

Navigating the menopause without a compass: A counsellor's journey



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I am a person-centred counsellor with a passion for helping and supporting vulnerable people. Throughout my years volunteering at a charity-run counselling service, my eyes were opened to the challenges faced by those living in poverty, and so wanted to work in an environment that allowed me a more 'hands-on' approach. The BSc (HONS) Critical Approaches to Counselling and Psychotherapy course enabled me to develop my knowledge and understanding of the political and social issues that impact the lives of marginalised individuals, and further developed my helping skills when working with vulnerable people. As a requirement of the 3rd year curriculum, I volunteered at a charity-run organisation that assists anyone experiencing or threatened with homelessness in the local community. Upon graduation, I was offered employment within the Outreach team and residential shelters, where I am now part of the team that is able to make a huge difference to the lives of the people who engage with our services.

Abstract

Introduction

This dissertation is an autoethnographic exploration of my phenomenological experience of working as a person-centred counsellor whilst going through menopause, where the negative impact of symptoms led me to the ethical decision that I was no longer fit to practice. This research aims to explore how my social background and Western cultural attitudes towards menopause influenced my experience, and to discover the degree to which my experiences are shared with other menopausal women, particularly those in the counselling profession.

Method

An autoethnographic approach was chosen using qualitative data produced through reflective introspection, creative writing, and journal accounts of my thoughts and feelings during this time. Data was analysed and then compared to findings in current literature, to discover the shared similarities and differences between my own experience of menopause, and the experiences of menopausal women in the general population.

Findings

Menopause is a naturally occurring life stage associated with the ageing process. In Western cultures, women are valued for their youthfulness, and ageing is associated with decline. This stigmatizes women as being ‘past their best’ causing them to remain silent about their suffering, which has led to a lack of menopause conversation leading to ignorance of symptoms both personally and in professional health settings. Most often, this results in women failing to seek or be offered appropriate treatment, causing them to navigate this climacteric life stage alone.

Introduction

Menopause is a naturally occurring climacteric stage of a woman's life, where the process of female ageing causes changes in hormone levels, expressed through physical and psychological symptoms (Menopause Support, 2022). Symptoms are wide-ranging, and affect both physical and mental health, making for highly individualised menopause experiences (NICE, 2015). Historically, menopause has been shrouded in myth, where the fear of shame and stigma (Marcianna, et al., 2010) means women often navigate this disorientating life stage alone.

With the exception of early-onset menopause influenced by genetic or medical factors (NHS, 2023), the majority of women experience a natural menopause which most usually occurs between the ages of 45-55 years of age – although for some women this can continue into their mid-60s (NHS, 2022). Not all women are symptomatic, but for those who are, menopause symptoms can have a significant impact on their physical and emotional well-being (Nuffield Health, 2017), which in turn, can have a devastating effect on their personal and professional lives.

Menopause affects 50% of the world's population (Schaedel & Ryder, 2022), yet antiquated attitudes within societies continue to facilitate feelings of shame and embarrassment (Edwards, et al., 2021), with many women preferring to suffer in silence rather than face the stigma attached to this stage of a woman's life (Harper, et al., 2022). As such, conversations around menopause are limited in both a social and professional context, with health professionals stating that they had received little or no training in menopause-related health difficulties (House of Commons, 2022; Collier & Clare, 2021). This correlates with my own experience

of being a person-centred therapist, where throughout the entirety of my five years of training, I cannot recall hearing the word ‘menopause’ mentioned once.

It is estimated that in the UK alone there are currently 13 million menopausal women (NHS, 2022), with approximately 80% of those women in work, and although there are no definitive figures, Statista (2022) states that there are approximately 220,000 registered therapists in the UK, with the British Association for Counselling & Psychotherapy (further referred to as the BACP) being the largest regulating body. As of 2022, the BACP declared that it has upwards of 58,000 members. Of those members, approximately 74% are female (BACP, 2017) with 66.5% aged between 45-64 years (BACP, 2020). These figures illustrate that the counselling profession is a heavily gendered occupation (Morison, Trigeorgis, & John, 2014) and that over half of its working population could be experiencing symptoms of menopause.

In 2022, the Department for Health and Social Care (2022) launched a call for evidence to inform a government-lead health strategy for women living in England, with the results identifying that effective care for women going through menopause is hampered by disparities in the training programmes and policies available to medical personnel. The report found that menopause education is optional and relies on self-directed learning, and that clinical guidelines frequently focus on the risks associated with hormone replacement therapy (HRT) as opposed to the benefits themselves. Although HRT is not without risk, recent findings (NICE, 2019) suggest that it is the most effective method in ameliorating the vasomotor symptoms of menopause such as hot flushes and night sweats, and is the first line of treatment offered by GPs.

HRT is available through monthly prescriptions, but unlike the devolved nations where prescription charges are free (Shuttleworth & Nicholson, 2020), English women who were not eligible for free prescriptions faced a yearly cost of £111.60 (Powell, Parkin, & Kulakiewicz, 2022). However, since April 1st 2023, women are now able to apply for the HRT prepayment certificate costing £19.30 (Gov.UK, 2023) per annum. Although this is a significant cost reduction, this may still prove unaffordable for some, causing them to endure menopause symptoms for lack of funds.

The visible nature of vasomotor symptoms contributes to a greater awareness surrounding their existence, however, not all menopause symptoms are visible. In a nationwide survey conducted by Generation Menopause (2020), fewer than 15% of respondents were aware that depression and anxiety were symptoms of menopause – despite 86% of respondents in the Health & Her (2021) market survey research (conducted in response to the Department of Health’s call for evidence) having admitted to having suffered mental health issues – while 9% considered taking their own lives.

Women who seek help through NHS services for the psychological difficulties experienced during menopause are assigned Cognitive Behavioural Therapy (NHS, 2022), whilst others seek help in the private sector. However, as previously discussed, the majority of therapists are female, and the workforce is largely comprised of women of menopausal age, therefore, statistics suggest that this could be a huge problem facing the counselling and psychotherapy profession, where counsellors supporting their client’s mental health and well-being may potentially be struggling to manage their own.

Background

Since I first began my research in 2021, I have noticed a substantially increased interest in menopause – not just in health services, but also in the business sector too. Forbes (Das, 2019) describes it as ‘The next big opportunity in Femtech’, with the global menopause market projected to be valued at 24 billion dollars by 2030, and with The Female Founders Fund concluding that catering to women’s menopause-related needs is a \$600 billion opportunity for companies (Hinchcliffe, 2020). However, throughout my menopause transition (between the years 2015-2018) the issue was nowhere to be seen, which may account in part for why I failed to recognise it.

Hindsight is a wonderful thing, but it can also make one feel incredibly stupid. I remember looking forward to the menopause because to my mind, it meant that I would trade painful monthly stomach cramps for the occasional hot flush. So, despite my usual robust mental health plummeting and my sense of self quickly evaporating, it never once occurred to me that this was menopause-related. To say that my knowledge about menopause was limited is putting it mildly: beyond hot flushes, I was ignorant.

There are several reasons I believe could account for my lack of menopause literacy. Primarily, my mother had experienced early menopause in her late thirties due to having a hysterectomy, and although she fell into a deep depression soon afterwards, neither she nor her GP associated it with menopause. I also cannot recall anyone I knew in my past talking about it or owning it, so I had no benchmark to compare myself to, or even relate to. The only person I knew at the time who mentioned going through menopause spoke only of hot flushes, confirming my belief that this was all that menopause entailed.

Another contributing factor towards my failure to recognise that I was menopausal was that as a counsellor, I had a strong tendency to consider psychological factors as being responsible for mental ill-health, so did not consider that my mental ill-health could be rooted in biological factors. In 2017, towards the end of my counselling practice, I had become aware that the innate personal qualities that had originally drawn me towards the profession – those of empathy, non-judgement, and compassion for others, were in very short supply, and concluded that professional burnout (De Hert, 2020) was solely responsible for this change.

As a member of the BACP, I was mindful of their Ethical Framework for the Counselling Profession (2018) which provides a set of guidelines for facilitating good practice and felt that I was beginning to fall short of those standards. For example, the acute onset of vasomotor symptoms would immediately pull me out of my client's frame of reference, so rather than being with the client, I would become anxiously preoccupied with trying to disguise the sweat that suddenly poured out of me, and distracted by the itchiness this caused to my scalp. When the flush passed, my clothes would be cold and sodden, and I would become preoccupied with trying not to shiver. In these moments, my primary concern was that this should not distract the client, however, I could not help but become distracted myself; raising my anxiety that the distraction had shattered all psychological contact and compromised the integrity of Rogers' Six Necessary and Sufficient Conditions (1956), where it felt like I had to rebuild psychological contact over again.

As my mental health deteriorated, so did my empathy. As a counsellor, I ought to possess the ability to address a client's worries without letting them affect me personally. However, I found myself judging clients for the first time, and would return home to sob at the irony that I was there for them, but nobody was there for me. In 2016, I took a four-month break, but on my

return, it felt as though nothing had changed. It became clear to me that it was unethical for me to continue counselling clients, so in 2017, I made the heartbreaking decision to cease practice.

For the next eighteen months, I continued my decline, until in 2018, after a chance conversation with a female stranger, I finally sought help. The stranger was the first person to mention menopause to me, and it was as though a light had suddenly switched on. Two days later, I visited my GP, and after only a couple of weeks of taking HRT, the black cloud that had enshrouded me for the last three years began to lift. This was replaced with guilt at the countless women of menopausal age I had previously counselled who had presented with similar symptoms to mine, and not once had I ever considered that the aetiology of their distress could be due to menopause.

Guilt was then replaced with anger at the vacuum within health services and society where help and information regarding menopause ought to reside. Several weeks later, on the 26th of November 2018, British journalist and TV presenter Mariella Frostrup's ground-breaking documentary, '*The Truth About Menopause*' (BBC1, 2018) first aired on the BBC, and for the first time, through the frank disclosure of her intimate struggle with menopause-symptoms, I saw menopause through a biopsychosocial lens; realising and appreciating the pervasive nature of its hidden symptoms, and it was here that my education, interest, and desire to speak openly about my experience began.

Three years later, in her documentary '*Sex, Myths, and The Menopause*' (Channel 4, 2021), British TV presenter Davina McCall shared her menopause story, leading Morris (2021) to state that thanks to celebrities such as Frostrup and McCall breaking their silence on the profound effect menopause had on their lives:

‘We know from the outcry following these documentaries that there is an urgent need for communication of the highest quality, promoted by people women feel they can trust and illustrated with real-world examples – women like them’ (Morris, 2021).

As a woman whose life was profoundly affected by menopause, I strongly agree with Morris’ statement, and as a counsellor who left the profession because of the impact symptoms had on my ability to practice ethically and with non-maleficence, I felt the need to explore my historical background and (then) current circumstances that culminated in my reaching this decision, whilst sharing my story as honestly and openly as I could.

Literature Review

Search Strategy

To discover what is currently known about the impact menopause has on practising counsellors, I first conducted a scoping review (See appendix 1) to obtain an overall picture of the available literature on the impact of menopause on counsellors in practice. Using Google Scholar, I made an initial ‘quick and dirty’ search (Erasmus, 2022), and in doing so, realised that whilst there was plentiful research available relating to the biomedical aspect of menopause and the usefulness of HRT and psychotherapy for managing symptoms, there seemed to be a dearth of research available on the impact of the menopause on the women who conduct the psychotherapy: the therapists themselves.

At this point, the scoping review appeared to uncover a potential gap in the research (Munn, et al., 2018), so I then began to search a variety of databases (see appendix 2) looking for articles concerning menopausal counsellors, with the inclusion and exclusion criteria guided by three key questions:

- How does menopause literacy affect the menopause experience?
- Does menopause affect women’s psychological well-being?
- How do menopause symptoms impact counsellors’ therapeutic work?

Choosing which criteria to include or omit helps define the search parameters and enables more targeted returns (City University of London, 2022), therefore I included articles that were peer-reviewed; dated between 2010 to 2022; addressed menopause-literacy and the effect menopause symptoms have on women’s wellbeing at home and in the workplace; focused on mental health workers and the counselling profession, were written in English and studied women between the ages of 45 and 65 who experienced natural menopause. The search

excluded all articles that were not peer-reviewed; published before 2010; written in a foreign language, or where women experienced early menopause due to medical conditions or treatments, as well as all biomedical investigations.

Keywords and Boolean operators were employed to produce more relevant findings, either by filtering out, expanding, narrowing down, or excluding publications that did or did not address the research topic (Alliant Libraries, 2022). However, there are limitations to keyword searches being that they respond to facts rather than questions; and as all terms are equally weighted, results are not sorted by usefulness (Copyright Clearance Centre, 2017). Nonetheless, the following keywords and Boolean operators were used in multiple searches and varying combinations:

- Keywords used with the Boolean operator AND: menopause; counsellors; health-literacy; workplace; work; women; mental health.
- Keywords used with the Boolean operator AND NOT: cortisol; breast; cancer; ovarian; oestrogen; testosterone.

From the results produced, articles were screened for selection by title, abstract, and results, then evaluated based on criteria from the Critical Assessment Skills Programme (CASP, 2022) to determine their suitability for inclusion in the review. The search highlighted a significant gap in the literature concerning the impact of menopause on counsellors and therapists. I was only able to find one article within the inclusion criteria that explicitly related to this, therefore articles were finally chosen based on their ability to answer the aforementioned three key questions based on the findings of women in general, which places limits on the scope of understanding the impact menopause has on counsellors in practice specifically.

Review of the Literature

Except for Khandehrooa, et al's. (2022) article investigating the effectiveness of health-literacy training on menopausal women, the words stigma and taboo were referred to repeatedly throughout all of the articles included in the literature review. In Edwards et al.'s (2021) qualitative exploration of women's perceptions of menopause, the words stigma and stigmatizing were mentioned 15 times – frequently concurrent with the word taboo. Participants spoke of the historical stigma surrounding menopause due to its perception of the 'failing female body', causing feelings of embarrassment and shame. Women spoke of menopause as a reminder that they are getting older, where an ageing body is associated with physical decline. They used words such as 'degeneration' and 'feeling discounted', with one participant stating that '*When you're old, nobody wants to bother with you*' (Edwards et al., 2021: 7), and another likening menopause as akin to being '*a dried-up tree, nothing pretty or fruitful about you... you're basically dead*'.

Steffan (2020: 207) states that '*menopause talk was emotive, fearful, and self-deprecating: a taboo topic that is shrouded in mystery, and to be endured in isolation for fear of the stigmatizing effect it would have on women*'. She suggests that it is the negative narrative surrounding female ageing that is responsible for women masking menopause symptoms, especially in the workplace, where women fear being rejected, passed over, or replaced, by younger females. In a study conducted by Geukes et al. (2016) exploring the impact of menopause on 'work-ability' in women with severe menopausal symptoms, they attribute their lower than anticipated participation rate to that of employees' fear of stigmatisation with their employers, despite assurances that the results wouldn't be shared with them.

Griffiths (2017) refers to the minimization of menopause symptoms in the workplace as being mere 'women's problems', and found that the majority of women would not disclose menopause-related difficulties to their managers because they were male. Harper et al. (2022: 10) go further to suggest that it is men's shameful attitudes towards menopause that creates negative stereotypical images towards women and are dismissive of genuine suffering, and that *'the taboo engrafts a cultural secrecy and isolation, where women are left to suffer in silence alone'*. Women reported men *'rolling their eyes'* (Harper et al., 2022: 11) if they dared to talk about menopause symptoms, stating that their suffering was perceived as weakness. Ironically, in January 2023; the government rejected proposals under the Equality Act (Legislation.gov.uk, 2010) to make menopause a protected characteristic, as it could discriminate against men (Green, 2023).

In Bodza, Morrey & Hogan's qualitative study (2019) to explore the impact of menopause on counsellors in practice, in an occupation where conversation is central to its purpose, all three counsellors disclosed that this was the first time they had ever spoken about their menopause experience. One participant stated, *'I would not necessarily talk to any men about it'* (including her male supervisor), and that it was *'the prospect of humiliation or not being taken seriously'* that had kept her silent (2019: 548). Another mentioned the word alone eleven times in her interview, stating *'As a counsellor going through all this, I feel very isolated'* (2019: 549), and all three participants spoke of the need for greater cultural awareness of the menopause, alongside open conversation about the subject.

The literature highlights that in general menopause remains a taboo subject and that the cultural perception of menopausal women being 'past their prime' creates a pervasive fear of judgment that prevents them from speaking out. Women stated their dismay at the dearth of menopause

conversation, and spoke of how the silencing of menopause-related distress resulted in feelings of aloneness and isolation.

Despite women's reluctance to speak about menopause, this is not to be confused with lack of desire. In Griffiths' (2017) study of menopause-related difficulties in the workplace, she states that '*Women were pleased to be asked about this topic, grateful that it was being taken seriously, and volunteered willingly, in large numbers, to participate*' (2017:165). Edwards et al. (2021) found that women were angry at the lack of conversation and wished for a society where talking about menopause was normalized. They concluded that after their participants listened to podcasts where women shared their lived experience of menopause, they experienced a shift in attitude and perception; reporting feeling newly empowered and less isolated, with a sense of community and belongingness and comforted in the knowledge that they were not alone.

The consensus throughout the literature was that the lack of menopause conversation resulted in a lack of knowledge and awareness of symptoms, not only in women's personal environments, but in medical settings too. Collier & Clare (2021) state that many women and health professionals appear to lack awareness of menopause symptoms, therefore as suggested by Menopause Support (2022), women fail to seek out, offer, or be offered appropriate treatment and support. Harper et al. (2022) state that women were outraged at reaching this stage of their lives without the knowledge or preparedness for how menopause could affect them. They found that 90% of participants had no formal education regarding menopause, and more than 60% of women did not feel informed about menopause at all, leading them to state:

‘The lack of education for women and their general practitioners is causing women to go through this important stage of their lives with a lack of knowledge and appropriate medical care’ (Harper et al., 2022: 1).

Throughout the literature, women repeatedly spoke of having gained the limited knowledge they had of menopause through anecdotal evidence. In the majority of cases, this amounted to awareness of the stereotypical symptoms of hot flushes and night sweats (Harper et al., 2022), but where *‘the down and dirty, nitty-gritty of it remained relatively unknown’* (Edwards et al., 2021: 5). Evidence would suggest that anecdotal evidence falls short of the mark when considering the diverse experiences of menopausal women, with some professing to sail through menopause, whilst others consider taking their own lives (Health & Her, 2021).

Women described the ‘hidden phenomenon’ of menopause as the psychological symptoms that left them feeling bewildered, confused, and unable to recognise themselves, with some stating that they *‘felt like they were going mad’* (Harper et al., 2022: 7). In many cases, this belief was perhaps re-enforced after visiting their GP, where they were prescribed antidepressants or selective serotonin reuptake inhibitors (SSRIs), and sometimes inappropriately referred to mental-health services (Collier & Clare, 2021). In some cases, women stated that they knew their anxiety and depression was caused by menopause, but were dismissed by GPs (some of whom were women) who misdiagnosed them as having a mental illness (Collier & Clare, 2021, Geukes et al., 2016). This caused women to lack confidence in healthcare providers (Edwards et al., 2021), creating an even greater reluctance to seek help.

Collier & Clare, both mental-health professionals with upwards of 70 years’ experience between them, state that *‘We are ashamed to say that in that time, neither of us can ever*

remember asking a woman about the experience of menopause' (2021: 3). They suggest that healthcare providers focus largely on the biological symptoms of menopause, where HRT is prescribed, however, research highlights the reluctance of some GPs to prescribe HRT due to overestimating its potential risks (Geukes et al., 2016, Harper et al., 2022, Collier & Clare, 2021). This, Morris (2021) claims, is due to confusion surrounding the menopause, which he states significantly worsened following the publication of the initial findings of the Women's Health Initiative (2002), where it was thought that HRT increased women's risk for developing breast cancer, heart disease, blood clots, and strokes; and though more recent and substantial research refutes these claims, the system is not sufficiently capable of quickly converting research into information.

The NICE guidelines (2015) state that there is now a widespread understanding of the low risk and superior effectiveness of HRT in ameliorating menopause symptoms, however, health professionals frequently fail to keep abreast of the latest empirically supported information and treatments. These findings add to women's confusion about the menopause and deprive them of the opportunity to make autonomous decisions regarding their treatment. This was reflected in Bodza, Morrey & Hogan's (2019) study, where one participant (counsellor) received a medical diagnosis of depression. She describes how her GP did not consider menopause in her diagnosis, and instead made several failed attempts to treat her with antidepressants, leaving her *'confused, scared, and feeling out of control'* (2019: 547) and lacking confidence in the medical profession.

The literature is peppered with anecdotal evidence from women supporting their overarching concern, that the lack of general menopause literacy within society is a significant barrier to them receiving appropriate treatment. They state that this is either through being unable to

recognise symptoms themselves, therefore they do not seek out appropriate treatment, or alternatively, oftentimes receive inappropriate treatment due to menopause-illiterate professionals. In their randomized control trial, Khandehrooa et al. (2020) found that participants who received menopause education training showed significant improvements in menopause-specific areas of their lives as opposed to those in the control group who had no menopause training. They assert that their results evidence that raising menopause awareness empowers women; leading to greater self-efficacy and autonomous decision-making, facilitating an improved quality of life.

The vast majority of the review articles (Collier & Clare, 2020; Geukes et al., 2016; Harper et al., 2022; Steffan, 2020; Edwards et al., 2021 & Bodza, Morrey & Hogan, 2019) state the need for improved training for all health professionals alongside current and accurate information to be made available to women. This view is supported by Edwards et al.'s (2021) findings, where after listening to podcasts of women's real-life experiences, there was a willingness to engage with health professionals and an increase in participant's help-seeking behaviours to treat and manage symptoms. The need for better education is acknowledged in the revised upcoming NICE Guidelines (2023) expected in 2024, to improve menopause literacy for GPs and health professionals.

Typically, menopausal women seek help for hot flushes and night sweats which are the most common and recognizable symptoms of menopause (John Hopkins Medicine, 2023), where an estimated 75% of women will experience these symptoms for approximately two years. The Nuffield Health Survey (2017) involving 3,275 women aged between 40-65 years, found that roughly one-quarter of participants described their menopause symptoms as being severely debilitating, with 60% reporting experiencing psychological symptoms such as anxiety,

depression, tearfulness, and irritability. Harper et al.'s (2022) online survey found that 68.9% of their participants reported experiencing mood swings, whilst 68.3% experienced brain fog; 66.8% suffered from fatigue, and 63.9% had difficulty concentrating. It is therefore unsurprising that Geukes et al. state that '*Over three-quarters of symptomatic menopausal women report serious problems in dealing with the physical and mental demands of their work*' (Geukes et al., 2016: 3).

Harris (2022) states that due to menopause-related difficulties, one-in-ten women consider leaving their job, with the Health & Her survey (2021) finding that 370,000 participants aged between 50 and 64 years had left or were considering leaving work due to menopause. Recommendations such as the availability of cooling fans and having the ability to control the temperature of the environment are suggested (Geukes et al., 2016; Steffan, 2020, & Griffiths, 2017), though as stated earlier, women are reluctant to disclose menopause-related struggles in the workplace for fear of stigmatization (Griffiths, 2017). This evidences that symptomatic women often struggle in the workplace, but that their reluctance to disclose these struggles to co-workers could be a barrier towards implementing potentially helpful environmental changes.

The unpredictable nature of vasomotor symptoms presents difficulties in trying to manage them – typically described as '*You just never know when something is going to hit*' ((Steffan, 2020: 207). Galgut (2015) suggests that this presents an ethical dilemma for counsellors, being that a core skill of the profession is to 'be in the moment' with the client, but the sudden onset of symptoms creates a disconnect. This concern was reflected in Bodza, Morrey & Hogan's research (2019), where one participant's vasomotor symptoms caused her to reflect that '*when I'm experiencing something like that, that can sometimes completely destroy what we have in*

the room' (2019: 550). Such was the interference of symptoms on her professional capacity to counsel that she considered it unethical for her to continue in practice, so left the profession.

All three counselling participant's in Bodza, Morrey & Hogan's study (2019) expressed their feelings of inadequacy when working with clients due to their struggles with their emotional well-being. Collier & Clare (2021) recognise this in stating that health professionals may be women in need of support themselves in addition to being accountable for the service users under their care. Geukes et al. (2016) found that 'work-ability' scores for menopausal women working in health services were lower than other professions due to the challenging nature of the work, with The Royal College of Nursing (2020) recommending that line managers should receive training on the menopause symptoms and signs, as well as how to manage, assist, and support any struggling employees, and that effective use of wellness and sick leave policies should be part of this support.

Throughout the literature, a recurrent theme that relates to possible causation for mental-health difficulties was the loss of identity. Women spoke of the internal confusion that diminished their self-worth, with one woman describing it as '*falling off a hormonal cliff*' (Harper et al., 2022: 9). Steffan (2020) spoke of the impact of the menopause on women's diminishing self-confidence, creating '*a threat to previously emotionally strong, resilient, and capable women*' (2020: 207), and leading to poor outcomes in the workplace. This statement was supported by Geukes et al. (2016), Griffiths (2017), and Bodza et al. (2019), whom all highlight the detrimental impact of the loss of self on 'work-ability'. In Bodza, Morrey & Hogan's study of the impact of symptoms on counsellors, they found that confusion about menopause-related changes permeated participant's personal and professional identities, with all three counsellors

speaking about the loss of self, and one stating that she didn't know who she was anymore (Bodza, Morrey, & Hogan, 2019: 549).

In summary, the literature illustrates that the difficulties women experience during menopause exist on a biopsychosocial level. Hormonal changes influence physical and psychological well-being, and this combined with negative cultural attitudes creates a domino effect that influences symptomatic women's quality of life. There appears to be plenty of discovery regarding women's knowledge and perceptions of menopause and the impact of symptoms in their personal and professional lives, however, there is limited research regarding the impact of symptoms on women who work in mental health services, to aid discovery of the effect menopause has on their ability to practice safely and ethically.

Methodology

Research Philosophy and Method

The individuality of menopause (Newson, 2019) makes it subjective by nature, therefore a constructivist approach was chosen for the research. Constructivists maintain that absolute truth or reality does not exist: rather, we as human beings construct our realities from our phenomenological experiences (Pabel, et al., 2021). This viewpoint raises criticisms from the positivist paradigm whose philosophical foundations lie in the belief that there exists a single reality that can be objectively identified and measured (Park, et al., 2020). As such, positivists view constructivism as soft science, open to subjective opinion and bias and lacking in provable fact (Denzin & Lincoln, 2017).

De Hegt (2020) argues that the fundamental aim of science is to understand phenomena, and as concluded by Franz (2022), not every phenomenon we hope to understand can be achieved through scientific measurement. This statement is particularly true of menopause, where subjectivity plays a key role in women's experiences (Jack, Riach, & Bariola, 2019). Therefore, operating from the constructivist paradigm and using a qualitative design, being that qualitative data is concerned with exploring the ontological experiencing of individuals to better understand a particular phenomenon (Cooper, 2008), best suited the purpose of the research.

In light of women's stated preference for hearing shared experiences of menopause, and the dearth of research specifically relating to the counselling profession, my intention was to explore my phenomenological journey through menopause using autoethnography as my vehicle for undertaking my research.

Data Collection

Using autoethnography as a research method is not without its critics (Wall, 2016).

Atkinson (2006: pp 400) argues that *'the goals of analysis and theorizing are too often lost to sight in contemporary fashions for subjective and evocative ethnographic work'*, whilst Bochner & Ellis (1996) propose that the value of autoethnography lies in the subjectivity of the researcher. However, in their later overview of autoethnography (Ellis, Adams, & Bochner, 2011) they question whether autoethnographers push the boundaries of literary license so that the narrative lies less in factual truth and leans more towards a work of fiction. Muncey (2010) suggests that the criteria for evaluating truth in autoethnography ought not to lie in fact, but in plausibility and resonance gained through reflexivity – the ongoing practice of self-reflection that encourages self-awareness (Darawsheh, 2014), and is the gold standard in determining the trustworthiness of qualitative research (Teh & Lek, 2018).

Humphreys (2005) suggests that autoethnography is inherently reflexive, therefore there is acknowledgement from the author that their narrative is not value-free, with the data seeking to *'describe and systematically analyse personal experience in order to understand cultural experience'* (Ellis, Adams, & Bochner, 2011: 1). This prioritises a more introspective, intimate degree of inquiry, allowing the author to examine their own phenomenological experiences from the past and present, enabling them to share their insights with the reader (Butler, 2011).

Making sense of my own experience from a cultural perspective meant revisiting childhood memories which enabled me to produce data regarding the origin of my perception of menopause. This requires trust in the accuracy of memory recall, which can arguably be unreliable (Tullis-Owen, et al., 2008). However, Bochner (2002: 86) states that *'It is not the facts themselves that one tries to redeem through narrative tellings, but rather an articulation*

of the significance and meaning of one's experiences', with Butler (1997: 928) stating that its intention is to *'draw an audience into a collective experience in which a version of truth is demonstrated for the collective to judge'*. I therefore laid trust in my recognition of the strong embodied sense these childhood memories have continually evoked in me, and believe they evidence the influence the 'then' culture had in shaping my menopause experience.

Madill, Jordan, & Shirley (2000) state that autoethnography's introspective nature raises questions regarding its objectivity: the extent to which research projects are undistorted by the biases of researchers (Given, 2008). Bias is widely accepted as any factor that causes a study's results to be distorted (Galdas, 2017) and can occur at any phase of the research process (Pannucci & Wilkins, 2010). However, there is much philosophical debate as to whether humans can be truly objective and unbiased. Ellis, Adams & Bochner (2011) argue that researchers always impact the phenomenon that they study, whilst Scott-Pollock (2021) ascribes this to the belief that humans understand and interpret phenomena through their individual lens. Having applied reflexivity prior to beginning my research, I concluded that it would be naïve of me to consider myself fully able to separate myself from the thoughts and feelings menopause evokes in me when it had such a profound impact on this period of my life. I have therefore been clear in owning my positionality within the research, and acknowledge that I am not looking at the phenomena through an unbiased lens.

Sparkes (2000) describes how some consider autoethnography to be self-centred, narcissistic, introspective, and individualized; casting doubt over its legitimacy. However, as individualized as human experience may be, people do not exist in a vacuum. In the case of menopause, women exist within the culture of a particular society, where politics and power shape societal norms at both the macro and micro level; influencing individual and collective phenomena

(Vanhee & Dignum, 2018). Research suggests that society and culture hold a strong influence over women's experiences of menopause (Hall et al., 2007), therefore as a woman whose menopause was influenced by the shared cultural norms of UK society, where women urgently want menopause communication that uses real-world examples from women like them (Morris, 2021), this somewhat negates the concern of individualization.

As a woman who experienced the emotional turmoil caused by menopause symptoms, I strongly agree with the power that hearing others' stories holds. I found the more 'scientific' research articles lacking in conveying any real sense of what I and many others experienced. The personal journal entries I chose to include as data, alongside meaningful song lyrics and representative images, I believe puts 'flesh on the bones' of the more 'scientific' research, and as described by Goldschmidt (1977), my intention in choosing autoethnography is to make human sciences more human, with a view to helping those with similar shared experiences develop a deeper understanding of themselves, whilst facilitating a more empathic understanding for those who have not.

Ethics

In academic research, ethics can be described as a set of moral principles and values that protects the rights of participants, safeguards them from harm; and ensures that the research has been conducted with integrity (Gregory, 2003). As autoethnography centres on the personal experiences of the author, this negates the need for research participants, however, the author does not exist in a bubble which gives rise to concerns regarding relational ethics. Relational ethics is prevalent in autoethnography because in telling the story there are 'characters' that offer supporting roles (Lapadat, 2017). As such, significant others may be implicated (Ellis, Adams, & Bochner, 2011) which requires their fully-informed consent. For consent to be fully informed, individuals must be given all information about taking part in the study that may

influence their willingness to participate and is crucial in respecting their autonomy (Barker, Pistrang, & Elliott, 2002).

An integral component of ethically-conducted research is confidentiality, which is understood to indicate that personally identifiable data about individuals will not be released without their consent (Wiles, et al., 2009). This means anonymising not just obvious information such as names, but also any identifiable information such as workplaces; roles within institutions, or communities. However, in telling the aetiology of my lack of menopause literacy, it would not be possible to avoid using certain identifying nouns. As stated by Barker, Pistrang, & Elliott (2002), not everyone shares the same boundaries when it comes to issues of personal privacy, and whilst some are comfortable sharing personal details about their life, others are highly protective.

After lengthy discussions regarding who would have access to reading my narrative; how long it would be stored on the university's hard drive; the harms and benefits of being included in the research, alongside the limits of confidentiality I would be able to provide, I was fortunate that the individual concerned fell into the former category, and willingly gave full consent.

Self-care

My primary concern was that I would experience negative psychological effects triggered by reimmersing myself in this distressing period of my life, however, after much reflection, I concluded that I am in a very different place than I was back then. I feel emotionally robust and free from the stigma of potentially discussing a decline in my psychological well-being: something that I had not felt able to do throughout my menopause. However, if needed, I had the support of my academic supervisor (herself, a professional counsellor) to discuss issues that

encroached upon my well-being; also, I was part of a weekly Personal Development group facilitated by a professional counsellor, where I had ample opportunity to explore my processes throughout the duration of the research.

Findings

INTER-CONNECTING THEMES & SUBTHEMES

- Ageism & Stigma
- Lack of Knowledge
- Impact of Symptoms on Wellbeing



FIGURE1

THEME	SUBTHEMES
STIGMA & LACK OF CONVERSATION	<ul style="list-style-type: none"> • Prevailing cultural attitudes make menopause a taboo subject • Ageism and sexism contribute towards stigma • Fear of stigma has a silencing effect, perpetuating menopause illiteracy
LACK OF MENOPAUSE LITERACY	<ul style="list-style-type: none"> • Lack of awareness of symptoms in women and health professionals • Inability to recognise symptoms means women fail to seek help • Inability for health-professionals to recognise symptoms means women are often failed by the profession
IMPACT OF SYMPTOMS	<ul style="list-style-type: none"> • Vasomotor symptoms impact sleep quality which is linked to low mood and performance • Hormonal changes affect mood/ confidence/ self-esteem • Symptoms can cause anxiety and depression

FIGURE 2

The literature contained within the research depicts three clear themes that share a symbiotic relationship and evidence the biopsychosocial nature of the menopause, with all three themes strongly correlating with my own menopause experience.

It would appear that the root cause affecting women's experiences of menopause is age-related stigma. Menopause is a natural part of the female ageing process, signifying the end of a woman's ability to 'bear fruit', and in Western cultures, a woman's value is based upon her youthfulness and ability to procreate. In today's society, women have greater life expectancy due to healthier diets and improved living conditions. Many women no longer fit the stereotypical image of ageing, yet the media continues to portray the older middle-aged woman in a negative light: depicting them as less desirable, less able, and in physical and mental decline. These stigmatizing stereotypes affect women's perceptions of themselves, activating an existential crisis facilitated by negative self-image and feelings about ageing. Women's loss of identity has a detrimental impact on their confidence levels and self-esteem, whereupon they fear that owning their menopause status could lead to age-related discriminatory treatment – especially in the work-place.

The stigma attached to menopause caused women to suffer in silence in an effort to ward off being viewed as old and past their prime. This silence resulted in a dearth of menopause conversation within society, where women spoke of menopause as being shrouded in mystery and a subject of myth and taboo. Through this lack of conversation, women had limited knowledge of the broad-ranging symptoms, which left them totally unprepared for the impact menopause would have on their lives. The literature suggests that lack of knowledge also exists within healthcare services. From the government down, there is repeated acknowledgement that more needs to be done to improve knowledge and education around menopause if there is to be an improvement in diagnosis and treatment. There was also strong acknowledgement of the need to improve support and understanding in the workplace if the exodus of valuable, symptomatic women is to be avoided. This appeared especially relevant in the healthcare sector, due to the challenging nature of the work.

The literature suggests that today, menopause has one foot out of the closet. Contributing towards this, are the growing number of celebrities willing to share their menopause experience, which has helped to ‘endorse’ and ‘normalize’ this life stage. There is also a clear, increased interest from the business sector, where now, menopause-related products are openly advertised on TV, raising public awareness in the mainstream. In the last four years, the visibility of menopause appears to have significantly increased helping to dissolve the secrecy surrounding this once-taboo subject. However, it would appear that the greatest barrier facing the menopause in becoming an issue that the majority of women are willing to openly discuss, is the cultural stigma associated with the ageing female body. It would therefore seem that until cultural attitudes change, this could prove too high a price to pay for open conversation

regarding menopause, through women's fear of the potential repercussions of carrying this stigmatizing label.

Discussion

When considering the impact menopause had on my professional life, it is first necessary to explore how it affected me on a personal level. As a person-centred counsellor, the use of self serves as the medium through which therapy is carried out, and the ‘self’ of the therapist is a crucial component in the therapeutic process (Aponte, 2022). By June 2017, I considered my ‘self’ to be broken, so will first explore the contributing factors towards this ‘breakage’, before moving to discuss how this impacted my professional capacity to counsel.

A Divine Intervention?

Reflection 1	<p><i>I vividly recall the moment I was able to name the increasing hell I’d endured over the last three years as ‘The Menopause’. It was 3.15 pm on Monday 1st October 2018, and I was standing outside of a church, where moments earlier I’d been attending the funeral of my long-time agent and friend. As I stood amongst the mourners, I remember feeling completely alone in the world. Towards the end of the service, Simon and Garfunkel’s ‘Bridge Over Troubled Water’ was playing, and I remember feeling blanketed in sadness, thinking, ‘I don’t have anyone to dry my tears; I have nobody when darkness falls, and pain is all around me all of the time’. Suddenly I felt the familiar burning in the small of my back that surged upwards through my body and instantly soaked me in sweat – the term ‘hot flush’ makes it sound so delicate – so I tore off my coat and quickly ran outside.</i></p> <p><i>As I stood there, tears streaming down my face and shivering almost convulsively in my freezing, sweat-soaked shirt, a woman I had never met before approached me and said ‘I take it you’re going through it too’? Assuming she was referring to the death of my agent, I replied that it was incredibly sad. She said ‘No, silly. The menopause! Have you got to the stage where you burst into tears for no reason, yet?’ Nobody warns you it’s going to be like this...’. The rest of her narrative was a blur, though I remember it resonating profoundly with everything I was experiencing. I was dumbstruck. This was the first time anyone had mentioned menopause to me, and how could a stranger know this of me when I had no idea myself?</i></p> <p><i>Since my epiphany, whenever the subject of menopause arises, I am, and will forever be dumbfounded. How on earth did I reach this stage of my life knowing next to nothing about it? I was not anticipating it happening nor do I have any recollection of when it did – only that at some point in 2015, I realised that I hadn’t had a period in some time... and not that I knew what to look out for, but I don’t remember any warning signs. Everything seemed normal. There were no changes in my menstrual cycle: it just abruptly applied its breaks and stopped.</i></p>
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FIGURE 3

In 2015, when I began my menopause, I was oblivious to the impact that it would have on my life, so paid little if any attention to it. My lack of knowledge and total unpreparedness pays testament to the absence of conversation there was throughout my adulthood, which correlates with findings throughout the literature regarding the absence of menopause conversation in the mainstream. Purohit (2020) suggests this is a symptom of sexism and ageism with her view supported by many examples evidenced in the literature, of how the stereotypical view of the ‘menopausal woman’ as being old and past her prime creates fear of shame, embarrassment, and stigma (Local Government Association, 2021).

Although this proved to be the strongest theme evidenced in the literature, I cannot lay claim to remaining silent through fear of the stigmatizing effect it may have had on me, because I knew so little about the menopause that I was not even aware of the associated stigma. Ultimately, I did not discuss it because I did not realise that it was responsible for what was happening to me, therefore it did not seem relevant. However, with regards to ageism, I am now able to recognise the part this played in my menopause experience, which until recently, and due to its implicit nature, I was blinded from seeing.

The Cissy and Ada Effect

Reflection 2	<p><i>Whenever I hear the word menopause, strangely, I'm transported back to my childhood. Growing up in the 1960s, in the terraced streets of Liverpool. Living next door to my nanna and spending a lot of time in the company of her and her friends. Gossipy old women with short tight perms and equally tight mouths. Conversations peppered with overly-exaggerated mouthed words and whispered sleights about friends who weren't there. Me. Always the constant observer. Eyes peeled and ears pricked to hear anything and everything I wasn't meant to hear... 'What's 'The Change', nanna'? I had no idea, but apparently, I'll find out when I'm older... Older? No thank you. I'm never gonna be old like you: not in a million years!</i></p> <p><i>Being around old people made me feel bad. Trapped, yet locked out. Devoid of joy. Restrictive. It was a world I never wanted to inhabit. Girls shouldn't do this, or behave like that. WHY NOT? I can and will do whatever I want, thank you very much. Lighting the flame of a</i></p>
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<p><i>burgeoning, angry feminist. Even then, I kicked back against what was expected of me as a female. Nobody was going to tell me how I should live my life. Nobody!</i></p> <p><i>I can't believe that I am the same age now as my nanna was back then. She looked SO much older.</i></p>
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FIGURE 4

During my life, and still to this day, on the rare occasion that I hear (or heard) the word menopause, in my mind's eye, I see Les Dawson and Roy Barraclough of 'The Les Dawson Show' fame...*forgive me, nanna, but they could have been modelled on you and your posse.* It was whilst watching this show that I first heard about the menopause, and so my enduring image of menopausal women is the image below.



FIGURE 5

I feel stupidly I in admitting that the sum of my awareness of menopause was based upon an antiquated comedy sketch featuring two men in drag, however, this was the stereotypical view of older women that I grew up with, and whilst I challenged these stereotypes on a personal level, the image in my mind's eye never changed. Because of this, I failed to make the association between my periods ending and becoming menopausal, because I thought it was something that only happened to old women – and I didn't, and still don't, see myself as an old woman.

Perceptions of menopause differ throughout the world. Hickey et al. (2022) state that cultural norms and values all play a significant role in how women experience menopause, with symptoms being less unpleasant in societies where age is revered, and where older women are considered wiser and superior (Kimani, 2022). Typically, western cultures value women based on their youth and ability to procreate, therefore ageing is seen as a sign of decline (Gupta, 2022). So, whilst I may not have been personally aware of the stigma attached to menopause, the prevalence of ageism in Western societies and cultures that keeps women silent thus maintaining the ignorance surrounding menopause symptoms (Harper et al., 2022) played a major part in influencing my experience.

As a child of the 1960s, my embodied memories of growing up resonate with the then attitudes towards women that depict the stigma associated with ageing women. I remember the male-dominated media (Study Smarter, 2023) portraying likeable women as young, fun, ditzzy, subservient, and overtly sexual objects, whilst older women were portrayed as miserable, unattractive, unreasonable nagging wives – presented as the bane of their husband's life due to their constant complaining regardless of legitimacy. Feminist theorists (Showalter, 1985) have long argued that historically women have been perceived as overly-emotional irrational beings prone to unpredictable emotional outbursts, whilst men are perceived as straightforward and rational – with the term 'hysterical' derived from the Latin word *hystericus*, meaning 'of the womb' (Etymology Dictionary, 2015): devaluing and invalidating women's genuine emotionally difficult experiences as being mere 'women's problems'.

Although the 1960s was a time of emerging changes in gender roles (Watson, 2023), the older female figures in my family did and still do conform to the stereotypical view that a working-class woman's place is in the home, and 'women's troubles' are most definitely kept under

wraps lest you embarrass someone, or worse still, make a ‘show’ of yourself. This transgenerational conditioning has, and always, will anger me. Bottling up one’s emotions is seen as preferable to expressing them and ‘losing face’, and I recall on more than one occasion during my symptomatic stage where my emotions rose to the surface, being told that I had ‘lost the plot’ and was mentally ill.

Although there is still some way to go before women share equal parity with men (Mordant, 2019), there has been a significant shift in the role of women in UK society today. Women enjoy greater independence and self-sufficiency (Akshathar & Naveen, 2021), and have become increasingly visible in influential positions such as politics, education, and the boardroom, and the emergence of the stay-at-home dad (Fatherhood Institute, 2023) means that the home is no longer solely considered the woman’s domain. I have vehemently rejected the outdated stereotypical image of women as being stay-at-home mums who belong to the weaker sex, and as such, my self-concept is that of a strong, fiercely independent and capable woman – however, as the menopause took its hold over me, that would dramatically change.

The Disappearance of the Fearless Woman

An Ode to Fearless Women

I think your bones were made in an elsewhere place
How else does anyone explain
this inconceivable strength that makes you.
The way you look into danger's mouth
and see no cemetery or death.
Instead, carve your name into
it's teeth with a switchblade,
defeat it so effortlessly
and throw your head back and laugh.
Paradox girl, mighty woman,
you are the thing that terrifies them.

Both monster and maiden, both cure and poison,
all of these things and at the same time human.
Defined by no man, you are your own story,
blazing through the world, turning history into herstory.
And when they dare to tell you about
all the things you cannot be,
you smile and tell them:
"I am both war and woman and you cannot stop me."
Nikita Gill, 2020

FIGURE 6

Of all the women's narratives I have read since beginning my research, the voices that were most emotive and resonated most strongly with me were the voices of the women who expressed their fear at losing their sense of self. The words '*I don't know who I am anymore*' seemed to play on permanent loop inside my head. My self-actualizing tendency (Rogers, 1959): once an unstoppable force that had driven me from one goal to the next, had ceased to function. The fearless woman I thought I was had disappeared, and I wholeheartedly believed this was my new permanent way of being. This left me feeling empty and without purpose which terrified me, and I had a dark and overwhelming sense of not wanting to be here anymore.

The psychological changes experienced by women are in part attributed to the reduction of oestrogen levels (Spencer, 2021), where there is substantial evidence to support that the drop-off of oestrogen affects mood and cognition (Hogervorst, Craig, & O'Donnell, 2022; Reicher-Rossler & De Geyter, 2007; Talukdar & Bora, 2017). Oestrogen is responsible for modulating the cerebral neurotransmissions that manage thoughts and feelings; contributing towards low mood, anxiety, and depression. However, Sergeant & Rizq (2017) argue that this 'hormone deficiency' model pathologises menopause, and colludes with stereotypical assumptions of biological determinism and age-related decline. They state that the over-reliance on biological explanations for menopause-related difficulties does not account for women's difficulties

experienced during menopause alone, and suggest that the individual's psychosocial environment plays an important part in how they view themselves and position their identity.

This viewpoint resonates strongly with me. I was aware of the biological aspects of menopause – the night sweats and hot flushes – so focused my attention solely on those, whilst I now realise it was the loss of identity where my real struggle lay. How much my loss of identity was influenced by the change in my oestrogen levels I will never know, but through the reflexive writing of this autoethnography, I have somewhat reframed my view of my menopause experience in recognizing ageism's part.

The United Nations *'60 is the new 50: Rethinking ageing in the SDG's era'* (UN, 2019) states that increased longevity due to improved diet and healthcare means that women can expect to live approximately 25 years longer than women of 100 years ago. However, the general societal assumption that women in their 50s are in the process of both physical and mental decline, coupled with my own perception of menopausal women as being elderly, may have caused me to unconsciously reject the notion that as a menopausal woman, I was approaching older age, and therefore possible that I banished acknowledgement of being menopausal from my awareness to disassociate myself from ageing.

On reflection, had I realised that menopause had the potential to affect my mental health and that I was going through a transitional period that many women experience whilst going through this life stage, I do not believe I would have fallen so far. I believe the secrecy that enshrouds menopause contributed towards my fear of 'not knowing', and my belief that this was permanent caused me to sink so low. Also, as described by Harper et al. (2022), the gradual

onset of accumulative symptoms means that women often cannot ‘see the woods for the trees’, something again, I concur with, and so before I had realised it, I had hit rock bottom.

The Frog in the Bathwater

Reflection 3	<p><i>‘Nothing changes instantaneously. In a gradually heating bathtub, you’d be boiled to death before you knew it.’</i></p> <p>Margaret Atwood: Author of The Handmaids Tale</p> <p><i>If my mental health had noticeably deteriorated immediately after my periods ceased in early 2015, then maybe – only maybe – I might have connected the dots and realised that my depression was due to the menopause. But, as with the boiling frog analogy, it wasn’t instantaneous, it was insidious; so, I sat in that bathtub for over three years – not boiling to death but very slowly drowning, and over time any ability I had to rescue myself had evaporated.</i></p> <p><i>After my enlightenment from the stranger, I sat across from my GP, a depleted and desperate shadow of my former self. This ‘new me’ was a far cry from my self-concept. I’ve always understood myself to be strong and resilient, with a moderate degree of self-confidence, and an undefeatable attitude towards life. Yet there I was, recounting my abject misery to my female GP who fortunately specialised in menopause: stopping short of confessing that I’d had suicidal thoughts; but knowing the effect that this would have on my family had prevented me from acting on them. It wasn’t that I wanted to die – I just couldn’t see the point of waking up every morning to put myself through another day of hollowed-out emptiness; wondering where the real me had disappeared to, and worst of all, feeling terrified that she’d never come back.</i></p>
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FIGURE 7

If the onset of my symptoms could be described as chronic, then my recovery after beginning HRT could be described as acute. By my follow-up appointment, I felt significantly better:

‘Sail on silver girl... sail on by.

Your time has come to shine... all your dreams are on their way’.

(Simon, 1970)

Hope had returned to the void that its departure had created, alongside regret that I had waited three years before seeking help.

There are two main contributing factors as to why I did not seek help or begin taking HRT sooner. Firstly, although I was aware that night sweats and hot flushes were menopause symptoms, I had made the decision back in 2004, when menopause seemed way off on the horizon, that I would persevere with these symptoms as my aunt had died from ovarian cancer where HRT was cited as the cause. This correlates with Morris' (2021) findings, where he states that misinformation surrounding the risks of taking HRT following the Women's Health Initiative (American Medical Association, 2002) has cast a shadow for over 20 years on the care of menopausal women, where they stated that overall health risks did not outweigh the benefits of taking HRT: a view the literature suggests is still held by some women and health professionals, today.

The second reason for my reluctance to seek help was that I was not aware that my depression was or could be caused by the menopause. It was therefore my presumption that it was caused by burnout, and as a professional counsellor, I felt embarrassed to admit that I was deeply depressed.

Standing Too Close to the Elephant

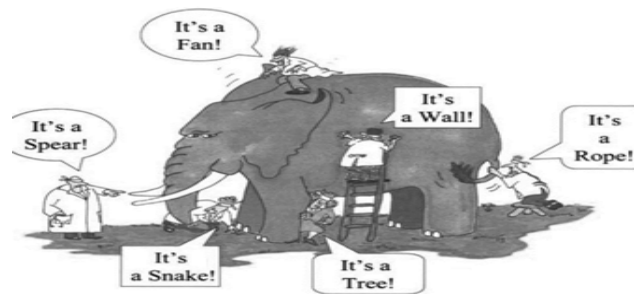


FIGURE 8

‘When one stands too close to an elephant, it is not the elephant one sees’ (Anon, 2023).

This exemplifies my situation at the onset of my depression. As a counsellor, I would look towards understanding my client’s ontological experiencing in relation to their current or past psychosocial events/ environment. As such, I related my depression to what was happening in my life without ever considering it could be a symptom of the menopause and biological in cause. My ignorance of the prevalence of psychological symptoms and inability to recognise them as belonging to menopause, resonates with the voices of many women quoted throughout the literature, evidencing that this is a commonly shared experience by women and health professionals alike (Collier & Clare, 2020; Harper et al., 2022; Steffan, 2020; Edwards et al., 2021 & Bodza, Morrey & Hogan, 2019).

Dr Louise Newson, author of *The Hayne’s Menopause Manual* (2019) and one of the UK’s leading menopause specialists, stated that despite being a menopause expert, she had failed to recognise her symptoms as belonging to the menopause (Wylde Moon, 2022). Harper, et al. (2022) describe how in the absence of their GP’s knowledge, women are frequently left to join the dots for themselves and are often left to struggle alone in the dark for several years.

This failure to see the big picture was reflected in the counselling profession (Bodza, Morrey, & Hogan, 2019), with Brayne (2013) stating that there is an alarming lack of knowledge about the menopause amongst counsellors and psychotherapists; highlighting the need for all health professional to be better aware of symptoms.

Towards the end of my practice, the only menopause-related ‘part of the elephant’ I could knowingly see was my struggle with sleep deprivation caused by perpetual night sweats. There is a strong link between low mood and sleep disturbance, especially during menopause (Jehan, Masters-Isarilov, & McFarlane, 20015), and though I was able to attribute this to menopausal hormone changes, I was still resistant to taking HRT due to my fear it could cause cancer.

Reflection 4	<p><i>I don't want to remember this, but the sweet relief that I no longer have to endure it is welcome...</i></p> <p><i>Every night without fail it would happen to the point that I'd start getting a horrible sinking feeling once it went dark outside. I'd delay going to bed for as long as possible... then about an hour after falling asleep, I'd wake up shivering; my bed, nightwear, and hair, would be drenched in sweat. I'd peel off my nightwear and change into dry clothes, then dry my bed and my hair with my hairdryer. I'd then struggle to fall back asleep, but eventually would, then about an hour later the whole cycle would begin again. On average, this happened three times per night – sometimes more – meaning that the next day I'd wake up feeling exhausted with wet clothes littering my floor. This continued for three years until I went to see the doctor and began taking HRT. I would never have gone for this alone, but becoming aware that my poor mental health could be due to menopause too, made it a no-brainer. 'I'll take the risk of developing cancer over how my life is now, any day'.</i></p>
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FIGURE 9

Alongside this, my once-healthy emotions seemed deeply buried, replaced with unhealthy thoughts and feelings that lay just below the surface and it seemed the slightest thing would cause them to erupt. I don't use this word for poetic licence: it was... the word that springs to mind is horrific. In the cold light of writing this, this seems like a gross over-exaggeration, yet in the act of allowing myself to recall my feelings at that time, I feel genuine fear. Palpitations. And I have tears in my eyes.

Back then, I had no control over my emotions. I would feel extreme anxiety just leaving my bedroom for fear that my 'mask' would slip and I would be exposed in public. Eventually, I learned to power-cry: suddenly bolting from social interactions to sob for no apparent reason, then returning; acting as though nothing had happened. I must have worn the mask too well because nobody ever seemed to notice, which hurt so much. I felt completely invisible, which culminated in me avoiding people at all costs, and as stated by women repeatedly throughout the literature, I felt completely alone with it.

*Hiding the hurt, hiding the pain,
Hiding the tears that fall like rain.
Saying I'm fine when I'm anything but.
This ache in my soul rips at my gut.
My skin is on fire; I burn from within.
The calm on my face is an ongoing sin.
The world must stay out; I've built up a wall.
My fragile lie will collapse should it ever fall.
Loneliness consumes me; it eats away the years
Until my life is swallowed by unending fears.
Waiting for someone to see I wear a mask
And care enough to remove it; is that too much to ask?*

Melisa Bernards, 2015

FIGURE 10

‘Who’s looking after me’?

The day I realised I was no longer fit to counsel; I was working with a female client who was talking about her depression. As I sat there, my usual non-judgemental, empathic ‘self’ got up and left the building; replaced by an angry individual who resented listening to someone else’s problems when they seemed trivial in comparison to her own. At this moment, I had one thought shouting inside my head: ‘WHO’S LOOKING AFTER ME’? The answer was no one: not even myself.

I had somehow managed to work through the interruptions caused by the sudden onset of vasomotor symptoms, though I constantly questioned whether I was truly offering Rogers ‘Six Necessary and Sufficient Conditions for Therapeutic Personality Change’ (Rogers, 1956) regarding remaining in psychological contact with my clients. However, on this day, I realised that I was no longer able to offer the ‘3 Core Conditions’ (Rogers, 1976) of empathy, unconditional positive regard, and congruence: the bedrock of Rogers’ person-centred approach.

As was the case with one participant in the Bodza, Morrey, & Hogan study (2019), I too had a male supervisor. At no point do I remember mentioning the word menopause to him, because being only aware of the vasomotor symptoms having an impact on my ability to counsel, like many women in the study, I had the attitude that you just ‘got on with it’. I did mention it in passing, but the subject was never explored. I have since considered whether had I had a female supervisor, there may have been a further exploration of this – perhaps even enquiring as to whether it was affecting my mental health – but that remains in the ‘things I’ll never know’

box. However, what I do know, is following the abovementioned session, and with a heavier-than-usual heart, in July 2017, I decided to cease practice.

Conclusions

This was an autoethnographic account of my menopause experience, where I was able to discover strong links between the three overarching themes that impacted my personal experience and the experiences of the women contained within the literature. These themes are:

- Ageist and sexist attitudes towards women contribute towards menopause being a deeply stigmatizing 'label', where women prefer to remain silent about symptoms and the suffering that they cause in order to avoid owning the label.
- The silencing of menopause has led to a lack of knowledge and understanding of this life stage including the wide range of symptoms. This lack of knowledge is also applicable to the healthcare sector, where menopause training is currently at one's own discretion.
- Lack of knowledge means that many women and health professionals are unaware that symptoms are menopause related, therefore fail to seek out or offer appropriate treatment and support.

As a result of these factors, many women suffer for several years before gaining access to treatment, and for some, the difficulties experienced during this time cause them to leave the workforce.

Limitations

A clear limitation of the study was the lack of literature relating specifically to counsellors in practice. The only study I was able to find (Bodza, Morrey & Hogan) was comprised of three counsellors – an extremely small sample size – therefore no conclusions can be drawn as to whether these findings are generalizable to all symptomatic menopausal counsellors in practice.

Although all three participants shared very similar experiences to those of my own; with two out of three ceasing to practice, this was a purposive sample, therefore it remains unclear as to the prevalence across the profession as a whole, of the impact menopause has on counsellors' ability to practice. This was also an interpretive phenomenological analysis with the primary researcher experiencing menopausal symptoms herself and stated that, as such, there was a strong rapport between herself and the participants. Although the primary researcher applied reflexivity throughout the research process, this could have influenced the interpretation of the data.

Implications for Practice

In the case of the three counsellors in Bodza, Morrey, & Hogan's study, all admitted to their lack of knowledge and understanding of menopause symptoms, and that taking part in the research interview was the first time they had ever spoken about it. Two of the three ceased to practice, describing similar difficulties experienced by myself when working with clients, acknowledging the difficulties vasomotor symptoms had presented during counselling sessions in maintaining psychological contact with the client, and their ability to hold a safe space when they were struggling themselves.

This suggests that menopause symptoms do present difficulties for counsellors and that there is limited knowledge of menopause within the profession. It therefore seems reasonable to consider there may be a substantial number of menopausal counsellors who are currently unaware that they are working with clients who are experiencing menopause-related difficulties, or that they are in fact managing their own. This highlights the need for raising levels of awareness of menopause within the counselling profession, perhaps with its inclusion in the training curricula and CPD workshops, or support groups – because whether counsellors

are menopausal or not, they may be supporting clients who are struggling with symptoms and unable to recognise them as such.

Recommendations for Future Research

Throughout the research process, it became apparent that the issue of stigma plays a significant role in women's menopause experiences, as attempts to mask symptoms in order to avoid the label left them frequently feeling confused, isolated, and alone. More research is needed to understand whether this influences the severity of symptoms in comparison to the severity of symptoms reported by women from different cultural backgrounds, where ageism is less prevalent, therefore stigma is less of an issue.

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