The mental health challenges, especially suicidality, experienced by women during perimenopause and menopause: a qualitative study.

Olivia Hendriks, BSc (Hons) MSc. Research Fellow, School of Psychology, Liverpool John Moores University, UK. ORCID ID 0009-0005-0990-318

Jason C. McIntyre, BSc (Hons) PhD FHEA. Senior Lecturer in Psychology, Liverpool John Moores University, UK. ORCHID ID 0000-0002-5601-524X

Abigail K. Rose, BSc DPhil. Reader in Psychology. School of Psychology, Liverpool John Moores University, UK. ORCHID ID 0000-0003-3267-7318

Clair Crockett, BSc (Hons) MBChB DRCOG MRCGP DFSRH. GP and Menopause Specialist, Newson Health Menopause and Wellbeing Centre, Stratford-Upon-Avon, UK. ORCHID ID 0009-0001-7207-3490

Louise Newson, BSc (Hons) MBChB (Hons) MRCP FRCGP. GP and Menopause Specialist, Newson Health Menopause and Wellbeing Centre, Stratford-Upon-Avon, UK. ORCHID ID 0000-0002-6756-3823

Pooja Saini, BSc (Hons) MSc PhD CPsychol FHEA. Professor of Suicide and Self-Harm Prevention. School of Psychology, Liverpool John Moores University, UK. ORCID ID 0000-0002-4981-7914

Corresponding author

Olivia Hendriks

Email: o.j.hendriks@2022.ljmu.ac.uk

Abstract

Background

Menopause, characterised by significant hormonal changes, can greatly impact mental health. While physical symptoms are well-known, the psychological effects, particularly suicidality, are underexplored. Suicide rates among women aged 45-55, the typical menopausal transition age, are notably higher, potentially linked to hormonal fluctuations that affect mood regulation. Despite this, little qualitative research exists on the relationship between perimenopause and mental health challenges, including suicidality.

Objectives

This study explores the mental health challenges, especially suicidality, experienced by women during perimenopause and menopause. It seeks to understand the factors contributing to these experiences and the role of healthcare in addressing them.

Design

Qualitative semi-structured interviews explored women's experiences of perimenopause and menopause, with a particular focus on mental health challenges including suicidality. The interviews were conducted and spanned from March 2023 to February 2024.

Method

Semi-structured interviews were conducted with 42 women, recruited from a private menopause clinic and the general population. Interviews, lasting 30-45 minutes, explored participants' mental health experiences during perimenopause and menopause. Data were analysed using reflexive thematic analysis, with NVivo 14 used for data management.

Results

Participants reported varying degrees of suicidality, from abstract thoughts to suicide attempts. Feelings of hopelessness and entrapment were common triggers. Delays in receiving appropriate hormone replacement therapy (HRT) and misdiagnoses, such as being prescribed antidepressants instead of HRT, worsened symptoms. Women reported significant improvements in mental well-being after receiving timely HRT. Peer support and lifestyle changes were also identified as beneficial.

Conclusions

Improved training for healthcare providers, timely HRT access, and holistic care are crucial for addressing perimenopausal mental health challenges. Women's Health Hubs, as outlined by the Women's Health Strategy for England, offer a potential solution for integrated care.

Keywords: menopause, suicidality, hormones, mental health

Introduction

Menopause, marked by significant hormonal shifts, is a critical phase in the female lifespan that can profoundly affect mental health [1]. While physical symptoms such as hot flushes and sleep disturbances are well-documented [2], the psychological impact remains underreported. Available statistics from the UK, USA and Australia illustrate that suicide rates amongst women are more frequent around the age (i.e., 45 – 55 years) of the menopausal transition [3] [4] [5], suggesting that mental health issues are particularly significant during this period. The limited research in this area indicates that menopause is characterised by decreasing or fluctuating oestrogen and progesterone levels, and suicides in women tend to cluster around these hormonal states [6], potentially via lower hormone activity reducing serotonergic function [7]. However, issues of suicidality and potential mediating and protective factors have not been adequately examined in existing research.

The current research primarily focuses on the biological and psychosocial aspects of perimenopause – the few years leading up to menopause [8] – as research has suggested that suicide risk can be more pronounced during this period [9] [10] [11] [12]. It is important to consider that the field of perimenopause and suicidality is complex and multifaceted, and is potentially related to hormonal changes, mental health history and social factors. However, there is a paucity of qualitative research on mental health challenges during perimenopause despite the benefits of phenomenological research in health care [13]. The significance of understanding the lived experiences of women and those around them can shed light on the factors contributing to suicidality during perimenopause and help identify

specific needs that may be overlooked in general mental health care. Furthermore, it is crucial in developing tailored mental health interventions unique to this life stage. Therefore, this study aims to explore the experiences of severe mental health issues particularly suicidality among women who are currently going through or have previously experienced perimenopause or menopause.

Method

Design

Qualitative semi-structured interviews explored women's experiences of perimenopause and menopause, with a particular focus on mental health challenges including suicidality. The interviews were conducted online to enhance accessibility, accommodate participants from diverse geographical locations, and provide a comfortable environment for discussing sensitive topics. The interview period spanned from March 2023 to February 2024. We employed a qualitative methodology to capture women's experiences in more depth and detail than previous quantitative work in this area. The consolidated criteria for reporting qualitative research (COREQ) checklist [14] was used to ensure we had covered all the appropriate elements necessary for a rigorous study.

Participants

A total of 42 women participated in the interviews. Seventeen of these women were patients of a private menopause clinic, and the remaining 25 were recruited from the general population through an advertisement posted on social media. This sampling method aimed to reduce potential bias and ensured more diverse perspectives. Menopausal status was determined through self-report. While sociodemographic details such as age, education level, and family situation were not systematically collected, participants were recruited from diverse backgrounds, including those accessing specialist menopause healthcare services and those from the general population. This approach ensured a range of perspectives on menopausal mental health challenges, though it does limit the ability to analyse differences based on sociodemographic factors.

The key themes identified in the study were consistent across both recruitment groups. To be eligible, women had to self-report current or previous experience of perimenopause, and must have faced mental health struggles, specifically suicidality or self-harming behaviours. Each participant received a £10 Love2Shop voucher as compensation for their time. While monetary incentives can enhance recruitment and engagement, they also carry potential risks of response bias, social desirability bias, and undue influence, which were carefully considered to ensure ethical and authentic data collection [15].

Materials

An interview schedule was used as an aid in exploring women's experiences. The questions were open-ended and organised around the key themes of: 1) general experiences of perimenopause or menopause; 2) support for managing suicidal thoughts or self-harm in the context of healthcare interactions; 3) comparison of suicidal ideation over time; 4) external support sought for mental health issues; and 5) additional insights or reflections on their experiences.

The research question was developed through a collaboration involving clinicians, researchers, carers and people with lived experience. People with lived experience were women who had personal experience of being in a suicidal crisis or had a suicide attempt or those who had been bereaved by a female suicide. Members of the group were involved in reviewing study materials and agreeing plans for the dissemination of the study to ensure that the findings are shared with wider, relevant audiences within the field.

Procedure

In the private menopause clinic, participants were invited to join the study at the end of their appointments and given the primary researcher's email to express interest. Those recruited via social media were similarly instructed to contact the researcher. After expressing interest, participants received the participant information sheet via email. Audio-recorded verbal consent was obtained before interviews, with participants informed they could pause or withdraw at any time. The rationale for obtaining verbal consent instead of

written consent was to increase accessibility and participant comfort, particularly given the sensitive nature of the study topic. Verbal consent allows for greater inclusivity, especially for participants who may feel uncomfortable signing formal documents related to their mental health experiences. Additionally, conducting interviews remotely meant that obtaining written signatures could have created logistical barriers.

To ensure well-being, participants were given the research team's contact details, and those who found the interview topics particularly distressing were offered a debrief session with a clinician from the specialist menopause clinic. While this was not a structured psychological intervention, it served as an immediate support mechanism to mitigate potential distress and ensure participants were not left feeling overwhelmed following their participation. All interviews were conducted one-to-one via Microsoft Teams, lasting 30-45 minutes. Interviews were conducted until data saturation was reached, meaning that no new themes or perspectives emerged in the later interviews, ensuring a comprehensive understanding of participants' experiences.

Data analysis strategy

The interviews were transcribed and analysed using Braun and Clarke's updated reflexive thematic analysis framework [16]. Key phases, included familiarisation with the data, generating codes, constructing themes, reviewing and defining themes, and writing up the results. Reflexivity was integral, with researchers actively reflecting on their own biases, assumptions, and positionality to prevent undue influence of the analysis. A hybrid approach combined a deductive framework to guide initial coding while remaining open to inductive insights that emerged from the data. After identifying and refining the codes, they were grouped into broader themes that encapsulated significant patterns across the dataset. Themes were collaboratively reviewed and agreed upon by the research team to ensure rigour. Data management and analysis were facilitated using NVivo 14 software [17].

Results

Forty-two women volunteered and took part in the study. All had experienced suicidality (i.e. suicidal thoughts, and/or behaviours, including self-harm) and most (95%, n = 40) had seen their general practitioner (GP) or a specialist for their symptoms. Participants reported severe mental health challenges during menopause, with 19 expressing a general sense of not wanting to be alive. Suicidal ideation was described by 12 women, seven of whom had both the means and motivation to act, while eight had self-harmed, and eight had attempted suicide. Only three had a prior history of suicidality.

Depression and anxiety were widespread, affecting 36 and 34 participants, respectively, while four experienced psychotic symptoms. Notably, only seven had a history of depression, and six had prior anxiety, suggesting these symptoms were new for most. Accessing care was a struggle, with 29 facing GP resistance and 14 experiencing delays in treatment. Of those who received treatment, 32 found HRT effective, while eight did not. Antidepressants were beneficial for only five, with 14 reporting no improvement. Lack of awareness was a key issue, as 26 participants did not initially recognise their symptoms as menopause-related, and 24 had to educate themselves. Many endured prolonged distress and misdiagnosis before identifying hormonal changes as the root cause.

The thematic analysis process [16] applied to the transcripts elicited key concepts evident in the data. These themes are essential in understanding the perimenopausal experience, from pre-diagnosis to post-treatment. The categories have been split into “Symptomology of Perimenopause: Cyclical Patterns, Physical Discomfort and Psychological Distress”, “You’re Just Dying Inside; What’s the Importance of Living?” and “Treatment: What Works and What Doesn’t” (See Figure 1).

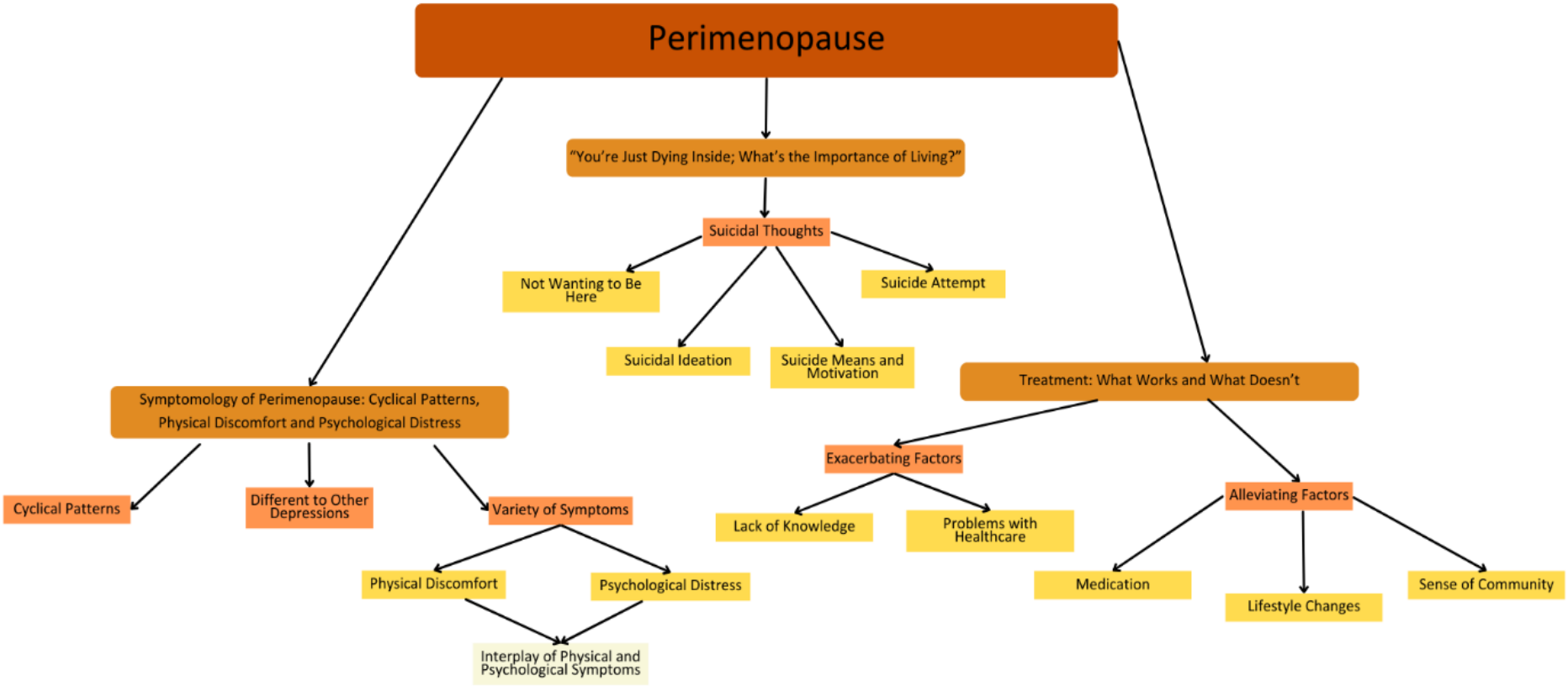

Fig 1. A thematic analysis map describing the themes and subthemes.

Symptomology of perimenopause: cyclical patterns, physical discomfort, and psychological distress

Cyclical patterns

In the interviews, women marked perimenopause by the interplay of physical and psychological symptoms, several of which they claimed to occur cyclically which may be related to hormonal fluctuations in the body. Women frequently reported that these symptoms intensified during the luteal phase of their erratic menstrual cycle, typically what would have been a week before their menstruation began:

"Particularly just before my period… I'd be getting quite intrusive suicidal thoughts" – Participant 9.

The wide and cyclical nature of these symptoms can be both predictable and disruptive, ranging from physical discomfort to severe psychological distress typically aligned with the menstrual cycle.

Physical discomfort

Among the most commonly reported physical symptoms of perimenopause were hot flushes – sudden, intense waves of heat that disrupt daily activities and sleep patterns. These episodes of overheating are often coupled with night sweats, leading to insomnia:

"They're very severe… I would have my bed sheets soaked… it felt like I was going to die from the heat" – Participant 14.

The hot flushes were reported by women to be tied to an increase in anxiety, which further complicated their ability to sleep. Alongside these temperature fluctuations, women reported experiencing musculoskeletal pains and body discomfort, which also prevented a restful sleep and subsequently caused fatigue:

"I've been parachuted… from being fit and healthy and active to being a decrepit, tired, old lady full of aches and pains" – Participant 30.

Psychological distress

The psychological symptoms of perimenopause are often just as debilitating as the physical ones, manifesting in a wide variety of ways. Several women reported a unique form of depression that differed from bouts of depression they had experienced pre-perimenopause. For instance, they retained energy, could function in daily life, and were clearly aware of their emotional state, recognising that something felt inherently abnormal. Additionally, they noted that their depressive symptoms emerged despite the absence of external stressors or significant life challenges. However, few noted similarities between the perimenopausal episode of depression and depression caused at other times of hormonal fluctuation, for instance during the luteal phase of the menstrual cycle when diagnosed with PMDD or postnatally but *"way worse".* This perimenopausal depression was also characterised by extremely low mood, a sense of fatigue, feelings of uselessness or being a burden to others. A sense of despair also characterised it, as few women believed that they had nothing left to offer. They were questioning their value and purpose and felt as though their life was effectively over:

"What's the point in being alive? What purpose, what function do I have? I've got nothing left to give, nothing left to contribute. Why am I still here?" – Participant 30.

Several women were confused by their feelings because they could see nothing wrong in their lives. Yet, despite the absence of obvious stressors, they found themselves overwhelmed by feelings of irrational sadness. One participant recalled feeling out of place in a psychiatric hospital because her life seemed stable and fulfilling, and her issues did not align with the challenges typically discussed in psychological therapy:

"I just didn't have anything to say [in therapy]… I felt ridiculous because everyone I was surrounded by had these huge life problems, and I was just like… I love my husband, I've got three great kids and I'm really enjoying my life. And they said I wasn't being honest. Sometimes I tried to make things up so I had something to say" – Participant 3.

Mainly, what sets this form of depression apart from clinical depression seems to be the awareness women maintain while experiencing it. Despite their emotional struggles, they understand that their mood shift is hormonally driven; a level of rational insight that isn't

typically present in traditional depressive episodes. However, with this brings a sense of powerlessness, as women are aware of their emotional descent, but feel unable to stop it:

"I believe the drop in oestrogen had caused issues with my brain. I could feel something wasn't right, but I couldn't stop it… I had enough insight to know that this was not me" – Participant 32.

In addition to depression, a majority of women experienced heightened anxiety, often for the first time in their lives. This included dread, paranoia and intrusive thoughts which could be suicidal in nature. Another cognitive challenge that was reported during the perimenopausal period was problems with memory, such as *"scary"* levels of brain fog and inability to concentrate which have knock-on effects on overall mental well-being.

One participant reported psychotic experiences during their perimenopause, such as auditory and visual hallucinations:

"I heard footsteps on the stairs and the landing creaking…there were two of me in the bedroom, and I couldn't actually work out which was the real me and which was the hallucination" – Participant 28.

This emotional volatility can lead to irritability and episodes of rage, as women try to navigate their new normal:

"My little four-month-old daughter wouldn't eat [her dinner]… I had this overwhelming sense of irritability and anger, I had to hide in the pantry. I've never felt it ever before" – Participant 1.

Interplay of physical and psychological symptoms

The physical and psychological symptoms experienced during perimenopause can lead to a significant loss of resilience, creating a vulnerable state where women may feel emotionally and mentally depleted:

"I got overwhelmed by the slightest thing, like taking a parcel to the post office. I just couldn't do it. It was too much" – Participant 11.

As the symptoms cycle through alongside major life events also occurring (e.g. relationship struggles, children moving out of the family home, physical health problems, financial difficulties), it can lead to feelings of failure, self-doubt and eventually suicidality.

"You're Just Dying Inside; What's the Importance of Living?"

Suicidality was prevalent among all the women interviewed, with each expressing varying degrees:

"There was a period where I gave up… I just wanted it all to end" – Participant 23.

This emotional distress did not always manifest as an active desire to end one's life but often stemmed from inability to see an escape from the constant struggle. Suicidal thoughts and ideations may be triggered by the overwhelming exhaustion due to navigating the intense physical and psychological symptoms, causing feelings of entrapment and hopelessness about the future:

"I'm going to die. I can't go on like this. I don't know where to go, I don't know what to do" – Participant 31.

However, the severity of suicidality during perimenopause varied greatly among women interviewed, ranging from distressing thoughts to life-threatening actions. For several, suicidal ideation was more abstract, with women idealising or fantasising about how they might end their lives as a coping strategy, without a plan to act on the thoughts:

"I could grab one of those [ropes] and hang myself in our house… it wasn't like I was intentionally exploring that as an option, but it was like my head was presenting these coping options to me" – Participant 5.

In contrast, others experienced more intense and urgent suicidal thoughts, where they not only imagined specific ways to end their lives but also had the means readily available and the motivation to act. Several women made plans to act on their suicidal thoughts but did not follow through either due to a moment of hesitation, fear, or because of loved ones:

"In 2018, I went out with the intention of ending my life. I had a plan, I knew exactly what, where, when, how…I would really have to fight hard not to go out and actually follow through with the plan that was in my head" – Participant 11.

Unfortunately, few women reached a critical point where the burden became unbearable, leading them to follow through with the plan to end their lives:

"I tried to throw myself in front of a train, I tried to drink myself out of here, and I just wanted to die… begged my husband to take me to Dignitas (euthanasia service)" – Participant 7.

For few interviewed, the onset of suicidality during perimenopause was profoundly traumatising, especially for those who had never experienced mental health difficulties before. The intensity of the feelings left them deeply unsettled and frightened that their brain might go there again:

"They've [suicidal thoughts] left a significant impact on me. I think I've got some sort of PTSD from it" – Participant 31.

Treatment: What Works and What Doesn't

Treatment varied for interviewed women and was sometimes influenced by a clinician's knowledge and expertise in both mental health and/or menopause. Women reported this from across both the menopause clinic and general population cohorts. Most of the women who reached out to the specialised menopause clinic did so after receiving ineffective mental health treatment, consequently causing their mental health to decline. The decline in mental health during perimenopause can be catalysed by various factors that intensify emotional and psychological strain. This included i) negative gender stereotypes about women and menopause, ii) lack of knowledge of menopause within the self, the healthcare system and society, iii) resistance from clinicians when treatment is sought out, iv) delays in receiving the correct treatment, and v) a lack of appropriate services. Additionally, several women interviewed felt a sense of shame at their inability to cope, which worsened their mental well-being. This shame was often rooted in societal expectations that women should be resilient, nurturing, and capable of managing their own emotions, and was compounded

by the cultural tendency to minimise menopause-related struggles, leading some women to feel isolated, weak, or as though they were burdening others by admitting to their mental health challenges.

Exacerbating factors increasing challenges for perimenopausal women

Negative female stereotypes during perimenopause sometimes pressure women to ignore their struggles. Society expects women to continue performing their roles as professionals, caregivers, or partners, disregarding the intense physical and emotional changes they experience:

"I feel like as a woman we kind of just get on with stuff. We have to… the whole family unit will just fail, so it's on our shoulders" – Participant 34.

The expectation of women being endlessly resilient caused few participants guilt for struggling. Additionally, the lack of knowledge that women had about their own menopausal transition often contributed to this, as a majority interviewed were unaware they were experiencing perimenopause at the time and that it affected mental health.

Not only was a lack of knowledge reported by women about their own health, but also a significant gap in knowledge about menopause and hormones among healthcare professionals:

"There was zero knowledge about hormones. They were doing their best with what they felt they knew, but they didn't know anything about this subject whatsoever. It's not on their assessments to ask about women's menstrual cycles" – Participant 2.

A significant challenge several women faced during their experiences with healthcare was the lack of awareness among general practitioners that perimenopause existed. Several women reported that clinicians told them they were too young to be menopausal if they were still having periods, being *"totally shut down"* if they queried it. A majority of women also found that their symptoms were not taken seriously in general practice, which often resulted in frustration:

"Nobody really listened until I went to the GPs and said I intend to end my life… nobody thought there was an issue" – Participant 11.

Several interviewed encountered resistance from their GPs when seeking help for their symptoms, which added to their distress. Doctors were often sceptical, despite women presenting with a range of menopausal symptoms, and reluctant to explore hormone replacement therapy as a solution.

"I was asking…could it be hormone-related? And they [GP] were saying, 'no, it couldn't'. It probably was about nine months of…being convinced it was hormones and him resisting" – Participant 5.

Several women reported experiencing dismissing and patronising attitudes from GPs, with certain doctors offering inappropriate or overly simplistic solutions to their complex symptoms, such as just *"to go on holiday".*

"I went to the GP… she said you just have to get over it. She said you can't take a tablet for everything" – Participant 42.

Two participants said their GP attributed their concerns to the *"Davina effect"* (increased menopause awareness following Davina McCall's documentaries) reducing their worries as media-driven. Others had similar experiences, being told to *"pull yourself together"* or that *"menopause doesn't affect mental health"*. One participant was advised to drink alcohol to manage her symptoms, despite having quit for health reasons, while another was told alcohol, not menopause-related depression would *"kill her"* first. One participant recalls a particularly invalidating experience with her GP:

"I remember we went out into the waiting room… this lady who was about 85, was old and struggling. She [GP] just glared at me and said: 'this is struggling', referring to the old lady" – Participant 7.

Several women expressed frustration over significant delays in receiving treatment from GPs, with several noting that when eventually provided, it often was incorrect. Few women had to prescribe and manage their own HRT because of this. One participant recalled her husband, a GP, having to prescribe it, as there was no knowledge of prescribing it amongst psychiatry, trauma orthopaedics or gynaecology:

"In the end, my husband had to prescribe it, pick it up from the chemist, [and] bring it into the hospital for them to load it on their system" – Participant 2.

Often, women were prescribed a wide range of *"mind-altering"* medications including antidepressants, anxiolytics, and antipsychotics before finally being offered HRT:

"They seemed really willing to repeatedly prescribe loads of different forms of drugs, and yet unbelievably resistant to prescribing my own hormones back to me" – Participant 5.

Several women shared that they underwent *"pretty brutal"* electroconvulsive therapy for their symptoms, even after suggesting it may be hormone-related.

Discussions in the interviews highlighted a significant lack of menopause-specific services available, leaving women feeling unsupported and without access to specialised care, with one participant stating that *"the NHS is busy doing other things"* so *"we just have to struggle"*.

There were also discussions about the lack of coordinated care even when support is available, with *"no joined-up thinking"* between psychiatry, endocrinology and general practice, leading to fragmented and ineffective treatment.

These negative experiences have caused few women to *"question the whole healthcare system",* feeling dismissed and unsupported:

"I saw numerous GPs, I spoke to somebody in a gynaecological department… and spoke to two different psychiatrists. And at no time during that journey, did anybody say anything about hormones" – Participant 5.

The negative experiences also made people turn to private healthcare services to receive appropriate treatment for their perimenopausal symptoms, but they acknowledged that this option may not be financially feasible for many, leaving them without the care they need:

"We're lucky that we're in a reasonable financial situation [to go private]. Unless you pay… no-one gives a shit. If I hadn't spent £300 speaking to somebody at [private service], what would have happened? I was literally left in the lurch. Unless you've got money you're

struggling. And that's probably why women are topping themselves, isn't it?" – Participant 32

Alleviating factors for managing symptoms

Despite the numerous challenges women can face during perimenopause, many find that there are ways to manage the symptoms and improve their quality of life. Understanding the importance of support, whether through effective medical treatment, emotional support from loved ones and those experiencing something similar, or lifestyle changes can make a positive difference in mental well-being.

One of the main alleviating factors for many women during perimenopause is HRT, which, at the correct dose, can regulate the hormonal imbalances that may cause the range of physical and emotional symptoms:

"I didn't start to feel better until I had my hormones replaced, and it was literally days that all those symptoms improved…I'm on max dose oestrogen, progesterone… and I've started on some testosterone as well. I feel amazing… all my symptoms have gone. You become a totally different person. I can't believe the change. I felt a weight had been lifted" – Participant 28.

For several women, HRT decreased feelings of suicidality specifically:

"Until I went on HRT, I thought if there was a way that you could go without hurting yourself… I would've taken that option" – Participant 24.

Few found that adding testosterone into their treatment plan was particularly beneficial, noting that it helped feeling *"a sense of joy and well-being, and feeling happy and settled".*

However, while HRT can be a highly effective treatment for alleviating many of the symptoms associated with perimenopause, it is not a cure-all. Many women still experience symptoms even after receiving the correct dose of HRT, but they are generally more manageable compared to before treatment:

"I felt as if I'd been stood on the edge of a cliff and it had enabled me to step a couple of feet backwards" – Participant 29.

Several women found that a combination of HRT and antidepressants was effective for them in managing the psychological symptoms of their perimenopause. However, while HRT has proven effective for many women in reducing psychological perimenopause symptoms, it does not work for everyone, and few continue to experience severe symptoms:

"Even with HRT, I still have to do quite a lot of things to be able to feel well enough to function in the world the way I want to" – Participant 41.

Aside from taking medications, several women found that making lifestyle changes, such as increasing their physical activity, and *"having the oxygen going through you",* had a positive impact on managing the psychological symptoms of perimenopause:

Similarly, dietary changes helped other women stabilise their moods:

What you put in and what you do to your body is ultimately what impacts on what happens to it. It doesn't make you immune to it, but… it definitely helps" – Participant 27.

Another factor that was found to be important for women going through perimenopause was feeling a sense of community which helped mitigate psychological symptoms, as talking to other women experiencing similar things provided emotional validation and reduced feelings of isolation:

"I found my tribe when I went to the menopause clinic because I was there with people who were non-judgmental and incredibly supportive…I think that the HRT may have been just as important as having felt validated and listened to and in a safe space with people who were going through the same thing" – Participant 8.

Additionally, workplace adjustments emerged as another vital factor in supporting women's health during menopausal transition. Women who reported having an empathetic and accommodating work environment described feeling less overwhelmed and more capable of balancing their lives, which in turn contributed to improved mental well-being.

"Our work has given us a women's room...for people that are in menopause. You can sit and chat with somebody, read some literature… it's not a medical setting, but at least the workplace has recognised there's a need for something, and that's brilliant" – Participant 24.

Discussion

Our study highlighted the severe mental health challenges women face during perimenopause, particularly suicidality, exacerbated by inadequate healthcare support which frequently lacked the knowledge and responsiveness needed to address menopausal symptoms appropriately.

The study found that suicidality was a significant concern among women experiencing perimenopause, with a majority of women reporting mild and abstract thoughts of death, and few attempting to end their lives. This spectrum of intensity is consistent with existing suicide research [18]. Some participants reported driving feelings of hopelessness and entrapment, feeling overwhelmed by their symptoms, viewing suicidal ideation as an escape from their persistent suffering. This aligns with the integrated motivational-volitional model of suicidal behaviour [19], which posits that perceiving no escape or solution is a precursor to suicidality.

The delays in receiving effective HRT and mental health support contributed to the worsening of symptoms, with most women reporting long waits, multiple appointments and having to *"fight"* before being offered treatment. This is consistent with research that found 7% of menopausal women attended a GP surgery over 10 times before receiving adequate treatment, 30% experienced delays in diagnosis, and 44% waited over a year for treatment [20]. When appointments were finally obtained, participants reported a lack of education on menopause from healthcare professionals, which ultimately led to the misdiagnosis of symptoms, as well as inappropriate advice such as simply learning to deal with symptoms or to go on holiday. Participants then described being prescribed antidepressants, anxiolytics, antipsychotics, and electroconvulsive therapy, instead of HRT, despite guidance from the National Institute for Health Care and Excellence [21] recommending HRT as a first-line treatment option, with discussion of risks and benefits. This is in-line with previous research showing many women are inappropriately offered antidepressants when seeking help for psychological menopause-related symptoms [22]. Current research also suggests that there is no clear evidence of antidepressants easing psychological symptoms during menopause [23]. Our study found that these alternative treatment pathways often led to the worsening of psychological symptoms. All healthcare professionals should understand the mental health aspect of menopause [24], including the heightened risk of suicidality at this time,

particularly those in primary care in order to better support menopausal women at risk and ensuring they receive appropriate, timely care.

Despite presenting with symptoms clearly linked to perimenopause, women were frequently told they were too young to be going through the menopausal transition, or that their symptoms were unrelated to menopause. As highlighted in previous research [25] we found that barriers to effective menopause care, including delays in receiving HRT and inappropriate prescriptions of psychiatric medications exacerbate mental health challenges. Unfortunately, this led to feelings of suicidality for several women in our study, as they saw no other way to persevere. However, most women in our study who received timely HRT described significant improvements in their well-being, including the diminishing of suicidal thoughts, aligning with the evidence that HRT can alleviate both the physical and psychological symptoms of menopause when used appropriately [8] [23]. In fact, depression and anxiety associated with perimenopause can effectively be treated with HRT with or without additional psychiatric support [26] [27] [28].

The study also highlighted key differences between participants from the specialist menopause clinic and those from the public, influencing symptom severity and access to treatment. Clinic attendees often reported more severe mental health symptoms, likely promoting their engagement with private healthcare services – a pattern observed in other areas of health research [29]. In contrast, those outside the clinic faced greater delays in recognising menopause-related distress and seeking treatment, consistent with research indicating poorer outcomes in public outpatient mental health care [30].

Additionally, some participants found that exercise, diet changes, and emotional support networks played an essential role in improving mental health and feelings of isolation. This is supported by research exploring the roles of Menopause Cafés – groups for women to openly discuss their experiences with menopause – on mental health. They have been described as the most successful way to facilitate social cohesion and the most effective method of reducing loneliness and stigmatisation experienced by menopausal women [31], however, there has been no empirical research exploring this.

Few women described finding empowerment in their shared experiences with others, highlighting the positive aspects of menopause and womanhood. One participant reflected:

"When I went into the clinic, there were women there who looked amazing. And then there was others who looked tired like me and a bit fed up and, and it just felt really empowering and special". This sense of community allowed women to feel less alone, as they understood that this was a transition unique to the female experience and found solitude in that. Another participant described the bittersweet moment of being in the waiting room of a menopause clinic, reflecting on the *"wonderfulness of being a woman"*, even as she experienced the end of her fertile years. Menopause, despite its challenges, is ultimately part of the journey of womanhood, with few participants highlighting the importance of embracing this stage of life.

Limitations

The study has several limitations. Firstly, the sample drawn from private clinic patients and online respondents may not represent the broader population, particularly those without access to private care or digital platforms. Conducting all interviews online may have affected the depth of responses and limited rapport with participants. Additionally, reliance on self-reported data may introduce recall bias, and the exclusion of non-English speakers may have omitted diverse perspectives. Furthermore, sociodemographic data were not systematically collected, limiting the ability to explore how factors such as age, socioeconomic status, and relationship status influence menopausal mental health, and the interview guide was not pilot tested prior to data collection. Future research should address these gaps to enhance generalisability and better understand the intersection of sociocultural and environmental factors with suicidality risk in menopause [32] [33].

Implications for the future

Changes are needed; a holistic and integrated approach to menopause care is vital, particularly in addressing the significant mental health challenges women face during perimenopause, including suicidality. An American study estimated the combined costs of lost productivity and medical expenses for women with perimenopausal depression at $10,000 per woman annually [34], underscoring the need for timely interventions to improve mental health outcomes and reduce financial burdens on women, families, and the healthcare system.

In addition to improving medical interventions, qualitative research on the lived experience of perimenopause plays a crucial role in advancing this field, as it provides insight into the emotional, social, and psychological challenges that many women face but may not be captured in biomedical models alone [35]. Studies exploring women's first-hand experiences highlight gaps in healthcare support, the stigma surrounding menopause, and the impact of delayed treatment, further reinforcing the need for comprehensive, patient-centred care [36].

The call for comprehensive biopsychosocial care aligns with the Women's Health Strategy for England [37], which recognises the gaps in healthcare for women and aims to improve menopause care through the establishment of Women's Health Hubs. These hubs offer a tangible solution – creating one-stop centres where women can receive a wide range of services, from HRT prescriptions to mental health support, in a setting designed to meet their unique healthcare needs. In addition, community-based support networks, such as Menopause Café's, should be considered to foster peer support, reduce isolation, and promote emotional well-being. Finally, different health services need to improve data-sharing practices to provide more efficient and appropriate care to women experiencing menopause, who may have sought help or been referred through several services.

Conclusions

In conclusion, the present results suggest the failure to adequately recognise the link between hormone imbalances and mental health alongside inadequate primary and social care during perimenopause has led to mental health difficulties and high suicidality rates. These issues not only impact individual mental health, but also place a strain on health services and negatively impact economic productivity. Improving access to women's health services, social support, and clinician knowledge of the range of treatment options available, will help to alleviate the identified problems. With the highest suicide rates observed in women of perimenopausal age, it is clear that action is urgently needed.

Declarations

Ethics approval and consent to participate

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013. All procedures involving patients were approved by Liverpool John Moores University Research Ethics Committee (LJMU REC ID: 22/PSY/080), and all participants provided informed verbal consent prior to enrolment in the study. The rationale for obtaining verbal consent instead of written consent was to increase accessibility and participant comfort, particularly given the sensitive nature of the study topic.

Consent for publication

All participants provided informed consent for their anonymised data to be used in this publication. No identifiable information has been included, and all efforts have been made to ensure confidentiality and privacy in reporting the findings.

Acknowledgements

We thank the study participants for granting permission for us to use their data for the purpose of this study. We are grateful to Newson Health for their assistance with recruitment and data analysis.

Author contributions

OH, PS, JCM, and AR conceived and designed the study. LN and CC contributed to study material development and recruitment. OH collected the data. OH, PS, JCM and AR analysed the data. OH led interpretation of study findings. All authors contributed to interpretation of findings. OH led the draft of the work. All authors read, commented on and approved the final version of the paper. OH is the lead author. PS is the senior researcher.

Funding

This research received funding from Newson Health Research & Education Limited.

Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Availability of data and materials

The authors confirm that the data supporting the findings of the study are available within the article and/or its supplementary materials.

References

1. Hogervorst E, Craig J, O'Donnell E. Cognition and mental health in menopause: A review. *Best Pract Res Clin Obstet Gynaecol*. 2022;**81**:69-84.
2. Sleep Foundation. Menopause and sleep. Sleep Foundation; 2024. Available from: https://www.sleepfoundation.org/women-sleep/menopause-and-sleep
3. Australian Bureau of Statistics. Intentional self-harm deaths (suicide) in Australia. 2022. Available from: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2022#intentional-self-harm-deaths-suicide-in-australia
4. Centres for Disease Control and Prevention. Suicide rates for females and males by race and ethnicity: United States, 1999 and 2020. 2022. Available from: https://www.cdc.gov/nchs/products/databriefs/db433.htm#:~:text=The%20suicide%20rate%20for%20females,during%20the%202000%E2%80%932020%20period
5. Office for National Statistics. Suicides in the United Kingdom: 2022 registrations. 2022. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2022registrations

6. Baca-Garcia E, Diaz-Sastre C, Ceverino A, Perez-Rodriguez MM, Navarro-Jimenez R, Lopez-Castroman J, et al. Suicide attempts among women during low estradiol/low progesterone states. *J Psychiatr Res*. 2010;**44**(4):209-14.
7. Arango V, Underwood MD, Boldrini M, Tamir H, Kassir S, Hsiung S, et al. Serotonin 1A receptors, serotonin transporter binding, and serotonin transporter mRNA expression in the brainstem of depressed suicide victims. *Neuropsychopharmacology*. 2001;**25**(6):892-903.
8. NHS. Menopause. NHS; 2022. Available from: https://www.nhs.uk/conditions/menopause/
9. An SY, Kim Y, Kwon R, Lim G, Choi HR. Depressive symptoms and suicidality by menopausal stages among middle-aged Korean women. *Epidemiol Psychiatr Sci*. 2022;**31**.
10. Nakanishi M, Endo K, Yamasaki S, Stanyon D. Association between menopause and suicidal ideation in mothers of adolescents: A longitudinal study using data from a population-based cohort. *J Affect Disord*. 2023;**322**:22-30.
11. Usall J, Pinto-Meza A, Fernández A, de Graaf R, et al. Suicide ideation across the reproductive life cycle of women: Results from a European epidemiological study. *J Affect Disord*. 2009;**116**(1-2):144-7.
12. Alblooshi S, Taylor M, Gill N. Does menopause elevate the risk for developing depression and anxiety? Results from a systematic review. *Australas Psychiatry*. 2023;**31**(2).
13. Finlay L. Exploring lived experience: principles and practice of phenomenological research. *Int J Ther Rehabil.* 2013;**16**(9).
14. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A practical guide. *Int J Qual Health Care*. 2007;**19**(6):349-57.
15. Singer E, Bossarte R. Incentives for survey participation: When are they "coercive"? *Am J Prev Med.* 2006;**31**(5):411-418.
16. Braun V, Clarke V. Thematic analysis: A practical guide. SAGE Publications; 2021.
17. Lumivero. NVivo (Version 14) [Software]. 2023. Available from: www.lumivero.com
18. Harmer B, Lee S, Rizvi A, Pal S, Jackson D, Saadabadi A. Suicidal Ideation. In: StatPearls. StatPearls Publishing; 2023. Available from: https://www.ncbi.nlm.nih.gov/books/NBK565877/

19. O'Connor RC. The integrated motivational-volitional model of suicidal behavior. *Crisis*. 2011;**32**(6):295-8.
20. Fawcett Society. Menopause and the workplace: Survey results. Fawcett Society; 2022.
21. National Institute for Health and Care Excellence. Menopause: Diagnosis and management. 2019. Available from: https://www.nice.org.uk/guidance/ng23/chapter/Recommendations#managing-short-term-menopausal-symptoms
22. The Menopause Charity. Antidepressants and menopause. 2021 Oct 21. Available from: https://www.themenopausecharity.org/2021/10/21/antidepressants-and-menopause/#:~:text=This%20is%20because%20there%20is,professional%20about%20their%20menopausal%20symptoms
23. Glynne S, Newson L. Rapid response to: Curb antidepressant prescribing to improve mental health, say campaigners. *BMJ*. 2023.
24. Currie H, Abernethy K, Hamoda H. Vision for menopause care in the UK. *Post Reprod Health*. 2021;**27**(1):3-8.
25. Barber K, Charles A. Barriers to accessing effective treatment and support for menopausal symptoms: A qualitative study capturing the behaviours, beliefs and experiences of key stakeholders. *Patient Prefer Adherence*. 2023;**17**:2971–80.
26. Behrman S, Crockett C. Severe mental illness and the perimenopause. *BJPsych Bull.* 2024;**48**(6):364–370.
27. Leonhardt M. Low mood and depressive symptoms during perimenopause – Should General Practitioners prescribe hormone replacement therapy or antidepressants as the first-line treatment? *Post Reprod Health.* 2019;**25**(3).
28. Herson M, Kulkarni J. Hormonal agents for the treatment of depression associated with the menopause. *Drugs Aging.* 2022;**39**(8):607-618.
29. Davitadze AP, Aleksandrova EA. Applications to public and private medical organizations: patients' choice. *Population.* 2023;**26**(2):139-152.
30. Bjørngaard JH, Garratt A, Gråwe RW, Bjertnæs ØA, Ruud T. Patient experiences with treatment in private practice compared with public mental health services. *Scand J Psychol.* 2008;**49**(4):385-392.
31. Weiss R. Menopause Cafés: It's good to talk. *Maturitas*. 2019.

32. Cortés YI, Marginean V. Key factors in menopause health disparities and inequities: Beyond race and ethnicity. *Curr Opin Endocr Metab Res*. 2022;**26**:100389.
33. MacLellan J, Dixon S, Bi S, Toye F, McNiven A. Perimenopause and/or menopause help-seeking among women from ethnic minorities: A qualitative study of primary care practitioners' experiences. *Br J Gen Pract*. 2023;**73**(732)
34. DiBonaventura MD, Wagner JS, Alvir J, Whiteley J. Depression, quality of life, work productivity, resource use, and costs among women experiencing menopause and hot flashes: A cross-sectional study. *Prim Care Companion CNS Disord*. 2012;**14**
35. Marnocha S, Bergstrom M, Dempsey L. The lived experience of perimenopause and menopause. *Contemp Nurse.* 2011;**37**(2):229-240. https://doi.org/10.5172/conu.2011.37.2.229.
36. O'Reilly K, McDermid F, McInnes S, Peters K. An exploration of women's knowledge and experience of perimenopause and menopause: An integrative literature review. *J Clin Nurs.* 2022;**32**(15-16):4528-4540. https://doi.org/10.1111/jocn.16568.
37. UK Department of Health and Social Care. Women's health hubs: Core specification. 2024. Available from: https://www.gov.uk/government/publications/womens-health-hubs-information-and-guidance/womens-health-hubs-core-specification