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Menopause and sleep problems

This article was updated in April 2026.

Sleep disturbance is one of the commonest symptoms of menopause, affecting 40–56% of menopausal women. Difficulties with sleep can lead to unpleasant daytime symptoms such as tiredness, fatigue and irritability. They may also contribute to a range of other negative outcomes, including:

- Increased severity of other menopausal symptoms.
- Worsened mental health, particularly depression and anxiety.
- Negative impact on relationships, work and daily activities.
- Cognitive effects such as impaired mental acuity, forgetfulness and reduced productivity.
- Poor quality of life.
- Worse physical health outcomes, including increased risk of metabolic

syndrome and poorer cardiovascular health.

([British Menopause Society, 2025](#); [Menopause 2024;31:724](#); [Front Neurol 2025;16:1460613](#))

1. Common sleep problems during the menopause transition

Sleep disturbance refers to changes in the quality, quantity or timing of sleep that affect wellbeing and daily function. The incidence of sleep difficulties in perimenopausal women is around 1.3–1.6 times greater than that of premenopausal women ([Front Neurol 2025;16:1460613](#)), affecting around 40–69% of women across the menopause transition ([Menopause 2024;31:724](#)).

Common sleep difficulties during the menopause transition include:

- Frequent night-time awakenings, often with difficulty getting back to sleep afterwards.
- Poor quality or non-restorative sleep.
- Difficulty falling asleep.
- Early-morning waking.

Chronic insomnia

Longstanding sleep problems can develop into persistent insomnia. This is defined as ([ICD-11, WHO 2019](#)):

- Frequent and persistent difficulty initiating or maintaining sleep that occurs despite adequate opportunity.
- There must be associated daytime impairment, with symptoms such as

fatigue, low mood, irritability, general malaise and cognitive difficulties.

- Symptoms must occur at least several times per week for at least 3 months.

However, the proportion of women meeting the criteria for a diagnosis of persistent insomnia is lower than for other sleep problems (between 4% and 40%) ([Menopause 2024;31:724](#)).

2. What are the causes of sleep problems during the menopause?

Menopausal sleep problems are often multifactorial, with several contributing factors, including:

- **Vasomotor symptoms:** hot flushes and night sweats may interrupt sleep.
- **Mood changes:** depression, anxiety and stress can both cause and result from sleep disturbance.
- **Other menopausal symptoms:** sleep may be disturbed by symptoms such as nocturia or musculoskeletal pain.
- **Sleep disorders:** conditions such as restless legs, snoring and sleep disordered breathing/sleep apnoea may affect sleep.
- **Lifestyle factors:** sedentary behaviour, excessive alcohol or caffeine, and overweight or obesity may all affect sleep.
- **Age-related changes in sleep:** this includes altered circadian rhythms and reduced night-time melatonin levels.

([British Menopause Society, 2025](#); [Menopause 2024;31:724](#); [Front Neurol 2025;16:1460613](#)).

Can hormone changes during menopause directly lead to insomnia?

It remains unclear whether hormone changes during menopause directly cause insomnia in the absence of other contributing factors.

- Both oestradiol and progesterone are neuroactive steroids that influence brain function, but evidence linking specific hormonal changes to sleep disturbance is limited and mixed ([JCEM 2023;108:e25](#)).
- Declining and fluctuating levels of oestradiol and progesterone may be associated with poorer sleep, while rising FSH levels are linked to reduced sleep efficiency, more awakenings and greater difficulty maintaining sleep. Progesterone appears to have a sleep-promoting role, with lower levels associated with increased sleep disturbance and sleep-disordered breathing. Oestradiol is also generally associated with better sleep, although the rate of change in hormone levels may be more relevant than absolute levels ([J Endocr Soc 2023;7:bvad036](#)).
- Rising FSH levels have been associated with difficulty staying asleep, while falling oestradiol levels are associated with difficulty both initiating and maintaining sleep ([Menopause 2024;31:724](#)).
- A small study from 2022 suggests that low oestradiol levels, but not low progesterone levels, were associated with increased night-time awakenings, but no changes in total awake time, even after accounting for hot flushes and depressive symptoms. This suggests that hormone changes may influence how easily sleep is interrupted ([J Clin Endocrinol Metab 2022;107:e4144](#)).

3. Vasomotor symptoms and sleep

- Around 75% of women experience vasomotor symptoms such as hot flushes and night sweats during the menopause transition.
- Women with moderate or severe vasomotor symptoms are up to three times more likely to experience frequent night-time awakenings. As only around one-third of awakenings occur at the same time as a hot flush or night sweat, it is clear that other factors also contribute to poor sleep during menopause ([Menopause 2024;31:724](#)).
- The degree of distress or how 'bothered' a woman feels by vasomotor symptoms often has a stronger impact on mood, sleep and quality of life than the actual frequency of symptoms.
- There is also a bidirectional relationship between vasomotor symptoms and low mood, largely mediated by sleep disturbance. Poor sleep can heighten stress and irritability, and in turn make it more difficult to cope with other menopausal symptoms ([Psychol Med 2018;48:2550](#)).
- Negative beliefs about sleep, vasomotor symptoms and behavioural avoidance are associated with more problematic or distressing symptoms ([Br J Health Psychol 2021;26:697](#)). These include:
 - Beliefs about social embarrassment (*Everyone is staring at me and it's so shameful!*).
 - Lack of perceived control (*The flushes are unbearable and will never end!*).
 - Worries about sleep (*I'll never get back to sleep again after being woken up. I'll feel dreadful tomorrow and I won't be able to cope...*).
 - Behavioural avoidance such as avoiding social situations.

4. Assessment of sleep problems

Assessment should include review of ([British Menopause Society, 2025](#)):

- **Patterns of sleep**, including time to fall asleep, and frequency of waking at night/early-morning waking.
- **Daytime impact** of sleep problems such as fatigue, sleepiness and mood or cognitive changes.
- **Sleep habits** such as screen use and a wind-down or relaxation routine at night.
- **Relevant lifestyle factors** such as alcohol, caffeine and physical activity levels.
- **Contributing factors** such as depression, anxiety, chronic pain, restless legs, nocturia or sleep apnoea.
- **Medication review**, looking for any drug treatment that may affect sleep such as corticosteroid, stimulants, beta-blockers and some antidepressants.

5. Management of sleep problems: an overview

Key components of management are summarised in the table below:

Lifestyle advice	Encourage patients to optimise sleep hygiene, maintain a healthy weight, reduce alcohol and caffeine, stop smoking and engage in regular physical activity. Be aware that sleep hygiene alone is not usually sufficient to treat established sleep disorders.
Optimise management of menopausal symptoms	This includes offering HRT when appropriate, which may improve sleep problems that are arising directly from vasomotor or other symptoms of menopause.
Address co-existing sleep, physical or mental health problems	Identify and treat any associated conditions such as depression, anxiety, nocturia, pain, restless legs or sleep apnoea.
Psychological therapies	Consider offering menopause-specific CBT for vasomotor and sleep-related symptoms, or CBT for insomnia (CBTi).
(British Menopause Society, 2025; Menopause 2024;31:724)	

6. Psychological therapies for sleep problems during menopause

- CBT for insomnia (CBTi): for women with chronic insomnia, CBTi has been shown to improve sleep in peri- and postmenopausal women with insomnia and vasomotor symptoms ([Sleep 2018; 41:zxx190](#)).
- Both CBTi and sleep-restriction therapy can improve fatigue, energy, sleepiness and work function, with CBTi showing additional benefits in emotional wellbeing and better resilience to physical and emotional

problems ([J Clin Sleep Med. 2019;15:999](#)).

- Menopause-specific CBT: NICE ([NICE 2015 \(updated 2024\), NG23](#)) recommends that we consider offering this for vasomotor symptoms and difficulties with sleep associated with the menopause.
 - This is based on evidence that CBT is beneficial for reducing the frequency and severity of menopausal symptoms.
 - The greatest impact is seen in a reduction in how much menopausal symptoms cause distress or 'bother' to the individual.
 - However, because of limitations in the quality of evidence, there remains uncertainty about outcomes and how large the effect of CBT is. For this reason, NICE says that CBT should be offered in addition to HRT, or as a sole treatment if people prefer not to take HRT/it is contraindicated.
 - Menopause-specific CBT delivered by specialist nurses can also improve vasomotor symptoms, sleep, anxiety and mood in women following breast cancer ([Psychooncology 2020;29:1514](#)).
- Other psychological therapies, including mindfulness and hypnosis, may also have some benefit on sleep for women with vasomotor symptoms ([BMS, 2025](#)).

7. HRT and sleep problems

HRT may improve sleep when problems are directly caused by menopausal symptoms such as night sweats or genitourinary symptoms. However, evidence suggests that improvements are mainly seen in women who also experience vasomotor symptoms ([Menopause 2024;31:724](#)).

The British Menopause Society ([BMS - managing sleep disturbance during the menopause transition](#), 2025) says that HRT may be an appropriate

treatment for insomnia symptoms during menopause, even in the absence of vasomotor or other symptoms, if there is a clear link to the menopause transition.

This is different from what NICE says. NICE advocates CBT for sleep problems, and does not recommend HRT for sleep problems in the absence of vasomotor symptoms (see below: ‘Treatment of mental health conditions in the menopause transition’) ([NICE 2015 \(updated 2024\), NG23](#)).

Evidence about HRT and sleep during menopause is emerging, but remains limited and somewhat inconsistent:

- A small RCT from 2019 found that HRT significantly improved sleep quality in perimenopausal women, even after controlling for vasomotor and depressive symptoms ([Menopause 2019;26:1318](#)).
- A systematic review found that HRT is associated with small improvements in self-reported sleep quality, but not with changes in objective sleep parameters measured by polysomnography. This suggests that HRT may influence the experience of sleep more than underlying sleep architecture. There was also some evidence that transdermal preparations may have greater benefit than oral routes, and that combined oestrogen and progestogen regimens are more effective than oestrogen alone, although findings varied between studies ([Menopause 2022;29:627](#)).

Isn't micronised progesterone good for sleep?

Progesterone is thought to have sedative and hypnotic effects, and oral micronised progesterone is bioidentical to endogenous progesterone, although manufactured synthetically.

A systematic review of 9 RCTs (n = 388 participants) and meta-analysis of 4 RCTs ([J Clin Endocrin Metab 2021;106:942](#)) found that:

- Micronised progesterone may improve self-reported sleep and some objective sleep parameters, particularly sleep-onset latency, and, in some studies, total sleep time and stages of sleep. However, findings were inconsistent and there was no clear overall improvement in sleep efficiency.
- Most studies used oral micronised progesterone at doses of 100–300mg, with some suggestion that doses of 200–300mg may have greater effects. There is no clear evidence that it is more effective than other progestogens.
- Most studies were carried out in postmenopausal women.
- The authors concluded that micronised progesterone shows potential benefits for sleep, but the size and consistency of these effects remain uncertain. Some of the improvement may also be due to reduced night-time vasomotor symptoms or the addition of oestrogen, rather than progesterone alone.

The methodology of this mini-review was subsequently critiqued in a letter which argued that the interpretation of the data may underestimate the effects of progesterone. In one included study, progesterone had little effect during a normal night of sleep, but showed clearer benefit when sleep was deliberately disrupted by overnight blood sampling. The meta-analysis included only the normal night and excluded the disrupted night, where benefits were seen. This could support the idea that progesterone may not act as a general sedative, but may help stabilise or restore sleep when it has been disturbed ([J Clin Endocrin Metab 2021;106:e4789](#)).

The BMS endorses micronised progesterone as the preferred option for endometrial protection in women with sleep issues ([BMS, 2025](#)). However, it:

- Acknowledges that the evidence supporting its efficacy for sleep is limited ([JCEM, 2021;106:942](#)).

- Reminds us that micronised progesterone is only licensed for endometrial protection and not for treatment of sleep problems. It does not advocate its use solely for sleep problems, which would be off-label, and the balance between benefit and possible risk (primarily of breast cancer) is unknown, especially if combined with an IUS.

8. Other drug treatments

Antidepressants are sometimes considered, but none are currently licensed for the treatment of sleep disturbance. Therefore, their use in women experiencing sleep problems during the menopause transition is not recommended, unless there is a clear indication for treating a co-existing mental health condition such as depression, in which case management should follow NICE depression guidelines ([Menopause 2024;31:724](#); [NICE 2022, NG222](#)).

There is some evidence that antidepressants (SSRIs and SNRIs) can reduce vasomotor symptoms, and may therefore indirectly improve sleep when the disturbance is related to these symptoms.

- NICE ([NICE 2015 \(updated 2024\), NG23](#)) does not recommend routinely offering SSRIs, SNRIs or clonidine as first-line treatments alone because it feels that they are not effective in relieving vasomotor symptoms, and have higher discontinuation rates than other treatments.
- The British Menopause Society ([Post Reprod Health 2020; 26:181](#)) does list SSRIs and SNRIs among non-hormonal options for vasomotor symptoms, typically when HRT is contraindicated or unsuitable:
 - Paroxetine 10mg first line for women not taking tamoxifen. Using this low dose is as effective as higher doses, and with fewer side-

effects.

- Citalopram, fluoxetine and escitalopram have also been shown to be effective.
- Venlafaxine 75mg for women with breast cancer who are taking tamoxifen. Avoid fluoxetine and paroxetine in this group due to impact on tamoxifen efficacy.
- Remember that paroxetine and venlafaxine are both in the highest-risk group for severity and likelihood of withdrawal symptoms on stopping antidepressant treatment ([CNS Drugs 2022;37:143](#)).



Menopause and sleep problems

- Sleep disturbance affects around half of menopausal women and is associated with fatigue, irritability and reduced quality of life.
- Sleep problems often result from a combination of vasomotor symptoms, mood changes, ageing, physical health conditions and lifestyle factors.
- Management should address lifestyle habits, underlying health or sleep disorders, menopausal symptoms and psychological wellbeing.
- HRT can improve sleep when symptoms are related to menopause.
- Menopause-specific CBT and CBT for insomnia may both improve sleep in perimenopausal women.

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