

Systematic Review

Exploring experiences, perceived barriers and needs of menopausal women: a qualitative meta synthesis

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ABSTRACT

This study aimed to identify, compare, and synthesize qualitative evidence to understand the experiences, perceived barriers, and needs of women undergoing menopause. A qualitative meta-synthesis was conducted to integrate findings across multiple studies and provide a comprehensive view of menopausal experiences. Published articles were systematically searched in PsycINFO, PubMed, ABSCO, Embase, and selected journals, along with reference lists, focusing on studies published since 2020. Eleven articles meeting predefined criteria were included in the synthesis. The studies included 227 participants experiencing natural or surgical menopause across diverse cultural contexts, including Sri Lanka, India, Iran, China, Malaysia, the UK, and the USA. Sample sizes ranged from 12 to 30, with ages spanning 35–65 years. The synthesis identified five overarching themes capturing the multidimensional experiences of menopausal women. These themes reflected the interplay of physical, emotional, social, and healthcare-related challenges during the menopausal transition. The findings highlight significant challenges faced by women during menopause. Strengthening coping strategies, facilitating peer support, providing empathetic and holistic care, and addressing societal taboos are essential strategies to help women navigate menopause with dignity, resilience, and improved quality of life.

Keywords: Women with menopause, Menopausal symptoms, Perceived barriers, Experience

INTRODUCTION

Menopause is a natural but complicated change in a woman's life that ends her reproductive cycle for good. It usually happens between the ages of 45 and 55 when the ovaries stop working.¹ Biomedically, menopause is defined as 12 months with no periods, but the actual experience of menopause goes much beyond hormonal changes. It includes a wide range of physical, emotional, and social adjustments that can persist for years.^{2,3} Common symptoms include hot flashes, mood swings, trouble sleeping, and pain in the genitals can make it hard to go about everyday life and make quality of life much worse.

Even though more people are aware of these problems, a lot of the research on menopause is still focused on biological issues. This often overlooks the personal

experiences and real-life situations that women face. Menopause can lead to various emotional and mental impacts on women. These include anxiety, depression, changes in identity, feelings of invisibility, and withdrawal from social interactions. These effects depend on a woman's culture, stage of life, and availability to care. Some women report unmet needs and obstacles in healthcare services. They often experience a lack of knowledge, a lack of empathy from providers, and social taboos related to aging and reproductive health. Despite this, many women face this transition with strength.⁴

Menopause also brings visible changes such as weight gain, skin aging, and hair thinning, which may clash with dominant ideals of youthfulness and femininity.⁵ These changes can impact self-esteem and mental health, even in later life. Studies show that 40% to 80% of middle-aged and older women report being unhappy with their bodies.^{5,6}

For example, Nazarpour et al found a direct link between body image dissatisfaction, symptom severity, and sexual functioning in Iranian women.⁷

Women's experiences of menopause differ greatly depending on social, cultural, and geographic factors. In non-Western and rural areas, menopause often comes with strong gender roles, little reproductive health education, and a lack of discussion about emotional well-being. A 2023 qualitative study of South Asian Canadian women highlighted the conflict between internalized cultural ideals and the realities of aging. Many women reported gradually moving toward empowerment and acceptance.⁸ Similarly, a 2025 mixed-methods study in Bilaspur, India found a strong connection between body composition and psychosocial distress. This highlights the need for health interventions that address both issues together.⁹ Research from rural India by Nissy (2025) and Rukmani (2023) also illustrates how menopause is experienced in relation to familial roles, social expectations, and restricted agency.^{5,10}

Taken together, these findings suggest that menopause is not a purely physiological event but a deeply personal, emotional, and social transition. Women's experiences depend on various factors, including healthcare access, cultural expectations, and personal identity. However, current qualitative studies on menopause are scattered across different fields and regions. This fragmentation makes it challenging to gather broad yet detailed insights. So, this meta-synthesis will aim to explore and synthesize the lived experiences, perceived barriers, and needs of women undergoing menopause. Based on existing qualitative studies, the synthesis highlights the emotional, physical, and social challenges women face, identifies gaps in healthcare services, and provide insights for improving support and interventions during the menopausal transition. By highlighting women's voices in various cultural contexts, including underserved and non-Western groups, this study aims to inform holistic, culturally appropriate approaches that go beyond symptom management to support well-being during menopause.

METHODS

This study adopted a qualitative meta-synthesis design, which involved three key stages: selecting relevant published studies and assessing their suitability for inclusion, conducting a quality appraisal of the selected studies and extracting key data, and summarizing and synthesizing the findings to generate comprehensive insights.

Identification and selection of studies

Relevant literature was identified through database searches in PubMed, CINAHL, EBSCO, Embase, and PsycINFO, supplemented by manual searches of selected journals and reference lists (Figure 1). The search focused on studies published from 2015 onward, using keywords

such as “menopausal women,” “experiences,” “perceived barriers,” and “needs.” To assess eligibility, two screening questions were applied: Did the study use qualitative methods for data collection and analysis? Was the study aligned with the focus of the meta-synthesis?

Inclusion criteria

Qualitative studies using phenomenological, grounded theory, ethnographic, or descriptive research designs and studies involving adult women experiencing menopause were included.

Exclusion criteria

Studies including participants with significant language or cognitive impairments, serious comorbid medical conditions, or prior psychiatric diagnoses, research focusing on caregivers' perspectives rather than the women themselves and studies using mixed methods, purely quantitative approaches, or case study designs were excluded.

Quality appraisal and data extraction

The quality of each study was assessed based on two main criteria: credibility and relevance. Eligible studies were evaluated using seven guiding questions.

Credibility

Were the sampling techniques and data collection methods clearly described? Was the data analysis process transparent and supported by adequate evidence to ensure auditability? Did the authors reflect on how their presence or pre-existing assumptions may have influenced the data (reflexivity)? Were outliers or contradictory data adequately addressed? Were alternative explanations considered, and were multiple perspectives included to ensure a balanced interpretation (fair dealing)?

Relevance

Did the study provide detailed information about participants, setting, and context to support the transferability of findings? Was the discussion of results thorough, including implications and the potential for analytic generalization?

Data synthesis

Condensed descriptive labels were used to summarize and categorize the perspectives across studies. Themes identified by the original researchers were reviewed and validated against the data. After summarizing each study's findings, the data were grouped under shared headings. This process enabled the development of overarching themes that integrated and synthesized insights across all included studies. Review of literature is mentioned in Table 1.

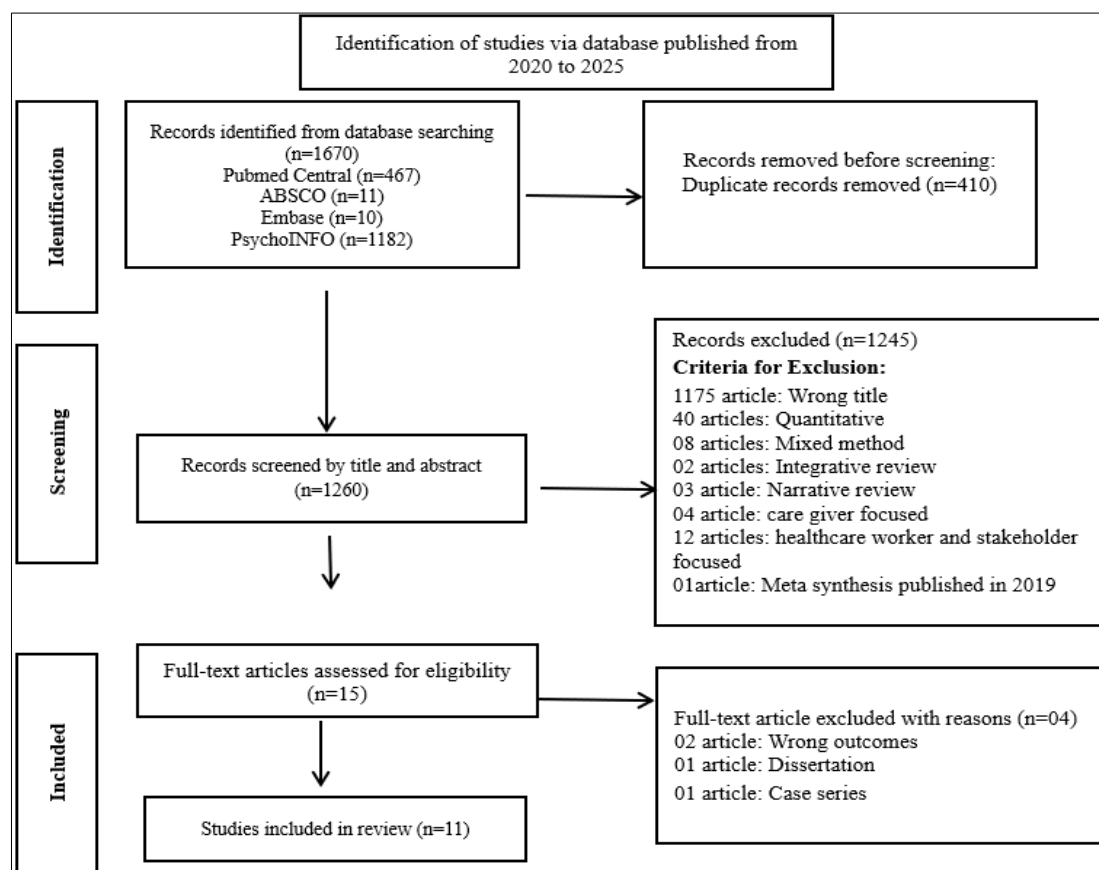


Figure 1: Summary of themes identified from the studies.

Table 1: PRISMA flow diagram of the selection process of articles of the meta-synthesis.

Author's name	Year	Title of the study	Subjects	Themes
Kannur et al ¹¹	2025	Qualitative study on experience of menopausal symptoms of middle-aged women in North Karnataka	A total of 12 menopausal women selected, six from rural and six from urban	The main themes identified include the menopausal experience, menopausal signs and symptoms, menopausal effects on daily life, and knowledge and coping methods
Toufeili et al ¹²	2025	Reproductive health experiences of women and non-binary people with early psychosis: a qualitative study	19 participants with early psychosis, including cisgender women, transgender women, and non-binary individuals assigned female at birth, and 36 clinicians from reproductive and mental health fields, including nurses, were recruited	Complex reproductive health needs exist irrespective of psychosis, psychosis does specifically impact reproductive health priorities and plans, Clinicians grappled with clinical complexity, and sometimes had different priorities than their patients
Khademi et al ¹³	2024	Perceived lack of behavioral control is a barrier to a healthy lifestyle in post-menopause: a qualitative study	A total of 30 menopausal women were divided into three groups of ten women from three different hospital of shiraz	False attitudes, perceived inability to engage in behavior, perceived inability to engage in behavior, perceived inability to engage in behavior.
Alswayied et al ¹⁴	2024	Menopause knowledge, attitudes and experiences of women in Saudi Arabia: a qualitative study	Twenty-nine Saudi women between the ages of 40 and 64 years were recruited	Mixed emotions towards menopause; experiencing biopsychosocial changes; and adapting to the transition

Continued.

Author's name	Year	Title of the study	Subjects	Themes
Rukmani et al ¹⁵	2023	Women's experience on menopause - a qualitative study	20 women were selected who experienced menopause	Affecting health, affects work, emotional wellbeing and loss of woman hood
Qiong et al ¹⁶	2023	"They see me as mentally ill": the stigmatization experiences of Chinese menopausal women in the family	Fourteen menopausal women aged 48 to 53 years participated in this study	Violent treatment, lack of attention and companionship, coping struggles, and despair
Barber et al ¹⁷	2023	Barriers to accessing effective treatment and support for menopausal symptoms: a qualitative study capturing the behaviours, beliefs and experiences of key stakeholders	The sample included 20 women aged 45–60 with menopausal symptoms, recruited from a UK-based consumer panel, and 40 healthcare professionals (30 general practitioners (GP) and 10 gynaecologists) from various regions across the UK	Barriers to seeking help, barriers to accessing/accepting treatment and support, GP barriers to diagnosis and offering HRT, barriers to women receiving care and HRT from gynaecologists
Refaei et al ⁶	2022	Women's experiences in the transition to menopause: a qualitative research	16 women over 45 years of age approaching menopause	Mixing menopause and aging, life change, confrontation of fear and hope, life adjustment, needs to facilitate the transition time
Kracht et al ¹⁸	2022	"It just seems like people are talking about menopause, but nobody has a solution": A qualitative exploration of menopause experiences and preferences for weight management among Black women	Twenty-seven perimenopausal and postmenopausal Black women recruited for the study.	Past experiences, menopause experiences, lifestyle program components, and lifestyle program development and considerations
Ishak et al ¹⁹	2021	Exploring women's perceptions and experiences of menopause among East Coast Malaysian women	A total of 20 women who had reached menopause	Perception of menopause, biopsychosocial changes, help-seeking behavior
Hankoon et al ²⁰	2021	Menopause is a natural stage of aging: a qualitative study	20 postmenopausal women of 46–55 years of age were participated	Menopause is a natural stage of aging, entering a new stage, managing menopause, and not the end of life

RESULTS

Summarizing and synthesis

This meta synthesis included 11 qualitative studies conducted between 2020 and 2025, with a total of 227 participants experiencing natural or surgical menopause across diverse cultural contexts, including Sri Lanka, India, Iran, China, Malaysia, the UK, and the USA (Table 1). Sample sizes ranged from 12 to 30, with participants' ages generally spanning from 35 to 65 years. A variety of qualitative methodologies were employed: six studies used phenomenological approaches, three were exploratory studies and two used grounded theory. This methodological diversity provided a rich foundation for understanding the multifaceted experiences of menopausal women. The synthesis uncovered five overarching themes that capture the complex and multidimensional experiences of menopausal women. These themes reflect the interplay of physical, emotional, social, and healthcare-

related changes that women undergo during the menopausal transition. The findings emphasize how individual perceptions, cultural expectations, and systemic healthcare gaps collectively shape these experiences (Figure 2).

Navigating bodily changes

Experiencing physical symptoms and discomfort

Across the reviewed studies, women consistently described menopause as a physically disruptive experience, marked by an array of distressing symptoms such as hot flashes, night sweats, fatigue, joint pain, and sleep disturbances. These manifestations were not only frequent but also deeply intrusive, often interfering with routine activities, interpersonal relationships, and occupational functioning. Despite their intensity, these symptoms were frequently normalized within societal discourse, leading to a lack of validation from family

members, peers, and even healthcare providers. This normalization created an environment where suffering was internalized, and help-seeking behaviors were discouraged or delayed. In younger women, particularly those with coexisting psychiatric conditions, the physical symptoms of menopause were compounded by medical neglect in institutional settings, such as psychiatric inpatient care, where menstrual irregularities and reproductive health concerns were often deprioritized. This further magnified the emotional and physiological toll of menopause, emphasizing a need for age- and condition-sensitive care pathways.^{12-15,19,20}



Figure 2: Themes and its subthemes of the meta synthesis.

Emotional and psychological turmoil

Menopause was also accompanied by significant psychological distress, with participants across studies reporting mood swings, heightened anxiety, irritability, and depressive symptoms. For many women, these emotional fluctuations emerged suddenly and with great intensity, often catching them off guard. The psychological changes were frequently misunderstood or dismissed by others, especially in cultural settings where mental health remains stigmatized or where emotional expression by women is deemed inappropriate. This lack of understanding left women feeling alienated, unsupported, and emotionally burdened. The internalization of distress, especially in the absence of adequate social or professional support, led many women to question their emotional stability and self-worth. The psychological impact of menopause was particularly profound for women already dealing with pre-existing mental health challenges, who experienced exacerbation of symptoms and greater vulnerability during this transitional phase.^{6,13,16}

Sexual changes and intimate challenges

In addition to physical and emotional discomfort, many women encountered significant changes in their sexual health, including vaginal dryness, reduced libido, and pain during intercourse. These alterations often strained

intimate relationships and created feelings of guilt, inadequacy, and emotional distance from partners. Cultural and religious norms, which often tied a woman's worth to her reproductive and sexual role, further compounded these feelings, leading many women to perceive themselves as "less of a woman." These changes were rarely discussed openly, even within marriages or clinical settings, due to the sensitivity surrounding female sexuality.

The silence and shame surrounding these issues not only impeded help-seeking but also intensified women's internal conflicts and relational tensions. In younger women, these challenges intersected with broader identity concerns, especially when compounded by the effects of psychotropic medications or reproductive planning anxieties.^{11,14,19}

Redefining self and womanhood

Loss of femininity and changing self-image

For many women, menopause symbolized a profound identity shift. The cessation of menstruation was often interpreted not merely as a biological change but as a loss of youth, fertility, and womanhood. This transition challenged traditional constructs of femininity, especially in cultures that closely associate womanhood with reproductive capability. Women described feeling "invisible," "aged," or "less attractive," reflecting the deep societal conditioning that links a woman's worth to physical appearance and reproductive function. These experiences led to a decline in self-esteem and a struggle with body image. In some instances, the loss of femininity was internalized, reinforcing feelings of inadequacy, especially among women whose partners or families also viewed menopause as a sign of decline.¹⁴⁻¹⁶

Reclaiming identity through adaptation

Despite initial psychological and emotional upheaval, many women demonstrated resilience by reframing menopause as a life stage that offered new forms of self-definition. Through adaptive strategies such as spiritual reflection, mindfulness, religious engagement, and seeking new roles in their families or communities, women began to rediscover purpose and inner strength. These practices often helped women shift their focus from loss to liberation, allowing them to embrace aging with dignity. Particularly among women with mental health conditions, this period marked a reclaiming of reproductive autonomy, where decisions about motherhood, relationships, and treatment were made based on self-awareness and readiness rather than societal pressure or illness trajectory.^{6,12,19,20}

Coping with stigma and invisibility

Stigma emerged as a significant barrier to healthy adjustment during menopause. Women frequently reported

being labeled as emotionally unstable, irrational, or irrelevant—labels rooted in sexist stereotypes and misconceptions about menopause. In many sociocultural contexts, menopause rendered women socially invisible, diminishing their roles in both public and private spheres. For women with psychiatric disorders, this stigma was even more severe, with added layers of judgment related to fertility, parenting ability, and medication use. These stigmatizing experiences led many women to withdraw socially, hide their symptoms, and avoid conversations about menopause, ultimately reinforcing cycles of shame, isolation, and unmet need.^{12,13,16,17}

Barriers to support and healthcare access

Normalizing and trivializing symptoms

Across the studies, a pervasive theme was the normalization of menopausal symptoms as “just a part of aging,” which led to the trivialization of women's suffering. Many participants internalized these societal beliefs, delaying medical consultations or never seeking care at all. This was especially pronounced in rural or traditional settings, where women often accepted physical discomfort and emotional distress as inevitable. Moreover, healthcare systems themselves often reinforced this normalization, with providers failing to initiate discussions or screen for menopause-related issues unless prompted. In mental health settings, these concerns were even more marginalized, with a clinical focus skewed toward managing psychiatric symptoms rather than holistic reproductive wellness.^{12,13,19,20}

Lack of awareness and misinformation

A critical barrier identified was the lack of accurate, accessible information about menopause. Many women, including those in younger age groups or with comorbid mental health conditions, expressed confusion and fear about what to expect during this transition. Myths and misinformation about hormone replacement therapy (HRT), fertility, and medication use were widespread. Particularly troubling was the fear among women on psychiatric medications that they would not be able to conceive or safely carry a pregnancy. This lack of clarity often discouraged women from initiating discussions with healthcare providers and led to anxiety, poor decision-making, and untreated symptoms.^{12,14,17}

Unsatisfactory healthcare encounters

Healthcare experiences were often marked by dismissal, time constraints, and lack of empathy. Women reported that consultations with healthcare providers were frequently rushed or superficial, with menopausal concerns deemed less important than other health issues. In psychiatric settings, reproductive health was rarely addressed, and questions about menstruation, contraception, or long-term planning were either overlooked or discouraged. This disconnects left women

feeling unseen and underserved, particularly those who had unique reproductive needs due to their age, health condition, or treatment plans.^{12,13,17}

Cultural scripts and social expectations

Gender roles and familial neglect

Traditional gender roles often dictated that women prioritize their families' needs over their own well-being. Menopausal symptoms were frequently concealed or minimized to avoid being perceived as weak or burdensome. In many patriarchal societies, menopause was treated as a private matter that should not disrupt family life. Among younger women, especially those living with mental illness, these dynamics were more complex as family members often disapproved of discussions around contraception, sexual health, or childbearing, compounding emotional distress and limiting autonomy.^{6,12,16}

Religious and cultural interpretations

Cultural and religious beliefs deeply influenced how menopause was experienced and interpreted. In some traditions, menopause signaled a decline in feminine identity, contributing to feelings of loss and despair. In contrast, other belief systems offered more empowering narratives. For example, in certain Muslim and Buddhist communities, menopause was viewed as a time of spiritual awakening, freeing women from reproductive responsibilities and allowing for deeper religious engagement and personal growth. These divergent interpretations shaped coping strategies and levels of psychological adjustment.^{4,19,20}

Silence and lack of peer discourse

Across cultures, menopause remained shrouded in silence, both in public discourse and within families. Women often lacked spaces to share their experiences or seek validation from peers. This silence was particularly burdensome for younger women with psychiatric conditions, who were already socially marginalized and now faced reproductive transitions without adequate support or peer understanding. The lack of dialogue reinforced feelings of abnormality and loneliness, making it difficult for women to find shared meaning or develop adaptive strategies.^{11,12,18}

Coping, support, and emerging needs

Reliance on self-care and informal networks

In the absence of formal health services or trust in the healthcare system, many women turned to informal and culturally embedded coping mechanisms. These included home remedies, dietary adjustments, herbal treatments, prayer, and conversations with female relatives or community elders. These strategies not only reflected local

beliefs but also filled critical gaps left by inaccessible or inadequate formal care. In resource-limited settings, these approaches were sometimes the only options available and played a vital role in sustaining emotional and physical well-being.^{13,15,20}

Importance of peer support and empathy

Peer support emerged as a powerful buffer against distress. Women valued safe, empathetic spaces where they could openly discuss their experiences and feel understood. These peer interactions helped normalize symptoms, reduce isolation, and promote self-acceptance. Some studies highlighted how peer-led groups fostered a sense of sisterhood and agency, empowering women to make informed decisions and take control of their health narratives.^{17,18}

Need for tailored education and support systems

Across studies, there was a strong call for integrated, culturally sensitive education and support systems that addressed not only the physical symptoms of menopause but also the emotional, social, and reproductive dimensions. Participants emphasized the need for healthcare providers to initiate conversations about menopause and to include it as a routine part of women's health services. For younger women and non-binary individuals with mental health challenges, the lack of inclusive reproductive education was particularly stark. They expressed the need for services that acknowledged diverse identities and supported long-term reproductive and mental health planning.^{6,12,13,17}

DISCUSSION

The main aim of the meta-synthesis was to assess the experiences of women going through menopause which were categorized in various themes as navigating bodily changes, redefining self and womanhood, barriers to healthcare access, cultural scripts and expectations, and coping and emerging needs. The findings of the meta-synthesis include various diverse and complex experiences of women living through this transitional phase of life.

In relation with navigating bodily changes, women consistently reported limitations in numerous aspects such as hot flashes, night sweats, sleep disturbances, mood swings, diminished libido, and fatigue which collectively imposed a burden on daily living.²¹⁻²³ Sexual health challenges were recognized as distressing and taboo, reinforcing the evidence that intimacy concerns remain under-addressed in routine care.^{22,24} However, contrast findings were observed in South Karnataka, where women reported a high prevalence of symptoms but perceived them as less severe, suggesting that perception and tolerance among women vary across regions and cultures.²⁵

There is a profound impact of menopause on identity and womanhood. Perception of reduced femininity, stigma, and invisibility impaired psychosocial well-being, while many women perceived this stage as an opportunity for resilience and autonomy.^{21,23,26} Similar themes of "biographical disruption" and redefinition were reported in international studies.²⁴

In contrast, findings reported by researchers in Jammu and Himachal Pradesh highlighted that many women interpreted menopause as a positive milestone, associated with relief from menstruation and new beginnings.^{27,28} These divergent perspectives reflect how socio-cultural interpretations shape self-perception.

Barriers to support and healthcare access were widely emphasized. Women reported that symptoms were regarded as normal and frequently overlooked by themselves and healthcare providers, leaving them with unmet needs.^{21,24} Limited knowledge, misinformation, and provider insensitivity further exacerbated this challenge.²²

Similar findings were observed by Wood et al, which noted gaps in provider training and stigma as major barriers.²³ However, research from Himachal Pradesh revealed that women had a relatively higher level of awareness, which reflected regional differences in community health education and literacy.²⁷

When it is concerned with cultural scripts and social expectations, it strongly influences women's experiences such as gender roles, neglect within families, and cultural silence reinforced isolation and distress. These findings correspond with cross-cultural research highlighting that menopause is often considered as decline or loss in collectivist societies, thus intensifying vulnerability.^{22,26} On the other hand, in certain communities such as rural Jammu, menopause was socially accepted and not perceived as a disabling event, suggesting that cultural context can either normalize or stigmatize the transition.²⁸

However, most women reported depending on coping strategies and support to adjust to menopausal challenges. Self-care practices, seeking peer support, and informal networks helped them adjust and regain control.²²⁻²⁴ Peer empathy and shared narratives were found to be protective and empowering. Nevertheless, women also highlighted the need for structured, culturally sensitive education and holistic care that goes beyond symptom management.^{21,24}

Contradictory findings from Karnataka and Jammu indicated that for some women, menopause was perceived as a normal life stage requiring minimal external support.^{25,28}

This shows that while formal interventions may be critical in some contexts, community norms and personal acceptance may serve as effective coping mechanisms in others.

Implications for nursing and healthcare practice

Nurses and primary-care providers are strategically placed to improve menopausal care. Practical steps include routine symptom screening using brief validated tools, empathetic counseling that validates emotional as well as physical concerns, and facilitating peer-support or group education sessions in communities. Training programs should equip nurses to recognize culturally shaped barriers to help-seeking and to deliver brief, evidence-based self-management advice like sleep hygiene, pelvic health, lifestyle measures and appropriate referral pathways. Nurse-led outreach such as community camps, tele-consultation, and liaison with local women's groups, can help normalize conversations, reduce stigma, and connect women to services — especially where specialist care is scarce.

Limitations

This review combined qualitative and quantitative evidence to give a rounded picture of menopausal experience, but several limitations remain. Studies differed widely in design, outcome measures and follow-up, which complicates direct comparisons and pooled inference. Regional clustering of primary research may limit transferability to other Indian states and under-represented groups.

CONCLUSION

Menopause was recognized as a complex transition due to physical, psychological, cultural, and social factors. Even though many women had experienced distress, they further showed resilience by redefining their self-concept and turning to informal network for support. However cultural taboo, poor healthcare, and stigma remain a hindrance to their well-being. To transform the perspective of menopause as a multidimensional life stage it requires recognition, empathy, and comprehensive support which can help the women navigate this transition with dignity and strength.

Recommendations

Future research should incorporate both qualitative and quantitative findings, study culture specific coping mechanisms, and explore the effects of structured interventions such as group education, peer support, and provider training to strengthen menopausal care.

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