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REVIEW ARTICLE

Reimagining menopause by expanding assumptions shaping research: A scoping review of gender and sexuality diverse people's experiences and expectations

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ABSTRACT

Background*:** Menopause is socially coded as an experience of hormonal change which threatens the vitality and identity of (cisgender) women in midlife; yet this framing overlooks the diversity in menopause experiences across age, gender and sexuality. The significance of these less visible experiences has led to calls to broaden the scope of menopause narratives and representations across research, policy, and practice. ***Methods: Using an established scoping review methodology, we identified eleven articles that reported empirical research from the perspectives and/or experiences of menopause among gender diverse people (which we widened to include sexuality diverse people where some analyses were equally relevant for gender diverse people). ***Results***: Three thematic categories were produced through our analysis, each implying a provocative expansion of assumptions about specific elements of the menopause experience, namely: timing of symptomology, gender and hormones, and sexuality and reproduction. Underpinning these findings is a pressing need for an alternative way of approaching menopause beyond its clinical characteristics, which, in turn, is carried over to the research that evidences these characteristics. ***Conclusions***: The centering of accounts of menopause that assume cisgender and heterosexual women's experiences to be both normative and normal constrain other social (re)imaginings. We argue for more expansive understandings of menopause beyond this normative and clinical framing to consider the more fulsome breadth of socially situated experiences and perspectives that better serves the needs of gender diverse people.

KEYWORDS
Clinical applications; gender and sexuality diverse; hormonal fluctuation; LGBTIQA+; research design; social imaginings

Introduction

Menopause is often assumed to be a midlife experience among (cisgender) women framed as a hormonal deficit (Meyer, 2001). Yet, this framing overlooks the age diversity in menopausal cisgender women as well as the distinct experiences of menopausal trans men and non-binary people. Menopause is clinically diagnosed retrospectively as occurring 12 months since an individual's last menses. Perimenopause, the period when symptoms can begin, can stretch for a long period of time before menopause can be definitively identified. Dominant experiences of menopause tend to follow a highly gendered and normative script for its medicalization, which makes a range of reductive assumptions about the bodies, lives, and priorities of those people experiencing dynamic and/or fluctuating hormones (Ferguson & Parry, 1998; Hickey et al., 2022; Krajewski, 2019; Thomas et al., 2024). The centering of accounts of menopause from the perspective of cisgender and heterosexual women also limits cultural and clinical understandings of menopause experiences that do not align with these dominant scripts (Flint & Samil, 1990; Glyde, 2022; Riach & Jack, 2021; Riach & Rees, 2022; Westwood, 2024b).

At the same time, women (cis and trans) and non-binary people assigned female at birth are commonly grouped under the umbrella of "women's health" in relation to gynaecological and reproductive health. Increasingly, literature documenting the health needs of gender diverse people is gaining recognition that the medical specialities grouped under domains of "women's

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health," including menopausal health, can perpetuate inequities and exclusions for those who do not normatively align with nor identify as women (e.g. non-binary or agender people), or who are socially and/or legally recognized as (transgender) men (Brady et al., 2022; Drysdale et al., 2021, 2024; Gibson et al., 2022; Newman et al., 2021). Despite this, menopause remains firmly associated with, and thus managed as solely, the experiences of cisgender heterosexual women at midlife.

In response, calls have been made for increased attention to be paid to the broad diversity of experiences of menopause, including perimenopause, and other acute hormonal fluctuations related to estrogen cessation/blocking and/or ovulation cessation, including among queer and trans people (Glyde, 2022; Hickey et al., 2022; Moline & Clerke, 2023; Thomas et al., 2024; Westwood, 2024b). Through our analysis of the literature included in this scoping review, we argue for more expansive understandings of menopause beyond its normative clinical framing to consider its socially inflected experiences and perspectives. Clinical parameters may work to exclude the experiences of gender and sexuality diverse people through the assumptions around who, how, when, and why a person may experience menopause-like symptoms. This may inhibit more capacious approaches to menopause to describe a range of life experiences related to acute hormonal fluctuations related to estrogen cessation/blocking and/or ovulation cessation.

Our broader project aims are thus twofold: we seek to increase understandings of gender and sexuality diverse people's experiences of menopause and/or acute hormonal fluctuations at different stages of the life course, and we also wish to better understand the diversity of menopausal experiences and how they converge with and diverge from the dominant experiences of cisgender heterosexual women. Underpinning this research is the need for an alternative way of approaching menopause beyond its clinical parameters. Our scoping review is intended to highlight how assumptions of cisgenderism and heterosexualism can at times be inadvertently reinforced by research design that evidences clinical framings—to the detriment of more comprehensively understanding the experiences and expectations among gender and sexuality diverse people.

Rationale for the review

Despite the fact that approximately half of the world's population may experience menopause, the lived experiences of menopause-related transitions vary greatly (World Health Organization [WHO], 2022). Menopause can occur through biological changes, or can be surgically, chemically, or biomedically (e.g. hormone therapies) induced, including as part of a suite of interventions related to gender affirming care (Cizek et al., 2017; Windt et al., 2024). If menopause is assumed to be a period of change framed largely as a biological event, then its social and cultural dimensions—the influences of gender norms and familial traditions, and how aging and menopausal fluctuations are culturally viewed—may be obscured (WHO, 2022). These assumptions can contribute to social stigma and shame associated with menopause (de Salis et al., 2018; Whiley et al., 2023), and can be reinforced by inadequate diagnosis and treatment attributable to shortfalls in general practitioners' medical training as well as limited access to specialist consultants (United Kingdom Parliament 2022); all of which enables dismissive narratives about the significance of menopause in peoples' lives (de Salis et al., 2018; Thomas et al., 2024). At the same time, these assumptions can serve to collapse the wide range of experiences at the average age associated with this process into a narrowly defined disease or pathology by emphasizing only the negative aspects of menopause (Hickey et al., 2022). We follow the World Health Organization's call that it is critical to see menopause as just one point in a continuum of life stages (WHO, 2022). Developing comprehensive responses that promote the health and wellbeing of all populations who may experience menopause, then, is more than just a public health imperative centered around processes of pathology and treatment (Thomas et al., 2024).

Literature concerning cisgender women's experiences of menopause likewise cautions against a deficit model that assumes this experience to be defined by loss, and instead demonstrates

evidence of positive experiences of increased agency, liberation, and enjoyment at this time (Dillaway, 2005; Hvas, 2006; Hyde et al., 2010; Ussher et al., 2015). Other literature points to variations over the life course that result in menopause in efforts to intervene in its association with midlife only (Johnston-Ataata et al., 2020). Recent literature reviews on menopause among gender and sexuality diverse people revealed strikingly few studies on alternative experiences of menopause (Mehta et al., 2024; Westwood, 2024b) and, of those that exist, current heteronormative, cisnormative, and binary-based constructions of menopause limit its applicability to gender and sexual diverse people (Westwood, 2024b). Westwood (2024b) notes that the exclusion of gender and sexuality diverse experiences in menopause literature results in only partial understandings of its social contexts, which impacts cis and trans people alike (Westwood, 2024b). Relatedly, while menopause hormone therapy and gender affirming hormone therapy share many similarities, risks associated with gender affirming hormone therapies in older adult life have been under researched compared to younger gender diverse people or cis women on menopause hormone therapy (Mehta et al., 2024). In a review on the impact of menopause on transgender health, Cheung et al. (2023) query the relevance of the term menopause to people who are not non-cisgender women, and they speculate that menopause can be considered relevant to only older trans people recorded as female at birth who do not use gender affirming hormone therapies that would typically cause menstruation to cease before the onset of menopause; that is, non-binary and trans men who are not using testosterone. Like other review findings that point to how menopausal experiences among sexuality diverse women and non-binary people were tightly bound to the experiences of healthcare during this phase (Sobel et al., 2024), clinical guidance and social factors remain crucial important in assessing menopause or gender affirming hormone therapies (Mehta et al., 2024). Sobel and colleagues (2024) note that menopausal non-binary people are likely to delay healthcare to alleviate symptoms, and that existing mental health conditions, such as depression (cited as higher among non-binary people than other people) may be exacerbated during menopause.

A note on terminology: we aim to use an expansive definition of menopause that includes the period of hormonal fluctuation leading up to the last menses (perimenopause), the event marking twelve months since the last menses (menopause), as well as other acute hormonal fluctuations related to estrogen cessation/blocking and/or ovulation cessation, to accommodate the diversity of experiences that can be grouped under this umbrella term. At the same time, symptoms can be experienced by people undergoing fluctuations due to gender affirming hormone therapies and other biomedical changes and interventions that mimic menopause. For example, trans and gender diverse people who may experience or anticipate acute hormonal fluctuations related to estrogen cessation/blocking and/or ovulation cessation may not recognize their experiences or symptoms as "menopause," and instead may prefer to categorize it as part of their broader gender affirmation journey. As such, we find that some experiences may be excluded from definitions of menopause, such as vaginal atrophy experienced by some trans men and non-binary people, even though it is recognized that vaginal atrophy is a potential postmenopausal symptom among cisgender women (Pandit & Ouslander, 1997; Panichaya et al., 2024). While clinical definitions of menopause dominate the literature, we also consider other variations of menopausal experiences that cause a person's ovaries to stop functioning before menopause would usually occur. At the same time, recognizing the limitations of socially inscribed definitions of menopause in research is also valuable, as evidence of their omission in literature also informs us of the ways that menopause, as a gendered term, becomes reinforced through research design. In looking more widely at the research that shapes clinical applications, we are interested in how menopause is defined and operationalized in the studies under review- and how it then influences gender diverse people's expectations and experiences.

Materials and methods

Scoping reviews synthesize evidence and assess the scope of literature on a topic. The value of adopting a scoping review methodology lies in its broader approach to mapping literature and addressing research questions than other systematic reviews. Unlike systematic reviews, the aim of a scoping review is to map the key concepts that underpin a research area (Arksey & O'Malley, 2005). Scoping reviews are commonly conducted to summarize and disseminate research findings, identify research gaps, and make recommendations for future research. But they may also be carried out to determine the way the research has been conducted (Peters et al., 2015); that is, to provide useful insight into the nature of a key research concept, to clarify working definitions, and identify conceptual boundaries of a topic or field (Peters et al., 2015, 2021). Accordingly, a scoping review was determined to be the best methodology for exploring what is known about gender and sexuality diverse experiences and expectations of menopause beyond the assumptions attributed to cisgender heterosexual women.

Our process for scoping evidence for this article followed established standards for synthesizing published evidence on a particular topic (e.g. Joanna Briggs Institute (JBI); see Peters et al., 2015, 2021), which in turn consolidates and extends earlier works describing scoping review methodologies (e.g. Arksey & O'Malley, 2005; Levac et al., 2010). We used the PRISMA extension for Scoping Reviews (PRISMA-ScR), which is a checklist containing reporting items when completing a scoping review (Preferred Reporting Items for Systematic reviews and Meta-Analyses [PRISMA], 2024), in combination with JBI's updated guidance for the conduct of reviews (Aromataris et al., 2024). We developed a scoping review protocol prior to undertaking the review itself following the same process as the conduct of a systematic review. Our scoping review protocol pre-defined the objectives and methods of the scoping review and established clearly defined inclusion and exclusion criteria (Peters et al., 2015). To start, we iteratively defined the review objective, and the research questions needed to achieve that objective. Our interest at the outset was to think beyond the clinical application of menopause that allowed us to consider outlier perspectives and experiences. The population, concept, and context framework (PCC) guided the development of specific inclusion criteria, facilitated the literature search, and provided a robust structure for the development of the scoping review (Peters et al., 2021). We focussed on gender and sexuality diverse people's (population) experiences and/or expectations of menopause (concept) as we wanted to understand these experiences beyond characterizations of menopause according to the experiences of cisgender heterosexual women, including their operationalization in research design, sampling and analysis (context).

While our original focus was on menopause experiences among all people with ovaries, we expanded this to include experiences among sexuality diverse people to recognize the deeply imbricated and intersectional relationship between gender and sexuality. Gender and sexuality, while analytically separable, are both closely interrelated (Richardson, 2007). Research that is intended to highlight diversity within populations will often measure both variables and a recent large population-representative cohort study among Australian adolescents show a strong association between gender diversity and sexuality diversity (Marino et al., 2024). We also included expectations of menopause in recognition that attitudes can shape experiences and the embodied symptoms of menopause. Given our interest in reviewing contemporary research on our topic and reflecting the age of literature exploring menopause as a topic, we limited our review to articles published from 2000 to 2024, and only included peer reviewed publications to highlight where researchers had directed their attention and resources to ensure recency and relevancy of the findings. A further inclusion criterion was added to limit publications to those which allowed gender and sexuality diverse people to share their own experiences relating to menopause. The articles did not need to follow a qualitative methodology necessarily, but participants needed to have been given an opportunity to provide their own accounts of experiences. Accordingly, systematic,

scoping and narrative literature reviews were subsequently excluded in the last screening phase.

We ran database searches on April 5, 2024 and screened according to the inclusion criteria. As we started to undertake our review, we saw relevant articles published throughout 2024 and so we reran the data base searches again on November 25 to pick up more recent publications that year. We conducted this final screen to ensure the most up to date research was included in this scoping review. Searches were conducted on electronic academic databases: Scopus, Web of Science, MEDLINE (including records published in PubMed), PsycINFO, ProQuest and CINAHL. The inclusion and exclusion criteria for this search, as well as the key search terms, are provided in Tables 1 and 2.

Finally, we applied the protocol in conducting our systematic searches and screening results according to the eligibility criteria on the full versions of articles, including results from both database searches (Figure 1).

A total of 2,354 references were obtained from database searches and were charted in Excel, including title, abstract, and keywords, after duplications were removed. Title and abstracts were read by two members of the research team. 2,331 articles were excluded as they did not meet the PCC framework applied to the scoping study, and four articles were further excluded as they did not meet the peer reviewed criteria at the second screening stage. The 23 articles identified from the database searches were then read in full, and a further 15 articles were removed because they did not meet the inclusion criteria (that is, if on reproductive care more generally with no explicit mention of menopause, if on developing clinical guidelines with no direct inclusion of LGBTIQA+ experiences or perspectives, or if articles reported on literature reviews). A further

Table 1. Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
• English language. • Published in or after 2000. • Published in peer-reviewed journal. • Focused primarily on non-cisgender and/or non-heterosexual people. • Focused on lived experience (qualitative and quantitative research methodologies were included if articles under review satisfied the above criteria).	• Language other than English. • Published before 2000. • Not published in peer-reviewed journal. • Primary focus is not on non-cisgender and/or non-heterosexual people. • Primary focus is issues other than lived experience, e.g. clinical guidelines, models of care, health promotion, advocacy frameworks, and review articles.

Table 2. Search terms.

Gender and sexuality diversity	Menopause
lgb* OR lgbt* OR gay* OR lesbian* OR homosexual* OR bisexual* OR queer OR trans* OR transgender OR non-binary OR "sexual minority" OR "gender minority" OR "gender divers*" OR "gender fluid" OR "gender nonconforming" OR "sexuality diverse"	Menopause OR perimenopause; acute hormonal fluctuation AND estrogen cessation[#]; acute hormonal fluctuation AND ovulation cessation[#]; acute hormonal fluctuation AND estrogen blockage [#]These combinations of terms did not yield any results

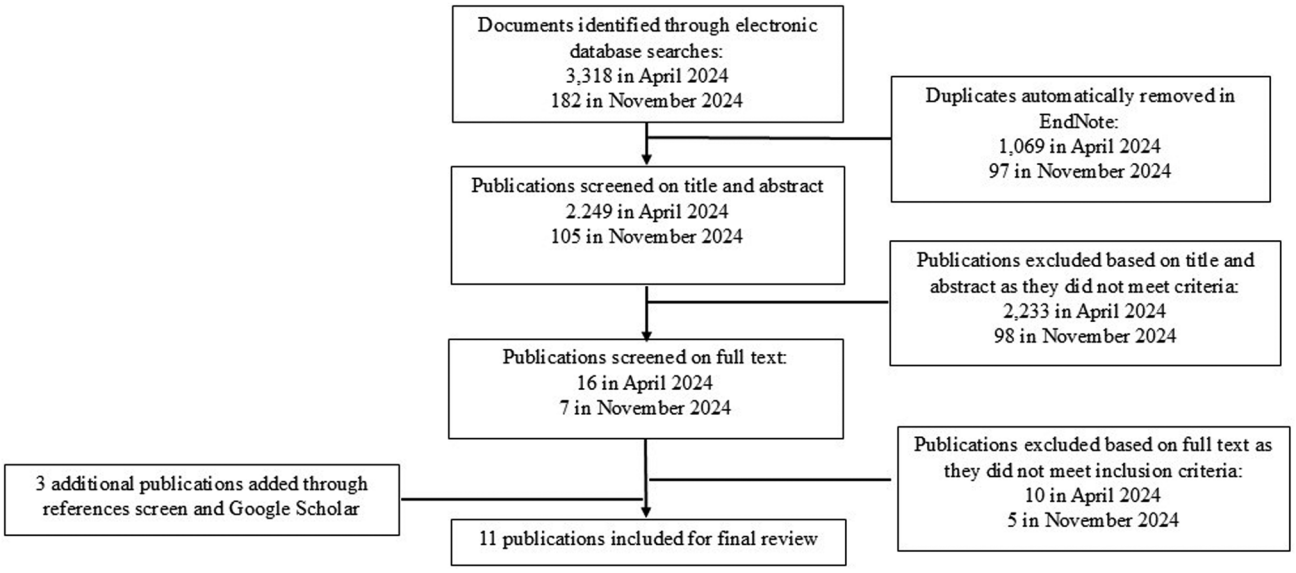

Figure 1. Simplified PRISMA protocol for systematic reviews (see Moher et al., 2009).

three articles were included after scanning the reference lists of all eligible articles and verifying through a Google Scholar search using the same search items.

Relevant information was synthesized and interpreted by sifting, charting and sorting according to key issues and themes. This involved an iterative process in which we constantly returned to, reflected on, and made meaning from the data to ensure a thorough familiarity with the research scoped (Braun & Clarke, 2012). We first created an annotated bibliography based on the findings of each article under review, which allowed us to see patterns and connections between them. We next returned to our research question to reorganize findings based on normative assumptions underpinning the research design of each study. This led us to reflect more meaningfully on methodologies (design, sampling, recruitment, presentation of data, etc), which we then incorporated into our analysis. The diverse composition of the research team, which included a cultural theorist of LGBTQIA+ health, a health and justice researcher, and a socially engaged designer for menopausal health, aided in the more expansive analysis of the articles scoped in this review.

Results

Using scoping methodology, we included 11 articles in this review. Of note, three articles reported on findings from a single study (see Hyde, Nee, Drennan, et al., 2010; Hyde, Nee, Howlett, 2010; Hyde et al., 2011) but we included only the article that reported sexuality in participant demographic characteristics and presented findings stratified according to sexuality (Hyde et al., 2011). We also screened three articles from the same author(s) (Toze & Westwood, 2024; Westwood, 2024b, 2024a), but included only the two articles that reported on participants' experiences (Toze & Westwood, 2024; Westwood, 2024a) See Table 3 for a list of included articles and their research focus, target sample, country of origin, and methodologies used.

Three thematic categories were produced through our analysis of the small amount literature on this topic, each related to the expansion of assumptions about specific elements of the menopause experience, namely: timing of symptomology, gender and hormones, and sexuality and reproduction.

Expanding assumptions about timing of symptomology related to menopause

Midlife was associated with experiences of menopause in eight studies under review, which was reflected in research design, sampling and presentation of data.

Mohammed and Hunter's mixed methods study explored 67 trans women's expectations of reaching 50 years of age or their experiences if over 50 years of age with respect to their use of gender affirming hormone therapies, as the authors identify 50 as "the age when cisgender women typically go through menopause" (p. 99). Midlife was also evident in research sampling in an article that included data on menopause in its broader study (Kelly, 2008). While Kelly's mixed methods study on lesbian women's perspectives on hormone replacement therapy (HRT) lists age ranges between 39 and 64 years of age for the 116 survey respondents, interviews were conducted with 20 women only ranging in age from 46 to 60. However, the age of participants is not provided in the data presented according to each of the themes identified through the analysis, and so experiences and perspectives recounted cannot be stratified by age. While only three of 20 participants who participated in an interview were taking HRT at the time, "many" women resisted the medicalization of menopause and instead viewed menopause as just another life stage, enabling the assertion that HRT is understood to intervene in or "suspend" the biological changes at midlife that would otherwise "reflect a 'normal' or usual transition from perimenopause to postmenopause" (p. 304).

Of the articles that took menopause to be the primary focus of the research, two defined menopause as a biomedical event or transition over a midlife age range (Kruk et al., 2021; Winterich, 2003). Kruk and colleagues used a subset of a larger dataset from the Midlife in the United States survey (age range 20–75 years) to statistically analyze the responses of 3,471 women (mean

Table 3. Articles included in this scoping review.

Article details	Research focus	Target sample	Location	Methodology
Degges-White, S., & Myers, J. E. (2007). Transitions, Subjective Age, Wellness, and Life Satisfaction: A Comparison Between Lesbians and Heterosexual Women in Midlife. *Journal of LGBT Issues in Counseling*, *1*(2), 21–43.	Experiences of midlife	Sexuality diverse women	United States of America	Quantitative methods using validated and/or scaled instruments
Glyde (2023). How can therapists and other healthcare practitioners best support and validate their queer menopausal clients? *Sexual and Relationship Therapy*, *38*(4), 510–532.	Experiences of menopause	Queer people	United Kingdom	Qualitative methods (interviews, focus groups)
Hyde, A., Nee, J., Howlett, E., Butler, M., & Drennan, J. (2011). The ending of menstruation: Perspectives and experiences of lesbian and heterosexual women. *Journal of Women & Aging*, *23*(2), 160–176.	Experiences of menopause	Sexuality diverse women	Ireland	Qualitative methods (interviews, focus groups)
Kelly (2008). A lesbian feminist analysis of the demise of hormone replacement therapy. *Women's Studies International Forum*, *31*(4), 300–307.	Experiences of hormone replacement therapies	Sexuality diverse women	Australia	Qualitative methods (interviews, focus groups)
Kruk, M., Matsick, J. L., & Wardecker, B. M. (2021). Femininity Concerns and Feelings About Menstruation Cessation Among Lesbian, Bisexual, and Heterosexual Women: Implications for Menopause. *Journal of Women's Health (2002)*, *30*(12), 1751–1760.	Experiences of menopause	Sexuality diverse women	United States of America	Quantitative methods using validated and/or scaled instruments
Mohamed, S., & Hunter, M. S. (2018). Transgender women's experiences and beliefs about hormone therapy through and beyond mid-age: An exploratory UK study. *The International Journal of Transgenderism*, *20*(1), 98–107.	Experiences of hormone replacement therapies	Trans women	United Kingdom	Mixed methods (survey with validated measures and open-text questions)
Pullen Sansfaçon, A., Temple-Newhook, J., Suerich-Gulick, F., Feder, S., Lawson, M. L., Ducharme, J., Ghosh, S., & Holmes, C. (2019). The experiences of gender diverse and trans children and youth considering and initiating medical interventions in Canadian gender-affirming speciality clinics. *The International Journal of Transgenderism*, *20*(4), 371–387.	Experiences of gender affirming healthcare	Gender diverse young people	Canada	Qualitative methods (interviews, focus groups)
Thomas, C., Dwyer, A., Batchelor, J., & Van Niekerk, L. (2024). A qualitative exploration of gynaecological healthcare experiences of lesbian, gay, bisexual, transgender, queer people assigned female at birth. *Australian and New Zealand Journal of Obstetrics and Gynecology*, *64*(1), 55–62.	Experiences of gynaecological healthcare	Sexuality diverse women + Non-binary people and transgender men	Australia	Qualitative methods (interviews, focus groups)
Toze, M., & Westwood, S. (2024). Experiences of menopause among non-binary and trans people. *International Journal of Transgender Health*, *0*(0), 1–12.	Experiences of menopause	Gender diverse people	United Kingdom	Subset of mixed methods (survey with open-text questions)
Westwood, S. (2024). "GP services are still heteronormative": Sexual minority cisgender women's experiences of UK menopause healthcare – Health equity implications. *Post Reproductive Health*, 20533691241279887.	Experiences of menopause healthcare	Sexuality diverse women	United Kingdom	Subset of mixed methods (survey with open-text questions)
Winterich, J. A. (2003). Sex, Menopause, and Culture: Sexual Orientation and the Meaning of Menopause for Women's Sex Lives. *Gender & Society*, *17*(4), 627–642.	Experiences of menopause	Sexuality diverse women	United States of America	Qualitative methods (interviews, focus groups)

age of 48.08) who both self-reported sexuality and feelings about menstruation cessation (Kruk et al., 2021). Likewise, in a qualitative study of women's experiences of sex after menopause, Winterich defined menopause as the transition time from the start of perimenopause to 12 months since last menses to focus on biological causes of menopause (p. 628). Accordingly, the author targeted heterosexual and lesbian women who had experienced menopause with their ovaries still intact for recruitment but excluded surgically induced menopausal people (and presumably also chemically induced or subject to other biomedical interventions that ceased menstruation) because their experiences of menopause were "sudden" and "more difficult" (p. 632). The implications of this research criteria similarly serve to cement a particular assumption of menopause as occurring biologically, and without biomedical intervention, at midlife.

The midlife age range is also implied in three studies for which eligibility for inclusion was broadly based on participant self-selection: "menopausal" (Hyde et al., 2011), "experienced/currently experiencing the menopause" (Toze & Westwood, 2024) or "queer" (Glyde, 2023). While Glyde notes that menopause can commence through surgical removal of the ovaries before midlife, the 12 participants in this interview-based study were all within the midlife age range

(age 46–62, mean 50.75). Similarly, Toze and Westwood draw on a larger dataset ($n = 66$) of LGBTQ+ people included ages ranging from 18 to 89 to identify gender diverse people who experienced/ing menopause; however, of the 15 respondents who indicated their gender was not the same as that recorded at birth, five were aged 40–49, eight aged 50–59 and two were aged 60–69. Also, in Hyde and colleagues' study of 39 self-selected "menopausal women," 31% were within the 50–54 age range, followed by further 28% within the 55–59 age range (and the youngest age range listed was 40–44). Notably, Hyde and colleagues tended to oscillate between implied definitions of menopause with which they interpret their findings. On the one hand, their discussion notes that as menopause is defined as occurring 12 months since last period and so menopause can only ever be retrospectively experienced as the end of menstruation, heightened emotional responses to menopause may be bundled with other significant life changes. On the other hand, their presentation of findings associated with symptoms of menopausal hormonal fluctuation, such as irregular periods, premenstrual bodily changes, and mood swings, are suggestive of a definition of menopause associated with a longer phase or transition period, albeit one that remains wedded to midlife. This accords with Toze and Westwood's findings that list problems with memory/concentration, hot flushes, and difficulty sleeping as the three highest reported symptoms among gender diverse people who experienced menopause, although only reported among gender diverse people aged between 40 and 69. However, Hyde and colleagues make the distinction between the effects of menopause (in particular, vasomotor symptoms which were seen to impact "heavily" on participants) and menopause as the embodied experience of the permanent termination of menstruation (which they reported as being "accepted passively and unemotionally" by most participants in their study) (p. 166). To separate effects of menopause (that is, the acute hormonal fluctuations that characterize the period from perimenopause to menopause completion) from the symbolism associated with menopause (that is, as an end to menstruation) risks implying that there is a greater social and cultural impact to the idea of menopause, but not its embodied experience.

Finally, in Degges-White and Myers (2006) study comparing heterosexual and lesbian women's reported subjective (as opposed to chronological) age and measures of wellness and satisfaction, they included survey responses from respondents aged between 35 and 65 to account for their assertion that "no single, universal age range has been defined as the midlife period" (p. 25). Of the 207 responses included for analysis aggregated by sexuality, over half of lesbian women and heterosexual women identified "entered perimenopause" and just under a third identified "completed menopause" as one of the 27 listed life transitions they had experienced, with the mean age of this occurring at 43.70 and 43.56 years, respectively, when entered perimenopause, and 49.80 and 47.52 years, respectively, when completed menopause. Notably, while the ages at which lesbian and heterosexual women experienced these two transitions was similar, the expectation of age associated with menopausal transitions varied, with lesbian respondents anticipating that the onset of perimenopause would occur at age 40 and menopause completed by age 59, while heterosexual respondents expected that these transitions would start at age 54 and finish by age 60. Why lesbian women expect to commence perimenopause at ages lower than those of heterosexual women was not explored in the article, but the implications of noting this statistical finding without seeking to determine why could inadvertently reinforce the primacy of cisgender heterosexual women's experience of menopausal transitions occurring in the 50s (and further, that outlier experiences do not deserve attention).

There are three exceptions to menopause as associated or synonymous with midlife, which serve to extend assumptions of the timing of menopause and its associated symptomology. Westwood (2024a) documented 51 sexuality diverse women's experiences of menopause-related healthcare, which included respondents aged between 18 and 89. However, most respondents (80%) were within the midlife range of 40–69. The only supporting quotes attributed to people outside of that midlife range (two cisgender lesbians: an 18–29-year-old who was undergoing

early menopause owing to a clinical condition and a 30–39-year-old who went through menopause, no cause provided) both referenced healthcare providers' dismissal of the impact of menopause based on patients' sexual orientation. Thomas and colleagues' (2024) explored experiences of gynaecological healthcare among 22 LGBTQ+ people recorded as female at birth ranging in age from 20 to 60+ years, with 50% of participants in the 20–29 age range and 45.5% in the 30–39 age range (no participants were between 40 and 59 years of age and only one participant over 60 years of age). Likewise, Pullen Sansfaçon et al. (2019) analyzed the experiences of 12 trans and gender diverse young people undergoing gender affirming healthcare ranging in age from 9 to 17 years old. The implications of these three research studies are further analyzed below.

Expanding assumptions about gender and hormones related to menopause

Of the articles analyzed in respect to assumptions related to gender and hormones, two articles included data from both sexuality diverse people and gender diverse people (Glyde, 2023; Thomas et al., 2024), and three focussed on gender diversity in the context of menopause (Mohamed & Hunter, 2019; Toze & Westwood, 2024) and gender affirming healthcare (Pullen Sansfaçon et al., 2019).

Thomas and colleagues' (2024) study on LGBTQ+ peoples' experiences of gynaecological healthcare is included in this review as it contains an explicit mention of menopause. However, the single mention of menopause is associated with only one of 22 LGBTQ+ people assigned female at birth interviewed for the study, who is reported to have described "the hormonal changes they experienced during menopause as an empowering source of gender euphoria and liberation" (p. 60). While it is unknown whether menopause was experienced with ovaries at midlife or if menopause was the result of surgical removal of ovaries at a younger age, Thomas and colleagues' findings are suggestive of a strengths-based lens to menopausal somatology, rather than the deficit lens based on its cultural and social symbolism (loss of femininity, motherhood, womanhood, etc.). A further potential implication of these findings is that hormonal fluctuations experienced across the life course in the context of gender affirming healthcare are like those experienced across menopause in midlife, and as such, warrants consideration of how positive experiences and strengths of menstruation cessation among LGBTIQA+ people can be similarly located among cisgender heterosexual women to affirm a gender identity beyond social expectations of femininity (rather than simply its loss). Pullen Sansfaçon et al. (2019) also identified themes relevant to young people's access to and experiences of medical intervention (mostly puberty blockers, but also hormone therapies and surgery). They identified unwanted side effects of puberty blockers, such as hot flashes and mood swings, as negative experiences of medical intervention; symptoms which align with other studies that report on menopause symptomology (Monteleone et al., 2018; Santoro et al., 2015). Evidence cited in respect to this assertion included quotes from 15- and 17-year-old trans men). What is novel about these two articles described here is the implied suggestion that menopause (or at least menopause-like symptoms) can be experienced by people who have not been recorded as female at birth and/or who are outside of the midlife range. Toze and Westwood (2024) also reported on themes related to gender and hormones in their subset of 15 gender diverse people experiences of menopause. While their respondents were all in an expansive midlife age range (40–69 years of age), the authors found that effects on embodied gender identity through experiences of menopause were strongly associated with a non-binary identity, with people describing shifts or fluidity in how they dynamically questioned, felt discomfort in, or reaffirmed their gender through that experience. Menopause, the authors found, prompted an embodied disconnection to "female-ness" because of how many respondents perceived bodily change from, and social attitudes to, menopause as typically female experiences.

Yet, an additional finding from this suite of articles is that the experience of biological change in the body is influenced by competent, knowledgeable, and respectful healthcare. Thomas et al.

(2024) also assert that perceptions of healthcare provider incompetency were a barrier to gynaecological healthcare, including the provision of appropriate HRT administered in the context of gender affirmation and understanding its impact on symptoms associated with menopause. In a similar vein, Glyde (2022) interviewed 12 self-selected "queer" participants in four countries to ascertain their therapy needs when menopausal, including one participant assigned male at birth because Glyde was interested in the broader biopsychosocial impacts of menopause. Glyde's findings similarly reflect Thomas and colleagues' assertion that healthcare should affirm patients' experiences and provide accurate information on symptoms and associated medical interventions following appropriate training and development. In focusing on therapy and counseling to menopausal clients, Glyde also recommends that therapists acknowledge the diversity of experience of menopause, rather than make assumptions, and to acknowledge that both they and their clients may hold inaccurate information about menopause. Toze and Westwood (2024) also found that the disassociation with "female-ness" among nonbinary respondents added to challenges in navigating cisnormativity, resulting in difficulties in identifying appropriate information and resources and accessing healthcare services. Taken together, these findings are suggestive of the implication that knowledge about menopause may be a product of pervasive social scripts that maintain the dominance of menopause experiences related to cisgender and heterosexual women defined as a period of loss related to "female-ness" or femininity. If framed in this way, menopause can be at once either be not relevant or highly impactful to gender diverse people owing to shifts in gender or sexuality identity through the process of hormonal fluctuation associated with menopause.

In the only study to explore the experiences of trans women in midlife, Mohamed and Hunter (2019) go beyond discussion of the medicalization of menopause (provision of HRT) to consider its wider social and cultural dimensions. Their mixed methods cross-sectional approach generated data related to standardized measures on beliefs about medicines and open text questions. Most respondents (96%) were taking gender affirming hormone therapies at the time but did not view menopause as relevant to them, and, of those aged 50 years and over, did not report having experienced menopause. However, of those participants within a midlife range, some described physical symptoms similar to those of menopause experienced by cisgender women, such as reduced energy, mood swings, and reduced libido. Other symptoms, such as hot flushes and mood swings, were also experienced with changes to their gender affirming hormone therapies, which they understood as akin to menopausal symptoms. Notably, while some participants had no or unclear expectations when reaching midlife, others speculated that their use of gender affirming hormone therapies would change at this time in order to simulate the hormonal changes associated with cisgender experiences of menopause, and thus anticipated menopausal-like symptoms. However, similar to the findings about that closely connected the quality of healthcare with menopause experiences, Mohamed and Hunter demonstrate that many participants would be guided by medical advice at this stage. Despite a belief in healthcare providers' competency in managing hormone therapies at midlife, participants expressed concerns over long term hormone use, including uncomfortable side effects. Crucially, however, the experience of menopause symptoms through hormonal therapies cessation or change was considered a choice, with one woman stating, "I have the option of never experiencing it [menopause]" (p. 102), which suggests a level of agency among trans women that cisgender women do not have. The authors also speculate that while younger trans women may not be thinking about menopause, it is likely to be more relevant to older trans women.

Expanding assumptions about sexuality and reproduction related to menopause

Six articles reported on data collected from sexuality diverse people (Degges-White & Myers, 2006; Hyde et al., 2011; Kelly, 2008; Kruk et al., 2021; Westwood, 2024a; Winterich, 2003), but of those, four (Degges-White & Myers, 2006; Hyde et al., 2011; Kruk et al., 2021; Winterich, 2003)

included data on menopause's association with sexuality and reproductive capacity. The remaining two looked at sexuality diverse women's perspectives on healthcare, specifically the medicalization of menopause through the prescribing of menopause hormone therapy (Kelly, 2008) and general practitioner-provided menopausal healthcare (Westwood, 2024a). Both found that healthcare providers did not provide competent, respectful and patient-centered care that accounted for sexuality diversity owing to heteronormative assumptions around menopause. Simply, such assumptions result in healthcare inequities. While focussed on the experiences and perspectives of sexuality diverse people, their findings align with those on gender diverse people (Glyde, 2023; Thomas et al., 2024; Toze & Westwood, 2024) where attention to social, not just clinical, meanings associated with menopause holds relevance to, and impact on, gender and sexuality identity.

In relation to reproduction, Kruk et al. (2021) and Degges-White and Myers (2006) were similar in that their research design was intended to explicitly test hypotheses relating to correlates of gender, sexuality, and menopause, with both comparing the experiences of sexuality diverse women (lesbian, bisexual) with those of heterosexual women. However, in Kruk and colleagues' study, lesbian and bisexual identified participants were collapsed into the category of sexual minority women, while Degges-White and Meyers excluded from bisexual women from their analysis as they argue that the sample size of 14 was too small to permit meaningful comparison. Specifically, Degges-White and Myers (2006) reported no significant differences in the number of transitions experienced between lesbian and heterosexual women on associations between frequently and dynamically experienced 27 life transitions, and subjective age and wellness: the impact of the experience of perimenopause was rated as similarly low for both lesbian women and heterosexual women (2.57 and 2.53, respectively, on a 5-point Likert scale). Their findings undermine the expectation that menopause is experienced as a significant life event that prompts a revaluation of sexual and reproductive capacity. Likewise, Kruk et al. (2021) found that of the women who responded with positive or negative feelings around menstruation cessation, sexuality diverse women felt less regret associated with menopause, which was correlated with their lower concerns over attractiveness and fertility. Their conclusions suggest that associations and perceptions of menopause were bundled with broader social expectations and norms. However, close to a third of the overall sample were excluded if participants responded that they had no particular feeling about menstruation cessation as the authors only wished to measure relief or regret over menopause. This eligibility criteria could be potentially interpreted as holding the expectation that menopause should prompt an emotional response, and excluding participants because they do not may skew the findings in favor of reinforcing assumptions related to menopause and its association with reproduction, sexuality and femininity.

Hyde et al. (2011), and Winterich (2003) similarly compared the experiences of lesbian women with heterosexual women in midlife. Winterich found that all women (heterosexual and lesbian) who reported sexual wellbeing communicate openly with sexual partners and are flexible in adapting sexual practices to changes brought about by menopause; relatedly, heterosexual women who reported problems in their sex lives were constrained by prevailing and pervasive cultural ideas around menopause, gender, and (penetrative) sex. By including analysis of respondents who reported no particular feelings or emotions toward menopause (as opposed to Degges-White and Meyers' eligibility criteria), Hyde and colleagues show that "virtually all heterosexual women" were indifferent to the cessation of menstruation, in contrast to "only a minority of lesbian women," (p. 166). In contrast to Kruk and colleagues' findings, however, Hyde and colleagues found that there were higher indications of regret over menstruation cessation among lesbian women than their heterosexual counterparts (specifically described as a sense of grief), which was associated with menstruation as triggering a change to gender identity, loss of womanhood, and/or loss of potential for motherhood. This, the authors speculate, may be because lesbian women can be more reflexive to restrictive

discourses on femininity and the role of motherhood than heterosexual women, who may just accept these standards and take them for granted. Despite these contradictions, it is clear that both social and clinical considerations are warranted in determining the broader effects of menopause on people who will or have experienced it in order to challenge heterosexist assumptions that focus solely on reproductive capacity and/or cessation.

Discussion

Our scoping review aimed to illuminate how dominant assumptions related to menopause are underscored in research that sets out to provide evidence of gender and sexuality diverse people's experiences and expectation of it. The low number of articles included in this review, all from the Global North, limits its applicability and generalizability. There might have been some synonyms we missed for describing menopause, and so articles may have been unintentionally excluded if they used different terminology and keywords. For example, menopause may not be the term used for gender diverse people who cease menstruation owing to gender affirming healthcare. Despite these limitations, there are some valuable insights gleaned from this small amount of literature. In the 11 articles reviewed, the concept of menopause was clinically framed by the dominant experiences of cisgender heterosexual women, often in ways that often served to obscure or exclude outlier perspectives, in all but three articles. In recognition while that gender and sexuality are often intertwined, we included articles that on sexuality diverse people's experiences as the implications of these findings may also be relevant to gender diverse people.

Overall, our findings reveal that assumptions related to the timing of symptoms, the impact of hormones and gender expression, and its associations with sexuality and reproduction were in turn carried over to research design, sampling, analysis and presentation of data—thus reinforcing assumptions through the research that evidences them. Despite considerable variation in ages that people experience menopause and recognizing that not all menopausal symptoms arise from "natural" biological changes occurring at midlife, menopause is firmly associated or synonymous with the midlife experience of people with ovaries, as evidenced by menopausal age-based definitions (Kruk et al., 2021; Mohamed & Hunter, 2019; Winterich, 2003), research eligibility criteria (Kelly, 2008), and presentation and interpretation of data (Degges-White & Myers, 2006; Glyde, 2023; Hyde et al., 2011; Toze & Westwood, 2024). The dominance of narratives that attach menopause to midlife is evident in such research design even to the extent that trans women who may have a choice over whether or not to go through menopause are asked if they would anticipate changing or ceasing their gender affirming hormone therapies to mimic this life stage most associated with cisgender women (Mohamed & Hunter, 2019). Relatedly, any implied separation of menopause as the symbolic definition of ceasing menstruation and the embodied symptoms associated with menopause suggests that menopause carries social and cultural meaning that is anticipated to generated strong emotional responses (either relief or regret) independent of physical and emotional changes brought about by the transition period across perimenopause, menopause and post-menopause (Kruk et al., 2021). This eligibility criteria could be potentially interpreted as holding the expectation that menopause should prompt an emotional response, and excluding participants because they do not may skew the findings in favor of reinforcing this interpretation and undermines its association with sexuality and femininity—in effect, as self-reinforcing research design. By looking specifically at the experiences of menopause among gender and sexuality diverse people, the inclusion of alternative perspectives and expectations associated with menopause is important as there is increasing evidence that attitudes toward menopause can shape the experience of it (Ayers et al., 2010; Hunter & Rendall, 2007; Hunter & Chilcot, 2013). Accordingly, describing menopause purely in terms of physiology and symptomology misses a broader range of other socio-cultural determinants, prior health and reproductive histories, and lifestyle and environmental factors that are instrumental in shaping expectations and experiences.

At the same time, these findings of experience among gender diverse people also reveal that that hormonal fluctuations experienced across the life course in the context of gender affirming healthcare are like those symptoms experienced across menopausal transitions in midlife (Pullen Sansfaçon et al., 2019; Thomas et al., 2024; Toze & Westwood, 2024). As such, in similar ways that puberty can prompt a (re)consideration of gender (and sexuality) (Steensma et al., 2011), menopause can be approached within the context of fluctuating hormones as an experience that impacts on gender identity (Glyde, 2023; Pullen Sansfaçon et al., 2019; Thomas et al., 2024; Toze & Westwood, 2024). Instead of a deficit lens that describes menopause as a period of decline marked by the loss of reproductive capacity, these findings warrant consideration of how positive experiences and strengths of menstruation cessation among gender diverse people could be similarly located among cisgender heterosexual women to affirm a gender identity beyond social expectations of femininity and reproduction (Degges-White & Myers, 2006; Hyde et al., 2011; Toze & Westwood, 2024; Winterich, 2003). Specifically, we need a strengths-based approach that learns from preexisting gender affirmation activities that reflects, for example, that for some people who do not identify as women, menopause may be welcomed as an experience or contribution to gender affirmation (Glyde, 2022, 2023; Thomas et al., 2024; Toze & Westwood, 2024). At the same time, pervasive social scripts emphasize the gendered meanings attributed to menopause, which is reflected in how menopausal symptoms experienced through processes of gender affirmation are omitted from the category of menopause if the concept remains limited to biological event, free from biomedical intervention occurring a midlife only. Underpinning these findings is the influence of competent, knowledgeable and affirming medical care in addressing menopausal symptomology (Glyde, 2023; Mohamed & Hunter, 2019; Thomas et al., 2024; Westwood, 2024a), irrespective if prompted by a midlife biological event or through biomedical interventions. If menopause is assumed to have limited relevance to gender diverse people, then this may raise questions about how well-prepared healthcare providers are to provide care for anyone with experiences of hormonal fluctuation that requires medical intervention.

Conclusion

Understanding the distinctive health and wellbeing needs of all people experiencing menopause is essential to developing the fields of reproductive health, gynecology, and endocrinology to ensure they can accurately and appropriately respond to and support the diversity of health and wellbeing needs associated with these experiences—including acute hormonal fluctuations related to estrogen cessation/blocking and/or ovulation cessation experienced by gender diverse people. If assumptions about menopause perpetuate reductive, harmful, and limiting social scripts that center the dominant experiences of cisgender heterosexual women, the answer is not to simply conduct research to include outlier experiences among gender (and sexuality diverse) people into the corpus of existing literature; it requires a rethinking of how more creative, socially inflected research can go beyond a limited and limiting clinical model. If the gendering of medicine is being increasingly enacted in complex and hidden ways, then we can miss the opportunity to reimagine menopause in more capacious ways that will benefit cisgender and transgender people alike.

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