Why Sleep Falls Apart During Menopause and What You Can Do About It Transcript

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Podcast introduction and sleep study context

Historically, the sleep study was a very big test. You go somewhere, you spend the night, your wired for sound up and down. I mean, it's just a horrific experience.

It would really make an impression on you. So anytime I ask someone, have you had a sleep-study? And they say, I don't know. I know, they have not had.

They didn't, yeah. And it is the right thing to do for some people with complex sleep disorders if they've had neurological problems or some, you know.

So we're not saying that nobody should have one of those anymore, but they are quite an obstacle to good care for a lot of people. Have you made it past menopause, or are you going through it now?

I'm Dr. Pat McShane, and on the Women's Health Span Voices podcast, I'll guide you through the health challenges of the menoppausal years and beyond, guiding the way to thriving in this powerful era of your womanhood.

Hello and welcome to Women's HealthSpan Voices. I'm very, very excited today to have Dr. Audrey Wells, who is a sleep physician among her other training.

And I'll let her tell a little bit about that. We're going to kind of jump into some deep subjects here today, not just the easily available material about don't drink coffee in the afternoon.

some of the obvious things that we can do to impact our sleep. But Dr. Wells has a background in the importance and the physiology of sleep, especially around menopause.

So let's dive in right there and talk about the the Physiology of Sleep as we go from our pre-menopausal reproductive age years through menopsause and then into post- menopus.

Dr Audrey, great to have you. Yeah, it's great to be here. I love talking about this subject. It's a passion of mine. And I also like to start out with a lot of humility because I am a menopausal woman, I have had sleep problems.

Menopause and changing sleep physiology

So I like say not only am I book smart about the topic, but I'm street smart as well. I remember when I first started having, you know, deep menopausal symptoms, I went on estrogen replacement and I'm like, all of a sudden, oh my God, i can sleep again.

I hadn't really thought about sleep so much, but so I hear you on that. Yeah. And I think where women are concerned, there's not enough attention paid about all of the drivers and factors that can influence sleep.

So I'm excited today to talk about lifestyle changes, when you should get a sleep evaluation, and what really you can expect from returning to the natural pleasure of sleep And the tremendous importance of sleep on our total well-being, it's foundational to our well being.

It's been added on even by the American Heart Association as one of life's essential eight that we need to be paying attention to. So, please tell us what happens between our reproductive years and our post-menopausal years that disrupts so many people's sleep.

Yeah. So, you know, this is a tricky time. And a lot of times sleep is one of the first symptoms that a woman will

experience when transitioning from a reproductive time to perimenopause and then menopausal.

likely to get attention but what I see so often is that the symptoms are explained away by something else like stress or I've just got a lot going on right now or i have your regular bedtimes or you know the something is just kind of swept under the rug.

But the truth is, there's fundamental physiologic changes taking place in a woman's body that interrupt or shorten sleep time. For example, as a women's hormones start to fluctuate and become less reliable or less in the pattern, that affects temperature stability, it affects internal stress hormones, it affects appetite, and it effects the ability to stay asleep and even get to sleep.

Mm-hmm. So many women in early perimenopause will start having sleep problems, and then often when they are having the hot flushes, flashes that are typical for menopausal sleep is another big piece of that.

Do you find that as we get into our, well beyond our menomoposal transition in our 50s, 60s and 70s that women still have a lot of sleep issues or is there some recovery after that transition period?

You know, unfortunately, there's usually not recovery or even a return to a satisfying baseline. And there are different drivers that are related to this, but I would say that in my two decades of experience in treating adults and women with sleep problems, The menopause transition results in an erosion of sleep quality and ultimately loss in trust of asleep.

And it's hugely frustrating. It's frustrating on my end as well, because this has not been well studied in the literature and research. So in some ways, we are left kind of groping for effective treatment.

Or trying to even name the problem accurately because, again, things are explained away. Or sometimes, you know, there's this interesting thing that comes up where a woman will describe insomnia and she will use that word.

But insomnia is a great masquerader. So even though the experience of the individual is that of insomnia, particularly middle-of-the-night awakenings, there's oftentimes a root cause driver that looks like insomnia, but it's something else.

And that results in years of either misdiagnosis or an undiagnosed sleep problem. And what might those other causes be? They generally fall in three buckets.

So typically, if a woman does present to the primary care provider or even a specialist with sleep complaints, the most common one for women in perimenopause and menopausal is middle of the night awakenings that become prolonged.

And I'm sure you can identify with this. I am sure the audience is like, yes, that's the one thing. If I had a magic wand, That would be the thing that I would solve.

And the truth is, there are often more than one sleep disorder taking place.

Sleep apnea in menopausal women

So I always hold that in my mind. But I want to give you a couple of statistics that, I hope, are useful to the group of women is markedly underserved when it comes to going to a sleep evaluation, getting a woman-centric testing and interpretation, and then being offered treatments that are palatable, that comfortable, or that fit her life.

Okay, so here's a statistic I think will blow your hair back. Among women in the menopausal period, so this is about age 50 and beyond, we're talking about multiple decades of a woman's life, her risk for sleep apnea is 1 in 2. One in two women in menopause will have some degree of sleep apnea, which is a breathing disorder.

Now the problem is, and I can feel the audience recoiling, is they're like, no, I don't want the mask, the machine,

blah, you know, well I get it, but this is breathing a disorder and you will not escape the effects of an untreated breathing disorders.

It will slowly erode your health. It will erode your brain health, your metabolic health your cardiovascular health and your mental health. And it makes sense, right?

And some people who don't see themselves as having a sleep disorder actually have sleep apnea. Maybe you could tell us a word about that. People who wake up tired, who are sleepy all day, interaction with blood pressure, etc.

Yeah, and what I hear a lot as a person starts to resist the idea that they could possibly have sleep apnea is, I don't snore. Or I Don't Snore All The Time.

And I'm here to tell you that for women, sleep Apnea Is Typically A Silent Disorder. But all the questionnaires that you see and all of the interviews that do with your clinical providers focus on snoring.

because it's a man's symptom, and that's historically who has been studied in the research populations. But for women, they will typically be silent, And they typically won't drop their blood oxygen levels as much, although they do do that, but it will be disruptive to sleep quality.

And so the focus becomes more on the tiredness during the day. Now, women report tiredness rather than sleepiness. But again, the questionnaires like the Epworth Sleepiness Scale are very focused on the propensity to fall asleep, whereas a menopausal woman will most often say, I can't nap anymore.

You know, I used to be able to lay down in the afternoon and take a nap. I can't do that anymore. So it's not sleepiness that they would report. It's tiredness.

Its brain fog. its walking into a room and forgetting what was I here for. Having a conversation and groping around for names. Those are all signs, subtle signs of sleep deprivation that could be tied to a breathing disorder like sleep apnea.

Well, thanks. That's great information to go through that a little bit more. So if someone comes into you and says either have trouble getting to sleep or I wake up at two or three and I can't go back to asleep very readily, what is the recommended approach clinically?

Questions about medications and other disorders and then what kind of workup would you recommend for her? For women, I think it's really important to take a comprehensive approach.

So I want to say plainly that even though we spent a few minutes talking about sleep apnea, and that is going to be on my radar when I do an evaluation for someone, It is by no means the situation where I have a hammer and everything looks like a nail.

A woman's sleep needs to be evaluated with a very broad lens, similar to how you would talk to somebody who wanted to lose weight about their exercise, nutrition habits, stress level, all of that.

Sleep is also in that trifecta for health. What you eat, how you move, and how your sleep are going to be the big drivers of how live and live long. So with sleep, you have to take in some information about medical history, about medications that might promote daytime sleepiness or nighttime insomnia.

I would necessarily talk to a woman about risk factors related to their physical makeup, not only their body habitus, menopausal status is going to increase risk.

foresleep apnea, insomnia, restless leg syndrome, and circadian rhythm disorders. So I would walk a woman through what might be pulling those different levers.

And then on the back end of an evaluation, you have to offer treatment options that address multiple facets of a women's sleep health. It's not just, let's treat your insomnia and forget about the rest.

You have to look at what is a woman taking on in terms of cognitive burden that prolongs those nighttime awakenings because that's the only white space she has to think about what she had to do, what would have done differently, how this relationship or that is going, you know, those things that come up in the middle of the night.

And tomorrow. How do we manage tomorrow? Yes. That brain chatter, right? Yeah. I mean, that stuff is worth addressing because it's part of what increases or decreases the likelihood of restorative sleep.

Clinical evaluation and treatment options

Tell us a little bit about sleeping pills. Do you ever recommend that? And do most of the people who come in to see you already have a history, oh, I've tried five different sleeping Yeah, you know, I would say by the time someone comes to a sleep medicine specialist, they've tried a number of things.

They've try Googling. Now they have tried the AI questions. And sometimes they even had a prescription from their primary care provider that they may or may not like, meaning they are willing to continue and want to or don't really want be on that long term.

And I would say when it comes to swallowing pills and potions, there's basically three categories. One is the prescription medication. And, I do think there is a role, but in very select circumstances and always with an exit plan, okay?

Because the prescriptions medications meant for sleep, the vast majority of them, are really meant short-term use and they are not durable for long- term treatment.

meaning over time, the effects tend to go away because you become tolerant. Some people use the word addiction, but it's really a tolerance to the medication, meaning you don't get the effect at the same dose, so you end up having to ramp up or take it more frequently.

So for prescription medications, yes, there is a need, but again, have an exit plan if that's something that a person would like to try. Second category is supplements.

And supplements are a billion dollar industry. They're not well regulated. There's been multiple carefully constructed research studies showing a number of contaminants in supplements that can undercut the effectiveness.

That being said, I am not one to yuck someone else's yum. And the reason I say that is because as long as a supplement is not doing harm, a person may get a psychological benefit or even a small physiological benefit from a supplemental.

And sleep has a lot of psychological overlay, so taking something is very attractive when you think about a personal who's struggling with sleep problems.

However, the reality is that supplements are not terribly effective for most people, and it's a really heavy lift for that supplement alone to make a meaningful improvement in someone's sleep.

So we talked about prescription meds, we've talked supplements. Third is other substances. And here I'm talking about self-medicating with alcohol or cannabis or, you know, sometimes even exercise can be used and that's a more functional way to address sleep problems.

But in general, for menopausal women, alcohol is going to be your enemy when it comes to sleep. disrupt your sleep totally. The only benefit to alcohol is it shortens the time to get to sleep at the beginning of the night.

That's usually not a huge issue for most of folks I see. Cannabis or CBD, CBN, TBG, THC, all of that. It's a little bit trickier because again, the tolerance issue comes into play.

So if someone decides to pursue that route, I tell them to really limit their use to less than half the days per week, so maximum three, maybe four nights per.

And stick in with the CBD arm, not so much the THC, which is going to give you the hallucinogens. Okay, that's good to know. What about hormone therapy, estrogen therapy and other hormones for that matter, DHEAS and testosterone in women?

Yeah, so I'm menopause certified and from that perspective, I am a huge advocate of hormone replacement therapy which is a historically misunderstood question.

as you know. So I feel like we're just kind of getting a handle on that, but I'll give you a few examples. One is, people often go toward hormone therapy to treat nighttime hot flashes.

Those hotflashes at night are something that's easily solved with hormone replacement, specifically estrogen and good candidates. Until you speak with someone who is experienced and expert in therapy and hormone replacement, you actually don't know, I think, whether you're a good candidate for hormone-replacement therapy or not.

And sometimes it's a question of benefits versus risk. So estrogen can go a long way towards solving nighttime hot flashes, but it doesn't work for everyone.

And in that instance, we look at other ways to treat nighttime awakenings or prolonged awakennings. A lot of women complain of waking up at night to go to the bathroom multiple times.

This is getting into the area of vaginal health and health of their urethra, which can be linked. So just about every woman in menopause would benefit from vaginal estrogen therapy.

which can impact significantly your urethral health and getting up multiple times at night to use the bathroom, which is going to be that stimulus for awakening.

And if I could pull back that stimulus and keep a woman asleep just by having her take vaginal estrogen, then I've made a meaningful difference in her life.

I'm curious to know what you think about that. I think the data are pretty clear at this point that vaginal estrogen is recommended for most women, I would say, in menopause.

And the genital urinary symptoms of menopus only get worse rather than, you know, the hot flashes and the brain fog. Some of the other symptoms tend to diminish, but the vaginal and urinary symptoms, tend get worse.

It just, there's so little risk. So little of it is absorbed, which then of course means that you're not getting the bone benefits from the estrogen or the sleep benefits.

So if you're saying, well, I'm taking, you know, vaginal estrogen, how come I can't sleep? It's because you are not absorbing very much of it. You might still need to be on a different kind of route of administration, topical or even oral.

Yes, exactly right. And that's an important difference when you're looking at the expected benefit from that supplemental estrogen. Now, progesterone is another interesting hormone when it comes to sleep.

Progesteron has a soporific effect. That means it helps you feel sleepy. So even in women who do not have a uterus, in which progesterone is not indicated to kind of oppose that estrogen effect on the uterine lining, you can still get pro gesterones, micronized pro-gesteron for sleep specifically.

And in about a third, maybe a half of women, it will have a noticeable and positive impact on sleep quality and sleep duration. So I think proesteroin is worth considering for a woman in menopause, even in the absence of a uterus.

Interesting. Maybe go back a little bit and talk about the investigation or the workup as we say. Who needs a sleep study and what do you find when you do that that's approachable clinically?

Hormone therapy and vaginal estrogen

Yeah. So I'll tell you that historically, the sleep study was a very big test. You go somewhere, you spend the night, your wired for sound up and down.

I mean, it's just a horrific experience. It would really make an impression on you. So anytime I ask someone, have you had a sleep-study? And they say, I don't know.

I know, they have not had. They didn't, yeah. And it is the right thing to do for some people with complex sleep disorders if they've had neurological problems or so.

So we're not saying that nobody should have one of those anymore, but they are quite an obstacle to good care for a lot of people. Right, and very labor intensive as well.

So there was kind of these limiting factors that prevented people from getting tested, not to mention being very expensive. Nowadays, there's been kind this inflection point with testing such that home sleep testing is very common.

It's very much surpassed the in-lab sleep study, which is the one where you go somewhere else and get many more sensors applied. So home sleep testing now tends to be the very first way that someone gets any sort of evaluation of their sleep quality and whether they have a sleep-related breathing disorder like sleep apnea.

Who should get one? I'm going to tell you that because in the past things were so limited, and we've now experienced this opening up of availability of testing, where I would like to see things go is kind of the root of mammogram, the route of colonoscopy, route the bone density scan.

And here's why. Sleep disorders are insidious. Even though you are the one doing the sleeping, you have a tangential experience of your sleep. And so typically, people who have sleep problems develop are years, like at least two years away from having major symptoms that they would report to their doctor.

Similar to the idea that you could have colon polyp, and you wouldn't be symptomatic for a number of years. So I would like to see women take a very proactive approach with their sleep health and get tested early even upon entering perimenopause.

Couple reasons for that. One is it's cheap. Oh my goodness, it is cheap for the benefit that your sleep health can deliver to you. This is a very inexpensive test and it something that we do routinely at sleep.com.

The other reason is, at the very least, it's going to give you baseline data about your sleep. The test comes back negative for abnormalities. It comes normal.

Its reassuring, whatever. Now you've got that floor from which to judge if anything changes in the future. That's the least that you can expect. And I think a lot of times, gosh, if I had to put a number on it, I'd say it's more than 50% of the time, people are surprised that something comes back positive on the test.

And then they're in a powerful place to make a decision about that because in the absence of symptoms, that condition is most likely mild and it might affect the way you choose to live your life.

Okay? So then you have lifestyle choices available to you and you can decide to monitor symptoms and choose

treatment options when those are going to be more impactful.

So it's a long answer to your question, but fundamentally, I think women, especially women in perimenopause and menopausal should consider getting a sleep evaluation now, regardless of what symptoms they're having, similar to a mammogram, colonoscopy, bone density test.

Interesting. I haven't heard that viewpoint expressed before, but obviously coming from your tremendous clinical experience and expertise, that's a powerful, powerful message to think about.

Look, women have been underserved. You know this. Totally. It's time to get ahead of the game. When you think just about the rate of dementia in women compared to men, What do you think could be driving that?

Sleep? Hmm. Sleep is for the brain, literally. So if you want to preserve your brain health, get on top of it early.

Sleep testing and home study approach

Yep. And we catch up on heart disease. I mean, the list goes on and on. That's powerful information. Thank you. When one does do a sleep study, I presume apnea is sleep apnoea, obstructive sleep Apnea, is probably the major thing that would come out of that.

But what other kinds of diagnoses might be helpful in the treatment plan from a Sleep Study? Yeah, this is such a good question because the home sleep test, the garden variety home Sleep Test is best at looking for sleepapnea.

particularly the obstructive type, it's not perfect, just like no medical test is perfect. It's 100% sensitive, but that's when the clinical oversight and expertise comes into play.

So it is usually the case that the insurance wants to do a home sleep apnea test as a first-line measuring tool, Then an in-lab sleep study may be a consideration.

It may a be consideration to repeat the home sleep test, especially if symptoms are present or risk factors are presence. And a third option, which I always think is a really good option is doing a multi-night home test.

This is because you know, I know every night of sleep is not the same. Different. So when you look at a data set that's expanded to accommodate that variability, you're more likely to come up with a picture that is representative of what's going on.

So the approach that we take at sleep.com is to Be very cautious when telling a woman, especially, you have a negative sleep test. Ooh, that kind of bothers me.

I would much rather say you haven't inconclusive sleep tests because then you're not sort of gaslit into thinking, well, it can't be sleep apnea or sleep disorder because I had a So language around that is very important.

We just covered the concept that every night is a little bit different as far as our sleep. And I want to bring in a concept, that's relatively new, which is the chronobiology of sleep and the idea that, yes, our goal of getting seven to nine hours per night is a great starting point, if we're having difficulty achieving that much sleep.

But another piece of it is the time of day that we choose to go to sleep, or that were able to to asleep, and that consistency with our circadian rhythm, our chronobiology, is relevant also.

And I don't know, we didn't talk about this before, If you care to add something into that statement that I just made. Yeah, and we can take the conversation wherever you want.

You can tell I'm passionate about this. Okay, so let's talk about timing. And timing is one of three components that sleep health encompasses. A lot of people focus on quantity.

you said seven to nine hours. New data suggests that people who are closer to the nine hour mark are probably compensating for some problem in sleep quality.

So I'll plant that seed. Usually adults are in the seven to eight hour window when it comes to sleep need. That's quantity. Quality is how much deep sleep you're getting, how many REM sleep your getting.

How your… That was going to be my next question. Yes, yes. Like how you are cycling through those different sleep stages, How stable your sleep is. All of that is qualitative.

So you know how well you feel you slept. and how well your wake quality is too, because they're kind of two ends of a swinging pendulum. Where timing is concerned, you brought up the chronobiology, and I'll talk about that next, but also recognize that timing means the placement of your sleep window.

And the more consistent that is, meaning keeping your wake up time the same seven days a week, not five, seven, days, a, week and your bedtime about the, same within an hour.

Your brain is going to bookmark those times so that the transition from sleep to wake in the morning or the transmission from wake to sleep at night is much more efficient, okay?

And that's important for your brain. Your just wants a pattern. So that's one aspect of timing. Where the chronobiology is concerned, this is your propensity to be more of a night owl or a morning lark, an early bird, or in between, which I call a third bird.

And that is about 65% of the population. So most people have a bedtime. They want to go to bed around 11, maybe 10 or 11. Wake up at about 6 or 7 in the morning, something like that.

Night owls want to go to bed in the wee hours of the morning. Early birds want go bed earlier than 10 PM. And you know, the genetics of this are fascinating.

If you look at one or both parents, you will likely see someone that looks like you, siblings included, and also your own children if you have them. So this is a lifelong sort of genetic script that you're going to follow.

But interestingly, as a woman ages, she'll shift a little bit earlier and earlier in the day. Yeah. Has that happened to you? Yes, it has.

Sleep timing, chronobiology, and light exposure

And I've also read that I did a podcast on chronobiology recently, and that was one of the findings that came across is that our sleep shifts to an earlier pattern, earlier sleep onset and earlier awakening as we age, both men and women, but I think it's even more pronounced in women.

It is, it is. And sometimes I will leverage that for a woman with early morning awakenings. It depends a little bit on work obligations or social obligations, but sometimes that earlier shift will solve the problem of middle of the night awakennings.

So it's an interesting way to play with chronobiology. You could say, four o'clock, no worries, just go to bed at eight or nine and you'll be fine. Yeah.

And, you know, as an extreme early bird myself, that's something that I work into my life and I know that it can be done. whether you want to do it or not, that's what kind of lends itself to the personalization of sleep treatment.

But sometimes that all by itself can unburden a woman from thinking like, it shouldn't be this way, which ironically will prolong your nighttime awakening.

One thing, if you go to sleep very early, you should eat earlier, eat dinner and not have that be the main, the 1200

calorie meal if possible, but socially all of these things are complicated.

Not easy to pull that one off. Another quick little maybe topic here is blue light and red light, and avoidance of blue at night and exposure to blue in the morning.

On the other hand, that came up again in my circadian rhythm examination. how you feel that that may impact someone's sleep. Yeah. So look, I don't think our little screens are going away anytime soon, so we have to learn to live with them.

I'm going to give you a little tip. Um, i have my handheld computer right here. This is my son. If you do a triple click, With your phone, you can get this nice red screen and that is what is needed to really protect the blue light exposure at night.

This is an accessibility feature for the newer iPhones. You can them with the older iPhones with settings. I don't know about Android, but I suspect this is available there too.

The blue light does need to be managed, especially if it's very proximal to your face. And that includes doing this, which is what I have to do if I don't have my readers on.

I mean, anything that is arm's length is going to offensive because you literally have cells in the back of your retina that communicate with your brain's body clock to say, it is time to awake.

Now, the problem is people will tell me all the time, no, I look at my phone and I can still go to sleep just fine. And I'll say, oh, yes. But if I had you in the sleep lab with all of the EEG sensors on your head and was looking at your sleep quality, It's trash, and you perceive that you're sleeping, but what I'm seeing are interruptions that are occurring because you've given your brain that mixed signal.

So even if you were able to get to sleep okay, you are still sabotaging your sleep quality, And you don't want to do that. The second thing I think is really important to point out is it's not just the light.

It's the hypnotizing effect from scrolling and searching and watching and the program goes to the next automatically. And you know, you're getting that reward seeking behavior Because dopamine is on a circadian rhythm and dopamine goes down at night, so your brain starts searching out for reasons for pleasure.

And what better than the little computer at the end of your arm to give you that dopamine fix? So you become emotionally in line with that. And next thing you know, you plan to just watch a few memes or whatever, but then it's an hour later.

Yeah. Right. So it will hypnotize you as well. Yes, yes, that's interesting. And wearables, the phones and the sleep ring, do you say for the person who doesn't sense that they have sleep issues or those who do, are those useful tools?

Yeah, let me give it to you straight because in the past year or two, the big marketing angle from wearables when it comes to sleep is like, oh, we can tell you if you have sleep apnea.

Oh no, you can't. It's only helpful if it's positive. And if its positive, You better beat a path to your local sleep position because if It is positive and this little thing can pick it up, it means it is really positive Really bad.

Yeah. You're far down the path. Yep. We do not want, you don't want to get your medical advice from your wristwatch or your ring. So really like check internally first.

I think there's a tendency to over credit some of these wearable devices and I like them because they give attention to sleep, but yeah, they're only helpful if it's positive.

Useful, useful to know. And let's assume that we have someone who's in the half of senior women who don't have

sleep apnea.

Wearables, insomnia treatment, and closing advice

How often are you able to come up with a fix for the sleep issues? Is it lifestyle? is it some medication or a different diagnosis that? We haven't talked about yet.

Maybe just another little minute or two about treatment. Yeah, women need a full treatment menu, okay, because as I mentioned before, a lot of times there's more than one thing going on and a woman would benefit from looking at her stress level, her social demands, and her insomnia related to that, you know, beta blocker she's taking in the morning and not at night or whatever.

You know it's a number of things that need to be sort of systematically addressed. Now, we talked a little bit about sleep apnea, and I would say that there's a whole treatment menu when it comes to that.

Same for insomnia. And my approach is not to reach for prescription medications as first-line therapy unless somebody's really in trouble. A much more durable therapy is going to be brief behavioral therapy or cognitive behavioral theory.

I want to very clear, this is sleep hygiene. sleep hygiene is like, you Google and it says go to bed at the same time and make sure you exercise and get bright light.

Very surface level, right? BBT, brief behavioral therapy and CBTI, cognitive behavioral fear for insomnia, is more of an investment in the way your brain thinks.

or doesn't at night. And the way you respond to that with your emotional regulation and the things that you choose to do or not do. So working with somebody or working technology is a better way to reform the natural process of sleep so that can enjoy it again and it's much more durable over time.

And bonus, it really can help you look at other maladaptive patterns in your life and help with those too. And here I'm kind of subtly alluding to the emotional and cognitive overburdens that women tend to experience as caregivers.

Really? Do you see that in your practice? Almost universally. Yes, indeed. Not to mention the lack of information about how this is all impacting us and how we can get through it.

Anything else I should be asking you that I have not asked you about sleep disorders in postmenopausal women? You know, what I would like your audience to hear is that I think women in general are looking at the second half of their life with a lot of authenticity.

They want the vitality. And in my mind, if you are someone who is motivated to improve your health, you would have an enormous blind spot in your plan if don't address your sleep.

Because poor sleep, no matter what the root cause of your situation with poor asleep, poor is going to be a factor in you independence. It can literally determine how you spend the last 10 years of you life.

And it's a fact in the top 10 causes of death. cardiovascular disease, cancer, dementia, diabetes, and all the complications related to that, obesity.

Sleep is a driver for all of these things, or it can insulate you from these thing. So I like to think of sleep as an amplifier. And if you do it well, you're going to harness its power to really take control of your health.

I hope that message is motivating. How could it not be motivating? It's a powerful summary, basically, of a lot of the things that we've just talked about, and I really appreciate it.

I'm sure our audience will as well. Well, Dr. Audrey, this has been fantastic. little details that I keep seeing about

sleep health. And it's just been a marvelous tour of the things that people can be looking at and doing.

I really, really appreciate it for your great experience and expertise. Thank you so much. It's been my pleasure, Pat. Okay. Take care. Great to have everybody along.

See you soon again in our next podcast. Thanks for listening to the women's health span voices podcast. If today's episode spoke to you, follow the show and share it with a friend ready to take charge of her health and please leave a review.

It helps more women find us.