

The Relationship Between Belief in Menopause Myths and Depression Levels in Perimenopausal Women

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Abstract

Background

The hormonal changes that occur during menopause can lead not only to physical changes but also to psychological and emotional changes.

Aim

The aim of this study is to examine the relationship between belief in menopause myths and perimenopausal depression among women in the perimenopausal period.

Methods

This descriptive and exploratory study was conducted online between April and September 2025. A total of 298 women in the perimenopausal period were included in the study. Data were collected using a questionnaire developed by the researcher, the Menopause Myths Scale, and the Perimenopausal Depression Scale.

Results

The participants' average age was 47.86 ± 2.79 years. 52.3% of the women had not received information about menopause, and 61.4% had not consulted a doctor regarding menopause. The total score on the Menopause Myths Scale for women was 33.16 ± 12.21 , indicating a moderate level of belief in myths, and the total score on the Perimenopausal Depression Scale was 13.19 ± 9.89 , indicating low-to-moderate levels of depressive symptoms. A moderate positive correlation was found between the total score of the Menopause Myths Scale and the total score of the Premenopausal Depression Scale. It was determined that scores related to the impact on sexual life and scores related to the impact on family and social life are significant parameters influencing the risk of mild or higher depression ($p < 0.05$).

Conclusion

Educational programs on menopause should be developed, and counseling services aimed at dispelling myths about menopause should be provided. It is recommended that women presenting with menopausal symptoms undergo psychological assessment and that early screening programs be established for women at high risk of depression.

Introduction

The perimenopausal period is defined as early perimenopause—a persistent menstrual delay of 7 days or more—and late perimenopause—the absence of menstruation for more than 60 days intermittently over a period of 1–3 years [1]. While the average age of menopause onset in Turkey is 46–49 [2], global data indicate an average age of 50–52 [3]. The World Health Organization reports that by 2030, approximately 1.2 billion women worldwide will be in the postmenopausal period, and approximately 47 million women will enter menopause each year [4].

Just as in other areas, myths that have persisted from the past to the present are quite widespread and similar when it comes to the menopausal period. A woman's geographic location influences how she perceives menopause and increases her need for social support during this period. This is because the beliefs and myths a woman holds regarding menopause cause her to struggle during this time [5].

In a study conducted in the United Kingdom, 49% of postmenopausal women reported that they did not feel sufficiently informed about menopause and that a lack of knowledge regarding the menopausal process negatively affected their attitudes and experiences [6]. Similarly, in another study conducted in the UK with women over the age of 40, it was determined that women had limited knowledge prior to menopause, that there was a need for education on the subject, and that this lack of knowledge caused women to be caught unprepared for the menopausal process [7]. In a qualitative study conducted in Saudi Arabia by AlSwayied and colleagues (2024), women reported experiencing certain concerns regarding menopause, such as the end of fertility, the perception that their attractiveness would diminish, and menopausal symptoms [8]. In a study conducted in India by Durairaj and Venkateshvaran (2022), it was reported that middle-aged women have limited knowledge about menopause and that menopausal symptoms are commonly experienced [9]. In a study conducted in Poland by Żmuda et al. (2025) with 267 women aged 40–65, it was determined that the severity of menopausal symptoms reduced life satisfaction, whereas positive attitudes toward menopause increased life satisfaction [10]. In a study by Atkan and Oflaz (2023), it was emphasized that negative automatic thoughts and stigmatizing beliefs regarding the menopausal process may influence women's experiences of menopause [11].

Menopause is not merely a period of biological changes in a woman's life, but a multifaceted transition that also involves psychological and social dimensions. During this period, fluctuations and a decline in estrogen levels, in particular, can affect the central nervous system and lead to mood changes. For this reason, the menopausal transition is recognized as a vulnerable period for the onset of depressive symptoms [12]. A comprehensive systematic review reported that the prevalence of depression among women during menopause is approximately one-third [13]. Furthermore, it is stated that the risk of depression during the menopausal transition increases significantly compared to the premenopausal period [14].

The aim of our study is to determine the relationship between belief in myths about menopause and depression levels among women in the perimenopausal period.

Research Questions

1. What is the level of depression among women in the perimenopausal period?
2. What is the level of belief in menopause myths among women in the perimenopausal period?
3. Is there a significant relationship between the level of belief in menopause myths and depression levels among women in the perimenopausal period?

Materials and Methods

Study Design

This study is a descriptive and correlational study.

Participants and Sampling

The study was conducted via an online survey through social media platforms (WhatsApp, Instagram, Facebook) between April and September 2025. The online survey method was chosen to reach women living in different regions and cultures. Since the study population was unknown, the sample size was determined using the Raosoft sample calculator to be 295 participants, based on a 95% confidence interval and a 5% margin of error. A total of 298 women aged 45–50 who agreed to participate via online survey forms using the snowball sampling method were included in the study. As a result of the post-hoc power analysis conducted using the G*Power 3.0.10 program with the data obtained from the study (), the study's power was found to be 100%, which is sufficient for a 5% margin of error and a 95% confidence interval with a sample size of 298.

Data Collection Tools

Research data were collected using a demographic questionnaire, the Menopause Myths Scale, and the Perimenopausal Depression Scale.

Demographic Questionnaire:

This form was developed based on the literature and consists of demographic information about the women and 11 questions related to menopause.

Menopause Myths Scale (MMS):

The Menopause Myths Scale was used in the study to identify myths about menopause. Developed by Erol and Beydağ (2025), the scale was created to assess misconceptions regarding the menopausal period in a multidimensional manner; it covers the dimensions of impact on sexual life, impact on family and social life, and impact on mental health. During the scale's development process, it was emphasized that societal beliefs about menopause reflect not only physical changes but also perceptions regarding

women's psychological and social lives. The scale's "impact on mental health" subscale is particularly important for assessing the psychological consequences of misconceptions about menopause. The scale consists of 13 items and 3 subdimensions (impact on sexual life, impact on family and social life, and impact on mental health). The five-point Likert-type scale contains no reverse-scored items. Scores on the scale are assigned as follows: "Strongly agree = 5, Agree = 4, Undecided = 3, Disagree = 2, Strongly disagree = 1." As the score on the scale increases, the level of belief in menopause myths also increases. The Cronbach's alpha value for the scale was found to be 0.87 [5]. In this study, the Cronbach's alpha value was found to be 0.956.

Perimenopausal Depression Scale (Meno-D):

The scale was developed by Kulkarni et al. (2018), and validity and reliability studies in Turkish were conducted in 2024. The scale was developed to assess the severity of perimenopausal depression symptoms. The scale consists of 12 items and five subscales related to energy, paranoid thoughts, irritability, self-esteem, isolation, anxiety, somatic symptoms, sleep disturbance, weight, sexual interest, memory, and concentration. All items on the scale are scored on a scale of 0 to 4. The lowest possible score on the scale is 0, and the high e score is 48. As the score on the scale increases, the severity of depression increases. A score range of 20–24 indicates mild perimenopausal depression; a range of 24–32 indicates moderate perimenopausal depression requiring treatment; and a score of 32 or higher indicates severe perimenopausal depression requiring treatment. In the Turkish adaptation of the Perimenopausal Depression Scale (Meno-D), the scale's total Cronbach's alpha coefficient was found to be 0.75 [15]. In this study, the scale's Cronbach's alpha value was found to be 0.928.

Data Collection Procedure

Data were collected via surveys on online platforms (WhatsApp, Instagram, Facebook). Data were shared on social media networks using the snowball sampling method, and researchers were invited to participate. No identifying information, such as names, contact information, or IP addresses, was collected. To reduce duplicate participation, the "Limit to 1 response" setting available in Google Forms was activated. However, because no advanced verification procedures (e.g., IP based tracking or duplicate detection algorithms) were implemented, duplicate responses could not be completely excluded. All questionnaire items were mandatory; therefore, there were no missing data.

Data Analysis

Statistical analyses were performed using the SPSS (IBM SPSS Statistics 31) software package. Frequency tables and descriptive statistics were used to interpret the findings. Nonparametric methods were used for measurement values that did not follow a normal distribution. In accordance with nonparametric methods, the "Mann-Whitney U" test (Z-table value) was used to compare measurement values between two independent groups, and the "Kruskal-Wallis H" test (χ^2 -table value) was used to compare measurement values among three or more independent groups. For pairwise comparisons of

variables showing significant differences among three or more groups, the Bonferroni correction was applied. When at least one of two quantitative variables did not follow a normal distribution, the “Spearman” correlation coefficient was used. The “Binary Logistic Regression: Backward LR” model was used to identify factors influencing the risk of mild or higher-level depression.

Ethical Considerations

Approval was obtained from the Istanbul Okan University Ethics Committee on March 5, 2025, prior to the start of the study. Permissions to use the scales employed in the study were obtained. All participants were provided with an explanation of the study’s purpose, and their agreement to participate in the study was confirmed by their signing the informed consent form. The study was conducted in accordance with the principles of the Declaration of Helsinki. As data were collected via an online survey, the CHERRIES (Checklist for Reporting Results of Internet E-Surveys) guidelines were followed.

Results

The mean age of the participants was 47.86 ± 2.79 years, and 47.0% were college graduates. Among women, 56.4% were employed, and 65.1% reported that their income was equal to their expenses (Table 1).

Table1 . Distribution of demographic characteristics

48.7% of women have not yet entered menopause. Of those who have entered menopause, 40.6% did so naturally. 52.3% of women have not received information about menopause, 61.4% have not seen a doctor, and 81.5% have not taken medication. 27.9% of women reported perceiving the menopausal period as “bad,” and 21.5% stated that they received adequate support from their loved ones during menopause (Table 2).

The total MMÖ score was 33.16 ± 12.21 , indicating a moderate level of belief in myths. When the subscales were examined, the total score for the “Impact on Sexual Life” subscale was 12.27 ± 5.17 ; the total score for the “Impact on Family and Social Life” subscale was 12.87 ± 4.58 ; and the total score for the “Impact on Spiritual Life” subscale was 8.03 ± 3.89 (Table 3).

The total Meno-D score was 13.19 ± 9.89 , indicating a low-to-moderate level of depressive symptoms. When the subscales were examined, the total score for the Self subscale was 3.52 ± 3.46 ; the total score for the Somatic subscale was 2.87 ± 2.05 ; and the total score for the Sleep subscale was 2.61 ± 1.89 (Table 3).

A positive, weak-to-moderate, and statistically significant relationship was found between myths regarding the impact on sexual life and self-concept, cognitive, somatic, sleep, sexual, and Meno-D – Total ($p<0.05$) (Table 4). As self-concept, cognitive, somatic, sleep, sexual, and Meno-D – Total scores increase, myths regarding the impact on sexual life will also increase.

A positive, moderate, and statistically significant relationship was found between myths regarding the impact on family and social life and self-concept, cognitive, somatic, sleep, sexual, and Meno-D – Total scores ($p < 0.05$) (Table 4). As self-concept, cognitive, somatic, sleep, sexual, and Meno-D – Total scores increase, myths regarding the impact on family and social life will also increase.

A positive, weak-to-moderate, and statistically significant relationship was found between myths regarding the impact on spiritual life and self, cognitive, somatic, sleep, sexual, and Meno-D – Total ($p < 0.05$) (Table 4). As self-concept, cognitive, somatic, sleep, sexual, and Meno-D – Total scores increase, myths regarding the impact on spiritual life will also increase.

A positive, weak-to-moderate, and statistically significant relationship was found between MMS – Total and self-concept, cognitive, somatic, sleep, sexual, and Meno-D – Total ($p < 0.05$) (Table 4). As self-concept, cognitive, somatic, sleep, sexual, and Meno-D – Total increase, MMS – Total will also increase.

As a result of the Backward:LR logistic regression analysis conducted using all scores from the myths scale in this study, the classification accuracy of the logistic regression model was found to be 83.2%, and the Hosmer–Lemeshow test indicated that the model fit the data well ($\chi^2_{(8)} = 3.054$; $p = 0.931$) (Table 5). Furthermore, according to the Nagelkerke R^2 value, the model explains 41.4% of the variance in the dependent variable. The final optimal model, derived from the Backward:LR model using all scale scores, is presented in the table. In the current model, it was determined that sexual life impact scores are a significant parameter affecting the risk of mild or greater depression ($p < 0.05$). When sexual life impact scores increase by 1 unit, the risk of mild or greater depression increases by a factor of 1.161 (OR = 1.161). It was determined that family and social life impact scores are a significant parameter affecting the risk of mild or greater depression ($p < 0.05$). When family and social life impact scores increase by 1 unit, the risk of mild or greater depression increases by a factor of 1.338 (OR=1.338) (Table 5).

Discussion

It is noteworthy that 52.3% of the women in the study had not received information about menopause. This finding indicates that menopause remains a taboo subject and that women primarily obtain information about this period from environmental sources. Forty-seven percent of the women participating in the study were college graduates. It was observed that educational status did not affect the acquisition of information about menopause. The literature indicates that a lack of information about menopause increases belief in myths, and that these misconceptions create a psychological burden [16].

In the study, the total mean score on the Menopause Myths Scale (MMS) was found to be 33.16 ± 12.21 ; the scores for the subscales were reported as 12.27 ± 5.17 for the impact on sexual life, 12.87 ± 4.58 for the impact on family and social life, and 8.03 ± 3.89 for the impact on mental well-being. These findings indicate that women hold a certain level of myths regarding the menopausal period. In particular, it can be said that misconceptions related to family and social life and sexual life are more pronounced than those related to psychological well-being. This suggests that menopause is perceived not merely as a biological process but as a multidimensional life stage influenced by social and cultural beliefs. Similarly,

a study conducted in India reported that misconceptions about menopause are widespread among women [17]. A qualitative study conducted in Saudi Arabia found that women's perceptions of menopause are influenced by cultural values [8].

The total Meno-D score of 13.19 ± 9.89 indicates that the level of depressive symptoms among the women participating in the study was generally in the low-to-moderate range. However, upon examining the subscales, the emergence of more pronounced symptoms—particularly in the areas of self-perception, somatic symptoms, and sleep—is noteworthy as it reflects the multidimensional effects of the menopausal transition. This finding is consistent with the literature highlighting that menopause is a complex process involving not only emotional but also physical and cognitive dimensions [12].

The study found a positive and statistically significant association between menopause myths and perimenopausal depression. According to the correlation analysis, a positive and moderately significant relationship was determined between the total score for menopause myths and the total score for depression ($r = 0.640$; $p < 0.001$). This finding indicates that an increase in incorrect and negative beliefs regarding the menopause process is associated with an increase in depressive symptoms. The study identified positive and significant relationships not only between the total scores but also between the subdimensions of menopause myths and all subdimensions of depression (self, cognitive, somatic, sleep, and sexual) ($p < 0.001$). This suggests that menopausal myths have a multidimensional effect on psychological well-being and may influence not only mood but also cognitive and physiological dimensions. The literature indicates that negative beliefs and expectations regarding menopause lead women to perceive this period as more stressful and threatening, which in turn may increase depressive symptoms [18]. A study by O'Reilly et al. (2024) also demonstrates that the menopausal process can influence women's self-perceptions and increase psychological vulnerability [19].

As a result of the logistic regression analysis conducted to examine the effect of menopause myths on perimenopausal depression, it was determined that the "Impact on Sexual Life" and "Impact on Family and Social Life" subscales of the Menopause Myths Scale are significant predictors of the risk of mild or higher levels of depression. According to the analysis results, the "Impact on Sexual Life" subscale was found to be significantly associated with the risk of depression ($OR = 1.161$; $95\% CI = 1.077-1.252$; $p < 0.001$), while the "Impact on Family and Social Life" subscale showed an even stronger association ($OR = 1.338$; $95\% CI = 1.188-1.508$; $p < 0.001$). These results suggest that misconceptions regarding menopause do not merely stem from a lack of information but may also influence women's psychological adjustment processes. In particular, it is believed that beliefs such as the notion that menopause will negatively affect sexual life, that it signifies the end of womanhood, or that it will lead to estrangement between spouses may negatively impact women's body image, self-esteem, and life satisfaction. Such cognitive patterns may lead to the perception of the menopause process as more threatening and uncontrollable, thereby facilitating the emergence of depressive symptoms. It is noteworthy that, in the study, myths related to family and social life were found to be more strongly associated with depression. Beliefs that menopause will diminish a woman's value within the family, negatively affect her social roles, or cause deterioration in interpersonal relationships can lead women to

develop negative evaluations of their social identities. Particularly in cultures where socially assigned roles are prominent, viewing menopause not merely as a biological change but also as a life event linked to social status and feminine identity can increase psychological vulnerability. Therefore, the finding that misconceptions regarding family and social life had a greater impact on depressive symptoms can be considered an expected result.

In this study, a logistic regression analysis was conducted to identify factors influencing the risk of mild or more severe depression in perimenopausal women. The results revealed that the “Impact on Sexual Life” and “Impact on Family and Social Life” subscales of the Menopause Myths Scale significantly increased the risk of depression. According to the analysis results, each one-unit increase in the myth score related to sexual life increased the risk of depression by 16.1%, while each one-unit increase in the myth score related to family and social life increased the risk of depression by 33.8%. This finding indicates that depression during menopause cannot be explained solely by hormonal changes; rather, women’s beliefs and perceptions regarding menopause also have significant effects on mental health.

Myths that menopause negatively affects sexual life, marks the end of womanhood, or reduces sexual attractiveness can negatively impact women’s body image and self-esteem. It has been reported that negative cognitive schemas regarding menopause are associated with depressive symptoms, and that perceiving the menopausal period as a threatening life event can negatively affect mental well-being [18, 20]. For this reason, the identification of myths related to sexual life as an independent variable that increases the risk of depression in our study can be considered an expected result.

It is noteworthy that the second most significant variable influencing the risk of depression in this study was myths related to family and social life. Beliefs that a woman entering menopause will lose her value within the family, that it will lead to a rift between spouses, or that she must withdraw from social life can cause women to view their social roles negatively. The literature reports that a lack of social support is one of the most significant predictors of depressive symptoms observed during menopause, and that negative social perceptions regarding the menopausal process reduce women’s quality of life [21].

In our study, the finding that women who reported not receiving sufficient support from their families and close relatives had significantly higher scores on both the menopause myths scale and the depression scale supports this view. Adequate family and social support during menopause enables women to cope more effectively with the symptoms they experience and helps maintain their psychological well-being. Conversely, a lack of support can increase feelings of loneliness and social isolation, thereby paving the way for the development of depression [18].

In our study, the finding that women who perceived the menopausal period negatively had significantly higher scores on both menopause myths and depression scales highlights the importance of cognitive assessment processes in depression risk. Negative expectations and misconceptions regarding menopause may cause women to perceive their symptoms as more intense. It has been reported that negative attitudes toward menopause are associated with levels of depression and that how a woman perceives menopause is a significant factor affecting her mental health [21].

Strengths of the Study

Since the Menopause Myths Scale is a newly developed measurement tool, studies on its use in the literature are limited. Furthermore, the lack of research examining the relationship between the level of belief in menopause myths and depression during the premenopausal period points to a significant gap in the body of knowledge in this field. Accordingly, it is believed that the present study will provide original and significant contributions to the literature by both providing evidence for the use of the Menopause Myths Scale in different samples and by elucidating the relationship between menopause myths and depression during the premenopausal period.

Limitations

This study has several limitations that should be considered when interpreting the findings. First, the cross-sectional design does not allow for causal or directional inferences between variables, even though multivariate regression analysis was conducted. Second, data were collected via a web-based survey using a non-probability snowball sampling method, which may have introduced selection bias and self-selection bias and limited the representativeness of the sample. Third, all data were based on self-reported responses and may therefore be subject to response bias and social desirability bias.

Conclusion

In conclusion, the findings of this study indicate that the risk of depression during the perimenopausal period is not solely attributable to biological and hormonal changes; rather, myths about menopause—particularly those related to sexuality, family life, and social roles—are significant determinants in the development of depression. For this reason, educational and counseling programs for women going through menopause should focus not only on symptom management but also on dispelling myths about menopause. Psychoeducational and counseling interventions conducted by healthcare professionals—particularly nurses—can help women view the menopause process in a more realistic and positive light, thereby effectively reducing the risk of depression.

Declarations

Data Availability

Data are available from the corresponding author upon reasonable request.

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Ethical Approval

Approval was obtained from the Istanbul Okan University Ethics Committee on March 5, 2025, prior to the start of the study. Permissions to use the scales employed in the study were obtained. All participants were provided with an explanation of the study’s purpose, and their agreement to participate in the study was confirmed by their signing the informed consent form. The study was conducted in accordance with the principles of the Declaration of Helsinki. As data were collected via an online survey, the CHERRIES (Checklist for Reporting Results of Internet E-Surveys) guidelines were followed.

CRediT authorship contribution statement

Conceptualization: KDB, EMT

Methodology: KDB, EMT

Validation: KDB, EMT

Formal Analysis: KDB, EMT

Investigation: KDB, EMT

Resources: KDB, EMT, NAD

Data Curation: KDB, EMT

Writing—Preparation of the Original Draft: KDB, EMT, NAD

Writing—Review and Editing: KDB, NAD

Visualization: KDB, NAD

Supervision: KDB, NAD

Declaration of Conflicts of Interest

The authors declare no potential conflicts of interest regarding the research, authorship, or publication of this article.

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Consent for Publication

Not Applicable.

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Tables

Tables 1 to 5 are available in the supplementary files section

Supplementary Files

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