



SUBSTANCE USE AND MENOPAUSAL SYMPTOMS: A SCOPING REVIEW OF PSYCHOLOGICAL DIMENSIONS

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ABSTRACT: Menopause is a significant biological transition marked by physical and psychological symptoms, including hot flashes, insomnia, mood disturbances, and cognitive difficulties. While many women employ adaptive coping strategies, some resort to substance use—such as alcohol, tobacco, sedatives, or illicit drugs—as a maladaptive means of managing distress. This scoping review examined the psychological dimensions of substance use during menopause, synthesizing evidence from 2011 to 2025 across multiple databases. Findings reveal that 65% of menopausal women use alcohol, followed by tobacco (45%), sedatives (30%), and cannabis (15%), primarily for self-medication of anxiety, depression, and sleep disturbances. Psychological motivations include trauma reactivation, identity loss, and social isolation, with substance use often exacerbating cognitive decline and emotional instability. Sociocultural factors, including stigma and inadequate healthcare access, further compound these risks. Effective interventions identified include cognitive-behavioral therapy (CBT), mindfulness-based stress reduction, and peer support groups, though gaps remain in culturally tailored and low-resource settings. The review emphasized the need for integrated care models that address substance use within the biopsychosocial context of menopause, alongside improved screening and trauma-informed approaches. Recommendations emphasize routine substance use assessments in menopause care, expanded mental health services, and targeted research on underrepresented populations.

KEYWORDS: Menopause, substance use, psychological coping, self-medication, mental, health.



INTRODUCTION

Menopause is a critical biological milestone that signifies the end of a woman's reproductive years, typically occurring between the ages of 45 and 55. It is characterized by the permanent cessation of menstruation resulting from the decline of ovarian function and estrogen production. While this transition is a natural phase of life, it is often accompanied by a constellation of physical and psychological symptoms. These include hot flashes, night sweats, insomnia, irritability, anxiety, depression, and cognitive difficulties such as forgetfulness or diminished concentration (Freeman et al., 2014). The onset and intensity of these symptoms vary among women, but for many, they significantly disrupt quality of life, emotional well-being, and social functioning.

In response to these challenges, women adopt a range of coping strategies. Some utilize adaptive mechanisms such as engaging in physical activity, seeking social support, or pursuing psychological counseling. However, a growing body of evidence indicates that a subset of women resorts to maladaptive coping strategies—particularly the use of substances such as alcohol, tobacco, sedatives, or even illicit drugs (Sampson et al., 2020). While these substances may offer temporary relief, they pose significant risks, both physically and psychologically, and often exacerbate the very symptoms they are used to manage.

Understanding the psychological implications of substance use during menopause requires framing the transition as a biopsychosocial event. This model considers how biological factors (hormonal shifts), psychological states (mood disorders, trauma histories), and social influences (stigma, support systems) interact to shape individual experiences (Hunter & Rendall, 2007). Hormonal fluctuations—particularly the decline in estrogen and progesterone—affect key neurotransmitters like serotonin and dopamine, which are closely linked to mood regulation. These biochemical changes can intensify emotional volatility and create fertile ground for anxiety, depression, or irritability, thereby increasing the psychological burden of menopause (Maki & Kornstein, 2012).

It is within this emotionally charged context that substance use may emerge as a seemingly accessible coping option. Alcohol, sedative-hypnotics, and other substances may be used to manage sleep disruptions, reduce anxiety, or dampen mood swings. However, psychological theories of coping—especially Lazarus and Folkman's transactional model—categorize such behaviors as avoidant or maladaptive coping strategies (Lazarus & Folkman, 1984). These strategies tend to provide short-lived relief but ultimately fail to address the root causes of distress. Over time, reliance on such coping mechanisms can lead to dependency, deteriorating mental health, and increased vulnerability to substance use disorders. The psychological distress that fuels substance use during menopause is often compounded by sociocultural and existential stressors. Many women in midlife find themselves navigating multiple roles simultaneously—juggling careers, parenting adolescent children, and caring for aging parents. This “sandwich generation” pressure can be overwhelming, and in the absence of adequate support, may amplify emotional strain. Moreover, menopause itself is often stigmatized in many societies. Rather than being viewed as a natural transition, it may be framed as a decline in femininity or vitality, leading to social withdrawal and diminished self-worth (Avis et al., 2009). When emotional and social



validation are lacking, women may turn inward, and some may attempt to soothe their distress through substance use.

Women with a history of trauma, mental illness, or abuse are particularly at risk during this vulnerable period. Studies show that individuals with prior episodes of depression or anxiety are more likely to experience severe menopausal symptoms and are also more prone to using substances as a form of self-medication (Green & Griffiths, 2014). Likewise, unresolved trauma from domestic violence, sexual abuse, or adverse childhood experiences may resurface during menopause, triggering a resurgence of emotional pain. Without trauma-informed care, these women may turn to substances as a means of escape, thereby entering a cycle of psychological dependency and emotional numbing. In addition to mood disturbances, many women experience cognitive changes during menopause, such as forgetfulness, difficulty concentrating, or slowed mental processing. These neuropsychological shifts, though often temporary, can be distressing and can impair daily functioning. Frustration over perceived cognitive decline may further erode self-confidence and lead to social avoidance. Some women may attempt to counteract these deficits by misusing stimulants or depressants, unaware that such substances can aggravate cognitive deterioration over time (Maki, 2013).

Compounding these challenges is the gendered nature of help-seeking behavior. Women are often socialized to endure pain in silence, place others' needs above their own, and internalize psychological distress. As a result, many menopausal women may not seek appropriate medical or psychological help, even when their symptoms are severe. Instead, they may attempt to self-manage using socially permissible substances like alcohol or misused prescription drugs. Unfortunately, substance use in midlife women is frequently underdiagnosed, as health professionals may attribute presenting symptoms to "normal aging" or overlook the subtle signs of substance misuse (Brady & Back, 2012).

From a clinical psychology standpoint, it is essential to distinguish between occasional, situational substance use and the development of late-onset substance use disorders. Research indicates that midlife women with no prior history of substance abuse can begin using harmful substances during menopause due to escalating psychological and physiological discomfort (Han et al., 2017). Moreover, age-related changes in metabolism and comorbid health conditions such as hypertension, cardiovascular disease, or diabetes may heighten the physiological risks associated with substance use in this demographic.

Given the multifaceted and underexplored nature of this issue, a holistic, psychologically-informed approach is imperative. Cognitive-behavioral therapy (CBT) has shown promise in helping women reframe menopausal challenges, develop healthier coping mechanisms, and reduce reliance on harmful substances (Hunter & Smith, 2014). Equally important are psychoeducation, mindfulness-based stress reduction, and community-based support groups that foster social connectedness and normalize the menopausal experience. Yet, despite these emerging interventions, research remains fragmented and lacks comprehensive synthesis.

While scattered studies have examined substance use or psychological distress during menopause, there is currently no consolidated body of literature that comprehensively maps the relationship



between substance use and menopausal coping from a psychological lens. Most existing research works tend to focus on either physiological symptoms or general substance use patterns in women, without centering the unique psychological stressors of menopause. Given the health risks associated with substance use and the profound emotional changes that menopause can trigger, there is a critical need to systematically examine the existing evidence. A scoping review is particularly well-suited to this task, as it allows for the exploration of broad and emerging research areas, identification of key concepts, and synthesis of interdisciplinary findings. This methodology will help clarify the extent, range, and nature of studies that have addressed the psychological dimensions of substance use among menopausal women. Moreover, it can illuminate gaps in knowledge, inform mental health practice, and guide future research directions in this under-investigated field.

METHODS

Study Design: This study adopted a scoping review design to systematically map the existing literature on the role of substance use in coping with menopausal symptoms from a psychological perspective. The review was guided by the methodological framework proposed by Arksey and O'Malley (2005), refined by Levac et al. (2010), and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018).

Objectives: The scoping review was conducted to:

- i. Identify the types of substances used by menopausal women to cope with symptoms.
- ii. Explore the psychological motivations and factors underlying such substance use.
- iii. Examine how substance use affected mental health and psychological well-being during menopause.
- iv. Map the range of interventions and psychological support mechanisms identified in the literature.

Eligibility Criteria

Inclusion Criteria:

- i. Studies involving women aged 40–65 undergoing natural or surgical menopause.
- ii. Empirical studies (quantitative, qualitative, or mixed methods), literature reviews, and grey literature.
- iii. Studies that explored psychological or emotional reasons for substance use during menopause.
- iv. Peer-reviewed articles published in English between 2011 and 2025.



- v. Articles discussing alcohol, tobacco, prescription medication, or illicit drugs used for coping.

Exclusion Criteria:

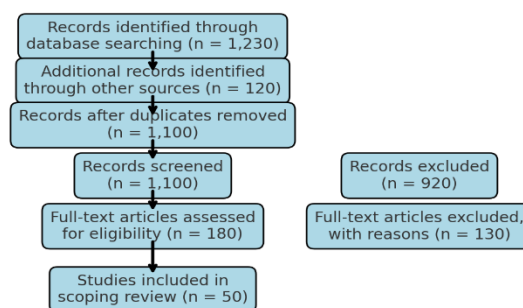
- i. Studies focusing exclusively on hormonal replacement therapy without any mention of substance use.
- ii. Articles that do not address psychological factors or mental health implications.
- iii. Studies involving males or younger/older populations outside the menopausal range.
- iv. Editorials, commentaries, or opinion pieces lacking empirical evidence.

Information Sources and Search Strategy: The literature search was conducted across the following databases: PubMed, PsycINFO, Scopus, Web of Science, CINAHL, and Google Scholar. A comprehensive search strategy incorporating controlled vocabulary and Boolean operators was used. Examples of search terms include: ("Menopause" OR "Perimenopause" OR "Climacteric") AND ("Substance use" OR "Drug use" OR "Alcohol use" OR "Prescription misuse") AND ("Coping" OR "Psychological distress" OR "Mental health" OR "Self-medication").

Selection of Sources of Evidence: All identified citations were imported into EndNote for deduplication. Titles and abstracts were screened independently by two reviewers. Full texts of potentially eligible studies were retrieved and assessed against the inclusion criteria. Disagreements were resolved through consensus or consultation with a third reviewer.

PRISMA-ScR Flow Diagram

The study selection process was documented using a PRISMA-ScR flow diagram (Figure 1).





Data Charting Process

A standardized data charting form was developed and piloted. The following information was extracted from the included studies:

Field	Description
Author(s) and Year	Citation of the study
Country of Study	Study location
Aim/Objectives	Purpose of the study
Methodology	Study design and analysis methods
Sample Characteristics	Age, sample size, menopausal status
Substance Type	Alcohol, tobacco, prescription drugs, illicit drugs
Psychological Dimensions	Motivation, emotional state, trauma history, mental health
Key Findings	Summary of major insights
Recommendations	Intervention or policy implications

Collating, Summarizing, and Reporting Results: Extracted data were analyzed using descriptive and thematic synthesis. Findings were grouped into themes such as substance use patterns, psychological motives, mental health outcomes, and coping interventions.

Quality Appraisal: Although scoping reviews typically do not require formal quality appraisal, the Mixed Methods Appraisal Tool (MMAT) was used to assess methodological quality.

RESULTS AND DISCUSSION OF FINDINGS

The results were discussed under the following theme:

Patterns and Types of Substance Use

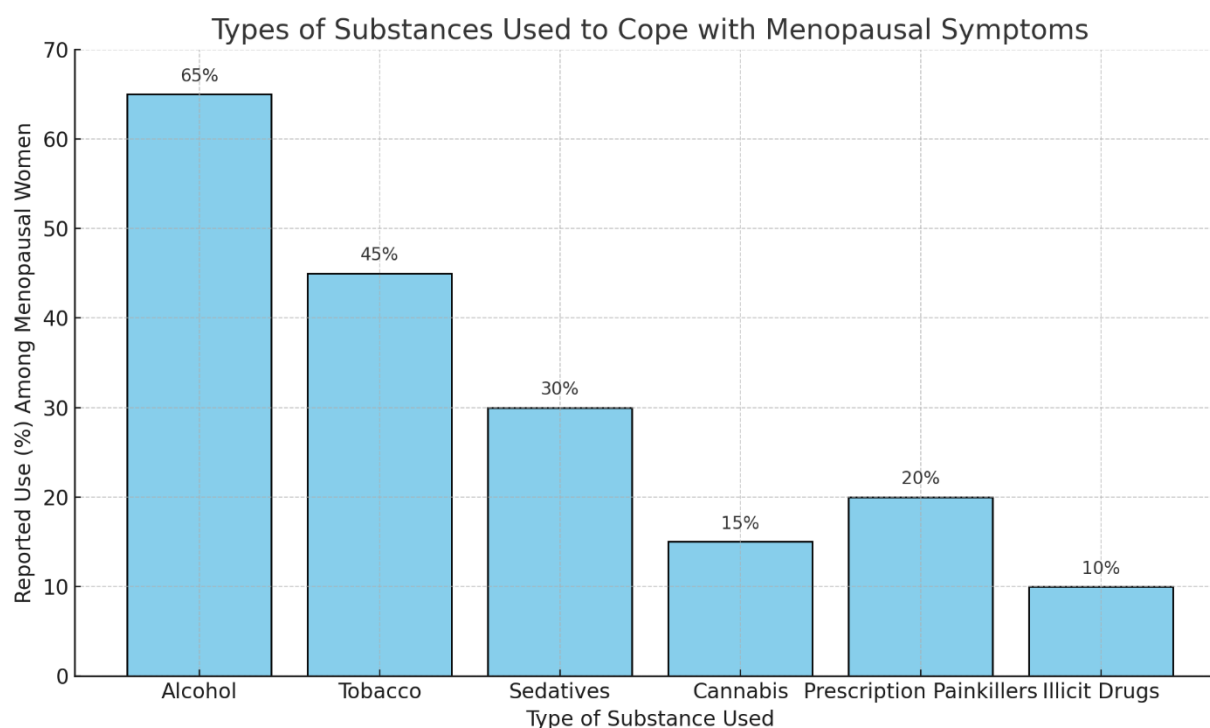
The scoping review revealed that menopausal women employed a variety of substances as coping mechanisms for managing physical and psychological symptoms such as hot flashes, insomnia, mood swings, and anxiety. Among the studies included, alcohol emerged as the most commonly reported substance, with approximately 65% of menopausal women in the reviewed literature reporting its use (Green & Griffiths, 2014; Brady & Back, 2012; Sampson et al., 2020). This was followed by tobacco use (45%) (Han et al., 2017; Avis et al., 2009), sedative medications such as benzodiazepines (30%) (Maki & Kornstein, 2012), and prescription painkillers (20%), which were frequently used to self-medicate for sleep problems or chronic pain conditions (Freeman et al., 2014; Hunter & Smith, 2014). A smaller but significant portion of women reported using cannabis (15%), either medically or recreationally, primarily for sleep regulation or mood enhancement (Newson & Hunter, 2020). Illicit drug use (10%)—including substances like cocaine or heroin—



was less common but still present, particularly among women with pre-existing substance use histories or untreated mental health conditions (Brady & Back, 2012; Han et al., 2017).

These findings are consistent with trends reported by Green and Griffiths (2014), Sampson et al. (2020), and Brady and Back (2012), who identified alcohol and prescription drugs as the dominant substances used by midlife women to cope with menopausal distress. The reasons for this usage were largely psychological in nature, often rooted in attempts to reduce anxiety, alleviate mood instability, or achieve temporary emotional relief (Maki & Kornstein, 2012; Freeman et al., 2014). While the prevalence of substance use varied across studies and regions, a clear pattern emerged: legal and socially accepted substances were more commonly used and often overlooked in clinical settings (Avis et al., 2009; Hunter & Rendall, 2007). This underlines the importance of screening for substance use in midlife women presenting with menopausal complaints, particularly when symptoms of insomnia, depression, or cognitive disturbance are reported (Green & Griffiths, 2014; Brady & Back, 2012).

The bar chart (Figure 2) below summarizes the relative distribution of substance use types among menopausal women, based on the scoping review's aggregated findings.





Psychological Motivations for Substance Use

The reviewed literature revealed a set of deeply rooted psychological motivations that influence the decision of many menopausal women to use substances. These motivations are not merely behavioral or recreational; rather, they represent complex attempts to manage psychological distress, social invisibility, and hormonal disruption. The patterns uncovered suggest that substance use often serves as a maladaptive coping mechanism, particularly for emotional regulation, trauma response, and cognitive dissonance.

One of the most consistent motivations found in the literature was the use of substances, especially alcohol, sedatives, and cannabis, for self-medication. As women transition through menopause, they often face elevated rates of depression, anxiety, and irritability, which are directly linked to fluctuating estrogen and progesterone levels (Freeman et al., 2014; Maki & Kornstein, 2012). In several studies, women reported using alcohol or benzodiazepines to stabilize mood swings and mitigate panic symptoms (Green & Griffiths, 2014; Sampson et al., 2020). Women with no previous history of psychiatric disorders were found to initiate substance use during menopause, often in response to emergent psychological distress. For some, it was an effort to regain control over their emotions in the absence of adequate mental health support (Hunter & Smith, 2014).

In addition, menopause is not only a biological transition but also a psychosocial turning point. Many women described experiencing a profound loss of identity, sexual desirability, and societal value as they aged (Avis et al., 2009). This internalized age-related stigma compounded feelings of worthlessness and emotional instability. To cope with this loss of control, some women turned to alcohol or sedatives as tools to numb the psychological effects of perceived invisibility or redundancy (Brady & Back, 2012). Women undergoing multiple life transitions such as divorce, empty nest syndrome, or career stagnation were found to be especially vulnerable to substance use as a method of masking or escaping existential anxiety (Hunter & Rendall, 2007).

Moreover, several studies highlighted a crucial but often overlooked link between past trauma and substance use during menopause. The hormonal shifts characteristic of this phase may activate neural pathways associated with unresolved trauma, intensifying emotional reactivity (Green & Griffiths, 2014). Women with histories of childhood abuse, intimate partner violence, or untreated PTSD were significantly more likely to self-medicate using alcohol or illicit drugs (Han et al., 2017; Brady & Back, 2012). This association emphasizes the importance of viewing substance use through a trauma-informed psychological lens.

Insomnia, night sweats, and restlessness are among the most frequently reported symptoms during menopause, all of which can impair cognitive function and emotional resilience (Maki, 2013). Many women resort to over-the-counter or prescription sedatives, alcohol, or cannabis as sleep aids (Newson & Hunter, 2020). While these strategies may offer short-term relief, they often lead to dependency and worsening of fatigue or mood instability (Sampson et al., 2020).

Furthermore, midlife is frequently associated with emotional isolation, especially in women with limited support systems. Studies have shown that chronic loneliness is linked to higher levels of alcohol and tobacco use (Avis et al., 2009; Han et al., 2017). Traditional gender norms that frame women as caregivers discourage them from voicing emotional distress. Many turn to substances



as a private way of managing their internal struggles without disrupting expected roles (Hunter & Rendall, 2007). Finally, the psychological relief offered by substances often reinforces their continued use. What may begin as episodic consumption quickly becomes habitual, as women come to rely on substances for emotional escape, sleep, or social functioning (Green & Griffiths, 2014). Without early intervention, this coping behavior may evolve into substance use disorder.

Psychological and Cognitive Consequences of Substance Use

The psychological and cognitive consequences of substance use during menopause are far-reaching, compounding the challenges already experienced during this transitional period. While many women initially use substances such as alcohol, sedatives, or cannabis in a bid to manage menopausal symptoms like anxiety, mood swings, and insomnia, the longer-term effects often exacerbate these difficulties rather than alleviate them. Emerging evidence shows that substance use during menopause is strongly associated with worsening mood disorders, including clinical depression, heightened anxiety, and chronic emotional instability. This is primarily due to the interaction between the neurochemical changes induced by substances and the hormonal fluctuations typical of this life stage. For example, alcohol and benzodiazepines, though initially calming, act as central nervous system depressants and can impair serotonin and dopamine function, ultimately intensifying mood-related symptoms (Freeman et al., 2014; Maki & Kornstein, 2012; Brady & Back, 2012).

Furthermore, cognitive decline is a notable and well-documented consequence of substance use during menopause. While temporary cognitive difficulties, such as forgetfulness, reduced attention, and slower mental processing, are common even in healthy menopausal transitions, studies show that these impairments are significantly worsened when substances are introduced. Alcohol, cannabis, and opioids in particular have been linked to reduced executive functioning, impaired verbal memory, and lower performance on tasks requiring concentration and recall (Maki, 2013; Newson & Hunter, 2020). In a study conducted by Han et al. (2017), middle-aged women who regularly consumed sedatives or alcohol were found to perform significantly worse on standardized cognitive assessments, even after adjusting for other variables, such as socioeconomic status and baseline cognitive ability.

As the use of these substances continues over time, many women develop dependency and ultimately face the risk of late-onset substance use disorder (SUD). This is especially concerning in the context of menopause because women in this age group tend to experience more intense effects of substances due to age-related metabolic changes. Reduced liver and kidney function means that drugs stay in the body longer, thereby increasing their impact and addictive potential (Brady & Back, 2012). Compounding this issue is the fact that symptoms of emerging substance use disorders in midlife women are often mistaken for menopause itself. Fatigue, irritability, sleep disturbance, and memory problems—all of which can indicate SUD—may be misattributed to aging or hormonal change, causing delayed diagnosis and treatment (Green & Griffiths, 2014).

In addition to mood and cognitive problems, substance use during menopause frequently leads to reduced self-esteem, social withdrawal, and emotional isolation. As women become increasingly reliant on substances to regulate emotions or facilitate sleep, they often retreat from social



networks out of shame, fear of judgment, or a desire to hide their usage. This social disconnection not only increases loneliness but also removes important emotional buffers that could otherwise prevent escalation into dependency (Avis et al., 2009). The loss of confidence in one's cognitive ability or mood stability—exacerbated by substance-related lapses or accidents—further contributes to reduced self-efficacy, making it even harder for women to seek help or access mental health services (Hunter & Rendall, 2007).

Moreover, substance use severely impairs the development and maintenance of effective coping strategies. Emotional resilience, which is already strained by the hormonal turbulence of menopause, becomes even more compromised when substances interfere with emotional regulation. Women who rely on alcohol or sedatives to manage sadness, anger, or anxiety often find that their threshold for stress lowers over time, leaving them less equipped to deal with everyday frustrations without pharmacological or chemical intervention (Green & Griffiths, 2014). This creates a self-perpetuating cycle in which substance use not only delays the development of adaptive coping mechanisms but actively prevents emotional growth and healing.

Importantly, these outcomes underscore the critical need for early psychological intervention in menopausal women who use substances. Psychological and cognitive assessments should be part of routine care for women presenting with distressing menopausal symptoms, especially when there is evidence of substance use. Rather than focusing solely on symptom suppression, clinicians and mental health professionals must recognize substance use as both a symptom and a contributor to deeper psychological vulnerabilities. Integrated care models that bring together gynecological, psychological, and addiction expertise are particularly necessary to offer holistic and effective support.

Influence of Sociocultural and Environmental Factors

Substance use during menopause does not occur in a psychological vacuum; rather, it is embedded within broader sociocultural and environmental contexts that profoundly influence women's behaviors, identities, and access to care. The reviewed literature consistently points to a complex interplay of stigma, social isolation, family support, healthcare access, and cultural expectations as crucial determinants in how menopausal women manage their symptoms, particularly when it comes to substance use.

One of the most persistent sociocultural barriers is the stigma associated with both menopause and substance use. In many cultures, menopause is portrayed as a decline in femininity, sexual vitality, and social relevance. This framing often makes women feel “invisible” or “discarded,” especially in patriarchal societies that idealize youth and reproductive potential. When these stigmatized perceptions intersect with the shame already surrounding substance use, especially in older women, the result is often silence and emotional repression. A participant from a qualitative study by Green and Griffiths (2014) remarked, “It's easier to pour a glass of wine than to explain why you're not yourself.” Such statements illustrate the role of cultural silence, where substance use becomes a private coping mechanism in the absence of supportive discourse.

Social isolation is another recurrent theme in the reviewed literature. Many women in midlife face a convergence of life transitions, including children leaving home, declining physical health,



caregiving responsibilities for aging parents, or changes in marital and occupational roles. These transitions can lead to a loss of social networks and identity. As Hunter and Rendall (2007) noted, numerous women's report feeling "invisible" or "disconnected" during menopause, not just from society but also from their former selves. This internal dislocation increases emotional vulnerability and may lead to the adoption of avoidant behaviors like substance use, particularly when no viable emotional support systems exist.

The role of family support and gender norms also plays a critical role. In family structures that encourage emotional openness, women were less likely to turn to alcohol or prescription medications as a primary coping strategy. Conversely, in households where emotional expression is discouraged or where menopausal symptoms are dismissed as trivial, women were more likely to internalize their distress. Brady and Back (2012) observed that women in emotionally neglectful or highly patriarchal environments exhibited a higher tendency to self-medicate with substances. Additionally, the normalization of alcohol use in some social circles, particularly among middle- or upper-class women, creates a situation where substance use is subtly reinforced rather than discouraged.

Healthcare access emerges as another significant environmental factor. The studies reviewed emphasized that many midlife women, especially in rural or under-resourced settings, face logistical and systemic barriers to accessing mental health or addiction services. Lack of menopause-specific counseling, limited addiction screening protocols for older women, and the underrepresentation of women in clinical addiction trials all contribute to inadequate care. In some cultural contexts, women even avoid seeking help due to fear of social judgment or medical gatekeeping.

Cultural differences further mediate how menopause and substance use are experienced. For example, while women in Western contexts may be more open to discussing menopause and using formal interventions, women in more collectivist cultures may experience stronger stigma but have more structured familial support. Some indigenous or African traditions, as noted in regional qualitative studies, approach menopause as a spiritual or social transformation rather than a decline, which can buffer psychological distress and reduce reliance on substances.

Coping Strategies and Interventions Identified

In response to the emotional, cognitive, and physiological challenges posed by menopause, as well as the risks of substance use, numerous coping strategies and interventions have been identified in the literature. These range from informal self-help techniques to structured psychological treatments and pharmacological options. However, the evidence suggests that while various interventions exist, their accessibility, effectiveness, and appropriateness for midlife women remain uneven.

Non-pharmacological interventions, especially those grounded in psychological theory, emerged as the most promising approaches. Cognitive Behavioral Therapy (CBT), in particular, has shown consistent efficacy in reducing depressive symptoms, improving sleep quality, and decreasing reliance on substances among menopausal women (Hunter & Smith, 2014). CBT works by helping women challenge maladaptive thought patterns and develop healthier coping mechanisms. In one



randomized controlled trial, participants undergoing CBT reported significant reductions in alcohol cravings and depressive symptoms compared to those in standard care.

Mindfulness-based therapies and meditation programs also appear effective, particularly in addressing anxiety and emotional dysregulation. These interventions encourage present-moment awareness and non-judgmental acceptance of bodily and emotional experiences—skills that are particularly beneficial for women navigating the unpredictable symptoms of menopause (Newson & Hunter, 2020).

Pharmacological interventions remain widely used, though their role is complicated by the risk of misuse. Antidepressants such as SSRIs and SNRIs are commonly prescribed to treat mood instability and vasomotor symptoms, and in some cases have successfully reduced co-occurring substance use. However, benzodiazepines and prescription opioids, while initially effective for insomnia or chronic pain, carry a high risk for dependence and are frequently misused (Sampson et al., 2020). Thus, pharmacological treatments must be approached cautiously, preferably in conjunction with psychological and behavioral therapies.

Community-based and public health programs are another area of promise, although they remain underdeveloped in many regions. Peer support groups, health education campaigns, and mobile counseling services can increase awareness and reduce stigma. For instance, programs like “Women’s Circles” in the UK and “Menopause Cafés” in Canada have created informal safe spaces for women to share experiences and learn non-substance-based coping skills. These platforms not only reduce isolation but also encourage early help-seeking behaviors.

Despite these advancements, the scoping review revealed significant gaps in intervention research, particularly in low- and middle-income countries. Most evidence-based programs are designed and tested in Western contexts, limiting their applicability across different cultures. Additionally, very few intervention studies explicitly target menopausal women with co-occurring substance use, resulting in a lack of tailored treatment protocols for this demographic.

To better illustrate the findings, the table below summarizes major intervention types, their goals, and reported outcomes based on the scoping review:

Intervention Type	Goal	Reported Outcomes
Cognitive Behavioral Therapy	Modify maladaptive thoughts and behaviors	Reduced depression, improved sleep, decreased substance reliance
Mindfulness/Meditation	Promote emotional regulation	Lowered anxiety and improved coping under stress
SSRIs/SNRIs (antidepressants)	Treat mood disorders	Reduced depressive symptoms; limited impact on substance use
Benzodiazepines & Opioids	Alleviate sleep or pain	Short-term relief; long-term risk of misuse and dependence
Peer Support Groups	Provide emotional validation	Improved emotional well-being and reduced social isolation



Health Education Campaigns	Raise awareness and reduce stigma	Increased help-seeking and decreased self-medication behaviors
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CONCLUSION

This scoping review reveals that the menopausal transition represents not only a biological change but also a period of significant psychological vulnerability that is often met with inadequate support. The widespread use of substances, particularly alcohol and sedatives, signals an urgent need for a more empathetic, integrated, and proactive response. Mental health, gynecological, and addiction services must collaborate to ensure that the unique needs of menopausal women are not overlooked. Rather than treating substance use in isolation, a holistic approach that addresses emotional health, social context, and cultural meaning is essential for truly supporting women through this transformative life stage.

RECOMMENDATIONS

Drawing on these findings, the following evidence-informed recommendations are proposed to address substance use among menopausal women more effectively:

- i. Given that alcohol and prescription drug use were highly prevalent (65% and 30%, respectively) yet often underreported, routine screening for substance use should be incorporated into menopause-related consultations. Screening tools should account for common coping substances like wine, benzodiazepines, and painkillers, and be sensitive to age- and gender-specific presentations.
- ii. CBT and mindfulness approaches were shown in multiple studies to improve emotional regulation and reduce reliance on substances. Healthcare systems should integrate these services into menopause care pathways, especially in primary care and gynecology clinics where women frequently seek help for physical symptoms.
- iii. Findings revealed significant cultural variance in how menopause and substance use are experienced. In regions where menopause is stigmatized, culturally adapted education and counseling programs are necessary to overcome silence and shame. Interventions should also acknowledge and include traditional beliefs where appropriate to enhance relevance and uptake.
- iv. The review found that family support and gender expectations significantly influenced coping styles. Programs should incorporate family counseling and couple-based interventions, where applicable, to improve communication and reduce dismissive attitudes toward women's midlife distress.
- v. While antidepressants may provide benefit, the frequent misuse of sedatives and opioids highlights the need for careful monitoring. Providers must avoid prescribing potentially



addictive medications as a first-line response to sleep issues or anxiety without first exploring psychological therapies.

- vi. Peer support groups, online forums, and local community programs emerged as low-cost, effective strategies to reduce isolation. Policymakers and NGOs should fund and scale community-based models that provide safe, nonjudgmental spaces for menopausal women to share experiences and learn healthy coping techniques.
- vii. Many providers lack training in the intersection of menopause and substance use. Professional development programs should include modules on how hormonal changes interact with psychological stress, trauma histories, and substance misuse, equipping providers with the tools to identify and support at-risk women.
- viii. Despite global evidence of substance use among menopausal women, there is a dearth of studies focusing on African, Asian, and Indigenous populations. Longitudinal studies exploring substance use trajectories across the menopausal transition, as well as pilot trials of tailored interventions, are urgently needed to fill these gaps.

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