almost Naked Organic Personal Lubricant ($12; goodcleanlove.com)—can help you stay in the erogenous zone.



THE MAXIMUM MAXI You never know when the prodigal period will make a sudden—and dramatic—reappearance. Keep at least one heavy-flow pad (with wings; you'll thank us) and an ultra-absorbent tampon in your bag at all times. –CATHRYNE KELLER

PROCEED WITH CAUTION

SOME WOMEN WITH DISTRESSING MENOPAUSE SYMPTOMS ARE WILLING TO TRY ALMOST ANYTHING TO RELIEVE THEM. HERE ARE TWO COMMON TREATMENTS TO THINK TWICE ABOUT.

CUSTOM-COMPOUNDED "BIOIDENTICAL" HORMONES
These pills, creams, gels, shots, and implanted pellets are made at compounding pharmacies based on an individual patient's needs. While they aren't necessarily *bad*, they're not always what they seem. None of them are FDA-approved, which means they aren't required to meet the government's labeling, safety, and quality control standards. As a result, customized compounded hormones can vary in their purity and potency; this is why such products are frowned upon by not only the FDA, but also the North American Menopause Society and the American College of Obstetricians and Gynecologists.

"VAGINAL REJUVENATION"
You may have heard some buzz about lasers or radio-frequency devices that can solve all your vaginal woes. But the procedures are expensive, their results are only temporary, and none are FDA-approved or cleared for the treatment of menopause-related symptoms. In fact, last year the FDA explicitly warned that their effectiveness and safety in treating such symptoms has *not* been established. –C.P.

with a lot at stake personally. Even rockstar female scientists who vacation together in California wine country, as the Mayo Clinic's Stephanie Faubion recently did with incoming NAMS president and hot-flash specialist Rebecca Thurston and cognition authority Pauline Maki. ("Women's Health Experts—They're Just Like Us!") But while we can't yet put a stop to all internal conflagrations, we can redefine what it means to have them.

Because the truth is, menopause is not an end. It's a beginning. A searing initiation. A crucible in which a more essential version of ourselves is forged. We go through the fire and come out refined—able, often for the first time ever, to focus on the things we care about most. (And yes, we can focus: Maki says the brain fog related to the loss of estrogen in perimenopause dissipates postmenopause—possibly because, in a scenario researchers are at this very minute exploring, the brain develops its own ingenious neurological work-arounds.)

What do some of our most formidable, fearless leaders have in common? They're women who came to the fullness of their powers on the other side of menopause, and now they're running Congress (Nancy Pelosi), running for president (Elizabeth Warren), sitting on the Supreme Court (RBG). Think of Christine Lagarde, Patti Smith, Ruth E. Carter, Sister Helen Prejean—all forces to be reckoned with as younger women, but none of them as deeply visionary, as thoroughly glorious as when they got to the other side. And then there's Belinda Frears, that Kristin Scott Thomas character in *Fleabag:* a successful businesswoman who, in one episode, has a martini at a bar with the show's obviously smitten 33-year-old female protagonist. At 58, Belinda is every inch her own awesome dame—knowing, confident, worldly, humane, and damn sexy—and she has wisdom to share. Being a woman, Belinda says, is about pain—women are born to pain, what with the cramps, the aching breasts, the childbirth, and so forth. And then: "Just when you feel you are making peace with it all, what happens? The menopause comes, the fucking *menopause* comes. And it is...the most...*wonderful* fucking thing in the world. Yes, your entire pelvic floor crumbles, and you get fucking hot and no one cares, but then...you're *free.* No longer a slave, no longer a machine with parts. You're just a person, in business...It *is* horrendous, but then it's magnificent. Something to look forward to."

Wouldn't you raise a glass to that?

Additional reporting by *Serena Alagappan, Corrie Pikul,* and *Deborah Way.*

YOUR BAG OF TRICKS AND PROCEED WITH CAUTION ILLUSTRATIONS: HENNIE HAWORTH.