A qualitative study exploring women's experiences of their mental health during perimenopause and menopause

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Abstract

The study of women's mental health during perimenopause and menopause is pivotal in understanding the needs of women and for supporting their overall wellbeing and quality of life during this life phase. However, despite its importance, this area remains largely under-researched, necessitating further exploration. The aim of this study was to explore women's experiences of perimenopause and menopause in relation to their mental health for the purpose of developing an understanding of the complexities of mental health during this transitional phase. Responses from 79 qualitative surveys and 8 semi-structured interviews were collected and analysed thematically within a critical realist framework. Four themes were identified. The first theme, '"what is wrong with me?": complexities of sense making', reports on how mental health can be influenced or exacerbated by an absence of education and awareness of perimenopause/menopause. The second theme, '"someone other than myself": crises of identity', highlights the process of identity transition through peri/menopause, illustrating how this adjustment can impact women's emotional and interpersonal experiences. In the third theme, 'the impact of mental health during peri/menopause: "Existing, not living"', women recounted experiences of psychological distress, with some describing its severity, including a small number expressing suicidal ideation. The final theme, 'women's experiences of help seeking: "stuck me on antidepressants"', reports on women's experiences of seeking support for signs and symptoms associated with peri/menopause, including for their mental health. Three themes contained one subtheme. These findings contribute to current understandings of mental health during peri/menopause, underscoring the necessity for increased awareness and education among healthcare practitioners, including counselling psychologists, as well as among women themselves.

Chapter 1: Introduction

Perimenopause and menopause affect half the global population (Harper et al., 2022). Despite this, there remains much that is missing from our knowledge of women's experiences, especially in relation to mental health. What is known, is that during perimenopause/menopause, women's hormone levels (particularly oestrogen and progesterone) start to fluctuate and decline, leading to irregular menstrual cycles and other physical and psychological signs and symptoms (Nelson, 2008; Ellington et al., 2022). These can include, though are not limited to, irregular periods, poor sleep, mood swings, anxiety, depression, reduced libido, brain fog, fatigue, and vasomotor symptoms (Nelson, 2008; Jane & Davis, 2014; Newson & Panay, 2018; NICE, 2019; Ellington et al., 2022; O'Reilly, 2023). Vasomotor symptoms are characterised as "episodes of profuse heat accompanied by sweating and flushing, experienced predominantly around the head, neck, chest and upper back" (Thurston & Joffe, 2011, pp. 489 – 501), referred to as 'hot flushes/flashes' and 'night sweats'. Extensive research has focussed on the biological processes of perimenopause/menopause, offering a comprehensive understanding of physiological, anatomical and pathobiological aspects. This research includes pharmacology and the development of medical interventions such as hormone replacement therapy (HRT) to address problematic symptoms (Lobo et al., 2000; Cagnacci & Venier, 2019). However, there has been a noticeable lack of attention given to women's emotional, psychological, behavioural, and cognitive experiences of perimenopause/menopause.

For most women, perimenopause/menopause begins at midlife which is "typically defined as a transitory rather than distinct phase of the life cycle" (Brooks-Gunn & Kirsch, 1984. p.11). However, during this time women often face competing demands in their personal and professional lives. In Western societies, the discussion of perimenopause/menopause can be stigmatised because of its association with aging in a society where youthfulness is privileged (Chrisler, 2013). Negative stereotypes of perimenopausal/menopausal women persist in society today, particularly surrounding aging, hot flushes, and mood swings (Hickey et al., 2022). These cultural attitudes are expected to influence women's experiences of perimenopause/menopause (Ayers et al., 2009; Hunter, 2015; Hickey et al., 2022).

Data suggests that as many as 9 in 10 women experience mental health challenges during perimenopause/menopause (UK Parliament, 2024). However, previous research does not adequately capture women's experiences of mental health during

perimenopause/menopause nor the complexities of understanding mental health at this time of life. There is a distinct lack of knowledge and understanding of mental health during perimenopause/menopause, existing not only among women but also professionals who work with them (Brayne, 2011; Collier & Clare, 2021; Harper et al., 2022). This thesis, written by a counselling psychologist in-training, aims to contribute to addressing these gaps by capturing both the experience and complexity that transcends pathology and symptom reporting, to a more in-depth exploration of mental health during perimenopause/menopause. Through this increased understanding, it is hoped that professionals, such as counselling psychologists, will be better equipped to provide appropriate and helpful support to women at this time of life as well as improved services for women in the future.

The above provided a brief introduction to the topic and identified gaps in literature that will be discussed further in Chapter 2. The remainder of this chapter will outline and define terminology related to perimenopause/menopause and mental health, explaining their relevance in the context of counselling psychology.

(1.1): Terminology and definitions of perimenopause/menopause

Perimenopause and menopause can be a time of uncertainty for women, including in relation to physical and psychological signs and symptoms, fertility, relationships, and ageing (Dillaway, 2020). Further uncertainties arise from attempting to navigate the often indistinct and complicated definitions of the phases of transition. To place these uncertainties in context, it is necessary to first outline relevant terms, definitions and the phases of reproductive aging associated with perimenopause and menopause. Existing literature outlines four reproductive phases relating to peri/menopause, defined as follows:

- **Premenopause:** The time from the onset of a woman's first period to the beginning of perimenopause (Panay et al., 2020).
- **Perimenopause:** A term used to describe the time leading up to menopause which can last for several years and is commonly associated with hormone and menstrual cycle changes and subsequent signs and symptoms (Dillaway, 2006; Fausto-Sterling, 1992).
- **Menopause:** Defined as being reached one year after periods stop, when menstruation ceases and ovaries no longer release eggs for reproductive purposes (Currie et al., 2017).

- **Postmenopause:** The postmenopausal phase is used to refer to the phase of life that follows menopause (Newson & Panay, 2018).

Women are expected to transition from each phase to the next. However, the terms ‘menopause’ or ‘menopausal transition’ are often generalised to encompass all phases of the transition, including perimenopause, and are widely adopted by women and researchers (National Institute on Aging, 2022). Sherman (2005) emphasises that stages of menopausal transition tend to overlap, making it unclear where one stage begins and another ends. Although these phases of reproductive ageing are outlined in medical literature and research, both medical practitioners and women encounter difficulties clearly identifying which phase they might be in, owing to the absence of clear biological markers of peri/menopause as well as variations in women’s experiences (Sherman, 2005; Nelson, 2008; Harper et al., 2022). For women, the uncertainties surrounding terms, definitions, and stages can make navigating peri/menopause challenging. Due to the variability in women’s experiences and understandings of these definitions, this study will use the term ‘peri/menopause’ to include both perimenopause and menopause.

(1.2): Definitions of mental health

The term ‘mental health’ is widely used in Western societies to broadly describe the emotional, psychological, behavioural, and cognitive health of individuals (Manwell et al., 2015; World Health Organisation, 2022). However, there are various conceptualisations of ‘mental health’; for example, those found in the medical model (biomedicine) (Huda, 2020), positive psychology (Synder et al., 2016), and others across the health and social sciences literature which are briefly described in this section. Thus, the counselling psychology approach to ‘mental health’ will be discussed and some definitions of ‘mental health’ will be outlined.

The biomedical approach to 'mental health' centres on the diagnosis and treatment of psychopathology and has been widely adopted in Western culture and the UK national health system. Within biomedicine, mental 'ill-health' is realised when an individual's symptoms indicate illness or disorder (Galderisi et al., 2015). This model often guides how health professionals treat mental 'ill-health/illness' and support individuals in psychiatry and mental health services (Barnes et al., 2022). The biomedical approach to the treatment of mental health conditions involves identifying and targeting symptoms, akin to physical health. The

Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) serves as an illustration, guiding clinicians in diagnosing and treating individuals based on their symptoms' compatibility with specific mental 'disorders', such as depression, anxiety, and schizophrenia (American Psychiatric Association, 2022).

While many health practitioners consider the biomedical perspective to offer advantages, including the development of effective medications that can alleviate symptoms for some, and in providing a framework for making sense of difficulties through diagnosis (Huda, 2020), many in psychology have offered differing perspectives. Counselling psychologists, health psychologists and those in the field of positive psychology, for instance, argue that determinations of 'mental health' should extend beyond symptomology, pathology, and individual dysfunction (Kobau et al., 2011). These perspectives reject the notion that pathology derives from within an individual, emphasising the importance of considering other factors, such as the person's environment, socio-economic circumstances, and wider background and cultural context, when determining 'mental health' or 'mental ill-health' (Johnstone & Boyle, 2018).

Within positive psychology, for instance, rather than a focus on 'mental health' or illness, the emphasis is on strengths, resources, adaptability, wellbeing, and the resilience of individuals and communities (Synder et al., 2016). Practitioners adopting this approach characterise mental health challenges as "problems in living," rather than disorders or diseases, acknowledging that difficulties arise from conflicts and challenges encountered in daily life as part of the human experience (Maddux, 2021, pp. 72-87). Rather than concentrating on symptoms, this perspective considers components of wellbeing, such as positive emotion, engagement, relationships, meaning, and accomplishment (Seligman, 2019). These strength-based and wellbeing models aim to challenge the prevailing biomedical discourse that attributes mental illness solely to internal factors within the individual.

The discipline of counselling psychology is informed by a multitude of approaches but largely has its roots in humanistic principles and an epistemological position of phenomenology, which is grounded on the belief that there is no single or superior way of "experiencing, feeling, valuing and knowing" (Division of Counselling Psychology, 2008, pp. 1–2). CP approaches are fundamentally critical of dominant discourses like the medical model and positivist assumptions that human experience can be explained and treated within the framework of pathology (Volker, 2017). Further, it acknowledges the multi-faceted nature of 'mental health,' encompassing biological, psychological,

developmental, social, environmental, and cultural factors. Many counselling psychologists would argue that the biomedical stance on disease/dysfunction existing within an individual is reductionist as it precludes subjective experience (Woolfe et al., 2016), and may well also be critical of positive psychology approaches for their simplicity and focus on positive emotions which can be argued as diluting the complexity of human experience (Van Zyl et al., 2023). For these reasons, counselling psychologists are likely to align themselves with person-centred and holistic approaches, tailoring support to the individual.

As the discipline has grown, counselling psychologists have been forced to grapple with these core principles while navigating systems and organisations that promote practices underpinned by the medical model. For instance, the Improving Access to Psychological Therapy (IAPT) programme adopted by the National Health Service (NHS) focuses on measurable reductions in symptomology through outcome measures and monitoring, which creates a tension for practitioners as they face working with symptoms as opposed to individual experience (Binnie, 2015; Brunn, 2023). Working within these settings poses a unique challenge for counselling psychologists as they are forced to engage with a disease-orientated model of practice whilst maintaining a critical perspective (Loewenthal & Larsson, 2012). Notwithstanding these conflicts, alternative perspectives from counselling psychologists in these settings can be highly valuable. Their contributions to multi-disciplinary teams and humanistic and social justice values can help shape organisations and support individuals who may otherwise face challenges accessing therapy (Omylinska-Thurston & Frost, 2022).

More widely, efforts have been made to formulate a universal definition of 'mental health' (Galderisi et al., 2017; World Health Organization, 2004). However, challenges in doing so persist due to variations in how the term is interpreted among individuals, communities, and across cultures. Western individualist cultures such as the UK emphasise the needs of individuals in society, evaluating 'mental health' based on factors such as personal fulfilment and happiness or the absence of problematic symptoms. In contrast, Eastern collectivist cultures such as China often focus more on the welfare of the community (Wang, 2022). Within Eastern philosophical frameworks like Taoism and Confucianism, principles of self-elimination (Wang & Wang, 2020) and the transformation of individual desires (Aggarwal, 2019) are emphasised, aiming for harmony between man, nature, and society. Experiences of 'mental health' are, therefore, not universal and may be defined, understood, and experienced differently across cultures. For instance, while Western

approaches may include individual therapy or medication to target symptoms, Eastern practices of healing might involve support networks in the community, meditation, and more holistic methods.

Despite the prevalent use of the term 'mental health' in Western society, in recent years, many counselling psychologists and other professionals within the psych-disciplines (clinical psychologists, social psychologists, psychotherapists etc.) have used terms like 'psychological distress' or 'human distress' interchangeably with 'mental health'. This shift reflects a broader trend among some psychologists to move away from medicalised understandings of mental health difficulties, such as psychiatric diagnosis, towards alternative frameworks that consider the broader social, cultural, and environmental context in which distress occurs. These approaches emphasise understandings of distress as a natural response to life circumstances, rather than as a sign of individual pathology. Examples of these alternative frameworks are the 'Drop the Disorder' movement and 'The Power Threat Meaning Framework' (Johnstone & Boyle, 2018; Watson, 2019).

These practices aim to move away from potential binary oppositions between 'mental health' and 'mental ill-health' and use of pathologising discourse. The contention with binary oppositions is that they are opposing ideas or terms that are rigidly defined and used to understand each other and therefore one cannot exist without the other (Derrida, 2016). In other words, a person may only be 'mentally healthy' or 'mentally ill,' with no space for anything in between. This proves problematic when considering the complexities of human experience and the blurry boundaries between these categories. Therefore, in this study, a broad and collective definition of 'mental health' will be adopted, encompassing the emotional, behavioural, cognitive, and psychological wellbeing of individuals.

(1.3): Relevance for counselling psychology

The profession of counselling psychology aims to support the psychological and emotional wellbeing of individuals, groups, and communities (Galbraith, 2017). The study of peri/menopause in relation to mental health is relevant to the field of counselling psychology because it can help contribute to understandings of the psychological and emotional impact of peri/menopause on women's lives. These understandings can provide insight for professionals in providing appropriate support to women by helping them navigate the

emotional and psychological aspects of their experience. Counselling psychology values the subjective experiences and perspectives of individuals whilst accounting for the wider context, as well as cultural and historical discourses and perspectives (Douglas & James, 2014). This places counselling psychology in a unique position to help women navigate the cultural and societal expectations and stereotypes related to aging and peri/menopause (concepts to be discussed in depth throughout this thesis), which could present further challenges for women's mental health.

Despite there being a burgeoning body of materials available to women within wider society (e.g., The Menopause Charity website, Menopause and Me website and Balance website and app etc) and many workplaces producing policies to support women (e.g., NHS England, 2022), there is currently no guidance for practitioner psychologists or therapists in supporting women during peri/menopause. In the current NICE guidelines for the diagnosis and management of peri/menopause, health professionals are advised to inform women that peri/menopause may result in low mood and are advised to consider medical treatments such as HRT and/or wider approaches such as CBT for the treatment of depression and anxiety associated with peri/menopause (NICE, 2019). Despite this, support for the broader mental health and emotional impact of peri/menopause on women is neglected within the psychological therapy literature and guidance (Brayne, 2011). Aspects such as the biology and physiology of peri/menopause are well researched (Hillard et al., 2017), but the social, psychological, and emotional aspects of experience are less attended to and argued to have been neglected (Hunter, 2019). Counselling psychologists therefore have an important and unique role in highlighting these discrepancies and to give necessary attention to these overlooked aspects of women's experiences.

Chapter 2: Literature Review

(2:1): Biomedical perspectives of peri/menopause

There is no singular perspective on peri/menopause, but rather a multitude of viewpoints, including biomedical, feminist, psychological, social, and cultural (Hunter & Rendall, 2007; Ayers et al., 2011; Hunter & Edozien, 2017). These perspectives inform, develop, and often challenge each other's viewpoints. The following chapter will provide an outline of the various perspectives of peri/menopause as well as an overview of the literature relating to peri/menopause and mental health and the current support options available to women, such as hormone replacement therapy (HRT) and psychological therapies.

The medicalisation of the female body, whereby natural reproductive processes are treated as medical conditions requiring diagnosis and medical treatment, is a central subject in the psychology of women (Chrisler, 2013). Within social sciences literature, the biomedical viewpoint emphasises that peri/menopause is a biological transition, the symptoms of which largely understood to be problematic for women. This viewpoint was expressed by Robert Wilson (1966), author of the controversial book *Feminine Forever*, who described peri/menopause as a "deficiency disease" (p.12) and time of "emotional irritability and instability" (p.18), and suggested hormone replacement therapy (HRT) to prevent the "living decay" (p.43) of menopause (Wilson, 1966). Although attitudes have since evolved, the view that peri/menopause is a 'deficiency' has proven enduring within biomedicine, evidenced by the medicalisation of peri/menopause still prevalent today.

While treatment of peri/menopause with HRT may be useful to manage problematic symptoms, some findings, including those found in the Lancet study (Hamajima et al., 2019) and the heavily contested Women's Health Initiative (WHI) study (2002) have shown an increase in the risk of breast cancer among women who use HRT. As a result, the National Institute for Health and Care Excellence (NICE) guidelines advise against the use of HRT for women with a history of breast cancer (NICE, 2019) and instead recommend an individualised approach to assessment and treatment (Newson and Panay, 2018; NICE, 2019; Hamoda et al., 2022). Although some women accept these risks due to the perceived benefits of HRT (Bluming and Tavris, 2018). Debates surrounding the validity of the WHI study's

findings[1], particularly in younger populations, highlight the complexity of the risk-benefit analysis.

In addition to the aforementioned studies that linked the use of HRT with breast cancer, others have associated HRT with blood clots and strokes, leading to a decline in women accessing this treatment in Western countries (Cagnacci & Venier, 2019; NHS, 2023). However, other treatments, including non-hormone medications like clonidine and gabapentin used for the management of hot flushes and nights sweats (NHS, 2022) show further evidence of how peri/menopause may be treated within a biomedical framework. While medical narratives within health and medical literature concerned with experiences of 'the menopausal woman' have become more nuanced, biomedical discourse on peri/menopause still predominantly revolves around hormones, cycle changes, problematic 'symptoms', and medical treatments (Niland & Lyons, 2011; Orleans et al., 2014; Honour, 2018).

Woolfe (2016) argues that biomedicine has serious implications when applied to topics such as mental health and peri/menopause. In Woolfe's view, the notion of menopause as a 'deficiency' sets women's subjective experiences apart from the 'norm', privileging biomedical 'truths' at the expense of other accounts of reality (e.g., social and cultural). The idea that experiences of menopause can be generalised is problematic for women, whose experiences vary from one another and across cultures (Freeman & Sherif, 2007; Khoudary et al., 2019). For example, researchers have reported that within Western cultures, some women have a relatively unproblematic experience of peri/menopause with few symptoms or disruptions, whereas others have found that this can be a turbulent time during which they experience considerable distress (Gibbs et al., 2013; Muslić & Jokić-Begić, 2016). Further studies highlight variations in experiences of peri/menopause according to location and cultural context (Avis et al., 2001), such as Japanese and Arab women reporting fewer peri/menopausal symptoms than women in the Western world (Lock, 1993; Bener & Falah, 2014). Therefore, questions arise about the suitability of a one-size-fits-all approach to treatment.

Nonetheless some medical practitioners emphasise the benefits of HRT (NHS, 2022; Newson, 2016; Baber et al., 2016; Lega et al., 2023). Furthermore, that the risks may in fact be lower than indicated in previous reports (Newson, 2016; Scott, 2018; Roberts, 2007; Burger, 2006). These practitioners advocate for an individualised approach to the treatment of

1 Validity of WHI study findings to be discussed further on p.15

peri/menopause; one that emphasises individualised consultations, shared decision making, and choice for women, including, if deemed beneficial, medical treatment. This involves ensuring women are advised on both the benefits and risks of medical treatment such as HRT, as well as non-hormone-based medications, and are provided with the appropriate information to make informed choices (Newson & Panay, 2018). These studies serve to further highlight the difficulty of unravelling the breadth of conflicting information that forms and informs decision making surrounding HRT, as well as the complexity of peri/menopausal experience.

Voices such as Newson, Scott and Panay, which dominate the current peri/menopause discourse in the UK, can portray peri/menopause as a period of disease and decline, emphasising HRT as a near-universal solution. However, this reductionist view overlooks the diverse experiences of women, many of whom navigate peri/menopause with minor or no symptoms and do not require HRT. Consequently, the 'menopause as disease and decline' narrative can marginalise and invalidate the experiences of women who find peri/menopause to be a natural and manageable life stage. It is crucial not to accept these perspectives uncritically, as they shape broader social attitudes and understanding of this phase in a woman's life, and instead recognise the multifaceted nature of peri/menopause experiences. The following section will provide a more detailed overview of biomedical treatments.

(2.2): Biomedical treatments (hormone replacement therapy and antidepressants)

As discussed above, biomedical treatments aimed at addressing problematic signs and symptoms associated with peri/menopause include HRT; usually a combination of two hormones – oestrogen and progestogen. There is evidence to suggest that HRT can effectively alleviate night sweats, hot flushes, low mood, reduced libido, and vaginal dryness (NHS, 2022; Newson, 2016; Baber et al., 2016; Lega et al., 2023). In certain cases, testosterone is also prescribed to address issues like reduced libido, brain fog, and fatigue, although some women in the UK may face difficulty accessing this (Scott & Newson, 2020; Newson, 2021) as well as HRT more generally. Beyond symptom management, HRT is reported to reduce the risk of cardiovascular disease, osteoporosis, and type 2 diabetes amongst other diseases (Newson, 2021). Despite approximately 80% of women experiencing peri/menopausal signs and symptoms, only a small percentage (around 10% - 17%) currently receive HRT in the UK (Newson, 2016; Cumming et al., 2015; NICE, 2019).

The aforementioned WHI study connecting the use of HRT to breast cancer accounts for some of the reduction in the uptake of HRT despite containing methodological flaws. For instance, women recruited for the study were an average of 63 years old, yet the findings were generalised to apply to women of every age group. Therefore, the study's findings cannot determine the risks to women in their 40s and 50s – the typical range of many who are peri/menopausal (National Institute on Aging, 2021). Furthermore, some argue that participants in the WHI study were predisposed to a heightened risk of cancer or cardiovascular disease, as a number of them were either overweight or obese (Newson, 2016). This has led to the suggestion that the evidence linking HRT with breast cancer and other conditions has been widely misinterpreted, and that the risks exaggerated by the media, likely causing anxiety and concern among women in society and hesitancy among GPs to prescribe HRT, resulting in many women missing out on the potential benefits (Reid, 2018; Rymer et al., 2019).

Perhaps due to the conflicting messaging around HRT, anti-depressants have been prescribed to women to treat low mood and fatigue during peri/menopause (Kim & Joffe, 2006; Scott, 2022). Low mood is one of the most reported symptoms experienced by peri/menopausal women (Gibbs & Kulkarni, 2014). This has led to some GP's arguably misdiagnosing peri/menopause as depression. A study by Newson and Connolly (2019), conducted with 3000 UK women, showed that up to 66% of participants had been offered antidepressants for symptoms potentially linked to peri/menopause. Despite the prevalence of low mood amongst peri/menopausal women, arguments persist against attributing these symptoms to mental illness, and therefore treating them as such (Glynne & Newson, 2024). If experienced at a time of peri/menopause, it is claimed that HRT should be the primary treatment for (non-severe) low mood as there is no evidence to suggest that anti-depressants improve such symptoms (Scott, 2018; NICE, 2019). This becomes increasingly significant in light of the *Women's Health Strategy for England* report (2022), that noted difficulties women sometimes face in accessing HRT through GPs, in part due to a reluctance to prescribe HRT or failure to recognise low mood as a sign of peri/menopause.

Whilst the NICE guidelines are clear that anti-depressants should not be used as a first-line treatment for low mood in peri/menopause, they are still frequently prescribed to women for the treatment of vasomotor symptoms such as hot flushes. This may partially be because, as some studies have suggested, women experience a reduction in the frequency of hot flushes when using selective serotonin reuptake inhibitors (SSRI's) such as paroxetine and serotonin-norepinephrine reuptake inhibitors (SNRI's) such as venlafaxine (Stubbs et al.,

2017; Shams et al., 2014). However, conflicting findings leave uncertainties about their overall efficacy in treating hot flushes (Loprinzi et al., 2009). While the origin of hot flushes is still not fully understood, research has indicated that hot flushes are linked to an overloading of serotonin-receptor sites in the hypothalamus, which are then blocked by SSRI's or SNRI's (Stearns et al., 2002).

(2.3): The 'medicalisation of menopause': Feminist perspectives

The notion of peri/menopause as preventable and treatable through medical intervention, commonly referred to as the 'medicalisation of menopause' and exemplified by the biomedical treatments discussed above, has itself been argued as problematic for women. Certainly, over the last century, a paradigmatic shift has occurred, transforming perceptions of peri/menopause from a normal and natural part of aging to something deemed preventable and treatable through medical intervention (Utz, 2011). This shift, commonly referred to as the 'medicalisation of menopause', is argued by some to have been created by the pharmaceutical industry and the media, who together turned women's health and wellbeing, particularly non-pathological biological processes, into profit by portraying peri/menopause as a deficiency illness requiring HRT, thus giving rise to a 'menopause industry' (Klein & Dumble, 1994). During the 1990s, feminist thinkers like Coney (1994), Klein (1992), and Greer (1991) sought to challenge and undermine what they perceived as the oppression caused by the medicalisation of peri/menopause. They redirected attention to the embodied experiences and perspectives of women, arguing against the pathologisation of peri/menopause. Their aim was to promote a more holistic and accepting approach, viewing peri/menopause as a normal life stage (Golstein, 2000), a natural aspect of aging that is not necessarily harmful or pathological.

One of the enduring legacies of these feminist thinkers' critiques of the overmedicalisation of peri/menopause, was the exposure of the profit-driven nature of the women's health market and its impact on current attitudes towards peri/menopause and aging compared to previous generations (Klein & Dumble, 1994; Gannon, 1999). It has continued to be argued that if women are made aware of how and why attitudes, stereotypes and prejudices associated with peri/menopause developed and persist, they will be better able to make informed choices to either reject or align with cultural notions of the deficiency perspective (Ussher, 2008; Ussher, 2011). However, potential disadvantages of some feminist perspectives include the resistance to embrace a new era of technology, possibly leading to a

denial of the efficacy of medical interventions that could benefit some women. These perspectives may risk raising fear among women who feel the need for medical assistance but resist medical discourses. Consequently, others have taken the view that advocating for informed decision-making and considering medical treatments when necessary, could be beneficial for women (Love and Lindsay, 1998).

Contemporary feminist scholars have often argued that biomedical accounts fail to consider the diverse experiences of women during peri/menopause, including positive aspects like the relief from menstruation, and the empowerment and freedom that this life phase can bring for some (Hvas, 2001; Hyde et al., 2010; Hinton, 2013). Free from periods and concerns about pregnancy, some women report a transformative and liberating transition, contradicting biomedical ideas of emotional instability and hardship (de Salis et al., 2017; Wilson, 1966). Consequently, feminists advocate recognising peri/menopause as potentially empowering rather than a period of decline. Indeed, recent writings highlight the crucial roles postmenopausal women have played in the development of the human societies, often taking highly valued roles in communities and families, challenging the prevailing notion of declining worth and status associated with peri/menopause (Mattern, 2019). Feminist discourse supports the value of women in this life phase, encouraging women to embrace increased control and autonomy over their life, rather than resist aging (Gannon, 1999; Norlock, 2016). These contemporary feminist thinkers continue to wrestle to reclaim peri/menopause and reject notions that peri/menopause is a negative life change amidst a culture of medicalisation.

While most contemporary feminists accept society is informed by medical discourses and do not deny that medical intervention may be helpful for some, an emphasis is placed on ensuring that women are empowered and have choice and control (Norlock, 2016). Within this context, feminists propose diverse approaches to healthcare. Some advocate for individualised healthcare assessments to determine the most suitable medical interventions tailored to individual needs (Newson, 2016; Scott, 2018; Roberts, 2007; Burger, 2006). Others call for an equal share of power within the medical industry, and an industry that responds to women's concerns, in the restoration of perceived power and control in a medical context (Worcester & Whatley, 1992; Utz, 2011).

Potential implications

While some feminist critics (e.g., Greer, 1991; Klein, 1992; Coney, 1994) have scrutinised the medicalisation of peri/menopause, others have raised concerns about the broader health consequences if women opt against medical treatments such as HRT due to feminist ideology (Guillemin, 1999), despite compelling evidence suggesting the preventive and beneficial aspects of HRT for conditions such as heart disease, vaginal atrophy, and osteoporosis (Gambacciana & Levancini, 2014; Hodis & Mack, 2022). It has been argued that by viewing peri/menopause through an ideological lens may lead women to overlook its biological reality (Ussher, 2008; Lupton, 2012), thus potentially influencing women's decisions on seeking medical intervention.

In their critique of the biomedical model, feminist thinkers and others advocate for an approach that focusses less on pathology and more on a recognition of peri/menopause as a natural life event. Despite potential problems associated with the pathologised approach, emphasised by critics like Greer (1991), Klein (1992), Coney (1994), and Woolfe (2016), it is important to acknowledge both the biomedical and feminist perspectives. This balance is crucial in taking a holistic view of the impact of peri/menopause on women's mental health.

(2.4): Bio-psycho-social-cultural perspectives of peri/menopause

Alternative perspectives of peri/menopause account for psychological, social, and cultural factors which may influence on women's experiences of peri/menopause (Hinton, 2013). Consequently, literature often characterises peri/menopause as a bio-psycho-socio-cultural transition to encompass these diverse perspectives (Stephens, 2001; Hunter & Rendall, 2007; Ayers et al., 2011; Hunter & Edozien, 2017). While biological factors have been previously discussed, this section will focus on examining the psychological, social, and cultural elements that have been considered to impact women's mental health experiences during peri/menopause.

Psychological perspectives

Psychological perspectives include the attitudes of women and society towards peri/menopause, women's behavioural and cognitive responses, and their attributions and appraisals of associated signs and symptoms (Hunter, 2015). Historically, psychoanalytic theorists have also incorporated mental health into their theories related to women's experiences during peri/menopause. Deutsch (1945) and Bemesderfer (1996), for instance,

related women's mental health during this period to the loss and mourning of their ability to reproduce and thus function as sexual beings, whilst others have attributed mental health challenges to 'empty nest syndrome', when children eventually leave the home (Defey et al., 1996). In these writings, experiences during peri/menopause were described as a "mental crisis" and "traumatic" and, whilst not adopted into current mainstream understandings, have contributed to the plethora of literature that relates peri/menopause with women's 'mental crises' and perpetuated the deficit model (Deutsch, 1945). More recent studies have explored the negative impact of the loss of fertility, especially for those who experience an early peri/menopause (Singer, 2012).

Although there are limited understandings of psychological distress and mental health related to peri/menopause, it is widely accepted that this may be a time that women may experience mood and emotional changes (NICE, 2019). These psychological perspectives consider various intrapsychic and interpsychic factors that may influence women's overall mental health and wellbeing at this phase of life. Intrapsychic factors include psychological processes that are considered to occur within the psyche of an individual, such as one's personality, cognition, emotions, attitudes, approach to coping, beliefs about the self, identity, and self-esteem, amongst others (Ussher, 2000; Leary et al., 2015; American Psychological Association, 2018). For example, it has been found that women with lower self-esteem report more problematic symptoms of peri/menopause (Quiroga et al., 2017), as well as those with negative body image (Ayers et al., 2009). Poor memory whilst peri/menopausal has also been reported as troubling and impactful on self-esteem (Greendale et al., 2011). A systemic review of literature found that factors of resilience comprising women's ability to feel self-compassion, acceptance, self-efficacy, optimism, emotional stability, amongst other factors were associated with increased wellbeing at the time of peri/menopause (Süss & Ehlert, 2020). Interpsychic processes refer to external influences such as interpersonal relationships and support from family and friends (Bolognini, 2004). Interpsychic processes tend to overlap with social and cultural factors and can have an impact on women's internal experience of peri/menopause (Hinton, 2013).

A cognitive psychology model would consider individual's thoughts (cognitive appraisals) about phenomena and their influence on emotions, physiological responses, and behaviour (Hunter & Mann, 2010). For example, women who think of hot flushes as embarrassing may be more likely to worry or feel anxious about having one which may in turn make the physiological experience more debilitating (Rendall et al., 2008; Hunter & Mann, 2010; Ayers et al., 2011). Whilst studies have not found a direct link between anxiety

disorders and hormonal change, women who experience anxiety are reported to be more likely to suffer from more severe vasomotor symptoms such as hot flushes and night sweats (Jaeger et al., 2021). Alternative psychological perspectives may consider relational factors, such as how women relate to themselves, their internal (e.g., constructions of identity) and external worlds (e.g., mother and daughter relationships) and what associations and meaning are made through their own peri/menopausal experience (Hinton, 2013; Mordas & Kuz'micheva, 2021). For example, some women have spoken about the impact of peri/menopause on their perception of themselves, their self-esteem, their bodies, and identities as sexual and feminine beings (Singer, 2012).

In summary, earlier writings on peri/menopause focussed predominantly on peri/menopause as a traumatic time of life, though more recent psychological understandings of peri/menopause experiences are more nuanced, with inclusion of acknowledgement of other factors which may impact women's experience of peri/menopause. This includes peri/menopause discussed in a more positive light.

Cultural factors

While cultural and social factors tend to overlap, the discussion of cultural aspects of experience, such as differences in perceptions of peri/menopause, mental health and aging, cultural taboos, gender roles and expectations, religious beliefs, approaches to healing and views of Western medicine are important because they help aid understanding of the factors that may shape women's experiences of mental health during peri/menopause.

Whilst peri/menopause is a universal event for women, studies suggest that women's experiences are individual and can vary across cultures and climates (Avis et al., 2001; Freeman & Sherif, 2007). For example, in some cultures the transition to postmenopause is associated with heightened status (Berterö, 2003; Jones et al., 2012) and is seen either as a neutral or positive experience. Cultural differences in women's experiences of symptoms can vary, such as Japanese women reporting fewer hot flushes than women in Western countries (Lock, 1994; Freeman & Sherif, 2007). Murphy et al. (2013) presented findings of a grounded theory study conducted with six focus groups with Qatari women on their experiences of peri/menopause. Despite menopause translating as 'the hopeless age' in Arabic, the study found that women overall had more positive experiences of peri/menopause compared to women in Western countries. The participants in the study argued that their positive experiences were reliant on the support from husbands, family, and community more

broadly, as well as their religion and cultural practices. Despite this, some women felt shameful about their experiences of peri/menopause and chose to hide this from their significant others. These findings evidence differences in how peri/menopause is experienced across cultures.

Other studies have highlighted cultural differences when considering gender norms, roles, and expectations of women in society. For example, in Western countries women can lead stressful work lives, whilst this may not be the norm in other cultures. Interestingly though, results from the SWAN (Study of Women's Health Across the Nation) study showed that employed women reported less difficulties with sleep and memory than those not in full-time employment (Pitkin, 2010). In many cultures, the status of 'grandmother' and providing support to the wider family is a highly valued role (Hawkes, 2003; Mattern, 2019). Within some cultures, discussion about mental health is stigmatised and women may be less likely to discuss their difficulties openly or seek support (Vogel & Wade, 2022; Snowdon et al., 2022; O'Reilly et al., 2022). Thus, it may be possible that research does not reflect the full range of experiences across cultures, especially if some groups or cultures may be reluctant to discuss their experiences of peri/menopause and mental health. These understandings are helpful for considering diversity and the influence of culture on experiences during peri/menopause.

Social factors

Social factors, including women's socioeconomic status, location, access to healthcare, level of education, social support (including in the workplace), their attitudes towards aging, as well as their individual life circumstances are believed to influence their experience during peri/menopause (Freeman & Sherif, 2007; Hickey et al., 2022).

Research has brought attention to healthcare inequalities arising among those from low socioeconomic backgrounds, due to factors such as financial deprivation, which impacts on women's means to access healthcare (e.g., prescription costs), lifestyle factors, such as their nutritional intake, and their wider mental health (Namazi et al., 2019). Women in the UK, who are married, and of a high economic status, tend to report better health outcomes, including during peri/menopause, which further highlights these disparities (Wood et al., 2019). The term 'gender health gap' refers to discrepancies in healthcare between men and women, with women's healthcare (especially reproductive) considered as poorly understood/delivered when compared to that which is provided to males (Lupton, 2012; Alcalde-Rubio et al., 2020).

Peri/menopause predominantly occurs during mid-life, which is often a time associated with balancing work-life with caring for children and/or elderly parents. For many women, juggling these responsibilities can be stressful; thus, it may be difficult for them to separate these experiences of midlife and their impact from those of peri/menopause (Thomas et al., 2023). It may also be challenging for women to attend to their experiences of peri/menopause (e.g., noticing bodily changes) as they have so little time for themselves because of these family and caring responsibilities (Dare, 2011; Dillaway, 2020). As a result, social support from intimate partners, family members and friends are important for women during peri/menopause (Koch & Mansfield, 2004; Erbil & Gümüşay, 2018). Similarly, increased familial support has been linked with fewer reported symptoms of peri/menopause (Zhao et al., 2019). Additional support with responsibilities such as childcare may reduce stressors and influence women's overall experience during midlife. Workplace support is also considered crucial as many women have left their jobs due to difficulties associated with peri/menopause at midlife (Hardy et al., 2018). These findings indicate that social support and social circumstances may influence on women's experiences of mental health during peri/menopause.

Public discourses and media portrayals of midlife women, peri/menopause and mental health can also influence women's experiences (Hickey et al., 2022). Studies have shown that women with more negative views of peri/menopause (i.e., those who see it as a medical condition associated with decline and degeneration) report more symptoms, including hot flushes and night sweats, than those with positive views, indicating that peri/menopausal symptoms cannot be attributed to biology alone (Ayers et al., 2009; Nosek et al., 2010; Erbil, 2018). Social factors therefore overlap with the cultural because societal representations of women at midlife can become imbedded in the culture and influence women's attitudes.

These findings indicate that the possible presence of stressors and the complexities surrounding this life phase may influence women's experience of peri/menopause and subsequently their mental health. It is suggested that to fully account for women's experiences in peri/menopause research, the impact of psycho-social and cultural factors during midlife need to be better understood (Hyde et al., 2010). This would allow for a more complete picture of women's experiences during peri/menopause which would help to equip professionals, such as counselling psychologists, with the knowledge they need to effectively support women at this phase of life.

(2.5): Overview of qualitative literature relating to mental health during peri/menopause

Qualitative literature on the experiences of women during peri/menopause is limited and even fewer discuss mental health during peri/menopause. However, presenting an overview of the available qualitative data is critical because it helps to contextualise factors identified through quantitative research. Understanding the experiences of women during peri/menopause, particularly from a qualitative perspective, is important because it produces rich, nuanced insights that help to bring awareness to the complexities associated with the topic whilst providing common themes and patterns within the data that may have relevance to the current study (Tracy, 2019; Silverman, 2020). This overview will first focus on studies which discuss women's perceptions and constructions of peri/menopause before looking at other studies which have focussed on distress during peri/menopause.

Through the lens of pre-existing conditions

A body of qualitative research has looked at how women with mental health conditions and developmental disabilities (e.g., autism) construct their understandings of peri/menopause. In a study with women with diagnoses of bipolar disorder, women's experiences were reported to be constructed through the lens of their bipolar disorder as the dominant factor, through which they made sense of peri/menopause (Perich et al., 2017). For example, women described mood changes using existing discourses surrounding bipolar disorder such as "my lows are much lower" and "more rapid cycling through menopause" (Perich et al., 2017, p. 3). Women spoke of their challenging experiences of managing their mental health, anxiety, anger and rage and a loss of control during peri/menopause. However, the data of the study was analysed within a social constructionist framework, emphasis was on the influence of culture, language, and discourse, rather than the realities of the accounts of lived experience. Similar findings with seven postmenopausal autistic women showed that challenges during peri/menopause were discussed through their existing framework of autism, using language such as "when my autism broke" and "violence, self-injury, all these things people associate with autism" to describe their experiences (Moseley et al., 2020). Some women also reported pre-existing sensory challenges to be exacerbated and new sensory sensitivities as a result of peri/menopause. These findings indicate that some women with diagnosed mental health or developmental disabilities conditions may have similar experiences to those without formal

diagnoses, but they are often heightened or seen through the lens of their pre-existing conditions.

The study of distress during peri/menopause

Other studies have explored women's experiences of distress during peri/menopause. Nosek et al. (2010) conducted a narrative analysis study to examine women's experiences during peri/menopause. The study found that women experienced shame, embarrassment, and stigma as manifestations of distress in relation to outwardly expressed signs and symptoms (e.g., hot flushes) as well as prevailing social and cultural discourses on peri/menopause and aging (e.g., menopause being trivialised and society valuing youth/attractiveness). A limitation of this study, however, was that only women who self-reported distress during peri/menopause were able to participate in this study. Another study conducted with forty-eight mothers in the UK concluded that distress related to both biological and social aspects of experience, including the ending of reproductive, sexual, and other identities (De Salis et al., 2017). Reproductive identity has also been associated with distress in women experiencing premature peri/menopause (Singer, 2012). A recent study by O'Reilly (2023) reported heightened levels of anxiety, depression, emotional instability, and diminished self-worth among women during peri/menopause. However, the analysis was constrained by its focus on surface-level interpretations of the data without exploring deeper nuances or underlying factors. Other qualitative studies attributed distress to factors mirrored in the wider literature such as 'uncertainty about changes' around diagnosis and challenges identifying the origin of their difficulties related to the lack of available information and knowledge around peri/menopause (Dillaway, 2020; Karavidas & de Visser, 2021). The findings from these studies suggest that experiences during this phase of life are multi-faceted and women may be forced to navigate complex intrapsychic and interpsychic processes during peri/menopause.

Psychosis and hormonal change

A narrative review of clinical and pre-clinical data found that the highest risk of psychosis in women overlaps with the age range most aligned with the perimenopausal stage of the transition as a possible result of hormone changes (Culbert et al., 2022). Research has also found that symptoms compatible with psychosis can present for the first-time during peri/menopause (e.g., visual and audible hallucinations, delusions and disorganised thoughts)

(Crow & Jasberg, 2016). For women with an existing diagnosis, symptoms of schizophrenia may worsen and become resistant to treatment at this time (Seeman & González-Rodríguez, 2018). These findings align with various quantitative studies investigating the prevalence of psychosis in the population which have found that in women the risk of psychosis increases during midlife and that this may be attributed to the reduction in oestrogen levels caused by peri/menopause (Kirkbride et al., 2012; Ochoa et al., 2012; Usall & Huerta-Ramos, 2016). Despite these findings, researchers highlight the complexities of examining mental health during peri/menopause, as various other factors can contribute to women's susceptibility to poor mental health/mental illness (Thomas et al., 2018). This evidences that biological changes can contribute to mental ill-health and therefore emphasises the bio-psycho-socio-cultural approach to understanding mental health at the time of peri/menopause.

The above body of qualitative literature exhibits several strengths and limitations. The strength of these studies includes their insights into an under-researched area. One notable limitation was sampling bias, where studies were more saliant to participants who have experienced a more challenging peri/menopause, thus underrepresenting those with milder, more manageable or positive experiences of their mental health during peri/menopause. Additionally, the majority of participants in these studies are typically white women from English-speaking backgrounds from countries such as the UK and Australia. This lack of diversity means that the experiences of women from different racial and ethnic backgrounds are not adequately captured. Furthermore, selection bias is evident in studies that recruit participants exclusively online, as they indirectly exclude those without access to technology.

(2.6): The prevalence of mental health/psychological distress during peri/menopause – an overview of quantitative research

The impact of peri/menopause on mental health has been studied quantitatively but results have been mixed, with some studies indicating a link between this phase of life and mental health (illness or disorder), and others suggesting there is no clear evidence for these claims. Therefore, understanding the prevalence of mental health/psychological distress during peri/menopause from this data is complex. Researchers face a multitude of methodological challenges when conducting research in this area such as difficulties defining phases of menopausal transition, the definitions and measurement of mental health/disorder (i.e., diagnostic tools, self-report measures and usually opting to study one 'disorder' such as depression, for example), as well as the multitude of independent risk factors/covariants such

as social factors and current health (Hunter, 2015). Whilst I will attempt to look beyond biomedical and diagnostic language in this research, due to how mental health is studied quantitively, the overview of quantitative research data outlined below will predominantly refer to mental health using these terms.

The idea of reproductive mental health

The prevalence of depression generally among women over the lifespan is reported to be twice as high as seen in men worldwide (World Health Organisation, 2023). Research has suggested that during perimenopause the rate of depression becomes 2-14 times higher among women than before this phase of life (Schmidt et al., 2000; Cohen et al., 2006; Freeman et al., 2006). Historically, women's experiences of peri/menopause have been pathologised and myths and misconceptions surrounding women's 'madness' were perpetuated through various clinical and societal lenses (Ussher, 2011). Changes in women's reproductive capacity were considered to be a source of 'hysteria' and 'neuroses' and the link between peri/menopause and mental ill-health has thus been the subject of clinical research (Ussher, 2011). This has led to the modern-day idea of "reproductive depression" which is thought to be a depression caused solely by hormone and menstrual cycle changes (Studd & Nappi, 2012).

Studies which support the idea of a 'reproductive mental health' include those where findings suggest that mental health during peri/menopause is experienced as distinct than when compared with mental health status in other phases of the lifespan (Öztürk et al., 2006, Kulkarni, 2018). Öztürk et al.'s (2006) study found that women have a reduced ability to feel pleasure (anhedonia) during peri/menopause. There are also studies that show women at higher risk of developing mental health difficulties (e.g., depression and/or anxiety) as a result of hormonal changes (Douma et al., 2005). Using data from the Study of Women's Health Across the Nation (SWAN) study, Bromberg and Kravitz (2011) findings suggested that women are at higher risk of depression during peri/menopause and after (post-menopause), which aligned with the findings of other studies (e.g., Li et al., 2016). These studies support the idea that mental health at peri/menopause can be distinguished from mental health difficulties at other stages of life.

The idea that mental health during peri/menopause is distinct and can be attributed overtly to biological factors is supported by several quantitative research studies. These studies suggested that mental health disorders such as anxiety, depression, bipolar and

psychosis can develop for the first-time in women during peri/menopause (Usall & Huerta-Ramos, 2016, Mulhall et al., 2018). Additionally, other studies found that biological changes associated with peri/menopause may even trigger the onset of mental illnesses such as psychosis (Kirkbride et al., 2012; Ochoa et al., 2012). Perich et al. (2017) conducted a systematic review on the prevalence of mood changes in women with a diagnosis of bipolar disorder during peri/menopause. They found that over half of women report worsening of mood symptoms and 'depression' as the most prominent disorder. However, these results cannot be generalised because there may be other factors that influence mood in women diagnosed with bipolar such as those with genetic vulnerabilities or hormonal sensitives that mean they are more at risk (Aragno et al., 2022). In a study by Mulhall et al (2018), depression was the most prevalent symptom/disorder reported during perimenopause and anxiety was most common in postmenopausal women. Other studies have found that women who initially report low levels of anxiety prior to perimenopause were more likely to present with heightened anxiety in other phases of the transition (Bomberger et al., 2013). Another study found that women diagnosed with an anxiety disorder prior to perimenopause experienced vasomotor symptoms as more problematic than those without diagnosed anxiety disorders (Jaeger et al., 2021). The findings from these studies therefore may suggest a link between peri/menopause and mental health disorders/illness, whilst also suggesting this can vary depending on the phase of peri/menopause and whether women have a history of such symptoms.

Other studies have looked at the relationship between mental health disorder/illness and biological changes arising from peri/menopause and found no clear evidence to suggest that peri/menopause (hormonal changes and/or associated symptoms) triggers or heightens mental health difficulties in women (Avis et al., 1994; Yonkers et al., 2000). However, statistics indicating higher rates of depression, coupled with women's reports of mental health related signs and symptoms, highlight complexities in this relationship. Judd et al. (2012) further studied the link between depression and peri/menopause and argued that whilst symptoms compatible with depression are common during the peri/menopausal transition, evidence is insufficient to suggest that 'reproductive depression' occurs as a biological response to hormonal change. Whilst many researchers argue that mental health at the time of peri/menopause is a result of an interplay of biological, psychological, social, and cultural factors and that depressed mood should not solely be attributed to biological factors (Hunter, 2015), many women are prescribed anti-depressants at this time (Hill et al., 2016).

Wellbeing during peri/menopause

Studies in the 1990's investigated women's wellbeing (e.g., broadly encompassing their physical and mental health) during peri/menopause and found no evidence that peri/menopause effects overall wellbeing. Instead, they suggested that wellbeing during peri/menopause related to current health status, psychosocial and lifestyle variables (Collins & Landgren, 1994; Dennerstein, 1996). Other studies have showed that women who have experienced negative life events were more likely to develop depression during the time of peri/menopause (Gibbs et al., 2013). Research conducted on women before and after a hysterectomy (surgical menopause) for benign disease reported that most women had an increased sense of wellbeing following the procedure (Shifren & Avis, 2007). However, it was reported that women with a history of depression showed a worsening of low mood following the surgery. Findings from these studies show that all too often mental health and wellbeing are over simplistically attributed to hormonal changes during menopause, when wider health concerns and social and cultural factors are at play.

(2.7): Treatment seeking

Around half of women experiencing signs and symptoms of peri/menopause in the UK will seek support from their GPs (Constantine et al., 2016; Newson, 2020) and figures from around 5 years ago indicated that few women (as low as 10% in some parts of the UK) will be prescribed HRT (Cummings et al., 2015; Newson, 2016). Although, this may be a changing picture given the increased cultural interest in peri/menopause within a UK context (Jermyn, 2023). It is reported that those that do visit their GPs for support and advice do so because of physical symptoms such as changes in periods, hot flushes, or night sweats (Ayers & Hunter, 2012; Hunter, 2020). Only a small minority of women will seek psychological support (e.g., see a therapist or psychologist) specifically for peri/menopause related signs and symptoms (Huang et al., 2023). It is possible that many women are unaware of the mental health aspects associated with peri/menopause and may be less likely to attribute these signs and symptoms to peri/menopause and/or may have them misdiagnosed by the GP (Newson & Panay, 2018; British Menopause Society, 2023). There may also be other factors at this time of life that women may attribute their mental health challenges to as noted above such as stress associated with caring for children whilst juggling work and other commitments, for example (Hunter, 2019; Dillaway, 2020; Hickey et al., 2022). It is also understood that some women can experience embarrassment and shame about their

peri/menopausal status or from associated signs and symptoms (Nosek et al., 2010; Women and Equality Committee, 2022) and, as a result, may not want to visit their GP.

In addition to or instead of seeking support from their GP, some women opt for non-medical alternatives such as natural therapies including herbal remedies, vitamins, and supplements. This has led to a plethora of products marketed to help women manage peri/menopause and their health more generally at midlife. This has occurred despite the lack of evidence for the efficacy and/or safety of some of these products (Johnson et al., 2019).

(2.8): Specific psychological treatment and interventions

Within the field of counselling psychology and applied psychology disciplines more generally, literature discussing alternatives to biomedical treatments for menopause are few. However, Cognitive Behavioural Therapy (e.g., CBT-MENO) has been specifically adapted for reducing symptoms associated with peri/menopause, such as hot flushes, night sweats and problematic beliefs linked to depression (Green et al., 2019; Donegan et al., 2022). The authors achieved this by developing a protocol aimed at addressing negative cognitions related to peri/menopause and enhancing individuals' coping mechanisms for managing associated symptoms. Additionally, a recent update to the NICE guidelines states that CBT can be useful for depressive symptoms and sleep difficulties and is recommended alongside or as an alternative to HRT (NICE, 2023). Rating scales have been developed such as the 'Hot Flush Belief Scale' (Rendall et al., 2008) to help evaluate these interventions for their effectiveness through clinical controlled trials (Ayers et al., 2011; Mann et al., 2011). More recent research has concluded that CBT is safe and effective for both the treatment of vasomotor symptoms (Hunter & Chilcot, 2021), and mild depressive symptoms associated with peri/menopause (Green et al., 2019). CBT aimed at managing vasomotor symptoms has also been shown to be helpful in the format of group settings and self-help (Hunter & Chilcot, 2021). Whilst it is beneficial to have viable alternatives to medical interventions for women, the emphasis on the reduction of symptoms may not be suitable for those women whose difficulties are influenced or exacerbated by a broader context and range of factors.

Alternative therapeutic approaches have been advocated for and involve counselling that considers psychological, emotional, social and cultural factors, within a context of attention also being paid to women's lived body experiences (Hinton, 2013). This may involve supporting women with adjustment and processing feelings such as loss (Singer, 2012) and relational aspects such as developing an awareness of the influence of

intergenerational relationships (e.g., those from within different generations within families such as mother-daughter) (Hinton, 2013). It has been argued, however, that due to lack of knowledge and awareness surrounding peri/menopause, counsellors may find it challenging to connect with their client's emotional and mental health needs during peri/menopause (Brayne, 2011). Counsellors may even have difficulty in noticing when they themselves are experiencing peri/menopause and may be unaware of the possible impact on their work (Bodza et al., 2019). That said, professionals such as counsellors, psychotherapists and counselling psychologists prioritise being with the person over their symptoms. They aim to create a safe, supportive environment and build a trusting therapeutic relationship which enables current issues to be explored, regardless of specialist knowledge of peri/menopause (Kahn, 1991). However, due to the absence of guidance for supporting women during peri/menopause, practitioners may face uncertainties in how to best assist them.

Psychosocial interventions have been promoted as alternatives to medical treatment and include yoga, relaxation, breathing techniques, hypnosis, acupuncture, reflexology, and mindfulness (Hunter, 2019; Johnson et al., 2019). Studies have shown that yoga can reduce peri/menopausal signs and symptoms (Cramer et al., 2012; Susanti et al., 2022) as well as mindfulness (Sood et al., 2019). Other studies have also reported lifestyle changes such as increased exercise, healthy diet, reduction of caffeine and stopping smoking to improve peri/menopausal symptoms (Hunter, 2019; Anderson et al., 2020; NHS, 2022).

(2.9): Rationale for study

Aspects that have gained most attention in menopause research thus far are the use of biomedical treatments such as hormone replacement therapy (HRT), the management of problematic signs and symptoms and the relationship between menopause and pathology (Hulley et al., 1998; Schmidt et al., 2000; Nelson, 2008; Kaunitz & Manson, 2015). Research on menopause has principally been collected through quantitative methods such as clinical controlled trials and analytical epidemiological studies (Rossouw et al., 2002; Greiser et al., 2005; Vickers et al., 2007). More recently, qualitative studies have explored women's subjective experiences of menopause (Dillaway, 2005; Winterich, 2007; Dillaway, 2008; Dillaway & Burton, 2011). These studies discuss women's expectations and views on peri/menopause and aging that can often be positive but are influenced by factors such as appearance concerns and the perceptions of loved ones. However, through extensive examination of the literature, qualitative research on women's experiences of the impact of

peri/menopause on mental health is limited, with the majority of research quantitative in design (Freeman et al., 2006). A qualitative approach will enable a more in-depth exploration of the impact of peri/menopause on mental health by focussing on individual perspectives, the experience of which cannot be conveyed via a statistical and/or numerical analysis. The study addresses a critical gap in current literature by being inclusive of women with and without pre-existing mental health conditions, offering a broader and more nuanced understanding of mental health at the time of peri/menopause.

(2.10): Aims and objectives

The aim of this study is to explore women's experiences of perimenopause/menopause in relation to their mental health for the purpose of developing an understanding of the complexities of mental health during peri/menopause. The objective of the research is to conduct surveys and interviews with peri/menopausal women to explore their understandings of peri/menopause in relation to their mental health. The study aims to generate knowledge that will be useful for practitioners who work with women such as counselling psychologists, counsellors, and mental health professionals in providing further insight and understanding into the complexities of mental health and wellbeing during peri/menopause. Furthermore, the study will also provide a platform for women from which to have their underrepresented voices and experiences heard.

(2.11): Research questions:

What are women's experiences of their mental health during peri/menopause?

What are the complexities of understanding mental health during peri/menopause?

Chapter 3: Methodology

(3.1): Research design

A qualitative methodology was chosen for this research because it not only provided a data set that allowed for a rich and detailed examination of the experiences and perspectives of peri/menopausal women (Willig, 2012), but also gave direct voice to the participants of the study. Much of the academic literature in peri/menopause research suggests that women often

feel silenced or are fearful of speaking up about their experiences (Brayne, 2011; Nosek et al., 2010), and so a qualitative approach was deemed ideal in this context. This becomes especially significant in the context of the social stigma attached to peri/menopause and associated mental health issues (Chrisler, 2011; Hunter, 2019; O'Reilly et al., 2022), where women's stories are often overlooked or minimised. By employing qualitative methods, the objective was to capture the multifaceted nature of peri/menopause experience and allow participants to share their stories, concerns, insights, and experiences in their own words.

Qualitive research allows for data to be analysed and interpreted by the researcher to identify patterns of meaning that can contribute to psychological knowledge and understanding of societal issues and is therefore suited to exploring mental health and peri/menopause (Tracy, 2019; Willig, 2022). Qualitive research, however, is not limited to exploring lived experience (Silverman, 2020) but also allows the researcher to gain critical insight into how mental health and peri/menopause play out for women within their social and cultural contexts. For instance, the ways in which media portrayals, normative gender expectations and individual life circumstances, amongst other factors, inform how women conceptualise peri/menopause and aging (Ussher, 2008). A qualitative approach, therefore, will explore experiences and processes for the development of an understanding of distress at the time of peri/menopause.

(3.2): Epistemology

A critical realistic position was chosen for this study to enable an exploration of women's subjective realities whilst also recognising these are situated within the wider context and as "shaped by culture, language and politics" (Ussher, 2008, p.1781). A realist position assumes that knowledge acquired through data collection is 'truth' and that experiences are representations of 'realities' of the human condition. In contrast, a relativist position rejects the notion of the existence of an accessible and identifiable 'truth', and instead argues that experiences are distorted and constructed by social and cultural discourse (Willig, 2022). Critical realism aims to overcome the limitations of both realist and relativist positions, by allowing for a pursuable reality whilst recognising that reality is mediated by discourse, social and cultural factors (Bhaskar, 1975; Archer et al., 2013). This is to say that whilst knowledge helps us to understand the world, these experiences may not provide us with direct access to reality because social and cultural factors shape our perceptions and understandings of the world (Willig, 2022). This study therefore aims to explore the lived

experiences of women, their understandings of their bodies and mental health, within their social and cultural contexts (Sims-Schouten et al., 2007), an aim that has evolved and been refined through engagement with the literature. A critical realist epistemology will ensure that social and cultural factors are considered (e.g., dominance of the medical model, stigma, beauty standards, gender roles in society etc.) while ensuring that the effects of peri/menopause on both body and mind are not overshadowed amid broader discussions of discourse (Bhaskar, 2010).

A critical realist approach to this study fits within the parameters of counselling psychology as it recognises women's lived experience within the dominance of the medical model while committing to view pathology through a critical lens by challenging the 'medicalisation of distress' (Woolfe, 2016; Loewenthal & Larsson, 2012; Sanders, 2006). A critical realist framework has previously been advocated for its use in exploring embodiment in peri/menopause (Ussher, 2008). Ussher (2008) discusses the advantages of recognising the importance of the material 'menopausal body' whilst acknowledging that embodied experiences may be influenced by dominant discourses and diverse social and cultural contexts. The study will contribute to counselling psychology in its exploration of women's lived experiences around mental health and peri/menopause, moving beyond a reliance on the biomedical. The study will also add to the literature of so called 'taboo topics' (Chrisler, 2013), contributing to new knowledge and understanding of peri/menopause in an attempt to challenge existing stigma and stereotypes.

(3.3): Data collection

This research used both qualitative surveys and semi-structured interviews. By offering this choice, participants could engage with the study in the way that felt most comfortable for them. It has been reported that some women can experience embarrassment and shame about their peri/menopausal status or from associated signs and symptoms (Nosek et al., 2010) and are often 'silent' and 'alienated' in their distress (Engebretson & Wardell, 1997; Harper, 2022; Kragjewski, 2018; O'Reilly et al., 2022). As a result, they may look to internet sites and forums for help and advice, or to discuss their experiences anonymously. Given this, qualitative surveys are valuable for their broad reach and ease of circulation in online forums, offering direct access to a wide range of potential participants and diverse populations while offering an inclusive mode for engagement (Braun & Clarke, 2021; Braun and Clarke, 2013).

Thus, this approach helped to facilitate involvement of women seeking privacy and felt-anonymity to participate in the study.

Qualitative surveys also capture in-depth, detailed, and wide-ranging accounts of experience while enabling the researcher access to viewpoints and language used by participants (Braun & Clarke, 2021). This fits within a critical realist framework as surveys can be used to 'unpack and interrogate meaning' of neglected and sensitive topics such as mental health and peri/menopause (Terry & Braun, 2017). The survey was also used as a recruitment tool and participant responses were used to inform the interview schedule. This enabled further elaboration and exploration of areas of interest that were first reported in the surveys. However, participants had the option to just complete the survey, just the interview or both.

Interviews allow researchers to gain insight into individuals' 'social worlds,' their unique experiences, and positioning within them, and how they understand themselves and their experiences within these worlds (Silverman, 2020). They offer a unique and valuable approach in research, enabling the interviewer to explore the personal, 'hidden stories' of participants whose voices may be underrepresented (Burman, 1994). Furthermore, interviews, which can be individually tailored based on participants' survey responses, provide an adaptable mechanism for gathering in-depth insights, which can be crucial in facilitating a meaningful and trust-based rapport between researcher and participant, as highlighted by Smith (1995). Braun and Clarke (2013) assert that interviews are especially suitable when participants have a 'personal stake' in the subject matter. In this study, which delved into the personal (sometimes 'taboo') subjects of peri/menopause and mental health, the choice of interviews was rationalised by the recognition that women were more likely to share their personal experiences and narratives in a one-on-one setting. The deeply personal nature of these topics often necessitated a safe and private environment for participants to open up about their experiences. It was, therefore, considered that there would be greater opportunity for in-depth detail to be accessed as interviews facilitated the collection of comprehensive and complete personal narratives.

Semi-structured interviews, as opposed to structured interviews, were used in this study. Semi-structured interviews offer a methodological advantage by combining predetermined questions while permitting the interviewer flexibility to adapt the flow of the conversation, perhaps by changing question order, introducing or retracting questions from the schedule in response to the participant, etc. This flexibility allows for deeper exploration of topics that require further elaboration (Dearnley, 2005), which is particularly important

when discussing intricate or emotionally sensitive topics, as it enables participants to express themselves more freely and researchers to uncover more nuanced insights.

Participants were given the option of online (Zoom/Microsoft Teams), telephone, or in-person interviews, subject to the context of the COVID-19 pandemic and participant convenience. This flexible approach to interviewing provides many benefits, including allowing for participant choice and control over the setting and medium through which the interviews were conducted, which may go some way in helping them to feel more at ease with the process and therefore able to provide detailed responses to questions (Hanna & Mwale, 2018). While in-person interviews are most used by researchers, virtual and telephone interviews can be considered as viable alternatives to in-person interviews (Holt, 2010), offering a cost-effective and convenient way of accessing a diverse population of participants who may otherwise be unable to participate due to location, travel or time constraints (Gray et al., 2020). However, online interviews offer numerous advantages beyond geographic accessibility and cost/time-effectiveness which make them valuable. A non-exhaustive list of such advantages could include: ease of recording and transcription, increased comfort for both researcher and participant (which may reduce the risk of missing crucial information and facilitate more open and honest responses), flexibility in planning and conducting interviews. While previous concerns about using virtual interviews for the purposes of qualitative research involved the lack of non-verbal cues available to the researcher, studies comparing video and in-person interviews have concluded that the quality of the interviews is not lost as a result of being virtual and participant experiences are, in fact, enhanced (Deakin & Wakefield, 2013). Thus, video interviews (of adequate visual quality) have been evidenced to provide an effective form of visual contact for the purposes of research (Hanna & Mwale, 2018; Hanna, 2012).

In summary, qualitative surveys and semi-structured interviews were chosen as the most suitable research methods due to their flexibility, ability to inform one another, and suitability for probing personal narratives and sensitive/taboo subjects in the matters of peri/menopause and mental health research. These methodological choices were grounded in the need to ensure that participants were comfortable sharing their experiences and that the research captured the richness and depth of their experiences.

(3.4): Ethical approval

Ethical approval for this research was obtained from the University of the West of England, Faculty Research Ethics Committee (FREC) (Appendix 1). The research adhered to The

British Psychological Society's (BPS) Code of Human Research Ethics (Oats et al., 2021) and the BPS's Code of Ethics and Conduct (2021). The ethics application considered all relevant areas such as informed consent, voluntary participation, withdrawal, and data management, and details of each of these areas are discussed in the following sections.

(3.5): Risks and fully informing participants

A risk assessment was completed (Appendix 7) and the potential for distress was acknowledged in the participation information sheet (PIS) and participants were asked to carefully consider what participation involved before taking part. The PIS also included contact details of relevant organisations should participants require additional support should issues be raised as a result of taking part in the study. The comfort and welfare of participants was assured by frequently checking-in on their wellbeing throughout the interviews. They were also reminded of support organisations at the end of the interview. Participants who took part in the surveys were also directed to a debrief page at the end of the survey which thanked them for their participation and provided the support organisations that had been first listed on the information sheet.

As a mental health professional and counselling psychologist in-training currently working in professional practice, I have extensive knowledge and experience of working in mental health, the management of distress and risk, and of support services that can be accessed by participants if required. I was therefore fully qualified to conduct interviews on this topic. I was also aware of my own wellbeing during the study and in the eventuality that I needed further support, it was possible to debrief with my supervisor/s or use the university support systems.

(3.6): Inclusion and exclusion criteria

In previous qualitative and quantitative studies conducted with peri/menopausal women, researchers have used classification systems for determining menopausal status such as the Stages of Reproductive Aging (STRAW) classification criteria (Soules et al., 2001; Harlow et al., 2012) or the Monash Women's Health Program Menopausal Staging Algorithm (Jane & Davis, 2014). The STRAW+10 guidelines broadly delineate women's reproductive aging based on hormonal and menstrual cycle changes (e.g., measurement of the follicle-stimulating hormone level, variation in menstrual cycle frequency, flow and length and presence or absence of peri/menopause symptoms) and have been acclaimed as the 'gold

standard' amongst researchers for determining menopausal status (Panay et al., 2020; Gibbs & Kulkarni, 2014). However, classification systems such as STRAW+10, while beneficial as a guide for medical research, are limited in that they cannot be universally applied to all women. Thus, several areas of further research have been identified to address these gaps (Harlow et al., 2012). These tools were rejected for use in this study as they may not fully capture the uncertainties and complexities underlying the phases of menopausal transition which has formed part of the interview schedule.

The inclusion criteria stipulated that women must be over the age of 18 years and self-report as peri/menopausal. Women were invited to self-report peri/menopausal status because some women may choose not to seek a clinical diagnosis while others struggle to be taken seriously by their GPs, particularly in the context where there are uncertainties around definitions and phases of the menopause transition. In clinical research the terms perimenopause, menopause and postmenopause are used to define phases of reproductive aging in women, although there are uncertainties among women around these definitions, the language used by medical practitioners and what 'stage' of menopause they may be in (Dillaway, 2020). It has also been noted that perimenopause is particularly difficult to formally diagnose with some definitions relying on bodily changes such as variation in periods, or hot flushes, whereas others focus on hormone levels, which may be limiting given that these vary within and across individuals (NICE, 2019). Women are therefore considered to be the experts of their own bodies and able to self-identify as peri/menopausal.

This study did not have a prescriptive age criterion, (for example, 40-55 years) because there are various reasons why women may experience peri/menopause earlier than others and by not having a specified age range ensured these women could be included. Women were asked to provide their age on the demographic form provided prior to taking part.

Women who experience a surgical peri/menopause were respectfully excluded from the study because research suggests that these women's experiences may be unique compared to those who do not undergo surgery (Hunter, 2012).

(3.7): Involvement of individuals with mental health conditions

This study required individuals with lived experience of peri/menopause and mental health to take part. Therefore, those with diagnosed mental health conditions were welcome to participate. Participants were informed of the potentially distressing and sensitive nature of the topic in the PIS prior to taking part and were advised that they must have the capacity to

consent for themselves to be eligible to participate. The PIS details that individuals who are unable to consent for themselves are respectfully excluded from the study.

(3.8): Recruitment

A purposive method was used to reach participants experiencing peri/menopause, and who therefore had experiential and expert knowledge of peri/menopause and mental health. Permission was sought to recruit via Menopause Cafés (https://www.menopausecafe.net) and the Menopause Matters online support forum (https://www.menopausematters.co.uk). The details of my study were shared by these platforms and further circulated by social media users to other internet sites/forums which allowed me to successfully recruit for this research. In an effort to recruit participants from diverse populations such as people of colour and those with disabilities, I also tried to recruit via inclusive platforms/forums such as GEN M, Black Women in Menopause, Noon, Menopause Chit Chat, SIDE by SIDE (by MIND) and SANE. The moderators of these forums were approached to request access to their platforms for recruitment purposes but unfortunately some forums did not allow for postings about research and others did not respond to my request.

(3.9): Interview schedule and survey questions

The survey and semi-structured interview questions consisted of open-ended questions based on the current literature on mental health and peri/menopause and on my own knowledge of mental health and wellbeing as a counselling psychologist in-training. To develop these questions, I first conducted a comprehensive literature review on the topic of peri/menopause and mental health. Initial questions were drafted and then piloted with one interviewee and six survey participants. Based on their responses and feedback, the questions were further revised to ensure clarity and relevance to the study's aims.

The survey schedule included questions such as the ones listed below:

- Can you tell me a little bit about you and your experiences of peri/menopause?
- What were your beliefs and understandings of peri/menopause before you started experiencing it yourself? You might like to discuss how your experiences and understandings have changed over time (if they have).
- How would you describe your mental health during peri/menopause? What has it been like? (You may want to consider any positives and negatives)

The full schedule can be viewed in Appendix 6. In the survey, participants were given the opportunity to report on anything else of relevance to the topic that had not been addressed by the questions and provide feedback. This feedback was then used to make further revisions, if appropriate. Most of the interviewees were recruited following their participation in the survey and their responses to the survey questions were reviewed to create individualised interview schedules. This process aimed to facilitate a fuller exploration of each participant's unique experiences. The interview schedule served as a guide to provide structure to the interviews and to ensure the research questions were addressed. The interviews were conducted in a conversational style, allowing for adaptations and flexibility in responding to participants and ensuring they were given adequate space for in-depth exploration of experiences. All interviews were audio recorded and transcribed verbatim using an orthographic transcription convention (Braun & Clarke, 2013).

(3.10): Procedure, consent and withdrawal

Recruitment calls contained a link to access Qualtrics (https://www.qualtrics.com, appendix 2), where potential participants were first presented with a participation information sheet (PIS) (Appendix 3). If a participant expressed interest in an interview, they were sent an interview PIS separately via email (Appendix 4). The PIS provided details about the study, the researcher, data management, voluntary participation, risks/benefits, support, and their right to withdraw. The PIS explicitly states that the topic of study is personal and potentially sensitive and requests that participants think carefully about participation. Participants were then required to provide their informed consent via an online consent form on Qualtrics (Appendix 5). All participants were given an opportunity to ask questions prior to taking part – although none did - and were provided with contact details of the researcher for the purpose of asking further questions, and in case of withdrawal. Participants were explicitly informed that they had the right to withdraw up until the time of data analysis and were advised to contact within 28 days should they wish to withdraw from the study. Participants were informed that deciding not to take part or withdrawing from the study would not incur any penalty or affect their relationship with any of the organisations used to help recruit for this study. No one requested that their data be withdrawn.

(3.11): Participants

This study explored the experiences of 80 participants. Among them, 79 participants completed qualitative surveys, and out of those, seven also participated in semi-structured interviews. Additionally, one participant completed an interview only. Qualitative projects take numbers as guidelines, though the quality of data is also a factor in determining sample size. Therefore, this study aimed to collect a maximum of 60-100 qualitative survey responses in accordance with Braun et al.'s (2020) considerations for the use of surveys for medium-size qualitative studies. Eight semi-structured interviews were deemed sufficient to answer the research questions due to the high quality of data collected from both interviews and surveys.

(3.12): Demographics

All participants identified as female/women. Most participants identified as heterosexual, white British, married, or otherwise in a relationship, and employed with an educational level of GCSE/O level/AS/A levels and above. 11 participants described themselves as disabled and 23 participants reported to have a long-term mental health condition which were predominantly reported as anxiety and depression. Out of the eight interview participants, six chose virtual interviews (Zoom) and two chose telephone interviews as their first choice of modality. All 80 participants fully completed their survey and interviews. Several surveys were left blank on Qualtrics and consequently were removed. These did not contain any partial responses.

Table 1: Demographic information

	SUBCATEGORY	PARTICIPANTS	OTHER
GENDER	Female	80	
SEXUALITY	Heterosexual	75	
	Bisexual	3	
	Lesbian	1	
	Other	1	[1 x pansexual]
AGE	39-59 years	Mean = 49 years	
ETHNICITY	White British	56	
	White	7	
	British	2	
	White Scottish	6	
	White Welsh	2	
	White Irish	1	
	White European	1	
	Mixed	1	
	White American	1	
	White Australian	1	
	Jewish Eastern European	1	
	None stated	1	
DISABILITY	No	67	
	Yes	11	
	Prefer not to say	2	
LONG-TERM MENTAL HEALTH CONDITION	Yes	23	
	No	57	
RELATIONSHIP STATUS	Married	40	
	Partnered	19	
	Single	14	
	Divorced/Civil partnership dissolved	4	
	Civil Partnership	1	
	Separated	1	
	Other	1	[1 x non-specified]
OCCUPATIONAL STATUS (OPTION TO SELECT MORE THAN	Full-time employed	46	
	Part-time employed	20	
	Unemployed	8	
	Student	1	

ONE/ALL THAT APPLY)	Carer	1	
	Other	7	[5 x self-employed, 1 x full-time mum and 1 x career break]
HIGHEST LEVEL OF EDUCATION	Postgraduate (PhD/DPhil)	3	
	Postgraduate degree (master's or equivalent)	23	
	Bachelor's/undergraduate degree	24	
	GCSE's/O levels/AS/A levels	15	
	HND/professional qualification	6	
	BTEC/vocational qualification	3	
	Other	6	[1 x OU degree, HNC, NVQ level 2, IWFM examinations, PGCE]

(3.13): Data protection

To ensure confidentiality and anonymity and comply with the General Data Protection Regulations (GDPR), all data collected were electronic and stored on my secure UWE OneDrive account and password protected which only I and my supervisors had access to. Data was anonymised manually by removing identifying information and using participant chosen pseudonyms to report data. Once data was securely pseudonymised, personal data was securely destroyed. Demographic information has not been reported in a way that any individual participant can be identified.

(3.14): Reflexivity

In contrast to quantitative research in psychology whereby the subjectivity of a researcher is considered a source of contamination or bias, the process of reflexivity is viewed as critical for producing quality research (Braun & Clarke, 2021). Qualitative researchers view their preconceptions, experiences, beliefs, personal characteristics, and demographics not as

inherently problematic but rather as valuable resources for their research (Bukamal, 2022). Through the process of reflexivity, researchers make themselves and their subjectivity visible and explicit to ensure their influence on the research is acknowledged and utilised. For this reason, I kept a reflexive research journal throughout the study, informed by 'cyclical' models of learning, such as David Kolb's experiential learning theory (1984) which illustrates how learning occurs through experience and reflection. This reflexive approach fosters critical thinking (Thorpe, 2004) and provides insights into how my experiences, culture and background amongst other factors inform my approach to the study and its results (Etherington, 2004).

I am a 32-year-old white female with an interest in reproductive mental health. As I have not yet experienced peri/menopause myself, I am considered an 'outsider' in this research (Braun & Clarke, 2013; Bukamal, 2022). Given this, I view my engagement with reflexivity as necessary to ensure the rigour of this research. Rigour is attained through self-awareness and transparency of how my subjectivities, assumptions and biases may influence the research process and analysis (Jamie & Rathbone, 2022). What I felt I could bring to this research were my perspectives from counselling psychology, familiarity with navigating complexity in a professional context, and the ability to apply the framework of critical realism, aimed at understanding complex and multi-faceted phenomena.

From the outset of this research, I referenced in my journal about the process of acquiring knowledge about peri/menopause and mental health. I acknowledged the challenges navigating this topic with limited understanding, having never learnt about, or having discussed peri/menopause explicitly. Despite this, I had a basic understanding that it was associated with the end of being able to have children and that women sometimes experienced hot flushes. I was more aware, however, of negative societal representations of midlife and older women (e.g., associations with decline, vulnerability and emphasis on the prevention of aging; Hudson, 2021), and the ways in which women (with and without mental health difficulties) have been portrayed in medical and psychological literature through history (e.g., the tendency to pathologise women's behaviours and representations of women as 'mad'; Ussher, 2000; Ussher, 2011, 'sad' or 'out of control'; Appignanes, 2009). Additionally, as a woman in the UK, it has felt near impossible to shield from the influence and pressures from modern media depictions of women's youth, beauty, and aging. I occasionally felt frustrated by the ways in which women's feelings, experiences, and understandings of themselves were negatively influenced and their distress heightened by societal and cultural notions of peri/menopausal and midlife women.

As a counselling psychologist in-training, I am typically critical of dominant discourses, such as the medical model, and I advocate for underrepresented groups. This critical stance influenced my perspective on the topic, as I valued women's lived experiences while also being aware of the negative influence of societal and cultural biases. Nevertheless, prior to the research, I did not hold strong views on peri/menopause and did not align with any specific perspective.

A tension arose from my decision to investigate experiences of mental health, a topic often discussed in medicalised terms to help make sense of complex experiences, feelings, and emotions. My professional background led me to explore mental health during peri/menopause, although I grappled with my choice of two medicalised areas which may or may not impact on one another and trying to better understand such complex and multi-faceted experiences. By choosing to conduct qualitative research within a framework of critical-realism, I hoped to capture some of these complexities. However, descriptions of experience were sometimes reduced to biomedical/diagnostic terms such as 'anxiety' or 'depression', especially in the surveys as I was not able to prompt further on how this felt for them and what it was really like, beyond reporting symptoms.

Additionally, being an 'outsider' meant that I was not affiliated with any communities, groups, or organisations associated with women at this phase of life. This may have affected recruitment, as I did not have my own social network to call upon, necessitating outreach to platforms with which I had no prior connection. Recognising my status as 'outsider', I found myself more comfortable with surveys, given my personal preference for privacy and knowing I could not be seen, judged for my age, or knowledge on the topic. Thus, I was cognisant of my lack of lived experience during interviews and worried about how participants might perceive me. Despite feeling anxious prior to the interviews, each interview felt relaxed and conversational. Some of the women verbally acknowledged my lack of personal experience of peri/menopause (referring to my status of premenopause/my age), though said they were pleased researchers (of all ages) were showing interest and working on the topic. Whilst my experiences would have been unique, I considered whether having shared experiences might have enhanced rapport and participants' ability to relate to me as an interviewer. However, all the women were warm and supportive of the project which put me at ease, and I felt there was good rapport between us.

Berger (2015) suggests there are advantages and disadvantages to studying the 'unfamiliar'. Challenges may include researchers having difficulty putting themselves in the position of the 'other' and fully grasping the impact of a phenomenon on their lives,

potentially affecting the way experiences are then analysed and reported (Pillow, 2003). For instance, Berger (2015) notes that researchers who are unfamiliar with subject matter or a subculture may miss opportunities to identify masked or subtle themes within the data that only insiders might recognise. I had considered that my lack of lived experience may have influenced the construction of survey and interview questions due to not fully being able to relate to experiences of women's mental health challenges during peri/menopause. Conversely, studying the 'unfamiliar' as an 'outsider' may offer advantages by providing unique insights during data interpretation and analysis. Participants were positioned as experts in this study, encouraged to share their experiences openly with a receptive listener, rather than an expert in the field, a dynamic which likely facilitated comfort and space to share in-depth experiences.

The responses from both surveys and interviews offered profound insights and experiences, many of which were deeply heartfelt and moving. While part of me felt compelled to reach out to participants who shared significant personal challenges or distress, I recognised the importance of maintaining professional boundaries. Certain responses stood out as particularly poignant, prompting further exploration during data collection and analysis. However, I had to remain mindful of representing broader perspectives, rather than focussing on emotive individual cases of mental health during peri/menopause. This proved particularly challenging with the interview data because it was extensive and narratives comprehensive, which may have overshadowed other perspectives when interpreting and analysing data.

Managing both survey and interview data was challenging because of the substantial time required to read, unpick, and interpret survey responses prior to conducting interviews. I had concerns about the specificity of the questions related to mental health, despite scheduling them according to participants' survey responses. In my reflective journal, I document my overwhelm when faced with the unexpectedly high number of participants and their willingness to provide such detailed responses to the surveys. Navigating the initial stages of data analysis was time consuming, and I initially attempted to do this using Nvivo. However, this process felt convoluted, leading to the decision to analyse both datasets together in one word document, which proved more effective. I reflect that it was a challenge to confront this amount of data in the timeframe and to balance the voices of both my survey and interview participants, ensuring that both voices came through in the reporting.

In summary, listening to women's stories and learning more about mental health during peri/menopause from these nuanced perspectives has been a humbling experience. As an

‘outsider’, I've been able to maintain awareness of the various perspectives and discourses surrounding peri/menopause while also appreciating and valuing the lived experiences of women. Whilst I approached this topic with an open mind, I was initially more critical of the biomedical approach. Since speaking with women, my views have evolved, and preconceptions challenged as I have come to understand that many women find medical interventions (e.g., HRT) and recognition of their symptoms beneficial. This research has deepened my understanding of the complexities surrounding mental health during peri/menopause, informing my professional practice when working with women and my own future perspective as I approach this life stage.

(3.15): Rationale for the use of reflexive thematic analysis (RTA)

Reflexive Thematic Analysis (RTA) was the analytic method used in this study. Given its focus on the reflexive, this method requires researchers to reflect on their position in relation to the data (Braun & Clarke, 2021). This form of analysis is used widely for “developing, analysing, and interpreting patterns across a qualitative dataset, which involves systematic processes of data coding to develop themes” (Braun & Clarke, 2021, p. 4). One advantage of RTA is its theoretical flexibility, as it is not tied to an epistemological framework. This provides researchers with greater theoretical freedom, allowing for the development of broader patterns of meaning and flexibility to apply RTA to the theoretical framework of critical realism. Another advantage of RTA is that it is considered useful for studying topics in the field of health and wellbeing because it is a robust and sophisticated method through which the research can analyse data in-depth, but also report findings in an accessible manner (Braun & Clarke, 2014). An inductive approach to data analysis was used to fit with the aims of exploring women’s perspectives (Braun & Clarke, 2006).

(3.16): Data analysis: Process of coding and theme development

A six-step analytic process was undertaken in accordance with Braun and Clarke’s (2006, 2013) guidance for using reflexive thematic analysis. Examples of each phase are shown in Appendix 8.

(1) Before analysis: Data from the interviews was transcribed using Microsoft word or Microsoft teams (depending on the interview method) and were then checked and edited manually for accuracy. I initially considered using NVivo to familiarise myself

with and code the survey data, but later concluded that analysing the interview and survey data together would be more effective and I did not feel NVivo would be suitable for this.

To analyse both the survey and interview data together, I designed a two-column grid in a Microsoft Word document. The left-hand side of the grid was designated for participant data, while the right-hand side was kept blank for later coding. Each participant was assigned their own section within the same document. I then copied and pasted all the Qualtrics survey responses and interview transcripts into the respective sections for each participant.

(2) Phase 1 – Familiarisation: As well as the familiarisation which took place through transcription, further familiarisation came through reading participant accounts multiple times and making notes answering questions such as "how does this participant make sense of their experiences?" and "why might they be making sense of their experiences in this way and not another way?" as suggested in Braun and Clarke's guidance (2013, p. 206). These notes were then added to the Microsoft word document above each individual participant's section for reference.

(3) Phase 2 – Coding: The survey responses and interview transcripts were read line-by-line and initial codes were written in the right-hand column alongside the transcripts. All relevant material was coded, and initial patterns were identified. I was mindful to engage in both latent and semantic codes with the data.

(4) Phase 3 – Generating initial themes: Once coding was complete, I looked at larger patterns across the dataset. These codes were then collated and placed in a separate word document and grouped together if they related to each other or were similar. Codes were then further refined as I attempted to develop potential themes. Developing potential themes took place over an extended period of time and another word document was created so that I could easily make adjustments and 'play around' with positioning and order of themes. I initially started out with around eight potential ideas for themes. I was aware that I wanted to present a meaningful representation of my participants experiences and tell a story with the data.

(5) Phase 4 – Theme development: Once codes had been clustered and potential themes formed, they were further reviewed. I created a new word document and placed the

theme titles, clustered codes, and some related quotes from the dataset together and considered whether the themes were significant, viable and applicable to the broader dataset and relevant to my research questions. Through this process, around half of my initial themes were removed, leaving more robust provisional themes.

(6) Phase 5 – Refining and defining themes: These provisional themes were further revised and developed into final themes. To check that I understood the central organising concepts of the themes I was creating, I wrote a summary of each theme and subtheme. This process of revision and refinement prior to deciding on final themes was a challenge because I wanted to represent every voice in my data but had to accept that not everything could be included.

(7) Phase 6 – Writing up: The writing up process was central to the analysis (Braun & Clarke, 2013) as it allowed me to further assess, organise, and evaluate patterns within the dataset as well as ensure that quotations drawn from the surveys and interviews were faithful representations of participants' experiences.

Chapter 4: Results and Analysis

Four themes and three associated sub-themes were identified and are shown in the table below. This section presents the data using quotations from participant accounts to illustrate points made.

Table 2: Table of themes and sub-themes

Theme 1:	**Theme 2:**	**Theme 3:**	**Theme 4:**
"What is wrong with me?": Complexities of sensemaking	"Someone other than myself": Crises of identity	The impact of mental health during peri/menopause: "Existing, not living"	Women's experiences of help-seeking: "Stuck me on antidepressants"
Sub-theme:	**Sub-theme:**	**Sub-theme:**	
"Out of the blue": Preparing for the unexpected	"Flying off the handle": Jekyll and Hyde	"And it was my friend who said, 'Oh my God, have you felt suicidal?!'": The severity of distress during peri/menopause	

(4.1): Theme 1 - "What is wrong with me?": Complexities of sensemaking

This overarching theme captures the insights of peri/menopausal women who experience challenges with their physical and mental health but lack the contextualising lens of peri/menopause to help them make sense of their experiences. Absent an awareness and knowledge of peri/menopause, the women sought explanations for their signs and symptoms, often locating them in the possibility of serious illness. For example, when Marns started to forget words and her speech became impaired, she interpreted this as possibly related to her neurological health: "I thought I had early onset dementia; it was very frightening". Similarly for Chip, who experienced symptoms such as "heart palpitations, tingling in face and hands, not sleeping [and] lethargy", not having a frame of reference around peri/menopause left her feeling fearful about her prognosis: "the worst bit was being undiagnosed and thinking I was

terminally ill with a rare illness". In a similar vein, participant JK described "living in a state where I hadn't had anything checked out and I was actually beginning to think, well, is this actually menstruation that has just gone mad for some reason, or is there, is there something going on?". These experiences suggest that by not having peri/menopause as a frame of reference to aid understanding, women's mental health can be negatively affected as attempts are made to attribute these signs and symptoms to a root cause (in these cases pathology), which in turn can lead to anxiety, distress, and feelings of uncertainty about their overall health.

Grappling with uncertainties surrounding mental and physical health can be challenging as individuals may experience intensified feelings of anxiety, stress, and persistent thoughts of worry about their health. In this study, many women spoke about the impact of uncertainty on their mental health at the time of peri/menopause. Rachelrose spoke of exhaustion and fatigue, which she said led to "more anxiety about my health and a lot of hypochondria about having a terrible illness like cancer or dementia", revealing a deeper level of distress where the fear of serious illness became magnified by uncertainties about what was happening to her. This may be similar to what Sweeny (2018) theorises as 'existential discomfort' which involves the combination of feelings of uncertainty and a lack of control over health complications which can contribute to stress and anxiety. Such heightened anxiety not only compounds the challenges of navigating a transitory time of life but also emphasises the emotional toll of uncertainty on individuals like Rachelrose.

Tracy depicted her own feelings of uncertainty as a state of disequilibrium and described a process of "losing grip on reality" whilst navigating the unknown origin of her mental health difficulties which had been attributed to depression by doctors. The metaphorical description of "losing grip on reality" provides insight into the layers of disorientation that women can experience in this period, highlighting how misdiagnosis and the resulting confusion can exacerbate distress during peri/menopause. This further suggests the importance of having a conceptual lens with which to make sense of experience, but also to provide the language with which to describe its emotional impact. For these women, their lack of awareness of peri/menopause caused significant worry and confusion when confronted with signs and symptoms. The delay in recognition of their symptoms appears to have been a contributing factor to their heightened distress.

Many women themselves considered the lack of awareness around peri/menopause, believing that a contextual framework of peri/menopause and knowledge of the potential

impacts, including signs and symptoms, may have better prepared them for how they feel. Susette explained the significance of being able to make sense of experience, stating, "if you've got a bit of education and you think, 'well, this is because of this', you don't tend to think 'what's wrong with me, why do I feel like this'?" Ceilidh echoed this sentiment when she spoke of feeling "demystified" when a symptom she was experiencing was attributed to peri/menopause: "I went, 'oh, okay. That's what it is", suggesting that awareness gave her a lightbulb moment that enabled her to have a lens through which to better understand her experiences. Many women expressed a struggle to understand what was happening to them, revealing significant gaps in understanding and knowledge. Such gaps disrupt an individuals' ability to process experiences, potentially leading to a search for perceived 'normality' and sense making amidst uncertainty (Genuis and Bronstein, 2016). It becomes evident, then, that being able to 'make sense' of experiences provides the necessary emotional and cognitive scaffold for coping.

Some women spoke of further uncertainties upon visiting their GP. Lucy described feeling "sure something wasn't quite right" despite having "blood tests done three times over a few years and was told each time everything was fine". While Lucy *was* able to draw on peri/menopause as a lens through which she could make sense of her health and wellbeing, her own considerations of peri/menopause could not be validated through blood tests. There are currently no medical tests that definitively diagnose peri/menopause; therefore, awareness of peri/menopause among healthcare professionals is crucial to avoid misdiagnoses. Blood tests (such as follicle-stimulating hormone tests) can display varying results and cannot accurately determine menopausal status and therefore the NICE guidelines advise against their use in women over the age of 45 (NICE, 2019/2021). Hence, the medical model proves unhelpful due to it being constrained by a requirement for specific physical measures to evidence subjective experience.

Similarly, Anna and JenS reported feeling dismissed by their GPs who, rather than acknowledging the legitimacy of their experiences, attributed their symptoms to depression. "I feel like my GP has no interest in or understanding of what I'm going through", stated Anna, while JenS described how "I saw several GPs at my local surgery and all of them told me I had issues with depression and that the menopause doesn't affect women as badly as I was feeling". This sense of feeling dismissed, their experiences minimised, or needs not valued during this life phase was echoed by others like Tracy, who said she felt "fobbed off by doctors who told me I was depressed". These were the types of challenges that these women faced in having peri/menopause formally recognised/diagnosed. The significance of

this lies in the interrelation between perimenopause and mental wellbeing, as the failure to be heard and understood by healthcare professionals adds an additional layer of stress and anxiety, potentially exacerbating the wellbeing and mental health issues these women may already be grappling with. The question arises whether peri/menopause and mental health can truly be disentangled. It becomes evident that a lack of adequate knowledge and awareness of peri/menopause among health professionals contributes to this problem, leaving a critical gap in their understanding of the nuanced aspects of peri/menopausal experiences.

This knowledge gap may arise from insufficient training, limited awareness, or societal misconceptions surrounding women's health, thereby perpetuating a cycle where women's concerns are consistently undervalued during this crucial phase of their lives. If there is limited awareness among health professionals, then there is a risk of mental health or physical health concerns being attributed to other causes and potentially overlooked. This can be anxiety provoking for women as aside from their GP, they may not know where to go for suitable support and information. Research studies have found that there a multitude of signs and symptoms that can co-exist with hormonal changes (Newson & Panay, 2018), though some women and health professionals are only aware of physical changes, such as vasomotor symptoms and menstrual cycle changes. Within the NICE guidelines, mood changes are an associated symptom (NICE, 2019), though little is understood about the potential impact on women.

Without the contextualising framework of peri/menopause, some women made sense of signs and symptoms by attributing the root of their feelings/difficulties to various factors, including work and family life. Some attributed their signs and symptoms to illness, while others considered social factors and associated stressors including parenting, family dynamics, caring for elderly parents, relationships, and work stress amongst others. Wakeyee, for instance, “blamed it all on the stepson and blamed it all on the job”, while Pauline considered the possibility that her difficulties were a result of “the stress of the job” and “a relationship breakdown as well”. Importantly, this study collected data shortly after the Covid-19 pandemic, which may have impacted on the mental health and wellbeing of individuals at this time, as well as further limiting access to advice and support throughout this period. Kathy, for instance, “put the initial symptoms of perimenopause down to post-pandemic exhaustion”, highlighting the impact of such an event on her energy levels and further evidencing the difficulties of separating out different contextual factors. Alicia captured the broader impact of the pandemic and other social factors, stating, “working through the pandemic for the NHS was a definite contributor to increased stress and anxiety

and impacted on my peri menopausal journey. The balancing of supporting ageing parents, with increasing demands in relation to their health and my own family (in their 20's) also have been a factor". This complexity illustrates the challenge of disentangling peri/menopause from other things happening in these women's lives. Difficulties with work, family and interpersonal factors are likely intertwined with/exacerbated by peri/menopause, reflecting the intricate relationship between life events, mental health, and peri/menopause experience.

Many women discussed how they felt their mental health challenges were influenced or exacerbated by a lack of awareness and contextual understanding of peri/menopause, as well as their life circumstances. This suggests that a woman's life circumstances during midlife can influence their overall experience of peri/menopause (Namazi et al., 2019). Other women felt that attributing their difficulties to social factors created a barrier to their consideration of peri/menopause as a contributing factor to their deterioration in their mental health, which resulted in them living with the possible signs and symptoms of peri/menopause unknowingly. Some women attributed their symptoms to serious illnesses, exemplified by Marns fearing early onset dementia and Chip worrying about terminal illness due to symptoms like heart palpitations. These women's narratives underscore the impact of uncertainty on mental health during peri/menopause, exemplified by Rachelrose's heightened anxiety and hypochondria. The data therefore illustrates the importance of a peri/menopausal frame of reference for women to make sense of their experiences, emphasising its role in mitigating distress. Additionally, it highlights the challenges women face in seeking recognition and understanding from healthcare professionals, shedding light on the interrelation between perimenopause and mental health, emphasising the critical role of awareness among health professionals, and the potential for misdiagnosis, further complicating women's experiences of during peri/menopause. These factors represent barriers for women when attempting to understand their signs and symptoms and contribute to the impact of, and complexities in, understanding physical and mental health changes during peri/menopause.

(4.2): ***Sub-theme: "Out of the blue": Preparing for the unexpected***

Across the dataset was a sense of how these women were unprepared for peri/menopause and its impact, often due to a lack of awareness, knowledge, and education on the topic. In this sub-theme, possible explanations for this are explored, such as the absence of discussion of

peri/menopause within education, families, and society, potentially influenced by societal taboos and a focus on physical symptoms rather than psychological or emotional aspects associated with peri/menopause. The theme encapsulates the sense of peri/menopause as coming "out of the blue", as Wins described. The suddenness of peri/menopause is echoed by other women who explain peri/menopause as hitting "like a ton of bricks" (Wakeyee) and feeling "totally unprepared for what has happened" (Ceilidh). Some women explained they "knew nothing about perimenopause" (Sam) and had "no idea what perimenopause was and had not heard of it" (Grey). In some cases, peri/menopause was described as an unexpectedly "life changing" (Fiona) event that they found themselves navigating with minimal information or support. Bird said, "I had no idea it was like this. It impacts on my whole life". These experiences highlight the impact of a lack of awareness that these women had about peri/menopause and the gravity of its effects.

Many women in this study reported that they were forced to learn about peri/menopause themselves, through media or online sources, because they had not been taught the subject during their school years. Fiona says she finds it "utterly astonishing that we're not taught about this from a young age. Should be in the schoolbooks along with the other 101 health issues". As a teacher herself, participant JK described peri/menopause as "sadly lacking in terms of education" because "it's taboo so it doesn't get spoken about". As well as peri/menopause being considered taboo, Gig refers to other reasons for the lack of education around peri/menopause: "people don't care about what happens in menopause" because "it's not relevant in that moment. You know, it's not relevant to anybody until it happens". Whether due to stigma surrounding peri/menopause or its perceived suitability/relevance for inclusion in the syllabus, young people not being taught about peri/menopause during their educational years has been found to be common (Harper et al., 2022). As a result, there seemingly remains a widespread lack of understanding of peri/menopause among the younger population (Chrisler, 2013) and/or the tendency for negative or biomedical representations of peri/menopause to dominate Western popular culture and discourse (Hayfield & Campbell, 2022). A lack of education around reproductive health is problematic for women, because questions are left unanswered and myths and misconceptions go unchallenged, which may later influence women's perceptions and feelings about themselves and their bodies.

A lack of knowledge and education was illustrated by some women who spoke about their preconceptions of peri/menopause as different from their actual experiences. Karen said she "thought it was hot flushes when periods stop" and this was agreed by MaryM who

"originally thought it would be just hot flushes and nothing else". These quotes indicate that women's understandings were often limited to a small range of physical symptoms, resulting in a lack of awareness of the possible broader signs and symptoms associated with peri/menopause, especially in regards to mental health. These experiences were both *more* than those symptoms, and *not* those symptoms. As a result, women may not have the full awareness to recognise peri/menopause and the ways in which it might impact them. JK articulates the subsequent impact of this below when she says:

> I expected hot flashes and vaginal dryness! That's what I knew about, and I have neither. The symptoms I do have turned my life upside down and made me very scared and confused until I read and found out more about what I am going through.

Heidi spoke of her awareness that menopause signifies being "no longer able to have children" but "was not aware of perimenopause". The use of menopause as a generic term can be problematic as it may oversimplify experience and means women may not be aware about the lead up to menopause (e.g., perimenopause). Other women spoke of a broader understanding of signs and symptoms but felt that this knowledge did not prepare them for their own experiences. Annie captured this change in understanding when she said:

> Physically experiencing the menopause is different to reading about it and understanding it at an intellectual basis (a bit like describing the mechanics of sex is quite different from having sex)! My understanding is changed, as I hadn't quite anticipated how it would change other aspects of me physically - e.g. I had anticipated changed in facial hair but had not quite anticipated the challenges around the redistribution of body fat!

Many women in this study echoed Annie's thoughts about their change in understandings since experiencing peri/menopause themselves. Lou said:

> I had very little knowledge of symptoms nor understanding of the serious implications of them until I became unable to function. It has only been recently that the subject has been on the television and in the media, with celebrities pushing for information and awareness, that I fully recognise my own issues. People only ever talked about hot flushes and a few mood swings.

Kathy specifically highlighted the lack of preparedness around mental health challenges during peri/menopause when she explained, “I didn’t realise menopause can affect mental health. I didn’t realise for ages what was going on as I had no night sweats, which was my menopause knowledge at the time!”. Whilst experiences of peri/menopause may differ between individuals and many women will not experience mental health challenges during this life phase, a comprehensive awareness of the possible impact of peri/menopause would be advantageous for women as it would go beyond mere biomedical/physical understandings. Nickys71 expressed her want for more awareness when she said, “I wish more was known about the mental health impact of peri/menopause as I might have been better prepared for the way I feel”. Karen represented many women’s voices in this data when she said she “didn't realise the mental/emotional side” of peri/menopause.

While the absence of discussion about peri/menopause impacts women's preparedness for their signs and symptoms, it is not an isolated factor. A lack of open communication within families can also influence women’s’ readiness for this natural life phase. This dynamic, where the subject is both inadequately addressed in educational settings and remains unspoken within families due to societal taboos may further impact women’s knowledge and understanding of peri/menopause. Some women spoke of how the topic of peri/menopause had been “unspoken” (Yeedonissa) within their families. June, for instance, reported that her “mum was of a generation that didn't like to talk about 'women's troubles'” and the impact of this was that “neither my sister nor I realised what she was going through because she wouldn't talk about it”. In a study by Dillaway (2007), women often used their mothers’ experiences of peri/menopause as a framework to compare their own as well as to construct their own beliefs and understandings. Those who had not spoken with their mothers about peri/menopause sensed there were deficits in their knowledge and understanding (Dillaway, 2007), as was the case with June, leaving them without the context to recognise their own peri/menopause. Other women in this study, such as JK, spoke of the culture of silence within their families regarding peri/menopause. Reflecting on her mother’s silence on the topic, JK said:

> Looking back, I think she had some mood swings but that was never discussed and knowing her probably would never have been discussed anyway, she didn't talk about things like that really.

It is possible that the lack of disclosure and discussion in families may contribute to the lack of knowledge and understanding in wider society and women feeling that peri/menopause comes “out of nowhere”. Indeed, a survey study by (Newson, 2023) determined that 8 out of 10 women had not heard the topic of peri/menopause being discussed in their household growing up. This suggests that the lack of open communication on the part of these women's mothers regarding their peri/menopause experiences may be a contributing factor in the limited knowledge and education among some midlife women on this topic. Having been deprived of a comparative framework for peri/menopausal experiences, when their own signs and symptoms occur, they feel wholly unprepared.

The cultural taboo and stigma around reproductive processes such as peri/menopause throughout society (Chrisler, 2011) perpetuate negative perceptions and stereotypes surrounding peri/menopause as well as women’s feelings of shame and embarrassment and not wanting to burden others with their personal challenges. Vickyjo explained that she has felt “embarrassed about being peri menopausal. I think it’s still a taboo subject and has many misconceptions”. Susette discussed the possibility of her age as a factor as to why the topic was not discussed in her home when she explained, “I was a teenager when she [mum] was going through [peri/menopause] and it isn't something she would've ever discussed with me”. The experiences of Vickyjo and Susette illustrate how societal attitudes can make women hesitant to openly discuss their experiences of peri/menopause due to a sense of embarrassment. Thus, it is possible that the cultural taboo and stigma surrounding peri/menopause may contribute to women’s lack of preparedness for this phase of life.

Some women involved in this study described that despite learning about peri/menopause from female relatives, their own experiences did not necessarily align with others, which meant that, for them, what happened was unexpected. For example, Sam thought she would “sail through as my mum and nan had”, while MaryJ saw her mum having it “relatively easy or put other symptoms down to other disabilities”. Similarly, Lucy reflected that “my experience has been very different from my mum’s. She described it as ‘someone just switched the tap off’”. Doris, however, described having a “head start” and being “suddenly very aware of menopause” when her “mum developed breast cancer as a result of taking HRT” which caused her to feel “fearful of taking HRT” herself. Other women spoke of their experiences of talking to their female family members later in life, after they themselves began experiencing peri/menopause. Sandra, for instance, described talking “to my mum to compare her menopause”, while Wakeyee said, “I’ve talked to my mum recently about it because of what I'm going through, but we've never talked about it previously”. Most

women in this study spoke about the importance of talking with others and sharing experiences to help normalise and validate signs and symptoms of peri/menopause. Underscoring this, JK discussed the impact when peri/menopause is discussed in families:

> It helps them understand what their mum and that is going through. Whereas I think a lot of women in that position, if their family is uneducated about it, they just all of a sudden feel that they're fallen short because they can't do necessarily… or are not as on the ball about things or they're just a different person to who they were before and their family can't understand why that is.

This subtheme sheds light on the apparent unpreparedness for peri/menopause among women and the way it was seemingly out of the blue. Drawing on the experiences of women such as JK and Fiona, it begins by discussing educational gaps within schools, which often leave women ill-equipped to navigate peri/menopause. In addition, this subsection discusses the familial sphere, underscoring the parallel absence of open communication within families due to societal taboos, as suggested by participants such as Vickjo, who reported feeling embarrassed about being peri/menopausal, and June, who reflected on her mother's reluctance to openly discuss her experiences of "women's troubles". Overall, this subtheme emphasises how a lack of education and discussion, in both private and public spheres, can contribute to further deepening the sense of unpreparedness for peri/menopause felt by many women upon the arrival of its associated signs and symptoms.

(4.3): Theme 2 - "Someone other than myself": Crises of identity

In this theme, the emotional impact of peri/menopause is presented, and the ways some women can experience shifts in their sense of themselves and their identities because of peri/menopause, which may contribute to negative self-evaluations of mental health. The theme considers different aspects of identity such as the "battles" with both 'body' and 'mind' as women reported looking different as well as noticing cognitive changes which they described to be impactful on their self-esteem and confidence. Alice's comment encapsulated this themes central focus: "I feel like I've lost my sense of self, who I am, I look different, I feel different, I'm more cautious". Similarly, Sam echoed these feelings of estrangement from her previous identity when she said, "I want my life back; I want to find me again". Other women mirrored these sentiments, discussing their feelings of lost identity and mourning for their premenopausal selves: "just don't feel the same person, I was such a glass half full kind

of person before this!" (Newportgal). This mourning for a past self was discussed both through women's intrapsychic and interpsychic experiences and relate to mental health because of the adjustment involved with processing and adapting to significant life changes. The loss of one identity (e.g., premenopausal self/the old me) and transition to another (e.g., peri/menopausal/postmenopausal self/the new me), for some, may be a challenging and distressing experience, especially if unexpected and fraught with complexities such as feeling a sense of dislike towards their reformed selves.

While a natural part of the aging process is coming to terms with changes (e.g., in appearance, physical capabilities etc), adjusting to these changes can be emotionally challenging, and necessarily involves an evolution in personal identity (van Mens-Verhulst & Radtke, 2013; Sergeant & Riqz, 2017). Navigating this evolution with understanding becomes more manageable set within a firm anticipation of this phase of life. In contrast, signs and symptoms of peri/menopause can be experienced as occurring suddenly or without frame of reference which creates gaps in knowledge that can be disorientating, leading to a disruption in identity.

Many women expressed the difficulties of adjusting to their evolving identities during peri/menopause. Elizabeth encapsulated this struggle, reporting how hard it was to adjust to "the new me" and the process of "losing confidence in myself and my abilities […] It can be hard to find things difficult that were once easy". Similarly, Bird conveyed a sense of detachment from her former self, stating:

> I just find it difficult cause I've been in this weird, odd bubble for so long, but I don't know if there is another me outside of that, if you know what I mean. I mean, I'm not me really. I don't feel like me.

EmmyLou, on the other hand, described the emotional complexity of the transition:

> It's exciting and terrifying and exhilarating and joyful and hard work […] I feel like who I will be in ten years is not the same person as I am now and the idea of casting off everything I am in order to become whoever is in my future is dizzying.

Jens offered an insight into her experience of adjusting to changes, stating, "I had lost my identity and didn't recognise myself. I have mentally had to grieve for the person I used to be and accept the woman I have now become because of the menopause". A similar reflection

was shared by Sam: “I've experienced what feels like a loss of identity. I don’t feel like the same person, and this is hard to come to terms with”. From a counselling and psychotherapy perspective, Roger’s (1961) theory of personality defines a person’s self-concept (how we see and value ourselves) as formed by our subjective reality (perceptions) and as linked to our environment, societal discourse, experiences, social identities, and upbringing amongst other factors. Depending on cultural and social factors, women may experience a misalignment with their perception of themselves and base their self-concept on these influencing factors and as a result grieve for a lost self, whom they once perceived themselves to be.

Nicksy71 captured this idea of negative self-concept when she described, “I feel like I have lost the person I was and hate the person I have become” and MaryJ when she said, “I’m a completely different person”. Women’s discussion of the absence or loss of identity, through to the processing of changes and adjustment of identity reformation are important factors in understanding the complexities of mental health experience during peri/menopause, especially in the context of a lack of knowledge and support. This is also important for counselling psychologists who support individuals to process such experiences of shifts in identity through therapy.

Several women in this study linked their mental health challenges during peri/menopause to a loss of identity tied to social roles, such as motherhood. Peri/menopause marks (approaching) the end of women’s ability to conceive naturally, which, for many, has various meanings and emotional implications. JK, for instance, poignantly articulated how her identity is deeply connected to motherhood and fertility, stating: “Motherhood is a huge part of my identity; the role defines me, and letting go of my fertility has been traumatic as it closes that door completely”. For JK, the “end of being the source of life”, and connected sense of identity, were akin to experiencing an enduring grief: “a grief for that part of yourself, you know, that life giving incredible part of yourself, and for me, and I actually feel this to this day, it’s almost like in a way death has started”. This is consistent with a recent study by de Salis et al (2018) which suggests fertility is intrinsically linked to female identity and peri/menopause is often viewed as the indicator of the loss of this part of them.

As well as the impact of the loss of fertility for women, many women spoke of cognitive changes involving their memory, concentration, problem solving, decision making, attention, reasoning, language, and learning. Several described these changes as effecting their ability to function as they would hope, which they experienced as impactful on their sense of themselves. Fiona discussed her loss of confidence when she described having “gone from be

a fairly secure, resilient human being" to feeling like she had lost "confidence in myself and own decisions and abilities". Mrs G shared a similar loss of confidence, sharing having "had to put in place all sorts of measures just to navigate daily life" in order to mitigate "the forgetfulness and word blindness" that she initially thought was a sign of early onset dementia. She added:

> How do you explain to a colleague that you cannot remember what a stapler is called? And how do you explain finding the TV remote control in the fridge to your husband?

Jean related her experience to, "feelings of anxiety, imposter syndrome and cognitive change that couldn't be explained otherwise". Thus, for many women in this study, having to adjust to and come to terms with such cognitive changes caused psychological distress as well as challenges in their professional and personal lives.

Other women in the study spoke of dissatisfaction with their body image, including with their appearance and changes to their bodies. They explained how this had impacted on their perception of themselves and how they consider themselves to be perceived by others. Women expressed concerns that they not only *feel* different but look different, which they described to be impactful on their self-esteem, confidence, sex lives, and relationships. Pauline reported "struggling to be positive with my weight gain and body image" and Wakeyee said they "hate what it has done [to] my body", representing the discontent that women can feel about their bodies during peri/menopause. Some women also referred to the symbolism of the changes in their bodies when they stated, "if I lose the weight, [I] might even start to like myself again" (JK) and "I was looking in the mirror and I didn't recognise myself" (Gig), suggesting that their appearance is important for the construction of their identities. Writings by Norlock (2016) consider the impact of peri/menopausal weight gain on women's identities and describe identity as fragmented and changeable, and rather than holding firmly onto a past self (associated with a smaller or different body), she writes it may be necessary to accept a reformed identity to help manage and adapt to these present changes. This study's findings also relate to previous research that women construct their sense of themselves from prevailing discourses of women at midlife such as the value placed on youthfulness and appearance (Winterich, 2007; Sergeant & Riqz, 2016). This suggests that the role of being a female in a society whereby notions of beauty and youth are optimised, and the aging woman is degenerative can perpetuate negative self-concepts and ideas that women are "past it" and thus can disrupt the process of coming to terms with this life phase.

As body image can impact on the way women feel about themselves, it can also impact on intimacy in relationships. Alicia provided an example when she stated:

> My relationship has been impacted due to the change in my body, I have gained weight and this impacts on my body confidence. I also find I cannot be bothered with the physical side of my relationship as I once would have. I can now "take it or leave it" where sex is concerned, and this is very different from my early years. In some ways I am not bothered but I know this has impacted on my partner.

This was echoed by Daisy when she said, "It's difficult to have any interest in sex when you are not feeling good about yourself. This can be detrimental to relations with my husband". These women's accounts not only suggest an impact on women's feelings about their bodies their body confidence but also highlights interpersonal and relational factors. Some women in this study spoke of the extent of their sadness about losing their sex drive and wish to be intimate with their partners: "I can no longer have sex because of the pain it causes me, despite having a high sex drive. I hate myself, my body, and my life" (Bell). These experiences exemplify the challenges women may face in navigating sexual relationships and intimacy during peri/menopause which is consistent with previous research findings. For instance, a study by Hinchliff et al (2010), which explored the experiences of 12 British women concerning sex during peri/menopause, found that most reported changes in their sexual lives (e.g., feeling less satisfied, decreased sexual drive, impacted by physical changes such as vaginal atrophy). For some women, these changes led to distress and sadness. This was often the result of feeling unable to share their dissatisfaction with their partners, concerns about not being able to meet their partner's sexual needs or challenges in fulfilling their own (Hinchliff et al., 2010). These findings therefore considered the relational, interpersonal, psychological, and social context, as well as the biological in understanding sex during peri/menopause.

As well as the impact on sexual relationships, women spoke of the impact on their intimate relationships more broadly. Rita provided an example of this when she explained, "I am worried my husband will get fed up with me and have an affair". Previous research has documented women's concerns about infidelity during peri/menopause (Ling et al., 2008). Research exploring the views of male partners of peri/menopausal women indicates that men's awareness and attitudes towards peri/menopause, as well as their ability to provide their partners with support is influential during this life phase (Rodolpho et al., 2016; Parish

et al., 2019). Dillaway (2008) suggested that the views and behaviour of intimate partners of peri/menopausal women can influence a woman's overall experience of peri/menopause. For example, if a partner demonstrates understanding, women experience this as positive and helpful for the management of their signs and symptoms. Elizabeth, for instance, captured this when she credits her supportive partner for giving her "the confidence to embrace the new me". This highlights the role of a supportive network in women's lives in helping them adjust and adapt to changes in their identity.

Overall, the theme highlights the challenges, trepidation, fear, and disorientation women can often face during peri/menopause as they grapple with adapting to a new identity. Women report how social, relational, and interpersonal factors influence their experiences of their mental health during peri/menopause. Concurrently, the sense of excitement about transitioning into a future self, even if that self diverges radically from who they currently are is also presented, though were less common.

(4.4): *Sub-theme: "Flying off the handle": Jekyll and Hyde*

This subtheme relates to how women not only reported their shifting identity, but also feeling like someone *other* than themselves during peri/menopause. June described this sensation of "not feeling like the same person" as akin to being "hijacked", while Ann77 likened her transformation to encountering an imposter, stating, "I did not recognise the person I was. She was a new character that seemed to take me over". Many women in this study grappled with unpredictable moods, emotional dysregulation, and anger, at times feeling as if they were living a dual existence reminiscent of the dichotomy portrayed in "Jekyll and Hyde", with their peri/menopausal selves occasionally taking control. These women reported that this not only significantly impacted on their sense of themselves but also strained their relationships with family, friends, and broader social networks.

Some ways in which women felt different included feeling "irritable", "less patient" (Pauline), "short-tempered" (Leah), or "getting annoyed" (Rita) by things they would have formerly taken in their stride. Heidi expressed how she "become[s] irritable as everything is an absolute struggle", while Gig described a sense of "irritability and just intolerance to anybody and everything". These feelings, they explained, were markedly unfamiliar compared to their premenopausal selves and often manifested in ways that made them feel like strangers to themselves: "it makes me sad that I feel like someone other than myself and behave differently due to this" (Jean). Such changes in sense of self and behaviour are not

merely superficial; they can strike at the core of one's identity and self-understanding and can cause feelings of disconnection, confusion, and distress. Indeed, to feel a sense of estrangement from oneself is to become unmoored from one's way of understanding the world. The ramifications of this extend beyond challenges within interpersonal relations and can lead to heightened anxiety, feelings of isolation, a diminished sense of self-worth, and thus potentially impactful for mental health and wellbeing.

In this study, some women referred to fluctuating emotional states during peri/menopause, emphasising its negative impact on their overall functioning. Dancingmumliz expressed having "never experienced rage or a lack of emotional control like it. Always thought I was a stable person, but I haven't felt like that since". This sentiment was echoed by Wakeyee, who remarked, "for me, it was the anger, the anger issues. I, oh, I was flying off the handle. I couldn't keep my temper under control". Many women described grappling with darkened moods and short fuses, attempting to navigate the extremes of their emotions. Such emotional and behavioural shifts, reminiscent of the "Jekyll and Hyde" analogy, highlight feelings of powerlessness as they struggled to regulate their emotions. This perceived emotional instability and anger not only challenged their sense of themselves but also significantly impacted their mental health. These women's reflections underscore the distress of feeling estrangement from one's familiar self.

Most women who spoke of feeling "angry" or "rageful" discussed the effects of their emotions on their relationships, as interactions with others felt challenged. Anna described feeling that "the poor state of my mental health is negatively affecting all relationships. I'm often not nice to be around, I'm so quick to anger. Sometimes I'm just in such a black mood that no one can say anything right". Sandra resonated with this when she said, "I worry that the instant unreasonable red mist I experience will fracture relationships with friends and family". Here women convey their concerns about the possible impact of what they perceive are unacceptable expressions of emotion/anger on their close relationships. There is evidence that some women can feel isolated during peri/menopause and so connections with others can be supportive (Koch & Mansfield, 2004; Erbil & Gümüşay, 2018; Zhao et al., 2019). However, behaviour that creates distance between themselves and others may be detrimental to women's mental health as they become increasingly isolated in their distress and having to navigate a difficult transition alone without support.

In this study, women navigating peri/menopausal challenges reported often finding themselves not only feeling estranged from their own sense of self but also becoming perceived as strangers by those closest to them. Participant JenS shared how mental health

challenges and “issues with anger” had caused ruptures within her marriage, revealing that she and her husband “separated for 2 years when I started the menopause”. Similarly, MaryJ articulated the impact on her relationship, reporting that her, “relationship fell apart directly because of peri-menopause. How could he understand when I didn’t?”. These personal narratives suggest the potential collateral damage inflicted on intimate relationships when peri/menopausal signs and symptoms remain misunderstood by not only by women but also those closest to them.

Beyond intimate partnerships, women in this study reported that children and extended family members also bear witness to these emotional and behavioural shifts. Sam expressed concern over her escalating rage, reporting that she “would become very, very angry about little things, mainly things my young children did. I would cry and scream for no apparent reason”. Wakeyee expressed similar sentiments, fearing the repercussions of her emotional turbulence on her marriage and others when she described “exacerbated anger issues to the point where I felt I would ruin my marriage or harm someone”. Ann77's confession, “I hated everyone. I made life very tough for my husband and sometimes my children. I honestly felt I was losing the plot”, underscores the residual impacts of unaddressed/misunderstood shifts in personality, emotions, and behaviour during peri/menopause. So too Rita's admission, “I shout all the time. Nothing my husband or son does is good enough”. Collectively, these women’s stories shed light on the impact peri/menopausal challenges can have on women, their families, and relationships as they transform into strangers not only to themselves but within their own homes.

Whilst many women in this study discussed their fears of displaying what they viewed to be unacceptable expressions of emotion, others spoke of giving themselves permission to express theirs. For example, Emmylou described an alternative perspective on how she views rage and herself as rageful: “Rage. So much rage. But I feel like it’s warranted and has been bottled up inside me for my whole life. Being able to express it can be joyful”. This suggests that expressions of emotions are not necessarily problematic but rather societal discussion around rage and emotional dysregulation among women during peri/menopause itself is questionable, since they reflect longstanding gendered stereotypes of ‘hormonal women’ in popular culture (Chrisler, 2013). Chrisler (2013) points to the term ‘hormonal’ and how it is commonly “used to describe any emotional reaction that observers find to be excessive” (p.129). Therefore, it is important to be mindful of how these portrayals impact or perpetuate long held beliefs about women during peri/menopause.

In summary, this subtheme sheds light on the experiences of women feeling "hijacked" (Jean) by “a new character that seemed to take me over” (Ann77), reminiscent of a ‘Jekyll and Hyde’ dynamic and which manifest shifts in emotions and behaviour often characterised by ‘rage’. JenS expressed how this can impact intimate partner relations, revealing, that she and her husband “separated for 2 years when I started the menopause” due to mental health challenges and “issues with anger.” MaryJ’s similar experience underscored how this sense of transforming into a new person can be equally felt by others: “How could he understand when I didn’t?”. The experiences discussed in this subsection resonates with the overall themes of identities in crisis, relational strain, and mental health challenges, as women confront shifts in mood, behaviour, and sense of self during peri/menopause. The dichotomy between their familiar selves and out of control emergent selves can cause feelings of confusion, disorientation, and disruption, which may contribute to or exacerbate mental health difficulties for some women.

(4.5): Theme 3: The impact of mental health during peri/menopause: “Existing, not living”

This theme focuses on women’s experiences of navigating mental health challenges during peri/menopause, shedding light on how these challenges can diminish women’s ability to live their lives with a sense of purpose and fulfilment, rather than merely ‘existing’. While many women in this study leant on familiar labels like “anxiety” and “depression” to describe their mental health during peri/menopause, their narratives unveil a more granular level of distress. For many, the peri/menopausal phase coincided with a disengagement with the pursuits, interactions, relationships, and experiences that give life its richness, so that they found themselves trapped in a cycle of “existing, not living”. For these women, the ramifications of this extended beyond individual distress, permeating their private, professional, and social lives as mothers, partners, and friends. Thus, the contrast between ‘existing’ and ‘living’ becomes palpable.

In this study, several women described a sense of loss – of purpose, joy, and fulfilment – that defined their experience during peri/menopause. Doris, for instance, reported “a loss of meaning” that permeated her life, while Maisy lamented her life as “joyless”. Similarly, Sam, reflecting on her identity and visibility in the world characterised by her premenopausal life now absent, said, “I want my life back”. Each account underscored a shared feeling amongst these women: they found themselves merely ‘existing’ rather than ‘living’. This is to suggest that their lives during peri/menopause have been reduced to navigating daily

necessities rather than what they perceive to be a full life – i.e., pursuits, interactions, relationships, and experiences that enrich their lives. Therefore, 'existence' can be characterised as purely doing things necessary for surviving each day. 'Living', however, can be experienced as joy and pleasure, such as through having meaningful experiences and social relationships, having a sense of purpose, fulfilment, and belonging (Martela & Steger, 2016). When women are no longer able to engage in aspects of living that provide purpose and belonging, it is suggested that this may affect their overall mental health during peri/menopause. Heidi provides an example of this when she said, "I have given up a very good career because I do not feel capable anymore" demonstrating the many losses that may be experienced by women.

Recurrent in this study was a sense amongst women of a dampening of their emotions, describing having lost "enthusiasm for life" (Valentine), and "feeling emotionally disconnected" (MDW) from the experiences and relationships from which they had once derived enjoyment, pleasure, and fulfilment. Vickyjo conveyed this sense of altered emotional experience, stating:

> I've ordinarily or have done historically found joy in so many different things, you know, like a sunny day, a beautiful view, I don't know, a new member of family and all these sorts of things. So, and it's not that it's completely absent, it's just not to that level where I almost felt euphoria, you know, so it's kind of like brought it down a, you know, a notch or two.

A previous study by Öztürk et al. (2006) mirrored these findings, identifying a decline in pleasure among women due to hormonal changes during peri/menopause, a phenomenon they termed as anhedonia. Ceilidh's exemplified and added nuance to an understanding of this experience when she described her emotional state as stagnant, reporting:

> It's like, I'm not moving. It's like this straight line and I'm not going up and I'm not going down. I don't feel happy. Don't feel sad. Don't feel in a good mood. Don't feel in a bad mood, don't actually feel anything.

Beyond a diminished experience of pleasure, Ceilidh's account suggested that she lives in a state of emotional suspension, neither elated nor despondent, having lost the capacity to feel whatsoever. These narratives shed light on the changes in emotional landscape that many women face during peri/menopause, hindering their ability to engage fully in joyful and meaningful experiences that not only enrich one's life but are also conducive to good mental

health in fostering strong social relationships as well as a sense of purpose and fulfilment in life.

In addition to the lack of enjoyment or pleasure detailed above, women in the study described concerns about how their poor mental health during peri/menopause impeded their daily functioning and ability to perform everyday tasks. For some, the toll was severe, significantly impacting their day-to-day lives. June conveyed this when she labelled her experience as “debilitating”, while Lou highlighted how peri/menopause had affected her daily functioning, stating how she “struggled to function on a daily basis”. This sense of virtually at a standstill, with even the most basic daily routines becoming a significant challenge to undertake, was echoed by Bird, expressing, “I felt that I was barely functioning” and Louise (2), who shared how her mental health left her feeling “constantly overwhelmed”, even fearing driving, which had become a trigger for “panic attacks”. Such experiences indicate that women's struggles with mental health during peri/menopause extend beyond personal distress, with their struggles to engage with everyday life having implications for their overall wellbeing and interpersonal relationships, as well as their professional lives.

Several women in the study detailed the impact of peri/menopausal mental health challenges on their social lives. This is significant due to the importance of social support during peri/menopause as described earlier. Darcy expressed “not wanting to interact” due to persistent low mood, a sentiment echoed by Elizabeth, who described episodes of "extremely low mood", leading to her “not wanting to engage with people”. This sense of withdrawal extended to feelings of “anxiety”, as noted by Kathryn, who mentioned "shutting myself off” while Rita expressed a desire to avoid socialising altogether: “I just want to stay at home”.

Other participants, like Maisy and Nickys71, grappled with heightened social anxieties and self-consciousness that resulted in unwanted social withdrawals. Maisy reported, “not quite paranoid, but a social anxiety about people not wanting to be with me, feeling as though I was a continual 3rd wheel”, while Nickys71 said she would “relive conversations over and over again” suggesting that they are hypervigilant and analytical about their behaviour following social interactions. Chip's account highlighted the strain on friendships, noting the toll of demands placed on her by her former friends as overwhelming: “I have lost several friendships while undiagnosed because they kept pushing and pushing until I basically snapped”, while Donna articulated a shift from an outgoing social life to one dominated by anxiety, describing how her “social life has changed to always going out to hardly going out due to the fact I feel anxiety”.

Interestingly, some women, like Emmylou, described this social withdrawal in positive terms, emphasising a newfound independence from societal expectations: “having been a people pleaser my whole life, I’m absolutely loving the rapidly declining fucks”. However, the pervading sentiment was captured by Vickyjo, who admitted to "faking the joyous feeling" in social settings, emphasising the internal struggles many women face in navigating their social worlds during peri/menopause. As Maisy explained, “I began to feel very flat but over emotional. I would describe it as joyless. All the fun disappeared, and everything socially became an effort to pretend I was enjoying myself”.

In addition to withdrawing from living their social lives, women in this study articulated how challenges related to peri/menopause impacted their mental health and, consequently, their familial relationships. Sandra described “not wanting to participate on family activities”, precipitated by low mood, where she grappled with irritability and “feelings of being got at but then not sure if it is just me”. Kathy (2) similarly expressed a shift in her demeanour during peri/menopause, manifest as introversion and emotional volatility and which strained her familial relationships, stating that she “became very introvert, emotional, unsociable, unstable in my relationship with my daughters”. Kathy described, “I felt like an outsider looking in on everyone living their life .... and I wasn’t important in any of it”. Women’s narratives underscore the fundamental human need for connection within interpersonal relationships, as emphasised by Rogers (1951), especially within the family. Alice's reflection on her perceived loss of roles and purpose within her family, saying that she has “lost all my roles and purpose”, sheds light on how peri/menopausal symptoms can disrupt familial relationships. A diminished sense of purpose critically impacts identity, life satisfaction, and sense of self existing in the world (Allen, 2020).

In sum, the experiences shared in this subsection add further depth to an understanding of the challenges women face during peri/menopause, leading many to feel they are merely 'existing' rather than 'living’. These women’s stories not only articulate how peri/menopausal symptoms can disrupt and reshape interpersonal relationships with consequences across personal, private, and professional spheres, but also have far-reaching mental health implications.

(4.6): ***Sub-theme: “And it was my friend who said, ‘Oh my God, have you felt suicidal?!’”: The severity of distress during peri/menopause***

This subtheme underscores the severity of distress experienced by some women during peri/menopause, with distress for some reaching such severity that suicidal ideation was discussed. More than half of the women in this study reported negative experiences of mental health during peri/menopause. Additionally, several participants expressed concerns that their mental health challenges were either dismissed or attributed to other causes by health professionals. This theme emphasises the importance of acknowledging and addressing mental health aspects of peri/menopausal experiences to prevent potential harm to women.

Some women in this study expressed experiencing "severe low mood" and "depression" during peri/menopause, emphasising the significant impact on their lives. Notably, depression during peri/menopause has been identified as an "under-recognised entity" (Kulkarni, 2018, p. 183). This under-recognition may stem from various factors including challenges with diagnosing peri/menopause, difficulties in unravelling various signs and symptoms that women may experience, including mental health aspects of experience not being fully explored. The impact of low mood during peri/menopause was expressed by Lou when she described her emotional state as “to a point of no longer wanting to exist”. Lou’s account sheds light on how suicidal ideation can arise from the sense of ‘existing’ rather than ‘living’ as discussed in the preceding theme. Thus, this subtheme examines a deeper severity of distress experienced by some women during peri/menopause, underscoring the cumulative impact of signs and symptoms. Mary conveyed the depth of this feeling when she described feeling "dead inside," like an "empty shell," questioning the value of her existence (“[I] started to believe there was no benefit to my existence for anyone else”). These accounts, including references to peri/menopause as "torturous" from a "mental health point of view" (Nickys71), emphasise the need to recognise and take seriously the severe distress that some women may experience during peri/menopause.

While cross-sectional and longitudinal studies have linked peri/menopause to depression, research on suicide or suicidal ideation in this context remains limited. The most recent statistics in England and Wales show that the highest rate of suicides among women were those between the ages of 45 to 49 (Nasir et al., 2021). Similar trends emerge in other regions, including Western countries and Eastern countries such as Korea, where researchers have studied the relationship between peri/menopausal phases and suicidality (An et al., 2022; Ryu et al., 2022). In this study, a few women reported distress to the extent of suicidal ideation or suicidality. While this may not have dominated across the data, the extent of distress was striking, hence has been brought to the fore. Marns, for instance, reported being

“so desperately sad one week a month and seriously considered harming myself as it seemed like the only way out”, revealing the weight of her despair. In a similar vein, JenS spoke of the impact of the distressing uncertainty she faced, stating, “I spiralled into a pit of anxiety, worry that I had Alzheimer’s (because of brain-fog) and days where I wish my life would end because I could see no solution”.

Research has indicated the heightened risk of suicidal ideation among women during the perimenopausal phase of menopause (Usall et al., 2008). Mirroring these findings, Rita said she “felt suicidal”, while others expressed feelings of “hopelessness” (Annie) “worthlessness” (Gig) and “sadness” (Valentine) which is often language/feelings associated with low mood and depression (Gilbert, 2000). MaryJ described a distressing experience of mental health and suicidal thoughts, stating, “I became suicidal it got that bad, nothing cheered me, no joy in anything”. Similarly, Pauline recounted a distressing conversation with a friend:

> [I had] a feeling of, you know, it was just real anxiety. Well, what now I know was anxiety, mind race and stuff like that, so I wasn't sleeping properly. So, I thought, right, I've just gotta go. And it was my friend who said, oh my God, have you felt suicidal? She just came out and asked me and I realised, yeah, I did.

Lottie articulated the depth of her emotional distress, describing her experience as “hellish, the lowest I've ever felt; I wanted to die”. Similarly, Tracy expressed the impact on her mental health, stating, “[It was] badly affected. I felt incompetent in my job, my self-esteem and confidence plummeted, and I felt suicidal”. Notably, the women in this study frequently cited a myriad of distressing factors contributing to their emotional state. These factors included domestic abuse, bereavement, physical health factors, historic or pre-existing mental health difficulties, work-related stress, misattribution to illness and family issues amongst others. Bell captured the challenges, describing, “facing being infertile and dealing with the pain and sexual issues of atrophy have destroyed my sense of self and happiness and I have been suicidally depressed at times”. This emphasises the importance of recognising the multifaceted psychosocial, environmental, and personal challenges faced during peri/menopause, highlighting the need for support for those navigating significant distress.

As these accounts suggest, the emotional distress experienced by women during peri/menopause can be severe and multifaceted. Without adequate knowledge and understanding, women may find themselves navigating these challenges without a clear

contextualising framework, potentially resulting in severe emotional distress that can escalate to suicidal ideation.

(4.7): Theme 4: Women's experiences of help-seeking: "Stuck me on antidepressants"

This theme discusses women's encounters with support and 'treatment' concerning the mental health implications of peri/menopause, especially the challenge that arises when healthcare professionals are understood to have misinterpreted or misdiagnosed women's signs and symptoms. As Lou explained, "I eventually went to the GP whose immediate response was antidepressants", while others felt "fobbed off" (Tracy) or "totally dismissed" (Sandra). Some women reported dissatisfaction with antidepressants, suggesting that alternative treatments like counselling or HRT might offer more effective relief. Thus, this theme underscores the broader challenge women face: desiring their mental health challenges to be acknowledged distinctively from peri/menopausal symptoms while also seeking appropriate treatment, involving medical interventions if necessary. Despite the challenges of managing their mental health and struggles in accessing appropriate support and information, this theme shows that adaptive strategies can emerge as women seek to manage their symptoms and move forward with their lives in a positive way.

Many women in this study reported feeling uncertain about how best to navigate treatment options. Bird emphasised how daunting it was to seek help when she explained, "I don't go to the doctors, you know, and for me to go was a big thing", suggesting that seeking help becomes seen as something they would prefer to avoid hence peri/menopause was something to be endured without health professionals. In some instances, women spoke of managing their signs and symptoms alone until it reached a point where they felt they had no other option but to seek help as a last resort: "I've coped for about a year, but it got to the point that I needed to see my GP" (Katherine). These reports capture what it might take for women to attend their GP's and their feelings of apprehension and subsequent delay in seeking support. This indicates the need for a supportive approach by health professionals who have sufficient knowledge and understanding of women's needs to suitably assist women when they choose to seek support (O'Reilly et al., 2023).

In this study, women conveyed a sense of feeling disregarded and misunderstood by health professionals. Anna expressed this sentiment, noting how she felt her "GP has no interest in or understanding of what I'm going through" which was echoed by Pauline when she recalled her encounter with the GP:

> I went to the GP, I had a throat infection and I described that I'd been having night sweats and restless legs and could this be to do with the menopause? And the doctor blanked that question and asked me how long I had the sore throat and yeah. And you know, when you blink, and you think did he just say that? And I said, oh, well, I've had that about two weeks now. And he goes, oh, well, we'll get you on antibiotics for that. And that, that was it and I was out of the surgery.

Pauline's story underscores many women's experiences of a disconnect between their concerns and the medical responses they receive. Bird's account further emphasises this sense of dismissiveness: "For them just to sort of almost poo it and just, just get with it, you know, stop making a fuss, you know". Further to this, Bird expressed the courage it takes for women to seek help, stating:

> I thought if you, if you know how long, how many months it took me to pluck up courage to come here and then it was, it was almost, oh, you're just wasting my time.

In the context of women's uncertainties and trepidation about how and when to seek help, as well as appropriate support and treatments, the impact of being met with a sense of trivialisation and indifference is significant, potentially leading to women suffering distress and cumulative mental health issues due to a reluctance in seeking help as well as a lack of appropriate support and treatment.

Some women reported their preference to see a female GP in the hope that they would be better understood. Tracy said, "I specifically asked to speak with a female doctor, however she told me I was depressed and prescribed me antidepressants", suggesting that a lack of nuanced understanding of peri/menopausal symptoms and tendency to misdiagnose as depression is not necessarily due to a lack of awareness of the part of male GPs. Nonetheless, a few women spoke of the challenges of how they were perceived by their GP's. Tomps, for instance, described seeing,

> A young male GP who did discuss with me anti-depressants vs HRT, but - I think because I cried during the appointment and he may have felt uncomfortable with me expressing perfectly normal feelings, he prescribed antidepressants.

This speaks of women's perceptions of how emotions and/or peri/menopausal women are viewed in society, which may create further barriers to seeking help.

Several women in this study reported feeling dismissed and overlooked by health professionals, and in some cases being given antidepressants, in contradiction with NICE guidelines (see NICE, 2019). These guidelines indicate the lack of evidence that antidepressants are effective for managing low mood during peri/menopause (NICE, 2019). Participants expressed reservations about the efficacy and appropriateness of antidepressants for peri/menopausal symptoms. EmmaB reflected, "still on antidepressants - don't know if that's good or bad". Similarly, Fiona highlighted confusion with medical advice and uncertainty regarding the helpfulness of her treatment, noting, "conflicting advice amongst GP's and consultants as to whether I should try venlafaxine [antidepressant, SNRI] to help with night sweats". Laura encapsulated the sentiments of numerous women discussing their experiences of having been immediately prescribed antidepressants without discussion or guidance of alternative treatments, stating, "antidepressants at first, not sure I was given correct info re HRT".

In light of these experiences, questions emerge regarding the expertise and autonomy of women in their own treatment decisions. Women spoke of not being considered the experts of their own bodies and as a result their voices fade into the background. This sentiment was captured by Maisy:

> I firstly spoke to my GP who recommended anti-depressants. I knew I was not depressed - I didn't feel down, depressed, or hopeless. I felt unworthy, fearful, unsure, alone, incredibly anxious, flat, joyless, sad, worried, lost and many other things, but not depressed (I've been there, I know what that feels like). Still I had to try the anti-depressants, the GP said to give them a few months, I really didn't want to take them but wasn't offered a choice at that time.

Lou furthered this sentiment, revealing that after having been prescribed antidepressants she "felt worse after taking them and was advised to persist, until I could not function in any way, and she agreed I could stop". These accounts suggest that women may experience a loss of power and autonomy as they relinquish control of their bodies to doctors, despite not agreeing with these decisions. Societal representations of doctors typically include that they are reassuring, fully informed, knowledgeable, empathetic, diagnose problems quickly and are 'experts' in the body (Hayfield & Campbell, 2022) which may be a barrier to many women to challenge and advocate for themselves in these interactions. This is significant for

women as not only are they not getting suitable support for their needs, but they are forced to surrender their own expertise of their bodies which can be disempowering, perpetuating women's feelings of not being heard or understood, thus impacting on their overall sense of wellbeing.

Further to concerns related to the efficacy of treatments, many women expressed apprehensions about potential misdiagnoses and felt compelled to challenge their doctors in order to receive what they believed was the appropriate treatment for them. Jo recounted how she "went to GP, took my list of issues and asked for HRT…I had done my research and was clear why I didn't feel this needed anti-depressants". These findings are consistent with previous research that showed women themselves are likely to influence GPs treatment decisions around prescriptions of HRT (Hyde et al., 2010) which contrasts with other accounts in this study of limited choice and control. Similarly, Vickyjo detailed a challenging interaction when she said:

> The doctor then said, right, well I can prescribe you antidepressants. And I was like, no I don't want antidepressants. I'm not depressed […] I had been on antidepressants for a short period of time and I think I was misprescribed then.

These experiences suggest a lack of trust in GPs and other health professionals among many women seeking support for problematic peri/menopausal signs and symptoms. Such encounters left many feeling "helpless" (Anna) and anticipating confrontations, as described by JenS who "expected a battle," or Grey who felt compelled to "fight" for appropriate support. Anna's difficult experience when seeking support for her concerns about peri/menopausal symptoms were exacerbated when met with a directive to "lose weight", trivialising her concerns. Daisy similarly felt her concerns trivialised and dismissed, recounting being told that her "low moods and lethargy" were attributable to lifestyle choices, stating that she was "dismissed as being unfit or consuming too high a volume of caffeine/alcohol despite having reduced my intake considerably". Such dismissals are significant as they not only perpetuate unhelpful myths and misconceptions about peri/menopause and midlife women, but also diminish women's faith and trust in healthcare professionals to provide suitable and individualised support.

Within this study, numerous women shared their experiences of seeking and taking HRT to address the mental health challenges associated with peri/menopause. Some felt dissuaded from pursuing HRT, of being "talked out of it" (Vickyjo), either by healthcare professionals

or loved ones, often citing concerns about potential health risks as well as a lack of education. As Vickjo explained,

> And I think the education side of it, its raising awareness, but it's about HRT because I was so scared of it. I really was. And I was just like, oh God, it's there. I can't do it. Cause you know, I will get cancer.

Wins echoed this sentiment, mentioning that "the fears around HRT and cancer were exacerbated by the internet", but went on to emphasise the benefits she experienced: "since having the gel, I have seen such a huge positive change and would recommend it to anyone". Tomps highlighted its positive impact, noting how her "anxiety disappeared after starting HRT", while Sonia credited HRT for having made her "feel normal again". Gig reported a similarly positive experience, sharing that,

> It's definitely made a difference. I feel part of human race again. I feel accountable again. Even my boss said you are more present, you're there more productive, which is what you should be. So it's been noticed by everyone.

However, some women noted that navigating HRT often proved to be a process of trial and error. Laura acknowledged this, noting, "[I] tried several HRT before I found the right combination". Additionally, many women encountered practical challenges related to accessibility and availability. Sam, for instance, described how she, "got gel and tablets as HRT but have had to change to patches as unable to get gel". June confirmed these supply challenges, observing, "it's not available at the pharmacy - trying to get a prescription fulfilled is incredibly stressful at the moment". Such obstacles can exacerbate anxieties, as highlighted by Pauline: "I have regular anxious moments when my HRT is unavailable". Yeedonissa echoed this sentiment, attributing recent "shortages in HRT" to heightened feelings of "low mood, anxiety, and ruminating". The accounts of these women provide positives perspectives on the use of HRT. While some expressed initial reservations, often influenced by concerns about potential health risks, many emphasised the significant improvements in their mental health, such as reduced anxiety and restoration of 'normalcy'. For these women, HRT has played a positive role in alleviating their signs and symptoms.

In this study, while some women recounted challenging interactions with their GPs, it is important to note that others shared positive experiences and emphasised the importance of

the support received from medical professionals. Several women mentioned their GP as "extremely supportive" (Jo) and "amazing" (EmmyLou), noting that the process of seeking medical treatments like HRT was "straightforward" (Katherine). Some participants highlighted the beneficial role of antidepressants in managing peri/menopausal symptoms. For instance, Wakeyee described her difficulties with emotional dysregulation being recognised by her GP, who she said, "put me on the antidepressants and thank goodness, I'm sleeping now, and the anxiety is back under control". Similarly, Marns felt "saved" by antidepressants, and Sam acknowledged that they "helped immensely" during peri/menopause. These positive accounts underscore the necessity for nuanced approaches to peri/menopausal support, emphasising that treatments should be individualised rather than adopting a one-size-fits-all strategy (Newson & Panay, 2018).

In this theme, the challenges women encounter when seeking medical support for peri/menopause have been highlighted, especially when their concerns are dismissed, or symptoms misdiagnosed. Many women in the study found themselves prescribed antidepressants, while several questioned the efficacy of this treatment. Numerous participants' accounts emphasised a sense of their symptoms being misunderstood or trivialised by GPs, exacerbating feelings of helplessness and mistrust in healthcare professionals, and potentially erecting further barriers to help-seeking, which is an already daunting prospect for many women. Women either found themselves relinquishing control over their bodies and treatment decisions or 'battling' for appropriate support. While some women expressed reservations about antidepressants as an effective treatment, and concerns related to the health risks of HRT, several shared positive experiences with these treatments and beneficial outcomes, emphasising the need for individualised care and a nuanced understanding of peri/menopausal symptoms.

Chapter 5: Discussion

(5.1) Summary of themes

The overarching theme '"*What is wrong with me?": Complexities of sensemaking'* highlighted the psychological and emotional impact of an absence of contextual framework for understanding peri/menopause. Without peri/menopause as a frame of reference, women sometimes misattributed their signs and symptoms to serious illness as well as other factors (e.g., relationships, the covid-19 pandemic etc) which caused significant distress and uncertainty. The findings emphasise the importance of having an awareness of peri/menopause to provide the necessary cognitive and emotional scaffolding to support women to navigate this phase of life. The themes subtheme '"*Out of the Blue": Preparing for the unexpected'* reported on women's feelings of unpreparedness for peri/menopause and its associated signs and symptoms. The findings from this study suggest that women lack awareness and knowledge about peri/menopause, especially its possible implications for their mental health. This was indicated to be a result of a lack of discussion in mainstream education and within families, which was considered to be related to societal stigma. These findings therefore confirm earlier research findings that peri/menopause is somewhat a hidden and unspoken phenomenon (Sergeant & Rizq, 2017). However, for women who *had* spoken with family members, the findings showed that they tended to use these narratives of peri/menopause as a framework for their own, though their experiences would often be different, which would contribute to a sense of unpreparedness and confusion, which is confirmed by existing research findings (Dillaway, 2007). The findings from this current study therefore indicate the need for challenging existing stigma and stereotypes around reproductive health and aging, through encouraging intergenerational communication and open discussions within society, including in education.

Overarching theme '"*Someone other than myself": crises of identity'* considers the role of shifting identities when thinking about women's experiences of mental health during peri/menopause. The findings suggest that these shifts can be unexpected, leaving women grappling to adjust to their reformed identities. Whilst previous research has suggested that the transition to menopause can be transformative, and the concept of one's stabilised identity as an important aspect of wellbeing (Norlock, 2017; Sergeant & Rizq, 2017), this study finds that the process to adapting to changes can be a complex and distressing experience for some individuals. The exploration of identity in this context is thereby novel in that it considers the

interplay between women's identity, psychosocial factors, self-concept, and mental health. This challenges existing research that have presented less sophisticated portrayals of identity during peri/menopause. Instead, this current study paints a more complex picture of mental health during peri/menopause which looks beyond mere biological factors underpinning mental health difficulties.

The overarching theme '"*Existing, not living*": *The impact of mental health during peri/menopause'* features women's disclosures of their struggles with their mental health during peri/menopause, emphasising their difficulties with engaging with a life of meaning and purpose. While some studies have found that women can experience mental health challenges during peri/menopause (O'Reilly, 2023), this study's presentation of women's experiences goes beyond conventional discussions of mental health and reports of symptomology found in existing research. The themes subtheme '"*Oh my God, have you felt suicidal?!": The severity of distress during peri/menopause'* delves deeper into women's reports of serious mental health concerns during peri/menopause, which, for a few women, were expressed as suicidality. These findings show the critical nature of women's desperation and distress and illustrates the requirement for mental health concerns to be taken seriously during this phase of life by health professionals, including counselling psychologists. Through exploring women's lived experiences within a qualitative framework, experiences of mental health have been made explicit which challenges existing quantitative research that underestimates the impact of mental health during peri/menopause.

Theme 4, '"*Stuck me on anti-depressants": Women's experiences of help seeking'* highlights experiences of women seeking support for peri/menopausal signs and symptoms. Many women reported feeling dismissed by health professionals, and in some cases were prescribed antidepressants. Many women rejected the notion that they were clinically depressed and attributed their mental health challenges to hormone changes associated with peri/menopause. Some women felt they had to push for treatment they thought was suitable for them. These findings present nuanced perspectives on the medicalisation of peri/menopause as there appeared to be a tension between women not wanting to be diagnosed with a mental health condition but wanting their mental health to be taken seriously while seeking treatment such as HRT. This theme suggests then that it is crucial to differentiate between signs and symptoms indicating depression and mental health that is associated with or exacerbated by peri/menopause. These findings indicate that more recognition by health professionals is required in response to women feeling misunderstood and symptoms misdiagnosed or misattributed. This is particularly significant in cases where

women report being at possible risk of harm, indicating suicidal thoughts. These findings confirm previous research that suggests there are challenges and barriers to women getting suitable support for difficulties relating to reproductive health (British Menopause Society, 2023; Newson & Panay, 2018). Women's reports pertaining to a lack of control and autonomy over their bodies and treatment decisions was a novel finding in this study because research is limited on women's experiences of healthcare during peri/menopause. Whilst societal discourse indicates doctors in society are typically considered to be reassuring, empathetic, and are experts of the body who will provide answers and diagnose peri/menopause (Hayfield & Campbell, 2022), this is not consistent with the realities of women's experiences reported in previous studies (Hyde et al., 2010; Cooper, 2018; Harper et al., 2022).

The current study findings align with previous research that suggests that mental health (as well as lived experience more broadly) during peri/menopause is influenced by an interplay of biological, psychological, social, and cultural factors and context (Stephens, 2001; Hunter & Rendall, 2007, Ayers et al., 2011; Hunter & Edozien, 2017). The study further validates previous research noting the challenges of disentangling peri/menopause from other concurrent life events experienced by women during this life phase (Hinchliff et al., 2010), as well as the difficulties faced when attempting to separate mental health and peri/menopause. These findings show that women's experiences of their mental health during peri/menopause is complex and multi-faceted which differs from previous studies (such as those conducted within biomedical frameworks) which report symptomology and more generalised accounts of women's experience (e.g., limited to vasomotor symptoms). Thus, these findings underscore the individual and diverse nature of peri/menopausal experiences which challenge accounts that neglect to consider these complexities. As a result of some women feeling unprepared for peri/menopause, they may seek out their own information and education, demonstrating the importance of considering the individuality of women's experiences and highlighting the need for inclusive and accurate sources of information that relate to a broader population of women.

These findings do not indicate which participants disclosed a long-term mental health condition and which did not. This is because the aim of the study was not to quantify the presence or absence of mental health conditions among participants. Instead, the focus was on understanding and analysing the experiences of peri/menopausal women as a whole, irrespective of mental health status. The classification of a long-term mental health condition was self-reported and could vary in meaning from one participant to another. Therefore, the

study was open to all women, and their experiences were analysed and reported together to reflect the diverse nature of peri/menopausal experiences, without isolating those with long-term mental health issues from those without.

(5.2) Implications for counselling psychology

The findings from this current study suggest that peri/menopause is a time of life in which women's mental health can be influenced in various ways and is complex in that it can be difficult to disentangle from other influential factors (e.g., the social and cultural). Counselling psychology is uniquely placed to help unravel these complexities and aid understanding whilst supporting women in navigating and understanding their difficulties within biological, psychological, interpersonal, social, cultural, economic, and political contexts. At this current time, women may have difficulty directly accessing a counselling psychologist or others (e.g., clinical psychologist, psychological therapist, counsellor, mental health practitioner etc) to support them with peri/menopause because open access services are limited. However, the NHS website directs women looking for psychological support for peri/menopause related signs and symptoms to self-refer to NHS talking therapies without the requirement to see a GP first. This is important because it removes a barrier for women when seeking alternative support for their mental health during peri/menopause. Whilst NHS practitioners attempt to make individualised assessments to determine which therapy is suitable, CBT-MENO (the therapy specifically created for the treatment of peri/menopausal symptoms) is manualised (Green et al., 2012), which means that it is structured as a workbook that follows a set protocol. Some women may benefit from this approach, but others may seek a more relational and flexible approach.

In addition to the option of self-referring to NHS therapies, women may choose to seek private therapy if they require an alternative approach to therapy and have the financial means to do so. To reflect the findings of this study, it is suggested that a client-led, flexible, and relational approach to therapy may serve as a helpful alternative. Through the facilitation of a safe and comfortable environment, the multi-faceted nature of mental health during peri/menopause can be unpicked and worked through. CPs can support women through collaborative formulation which can help both client and therapist make sense of the processes, problems and maintaining factors, as well as how they interact with one another (Simms, 2017).

One of the values of CP is that practitioners are encouraged to be critical of their own attitudes, beliefs, and biases (British Psychological Society, 2015; Health and Care Professions Council, 2015) and thus reflect on their personal positioning in relation to topics such as peri/menopause and mental health. This current study indicated that societal discourses on peri/menopause and aging can be influential on how women feel about themselves and how they view and thus navigate this phase of life. Therefore, an implication of these findings is that is important for counselling psychologists to make visible these broader contexts and perspectives as well as being aware of their own attitudes and beliefs and being reflective and curious about their origin (Donati, 2016). Previous research has also indicated that therapists may also not be aware of their own peri/menopausal experiences and how it may impact clients (Brayne, 2011), so this is another example of where self-reflection and awareness will be useful.

In this study, many women attended their GP to seek advice, guidance, support and, in some cases, an explanation or cause for their signs and symptoms. Whilst the relationship between diagnosis and the principles of CP is complex, the results of this study suggest that when women have a frame of reference for their signs and symptoms, and are knowledgeable about peri/menopause, they may be better prepared to navigate this phase of life. Having peri/menopause diagnosed/confirmed meant that some women's concerns were validated, and they felt reassured to be told that what they were experiencing was a normal and natural part of aging, rather than something more sinister. The conflict for the field of CP is that one of its principles it to reduce stigma and discrimination, though diagnostic labelling, in some cases, has been argued to perpetuate stigma and stereotypes which may be harmful (Churchill, 2020; Christensen, 2013; Simms, 2017). The implication for CPs then, is not to assume that women do not want peri/menopause diagnosed but instead to empower and educate women to enable them to make informed choices depending on their own individual needs and wants.

(5.3): Wider implications of study

One of the outcomes of this study was that it highlighted the multi-faceted nature of peri/menopause, and the variety of ways women's mental health can be impacted at this phase of life. The findings of this study demonstrate the gravity of psychological distress as a result of competing factors and the marked finding that some women can experience severe distress, and even experience thoughts of self-harm/suicide.

Another finding from this study indicates that some women feel dissatisfied with their experiences with health professionals yet found it necessary to seek medical attention/intervention for their difficulties. An implication of this is that it highlights the possible lack of awareness, training or knowledge among some GPs and health professionals. This lack of awareness is not limited to health professionals but is more widespread with a general lack of knowledge among all professionals that work with women, including counselling psychologists.

This study also sheds light on the lack of education around peri/menopause. Many women spoke of having limited knowledge on peri/menopause until they started experiencing it themselves. This led to women experiencing significant distress, and relationship difficulties whereby loved ones also did not have knowledge or understanding on what was happening. Many have highlighted the ramifications of this absence of education and have advocated for peri/menopause to be introduced in mainstream education (Chrisler, 2013; Weatherhead, 2022). Whilst guidance has been published that instructs the need to focus on reproductive health in education (Department for Education, 2019), it is suggested that this should include the social, psychological, cultural, and relational factors associated with peri/menopause to provide education beyond biomedical knowledge and to thus extend beyond medicalised discourses. The advantages of this could be far-reaching, including women feeling more prepared for this life phase, more supported by loved ones and an increased acceptance and acknowledgment of peri/menopause in society more broadly which would benefit everyone.

(5.4): Summary of recommendations for future research

This study goes some way in highlighting the potential for serious harm for women during peri/menopause. Some of the participants in this study reported suicidal ideation and further research would be required to understand the scale of suicidal ideation and self-harm during peri/menopause. Additionally, such research could help raise awareness about the mental health implications for women at this time of life.

The study indicates that interpersonal and relational aspects of experience can affect women's mental health during peri/menopause. Some women in this study experienced ruptures in their friendships while others found great comfort in their friends. Many sought support from other peri/menopausal women through community forums, workplaces and online platforms. Previous research suggests that friendships are consistently highly valued

throughout women's lives (Deeks & McCabe, 1998), therefore indicating that disruptions in these friendships may be particularly challenging. Whilst studies have referred to friendships during peri/menopause (Deeks & McCabe, 1998; Dillaway et al., 2008), there is a need for further research to better understand the importance and effects of friendship and further interpersonal factors during this phase of life.

Many of the women in this study spoke about their encounters with their GPs, however only a small number said that they received counselling during peri/menopause and limited information on their experiences were provided. It is recommended that future research of women's experiences of relational-focussed therapy during peri/menopause may be helpful for improving therapist encounters for peri/menopausal clients.

(5.5): Summary of key clinical recommendations

Professionals who support women at this time of life would benefit from training and awareness on peri/menopause. This could include that experiences of peri/menopause are not universal and, in some cases, impact on women's mental health, and are not just confined to the physical. When working with women with deteriorating mental health during peri/menopause, it is recommended that determinations of risk (suicide and self-harm) are made to prevent harm for women. It is important that challenges to women's mental health be validated and understood in context, not downplayed, and taken seriously by all professionals. It is recommended then that CPs, as well as other practitioners, conduct risk assessments and refer to appropriate services if there are safeguarding concerns.

Support for women during peri/menopause should extend beyond medical assessments and diagnosis. The findings from this study suggest that women can experience significant distress at the time of peri/menopause. Therapy can provide a safe container for processing distressing experiences, supporting identity transitions, and addressing interpersonal factors. CPs can also support individuals to understand, contextualise and acknowledge their emotions. If there are specific signs and symptoms that are problematic, CPs can use approaches that are evidenced to be beneficial. A holistic assessment could provide individuals with increased treatment options. Currently, women who choose to seek support only see their GPs, unless they look elsewhere for support.

This study recommends that therapists and counselling psychologists be aware of how societal discourse impacts their perceptions and assumptions of peri/menopausal women.

Additionally, it would be beneficial to have guidance for therapists, including counselling psychologists, on how to support women during peri/menopause.

(5.6): Strengths and limitations of study

The findings from this study contribute to insights into the under-researched area of mental health during peri/menopause. The study demonstrated several strengths in its design and implementation. Recruitment of participants was efficiently carried out within a suitable time frame, which later allowed for sufficient time and attention to be paid to data analysis. The strategy of reaching out to well-established menopause advice and support platforms also proved effective for recruiting participants. Additionally, the inclusion of both qualitative surveys and semi-structured interviews as methods of data collection proved advantageous. Surveys not only served as a successful recruitment tool for interviews but also elicited rich and detailed responses from participants, exceeding expectations. Feedback from participants suggested they valued sharing their experiences in the format of a survey, with one participant specifically articulating her appreciation for the opportunity to contribute anonymously. This underscores the value of surveys in facilitating exploration of personal and taboo topics such as mental health and peri/menopause, especially among those who seek privacy and may otherwise feel reluctant to participate in research. Furthermore, the use of interviews allowed for deeper exploration of areas of interest identified in the surveys, which helped develop comprehensive and nuanced understandings of mental health during peri/menopause. The coherence between the methodology and epistemology, along with adherence to their principles, ensured the rigour and integrity of the study. The study represents in-depth narratives of women's lived experiences of health during peri/menopause, while also considering broader contextual factors, such as social and cultural influences, which may shape these perspectives, thus emphasising the complexities inherent in studying mental health at this life phase.

Despite attempts to recruit a diverse sample of women (e.g., those from minority ethnic backgrounds), only a very small number of these perspectives were represented. Through the creation of a survey method, it was hoped this would be far-reaching and easily shared on platforms that claim to support women from these populations. However, not every platform was accessible. Possible reasons for this may include the overall capacity of the forum administrators to respond to requests, or the platforms policy's not to be used for research. Another possibility is that the language used to advertise the study was not

accessible or tailored specifically to the community/group. Another consideration is that the study involved two stigmatised topics (mental health and peri/menopause) which may have impacted recruitment from more diverse groups. There are, however, an increasing number of studies on women's experiences of peri/menopause undertaken in different countries, which may provide more insight into these particular groups experiences.

Satisfactory representation of diverse groups is critical to reducing the disparities in healthcare. It is acknowledged that the experience of peri/menopause is not universal, and women's experiences can vary across cultures. By not being able to access individuals from these groups means that the voices represented in my research are from the UK and possibly influenced by Western culture and perspectives on peri/menopause. It is known that there are multiple reasons why diverse groups are less involved in research. These reasons include distrust of researchers and health professionals, time constraints, breaking culture norms/stigma, lack of awareness of being able to be involved in research (Shea et al., 2022). It is understood that there is a responsibility of the researcher to earn the trust of communities and build inclusive research engagement. This is understood to require time and overt efforts to earn the trust of minority communities (Passmore et al., 2022).

Another limitation of this study is that whilst effort was made to capture a wide range of experiences, it is possible that there is an overrepresentation of women in this study who experienced a difficult peri/menopause, because participation in this study may have appealed to a greater extent to such women. This may have also led to an underrepresentation of positive peri/menopausal experiences reported in the data.

(5:7): Further considerations

The data for this study was collected shortly after the covid-19 pandemic which may have influenced the results of this study. Some women reported that they attributed their difficulties initially to the pandemic (e.g., post-pandemic exhaustion). Whilst experiences of the covid-19 pandemic were individual, for many it was a time of significant uncertainty and worry (Sodi et al., 2021). Increased stress levels during this time may have impacted mental health aspects of experience during peri/menopause. The related reasons could include women not being able to engage with activities that would usually maintain wellness, such as spending time with friends and exercising, for example. Some people also faced significant economic stressors, such as facing the possibility of losing their jobs. Experiences of

treatment and support may also have been elevated by disruptions to the NHS and scarcity of care. Therefore, it is important to consider these findings within this context.

(5.8): Conclusion

In conclusion, this study reports on the experiences of women's mental health during peri/menopause using a qualitative methodology. The findings present a more in-depth and nuanced understanding of mental health at this time of life in comparison to studies conducted within biomedical and quantitative frameworks which can be limited to reporting symptomology. This study also highlights the complexities and challenges of disentangling mental health issues caused by hormonal changes from other psychological, social, and cultural factors that often impact women during this phase of life. The findings of this study suggest the importance of counselling psychologists and health professionals to have awareness and knowledge of peri/menopause and its possible implications for mental health and wellbeing, and to be mindful of the various factors that can influence women's individual experience of peri/menopause. This study reports on a variety of factors that counselling psychologists can support such as stigma, bringing awareness to societal discourse and its impact on women, interpersonal challenges, identity, and the serious nature of some women's distress. It is hoped this study will contribute to the current literature on peri/menopause and that further research will improve the quality of support women during peri/menopause.

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Appendix 1 – Ethical Approval – This appendix has been removed as it contains personal information

Appendix 2 – Recruitment Poster

Are you interested in talking about your experiences of perimenopause/menopause on your mental health?

Would you be willing to share your experiences, attitudes, and understandings and contribute to research designed to help increase understandings of peri/menopause and mental health?

Hello, my name is Kieta. For my doctorate research I'm conducting interviews and qualitative surveys to hear from women about their experiences of perimenopause/menopause in relation to their mental health, for the purpose of developing an understanding of the complexities of mental health during perimenopause/menopause.

I am inviting people to share their experiences through an online survey. If you are interested in contributing your experiences, you can complete the survey at https://uwe.eu.qualtrics.com/jfe/form/SV_bgh5W0DJjOBUMfQ

Alternatively, you can opt for an audio-recorded interview by sending me an email on kieta2.bennetts@uwe.live.ac.uk and I will get back to you within 24 hours.

I am a trainee Counselling Psychologist at the University of the West of England. My research has ethical approval and is supervised by Dr Nikki Hayfield and Dr Zoe Thomas.

I am looking forward to contributing to such an important area of study and to read your responses. Thank you.

Appendix 3 – PIS for surveys

Participant Information Sheet

Women's experiences of the impact of perimenopause/menopause on their mental health

You are invited to take part in research taking place at the University of the West of England, Bristol. Before you decide whether to take part, it is important for you to understand why the study is being done and what it will involve. Please read the following information carefully and if you have any queries or would like more information please contact Kieta Bennetts, Department of Social Sciences, University of the West of England (UWE), Bristol by email: kieta2.bennetts@live.uwe.ac.uk.

What is the aim of the research?

The aim of the study is to explore women's experiences of perimenopause/menopause in relation to their mental health, for the purpose of developing an understanding of the complexities of mental health during peri/menopause.

You are being invited to take part in a survey. I hope that the study will generate knowledge that may be useful for practitioners who work with women at this stage of life. I am also keen for women to have their voices and experiences heard.

Why have I been invited to take part?

To be eligible to take part you need to be over the age of 18, peri/menopausal and be happy to share your experiences and perspectives on your mental health in relation to peri/menopause. In this study, the term 'mental health' is broadly defined and involves the emotional, behavioural, cognitive, and psychological wellbeing of individuals. Mental health can be considered to apply to all and can be interpreted differently by individuals and across cultures. Therefore, you do not need to have a diagnosis of a mental health condition to take part. The term 'women' is used in this study as an inclusive term and therefore applies to anyone who considers themselves to be peri/menopausal. You may have received a formal diagnosis from a health professional, but you don't have to have been formally diagnosed – it may be that you have noticed changes that mean you define yourself as peri/menopausal.

If you have not had a period for over one year due to peri/menopause, then thank you for your interest, but unfortunately you are not eligible to take part (because one year after your periods end you are then defined as postmenopausal). If your periods have stopped for some other reason (e.g., you are on medication such as hormone therapies) and believe that you are peri/menopausal then you can still take part. If you have had a surgically induced menopause, I recognise that your experiences are likely to be different from those who have not. Therefore, thank you for your interest, but on this occasion, I am not able to invite you to

participate.

Do I have to take part?

No, you do not have to take part. Participation in this study is voluntary and you will be asked for your consent prior to being involved. Deciding not to take part or withdrawing from the study does not incur any penalty and will not affect your relationship with any of the organisations I have used to help me recruit for this study.

What are the benefits of taking part?

Participants often report that they enjoy taking part in research and that they like the opportunity to share their thoughts and experiences. Unfortunately, I am not able to offer any incentive to take part but very much appreciate the contribution of research participants.

What will happen to me if I take part and what do I have to do?

If you agree to take part, you will be asked to complete an online survey via Qualtrics. You will be asked to complete this by typing your responses to the questions. The survey consists of open-ended questions about peri/menopause and mental health. I anticipate that completion of the survey may take between 30-60 minutes, depending on how quickly you type and how much you have to say. I would be very appreciative if you are able to provide as much detail as possible when answering the questions to help me understand your thoughts and experiences in depth. I am also recruiting for people to take part in interviews so if you choose to take part in both the survey and interview, you will be asked to fill in the survey first. I will ask you to make a participant code so that I am able to identify your data if you decide to withdraw and you will be asked if you'd like to be given a pseudonym for the purpose of including non-identifiable extracts of data for any reports arising from the research. You will also be asked to provide some demographic information so that I have a picture of who has taken part.

What are the possible risks of taking part?

I recognise that this is a personal and potentially sensitive topic and if you think this survey may raise uncomfortable or distressing issues for you then please think carefully about whether you would like to participate. Participants must be able to consent to the study for themselves so if you are unable to do this for any reason then I'm afraid you are not eligible to participate. If you decide to take part and then change your mind, please let me know. A number of support organisations are listed at the end of this sheet.

What will happen to my data and information?

The aim of the survey will be to collect information that will be made anonymous – I will remove any identifying details about you or anyone else you mention. Anonymised extracts from the data, in which you will not be personally identifiable, may be quoted in conference presentations, written reports including my doctoral thesis and research papers, in teaching sessions, and other outputs arising from the study. The report will also be available on the University of the West of England's open-access Research Repository. The data will only be reported using your participant code/pseudonym. All the information I receive from you will be kept confidential, including if you contact me with your name and email address. If you leave an email address because you are interested in also taking part in an interview then this will be removed from Qualtrics and stored securely, separately from your survey data. Data will be gathered and stored on a secure internet server and completion of the survey will not require your name, so data is anonymised. All online data will be destroyed following completion of data collection. The personal information collected in this research project will

be processed by the University in accordance with the terms and conditions of the General Data Protection Regulations (GDPR). If you decide you want to withdraw during the survey, then you can simply stop answering the questions. I will assume that you are happy for us to use the written responses that you had already completed (the partial data). If you would prefer for your partial data to be removed, then please email me your participant code and I will remove your responses from Qualtrics. If you decide that you want to withdraw after taking part, then please contact me, quoting the participant code that you were asked to create at the start of the survey. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have started analysis of the data or published papers reporting the results. Therefore, I strongly encourage you to contact me within 28 days of participation if you wish to withdraw.

Who has ethically approved this research?

The project has been reviewed and approved by the Faculty/University of the West of England University Research Ethics Committee (ref HAS.21.11.027). Any comments, questions or complaints about the ethical conduct of this study can be addressed to the Research Ethics Committee at the University of the West of England at: Researchethics@uwe.ac.uk.

What if I have more questions or do not understand something?

If you would like any further information about the research, please contact Kieta in the first instance by emailing kieta2.bennetts@live.uwe.ac.uk.

What if something goes wrong?

For concerns, queries or complaints please contact my supervisors, Dr Zoe Thomas by email on zoe2.thomas@uwe.ac.uk or Dr Nikki Hayfield nikki2.hayfield@uwe.ac.uk.

Sources of support:

I hope that taking part is a positive experience, but if it raises any issues for you, then you may find some of the following resources helpful:

Menopause Matters are an independent website that offer information about menopause: https://www.menopausematters.co.uk/

Women's Health Concern aim to reassure and educate women about health and wellbeing. They have a factsheet about menopause which was produced in collaboration with the British Menopause Society: https://www.womens-health-concern.org/help-and-advice/factsheets/menopause/

My Menopause Doctor is the website of GP Doctor Louise Newson, who specialises in menopause. The site provides information, support, and resources: https://www.menopausedoctor.co.uk/ Healthtalk have some videos based on research with women talking about menopause which you might find interesting: https://healthtalk.org/menopause/overview

Menopause Café was set up in 2017 and hold some events for people to meet and talk about menopause: https://www.menopausecafe.net/

The British Menopause Society is aimed at educating health professionals, but includes resources which may be of interest to a wider audience: https://thebms.org.uk/

Perhaps if you are looking for more general support, this **Counselling Directory** allows you to search for counselling services in your area: http://www.counselling-directory.org.uk/

Appendix 4 – PIS for interviews

Participant Information Sheet
Women's experiences of the impact of perimenopause/menopause on their mental health

You are invited to take part in research taking place at the University of the West of England, Bristol. Before you decide whether to take part, it is important for you to understand why the study is being done and what it will involve. Please read the following information carefully and if you have any queries or would like more information please contact Kieta Bennetts, Department of Social Sciences, University of the West of England (UWE), Bristol by email: kieta2.bennetts@live.uwe.ac.uk.

What is the aim of the research?

The aim of the study is to explore women's experiences of perimenopause/menopause in relation to their mental health, for the purpose of developing an understanding of the complexities of mental health during peri/menopause. You are being invited to take part in an interview. I hope that the study will generate knowledge that may be useful for practitioners who work with women at this stage of life. I am also keen for women to have their voices and experiences heard.

Why have I been invited to take part?

To be eligible to take part you need to be over the age of 18, peri/menopausal and be happy to share your experiences and perspectives on your mental health in relation to peri/menopause. In this study, the term 'mental health' is broadly defined and involves the emotional, behavioural, cognitive and psychological wellbeing of individuals. Mental health can be considered to apply to all and can be interpreted differently by individuals and across cultures. Therefore, you do not need to have a diagnosis of a mental health condition to take part. The term 'women' in this study is an inclusive term and therefore applies to anyone who considers themselves to be peri/menopausal. You may have received a formal diagnosis from a health professional, but you don't have to have been formally diagnosed – it may be that you have noticed changes that mean you define yourself as peri/menopausal.

If you have not had a period for over one year due to peri/menopause, then thank you for your interest, but unfortunately you are not eligible to take part (because one year after your periods end you are then defined as postmenopausal). If your periods have stopped for some other reason (e.g., you are on medication such as hormone therapies) and believe that you are peri/menopausal then you can still take part. If you have had a surgically induced menopause, I recognise that your experiences are likely to be different from those who have not. Therefore, thank you for your interest, but on this occasion, I am not able to invite you to participate.

Do I have to take part?

No, you do not have to take part. Participation in this study is voluntary and you will be asked for your consent prior to being involved. Deciding not to take part or withdrawing from the study does not incur any penalty and will not affect your relationship with any of the organisations I have used to help me recruit for this study.

What are the benefits of taking part?

Participants often report to us that they enjoy taking part in research and that they like the opportunity to share their thoughts and experiences. Unfortunately, I am not able to offer any incentive to take part but very much appreciate the contribution of research participants.

What will happen to me if I take part and what do I have to do?

If you agree to take part, you will be asked to take part in an interview. I am also recruiting for people to take part in surveys so if you choose to take part in both the survey and interview, you will be asked to fill in the survey first. Interviews will be conducted online or in-person in line with your preferences alongside what is permitted by Covid-19 university policy and national measures.

The subject and focus of the discussion will be peri/menopause and mental health and your answers will be fully anonymised. The team are all experienced in the subject matter and are sensitive to issues it may raise. I anticipate that the interview will take approximately an hour. The interview will be audio-recorded. I will ask you to provide a pseudonym for the purpose of identifying your data if you decide to withdraw and for including non-identifiable extracts of data for any reports arising from the research. You will also be asked to provide some demographic information so that we have a picture of who has taken part.

What are the possible risks of taking part?

I recognise that this is a personal and potentially sensitive topic and if you think this interview may raise uncomfortable or distressing issues for you then please think carefully about whether you would like to participate. Participants must be able to consent to the study for themselves so if you are unable to do this for any reason then I'm afraid you are not eligible to participate. If you decide to take part and then change your mind, please let me know. A number of support organisations are listed at the end of this sheet.

What will happen to my data and information?

The aim of the interview will be to collect information that will be made anonymous – I will remove any identifying details about you or anyone else you mention. Anonymised extracts from the data, in which you will not be personally identifiable, may be quoted in conference presentations, written reports including my doctoral thesis and research papers, in teaching sessions, and other outputs arising from the study. The report will also be available on the University of the West of England's open-access Research Repository. The data will only be reported using your pseudonym and I will remove any details that I think might reveal who you are to others to make sure that no one can identify you. All the information I receive from you will be kept confidential, including if you contact me with your name and email address. Your interview will be audio recorded but the recording will not contain your name. When all outputs of the study have been published, all audio recordings will be deleted. For analysis, data will be transferred to be stored to a password protected UWE account. The personal

information collected in this research project will be processed by the University in accordance with the terms and conditions of the General Data Protection Regulations (GDPR). If you decide to withdraw during the interview, you can simply ask me to end the interview. If you decide that you want to withdraw after taking part, then please contact me, quoting your pseudonym. I would then discuss with you whether you would be happy for your data to be used up to the point of stopping the interview. If you decide you would not like this included, I will remove all of your data. I will also delete any personal details I have about you including emails and your email address. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have started analysis of the data or published papers reporting the results. Therefore, I strongly encourage you to contact me within 28 days of participation if you wish to withdraw.

Who has ethically approved this research?

The project has been reviewed and approved by the Faculty/University of the West of England University Research Ethics Committee (ref HAS.21.11.027). Any comments, questions or complaints about the ethical conduct of this study can be addressed to the Research Ethics Committee at the University of the West of England at: Researchethics@uwe.ac.uk.

What if I have more questions or do not understand something?

If you would like any further information about the research, please contact Kieta in the first instance by emailing kieta2.bennetts@live.uwe.ac.uk.

What if something goes wrong?

For concerns, queries or complaints please contact my supervisors, Dr Zoe Thomas by emailing zoe2.thomas@uwe.ac.uk or Dr Nikki Hayfield nikki2.hayfield@uwe.ac.uk.

Sources of support:

I hope that taking part is a positive experience, but if it raises any issues for you, then you may find some of the following resources helpful:

Menopause Matters are an independent website that offer information about menopause: https://www.menopausematters.co.uk/

Women's Health Concern aim to reassure and educate women about health and wellbeing. They have a factsheet about menopause which was produced in collaboration with the British Menopause Society: https://www.womens-health-concern.org/help-and-advice/factsheets/menopause/

My Menopause Doctor is the website of GP Doctor Louise Newson, who specialises in menopause. The site provides information, support, and resources: https://www.menopausedoctor.co.uk/

Healthtalk have some videos based on research with women talking about menopause which you might find interesting: https://healthtalk.org/menopause/overview

Menopause Café was set up in 2017 and hold some events for people to meet and talk

about menopause: https://www.menopausecafe.net/

The British Menopause Society is aimed at educating health professionals, but includes resources which may be of interest to a wider audience: https://thebms.org.uk/

Perhaps if you are looking for more general support, this **Counselling Directory** allows you to search for counselling services in your area: http://www.counselling-directory.org.uk/

Appendix 5 – Consent

Consent Screen

Thank you for taking part in the study of women's experiences of the impact of peri/menopause on mental health. Please ensure that you have read and understood the Participation Information Sheet. By completing this consent form, you are confirming your agreement with the following statements:

• I am over 18 years old and have read and understood the information in the Participant Information Sheet which I have been given to read before being asked to consent to this study.

• I have been given the opportunity to ask questions about the study and have had these questions answered satisfactorily by the research team.

• I agree that anonymised quotes may be used in the final report of this study and may be used in academic research papers, in conference materials, for presentations and other outputs from the study.

• I understand that my participation is voluntary and that I am free to withdraw at any time until the data has been anonymised, without giving a reason (please note, as detailed in the information sheet, you will need to make a note of your participant code/pseudonym and include this in your email so that your data can be identified and deleted).

• I agree to take part in the research.

Please tick the box below to confirm that you have read the information and consent to take part in this research:

☐ I do consent to take part

☐ I do not consent to take part

Appendix 6 - Survey/Interview Schedule

1) Please can you tell me about how you came to consider that you may be peri/menopausal?

2) Can you tell me a little bit about you and your experiences of peri/menopause?

3) What were your beliefs and understandings of peri/menopause before you started experiencing it yourself? You might like to discuss how your experiences and understandings have changed over time (if they have).

4) How would you describe your mental health during peri/menopause? What has it been like? (You may want to consider any positives and negatives)

5) Are there other factors that may affect your experiences of mental health during peri/menopause? If so, can you tell me about them? (You may want to consider life events/transitions that may have contributed)

6) Please can you tell me if you have sought any support for peri/menopause or mental health during this time? (You may want to consider your experiences of GP's, other health professionals or services and whether you were able to access the support you felt you needed)

7) Can you detail your experiences of any medical interventions or treatments (including HRT if applicable) you have received in relation to peri/menopause or for your mental health during peri/menopause?

8) Please could you describe how you have managed your mental health during peri/menopause? (You may want to consider whether you have used personal and practical resources, support strategies and networks etc)

9) Is there anything else that you think is important for me to know about what it is like for you to be peri/menopausal? Please include anything that feels relevant or important to you. This could relate to any changes to your mental health have impacted on your body, your physical wellbeing, your day to day life, your friendships, relationships, and whatever else you feel is relevant.

If you have any comments, suggestions or recommendations about the questions in this survey, then we would love to hear them. Please let us know your thoughts here:

Appendix 7 – Risk Assessment

University of the West of England BRISTOL

GENERAL RISK ASSESSMENT FORM

Ref:

Describe the activity being assessed:	**Assessed by:**	**Endorsed by:**
Surveys and interviews about the impact of the peri/menopause on mental health and wellbeing will be conducted. Participants will have the option of completing an online survey via Qualtrics or having online or in-person interviews. Online interviews will be carried out using programmes such as Microsoft Teams and in-person interviews will be carried out at a location agreeable to both the researcher and participant. For virtual interviews, personal laptops/computers or the telephone will be used. The interviewer/researcher may be lone working. Any in-person interviews will be held in line with current university/government Covid-19 guidelines	Student: Kieta Bennetts Director of Studies: Dr Nikki Hayfield	Dr Zoe Thomas
Who might be harmed: Participants completing surveys and interviews **How many exposed to risk:** Maximum of 120 participants	**Date of Assessment:** 30/06/22	**Review date(s):** 30/06/23

Hazards Identified ***(state the potential harm)***	**Existing Control Measures**	**S**	**L**	**Risk Level**	**Additional Control Measures**	**S**	**L**	**Risk Level**	**By whom and by when**	**Date complete d**
Distress of participants	A participant information sheet will be provided to participants prior to taking part in the study which includes information about what participation involves as well as details about inclusion/exclusion criteria. Participants will be asked to sign a consent form. Participants are provided information on how to withdraw from the study. They are informed	1	2	2	No additional control measures required.				Kieta Bennetts	Ongoing

	they do not have to provide a reason and that by doing so will not result in a penalty. The interviewer/researcher is experienced and fully qualified to manage and support individuals in distress. If a participant becomes distressed during the interview, the interviewer will stop the recording and questioning and ask the participant if they'd prefer not to continue with the interview. The interviewer would then signpost the participant to appropriate support organisations. If the participant is completing the survey, they are advised in the participant information sheet that they can simply stop answering the questions if they become uncomfortable or distressed. The interviewer/researcher will provide suitable signposting to support organisations for all participants in the study.									
Distress of researcher	The researcher/interviewer is a mental health professional and trainee counselling psychologist currently working in professional practice with extensive knowledge and experience of working with people and specifically in discussing sensitive topics such as mental health. The researcher/interviewer has awareness of support organisations if required. If the researcher/interviewer becomes distressed following an interaction with a participant, the researcher will arrange for a debrief session with a supervisor.	2	1	2	No additional control measures required.				Kieta Bennetts	Ongoing

	If meeting participants in person then the researcher will use a buddy system to ensure their safety and wellbeing										

RISK MATRIX: (To generate the risk level).

Very likely 5	**5**	**10**	**15**	**20**	**25**
Likely 4	**4**	**8**	**12**	**16**	**20**
Possible 3	**3**	**6**	**9**	**12**	**15**
Unlikely 2	**2**	**4**	**6**	**8**	**10**
Extremely unlikely 1	**1**	**2**	**3**	**4**	**5**
Likelihood (L) ↑ / Severity (S) →	**Minor injury – No first aid treatment required 1**	**Minor injury – Requires First Aid Treatment 2**	**Injury - requires GP treatment or Hospital attendance 3**	**Major Injury 4**	**Fatality 5**

ACTION LEVEL: (To identify what action needs to be taken).

POINTS:	RISK LEVEL:	ACTION:
1 – 2	NEGLIGIBLE	No further action is necessary.
3 – 5	TOLERABLE	Where possible, reduce the risk further
6 - 12	MODERATE	Additional control measures are required
15 – 16	HIGH	Immediate action is necessary

20 - 25	INTOLERABLE	Stop the activity/ do not start the activity

Appendix 8 – Examples of stages of analysis/workings out

Example of familiarisation (phase 1)

Familiarisation/noticings/insights

How does a participant make sense of their experiences?

[Pseudonym redacted] describes what sounds like trauma around waiting to know what was 'wrong' with her. She found the physical changes of perimenopause (flooding) to be worrying and distressing. This then impacted on her mental health. [Pseudonym redacted] describes feeling unprepared for these changes and traumatised by the loss of her fertility and questioned her purpose in this life.

Why might they be making sense of their experiences in this way and not another way?

[Pseudonym redacted]'s identity was closely tied with her status of 'mother', and it was traumatic for her to accept another phase of life and she experienced adjustment difficulties as a result. She also experienced quite significant flooding which she didn't feel was 'normal' even for a menopausal woman.

In what different ways do they make sense of the topic discussed?

[Pseudonym redacted] says that she can opt into negative stereotypes of the menopausal woman and acknowledges that the topic is stigmatised, taboo and closely entwined with societal views on aging women with negative connotations. [Pseudonym redacted] also makes sense of this topic through an educator's lens.

How would I feel if I was in that situation? Is this different from or similar to how the participant feels, and why that might be?

I don't think I would personally experience the loss of fertility as strongly due to not having children/not being able to place myself in [Pseudonym redacted]'s shoes, however I can relate to the loss she feels at youth, kind of like the stepping through the portal as she mentions to the unknown which can be understandably scary.

What assumptions do they make in talking about the world?

[Pseudonym redacted]'s assumptions about the world are strongly related to her own identity as mother. She makes assumptions that she won't be accepted in a world with no purpose or meaning.

Example of coding (phase 2) – survey example

Data	Codes
Please can you tell me about how you came to consider that you may be peri/menopausal?	
Very low mood, weight gain, joint pain, night sweats, anxiety, brain fog & poor memory	Mixture of physical and mental health changes Cognitive challenges Weight gain/body image
Can you tell me a little bit about you and your experiences of peri/menopause?	
Awful and when I have spoken with my friends I appear to have more symptoms or more severe symptoms. I felt like I was losing my grip on reality and I felt "fobbed off" by doctors who told me I was depressed. I truly believed I had early onset dementia	Sharing experience with others Comparing self to others I don't recognise myself Dismissed by health profession GP attributed symptoms to depression Worried about serious health conditions
What were your beliefs and understandings of peri/menopause before you started experiencing it yourself? **You might like to discuss how your experiences and understandings have changed over time (if they have)?**	
Very little. I knew about hot flushes but to be honest that was about it	Awareness only of physical changes
How would you describe your mental health during peri/menopause? What has it been like? (You may want to consider any positives and negatives)	
My mental health was badly affected. I felt incompetent in my job , my self esteem and confidence plummeted and I felt suicidal . It has improved since being on HRT. If I hadn't started on that I think was mental health would have worsened further.	Impact on career/work Negative experiences of MH during peri Lack of confidence/self-esteem Suicidal feelings Improvement in MH after HRT
Are there other factors that may affect your experiences of mental health during peri/menopause? If so, can you tell me about them? (You may want to consider life events/transitions that may have contributed)	
None that I can think of	Absence of other factors

Please can you tell me if you have sought any support for peri/menopause or mental health during this time? (You may want to consider your experiences of GP's, other health professionals or services and whether you were able to access the support you felt you needed)	
Yes, I rang my doctor who is female and a similar age to me. I specifically asked to speak with a female doctor, however she told me I was depressed and prescribed me anti-depressants. I asked for a blood test as I thought I could be menopausal. She initially refused saying it was depression however I insisted. I had a blood test & a few weeks later it was confirmed that I was menopausal. I immediately stopped taking the anti-depressants and thought I could handle things but my symptoms and my mental health got worse. After a few months I contacted the doctor and requested that I be prescribed HRT which I have now been on for approx 6 months. It has made a huge difference and the doctor (the same doctor) has been far more understanding & helpful. I felt dismissed and ignored by the medical profession & my employer. I felt invisible you society and of no use. This affected my mental health immeasurably	Gender of doctor GP attributed symptoms to depression Battle to be heard/take seriously Prescribed antidepressants Blood test confirmed perimenopausal status It's menopause, not depression Dismissed by health profession Lack of support at work Feeling invisible Impact of societal discourse
Can you detail your experiences of any medical interventions or treatments (including HRT if applicable) you have received in relation to peri/menopause or for your mental health during peri/menopause?	
I have been using HRT for approximately 6 months and it has improved my mental health. There have been side effects such as quick severe weight gain but I personally feel the benefits outweigh the negatives. I am on HRT patches	Benefits of HRT Side effects of HRT Weight gain
Please could you describe how you have managed your mental health during peri/menopause? (You may want to consider whether you have used personal and practical resources, support strategies and networks etc)	
I don't think I managed it very well at all. Now I am more aware and have researched the menopause I understand it better and I make sure I exercise, watch what I eat and talk more about it, all of which have helped my mental	Own research Exercise Controlling diet Talking helps Support not easily accessible

health. I found that support is difficult to find and it should be more readily available	
Is there anything else that you think is important for me to know about what it is like for you to be peri/menopausal? Please include anything that feels relevant or important to you. This could relate to any changes to your mental health have impacted on your body, your physical wellbeing, your day to day life, your friendships, relationships, and whatever else you feel is relevant.	
My body has changed beyond all recognition and to be honest I hate it. The menopause greatly affected my relationship prior to me being aware that I was actually menopausal. I thought I had early onset dementia and tried to end my relationship with my partner as I didn't want to be a "burden" to him. The menopause has severely impacted my work like as the brain fog, poor memory & lack of confidence made me feel complete incompetent. I felt useless and my employer was not supportive. There has since been a lot of "lip service" but no separate menopause policy has been put in place and I feel it is still a taboo subject	Body image/appearance concerns Impact on intimate relationship Worried about serious health conditions Impact on work/career Cognitive challenges Lack of confidence/self-esteem Lack of support at work Menopause as taboo

Example of initial themes and theme development (phases 3 and 4)

Identifying patterns from codes

Women saying that they no longer recognise themselves, they used to be like this and now they feel like this

Codes:
I don't recognise myself
Old me/new me
Feelings of abnormality
Invisibility
Existing not living

Examples:

[Pseudonym redacted]: "I just find it difficult cause I've been in this weird odd bubble for so long, but I don't know if there is another me outside of that, if you know what I mean. I mean, I'm not me really. I don't feel like me."

[Pseudonym redacted]:: "I feel like I have lost the person I was and hate the person I have become. I wish more was known about the mental health impact of peri/menopausal as I might have been better prepared for the way I feel."

[Pseudonym redacted]: "menopause felt very different- like I had lost my identity and didn't recognise myself. I feel like I have mentally had to grieve for the person I used to be and accept the woman that I have now become because of the menopause."

[Pseudonym redacted]: "I honestly felt I was losing the plot. I often did not recognise the person I was. She was a new character that seemed to take me over."

[Pseudonym redacted]: "I no longer recognise myself, I've got from constant 5/6 gear to struggling to get out of neutral. I'm a completely different person."

[Pseudonym redacted]: "I have experienced what feels like a loss of identity. I don't feel like the same person and this is hard to come to terms with emotionally"

[Pseudonym redacted]: "It makes me sad that I feel like someone other than myself and I behave differently due to this."

[Pseudonym redacted]: "Just don't feel the same person, I was such a glass half full kind of person before this!"

[Pseudonym redacted]: "I feel like I've lost my sense of self, who I am, I look different, I feel different, I'm more cautious, I feel invisible."

[Pseudonym redacted]: "It's exciting and terrifying and exhilarating and joyful and hard work. It's like the adolescence I never really experienced (being too much of a good girl who tried to avoid upsetting people). I feel like who I will be in ten years is not the same person as I am now and the idea of casting off everything I am in order to become whoever is in my future is dizzying."

Development of theme:
Loss of identity?

Example of theme development and theme defining (phases 4 and 5)

Theme 1 -

An “Out of the Blue” Taboo

(taboo, lack of preparedness, sense making, did know physical but not MH aspects, a neglected issue)

A pattern identified across the dataset was the lack of preparedness for peri/menopause and its impact due to factors such as women’s lack of education and knowledge, the topic not being discussed in families and society, expectations of physical symptoms only and the challenges of peri/menopause not being in a woman’s frame of reference when attributing symptoms.

[Pseudonym redacted]: - I had absolutely no beliefs or understandings of perimenopause before I started experiencing it myself. Here in the US, people don't talk about it so I had no idea what to expect.

[Pseudonym redacted]: - I didn't have any understanding of menopause at all.

[Pseudonym redacted]: - I had no idea of what it was about. It was never spoken about by anyone that I knew professionally or personally

[Pseudonym redacted]: I've never given it a thought. I just didn't think ahead to it really. And ‘It was for me, the important bit is when you are a young teenage girl, you have prepared for puberty and what's coming. I felt totally unprepared for what has happened. And it's not something that you talk about very much.

[Pseudonym redacted]: - I hadn't given it too much thought as I didn't expect it to happen at this stage in my life.

Appendix 9 – Thesis Article

A qualitative study exploring women's experiences of mental health during perimenopause and menopause

Abstract

Aims:

The aim of the study was to explore women's experiences of perimenopause/menopause in relation to their mental health for the purpose of developing an understanding of the complexities of mental health during peri/menopause.

Design:

A qualitative critical-realist study design was chosen to explore women's lived experiences of mental health and peri/menopause.

Methods:

Qualitative surveys and semi-structured interviews were utilised to explore the experiences of 80 UK based women. Data from 79 surveys and 8 interviews were analysed using reflexive thematic analysis.

Results:

Four themes were identified. The first theme, '"what is wrong with me?": complexities of sense making', reports on how mental health can be influenced or exacerbated by an absence of education and awareness of perimenopause/menopause. The second theme, '"someone other than myself": crises of identity', highlights the process of identity transition through peri/menopause, illustrating how this adjustment can impact women's emotional and interpersonal experiences. In the third theme, 'the impact of mental health during peri/menopause: "Existing, not living"', women recounted experiences of psychological distress, with some describing its severity, including a small number expressing suicidal ideation. The final theme, 'women's experiences of help seeking: "stuck me on antidepressants"', reports on women's experiences of seeking support for signs and

symptoms associated with peri/menopause, including for their mental health. Three themes contained one subtheme.

Conclusions:

These findings contribute to current understandings of mental health during peri/menopause, underscoring the necessity for increased awareness and education among healthcare practitioners, including counselling psychologists, as well as among women themselves.

Background

Differing Perspectives: biomedical, feminist, psychological, social, and cultural.

Peri/menopause is viewed through various lenses: biomedical, feminist, psychological, social, and cultural (Hunter & Rendall, 2007; Ayers et al., 2011; Hunter & Edozien, 2017). The biomedical perspective often portrays peri/menopause as a biological transition with problematic symptoms (Niland & Lyons, 2011; Orleans et al., 2014; Honour, 2018). Biomedical treatments for peri/menopausal symptoms primarily involve Hormone Replacement Therapy (HRT). It has been shown that HRT effectively addresses symptoms like hot flushes, night sweats, low mood, reduced libido, and vaginal dryness, and may also reduce the risk of cardiovascular disease and osteoporosis (NHS, 2022; Newson, 2016; Baber et al., 2016; Lega et al., 2023). However, despite its benefits, HRT usage remains relatively low due to concerns about its risks (e.g., of breast cancer) (Newson, 2016; Cumming et al., 2015; NICE, 2019).

Critics argue that biomedical perspectives, by focusing on hormones and symptoms, overlook the diverse experiences of peri/menopause, which vary across cultures and individuals (Freeman & Sherif, 2007; Khoudary et al., 2019). This challenges the notion of a universal peri/menopausal experience. However, medical treatments continue to emphasise the biomedical model. Nonetheless, some practitioners advocate for an individualised approach to treatment, acknowledging the limitations of generalised biomedical models (Newson, 2016; Scott, 2018; Roberts, 2007; Burger, 2006). This approach prioritises informed decision-making and tailoring treatment options to women's specific needs (Newson & Panay, 2018).

In recent decades, peri/menopause has undergone a significant transformation in societal perception, shifting from a natural aging process to a medicalised condition (Utz, 2011). Feminist thinkers in the 1990s challenged this medicalisation, advocating for a view that embraces peri/menopause as a normal life stage rather than a deficiency illness requiring medical intervention (Greer, 1991; Klein, 1992; Coney, 1994). However, critics caution against overlooking the biological reality of peri/menopause in favour of ideological perspectives, highlighting potential health risks if women opt out of medical treatments like HRT (Guillemin, 1999; Ussher, 2008; Lupton, 2012). Thus, many contemporary feminist scholars, acknowledging the potential benefits of medical interventions for some women,

have stressed the importance of individualised care, advocating for empowerment and choice in healthcare decisions (Norlock, 2016).

Psychological perspectives on peri/menopause encompass women's attitudes, behaviours, and cognitive responses (Hunter, 2015). Recent studies have explored peri/menopause as a multifaceted bio-psycho-socio-cultural transition, acknowledging the individuality of experiences (Stephens, 2001; Hunter & Rendall, 2007; Ayers et al., 2011; Hunter & Edozien, 2017). Thus, peri/menopause is understood to be influenced by intrapsychic factors like self-esteem and cognition (Ussher, 2000; Leary et al., 2015; American Psychological Association, 2018), as well as interpsychic factors including interpersonal relationships and social support (Bolognini, 2004). While earlier writings portrayed peri/menopause as traumatic (Deutsch, 1945), contemporary psychological understandings offer a more nuanced view, acknowledging the impact of biological, social, cultural and psychological factors on symptom experience.

Cultural and social factors can also be said to intricately shape women's experiences during peri/menopause. Several studies reveal diverse experiences across cultures, with some viewing peri/menopause positively as a transition to heightened status (Berterö, 2003; Jones et al., 2012), while others stigmatise it as a period of physical decline (Vogel & Wade, 2022; Snowdon et al., 2022; O'Reilly et al., 2022). Negative views are associated with increased symptom reporting, highlighting the interplay between societal representations and individual experiences. In addition, social factors, including socioeconomic status, access to healthcare, and social support networks, have been shown to influence women's overall wellbeing in this period (Freeman & Sherif, 2007; Hickey et al., 2022). Disparities in healthcare access due to financial constraints (Namazi et al., 2019), for instance, as well as the challenge of balancing familial and work responsibilities during midlife have been found to impact women's experiences of peri/menopause (Dare, 2011; Dillaway, 2020; Thomas et al., 2023). These findings underscore the importance of social support from intimate partners, family, and workplace environments (Hardy et al., 2018); Koch & Mansfield, 2004; Erbil & Gümüşay, 2018).

Studies of Mental Health during Peri/Menopause: Qualitative and Quantitative

Qualitative literature on mental health experiences during peri/menopause is sparse but crucial for understanding women's experiences during peri/menopause. Previous studies have explored how women's experiences are often constructed through the lens of pre-

existing conditions, such as bipolar disorder or autism, influencing how they perceive and discuss peri/menopausal challenges (Perich et al., 2017; Moseley et al., 2020). For instance, women in Perich et al's (2017) study described mood changes using existing discourses surrounding bipolar disorder such as "my lows are much lower" (Perich et al., 2017, p. 3). These findings indicate that some women with diagnosed mental health or developmental disabilities conditions may have similar experiences to those without formal diagnoses, but they are often heightened or seen through the lens of their pre-existing conditions.

Other qualitative studies have explored women's experiences of distress during peri/menopause and found it can be influenced by societal norms and personal identities. Nosek et al. (2010) conducted a narrative analysis study to examine women's experiences during peri/menopause and found that women experienced shame, embarrassment, and stigma as manifestations of distress in relation to outwardly expressed signs and symptoms as well as prevailing social and cultural discourses on peri/menopause and aging. Another study concluded that distress related to both biological and social aspects of experience, including the ending of reproductive, sexual, and other identities (de Salis et al., 2017). Reproductive identity has also been associated with distress in women experiencing premature peri/menopause (Singer, 2012). Other qualitative studies attributed distress to factors mirrored in the wider literature such as 'uncertainty about changes' around diagnosis and challenges identifying the origin of their difficulties related to the lack of available information and knowledge around peri/menopause (Dillaway, 2020; Karavidas and de Visser, 2021).

Additionally, research has also found that symptoms compatible with psychosis can present for the first-time during peri/menopause (e.g., visual and audible hallucinations, delusions and disorganised thoughts) (Crow & Jasberg, 2016). For women with an existing diagnosis of schizophrenia, some may also see their symptoms worsen and become resistant to medication at this time (Seeman & González-Rodríguez, 2018). These findings align with various quantitative studies investigating the prevalence of psychosis in the population which have found that in women the risk of psychosis increases during midlife and that this may be attributed to the reduction in oestrogen levels caused by peri/menopause (Kirkbride et al., 2012; Ochoa et al., 2012; Usall & Huerta-Ramos, 2016).

The impact of peri/menopause on mental health has been studied quantitatively but results have been mixed, with some studies indicating a link between this phase of life and mental health (illness or disorder) (Schmidt et al., 2000; Cohen et al., 2006; Freeman et al., 2006) and others suggesting there is no clear evidence for these claims. Historically, women's

experiences during peri/menopause were pathologized and myths and misconceptions surrounding women's 'madness' were perpetuated through various clinical and societal lenses (Ussher, 2011), contributing to the concept of "reproductive depression" attributed solely to hormonal changes (Studd and Nappi, 2012). Some quantitative studies suggest distinct mental health experiences during peri/menopause, including reduced ability to feel pleasure and heightened risk of depression and anxiety (Öztürk et al., 2006, Kulkarni, 2017). However, other research disputes a direct link between hormonal changes and mental health disorders, advocating for an understanding of mental health as influenced by biological, psychological, social, and cultural factors (Hunter, 2015).

Treatment

Therapeutic approaches like Cognitive Behavioural Therapy (CBT) adapted for peri/menopause have shown effectiveness in reducing symptoms such as hot flushes and mild depressive symptoms (Donegan et al., 2022). However, few women seek psychological support specifically for peri/menopause-related symptoms (Huang et al., 2023), often due to lack of awareness or attributing symptoms to other factors. Alternative approaches emphasise addressing broader psychological, emotional, social, and cultural factors, supporting women in processing feelings of loss, and interpersonal challenges (Hinton, 2013). Psychosocial interventions like yoga, mindfulness, and lifestyle changes have also been promoted as alternatives to medical treatment, showing potential in reducing peri/menopausal symptoms (Hunter, 2019; Johnson et al., 2019; Cramer et al., 2012; Susanti et al., 2022; Sood et al., 2019). However, the lack of available literature and guidance may pose challenges for professionals supporting women during this life phase.

Methodology

Research Design:

A qualitative methodology was chosen for this research because it not only provided a data set that allowed for a rich and detailed examination of the experiences and perspectives of peri/menopausal women (Willig, 2012), but also gave direct voice to the participants of the study. The depth and detail of lived experiences revealed through qualitative analysis cannot be adequately conveyed through statistical and numerical quantitative research analysis (Hancock et al., 2001).

Method

Qualitative surveys and semi-structured interviews emerged as the most suitable research methods due to their flexibility, ability to inform one another, and suitability for probing personal narratives and sensitive/taboo subjects in the matters of peri/menopause and mental health research (Dearnley, 2005; Braun & Clarke, 2021; Terry & Braun, 2017). These methodological choices were grounded in the need to ensure that participants were comfortable sharing their experiences and that the research captured the richness and depth of their experiences.

Ethics:

Ethical approval for this research has been obtained from the University of the West of England, Faculty Research Ethics Committee (FREC). Participants were informed of the potentially distressing and sensitive nature of the topic in the Participant Information Sheet prior to taking part and were advised that they must have the capacity to consent for themselves to be eligible to participate. Participants were then required to provide their informed consent via an online consent form on Qualtrics. Participants were informed that deciding not to take part or withdrawing from the study would not incur any penalty or affect their relationship with any of the organisations used to help recruit for this study.

Participants:

A purposive sampling method was used to recruit for this study. Permission was sought to recruit via Menopause Cafés (https://www.menopausecafe.net) and the Menopause Matters online support forum. The details of my study were shared by these platforms and were

further circulated by social media users to other internet sites/forums which allowed me to successfully recruit for this research.

This study explored the experiences of 80 participants. Among them, 79 participants completed qualitative surveys, and out of those, seven also participated in interviews. Additionally, one participant completed an interview only. All participants identified as female/women. Most participants identified as heterosexual, white British, married, or otherwise coupled, and employed with an educational level of GCSE/O level/AS/A levels and above.

The inclusion criteria stipulated that women must be over the age of 18 years and self-report as peri/menopausal. Women were invited to self-report peri/menopausal status because some women may choose not to seek a clinical diagnosis while others struggle to be taken seriously by their GPs, particularly in the context where there are uncertainties around definitions and phases of the menopause transition.

Data Analysis:

Braun and Clarke's most recent approach to thematic analysis, 'Reflexive Thematic Analysis' (RTA), was the analytic method used in this study (Braun and Clarke, 2021). This form of analysis is used widely for "developing, analysing, and interpreting patterns across a qualitative dataset, which involves systematic processes of data coding to develop themes" (Braun & Clarke, 2021, p. 4). A six-step analytic process was undertaken guided by Braun and Clarke's (2006, 2013) guidance for using reflexive thematic analysis.

Results and Analysis

Theme 1 - "What is wrong with me?": Complexities of sensemaking

This overarching theme captures the insights of peri/menopausal women who experience challenges with their physical and mental health but lack the contextualising lens of peri/menopause to help them make sense of their experiences. Participants expressed a lack of awareness, attributing signs and symptoms to serious illness, as described by Marns who said, "I thought I had early onset dementia; it was very frightening" which was echoed by Chip, "the worst bit was being undiagnosed and thinking I was terminally ill with a rare illness". These experiences suggest that by not having peri/menopause as a frame of reference to aid understanding, women's mental health can be negatively affected.

Participants expressed the importance of having education and knowledge to make sense of experiences. Susette stated, "if you've got a bit of education and you think, 'well, this is because of this', you don't tend to think 'what's wrong with me, why do I feel like this'?", suggesting that awareness enabled her to better understand her experiences. Despite this, many women found that their attempts to seek more information through their GPs were futile. Tracy said she felt "fobbed off by doctors who told me I was depressed". Many women spoke of uncertainties and distress associated with delayed recognition of their signs and symptoms. Rachelrose spoke of exhaustion and anxiety, which she said led to "more anxiety about my health and a lot of hypochondria about having a terrible illness like cancer or dementia". This heightened anxiety aligns with Sweeny's (2018) concept of 'existential discomfort', in which uncertainty and lack of control contribute to stress and anxiety. These women's narratives underscore the impact of uncertainty on mental health during peri/menopause.

Sub-theme: "Out of the Blue": Preparing for the unexpected

Across the dataset was a sense of how women felt unprepared for peri/menopause and its impact, often due to a lack of awareness, knowledge, education, and societal discussions on the topic. Women described the suddenness of peri/menopause who felt it hit "like a ton of bricks" (Wakeyee) leaving them "totally unprepared" (Ceilidh). Karen said she "thought it was hot flushes when periods stop" and this was agreed by MaryM who "originally thought it would be just hot flushes and nothing else", indicating that women's understandings were

often limited to a small range of physical symptoms, resulting in a lack of awareness of the possible broader signs and symptoms associated with peri/menopause, especially in relation to mental health.

Kathy specifically highlighted the lack of preparedness around mental health challenges during peri/menopause when she explained, “I didn’t realise menopause can affect mental health”. This was echoed by Nickys71 when she said, “I wish more was known about the mental health impact of peri/menopause as I might have been better prepared for the way I feel”. Whilst experiences of peri/menopause may differ between individuals and many women will not experience mental health challenges during this life phase, a comprehensive awareness of the possible impact of peri/menopause would be advantageous for women as it would go beyond mere biomedical/physical understandings.

This study found that peri/menopause is both inadequately addressed in educational settings and remains “unspoken” (Yeedonissa) within families due to societal taboos which further impact women’s knowledge and understandings. June, for instance, reported that her “mum was of a generation that didn't like to talk about 'women's troubles'” and Vickyjo expressed feeling “embarrassed about being perimenopausal” indicating that associated stigma may hinder open discussions on peri/menopause.

Overall, this subtheme emphasises how a lack of education and discussion, in both private and public spheres, can contribute to further deepening the sense of unpreparedness for peri/menopause felt by many women upon the arrival of its associated signs and symptoms, underscoring the need for increased awareness and open communication of peri/menopause.

Theme 2 - “Someone other than myself”: Crises of identity

This theme explores crises of identity experienced by women during peri/menopause, instigated by peri/menopausal symptoms. Alice’s comment encapsulated this: “I feel like I’ve lost my sense of self, who I am, I look different, I feel different, I'm more cautious”. Similarly, Sam echoed these feelings of estrangement from her previous identity when she said, “I want my life back; I want to find me again”.

The loss of one identity and transition to another, for some, is reported to be a challenging and distressing experience. Some participants expressed mourning for a past identity: “I had lost my identity and didn’t recognise myself. I have mentally had to grieve for the person I used to be” (Jens). Women’s discussion of the absence or loss of identity, through to the process of adjusting to a new ‘self’ are important factors in understanding the

complexities of mental health experience during peri/menopause, especially in the context of a lack of knowledge and support. This is also important for counselling psychologists who support individuals to process such experiences of shifts in identity through therapy.

Roger's (1961) theory of personality highlights how societal discourse, gender, and social identities as important factors in shaping self-concept. Several women in this study linked their mental health challenges during peri/menopause to a loss of identity tied to motherhood. Peri/menopause marks the end of women's ability to conceive naturally, which, for many, has various emotional implications. JK, for instance, articulated how her identity is deeply connected to motherhood and fertility, stating: "Motherhood is a huge part of my identity; the role defines me, and letting go of my fertility has been traumatic". This is consistent with a study by de Salis et al (2018), which suggests fertility is intrinsically linked to female identity and peri/menopause is often viewed as the indicator of the loss of this part of them.

Many women spoke of cognitive changes, including memory and concentration issues during peri/menopause. Others of dissatisfaction with their appearance and changes to their bodies. Mrs G., for instance, discussed her loss of confidence, sharing having "had to put in place all sorts of measures just to navigate daily life" in order to mitigate "the forgetfulness and word blindness" that she initially thought was a sign of early onset dementia. She added: How do you explain finding the TV remote control in the fridge to your husband?

Pauline reported "struggling to be positive with my weight gain and body image", while Wakeyee said they "hate what it has done [to] my body". For many women in this study, having to adjust to such changes, cognitive and physical, caused psychological distress. For many, the impact of changes to their body during peri/menopause extends beyond self-perception, with concerns about the effects on their intimate relationships, even partners' fidelity. Participant Daisy reported, "It's difficult to have any interest in sex when you are not feeling good about yourself. This can be detrimental to relations with my husband". The challenges women may face in navigating sexual relationships and intimacy during peri/menopause is consistent with previous findings (Hinchliff et al., 2010).

Overall, the theme highlights the challenges, trepidation, fear, and disorientation women can often face during peri/menopause as they grapple with adapting to a new identity, alongside the anticipation of transitioning into a future self.

Sub-theme: "Flying off the handle": Jekyll and Hyde

This subtheme reports women's experiences of their shifting identities and feeling like someone *other* than themselves during peri/menopause. Women described being "hijacked" (June) or encountering an imposter: "She was a new character that seemed to take me over" (Ann77), akin to a "Jekyll and Hyde" dynamic where their peri/menopausal selves occasionally take control. Women's struggles with unpredictable moods, emotional dysregulation, and anger strained their relationships with family, friends, and broader social networks.

Women described feeling "irritable", "less patient" (Pauline) and "short-tempered" (Leah), feelings that were unfamiliar compared to their premenopausal selves. These changes often manifested in ways that made them feel like strangers to themselves: "it makes me sad that I feel like someone other than myself and behave differently due to this" (Jean). This led to feelings of disconnection, confusion, and distress. Women also described fluctuating emotional states, including rage and a lack of control over their emotions which affected their relationships. Wakeyee described, "for me, it was the anger, the anger issues. I, oh, I was flying off the handle. I couldn't keep my temper under control". Some women expressed concern at their unacceptable expressions of emotion/anger would impact on their close relationships. This, in some cases, led to isolation. Partners and children were witness to these emotional shifts and were considered as collateral damage as peri/menopause was not only misunderstood by women, but also those closest to them.

While most feared expressing unacceptable emotions, others gave themselves permission to express themselves authentically. For example, Emmylou described an alternative perspective on rage, stating, "rage. So much rage. But I feel like it's warranted and has been bottled up inside me for my whole life. Being able to express it can be joyful". This suggests that expressions of emotions are not necessarily problematic but rather societal discussion around rage and emotional dysregulation among women during peri/menopause itself is questionable, since they reflect longstanding gendered stereotypes of 'hormonal women' in popular culture (Chrisler, 2013).

In summary, the experiences discussed in this subsection resonates with the overall themes of identities in crisis, interpersonal strain, and mental health challenges, as women confront shifts in mood, behaviour, and sense of self during peri/menopause. The dichotomy between their familiar selves and out of control emergent selves can cause feelings of

confusion, disorientation, and disruption, which may contribute to or exacerbate mental health difficulties for some women.

Theme 3: The impact of mental health during peri/menopause*:* "Existing, not living"

This theme focuses on women's experiences of navigating mental health challenges during peri/menopause, shedding light on how these challenges can diminish women's ability to live their lives with a sense of purpose and fulfilment. While some used familiar terms like "anxiety" and "depression" to describe their mental health, their narratives unveil a more granular level of distress. Many women reported a disengagement with experiences that give life its richness and finding themselves trapped in a cycle of "existing, not living".

Several women described a sense of a "loss of meaning" (Doris), joy and fulfilment in their lives. Some longed for their premenopausal selves: "I want my life back" (Sam) and others described an emotional dampening, numbness, and a diminished sense of pleasure, feeling unable to experience joy or sadness, existing in a state of emotional suspension. A previous study by Öztürk et al. (2006) mirrored these findings, identifying a decline in pleasure among women due to hormonal changes during peri/menopause, a phenomenon they termed as anhedonia.

Women also reported challenges in daily functioning and performing everyday tasks. For some, this was severe and "debilitating" (June), as they found themselves "barely functioning" (Bird) and feeling "constantly overwhelmed" (Louise2) by everyday life. These challenges extended beyond personal distress, impacting both their personal and professional lives. For instance, women described withdrawing from social activities, while others grappled with heightened social anxieties and strained relationships. These challenges strained familial bonds, leaving women feeling isolated and misunderstood within their own families. These women's stories not only articulate how peri/menopausal symptoms can disrupt and reshape interpersonal relationships with consequences across personal, private, and professional spheres, but also have far-reaching mental health implications.

Sub-theme: "And it was my friend who said, 'Oh my God, have you felt suicidal?!'": The severity of distress during peri/menopause

This sub-theme underscores the severity of distress experienced by some women during peri/menopause, with distress for some reaching such severity that suicidal ideation was discussed. More than half of the women in this study reported negative experiences of mental health during peri/menopause. Additionally, several participants expressed concerns that their mental health challenges were dismissed or attributed to other causes by health professionals, emphasising the importance of addressing these aspects of peri/menopausal experience to prevent potential harm.

Some women expressed experiencing "severe low mood" during peri/menopause, emphasising the significant impact on their lives. Depression during peri/menopause is often under-recognised (Kulkarni, 2018), leading to challenges with diagnosing and addressing mental health aspects of peri/menopause experience. Lou described her emotional state as "to a point of no longer wanting to exist", underscoring the depth of distress experienced by some women. A few women described feeling "suicidal". Similarly, Pauline recounted a distressing conversation with a friend:

> [I had] a feeling of, you know, it was just real anxiety. Well, what now I know was anxiety, mind race and stuff like that, so I wasn't sleeping properly. So, I thought, right, I've just gotta go. And it was my friend who said, oh my God, have you felt suicidal? She just came out and asked me and I realised, yeah, I did.

While there is research on depression during peri/menopause, research on suicide or suicidal ideation in this context remains limited. However, a few women reported distress to the extent of suicidal ideation or suicidality, shedding light on their despair. Notably, the women in this study frequently cited a myriad of distressing factors contributing to their emotional state such as domestic abuse, bereavement, physical health factors, historic or pre-existing mental health difficulties, work-related stress, misattribution to illness and family issues amongst others.

As these accounts suggest, the emotional distress experienced by women during peri/menopause can be severe and multifaceted. Without adequate knowledge and understanding, women may find themselves navigating these challenges without a clear contextualising framework, potentially resulting in severe emotional distress that can escalate to suicidal ideation.

Theme 4: Women's experiences of help-seeking*:* "Stuck me on antidepressants"

This theme discusses women's encounters with support and 'treatment' for mental health challenges during peri/menopause, especially when misinterpreted or misdiagnosed by health professionals. As Lou explained, "I eventually went to the GP whose immediate response was antidepressants", while others felt "fobbed off" (Tracy) or "totally dismissed" (Sandra). Other participants reported dissatisfaction with antidepressants, suggesting that alternative treatments like counselling or HRT might offer more effective relief.

Several participants shared their uncertainties about attending the GP. Pauline felt the "GP has no interest in or understanding of what I'm going through" and others reported that their concerns were trivialised when they finally found the courage to attend. Others described a lack of autonomy when it came to treatments decisions:

> [I was] not depressed (I've been there, I know what that feels like). Still I had to try the anti-depressants, the GP said to give them a few months, I really didn't want to take them but wasn't offered a choice at that time. (Maisy)

Several women expressed fears of taking HRT, citing concerns about its risks as well as a lack of information. As Vickjo explained,

> And I think the education side of it, its raising awareness, but it's about HRT because I was so scared of it. I really was. And I was just like, oh God, it's there. I can't do it. Cause you know, I will get cancer.

Despite these concerns, as well as uncertainties around the efficacy of HRT, many women described positive outcomes, such as reduced anxiety and improvements in their mood. Others also described positive interactions with their GPs, describing them as "extremely supportive" (Jo) and "amazing" (EmmyLou). Some also suggested that antidepressants were helpful for their individual circumstances: "Put me on the antidepressants and thank goodness, I'm sleeping now, and the anxiety is back under control" (Wakeyee). Overall, these findings underscore the need for individualised support and treatments for women, as well as more training and education for health professionals.

Discussion

These findings suggest a widespread lack of knowledge and understanding of peri/menopause, due to limited discussions within families and mainstream education, possibly reflective of societal stigma. The findings align with previous studies that peri/menopause is largely unspoken (Sergeant & Rizq, 2017), indicating that need for open communication intergenerationally and in educational settings. Education on peri/menopause, and its possible mental health implications is recommended, both for professionals, as well as in mainstream educational settings.

The exploration of identity in this study is novel, in that it considers the interplay between women's identity, psychosocial factors, self-concept, and mental health. This challenges less sophisticated portrayals of identity during peri/menopause. Instead, this current study paints a more complex picture of mental health during peri/menopause which looks beyond mere biological factors underpinning mental health difficulties.

Furthermore, the study shows the critical nature of women's distress during peri/menopause, urging health professionals to take mental health concerns seriously, especially given reports of misdiagnosis and suicidal ideation. This aligns with previous research highlighting barriers to suitable support for reproductive health difficulties (British Menopause Society, 2023; Newson & Panay, 2018). Women's reports pertaining to a lack of control and autonomy over their bodies and treatment decisions was a novel finding in this study because research is limited on women's experiences of healthcare during peri/menopause.

The findings underscore the complex and multifaceted nature of women's mental health experiences during peri/menopause, influenced by biological, psychological, social, and cultural factors. Counselling psychologists can play a part in untangling these complexities, although this support may not currently be accessible through NHS services. They emphasise the individuality of these experiences and the need for inclusive and accurate sources of information that relate to a broader population of women. Flexible, client-led approaches are recommended, acknowledging the diverse experiences of peri/menopause.

Conclusion

This study provides an insight into women's experiences of mental health during peri/menopause that moves beyond reports of symptomology. This study also highlights the complexities and challenges of disentangling mental health difficulties caused by hormonal changes from other psychological, social, and cultural factors that often impact women during this phase of life. It is hoped this study will contribute to the current literature on peri/menopause and highlight the need for further education and awareness of peri/menopause.

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