Everyone Has a *Theory* About You

For when you knew something was off, before anyone believed you.

by Yellow · spotyellow.com

A note before you begin

This book is for information and education. It is not medical advice, and it is not a diagnosis. Every woman's body, history, and circumstances are different, and nothing written here can account for yours.

Please do not start, stop, or change any treatment, medication, or dose on the strength of this book. If something in these pages speaks to your experience, take it to a qualified medical practitioner and decide together. Consult a registered doctor or qualified practitioner before making any change to your care.

Where this book describes what clinical guidelines say, or what a treatment can do, it is reporting published research and guidance, not prescribing for you. The studies, statistics, and clinical sources referred to throughout are listed in full in the Sources section at the back.

Six chapters back to your own authority.

Not another theory about you — information, so that by the last page the credible person in the room is you.

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01

Everyone Has a Theory About You

"I knew menopause might make you forget words or have hot flushes, but I had no idea how utterly debilitating it could be."

– a woman writing on Mumsnet, 2025

You are in a waiting room. Or a boardroom. Or your own kitchen at eleven at night, phone in your hand, open to a forum you found at two in the morning six months ago and never closed.

Someone has just handed you an explanation. Your doctor. Your husband. Your manager. The woman in the mirror. They said it with care. It is stress. You have a lot on. It is your age. It is anxiety. Have you thought about therapy. Maybe ease off the coffee.

You nodded. You are good at nodding. You built a career on the small competent nod that keeps a room moving. You nodded, you took the pamphlet or the prescription or the advice, you said thank you, and you meant it.

Something in you did not move.

That is the part no one saw. The nod was real. The stillness underneath it was also real. You know your own baseline. You have lived inside this mind for four decades. You know its weather: the days it runs hot, the days it goes quiet, the way it recovers. What was happening to you was not your weather. It was a different season, and no one had given you its name.

This chapter is about that stillness. The one that refused to nod along.

The theories, one by one

Let me lay them out the way they reached you. Not as a list of mistakes. As a procession of people who looked at you and offered the best thing they had.

No. 01 — ~~*Stress*~~

It is stress. This was the first one, and it was almost true, which is what made it stick. You do have a lot on. You always have. So when the word arrived, it fit your shoulder like a coat you already owned. The problem is that stress has been your companion for twenty years and it never once made you lose a colleague's name between your desk and the door of his office. This was new.

No. 02 — ~~*Burnout*~~

It is burnout. A kinder word, and a more fashionable one. It came with permission to rest, which you wanted, and a holiday, which you took. You came back. The fog came back with you. Burnout is real and burnout lifts when the load lifts. Yours did not lift when the load lifted. That tells you something, and you filed it away, and you said nothing.

No. 03 ~~*Anxiety*~~

It is anxiety. This one had a prescription attached. For some women it is two prescriptions, then a higher dose of the second. You may have filled it. You may have felt the sharpest edge of the dread soften while the fog, the joint ache, the three-in-the-morning waking, the body that no longer felt like yours, all stayed where they were. A treatment that touches one symptom and leaves the other nine standing is not a treatment for what you have. It is a treatment for what someone guessed you had.

No. 04 ~~*Depression*~~

It is depression. For many of you this was the official one. The one with a name in a file. And here is the cruelty of it: the hormonal shift you are living through can produce low mood, flat mornings, and a loss of interest that look identical to clinical depression from the outside. The Cleveland Clinic is blunt about it — the hormonal changes of this life stage cause sleep disruption, anxiety, appetite changes, fatigue, and mood disturbance, and every one of those is also a symptom of depression. So you were read by the overlap, and the thing underneath the overlap went unread.

No. 05 ~~*Mindset*~~

It is perimenopause of the mind. A newer theory, almost progressive, because at least it reaches for the right word. But it puts the change in your head, as attitude, as something a better mindset could fix. It is not in your mind. It is in your bloodstream, your brain receptors, your sleep architecture. The word was close. The location was wrong.

No. 06 ~~*Age*~~

It is just life at forty-five. The last one, and the most defeating, because it is not even a diagnosis. It is a shrug. It tells you that the floor falling out from under your own reliability is the standard issue of being a woman your age, and that the dignified response is to absorb it without complaint. You half believed it. That is the one that should make you angry later. We will get to anger. Not yet.

Read that procession again. Every theory came from somewhere. The doctor was working with twelve minutes and a training that never taught her this. Your husband was frightened and reaching. And the harshest theorist in the room, the one who decided you were not cut out for this anymore, was you.

What every theory had in common

Hold all six in your hand at once and a pattern appears.

Stress. Burnout. Anxiety. Depression. Mindset. Age. Every single one points away from your body and toward your character. Your coping. Your resilience. Your attitude. Your willingness to slow down. Each theory, however kind the delivery, asked the same silent question: what is wrong with the way you are handling your life?

Not one of them asked the other question. What is happening inside your body that you are handling this well despite.

That is the structural fact at the centre of this book. The theories failed in the same direction. They all located the problem in you, the person, rather than in the physiology you were carrying the person around in. And once a problem is located in your character, the solutions follow the location. Try harder. Worry less. Rest more. Think your way out of it. None of it worked, because none of it was aimed at the thing that was moving underneath.

Here is one woman's version of the thing that was moving underneath. A doctor who teaches this online described a patient: she got a call at work, took five steps toward her boss's office to pass on the message, and could not remember the caller's name by the time she arrived. Her memory had been excellent her whole life. Now she wonders, in private, whether she has early dementia.

Read that and notice what is not in it. No laziness. No weak character. A sharp woman walked five steps and a name fell out of her, and the only explanation anyone had handed her was a theory about her mind decaying. The truth is smaller and far less frightening: estrogen has a direct role in verbal retrieval and working memory, and when it swings, words drop. The name did not fall out because she is failing. It fell out because of a hormone.

The thing you noticed and could not name

You have been carrying a private piece of knowledge. Most women in your position have.

It is not a symptom. It is more precise than a symptom. It is the specific, wordless certainty that the explanation you were given did not match the thing you were living. You only had the mismatch. The doctor said anxiety and some animal part of you said that is not the shape of this. The shape of this is different.

You did not say it out loud. Saying it out loud would have meant claiming you knew better than the person with the medical degree, on the strength of a feeling. So you held it. You have been holding it for months, maybe years, in the place where you keep the things you are sure of but cannot prove.

That held thing is correct. This is the first promise this book makes you, and it is the one everything else rests on. The instinct that something was off, the instinct you overrode every time a credible person offered you a tidier story, was accurate. You were reading your own body. You were just never told that you were allowed to be the expert on it.

Listen to how it sounds from the inside, in the words of a woman who started a senior job and watched herself come apart at it.

> *"I started my COO job in March, and by June I was struggling. Writing an email took thirty minutes instead of three. I'd get frustrated and start crying, thinking, maybe I'm not cut out for this."*
>
> *– a woman, on her first months as COO*

Maybe I am not cut out for this. That is a theory too – the one she handed herself, in the absence of anyone handing her a better one. And it is the most expensive theory in the whole procession, because she believed it about her competence, her worth. A woman who could run a company concluded, on the evidence of a thirty-minute email, that she had been overestimated all along. The reason was not her ceiling. The reason was a documented cognitive effect of a hormonal transition that nobody had named for her.

How wrong the theory can get

Sometimes the theory does not just miss. It sends you down a different road for years.

A woman wrote about going to her local surgery again and again. She saw several different doctors. None offered help. One blood test came back, looked unremarkable, and on the strength of it she was in the end diagnosed with chronic fatigue syndrome – a serious, life-shaping label, attached to a woman whose actual condition was a hormonal transition that a

single blood test cannot rule in or out. She organised her life around a theory. The theory was wrong.

It does not outrank it. It never did.

What this book will not do

You have been handed a great many theories. You will not be handed another one here.

This book does not arrive with a verdict about you in its pocket. It will not tell you that you are stressed, or depressed, or past it, or imagining things, or in need of a better attitude. It has no theory about your character to sell you.

What it has is information. The numbers on how often women like you are misread, and why. The biology of what estrogen does across your brain and body, so the symptoms stop looking like a personal failing and start looking like a coherent picture. The reason a normal blood test means far less than you were led to believe. The language to walk back into a medical room and ask for what you are owed. And the honest map of where the help is, and where it is still thin.

The point of all of it is one thing. Not to replace the theories with a better theory of mine, but to put the authority back where it belongs. With you. By the last page you will be the credible person. You will know enough to form your own picture, hold your own ground, and recognise a wrong theory the moment it is offered to you, however kindly.

The way you are feeling is not because you are losing your mind. It is because you are *going through perimenopause.*

Not a mind coming apart. A body in transition, doing it without a map, while you kept going anyway. The map starts now.

An exercise

The Theory Inventory

Ten minutes, by hand or on a notes page, before you read Chapter 2.

1. At the top of the page, write: What I was told.

2. List every explanation you have been given for how you have been feeling — from doctors, partners, managers, friends, and yourself. Write them all, without editing or ranking. Include the ones you said only to yourself.

3. Next to each, write two things: (a) Did it feel true? and (b) What did you think, and not say?

4. Read it back. Notice which entries have the longest private column. That gap — between what you were told and what you held — is the subject of this whole book.

Why this works

Writing about emotional experience has been studied since the work of psychologist James Pennebaker in 1986, across more than four hundred trials since. Putting the gap on paper — the distance between the explanation you were handed and the thing you knew in private — lowers psychological distress and eases the cortisol load of carrying an unspoken thought. You are taking the first piece of evidence out of your body and putting it somewhere you can look at it.

You have been very well-behaved about all of this.

That ends now.

Chapter Two – Why They Missed It →

02

Why They Missed It

"The medical education system that trains clinicians in this country is late to the game and behind the times."

– Dr. Maria Sophocles, OB-GYN

You are back in the office. The results are in. Your levels, the doctor says, are within normal range. Everything looks fine. So you ask the only question you came to ask. Then why do I feel like this.

There is a pause. The pause is the part you took home with you. Then the words arrive: a lot on at the moment, probably stress, perhaps someone to talk to. You leave with a pamphlet you will not read, and on the way home you open your phone and type your symptoms into the search bar for the forty-seventh time, because the search bar, whatever else is wrong with it, has never once made you feel you were wasting its twelve minutes.

You walked out of that room holding a familiar weight. Not the symptoms. The other thing. The quiet verdict that you had failed to make your case. That if you were sharper, or more articulate, or less tired, you would have found the words that made the doctor see it. Put that weight down. This chapter is about why it was never yours to carry.

A woman on Mumsnet wrote a sentence that holds the whole of that weight.

> *"It's made me realise the internalised misogyny I've been holding, because I feel shame about it and somehow less of a woman because I'm going through it early. Logically I know that's nonsense, but I can feel it bubbling."*

Read what she names. She knows, in the front of her mind, that none of this is a verdict on her worth. And still the shame bubbles up, because it was installed long before her symptoms arrived, by a culture that taught her this part of a woman's life is a thing to hide. The shame is real. It is also borrowed.

The number, said without drama

Here is a figure, and I will hand it to you straight, because drama is the last thing you need from me. Nearly forty percent of perimenopausal women are misdiagnosed. In the age band you most likely occupy, between forty-five and fifty-four, one in three women is given a wrong diagnosis before anyone tells her the cause is hormonal. Not one in thirty. One in three.

Sit with what that does to the story you have been telling yourself. The story was: I should have known, I should have pushed harder, why did I believe them. The number does not survive that story. You were not the unlucky exception who drew one careless doctor. You were the common case. A third of the women who sat in those waiting rooms beside you walked out holding the

same wrong envelope, telling themselves the same private thing about their own failure to be convincing.

A private shame shared by millions of people is not a shame. It is a pattern. And a pattern points at the structure, not at the person standing inside it.

What they called it instead

The wrong diagnoses are not random. Anxiety disorder, thirty-three percent. Depression, twenty-seven. Mood disorder, twenty-five. Panic disorder, thirteen. Those are the labels written in the files of misdiagnosed women, in that order.

Read the list as a single sentence and you will hear it. Every one of those names is a name for something happening in her mind. Not one is a name for something happening in her body. The system, when it cannot find the cause, has a reflex, and the reflex is to file the woman under her psychology. The hormone never enters the room. The hormone was the thing that sent her there.

The doctor was never taught it

This is the part that should change how you feel about the woman across the desk. Only thirty-one percent of obstetrics and gynaecology residency programmes in the United States* include a menopause curriculum at all. The doctors most likely to treat this complete their training and most of them were never taught the thing. Eighty percent of medical residents described themselves as barely comfortable treating menopause. Seven percent felt prepared. Seven.

Dr. Maria Sophocles, who says the quiet part out loud, names it without softening: the medical education system that trains clinicians in this country is late to the game and behind the times. So picture the room again. Twelve minutes. A waiting list out the door. And a training that skipped the chapter you needed. The doctor was not careless. She was working, in good faith, from a map with your whole territory left blank.

If you want the measure of how deep the blank runs, consider the people whose whole job is women's health. Andrea Donsky spent seventeen years in health and wellness before her own symptoms arrived.

> *"I was in the health and wellness space for 17 years and I thought, wait, shouldn't*

I know all this? But I knew nothing."†

If a professional who built a career around women's health was never taught this, the gap in your twelve-minute appointment was not bad luck. It was the same blank, in a different room.

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† *Andrea Donsky, menopause educator and founder of Morphus, quoted in Cloey Callahan, "She secretly wonders if she has dementia: Menopause awareness online is translating back to the office," WorkLife (Digiday Media), 15 April 2024.*

* *We've looked at global data and examples for specific pointers where Indian data fell short.*

This is also why you ended up alone with a search bar at midnight. Only fifteen percent of women felt informed about perimenopause when their symptoms began. Forty-two percent turned to Google or family for answers. Twenty-six percent learned what was happening from their own doctor. The people with the training were the least likely source of the explanation.

A normal test that proved nothing

There is one more piece, and it is the one that did the most damage, because it came with the authority of a lab. Your hormone test came back normal. You took that to mean nothing was happening. Here is what no one explained. The standard test measures a hormone called FSH, and in perimenopause that hormone does not hold still. It can read eight one month and sixty the next, and both are normal for a body in transition. A single measurement is a photograph of a moving thing.

This is not a fringe opinion. The NICE guidelines and the position of the North American Menopause Society* say the same thing in plain language. Perimenopause is diagnosed from symptoms, not from a blood test. The woman's report is the evidence. The lab result, at this stage, is close to noise.

You were handed a normal result and you read it as a verdict on your sanity. It was never that. It was a snapshot of a moving target, presented as a still life.

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* *We've looked at global data and examples for specific pointers where Indian data fell short.*

The overlap that hid the whole thing

Now put the pieces together and you will see why this is a machine, not a mistake. The psychological symptoms of perimenopause — the anxiety, the low mood, the broken sleep, the fog that sits behind the eyes — line up almost point for point with the textbook picture of clinical depression and generalised anxiety. To a clinician who was never taught the hormonal version, the hormonal version is invisible. She is not missing it because she is bad at her job. She is missing it because what she is looking at is, symptom for symptom, the thing she was trained to recognise as something else.

> *"Menopause was not misunderstood because women weren't asking questions, but because medicine was never taught to answer them."*
>
> *– Dr. Mary Claire Haver, OB-GYN*

The failure was never in the asking. You asked. Sixty-four percent of women report that their pain was normalised or waved off by a medical professional, and the reason you stopped asking sooner was not weakness. It was the entirely sane response to being met, again and again, by a system that had no answer and mistook its own silence for proof that nothing was wrong.

The doctor who does catch it

Here is the fair objection. If this is a system failure, why do some women get caught? Why does one woman hear the word perimenopause on the first visit, while you saw three doctors and heard stress, stress, and a referral? The answer does not weaken the argument. It is the argument. The women who get caught early are the ones who happened to find a clinician who chose to learn the part the training left out. The fact that it is catchable in twelve minutes, by someone who knows what to look for, is the proof that your misses were never about the difficulty of the case. They were about who was in the chair. That is not a comfort. It is a target.

Underserved, not fooled

You were not naive. You were not slow. You did not fail to advocate for yourself. You walked into a structure that misdiagnoses two in five women like you, that trains its doctors to leave this page blank, that hands out a test it knows is unreliable and lets you read the result as a sentence. Inside that structure, you did the only rational thing a person can do. You trusted the experts.

Change one word and watch the whole feeling shift. You were not fooled. You were underserved. Those are different stories, and they leave you in different places.

The anger I promised you

In Chapter 1 I told you we would get to anger, and asked you to wait. This is the page. Let it in now, because you have earned it and because it is accurate. Be angry that a third of the women in those waiting rooms were handed the wrong envelope. Be angry that a test known to be unreliable was passed across the desk as a verdict. Be angry that the doctors most likely to treat this were never taught it. Be angry, most of all, at the months or the years you spent believing the fault was in your character.

I am not going to move you off this fast. Most books reach for the calm reframe right here. Not yet. The anger is not a thing to be managed out of you. It is information, the same way the held instinct in Chapter 1 was information. It is the part of you that knows the true size of what was taken and refuses to file it under fine. For most women it is the first honest step into getting better, because it is the moment the shame changes hands. You stop holding what was never yours, and you hand it back to the thing that earned it.

An exercise

The Timeline

Ten minutes, on paper or a notes page, before Chapter 3.

1. Draw a horizontal line across the middle of a page. This is time.

2. On the far left, mark when the first symptom appeared – the earliest thing you now recognise as part of this, even if you did not recognise it then.

3. Along the line, mark each doctor's visit, each diagnosis, each treatment you were given. Just the facts, in order.

4. Mark today on the far right.

5. Look at the distance between the first symptom and today. That gap is not a measure of your failure. Give it an honest name: how long you went without a map.

Why this works

Building a plain chronology of a hard experience, even with no framework to explain it, is a documented tool in trauma-informed care and medical self-advocacy. Pennebaker's foundational work showed that constructing a narrative of difficult events lowers the body's stress load. The timeline eases the weight of unexplained suffering, and hands you a clean factual record that makes your next clinical conversation sharper.

You were not fooled. You were underserved.

Now you know the difference. The anger that comes with knowing is yours, and you do not have to give it back at the door.

03

What They Gave You Instead

"I had women come to me on multiple antidepressants who had never experienced anxiety before their forties."

– Dr. Mary Claire Haver, OB-GYN

The prescription was for an antidepressant. Or an anti-anxiety tablet. Or, with no prescription at all, the advice to try therapy and to manage your stress. You filled it. You took it for six weeks, because six weeks is what they told you it needs. And something did shift. The sharpest edge of the dread went soft. But the weight stayed. The fog stayed. The feeling of being a stranger inside your own skin stayed exactly where it was.

So you told yourself the sensible things. Maybe it takes longer. Maybe the dose is too low. Maybe I am not giving it a fair chance. You did not let yourself think the other thought, the one that had been standing at the back of the room the whole time. Maybe this is the right medicine for the wrong problem.

This chapter is permission to think it.

Let me be clear, because it matters

This is not a chapter against medication. Antidepressants are real medicine. They have pulled people out of water they were drowning in. If you live with depression alongside this, or underneath it, the medication may be holding something genuine and you should not stop anything on the strength of a book. Hold that in mind while you read the rest, because the rest is sharp.

This is a chapter about what happens when the right treatment is aimed at the wrong cause. A treatment matched to your psychology, when the driver is your physiology, is not a scandal. It is the predictable output of the system you read about in the last chapter. But predictable is not the same as correct, and you do not have to keep living inside a prescription that was written to a guess.

What the guidelines actually say

Here is the thing almost no one told the women in that waiting room. The clinical guidance is not vague on this. NICE in the United Kingdom*, the North American Menopause Society, and The Menopause Charity all hold the same position, and it is blunt. Antidepressants should not be the first-line treatment for low mood that arrives with perimenopause. There is no good evidence that they address the psychological symptoms of this transition at the root, because the root is hormonal and the tablet is not.

A study in the Journal of Affective Disorders found that menopausal women in the United Kingdom* may be over-prescribed antidepressants and under-prescribed hormone therapy. The phrase the researchers used is worth keeping: many women are inappropriately offered

antidepressants when they first seek help. Not as a fallback after the right thing failed. As the first move, against the guidance, at scale.

** We've looked at global data and examples for specific pointers where Indian data fell short.*

What the right treatment can do

Now the other side of it, because permission without information is just a shrug. A study published in the journal Menopause in 2024 found that three months of menopausal hormone therapy lifted depressive symptoms in perimenopausal women. Three months. Not a lifetime of dose adjustments. A treatment aimed at the actual mechanism, producing a measurable change in the thing everyone had been trying to medicate sideways.

> *"Hormone therapy is first-line for most perimenopausal women with new mood symptoms — not an antidepressant."*
>
> *– Dr. Mary Claire Haver, OB-GYN*

Read that as the sentence you needed someone to say to you at that appointment, and did not get. New mood symptoms, arriving for the first time in your forties, in a body that is changing, point at the change. The first question should have been about your hormones. For most women, it never is.

Remember R, from Chapter 1, the woman who saw doctor after doctor and walked out with a diagnosis of chronic fatigue. Her story does not end there. She kept going. She demanded a referral to a specialist, and the specialist treated the actual cause, and here is what she wrote afterwards: *"HRT has helped with my aching joints, anxiety, and emotional ups and downs."*

Read the list. The aching joints. The anxiety. The emotional swings. Three symptoms from three different folders, the ones a mood tablet would never have touched, lifting together once the treatment was aimed at the one thing underneath them. That is what it looks like when the right tool meets the right cause. R is not a different woman from you. She is you, a few steps further down a road you have not been shown yet.

The signal you talked yourself out of

Here is the part I want you to sit with longer than the rest. When the medication did not fix the mood, you treated that as a failure of the medication, or a failure of you. It was neither. It was information.

A treatment that touches the right target tends to move it. When a tablet aimed at depression leaves the fog, the joint ache, the three-in-the-morning waking, and the strangeness in your own body all standing where they were, that is not a sign you need a higher dose. It is a sign the tablet is aimed at something other than what you have. Your body ran the experiment and reported the result. You were just taught to read the result as your own deficiency rather than as data.

You are trained to do this, and the training started long before any of these symptoms. Somewhere back there, a credible adult told you that the thing you felt was not the thing that was happening, and you learned to treat your own reading as the lower court and theirs as the higher one. So when your body returned a clear verdict — no change — you appealed it. You assumed the error was in your reading rather than in their diagnosis.

Look at the shape of that. The one instrument measuring the actual question, your own lived sense of whether you felt any better, was the single instrument everyone agreed to distrust. The lab was trusted. The guideline was trusted. The prescriber was trusted. You, the only person inside the body, were told to wait and see and not to read too much into it.

This is the habit the rest of this book exists to break. Your experience of a treatment is evidence. Not a mood, not an attitude, not a shortfall of willpower. Evidence. When the right treatment reaches the right cause, you will know it in your body, the way R knew it when her joints and her anxiety lifted in the same weeks. And when the wrong treatment is aimed at the wrong cause, the stubborn fact that you are not better is evidence too, and you are allowed to act on it.

Hold the honest edge of this, because it matters. For some women, the antidepressant was the right call and remains the right call. Depression and perimenopause can sit in the same body at the same time, and a woman can need both a hormonal treatment and a mental-health one. The point was never that the tablet is always wrong. It is that the tablet should not be the first and only answer to a hormonal cause, written in the first ten minutes, with no one ever asking about the hormones at all.

You do not have to stay on a treatment that is not treating the cause. That is not a recommendation to stop anything tonight. It is a sentence you are allowed to carry back into a medical room, which is where the next two chapters are taking you.

An exercise

What Your Body Already Knew

Ten minutes, in private, before Chapter 4.

1. Bring to mind one time in the last two years when a treatment, a diagnosis, or a piece of advice felt wrong to you, even though you accepted it.

2. Write what you noticed. Not what you thought in your head — what you felt in your body. Where did the doubt sit? What was the texture of it?

3. Write what you said out loud. Underneath it, write what you did not say.

4. You do not have to do anything with this. Just register one fact: you knew something.

Why this works

The ability to read your own internal signals — what researchers call interoceptive awareness — is tied to steadier emotion and more accurate judgements about your own health. Work from the Mindful Awareness in Body-Oriented Therapy programme shows that structured attention to body-level knowledge improves medical self-advocacy and weakens the habit of overriding a physical signal with an outside authority. This is the first step in rebuilding trust in your own instrument.

Your body has been trying to tell you something for a long time.

You were just never put in a room quiet enough to hear it.

04

The Actual Picture, All of It

"There is not a perfect blood test for perimenopause, because of the widely fluctuating hormone levels. It is often diagnosed by symptoms alone."

– Dr. Mary Claire Haver, OB-GYN

It is midnight and you are on your phone. You have typed your symptom into the search bar a hundred times before. This time something is different. You click a link and you read a sentence that holds six symptoms you had never once thought to put in the same room together, and you have had every single one.

You read it again. Then you screenshot it, which is a thing you do with evidence. Then you read it a third time, taking each word, in the particular silence of a body that has just said yes. That silence is the subject of this chapter. By the end of it you will have the whole picture, not a piece of it.

The symptom you would never have guessed

Heart palpitations. The flutter or the hard knock in your chest that sent you, maybe, to a clinic, certain something was wrong with your heart. Forty-two percent of women in this transition get them. Most go to be checked. Most are told the heart is fine, which is true, and sent home, which is incomplete, because no one mentions that a hormone in retreat can do exactly this.

Or the hair that changed texture. Or the joints that started aching for no reason you could name. You filed each of these under its own separate heading. A heart thing. A skin thing. A getting-older thing. You never filed them together, because no one told you they belonged in the same folder. They belong in the same folder.

Some of the symptoms in that folder are not subtle at all, and women are still sent home from them. The bleeding is the clearest example. One woman wrote, *"I'm bleeding heavily for about 22/23 days out of every 30."* Another tried to get hers looked at and met the same wall: *"I tried to get it investigated, was told it was normal. Have bled for up to six weeks at a time."* Bleeding for forty weeks of the year, told it was normal. That is not a woman failing to notice something is wrong. That is a woman noticing, raising it, and being filed under fine.

Why the symptoms cluster

For a lot of women this is the place where three years of separate worries fold into one, and the folding feels like two things at once. Relief that it is a single thing. And a strange vertigo at how long it sat in front of you without a name. Both are the right response.

There are more than thirty distinct symptoms documented in this transition, and the reason they travel together is one fact. Estrogen is not a reproductive hormone that happens to also do a few other things. It is a hormone with receptors across your brain, your blood vessels, your joints, your skin, your gut, your bones, your sleep architecture, your temperature control, and the

parts of your brain that find words and hold a thought in working memory. When estrogen starts to swing, every one of those systems feels the swing.

That is why the symptoms cluster. They are not thirty unrelated problems that arrived together by cruel coincidence. They are thirty windows onto one event. The fog and the lost word, the palpitations, the aching joints, the thinning hair, the sleep that breaks at three, the mood that drops without a trigger. One driver. Many windows.

Sixty to sixty-five percent of women experience cognitive disruption in this transition severe enough to affect their work. That is not a small group of unlucky women. That is most women, carrying a documented effect of a hormonal shift, while a part of each of them wonders if she is the only one losing her grip.

> *"Spoken language is my whole job, and I feel most days like I'm covering up this big secret — that actually my brain has atrophied and I'm really no longer able to do my job."*

She is not describing a lazy mind. She is describing a sharp mind, terrified, doing its job while convinced it has stopped being able to. Another woman put the loneliness of it as dark comedy — that she half expected to wake one day surrounded by doctors amazed she could walk, never mind work and raise children, who would give her a round of applause. Hear what is under the joke. She has been carrying something she believes would astonish a room of specialists, to work and school pickup, with no name for it and no applause.

The blood test, made plain once and for all

You met this already, and it is important enough to state on its own. The standard test measures FSH, and in perimenopause FSH moves. It can read eight one month and sixty the next, and both are normal for a body in transition. One measurement is a photograph of a moving thing. A normal result on a single draw does not mean nothing is happening. It means the hormone was at a particular point on the particular morning you bled into the tube.

The clinical guidance knows this. NICE and the North American Menopause Society* both say perimenopause is a clinical diagnosis, made from symptoms, not from a blood panel. If a doctor rules you out on the strength of one normal FSH, the doctor is doing the opposite of what the

guidance instructs. Your normal blood test was never proof that you were fine. It was a snapshot the guidelines themselves say should not be used to dismiss you.

Why it started before the obvious sign

The symptoms of perimenopause can begin while your periods are still regular, often two to ten years before your final one. The change in your body starts long before the change in your calendar. So when the fog arrived, or the palpitations, the one signal everyone is taught to watch for — the change in your cycle — had not happened yet. The dots were there. The line that joins them ran underneath the surface for years before it broke the surface at all. This is why you were handed every other explanation first. Stress, anxiety, depression, age. They arrived in the gap, and they filled it.

** We've looked at global data and examples for specific pointers where Indian data fell short.*

Why it looked like everything else

These symptoms get mistaken for anxiety, for depression, for attention disorders, for chronic fatigue. Not because they are the same conditions, but because estrogen regulates the very brain systems those conditions involve. Forty percent higher risk of depression in this transition compared with the years before it. Nearly fifty-nine percent of women reporting significant anxiety symptoms. Those are not thirty million character flaws. They are documented effects of a hormone acting on brain chemistry, in a body doing something entirely normal.

Not every woman carries the same weight

This is a spectrum, not a single fixed sentence handed to everyone. For some women the transition is light. For others it is the heavy end, and the heavy end is brutal. A woman called Cliffedge25 laid hers out without a filter.

> *"I can't sleep, can't think straight, can't remember words or names. I'm hot, emotional, and I feel like shit. I was asked who's grandma I am at my child's football last Saturday."*

Read that last line on its own. A woman at her own child's football match, asked whose grandmother she is. That is the heavy end, and it is not rare. Where you sit on that spectrum is information for the appointment in Chapter 5. It is not a measure of how much you are allowed to ask for.

What it has been costing you

The picture is not only made of symptoms. There is a cost attached to it that no one counts. For the first time, economists have put a number on it. Researchers at Stanford have documented what they call the menopause penalty: women earning around ten percent less in the years after menopause begins. Not because they became less able. Because they cut their hours, or stepped back, or left the job, in the same window that should have been their peak earning years.

And it tends to arrive carrying company. As one woman put it, daily life at menopause age often means the combined stress of a senior role at work while also supporting elderly parents. The transition does not wait for a clear week. It lands on top of the senior job, and the ageing parents, and the children not yet grown — which is part of why it was so easy to file the whole thing under stress. There was always enough stress nearby to take the blame.

How long this runs, and what is on the other side

One question sits under all of this. How long does this last. The honest answer is that it varies more than anyone wants it to. The transition itself runs four to eight years for most women, though for some it is shorter and for some it stretches past ten. It ends at menopause, which has an exact definition: twelve months after your last period, one date you can mark. Everything after that point is post-menopause, and it is the rest of your life.

Here is the part to hold on a hard day. The turbulence is loudest in the transition, when the hormone is swinging, not when it is gone. After menopause, the swinging stops. The level is low, but it is steady, and steady is something a body can settle into. A great many women describe the years that follow as a return to an even keel they had started to believe was gone for good. It is the shape of the thing. A turbulent passage, with a length, and another side. You are standing somewhere on a line that does not run on forever.

The gift hiding inside the picture

A nameless affliction is a thing that is wrong with you. A named transition is a thing that is happening to you, that happens to most women, that has a biology and a literature and a set of

responses. You did not imagine any of it. You were reading a real event in your own body, with no map, and you were reading it right the whole time.

An exercise

The Symptom Map

Ten minutes, on paper, before Chapter 5.

1. Make five columns on a page. Head them: Cognitive, Emotional, Physical, Sleep, Relational.

2. In each column, write any symptom you have had in the last two or three years, including the ones you dismissed, shrank, or pinned on something else.

3. Beside each one, write roughly when it began.

4. Read the whole page. Count how many you never once connected to a single underlying cause. Let that number land, without turning it into self-blame.

Why this works

Patient-reported outcome research shows that when people record and sort their symptoms before a clinical visit, they get more thorough diagnostic attention and carry less health anxiety. Naming and mapping symptoms, even in private, builds structure around distress that was formless. Work on health literacy from the Agency for Healthcare Research and Quality finds that organised symptom documentation is one of the single most effective tools a patient has for improving the accuracy of a diagnosis.

For three years you kept a dozen folders and believed the mess in them was yours.

It was one event the whole time, and you read every page of it before a single person agreed to call it by its name.

05

The Appointment You Deserve

"Perimenopause can be far more symptomatic than menopause itself, yet women are often told nothing is wrong."

– Dr. Jen Gunter, OB-GYN

You have been in this office before. You know the shape of it. You will describe something true and it will be made smaller in the describing. You will be offered a pamphlet, or a referral, or a come back in three months and we will see. You are going back anyway.

But this time there is a piece of paper in your bag, and for the first time you know, before you sit down, the exact name of the thing you are there to ask for. That changes the encounter more than you would think. A vague request is easy to wave off. A specific one is hard to ignore without looking like you are ignoring it.

What a good appointment looks like

Not a fantasy. A real and reachable thing. A good appointment is one where you put your symptom list on the table at the start, not the end. Where the doctor treats your report as evidence rather than a complaint to be managed. Where the words clinical diagnosis and treatment options and hormone therapy get said out loud by one of you, and met as real by the other. Where you leave with a next step that has your symptoms in it, not just a referral to a different waiting room.

You are not aiming for a miracle. You are aiming for a competent conversation in which your body is treated as the subject. That is a low bar that the system has spent years setting below the floor. Name it anyway, so you can tell whether you got it.

The exact sentences

Vague self-advocacy is just hope with better posture. Here are the specific lines. Say them close to word for word.

"I would like to discuss whether my symptoms might be related to perimenopause."

"I understand hormone tests can be inconclusive at this stage. Can we look at a clinical diagnosis based on my symptom pattern instead?"

"What is the full range of treatment options, including hormone therapy?"

"Can you refer me to a menopause specialist?"

These are not aggressive. They are not demands. They are the four sentences that move an appointment from a conversation about your character to a conversation about your physiology. The second one disarms the single most common dismissal — the normal blood test — before it can be used on you.

Permission to push back

You may need to say a thing twice. You are allowed to. The Menopause Charity, in its guidance for exactly this situation, is direct: if you feel you are not being listened to, repeat and restate. Persistence often pays when you can give a clear, rational argument, and you may need to repeat this to several doctors before you get the outcome you need.

Read that as the permission slip it is. The woman who restates her case is not being difficult. She is doing the documented, recommended thing. If part of you flinches at the idea of pushing back against a doctor, that flinch is not your manners. It is the training that taught you the person with the degree outranks the person in the body. That is false. Here is where you act on it.

> *"The fact that people are leaving physicians' offices not feeling listened to is a major issue that needs to be fixed."*
>
> *– Dr. Jen Gunter, OB-GYN*

You are not imagining the dismissal. A specialist is on record calling it a system-level failure. When it happens to you, the correct response is not to shrink. It is to restate, and if restating fails, to leave and find another room.

When the room fails anyway

Here is the honest part, the part most guides leave out because it is not uplifting. Not every appointment will go well. You may say all four sentences, in order, in a calm voice, and still meet a doctor who will not engage. If that happens, hear what it means and what it does not mean.

A failed appointment is information about the doctor. It is not information about you. It does not mean your symptoms are not real, or that you asked wrong. It means this particular clinician, working from the blank map you read about in Chapter 2, is not the one who can help you. The correct response to a blank map is to find someone holding a better one.

That someone exists. Menopause-trained and menopause-certified specialists are a real category, and there are directories that list them, including the directory kept by The Menopause Society. Certified means the clinician has done the specific training that most of the system skipped. You are allowed to want that kind. You are allowed to keep going until you find her.

What it looks like when she keeps going

You have been following R through this book — the one filed under chronic fatigue in Chapter 1, the one whose aching joints and anxiety lifted once the right treatment reached them in Chapter 3. This is the part in the middle, and it is the part worth studying, because this is where she did the thing the whole chapter is asking of you.

In her own words, R saw several GPs at her surgery and none of them offered any help. One doctor, whom she saw more than once, refused to listen when she mentioned the possibility of perimenopause. She had a blood test and was told it did not indicate she was going through it — the exact dismissal you now know how to answer. She was given the wrong label and could have stopped there, as most women do. She did not stop. She named perimenopause herself, to more than one doctor, and she kept naming it until she was referred to a specialist who treated the real thing.

Notice what R did and what she did not do. She did not produce a medical degree. She did not win an argument with cleverness. She repeated a clear, rational request, to more than one person, past the point where it was comfortable. That is the whole technique. The treatment that helped her was always there. What stood between her and it was a number of rooms she had to walk through, restating the same sentence, before one of them answered.

The real shift in this chapter

Underneath the sentences and the directory, one thing is changing in this chapter, and it is the thing the whole book has been moving toward. You are walking back into that room as a different person from the one who walked out of it. Not louder. Not angrier. More precise.

You know the numbers. You know why the blood test means little. You know what the guidelines actually say. You know that a dismissal is a fact about the dismisser. You are no longer hoping the credible person will see you. You are the credible person, carrying a document, asking for a medically sound response to a real condition. That is not a fantasy of confidence. It is just what it looks like when the authority moves back to where it belonged the whole time.

An exercise

The Appointment Prep Sheet

Fill this in before your next appointment. Put it on the table at the start, not the end.

1. My top three symptoms, with roughly when each began.
2. What makes each one better or worse.
3. Treatments I have already tried, and whether they helped.
4. Three questions I will ask, and will not leave without answers to.
5. What I want from this appointment, in plain terms: an attempt at diagnosis, a referral, a treatment plan.

Why this works

Healthcare communication research, including work from the Agency for Healthcare Research and Quality, shows that patients who bring written symptom and question lists ask more, get fuller answers, report more confidence, and reach better diagnostic outcomes. Putting the list on the table at the start of the visit, rather than the end, signals organised engagement and lowers the odds of being waved off. This is the single most studied, least glamorous tool a patient has, and it works.

You are not asking for a favour.

You are describing your experience and asking for a medically sound response. The two could not be more different.

06

What's Changing, and What You Can Do

"I didn't have the language for what I was experiencing."

– a working woman in urban India

You found a forum three weeks ago and you have been on it for an hour. Women you have never met are saying things you have never said out loud. Then one post stops you. I didn't have the language for what I was experiencing.

You read it twice. Then you do a thing you have not done in any of the months this has been happening to you. You type a reply. It is three words. Me too, exactly. That small act, a stranger telling another stranger me too, is the subject of this last chapter, and it turns out to be less small than it looks.

Where you actually stand

I am not going to end this book with a tidy promise that the system is fixed. It is not. You deserve the real picture, and this is also the part of the book that turns to the place you live in, because this is the part that changes by country.

Take the scale first. By 2024, more than 140 million women in India will be living through menopause, most of them between forty-five and fifty-five. Against that number, awareness of menopausal health is low. Low among women, low among the doctors who treat them, low among the people who write health policy. This is not a marginal issue affecting a handful of women at the edges. It is a transition that touches over a hundred million lives in one country, much of it in the dark.

That is the ground you have been standing on. The gap is real. You have been pushing against a real gap, which is the first thing that explains why it has been this hard.

Why you may never have said it out loud

There is a particular silence around this, and it is worth naming, because you may have read your own silence as avoidance. In India, the symptoms of this transition are under-reported, and the reason is not that women do not feel them. The reason is sociocultural. Many women, in cities and even more in villages, are reluctant to discuss these symptoms with their own families, let alone a doctor. The silence is not personal cowardice. It is a culture that never built a room where this could be said.

This is not only an Indian pattern. In the Gulf, the silence has a vocabulary of its own. The Arabic phrase for menopause translates to the hopeless age, or the age of despair. Qualitative research in Saudi Arabia found women struggling without a word, their experience made invisible by a taboo that surrounds the whole subject. In the UAE, the silence has teeth: there are

accounts of women dismissed from their jobs for not meeting standards while they were in the worst of their symptoms, with no framework anywhere to name what was happening or to protect them.

The same machinery runs in cultures that look nothing alike. In Japan there is a word, gaman, the virtue of enduring hardship without complaint, and it runs straight into a wall when the right thing to do is to speak up and ask for care. Different country, different word, identical result: her experience made invisible, and the invisibility mistaken for absence.

This silence does not only fall on older women. In India the rate of premature menopause, before the age of forty, runs around 2.2 percent, higher than the global average. If you are reading this in your thirties, told you are too young for any of it to apply, too young is just one more theory, and it belongs in the inventory you made in Chapter 1. So if you held this in private for months or years, understand what you were up against. Not your own weakness. A silence built over generations, that you were never given permission to break.

What is beginning to change

Now the part that is true and earned, not decorative. The conversation is starting to move. Platforms built for this are raising awareness in urban India, and some are working at the level of the system itself. One has partnered with the National Health Mission and trained more than four thousand ASHA community health workers in Karnataka, which is how a subject travels from a private forum to a village clinic. It is early. It is also real, and it did not exist in this form a few years ago. You do not have to wait for the system to finish changing to use what is already here.

The thing that makes all of it easier

Social support is not a soft addition to the real treatment. In the literature on this transition, it is one of the most consistent moderators of how hard the symptoms land. Women who talk about this with other women report lower symptom severity, seek help sooner, and carry less shame. The isolation is not just painful. It amplifies everything. It makes each symptom heavier by making you carry it alone and in secret.

These conversations are already happening, at a scale that would surprise you. The menopause forums on Mumsnet run for hundreds of replies, women answering each other in real time. On TikTok, the menopause hashtag has passed a billion views. And there is a pattern in who women

trust there. They trust the woman who says I didn't know either. Andrea Donsky, the wellness professional who admitted she knew nothing after seventeen years in the field, built her following on exactly that admission. The voice women lean toward is not the one performing certainty from a stage. It is the one that says, in effect, me too. Which is the same three words you just typed.

This is why the three words you typed into that forum matter. Finding one other person who is having this conversation does measurable work. It lifts part of the weight you have been holding by yourself since the first symptom you could not name.

You walked into this book carrying everyone else's theories about you. You are walking out with something different — your own picture, your own language, your own four sentences for the next appointment, and *at least one other person who knows.*

That is enough to begin. That was the only thing this book ever set out to give you.

An exercise

The Community Map

A short closing exercise. Ten minutes, before you close the book.

1. Write the names of two or three people in your life you could be honest with about this. Not to have it fixed. Just to be known.

2. Write one space, online or in person, where women are having this conversation in the open. You do not have to post. Reading counts.

3. Write one thing you learned in this book that you would want another woman to know – a colleague, a sister, a friend ten years younger than you.

4. You do not have to act on any of it today. Just notice that you have more than you did when you started.

Why this works

Social support is one of the best-evidenced moderators of how hard menopause symptoms land. Across cultures, women who talk about their experience with peers report lower symptom severity, more help-seeking, and less of the shame that makes everything heavier. Sharing health information with someone else also sharpens your own recall and understanding of what you are living. This is the first move toward the community layer that makes all of the rest of it lighter.

You are not at the end of something.

You are at the start of knowing. The distance between those two is the whole of this book, and you have already crossed it.

Everyone has a theory about you. By the last page, the one that counts is yours.

by Yellow · spotyellow.com

Sources

The numbers and clinical guidance in this book are drawn from named studies, medical bodies, and clinicians. They are listed here by chapter so you can find the origin of any figure or quote. Verbatim voices marked as community posts are real women writing in public forums, quoted by their usernames. Perimenopause is a fast-moving area of medicine, and guidance is updated over time. These were the sources current at the time of writing.

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