Abstract

Aim: The aim of this study was to discover if menopausal symptoms have implications for counsellors in their therapeutic work. *Method:* Semi-structured interviews were conducted with three counsellors who have experienced menopausal symptoms. The menopause is a unique experience for the individual therefore Interpretative Phenomenological Analysis (IPA) allowed for a detailed exploration of the participants' experiences. *Findings:* Four superordinate themes were identified: transitioning personal and professional identity during menopause; the limited dialogue about the menopause; the ethical dilemmas of practicing as a counsellor when menopausal and the influence of menopausal symptoms during client work. The findings of this study demonstrated that the participants each had very personal and individual experiences of the menopause. A lack of knowledge and understanding of the menopause and limited dialogue within society to discuss symptoms was also reflected in the counselling profession. The capacity to continue working therapeutically presented potential ethical dilemmas which were affected by menopausal symptoms. *Conclusion*: Counsellors' experiences of menopausal symptoms may create challenges in their therapeutic work, ranging from a mild distraction, a disconnection with a client, to the extreme of having to cease engaging with client work. Implications for therapeutic practice are discussed.

Keywords: menopause; menopausal symptoms; hormonal changes; counselling; counselling practice; client work

Introduction

Morrison, Trigeorgis and John (2014) state that 'Mental health services are inherently feminised'. Willyard (2011:1) and Rehfuss and Gambrell (2014) observe that there is a significant imbalance in the female to male ratio in the counselling profession. Figures from the British Association of Counsellors and Psychotherapists (BACP) state that 36,779 members are female compared to 6,875 male members, a ratio of 5:1 (BACP, 2017). The BACP statistics state that 23,086 of their female members are between the ages of 40 and 60 years, with the average age for menopause in the UK being 51 and symptoms lasting up to 12 years (The National Institute for Care and Excellence (NICE), 2015). This may mean that as many as 62% of BACP members could be experiencing menopausal symptoms to some degree (BACP, 2017).

The effects of the menopause on health and wellbeing

The menopause is commonly referred to as 'the change' or 'the change of life' associated with middle age in women (Ballard, Kuh & Wadsworth 2001). It is a time in women's lives when they may experience hormonal and life changes that can have varying implications for the individual (Ballard, Kuh & Wadsworth, 2001).

The menopause may cause varying levels of distress and discomfort (NICE, 2015). NICE (2015) state that '8 out of 10' women will experience symptoms of menopause in varying degrees with variable implications for wellbeing. The menopause is

caused by gradual oestrogen and progesterone depletion until a female discontinues ovulating and concludes her reproductive time of her life. This can occur over a period of ten to twelve years from peri-menopause continuing through to post-menopause (Miller & Rogers 2007). NICE guidelines (2015) describe a range of symptoms that are prevalent during the menopausal period of a women's life which may cause emotional and physical distress including: hot flushes and night sweats, mood changes, memory and concentration loss, vaginal dryness, a lack of interest in sex, headaches, joint and muscle stiffness, irregular, unexpected and heavy periods, insomnia, anxiety, depression and frustration (Miller & Rogers 2007, Baldo, Schneider & Slyer 2003). These symptoms may all have implications for counselling practice.

Working during the menopause

The Royal College of Midwives (2013) outlines that the menopause is an occupational health issue that requires further support for women experiencing symptoms. Griffiths, Maclean & Wong (2010) identified that over half of the women they questioned felt that menopausal symptoms significantly affected their working life. Distress experienced from symptoms of the menopause may be higher in a work environment compared to life in general (Griffiths Maclean & Hassard, 2013). Flushing has been linked to distress in the work environment when completing tasks that require attention to detail, working with strangers (such as new clients), male colleagues and formal situations, causing embarrassment (Reynold, 1999).

Attitudes towards the menopause

Whilst the menopause may not be a negative experience for all women (Yanikkerem, Koltan, Tamay & Dikayak, 2012; Nosek, Kennedy & Gudmundsdottir, 2012), the need for further dialogue around the menopause is well documented (e.g. Sergeant, 2015; Griffiths, 2010; Griffiths, 2016). The lack of open dialogue surrounding the menopause may negatively impact upon how women manage this period in their life (Griffiths, 2010). Counsellors are in an ideal place to support changing attitudes towards the menopause (Patterson & Lynch, 1988; Huffiman & Myers, 1999). Numerous studies highlight the need for counsellors to be aware of menopausal symptoms whilst working with the individual's unique experiences (e.g. Derry, 2004; Reynolds, 2002; Balabanovic, Ayers & Hunter, 2012; Cobia & Harper, 2005; Daire & Fairall, 2005). The National Health Service (NHS) Change Day (2015) recognises that there is a 'health care taboo' around the subject of the menopause and raising awareness of helping women through the menopause is a project that is championed (Nursing Times, 2015).

As a practising counsellor, Galgut (2015) worried that a disconnect with clients may occur as a direct result of menopausal symptoms, leading her to question her ability to adhere to professional standards. The BACP (2015) state that good practice relies upon putting clients first and working to professional standards through counsellor self-awareness and understanding of their resilience to support counselling work. A lack of discussion of the menopause may cause great distress (Sergeant, 2015; Griffiths, 2010; Griffiths, 2016) consequently, the menopause needs to be acknowledged formally within the counselling profession (Galgut, 2015).

Rationale

The limited narrative of practising counsellors highlights the need for discussion about the menopause within the psychotherapeutic fields on a professional and personal level. There are recommendations that the profession needs to be better informed (Derry, 2004; Galgut, 2015). This study aimed to contribute to this discourse.

Methodology

Design

The aim of this research was to explore how counsellors having menopausal symptoms experience their client work. The literature reviewed for this study suggests that the menopause is a unique experience for every woman therefore a qualitative approach to research was employed as it aims to describe, explore and analyse the way individuals create meaning of their life (McLeod 2015:92).

Interpretative Phenomenological Analysis (IPA) is an approach to qualitative research that allows for the study of the individual experience and interpretation (Pietkiewicz & Smith 2012) in order to gain understanding of the individual's perspective. IPA is 'committed to the examination of how people make sense of their major life experience' (Smith, Flowers & Larkin 2009:1) which may have implications for our identity (Braun & Clarke, 2013). There are a combination of three theoretical strands in IPA. Firstly, phenomenology which emphasises the subjective nature of lived experience. Secondly, hermeneutics which involves exploring how a particular experience is expressed and given meaning. Thirdly, idiography, which refers to the specific nature of particular experience, the participant's relationship to their experience and the context through which this is occurring. Together these strands

provide a multi-dimensional way of exploring experience (Smith, Flowers and Larkin, 2009). IPA was a suitable approach for this study because it is exploring menopause as a lived experience not just a broadly understood transition. This study is also exploring the holistic nature of menopausal experience in relation to client work. IPA has a view of a person that mirrors this aim, as individuals are viewed as bodily and psychological beings whose experiences are interconnected with specific contexts.

Semi structured face-to-face interview were used to elicit data for this research as it is considered an ideal way of collecting verbatim accounts from an individual (Braun & Clarke 2013). Each interview was transcribed verbatim which allowed for greater engagement with the interview and its nuances.

Participants

IPA is concerned with the details of an individual's account of their experiences (Pietkiewicz & Smith 2012). Therefore, three participants, as recommended by Smith, Flowers and Larkin (2009), who self-identified as having experienced or experiencing menopausal symptoms were recruited through purposive sampling. This small sample allowed a detailed understanding of each individual case leading to discussion across cases as well as common themes (McLeod 2015). Information on each of the participants in provided in the table below.

Insert Table 1 here

Ethics

This study was granted ethical approval from the university ethics committee. Detailed communication about the aims and purposes of the research was provided to all participants before they took part. Confidentiality was maintained through the

use of participant pseudonyms. All data was stored in accordance with the Data Protection Act (1998). All participants were made aware of their right to withdraw from the study and advised of constraints to retrospective withdrawal.

Interview schedule

In an attempt to enhance understanding of how counsellors having menopausal symptoms experience their client work, the interview schedule included questions about participants' experiences of the menopause, including physical, emotional, social and relational experiences (Griffiths, Maclean & Wong, 2010). Participants were asked about their experiences of the menopause in relation to their therapeutic practice (Griffiths Maclean & Hassard, 2013; Griffiths, Maclean & Wong 2010) and self-care, including use of supervision (Griffiths, 2010). Demographic information was obtained from the participants in order to identify the diversity and limitations of the sample. Participants were asked about their age, ethnicity, length of experience as a counsellor, current place of therapeutic practice and theoretical approach to their client work.

Procedure

Face–to-face interviews were audio recorded using a Dictaphone. Interviews ranged in length from 30-45 minutes. The indicative semi structural interview aimed to focus on understanding counsellors' experiences of having menopausal symptoms. The interview questions were developed in parallel with recommendations from Smith, Flowers and Larkin (2009) who suggest simple open questions which allow for the best results in analysing and interpreting the lived experiences of the participants.

Data analysis

Engagement with the analysis involved transcription of the interviews. This was followed by further immersion into the phenomenological experience of the participants, through listening to the recording and reading the transcript repeatedly to focus on each participant's narrative (Smith, Flowers & Larkin, 2009). Subsequently, descriptive, linguistic and conceptual comments were identified and noted within the transcript. Emergent themes were identified from this process. Connections between emergent themes led to the development of a master table of super-ordinate themes and themes. The final stage involved looking at the master table across all participants to make the connection across cases and illuminate what themes are most potent.

Researcher reflexivity

As a qualified counsellor who had begun experiencing menopausal symptoms, the primary researcher shared identity with the research participants. McLeod (2015) recommends on-going reflexive self-monitoring in an attempt to help reflect upon shared values and assumptions and develop an awareness of biases that may influence the research process and findings. Consequently, the primary researcher maintained a reflexive journal throughout the research process to help with self-reflection. Sharing characteristics and experiences can also enhance trust and sensitivity between the researcher and participants (McLeod, 2015). Whilst the participants were not asked about their perceptions of the primary researcher, there appeared to be a strong rapport, given that none of the women had spoken to anybody about their experiences of the menopause before taking part in this research but were open and trusting in sharing their experiences.

Findings

Insert Table 2 here

A focus on transitioning personal and professional identity during menopause

This superordinate theme highlights transitioning personal and professional identities experienced by Janet, Kathryn and Helen during the menopause. This involves confusion about physical and emotional changes that are occurring and the influence of limited dialogue about the menopause.

It is apparent in Janet's exploration that she was uninformed about the menopause and this created confusion that related to both her physical and mental health. She explains that she had no concept that the menopause could have such an impact and when asked if this was confusing she replied:

> Yes yes just because I did not know I was ill because I did not know the impact of the menopause (P5-L34).

The repetitive language and tone of voice expressed how strongly Janet felt about the confusion she experienced:

> I thought I was going mad literally going mad I couldn't get out of bed (P2- L 40).

The changes that Janet experienced were so far from her self-concept that she no longer recognised herself and this gave her concern and led to worries about her mental health. This was exaggerated by a medical diagnosis of depression and the medication used to treat her depression, however when the medication only helped for a short period of time she then felt like everything was taken away from her, she explains this as having: 'Pulled the rug again' (P2-L9), illustrating her sense of confusion and distress.

Each time the medication was changed, and she was given hope of recovery it was then taken away when symptoms returned, and this left her confused, scared and feeling out of control. This also resulted in a lack of confidence in the medical profession, as they did not consider the menopause within her medical diagnosis.

Janet then describes how her counselling training became instrumental in how she learnt to listen to and be aware of her own body in spite of confusion and lack of confidence in her medical diagnoses:

> If I had not gone through my counselling as a trainee…about listening and being totally aware I think I would have just honestly accepted what I was told whereas now I thought I know my body is telling me something is wrong and in the end I was right and I was poorly with having rare cysts that were up to 6cm in size and I had been carrying that (P2-L23-27).

Janet's understanding of being "totally aware" seems to highlight the nature of her connection to her own experiencing, which was confirmed eventually in her diagnosis. This inadvertently highlights her growing personal engagement with her own embodied self, emphasised in 'I was right'. Here this seems to confirm both the value of her counselling training and a moment of explicit embodied insight where her personal and professional identity overlap.

Janet also then suggests that this insight provided further clarity about decisions relating to her self-care and her client work:

> We did do boundary issues and ethical issues and whether we are okay to work and not work I found that was so good the having the choice of going

> actually I'm not gonna be fit I need to make sure all my clients are finished up (P5-L42-44).

Janet seems to emphasise how her counselling training provided a lens through which to make a professional choice about her work with clients. This gave her confidence in her identity as a therapist to make that choice. Paradoxically the clarity in these parameters and confidence in her choices also seems to reveal another layer of confusion in her personal identity. It dawns on her that there will no longer be a choice about having a baby:

> I had not totally understood and been aware …I would suddenly not be able to have children or choice and that choice was not mine anymore…That surprised me (P46-L54).

Kathryn's personal and professional identity transitions during menopause may relate to the way that her personal and professional identity seemed to be changing in tandem. She explains how menopausal changes were initially experienced implicitly:

> I was wandering around in this in a sort of fuzz really knowing that something is changing (P2-L15).

Later, she refers to the way that embodied counselling work led her to also connect with her own changing body:

> Very much about bodies and trying to tune into my body a lot I think that might have helped, so often talked about womb space and birthing and creating stuff from there was a bit of kind of spiritual stuff going on for me (P2-36-38).

This may suggest, like Janet, that there is an overlap between personal and professional identity where embodied engagement in counselling practice also enabled her to move through her confusion towards a sense of personal 'wholeness' (P3-L5).

Kathryn began her counselling training during this period of menopausal changing and so experienced changes to her personal identity and professional identity in tandem: 'I had two things going on at once' (P3-L14). Kathryn describes how her awareness of herself as a woman and as a counsellor are intertwined with ageing:

> I think the (counsellor) photo definitely reflects me as an older and older woman, so I think I might look like I'm okay to talk to, a non-threatening person (P3-L28-29).

Kathryn's use of repetition: 'older and older' sounds like time-lapse photography, simultaneously slowing down and highlighting at speed, the range of menopausal changes. It seems to emphasise an on-going process of personal changes that the menopause gradually brought into her conscious awareness. Kathryn also indicates how this transitioning may be evidenced in her professional photograph, drawing clients towards her. She describes her 'ageing' identity as a counsellor as 'non-threatening.' In the context of menopausal changes and a reference she makes to working well with children, adolescents and male clients, this sounds like a transition towards a hormonally benign state that is advantageous to her professional identity.

All three participants discussed the limited dialogue that is occurring around the menopause in both professional situations and in general conversation with friends and family. This may suggest that participants' sense-making about their menopause

is limited by a lack of open conversation; this in turn may affect perceptions of personal and professional identity.

Two participants stated that taking part in this research was the first time that they had spoken about the menopause. Helen is very honest and direct in stating that:

> 'I've not spoken to anybody about it' (before) (P5-L4)

And later states:

> I wished I had spoken to others about it, it makes me feel a bit sad really (P5-L9).

When interpreting these statements, it is necessary to extend the understanding of Helen's style of communication throughout the whole interview. It would appear that Helen does not express or divulge a great deal of personal information. This may make it difficult for her to discuss issues relating to the menopause that could be personal or intimate. The notion that she is experiencing sadness at having not shared the information suggests that Helen is beginning to contemplate that sharing of personal information about the menopause may be helpful to herself and others.

Helen describes her experiencing also as isolating, in a profession where talking is a key part of the work she says: 'as a counsellor going through all this, I feel very isolated' (P8-L.1). Helen managed this isolating experiencing through reading about menopause which 'helped me to understand what is going on for me' (P6-L186).

There seems to be a paradox as Helen reflects sadly upon being a professional in the *talking* therapies where her own experience of limited talk about the effects of the

menopause is rendering this a lonely transition. It is troubling the value of talking which is central to her professional identity.

Kathryn also states:

> To be honest I haven't really had the conversation in fact probably this is the first time I have ever spoken about it (P2-L30).

In interpreting Kathryn's interview, indicators pointed towards her experiences of external evaluation of the menopause that created a lack of dialogue. Kathryn explains her experience of humour and facetiousness in relation to menopause:

> It's got mostly negative connotations to it you know you getting old if fertility is diminished (P4-L29)

And then subsequently explains that:

> Because it's almost a joke one having a hot flush don't mind me in a bad mood (P5-L28).

Kathryn was comfortable to discuss menopause for the purpose of this research as she would be met with the respect and dignity that she felt that the menopause deserved, however the prospect of humiliation and not being taken seriously had silenced her from involvement in previous discussions.

When discussing a lack of dialogue of the menopause she used the word 'Taboo', illustrating that experiencing the menopause was restricted or forbidden. Kathryn suggested that if we had a better cultural understanding then we may find it easier to speak about the menopause:

> Really understood then I think we might be able to make it less of a taboo (P5L29).

Perceiving her menopausal experiencing as a taboo subject to talk about and using humour to protect her vulnerability about these changes when she does mention it may suggest that like Janet, who read about menopause, has managed the difficulty of engaging in open dialogue through personal strategies.

Kathryn explores the notion of culture further and whether a lack of dialogue was a result of our cultural beliefs and lack of respect for the aging process:

> Yes what I do think it would be helpful if there were because menopause is a rite of passage and it's a stage of life and it's got mostly negative connotation… I think it's but I think it's another phase of life not sure that's been explored particularly in our society (P4-L28).

Kathryn's belief system has given her a greater respect for the ageing process; however throughout the interview she makes reference to negative connotations from external beliefs which may be holding Kathryn back from truly acknowledging her personal views.

Helen also raises the issue of humour in relation to the menopause:

> Yes yes absolutely like I say men do not talk about it unless it's in a jokey way (P6-L41)

This may have implications for her ability to speak to men about the menopause:

> I would not necessarily talk to any men about that (P7-L2).

This may affect her counselling practice when working with male clients' or a male supervisor. However, Kathryn reported that she had spoken to her male supervisor about fatigue in relation to the menopause but nothing further, questioning whether she would feel comfortable to speak about the intimate symptoms of the menopause to a male client/supervisor.

Janet explored the limited dialogue about menopause within the professional setting and explained:

> I don't know I have been quite shocked and I felt quite alone actually (P9-L28).

She has been affected by the lack of response from other professional counsellors who she had assumed would meet her needs in relation to the menopause and this resulted in her feeling abandoned:

> I don't think I'm alone I really do not believe I'm alone on the process (P9 – L24).

Her sense of discomfort at being alone is reiterated through her use of repetitive language and the emphasis on 'I really don't believe I am alone'. Throughout the interview the world 'alone' appears eleven times and one of the final comments she makes highlights her loneliness:

> I hope your research will find out why I feel alone in this process (P14-L27).

This seems to echo the depth of isolation that she has experienced through her menopause.

Helen also expressed the loneliness she has experienced as a counsellor going through the menopause:

> As a counsellor going through all this I feel very isolated (P6-L44).

Dialogue surrounding the menopause was lacking for all three participants. This lack of dialogue has developed for different reasons for each participant. This ranged from the discomfort of talking about intimate and personal issues, the external evaluations that appears about the menopause and also one participant reviews the implication of culture upon the menopause. The participants also adopt different strategies to manage these difficulties such as private reading about the menopause and humour. The lack of dialogue also seems to influence experiences of personal identity through a disconnect from others. It also seems to affect professional identity in terms of valuing talking therapies for psychological wellbeing whilst feeling unable to talk about the menopause experience. This troubling of professional values which potentially undermines client work where there may be a focus on issues relating to stages of life. There may be an incongruence between the therapists' experiences of managing the limited dialogue about menopause *outside* the therapy room and facilitating a client to be vulnerable and explore their stage of life experiencing through dialogue, *inside* the therapy room.

There may be a connection between the attitudes towards menopause that the participants have experienced in relation to limited dialogue and the cultural exploration of menopause. The result of this limited discussion led to isolation and loneliness for the women which may have implications for them as counsellors.

A focus on the ethical dilemmas of practicing as a counsellor when menopausal

This superordinate theme explores the participants' experiences of issues relating to the menopause which have resulted in the exploration of whether the participants' capacity to continue practicing was affected by their menopausal symptoms.

In her interviews Janet states that she was unable to work:

> I was poorly I was not actually counselling in that process because I could not look after myself because I was poorly (P3.-L12)

And goes on to state that

> I was not fit to counsel (P3-L19).

Janet showed that she felt very confident in the decision that she had made, however she appeared to lose confidence when she spoke to her peers, who she felt did not understand about her returning to work:

> I was quite open about the fact that I had stopped my practice ethically and morally for the right reasons and yet not one came back and went that was good and that was the right thing to do but I didn't need anyone to tell me it was the right thing to do it was like yes I can really see your dilemma there (P8-L37)

As she speaks, Janet sounds very surprised not to have had any recognition from her peers who she had expected to offer support. Again this shows Janet's difficulties in being alone in the process of the menopause. She later reiterates that as a result of the lack of recognition from peers that it felt even more important that counsellors speak about the menopause:

> Yes, yes yes because I don't think I'm alone I really do not believe I'm alone on the process of what I have been through other than my experience is unique to me.

The repetition and authority of the above statement suggested that Janet wanted support and that it was difficult to find her way back to work in order to be considered professional. She goes on to discuss her concerns of the judgment she may receive when returning to work:

> Who is going to let me if I want to work for somebody be interviewed and then having to divulge this. Where is the boundary line on that to be honest because if I would have been employed there is transparency and openness counsellors' honest open transparency and how does that affect us in the workplace coming back if I want to work for an organisation whether I want to be self-employed is easier (P15-L2).

Janet's confusion and fear of being judged is apparent in the above statement. There is a fear that if she shares with people the 'madness' she experienced in her early menopause, that she fears being seen as unsuitable to work. There is a contradiction between the part of Janet who works ethically and wants to be transparent and the part of her who thinks it would be easier to be self-employed and then she does not have to risk being vulnerable by divulging her experience of the menopause.

The question of ethically making the decision to work appears to have been straightforward for this participant, who had followed the guidance in the BACP

ethical guidelines. Searching for ways back to a professional self proved to be more difficult as she had experienced a lack of support and understanding.

A focus on the influence of menopausal symptoms during client work

This superordinate theme outlines the influence of menopausal symptoms during client work. It captures participants' responses of disconnection, embarrassment and uncertainty about their professional capacity to work when experiencing symptoms.

Helen was the only participant who experienced recognisable menopausal symptoms whilst working therapeutically with clients. She shared examples of experiencing hot flushes, itching, hunger, memory loss, fatigue and tiredness.

> I find I am itching all the time and I think that when I'm with clients when I'm experiencing something like that that can sometimes completely destroy what we have in that room (P1-L32).

Helen recognises that her symptoms are creating a disconnection within her client work. The terminology she uses of 'completely destroy what we have' creates an image of complete breakdown of relationship with the client. However further on in the interview she goes on to state:

> I don't think it had any detrimental effect but it could have done and it's always there so it's something I have to remind myself about when I'm with my client's (P2-L10).

The language and emphasis changes throughout the interview and becomes less intense in relation to the impact upon her symptoms which had an effect upon her client relationship. It appears that through the process of dealing with her

menopausal symptoms, she is learning that it may be less of an issue than first thought.

Another symptom that Helen refers to is changes in body heat:

> The other thing I have experienced is body temperature sometimes I can be with my client and I can feel uncomfortable with the temperature (P3-L5).

Helen's account goes to focus upon how she experiences this:

> But it is something that can have an effect sat there with my clients and their focusing and looking at me and I'm thinking am I looking warm, as I feel embarrassed (P3 L11).

In analysing and interpreting Helen's interview there is a curiosity as to how many of her reactions are created by the embarrassment of speaking about personal or intimate issues, which may have implications for her client work:

> I feel like my client is one of the most important people talking to me at the time in that room and it's about them and I'm trying to do what is best for my client I'm not saying I feel like I am letting them down but I feel like there is a little part of me perhaps that's not what I ought to be (P3-L21).

Helen's account that she is confused by the experiences of menopausal symptoms in her client work, especially in relation to her feeling of adequacy as a counsellor, she appears to not want to admit openly to her fears of the effect it is having on her work with clients.

Helen's menopausal symptoms seem to have created a disconnect in her work and it would appear that she is still in the process of understanding her menopausal symptoms as her explanations change throughout the interview.

Helen has gone through a process from feeling overwhelmed by symptoms of menopause in her client work to working with her discomfort. This had been achieved by recognition of her symptoms and then finding a way of managing those symptoms.

Participants explored working whilst experiencing menopausal symptoms. Helen experienced extreme symptoms that resulted in her making an ethical decision to cease practicing as a counsellor. She then explored returning to work from a vulnerable position where she experienced no formal or informal support. Janet reported experiencing menopausal symptoms and developing ways of helping herself to work more comfortably: 'I look after myself on my days off to allow me to be ready and fit to go to clients because I was only part time' (P5- L30-31). Kathryn talks about discomfort when she is supporting clients in their self-care but is struggling with this in her own experience: 'I'm talking to you (client) about self-care, what am I role modelling here?' (P7-L21-22). For all three participants there seems to be a sense of uncertainty and inadequacy when working with clients that is brought on by their experiencing of the menopause.

Discussion

The aim of this research was to explore how counsellors having menopausal symptoms experience their client work. The findings of this study demonstrate that the participants had very personal and individual experiences of the menopause;

therefore using IPA for this study has been beneficial in understanding the participants' individual phenomenological experiences. The women reported that they experienced confusion about the physical and emotional changes they experienced which had implication for their personal and professional identities. Barriers to talking about their experiences and accessing support resulted in feelings of loneliness whilst ethical concerns and feelings of embarrassment and uncertainty about their professional capacity when experiencing menopausal symptoms further isolated the women.

A brief overview of the research findings, discussing the contribution of this research to literature on the menopause will now be considered. Reflection on the implications of the findings for the counselling profession will precede a discussion of the limitations of this research before outlining areas for future research.

Implications for counselling practice

Participants' accounts frequently reflected feelings of inadequacy and uncertainty within their counselling practice. In some instances, menopausal symptoms interrupted their client work and resulted in the counsellors experiencing a disconnect with their clients including having hot flushes during a therapy session which for some of the participants resulted in feelings of self-consciousness and embarrassment (Griffiths, Maclean & Wong, 2010). These finding show that menopausal symptoms do have implications for counsellors in practice, highlighting the need to raise awareness amongst counsellors of how menopausal symptoms may affect professional practice (Galgut, 2015; The Royal College of Midwives, 2013).

The research findings have highlighted a limited foundation in understanding the menopause and participants' experiences suggest that as a society we appear to have limited dialogue on the subject, which was reflected in the counselling profession. These findings highlight the need to raise awareness of the menopause and to tackle the notion that the menopause is shaming. Counsellors may benefit from greater understanding of the menopause, including hormonal changes that may contribute to a woman's wellbeing (Anderson & Posner, 2002) in both in counsellor training Curricula as well as in Continuous Profession Development courses.

The women's reluctance to discuss the menopause was often associated with a fear of negative external evaluation and assumptions that the menopause is a taboo subject. Given the lack of dialogue and the need for greater awareness of the menopause both within the counselling profession and more broadly within society (Sergeant, 2015; Griffiths, 2010; Griffiths, 2016), counsellors should be sensitive to stigma and limited understanding which may negatively impact on the use of therapy. Female counsellors who have experienced the menopause may consider using their awareness of the menopause as a way of empowering and supporting other women through group work in order to provide a forum to facilitate dialogue.

Limitations

These findings offer tentative understanding of counsellor's experiences of the menopause. Whilst the research has created interesting and informative dialogue about individual counsellor's experiences of the menopause, the subject of menopausal symptoms of counsellors was too large to explore within the confines of this research. This resulted in vastly differing experiences for each participant that in their own right would have validity for further research.

No consideration was given to cultural differences in the perception of menopause. However, Ayres, Forshaw & Hunter (2016) state that many non-European women often have a more positive outlook on menopause which relates to biological, psychological, social and cultural differences. This highlights that there is a need to give consideration to the individual experience, as there is no set narrative, and individual understanding of the menopause is unique to the individual.

Future research

Findings from the current study highlight the complexity of the women's experiences of the menopause. Research on the menopause is in its infancy (Sergeant, 2015; Griffiths, 2010; Griffiths, 2016); consequently further research is required to enhance understanding of women's experiences of the menopause, leading to the development of enhanced understanding, theory and practice.

Isolation was a pervasive theme within many of the women's narratives. Given that this was so strongly linked to wider social and cultural norms (Griffiths, 2010); this finding may have relevance and possible transferability to other women going through the menopause. Future research should aim to recruit women from a diverse ethnicity in order to further explore the role of cultural norms within the accounts of menopausal women. Further research may offer important implications for understanding the menopause, leading to the potential development of enhanced sources of support.

Conclusion

The finding of this research evidenced that the themes that relate to a lack of knowledge and understanding of the menopause and to the limited dialogue about

the menopause were of great importance to the participants. It evident from the research that counsellors experiences of menopausal symptoms created challenges in their therapeutic work, ranging from a mild distraction, a disconnection with a client to the extreme by having to cease engaging with client work.

There is clear argument in support of Griffiths, Maclean & Wong's (2010) research that shows that menopause can be an occupational health issue for some women, for a significant period of time and that support and understanding in the workplace would be of benefit to employees. This is especially pertinent to counselling as the evidence from the BACP indicated that 23,086 of their female members are between the ages of 40 years and 60 years and are of menopausal age. Therefore, if we consider that NICE (2015) state that 8 out of 10 women will experience symptoms of menopause in varying degrees with varying implications for wellbeing there may be many female counsellors needing support.

References

Ayres, N.B., Forshaw, M.J., & Hunter M.S. (2016). The Menopause. the psychologist.https://thepsychologist.bps.org.uk/volume-24/edition-menopause

Balabanovic, J., Ayers, B., & Hunter, M.S., (2012). 'Cognitive Behaviour Therapy for Menopausal Hot flushes and night sweats : A qualitative analysis of women's Experiences of group and self help CBT'. *Behavioural and Cognitive Psychotherapy* [online only], DOI: 10.1017/s1352465812000677.

Baldo, T.D., Schnier, M.K. & Slyner, M. (2003). 'The impact of menopause: implications for mental health counsellor. *Journal of Mental Health Counselling.* 25 (4) October pp. 311-322.

Ballard, K.D., Kuh, D.J., & Wadsworth, M.E.J.' (2001). 'The role of Menopause in women's experiences of the change of life'. *Sociology of Health & Illness,*(394) pp.397-424

Barbanel, L. (1990). 'Women therapist at midlife'. *Psychotherapy in private practice.* 8 (2). Pp.79-88.

Braun, V and Clark, V. (2013). *Successful Qualitative Research: a practical guide for beginners.* London: Sage.

British Association for Counselling and Psychotherapy. (2015). *Ethical Framework for the Counselling Professions*. Leicestershire: British Association for Counselling and Psychotherapy. http://www.bacp.co.uk/events/learning_programmes/ethical_framework/documents/ethical_framework_mono.pdf

Cambridge Dictionary of American Idioms. S.v. "pull the rug from under feet." Retrieved May 19 2017 from http://idioms.thefreedictionary.com/

Cobia, D.C., & Harper, A.J., (2005). ' perimenopause and sexual functioning: Implications for therapists'. *The family Journal; Counselling and Therapy for Couples and Families* . 13(2) 226-231.

Daire, A.P., & Fairall, H. (2005). 'Sexuality and Perimenopause: What counsellors need to know'. *Adultspan Journal.* 4 (2) ,fall. Pp.105-115

Data Protection Act (1998). *c.29.* Available at :

http://www.legislation.gov.uk/ukpga/1998/29

Derry. P.S (2004). *Coping with Distress During Menopause.* women and therapy 27:3-4 pp.165-177. DOI: 10.1300/J015v27no3.

Kronenberg, F (1990). Hot Flushes: epidemiology and physiology. Annals of the newyork Academy of science 592 P52-86

Galgut, C, N. (2015). Redefining the Menopause. Healthcare Counselling & Psychotherapy Journal. 15 (2) pp.22-25

Gartoulla, P., Worsley, R., Bell, R.J. and Davis, S. (2015). Moderate- severely bothersome vasomotor symptoms are associated with lowered psychological general wellbeing in women at midlife. *Maturitas.* 81 April pp. 487-492.

Gartoulla, P., Worsley, R., Bell, R.J. and Davis, S. (2016). 'Menopausal vasomotor symptoms are associated with poor self- assed work ability. *Maturitas*. 87 May pp. 33-39.

Griffiths, A. (2010). women need more support to beat the menopause 'taboo' in the work place. *The University of Nottingham .* ps://www.nottingham.ac.uk/news/pressreleases/2016/november/menopause-at-work-nottingham-expertise-informs-new-guidelines.aspx (Acessed 6/3/2017)

Griffiths, A. (2015). menopause at work –Nottingham expertise informs new guidelines. *The University of Nottingham*. ttps://www.nottingham.ac.uk/news/pressreleases/2011/march/menopauseatwork.aspx (Acessed 6/3/2017).

Griffiths, A., Maclean, S., & Wong, Y.Y.V. (2010). *Women's Experience of working through the Menopause.* Nottingham: The institute of work, Health & organisations. bohrf.org.uk/downloads/Womens_Experience_of_Working_through_the_Menopause-Dec_2010.pdf (Accessed 2/1/2017).

Griffiths, A., Maclean, S,J. & Hassard , J. (2013). 'Menopause and Work: An electronic survey of employs attitudes in the UK'. Maturitas76(2), pp 155-159

Hay-Gibson, N (2009). Interviews via VoIP: benefits and disadvantages within a PhD study of SMEs. Library and Information Research.

Huffman, B.S & Myeres, J.E (1999). *Counselling women in midlife: `An integrative approach to menopause.* Journal of Counselling and Development. Summer vol.77 pp.258-266

Miller, K.J & Rogers, A. (2007). The Estrogen Depression Connection. Oakland: Raincoat Books.

Mcleod, J (2015). Doing Research in Counselling and psychotherapy 3rdedn. London: Sage.

Morison, L., Trigeorgis , C. and John, M. (2014). 'Are mental health services are inherently feminised'. *The Psychologist.* 27 (6), June 414-415.

Nosek,M. Kennedy, H.P & Gudmundsdottir, M. (2012). Distress during the menopause Transition: A Rich Contextual Analysis of Midlife Woman's Narratives. Sage open. [Online only], DOI: 10.1177/2158244012455178.

Nursing times (2015). As nurses, it is uncomfortable to admit that we've been confused as everyone else about HRT stories'. *The Nursing Times.*

https://www.nursingtimes.net/clinical-archive/as-nurses-its-uncomfortable-to-admit-that-weve-been-as-confused-as-everyone-by-hrt-scare-stories/5083114.article. [online only]

BACP (2017). Customer Service Manager, British Association for Counselling and Psychotherapy.

Patterson, M.M, & Lynch, A.Q.(1988). Menopause: *Salient issues for counsellors* . Journal of Counselling and Development vol 67 pp. 185-187.

Pietkiewicz, I. & Smith, J.A (2012). A practical guide to using interpretative Phenomenolgical Analysis in qualitative research psychology. Psychological Journal, 18(2) pp.361-369.

Rehfuss, M.C. and Gambrell, C.E. (2014). 'Themes that facilitate the success of female counsellors in specialty areas'. *The American Counselling Association.* [Online only] DOI: 10.1002/J.2161-1920.2014.00051.x.

Reynolds, F. (1997). ' Psychological responses to menopausal hot flushes: implication for a qualitative study for counselling interventions'. *Counselling Psychology Quarterly.*10(3) pp.309-3322.

Reynolds, F. (1999). 'Distress and coping with hot flushes at work: Implications for counsellors in an occupational setting'. *Counselling Psychology Quarterly,* 12 (4) pp. 353-361.

Reynolds, F,. (2002). 'Exploring the long term experiences of Vasomotor instability: A five year follow up study of distress, perceived control and catastrophizing'. *Counselling Psychology Quarterly,*15 (1) pp.73-83.

Royal college of midwives (2013). *Working with the menopause*. Equality and diversity publication. /www.rcm.org.uk/sites/default/files/Equality%20and%20Diversity%20Publication%20-%20Working%20with%20the%20Menopause%2020pp%20A5_7.pdf.

Rubinstein, H.R. & Foster, J.L.H. (2012). I don't know whether it is to do with age or to do with hormones and whether it is to do with a stage in your life: making sense of the menopause and the body. *Journal of Health Psychology. 18 (2), pp.292-307*

Sergent, J. (2015). 'An exploration of woman's identity during the menopause: a grounded theory study.

Smith, J.A., Flowers, P. and Larkin, M. (2009) *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage

The National Institute for Health and Clinical excellence (2015). *Women whose lives are being affected by the symptoms of menopause should not feel they have to suffer in silence .* Available at :http:// www.nice.org.uk/news/article/women-with-symptoms-of-menopause-should-not-suffer-in-silence (Accessed 10 December 2016)

Willyard, C. (2011). 'Men: A growing minority'. *American Psychological Association.* http://www.apa.org/gradpsych/2011/01/cover-men.aspx

Yanikkerem, E. Koltan, S.O. Tamay, A.G. & Dikayak, S. (2012). Relationship between women's attitude towards menopause and quality if life. Climacteric, 15 (6), pp.

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Table 1: Characteristics of the sample (N = 3)

Pseudonym	**Janet**	**Helen**	**Kathryn**
Age	45-50	45-50	55+
Ethnicity	White British	White British	White British
Years of experience as a counsellor	5	4	5
Work environment	Varied practice mainly with 11-18 year old in school	Varied private practice. Student counsellor with 16-18 years old.	Varied small private practice. Charity for children who have experienced childhood violence or sexual abuse. Bereavement counselling.
Main theoretical approach	Humanistic	Humanistic	Humanistic

Table 2. Counsellors having menopausal symptoms superordinate themes and themes

Table of super-ordinate themes
A focus on transitioning personal and professional identity during menopause Confusion about menopausal changes permeating personal and professional identity Limited dialogue about menopause keeping personal and professional identity changes under wraps ***A focus on the ethical dilemmas of practicing as a counsellor when menopausal*.** Questioning of professional capacity Searching for ways back to professional self ***A focus on the influence of menopausal symptoms during client work*** A disconnect within client work Experience of embarrassment as result of vasomotor symptoms Questioning of the effectiveness of counselling practice