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"I was just a shell": Mental health concerns for women in perimenopause and menopause

Kate O'Reilly | **Fiona McDermid** | **Susan McInnes** | **Kath Peters**

Western Sydney University, Penrith, New South Wales, Australia

Correspondence
Kate O'Reilly, Western Sydney University, Locked Bag 1797 Penrith 2751, Australia.
Email: kate.oreilly@westernsydney.edu.au

Abstract

Early detection of deteriorating mental health for women who are experiencing symptoms associated with perimenopause and menopause is critical to ensure the well-being of women. Unfortunately, many women during this phase of their lives find it difficult to access relevant and timely treatment. This concurrent mixed methods study using an online survey and qualitative interviews explored Australian women's knowledge and experiences of perimenopause and menopause and specifically reports on findings associated with women's mental health. Four hundred and eleven women completed the online survey in its entirety and 25 women participated in semi-structured interviews between April and July 2022. Survey data were analysed using SPSS and, in this article, data are presented as descriptive statistics. Qualitative interviews were analysed using thematic analysis guided by Braun and Clarke (2013; 2019). Quantitative and qualitative data specific to women's mental health were integrated into three themes: (1) increased anxiety and depression, (2) a negative impact on emotions and (3) a negative impact on self-worth. Findings from this study will help to inform clinical services for women as it highlights the need to improve education about perimenopause and menopause for healthcare providers and women.

KEYWORDS
assessment, menopause, mental health, nursing, perimenopause, women

INTRODUCTION

Stigmatisation and taboos associated with women's menstrual cycles are steeped in ancient religious beliefs that menstrual blood is unclean, and any contact with a woman during this time would cause impurity (Leviticus 15: 19–33). Many modern depictions of menstruating women are that they are irrational, angry and aggressive, all of which are prejudicial as the socialised expectation is that women should be in constant control of their emotions (Chrisler & Gorman, 2020; Ussher & Perz, 2020). Chrisler and Gorman (2020) highlighted that many cultures have patriarchal structures which reinforce the negativity and silencing of anything to do with the uterus due to a misplaced belief that the uterus is responsible for hysteria in women. Evans (2018) explained that the Greek word for the uterus is hysteria, the origin of what was labelled hysteria, a medical condition which was attributed to the female sex. Hall et al. (2007) highlighted that cultural influences extend from menstruation through to menopause and while they recognised the individual experience for women, they reported that for some cultures which celebrate the matriarchy, for women in menopause, status was elevated to becoming a wise elder. Conversely, Hall et al. (2007) explained that in societies which have a more patriarchal structure, no such privilege was reported by women in menopause. Rather, women who lived in these social structures in countries such as Iran, India and Africa feared they were less valuable as they were no longer fertile. Piran (2020) explained that embedded sociocultural normative constructs influence the meaning women and the broader

society attribute to sexual and reproductive health, thus how women interpret and experience perimenopause and menopause are contextual. Findings from the literature review by O'Reilly et al. (2022) which included studies from several culturally diverse countries also found that sociocultural elements influenced women's experiences. There is a long history of diagnosis and treatment for women only being provided by males. This, coupled with the positioning of women as subordinates within society, highlights the misogynistic structures that women lived within making them unable to be self-determining regarding their health (Evans, 2018). Additionally, mental health conditions such as schizophrenia, anxiety and depression have been long associated with stigmatisation and marginalisation which is a barrier to individuals seeking treatment (Blum et al., 2021). This becomes more complex when considering gendered cultural influences on mental health with Edge and Bhugra (2016) highlighting that women from ethnic minorities are disproportionally vulnerable to a diagnosis of mental illness. The authors highlight that on one hand women from some ethnic minorities may have a higher risk of having experienced trauma for which they may be categorised as having a mental illness diagnosis. Conversely, women from ethnic minorities may be more likely to prioritise the needs of others over their own which may result in them being less engaged with mental health services. Additionally, language barriers may impact accessing services if women do not have access to an independent interpreter (Edge & Bhugra, 2016). Stigma related to both the menstrual cycle and mental health, in addition to inequity for women and girls in accessing sexual and reproductive health services (World Health Organization, 2022a, 2022b) perpetuates what O'Reilly et al. (2022) identified as an unspoken message that women should suffer through perimenopause and menopause in silence.

BACKGROUND

There are varying definitions in the literature for perimenopause, menopause and mental health. For the purpose of this article perimenopause is the transition phase in which women experience an imbalance of oestrogen and progesterone and menopause is reached when a woman has not had a menstrual cycle for 12 months (Prior, 2020). The definition of mental health from the (World Health Organization, 2022a, 2022b, n.p) is "a state of well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well and contribute to their community".

In a recent review of the literature, O'Reilly et al. (2022) highlighted women from various cultural backgrounds identified a change in their psychological well-being which was linked to perimenopause and menopause. The psychological symptoms reported by women which have been identified in the literature include anxiety and depressed mood (Abd Elazim et al., 2014; Abubakari et al., 2018; Alan et al., 2016; Christophe et al., 2020; Duffy et al., 2013; Herbert et al., 2020; Jurgenson et al., 2014; Khokhar, 2013; Memon et al., 2014; Mustafa & Sabir, 2012; Sayakhot et al., 2012; Tasnim et al., 2016; Ussher et al., 2019). Emotional lability which ranged from women feeling angry, agitated and irritable to feeling upset, tearful and feeling their self-esteem was low was identified across studies (Abd Elazim et al., 2014; Abubakari et al., 2018; Alan et al., 2016; Duffy et al., 2013; Herbert et al., 2020; Jurgenson et al., 2014; Khokhar, 2013; Memon et al., 2014; Mustafa & Sabir, 2012; Sayakhot et al., 2012; Tasnim et al., 2016; Ussher et al., 2019). Hooper et al. (2022) and TruelandTrueland (2022) highlight that the psychological symptoms women report during perimenopause and menopause can have deleterious impacts on women's lives. For women going through the fluctuating hormonal transition associated with perimenopause and menopause, diagnostic overshadowing as described by Molloy et al. (2021) could lead to health professionals misattributing symptoms to a mental health disorder, thus leading to inappropriate treatment for women.

This article presents findings from a mixed methods study exploring Australian women's knowledge and experiences of perimenopause and menopause. The aim of this article is to present data which is specific to the mental health of Australian women who are perimenopausal and in menopause to inform and improve the delivery of health care for women during this period of their lives.

METHODS

Design

The research was conducted using an equal weighting concurrent mixed methods design which included an online survey and qualitative interviews which aimed to explore Australian women's knowledge and experiences of perimenopause and menopause. This article provides the analysis of the quantitative and qualitative data which is specific to participants' mental health and uses the Good Reporting of a Mixed Methods Study [GRAMMS] checklist to report the findings (Appendix S1) (O'Cathain et al., 2008). Thierbach et al. (2020) explained that using mixed methods such as an online survey and interviews with equal weighting and concurrent design can offer complementarity in research. This concurrent design provided an increased opportunity for participation in a form which suited women. Additionally, the equal weighting allowed for each method to both enhance and provide a further detailed understanding of Australian women's knowledge and experience of perimenopause and menopause. The World Health Organisation (2015) identify that because gender is a social determinant of health, globally women compared to men are at greater

risk of poor health. The authors of this article recognised that the dearth of research which is specific to women's reproductive and sexual health is an example of health inequities. Thus, a critical feminist standpoint framework underpinned not only the design of the study but also the analysis of data (Naples & Gurr, 2014). Given menopause is unique to the female sex, using a feminist perspective for this research was not only logical but as highlighted by Chrisler et al. (2020) it is a way of raising consciousness about a topic which has had little attention globally.

Data collection

Following ethics approval from a University Human Research Ethics committee (Approval Number Withheld for Review) Australian women who self-identified as being perimenopausal or who were in menopause were invited through Facebook™ and Twitter™ to complete an online survey and then participate in semi-structured interviews. Completion of the survey implied consent and verbal consent was sought at the commencement of interviews. It was estimated that a minimum of 15 interviews would have provided rich data for thematic analysis.

Quantitative component

A search of the literature was conducted to explore if a tool had been developed which explored women's knowledge and experience of perimenopause and menopause. No single comprehensive instrument was found by the authors. However, incorporating two validated instruments following permissions into a single 32-item survey helped to answer the research question: What is Australian women's knowledge and experience of perimenopause and menopause? Prior to implementation, the survey was reviewed by 10 women who identified as being perimenopausal or in menopause to ensure suitability for the demographic. Minor adjustments to wording and formatting were made following feedback to ensure clarity.

The electronic survey was live from April to July 2022. The validated tools included in the anonymous online survey were the 23-item Women's Health Questionnaire (WHQ) tool (Hunter, 2000) and 9 items from the Menopause Knowledge Scale (MKS) (Appling et al., 2000) which had been adapted by Smail et al. (2020). These are summarised in Table 1. Examples of questions which are included in the survey are presented in Table 2.

Qualitative component

Women who indicated they wished to participate in an interview provided their contact details within the survey and were contacted by email or telephone by the research assistant. Semi-structured conversational interviews were conducted by the third author via telephone or online video conferencing tools. The interview guide was developed by all authors who were all female Registered Nurse academics, who have doctoral qualifications and expertise in qualitative work. Interviews were conducted from April to July 2022, conducted in English language, audio-recorded and transcribed verbatim. The mean duration of interviews was 28 min, with 11 h and 33 min of data being recorded.

TABLE 2 Sample of survey questions.

How would you rate your knowledge about menopause?
Do you know at what age menopause usually starts?
Where did you gain your knowledge of menopause from?
I feel miserable and sad
I have list interest in things
I feel life is not worth living
I suffer from backache or pain in my limbs
I have hot flushes

TABLE 1 Validated tools incorporated within the Perimenopause/menopause survey.

Tool name	Purpose	Scoring	Reliability[a]
Women's Health Questionnaire 23-item (Hunter, 2000)	Investigates six domains: anxiety/depressed mood, well-being, somatic symptoms, memory/concentration, vasomotor symptoms and sleep problems	4-point Likert scale 1 = Yes, definitely 2 = Yes, sometimes 3 = No, not much 4 = No, not at all	Cronbach's alpha coefficient >0.70
Adapted Menopause Knowledge Scale (Appling et al., 2000)	Explores knowledge of menopause	Lower scores indicate more knowledge about menopause Agree = 1 Disagree = 2	Cronbach's alpha coefficient 0.858

[a] Reliability is rated between 0 and 1, with 0 indicating poor reliability and 1 indicating perfect reliability. Ratings >0.70 are considered optimal (Findler et al., 2001).

Data analysis

Survey responses were downloaded from Qualtrics and exported into SPSS. Quantitative data were revised against eligibility criteria by a research assistant which was overseen by the research team. Pairwise deletion was used to mitigate the fact that not all participants completed all questions in the survey (Shi et al., 2020). Data were collated and frequencies and percentages for the mental health variables were determined. Qualitative data were uploaded to NVivo software for management. Participants transcripts were read whilst listening to audio recordings to ensure the accuracy of the transcription. Listening to participants oral narratives also allowed the authors to uncover participants' unique experiences that are often muted and reflect the dominant and thus more socially acceptable, patriarchal discourse (Anderson & Jack, 1991). Transcripts were then thematically analysed. As identified by Braun and Clarke (2013, 2019) the authors did not seek saturation but collected rich data from interview participants which was developed into themes.

RESULTS

A total of 480 records were downloaded from Qualtrics and exported into SPSS however, not all participants completed every question. A total of 411 women completed the survey in its entirety. Twenty-five women participated in interviews. Women who completed the survey were born in 35 different countries however the majority (73.8%, $n=301$) were born in Australia with 3.25% ($n=15$) of Australian-born women identifying as Aboriginal. The other countries of birth which were represented in higher numbers were the United Kingdom (10%; $n=41$), New Zealand (3.9%; $n=16$) and Germany (2%; $n=8$). The remaining countries of birth women reported were each less than 2% and are presented in Figure 1. The mean age of survey participants was 51.69 years and despite the inclusion of women from all states and territories in Australia, the majority lived in New South Wales (64.4%; $n=273$) (see Table 3). The overwhelming majority of survey participants reported being heterosexual (91.7%, $n=386$) and reported being in married or defacto relationships (80.0%, $n=341$) (see Table 4). Over half of the survey participants (54.1%, $n=230$) described their menstrual status as perimenopausal, with the remaining respondents reporting they had reached menopause. The 25 women who participated in interviews represented 10 different countries of birth with a majority of women (44%, $n=11$) in the 46–50 year age range (see Table 5).

Through integrating qualitative and quantitative results we found that many of the women who participated in this study identified changes to their psychological well-being, which included: (1) increased anxiety and depression, (2) a negative impact on their emotions and (3) a negative impact on their self-worth (see Figure 2).

Increased anxiety and depression – My anxiety became all too consuming

Qualitative findings from this study highlighted that many women who were perimenopausal or in menopause experienced changes in their psychological well-being. They reported increased anxiety and/or depression which coincided with the fluctuations of hormones they experienced during this phase of their lives. The following quotes are excerpts of what women revealed about anxiety and/or depression, highlighting the distress and the impact on their day-to-day lives. Mary highlights the increased feeling of anxiety she felt and a loss of control over her emotions.

> My anxiety came probably around five years ago. I've just noticed that, before, I was a fairly chill, go with the flow person and, when I started having the anxiety, I was noticing that I was losing it over nothing.
>
> Mary

Anxiety and panic attacks impacted Naomi's productivity. She was unable to manage the day-to-day stresses of the workplace, highlighting the deterioration in her well-being.

> Well, I had to give up work about four years ago because my anxiety became too all-consuming, too difficult, and the panic attacks…but I could almost hardly function because of how extreme the anxiety was in that period. It sounds weird to say but it feels like - sometimes it feels like I get almost panic attacks, coming from my uterus. I've said it before to my GP and he's like well, that can't happen. I'm like well, that's what it feels like. It feels like this surge of panic coming from there. It's an unusual thing.
>
> Naomi

Sleep disturbance was reported by women during interviews and within the survey. Vanessa highlighted that sleeplessness was a significant contributor to feelings of increased anxiety.

> The anxiety is the hardest. The sleepless nights are hard, and I think that then contributes to the anxiety the next day, because then I'm overtired…but it is the anxiety, and the sleeplessness is what affects me more.
>
> Vanessa

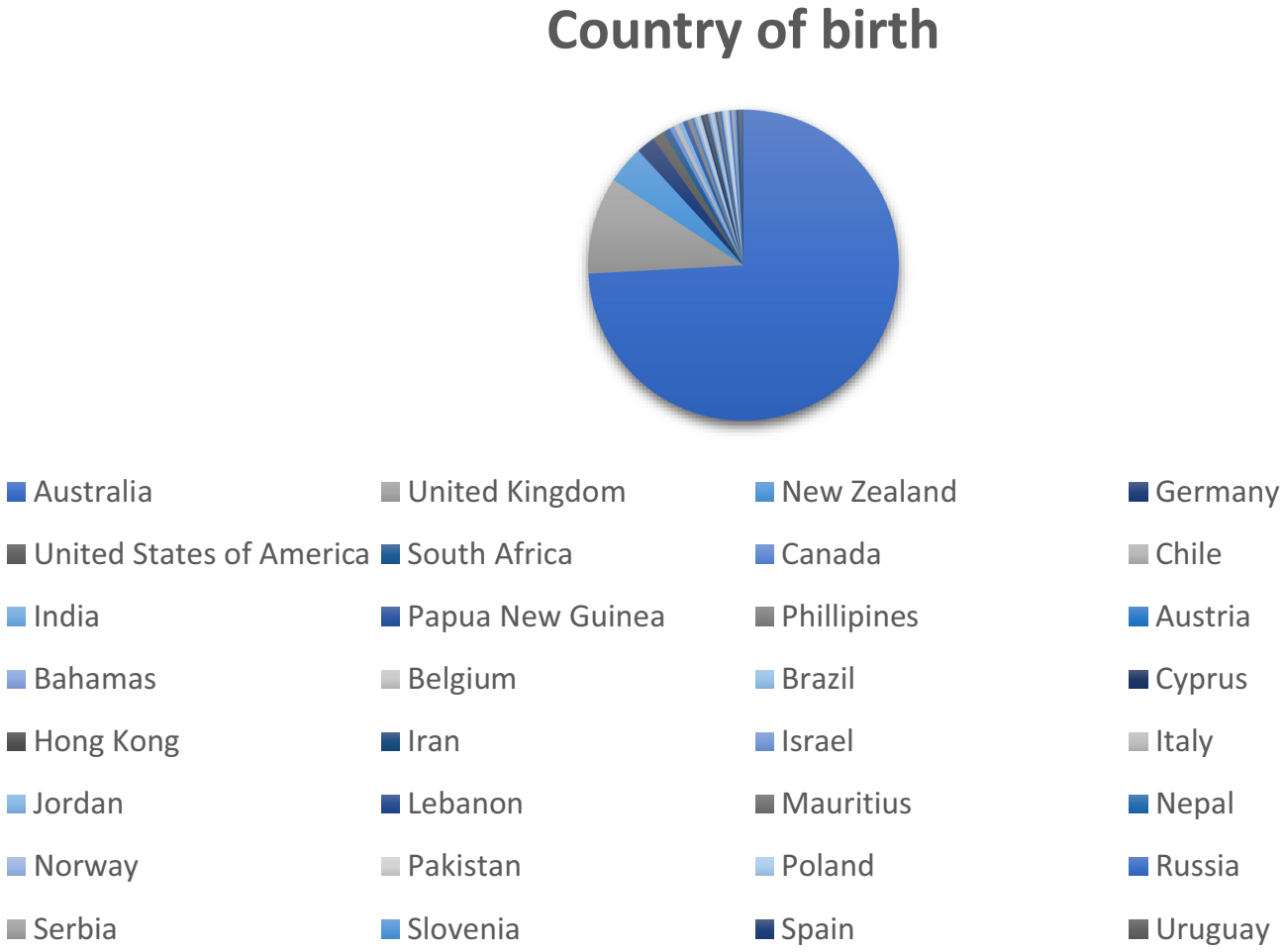

FIGURE 1 Countries of birth for survey participants.

TABLE 3 State/Territory of survey participants.

Participant variable	*N*=424
State/Territory	
New South Wales/ACT	273
Victoria	75
Queensland	26
South Australia	14
Western Australia	10
Norther Territory	10
Australian Capital Territory	8
Tasmania	8

Gayle's description of bursting into tears and feeling like she did not know what was wrong with her aligns with the feelings of tension women reported in the survey.

> I went to the doctor yesterday, the first thing I did was burst in tears and I went, my God, what is wrong with me? She [doctor] said to me…I'm going through menopause. I want my life back. I said to her [doctor], I said, what can I do? …Then she [doctor] said to me, she said, we need to put you on antidepressants… It's anxiety and depression, oh my God, yes, I'm actually going through that.
>
> Gayle

For Janet her state of well-being had declined so significantly that she no longer felt she was functioning to her fill potential.

> I realised the depression anxiety was getting worse and worse…I was just a shell; I'd drag myself around.
>
> Janet

Quantitative findings resonated with the experiences of women who participated in interviews. The adapted MKS (Appling et al., 2000; Smail et al., 2020) questions included in the survey asked women if they thought their risk of depression increased during the menopause period. More than three-quarters (83.6%; $n=347$) of the 415 respondents to this question agreed that there was an increased risk of depression during this phase. The WHQ (Hunter, 2000)

TABLE 4 Relationship status of survey participants.

Participant variable	*N*=426
Married heterosexual	286
Defacto heterosexual	55
Divorced	34
Single	31
Separated	11
Widowed	5
Same sex partnership	4

TABLE 5 Country of birth and age of interview participants.

Country of birth	*N*=25	Age range	*N*=25
Australia	15	Missing	1
New Zealand	2	36–40	1
Bahamas	1	41–45	4
Chile	1	46–50	11
Germany	1	51–55	7
Pakistan	1	56–60	1
Serbia	1		
Spain	1		
United Kingdom	1		
Vietnam	1		

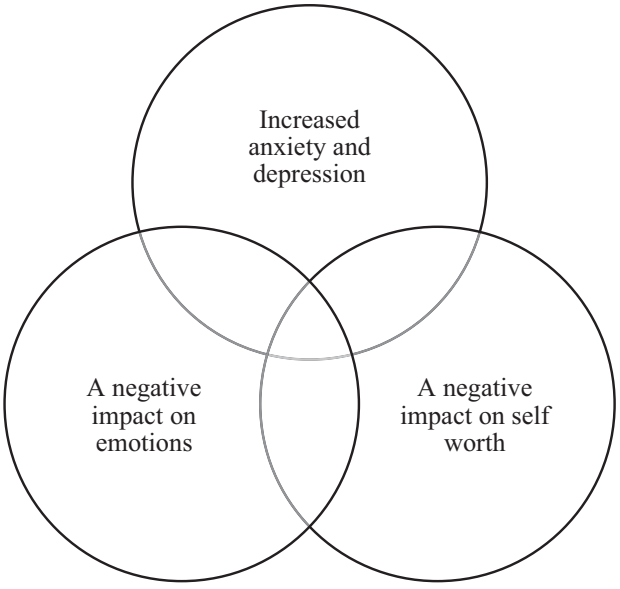

FIGURE 2 Diagrammatic representation of themes.

component of the survey asked women in different ways if they had feelings of anxiety. While more than half of the women who completed the quantitative survey reported limited or no feelings of anxiety (*n*=232; 56.2%), a large proportion of women who responded (*n*=113; 43.6%) did report definitely or sometimes being frightened or panicked for no reason. When asked if women experienced palpitations or had feelings of butterflies which can be a sign of anxiety there was a similar response with just over half of the women reporting not much or none of these (*n*=208; 50.4%) compared to just under half reporting definitely or sometimes having palpitations and butterflies (*n*=204; 49.4%). Additionally, participants in this study were asked about feelings of tension. More than two-thirds of the women did report definitely and sometimes feeling tense and wound up (*n*=276; 66.9%) compared to those who reported little or no feelings of tension (*n*=136; 33.0%).

Many women (*n*=219; 53.0%) in this study reported difficulty getting off to sleep which can also be associated with anxiety. Eighty-four women (20.4%) reported they definitely had difficulty getting off to sleep and 32.8% (*n*=135) reported that this was the case for them sometimes. The remaining 46.8% (*n*=193) reported few or no difficulties with getting off to sleep. Women in this study were asked if they woke early and then slept badly for the rest of the night. One hundred and six women (25.7%) responded that yes this was definitely what they experienced. For 41.3% of women (*n*=170) this was sometimes the case for them and 33% (*n*=136) of women, they did not experience this much or not at all. Additionally, women were asked if they felt more tired, 43.0% (*n*=177) of the 412 respondents identified that yes, definitely they felt more tired than usual and 40.7% (*n*=168) said that yes sometimes they felt more tired than usual. The remaining 16.3% (*n*=67) women responded no not much, or not at all related to feeling more tired than usual.

Negative impact on emotions – emotionally it's like a rollercoaster

Many women in this study reported that perimenopause and/or menopause had a negative impact on their emotions. Participants highlighted that this made them feel a disconnection from the person they identified as because they found it difficult to regulate the emotions they were experiencing. The following quotes highlight some of the emotional lability that women in this study experienced.

> I thought that I was more prepared than I really was. I think emotionally, it's like a rollercoaster… I was more moody. But not angry. I was just sad. I was just watching the TV and just suddenly crying a little bit. Very emotional, I would say. Very emotional.
>
> Marissa

The quotes from Ashley and Betty below illuminate that women not feeling in control of their emotions this could present in different ways. For Ashley, this was a more overt presentation of what she described as irrational.

> I expected to be basically a bit of a daytime lunatic in terms of probably a little bit irrational here and there, a bit emotional.
>
> Ashley

In contrast to Ashley above, Betty described inertia which appeared as though she had lost motivation.

> I felt not so well emotionally regulated for a little while, which I didn't like. Yeah, just I didn't like that – I didn't like being – feeling that I wasn't sort of on top of things…I lost motivation, I suppose in a sense, or felt possibly I was losing motivation. So, I didn't like that.
>
> Betty

In the quantitative survey for this study, women were asked if they felt miserable or sad. Overall, of the 412 women who completed this question less than half of the women responded that they had few or no feelings of feeling miserable and sad ($n = 195$; 47.3%). However, the largest proportion of women ($n = 185$; 44.9%) identified that yes sometimes they felt miserable and sad which aligns with the emotional lability women reported in interviews. The remaining 7.8% ($n = 32$) of respondents reported they felt miserable and sad.

Negative impact on self-worth – *I feel worthless*

In this study, some women who participated in interviews reported feeling less confident and less valuable which impacted their overall feelings of well-being. The following quotes are some of the narratives women who participated in this study shared. For Janet, the feeling of worthlessness impacted negatively on her relationships.

> It didn't really stop my social life as such, but it definitely had an impact on relationships, on my self-worth. Feeling of not being worth – they were definitely really strong.
>
> Janet

Claire did not report that life was not worth living in her interview however, she did report retreating which aligns with the survey results of some women reporting lower well-being.

> I think I did probably hide away in a little hole there for a while. I found it hard to just be around people in general.
>
> Claire

The survey asked women if they had feelings of well-being. In total, 411 women answered this question. Of these respondents over a quarter of women reported definitely having feelings of well-being ($n = 124$; 30.1%) and half of the women who responded said yes that sometimes they had feelings of well-being ($n = 213$; 51.8%). While the numbers are much smaller than women who overall had feelings of well-being there were 74 women (18.0%) reporting low or no feelings of well-being. The feeling of worthlessness that participants identified in interviews was also found in the survey. Twenty-five women (5.3%) of 412 who responded to the statement life is not worth living indicated life was definitely not worth living. Additionally, some women reported that they sometimes felt life was not worth living ($n = 62$; 15.1%). The remaining 78.9% ($n = 325$) of women who reported feeling that life was worth living aligns with the finding reported above that overall women had feelings of well-being. The finding of overall well-being is contrary however to the finding that over half of the women who completed the survey ($n = 231$; 55.0%) reported that they had lost interest in things.

DISCUSSION

Globally, research into women's health is improving, yet there is a paucity of Australian studies which specifically explore Australian women's mental health during perimenopause and menopause. Being underrepresented in research has led to a lack of knowledge and women receiving inadequate or inappropriate treatment for health concerns (Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), 2023). Apart from women being underrepresented in research, gender inequities and unequal power relationships exist that privilege men in terms of financial opportunities and access to education (World Health Organization, 2023). This leads to substantial gender disparities in health care which has resulted in poorer health outcomes for women worldwide (World Health Organisation, 2015). Therefore, the findings from this research are clinically important as they raise an awareness that the impact of perimenopause and menopause on women's lives is far-reaching not only in developed countries such as Australia but across continents. Timely and relevant assessment regardless of country is critical to ensuring women's health and wellbeing.

Weiss et al. (2016) highlighted the well-documented comorbidity of anxiety and depression with anxiety often preceding major depressive episodes. For women, they report an increase in depressive symptoms during perimenopause and menopause due to the hormonal irregularity. Participants in this study highlighted that their symptoms of anxiety and/or depression coincided with the change in their menstrual cycles. Krychman and Bachmann (2019) discussed the impact that depression and/or anxiety and hormones may have on sleep. Krychman and Bachmann (2019) also highlighted multiple factors such as financial strain, ill health,

carer responsibilities and increasing working hours, which can further interrupt sleep. Furthermore hot flushes, frequency of urination and weight gain which are reported during perimenopause and menopause by many women also act as interruptions to women's sleep. Women in this study identified interruptions to sleep and they reported feeling more tired than usual. This is an important finding because as identified by Krychman and Bachmann (2019) chronic sleep deprivation, which may be due to a constellation of factors for women who are perimenopausal or in menopause, increases the risk of a sharp decline in mental health so much so that the risk of suicidal ideation is heightened. This is deeply concerning because 25 women (5.3%) in this study indicated their life was not worth living and 62 women (15.1%) reported sometimes feeling the same. The authors of this article oppose any pejorative link between menopause and mental health and caution against a linear link being made between the two. However, it is critical that clinicians identify that fluctuating hormones may be one of a variety of factors which must be considered in the comprehensive physical and mental health assessment of women who may be in this phase of their lives. Suitable and timely interventions need to be available to all women to better support women's quality of life.

While some of the corporeal elements of menopause such as vasomotor symptoms appear to be well documented there remains a taboo associated with perimenopause and menopause (Chrisler & Gorman, 2020; Ussher et al., 2017). Krajewski (2019) highlighted that although there is an increasing discourse around the topic of perimenopause and menopause the way in which it is discussed which includes comedy, euphemisms and whispered tones perpetuates not so subtle messages that the topic remains secret women's business and that women's ageing bodies are failing them, implying they are less valuable. Krajewski (2019) highlighted the use of comedy has aided in bringing the discussion of menopause into the public domain and in some sense lifts a veil of secrecy. However, the danger is that in using humour to discuss perimenopause and menopause, women's experiences are trivialised and not given the full attention they deserve. The feminist underpinnings of this study highlight that research into women's sexual and reproductive health should not sit on the periphery any longer if we are to address the inequities recognised by the World Health Organization (2022a, 2022b).

Krajewski (2019), argues that perimenopause and menopause have been medicalised, and as such this positions women as subservient to a system which is yet to adequately meet their needs. The taboo associated with perimenopause and menopause is further compounded by the stigma associated with disruption to mental health (Murphy et al., 2017). Sociocultural elements continue to influence the discourse of perimenopause, menopause and mental health. While the silence may be lifting, the findings of this study highlight there is much that still needs to be done to ensure women are able to navigate this period of their lives free from silence, stigma and shame (Nosek et al., 2010). Enabling authentic discussions which refrain from using humour and euphemisms is critical to ensuring the development and implementation of services which are relevant for this heterogenous group of women.

CONCLUSION

Women in this study illuminated that stigma and shame associated with perimenopause, menopause and a deterioration in mental wellbeing continue to be perpetuated within society. The results from this study which include women from diverse cultural backgrounds highlight an unmet need for women globally. Findings can help to inform the design and provision of holistic services which include the need to consider the intersection of the sociocultural and physiological impact of perimenopause and menopause on women's mental health.

RELEVANCE FOR CLINICAL PRACTICE

Alterations to women's mental health during perimenopause and menopause can have deleterious impacts on women's employment, relationships and personal wellbeing. All the clinicians would benefit from education and training in this area but more specifically general practitioners and nurses working in primary health settings. Furthermore, nurses working in mental health settings require competence and expertise in assessment skills to ensure women presenting to mental health services are suitably supported during this period of their lives.

AUTHOR CONTRIBUTIONS

KO wrote the main script, KP prepared tables, FM compiled quotes, SM contacted participants and conducted interviews. All the authors reviewed the manuscript and contributed to the development of themes and discussion ideas.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflict of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

This research has been approved by the Western Sydney University Human Ethics Committee – Approval Number: H14724.

ORCID

Kate O'Reilly https://orcid.org/0000-0001-8644-3803

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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