# An Exploration of Psychological Practitioners Awareness and Knowledge of the Menopause, and Their Experiences of Working Clinically With Menopausal Clients

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A Thesis Submitted for the Degree of Doctorate in Clinical Psychology

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July 2024

# Acknowledgments

I would like to thank the clients I had worked with in therapy prior to my doctoral training. Their challenges with the menopause helped me understand why research into this topic is so important and had inspired this thesis. Wherever they are now, I hope they are doing well.

I would like to thank the fifteen participants who took part in this study. Their time and contributions were so important for this research. I hope they feel their voices have been represented in this work.

I would like to thank my thesis supervisors, Professor Frances Blumenfeld and Professor Camille Cronin, for their continued guidance, time and support during my research journey.

I would also like to thank the trainees and colleagues who have shown their support during my journey, often over many cups of coffee.

Last, but not at all least, I would like to thank my family and friends. Deciding to do a doctorate at a later stage in life was a big decision, and they have been there during the highs and lows. Undertaking a big piece of research can also be a long but enjoyable process, but having people to support me during those tough moments truly means the world to me.

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## Abstract

**Background:** The menopause is a biopsychosocial process that can affect many areas of a woman's life. The National Institute for Health and Care Excellence (NICE) guidelines for the management of the menopause recommends Cognitive Behavioural Therapy (CBT) for low mood and anxiety. However, research is still growing about the effectiveness of CBT and other psychological therapies in this area, and many gaps in knowledge remain. In the United Kingdom (UK), the menopause has also been identified as a priority area in the Women's Health Strategy.

**Aim:** The present study aimed to understand the level of awareness and knowledge of the menopause amongst professionals who deliver psychological interventions in statutory services in England. It additionally sought to understand their experiences of working clinically with menopausal clients.

**Method:** Participants were recruited through social media, close contacts and professional bodies. Fifteen participants completed a semi-structured interview conducted online. Data was analysed using Reflexive Thematic Analysis.

**Results:** Five main themes were constructed: 1) 'It's a Yes, No and Maybe'; 2) 'The School of Life'; 3) 'A Loud Silence in Services'; 4) 'Navigating Uneven Terrains'; 5) 'We Need to Hold Space for the Menopause'.

**Conclusion:** Findings indicated gaps in professional's knowledge on the menopause, and a lack of education and training on the topic. It also led to an understanding of the strengths and challenges that arose during their clinical work. Recommendations include intervention at the practitioner, provider and systems levels to support staff and address the psychological needs of people experiencing the menopause. The findings could contribute to national efforts to improve the care of women across the lifespan.

# Introduction

## 1.1 Chapter Summary

This chapter provides an overview of the biological, psychological, social and political factors associated with the menopause transition. A systematic literature review exploring the efficacy of Cognitive Behavioural Therapy (CBT) for symptoms of depression during the menopause is presented and critically discussed. The chapter will conclude with a rationale for the present study, along with aims and objectives of the research.

## 1.2 The Menopause

The population of the United Kingdom is 67.6 million, of which 34,492,000 are female (Official National Statistics, 2024). The menopause transition is a natural and transformative life stage that all women go through.[1] The biological changes that occur are part of a reproductive transition involving a neuro-endocrinological process where hormones decline, and influences aging and the entire body and brain (Georgakis et al., 2021; Mosconi et al., 2021; NHS, 2024).

The menopause typically occurs between the ages of 45 to 55 (World Health Organisation, 2024), and the average age in the United Kingdom is 51 (British Menopause Society, 2021). Women initially enter the stage of perimenopause, which can last months or years, where they experience symptoms akin to the menopause due to fluctuating hormones, but are still menstruating. Menstruation may be lighter and/or less frequent. Women enter the menopause when they have not menstruated for twelve months, and evidence suggests symptoms can last from four to twenty years (National Health Service, 2024; World Health

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[1] The author acknowledges that not all individuals who are born biologically female will identify as a woman. Trans men, intersex, non-binary, and gender diverse people also experience the menopause transition. The author chose the term ‘woman’ and ‘women’ to reflect research which focused on women’s experiences in research samples in order to highlight current research, gaps and promote future research, and not to erase or minimise the unique challenges faced by trans men, intersex, non-binary, and gender diverse people.

Organisation, 2024). The menopause occurs naturally, but can occur as a result of medical interventions, such as cancer treatment and hysterectomy. The menopause transition is associated with several symptoms: vasomotor symptoms (hot flushes and night sweats), low mood, anxiety, irritability, sleep disturbance, changes to sex drive, concentration and memory difficulties ("brain fog"), fatigue, vaginal atrophy, palpitations, joint pain and muscular pain (British Menopause Society, 2021; World Health Organisation, 2024). The British Menopause Society (BMS) (2021) highlight that 80-90% of women will experience menopausal symptoms and that 25% describe them as severe and debilitating.

Given the nature of menopausal symptoms and a lack of research, Mosconi et al. (2021) conducted an innovative study to understand how the menopause transition impacts the human brain. Multi-modal neuroimaging was used across stages of pre-menopause, perimenopause and post-menopause to explore the impact on white and gray matter structures, connectivity, energy metabolism and amyloid-beta deposition. The results revealed that each stage involved dynamic neurological changes affecting regions involved in higher order cognitive functions, and were independent of age, hysterectomy status and whether people were on hormone therapy. These changes were also specific to menopause endocrine aging, rather than chronological aging, following comparison with age matched males.

The study suggests there is an adaptive compensatory mechanism within the brain to cope with changes in oestrogen levels, which meant that in post-menopause states most brain regions either stabilised or restored. This is argued to correlate with recovery in gray matter volume and brain adenosine triphosphate. This suggests possible "brain resetting" which may account for a subsequent reduction in some menopause symptoms (e.g. hot flushes), although this requires further research. There were some findings noting limited recovery in some brain areas, which is argued to potentially explain the individual differences in some women's experience of the menopause transition, although these findings did not indicate impaired cognitive performance when compared to other groups. These findings provide ground-breaking neurophysiological insights into the brain during the menopause transition, and a framework to understand both vulnerability and resilience. Variability in menopause experience may also be based on medical history and environmental influences which were unexplored, and the sample comprised of highly educated participants and lacked diversity of ethnicities. Future research would need to account for these factors.

Other research exploring the association between higher levels of anxiety and depression symptoms in puberty, the perinatal period, and menopause has led to the notion of women being 'genetically vulnerable' (Halbreich, 2003), which has been challenged given global differences in the experiences of the menopause (Avis et al., 2001). Recent research has characterised the menopause transition as presenting a *"window of vulnerability"* for the onset or worsening of psychological symptoms, such as depression (Maki et al., 2018; Soares, 2017). Oestrogen is argued to have protective properties for mental health, and reproductive events such as menstruation, the postpartum period and menopause transition are linked with mood disturbances for this reason (Georgakis et al., 2016; Reilly et al., 2020; Soares, 2017). In a meta-analysis of 14 studies, Georgakis et al. (2021) found an inverse relationship between depression and post-menopause, proposing that longer exposure to endogenous oestrogen had protective effects. This has implications for those entering menopause at a younger age, with implications for the care required in clinical settings, such hormonal based therapies and psychiatric support. Given this, it is important to understand the pharmacological role of Hormone Replacement Therapy (HRT).

### **1.2.1** ***Hormone Replacement Therapy (HRT)***

There have been historical controversies around HRT, which has arguably impacted the care of women. Lobo et al. (2016) argue that HRT, particularly oestrogen based, should not only be prescribed for women experiencing moderate to severe hot flushes, but also as a prevention strategy for chronic diseases that emerge after the menopause. In the 1980's, HRT had demonstrated efficacy in research trials, with particular benefits for the prevention of osteoporosis, coronary heart disease, dementia, and for promoting increased longevity. However, research in the late 1990's by the Women's Health Initiative (WHI), a large randomised control trial studying the effects of oestrogen and progesterone largely in women 10+ years since menopause (Writing Group For The Women's Health Initiative Investigators & Writing Group For The Women's Health Initiative Investigators, 2002), had led to altered advice over concerns over breast cancer, stroke, pulmonary embolism and coronary risk. This led to global cessation of prescribing due to a fear over harm, and widespread media reporting of the dangers (Lobo et al., 2016).

In subsequent reanalyses of the WHI study data (Writing Group for the Women's Health Initiative Investigators & Writing Group for the Women's Health Initiative Investigators, 2002), the findings had been shown to be flawed as they were not stratified by age. Reanalysis demonstrated that when HRT is initiated in younger women before the age of 60, or less than 10 years after menopause, there was a window where risks of HRT were not significant (Lobo et al., 2016). Benefits include the reduction in coronary risk, and prevention of osteoporosis, new onset diabetes mellitus, reduction in menopause symptoms and improvements to quality of life and all-cause mortality. Whilst the advantages and disadvantages need to be considered for each person, there are no other pharmacological interventions which offer this type of prevention (Lobo et al., 2016). Further longitudinal studies where women are initiated on HRT at the appropriate time are required, but Lobo et al. (2016) argue that the use of HRT is coming back *"full circle"*. There has also been more positive messaging around HRT in the media since 2021 (Jermyn, 2023; Orgad & Rottenberg, 2023). However, HRT continues to be under-utilised due to a lack of knowledge amongst women and prescribers (Aquino et al., 2024; Doamekpor et al., 2023). The chapter will now explore psychosocial factors which can influence the experience of the menopause.

### 1.2.2 *A Biopsychosocial Experience*

The menopause is a biopsychosocial process (Hunter & Edozien, 2017) and has been shown to impact upon women's home life, sexual relationships, work and social life (Aninye et al., 2021; British Medical Association, 2020). Risk factors for depressive symptoms during the menopause can include prior history of mental health difficulties, history of reproductive related mood disturbance, psychosocial stressors, and the type of menopause symptoms experienced (e.g. sleep disturbance, vasomotor symptoms, cognitive functioning) (Maki et al., 2018; Natari et al., 2017; Weber et al., 2014). Midlife can also be a time of stress for women, such as having to manage the multiple demands of increased caring for older relatives, medical issues, children leaving home, changes in marital status, at the same time as navigating a career (Maki et al, 2018).

In a systemic review, the menopause was found to be a time of risk for recurrent episodes of depression. A bidirectional relationship was found between depression and vasomotor symptoms, with vasomotor symptoms having a stronger relationship with depression than the inverse. However, more research is needed to understand the differential effects of vasomotor symptoms on depression, and the role of depression severity with vasomotor symptoms (Natari et al., 2017). Moreover, Bryant (2011) conducted a systematic review given limited research on anxiety within the menopause transition, and to clarify whether anxiety predated or is a result of the menopause. Two themes were identified: the relationship between anxiety and the menopause, and anxiety and vasomotor symptoms. Symptoms of anxiety were found to be low during the transition, and the relationship between anxiety and vasomotor symptoms were predicted by attitudes to the menopause, changes in family life and optimism. However, methodological issues with the included studies (e.g. measurement of menopause status and/or anxiety symptoms, the use of invalidated measures) meant that more robust data is required. Recommendations were made for instruments to be used which do not falsely endorse high levels of anxiety, and instead refer to diagnostic criteria.

Other research has pointed to the nuances of treatment-induced menopause, as women can report more severe symptoms. In a study of 740 breast cancer survivors on Tamoxifen, prescribed to reduce the chances of cancer recurrence, Moon et al. (2017) explored the experience and attribution of menopausal symptoms. The study found that 60% of women reporting hot flushes and night sweats experienced severe symptoms, in addition to other menopausal symptoms (e.g. joint pain, vaginal dryness etc). Depression was associated with a two-fold increase of severe experiences of hot flushes and night sweats. Women who attributed such symptoms to Tamoxifen were three to four times more likely to experience severe symptoms than those who did not attribute their symptoms to tamoxifen, although more research is required.

A biopsychosocial perspective means accounting for embedded sociocultural factors which influence the experience. Meanings can be situated within cultures, and potentially add psychological burden to the experience (Dhanabalan et al., 2023; Hunter & Edozien, 2017). There are cultural differences in narratives, suggesting that meanings are not fixed. Dhanabalan et al. (2023) highlighted global differences in meaning attribution and divergent views on older women. Western patriarchal society perceives older women as *"second class citizens"*, whereas other cultures view the menopause as transformative and a new beginning. For instance, in Japanese culture menopause is referred to as *"konenki"*: *"ko"* referring to energy and renewal, *"nen"* as year/years, and *"ki"* as season and energy. Shamanic cultures view menopause as providing access to healing powers, and women increase in status in their communities by becoming spiritual leaders. Given this, menopause should arguably be viewed as *"...not just as a hormonal event, but the meaning for individuals and society and how this affects the experience"*, moving away from narratives of physical and mental decline, the loss of youth and sexuality, which does not reflect the reality for many (Samarasekara, 2024). Instead, a model that promotes a sense of empowerment for women is required.

In a systematic review, Dashti et al. (2021) also found that attitudes vary across regions, countries and cultures. Influencing factors included whether menopause was surgical or natural, the severity of menopausal symptoms, education, age, employment and ethnicity. A significant factor was age, as postmenopausal women had more positive attitudes than premenopausal and perimenopausal women. Women with medically induced menopause were more likely to have negative attitudes towards the menopause. Therefore, part of developing healthcare policies is to consider how to target attitudes to the experience. This is important given negative attitudes towards the menopause have also been linked with increased frequency and severity of menopause symptoms (Ayers et al, 2010).

Moreover, research highlights that the menopause is also an occupational health matter, and that further research is needed to support women across their lifespan in managing their reproductive health at work (Howe et al., 2023). Women form a large part of the global labour market (Rees et al., 2022), and women aged 45+ represent a large part of the UK workforce (Department for Work and Pensions, 2023). Over 75% of the UK's healthcare workforce are also women (Health Foundation et al., 2018). Menopause symptoms can impact the working lives of women, such as reduced working hours, unemployment and financial insecurity (Moline & Clerke, 2023; Rees et al., 2022) and can be related to experiences of gendered ageism and not meeting an *"ideal worker norm"* (Atkinson et al., 2021). This is relevant when considering needs within psychological care. Of note, one of the premises of NHS Talking Therapies services (NHS Talking Therapies, 2024), formerly known as ‘Improving Access to Psychological Therapies’ (IAPT), in England was an economic argument that improving psychological symptoms would lead to improved employment status (Clark, 2018; Layard et al., 2007).

Wariso et al. (2017) studied ninety women with depression associated with occupational and personal distress during the menopause transition. They reported decreased quality of life, adjustment and social support when compared to non-depressed perimenopausal women. However, longitudinal research that follows women through the transition is needed to understand factors which impact quality of life and that increase the risk of peri-menopausal depression. Other research has cited how other people’s perception of menopausal bodies can affect older female workers and can link with conflicts around their sense of identity in the world of work. This highlights the need to additionally consider internalised ageism (Steffan, 2020).

Cronin et al. (2021), in a narrative literature review, found that there is a unique opportunity for digital health interventions to ensure job retention of older women, particularly in industries facing shortages such as nursing and teaching. A further study by Cronin et al. (2022) explored women’s perspectives on such interventions that support them with their menopausal symptoms in the workplace. Focus groups of nurses with lived experience of the menopause across six countries (United Kingdom, Finland, Austria, Denmark, New Zealand, United States of America) found that the menopause had an impact on professional and personal lives. This included having to plan in advance, reduced confidence, increased anxiety, absences, reduced hours and concerns about seeking help in case they were perceived negatively by colleagues. Participants spoke of the invisibility of their experiences, a sense of unpreparedness and an accompanying discourse.

This study pointed to society being male by default, and the ironic nature of a large female workforce in the backdrop of a lack of awareness of the menopause within the workplace. The study recommends menopause awareness training for all staff, dismantling stigma through open dialogue, reasonable adjustments, flexibility at work, and employee's seeking help to reduce the exit of nurses from the health system. Participants felt that digital health interventions would be useful, such as to track symptoms, although further research is needed in terms of appropriate design. This aligned with the European Menopause and Andropause Society (Rees et al., 2022) recommendations, which advocated for the following: frameworks and policies to be inclusive of menopause; collaborative working with occupational health, human resources and healthcare professionals; for the physical environment to be addressed; for supportive work environments free from ageism or sexism so women are not marginalised, dismissed and/or discriminated against; for women themselves to access specialist advice; to be able to access training, healthcare and guidelines on evidence based menopause care.

There is momentum in understanding the impact of the menopause on working women. A scoping review of global interventions supporting women in the workplace (Howe et al., 2023) found that interventions supporting menopausal women were the most common (43% of articles), but there is limited research on understanding the interventions themselves, their design and how they are evaluated, and it is proposed that both policies and evaluations are co-designed.

### 1.2.3 *An Intersectional Experience*

Riach & Jack (2021) argued against homogenising the menopause experience, highlighting its complexities. Through an intersectional lens (Cho et al., 2013), aspects of race, gender, age and ableism can account for intersectional disadvantage and requires examination of the dynamics of power and inequality within organisations, structures, policies and practices to address menopause inequality. For instance, indices such as freedom, flexibility and autonomy are usually part of professional occupations, which often include middle class women rather than minority women and/or those of a lower socioeconomic status. This highlights the importance of not locating menopause as a ‘problem’ to be ‘managed’, but rather about transforming embedded structural and cultural practices within organisations that maintain intersectional disadvantage in the long term (Riach & Jack, 2021).

Furthermore, research highlights that experiences of racism, discrimination, chronic stress and trauma are related to more severe symptoms of the menopause, and additionally cardiovascular disease (Cortes & Marginean, 2022). Racialised minorities are less represented in menopause research, despite some variation in menopause symptom experience (BMS, 2023). Cortes & Marginean (2022) also identified community factors linked with health inequity, such as living in areas with less natural green spaces with high air pollution, which could contribute to earlier age of onset of menopause.

Individuals from the trans population are vulnerable to depression and suicide attempts due to experiences of minority stress due to discrimination (Tebbe & Moradi, 2016), and Lesbian, Gay, Bisexual, Trans and Queer plus (LGBTQ+) can experience sexual orientation micro-aggressions within psychological therapy (Shelton & Delgado-Romero, 2011). Glyde (2023) highlighted that literature focuses primarily on the experiences of heterosexual menopausal women. In a qualitative study of twelve LGBTQ+ identified participants who experienced the menopause, Glyde (2023) found that practitioners lacked knowledge about LGBTQ+ identities as well as the menopause, and that this compounded experiences of minority stress from ageism, ableism and misogyny. This pointed to a lack of non-heterosexual and non-cis template for the menopause, and to white and western cultural constructions of the menopause that promote a sense of yearning for youth, loss of fertility and attraction from men (Glyde, 2023). Recommendations include a survey to understand organisational factors (e.g. therapist attitudes across modality) to improve therapist confidence, and understanding the numerous discriminations faced by this group. Training should also be provided on gender, sex and relationship diverse identities.

These findings align with other research citing the problems associated with linking menstruation with womanhood, and the affect this has to marginalise people who have ovaries and menstruate but do not identify as a woman (Felice et al., 2021). It is important to generally consider minority members experience of the menopause in the imaginary (Jermyn, 2023). This connects with research on health inequality that indicates that race has been linked with delayed healthcare, unmet needs and adherence to treatment (Ben, 2017). Racialised minorities can also experience barriers to accessing mental health support and poorer outcomes within NHS Talking Therapies (formerly IAPT) (Alam et al., 2024; National Collaborating Centre for Mental Health, 2023). There is also limited research on minoritised LGBTQ+ individuals and how this mediates health inequality (McDermott et al., 2021).

### 1.3 Feminist Perspectives

Tasca et al. (2012) highlights how historical views of women’s mental health have included seeing women as inferior to men and prone to melancholy, and that the first disorder attributed to them was ‘hysteria’. Hysteria was attributed within Greek mythology to factors such as lack of intimate life or dysfunction of the uterus, with two approaches applied: scientific (medical) and magical-demonological (e.g. exorcism) approaches. This relates to women’s health because if a problem could not be explained in scientific terms, it was understood in magical-demonological ones; approaches updated since this time through westernisation and updated cultural interpretations (Tasca et al., 2012). Moreover, historical views of menopausal and older bodies have included those of it being undesirable and associated with illness and decay (Jermyn, 2023; Orgad & Rottenberg, 2023) with patriarchal demands for women to contain their pain and anger (Douglas, 2020).

Currently, the menopause has increased in visibility as part of a *"menopause turn",* from *"meno-doom"* to *"the new hot"*, with a new era of menopause activism (Jermyn, 2023). Orgad & Rottenberg (2023) argue that the Channel 4 documentary 'Davina McCall: Sex, Myths and Menopause' led to the *"Davina effect"*, which included shattering taboos around the menopause, an increase in women requesting HRT and workplace support. The programme demonstrates the culture of the western sphere with historic views of aging women as culturally and socially invisible and utilises feminist ideas of taboo and silence. The programme led to a shift in narratives since 2021, with positive accounts of self-transformation and empowerment, mainly by cis-gendered women (Jermyn, 2023; Orgad & Rottenberg, 2023).

Orgad & Rottenberg (2023) situated converging sociocultural and economic factors in the UK which led to the *"Davina effect"*: 1) the workforce consisting of a growing number of women, and women's reports of menopausal symptoms impacting them at work; 2) positive portrayals of ageing women in positions of power; 3) the gendered nature of the coronavirus pandemic exposing how primarily women front the care of others, in the context of limited number of menopause clinics in the UK and under funding of the social care sector; 4) increased cultural trends to believe women when they speak out, particularly following the '#MeToo' movement; 5) a lucrative "menopause market", or 'FemTech' industry (Felice et al., 2021), including new products in health stores, wellness programmes, apps, retreats and the *'Davina effect'* being involved in the rehabilitation of HRT in the media. Orgad & Rottenberg (2023) argue that the programme highlights the role of sexism and links with feminist tropes of breaking silence, demand for change, a collective 'fight' and liberation. It underscores structural systems that underpin discrimination experienced by menopausal women (e.g. lack of knowledge in the medical system, societal stigma, stigma around the use of HRT and lack of workplace support).

Conversely, the programme promotes individualised and privatised solutions involving HRT, lifestyle changes, seeing oneself as attractive through ageing, and working on one's wellbeing. This promotes neoliberal feminist notions of self-work, positivity and resilience, rather than exploring the role of wider state and health systems (Orgad & Rottenberg, 2023). This also contributes to the 'biomedicalisation' of the menopause (Conrad & Schneider, 1980; Felice et al., 2021), which pathologises it as a medical problem of hormone deficiency, with women compared to a male norm. Medicalisation can occur on three levels: *"conceptual"* when medical terms/model are used to define the problem; *"institutional"* when organisations treat it as a medical problem; *"the doctor-patient relationship"* where professionals diagnosis and treat a medical problem (Conrad & Schneider, 1980). Within this, HRT is viewed as a 'magic bullet' to remain feminine and promotes self-responsibility, thereby placing the work on women to fix themselves. This is arguably reflected in NICE (2015) guidelines for menopause care, which also promotes such individualised solutions.

Furthermore, dominant scripts around supporting women so they are economically active are positioned as positive, excluding those in marginalised groups in its imaginary (Felice et al., 2021; Jermyn, 2023; Orgad & Rottenberg, 2023). Felice et al (2021) argue that although the value of HRT is undeniable, they argue against medicalisation, viewing menopause as socially shaped and a social justice matter as it intersects between age and gender in terms of the experience of marginalisation. Through a participatory design approach, Felice et al. (2021) found that medicalised discourse could be resisted by conceptualising the menopause as a 'transformation' by accepting, reclaiming and attuning to the changes in the body in an embodied approach. This involves acknowledging lived experiences and addressing needs holistically to avoid individual burden. Structural oppression could be resisted by providing such agency to shift power from medical professionals, and deconstructing the idea of being a 'patient'. Therefore, resistance should include questioning the doctor-patient and institutional level of medicalisation, as described by Conrad & Schneider (1980).

### 1.4 UK Socio-Political Context

NICE launched long awaited guidelines in 2015 to raise awareness of menopausal symptoms, and provide guidelines on evidence based treatment options to improve the care of women (NICE 2015). These guidelines influence England and were updated in 2019, with a further update expected in 2024. For psychological symptoms, NICE (2015) recommends HRT for low mood, and Cognitive Behavioural Therapy (CBT) for low mood and anxiety. It also advises that menopausal women and healthcare professionals understand that there is no clear evidence for antidepressants to ease low mood in menopausal women who have not been diagnosed with depression.

Additional socio-political movements in the UK have occurred since the initial guidelines. The British Menopause Society in 2017 launched its 'Vision for Menopause Care' (Currie, 2019) advising that menopause is a major life event affecting all in the short and long term, and that all women should have access to accurate information. They also advised that healthcare professionals should have a basic understanding of the menopause and where to signpost women, that primary care teams have staff with specialist knowledge to manage referrals, and that there is leadership of multidisciplinary education.

The menopause has been identified by the UK government as one of seven key priority areas in the 'Women's Health Strategy' for England (Department for Health and Social Care, 2022) which takes a life course approach for better health outcomes for women and girls, and advocates for improved holistic care and wellbeing at work. This policy also led to a scheme reducing the price of HRT so that cost was not a barrier for some women to manage menopausal symptoms. The 'No Time to Step Back' policy (Department for Work and Pensions, 2023) also saw the introduction of a government ‘Menopause Employment Champion’ striving to enable older women to remain in the workforce with support, stating *“…perimenopause/menopause need not be a time for women to step back, step down or step out of their career”.* An important aspect of the policies involve support from healthcare and workplaces, and replies upon professionals being educated. This chapter will now take a closer look at CBT, recommended by NICE (2015) guidelines for depression and anxiety.

### 1.5 Psychological Theory and Cognitive Behavioural Therapy (CBT)

The theoretical underpinnings of CBT emanate from an integration of cognitive theory and behavioural theory. Whilst both are similar in that they are learning theories and consider change as a function of new learning, these theories represent two opposing philosophies (Early & Grady, 2017). Behaviourism represented a move in history towards a more scientific and positivist approach to human nature, focussing on human behaviour being constructed by the external environment and the learning of behaviour through classical conditioning (Pavlov, 1927), operant conditioning (Skinner, 1974), and observation and modelling (Bandura, 1986). In terms of cognitive theory, Ellis (1995) and Beck et al. (1979) moved away from prevailing psychoanalytic theory of the time, and instead, proposed a cognitive conceptualisation to explain human difficulties. This represented a shift away from positivism to a position of post-modern constructivism where people could construct their own realities in their minds. Cognitive theory focusses on the role of development and internal processes, namely unhelpful cognitions which require restructuring. Whilst behaviourism focusses on intentional change in behaviour (learning and unlearning) as a function of external contingencies, cognitive theory focusses on challenging cognitive activity.

Whilst these theories encompass differential assumptions, the amalgamation of these theories represented an acknowledgment of the importance of both cognitive and behavioural change, and a 'person in the environment' approach within a cyclical practice model known as CBT. CBT is a time-limited form of psychotherapy with a multidimensional view that explores the interconnections between experiences/situations, a person's cognitions (which are often linked to underlying beliefs about themselves, the world and others), emotions, physical symptoms and subsequent behaviours (Beck & Fleming, 2021). Interventions centre on strategies to restructure unhelpful thoughts and beliefs and alter behaviours that maintain psychological difficulties in order to foster change. CBT has developed a strong evidence base over time, such as for depression, anxiety, trauma, substance misuse and applications in physical health settings (Thoma et al., 2015). 'Third wave' approaches encompass acceptance and mindfulness-based approaches, and arguably represent the meta-cognitive level and a more behavioural approach at its roots (Early & Grady, 2017).

Of note, CBT emerged not because of a single cognitive behavioural theory, but the combining of two distinct philosophies. CBT has been argued to be a practice that inherently lacks a standalone cognitive behavioural theory. Some argue that CBT interventions may be skewed towards working more cognitively, that CBT should pay equal importance to interventions from both theories, and that it negates the role of wider context and systems of oppression (Early & Grady, 2017). For example, in comparison, the Socio-Ecological Model (SEM; Bronfenbrenner, 1986) provides a conceptualisation placing the individual at the centre of a system of nested layers, and proposes that health is impacted by interacting levels that include: the 'individual' (intrapersonal factors); 'microsystems' around the person (interpersonal interactions); 'mesosystems' (e.g. work, educational institutions); 'exosystem' (community, social context); 'macrosystem' (e.g. society, culture, religion); 'chronosystem' (i.e. policy, research). Interactions between influencing factors within and between each layer of the system are important. Comparatively, this model captures numerous influences, in addition to intrapersonal processes, allowing for biological, psychological and sociocultural perspectives.

Nonetheless, in terms of the menopause, given historic contention about HRT, non-pharmacological treatments have generally become of interest, particularly for those who cannot or choose not to use HRT (Aninye et al., 2021; Maki et al., 2018). This includes breast cancer survivors where HRT may be contraindicated due to the use of Tamoxifen, and CBT has the potential to provide self-management strategies to cope with menopausal symptoms (Moon et al., 2016; Van Driel et al., 2018). Non- pharmacological treatments can consist of psychological therapy, lifestyle interventions and alternative therapies (Taebi et al., 2018). CBT provides cognitive and behavioural strategies to improve mood, and lifestyle interventions to help manage menopausal symptoms; this fits within a biopsychosocial approach, capturing the influence of physical changes, cultural and social factors, mood, beliefs and symptom attributions (Hunter & Edozien, 2017).

Hunter & Mann (2010) developed a biopsychosocial model of hot flushes and night sweats based on CBT, highlighting that the experience is moderated by psychological processes. Their cognitive model of hot flushes elaborates on the interconnections between the role of cognitive appraisal of symptoms and behavioural responses as contributory to the experience of menopause. This model identifies maintaining factors that can be targeted in psychological interventions, thereby reducing distress associated with such symptoms. For instance, stress, anxiety and depressed mood are argued to lower thresholds for experiencing physical sensations, and contribute to unhelpful beliefs and illness appraisals, and CBT can reduce the functional impairment associated with vasomotor symptoms (Hunter & Chilcot, 2021).

Other applications of CBT for psychological symptoms associated with the menopause have been made, such as for depression (e.g. Mollaahmadi et al., 2019; Soori et al., 2018) and insomnia (e.g. Ham et al., 2020), although further research in this area is generally needed due to a paucity of data (Soares, 2017). CBT is available in multiple formats, such as guided or self-managed internet-based interventions for menopause symptoms, and can be cost effective for the health system (Verbeek et al., 2019). However, in a systematic review of CBT for menopause symptoms (e.g. vasomotor symptoms, psychological symptoms), although self-help formats were more cost effective, face to face interventions (individual and group) were shown to be more clinically effective (Mollaahmadi et al., 2021).

Research is growing in the utility of CBT and other psychological approaches. In a systematic review and meta-analysis, Van Driel et al. (2018) found psychological interventions (CBT, Mindfulness and Behaviour Based Therapy) for natural and treatment-induced menopause can be safe and effective in reducing bother related to hot flushes, but more research is required to compare psychological approaches directly as studies were limited, and the outcomes for sexual functioning were scarce.

CBT has accumulated evidence more generally for anxiety and depression (Twomey et al., 2015), and is already widely implemented within the NHS. This includes provision for adults in primary care in England under NHS Talking Therapies Services (NHS Talking Therapies, 2024) providing effective evidence-based therapy for large numbers of adults (Wakefield et al., 2021), and within secondary care mental health and tertiary settings for people with severe and/or enduring mental health difficulties (Haddock et al., 2014; Thoma et al., 2015). This would arguably mean that NICE (2015) guidance for the treatment of psychological symptoms during the menopause could be easily implemented in practice. However, how aware are professionals of the menopause? If they are aware, how much do they know? The author will now focus on this in relation to women themselves and healthcare professionals.

## 1.6 Menopause Awareness and Knowledge

Menopause education is important for both women themselves and healthcare professionals (NICE, 2015). Many women aged 40 and under have had limited education on the menopause (Munn et al., 2022). Results from an online survey of 947 women found that 90% of women had never been educated on the menopause at school, and 68.2% only sought information once they had begun experiencing symptoms (Harper et al., 2022). In recent years, steps have been taken to improve awareness and knowledge, with the BMS patient website 'Women's Health Concern' providing education to women (Women's Health Concern, 2024). University College London (UCL) has also launched a co-designed education and peer support programme for premenopausal, perimenopausal and menopausal women (UCL, 2024). However, many argue that menopause education should begin early at school (Harper et al., 2022; Munn et al, 2022).

In terms of professionals, General Practitioners (GP) in the UK are first line of consultation for women, and the gatekeepers to further support within the NHS, yet menopause training is not mandatory for them (Dintakurti et al., 2022), and lack of knowledge can impact decision making and lead to a lack of appropriate medical care (Harper et al., 2022). In a survey of 173 UK based NHS GP's, it was found that 52% of GPs felt they lacked support in treating menopausal patients, and 77.5% felt medical training and GP training on the menopause should be improved. Nonetheless, 60.7% felt comfortable in managing and offering treatment options to menopausal women, and 22.5% felt NICE guidelines were clear (Dintakurti et al., 2022). These findings signify the importance for Continuous Professional Development (CPD) hours for menopause education to be fixed for professionals to improve menopause care.

Menopause education is also important to support healthcare professionals, who also experience the menopause themselves. Bodza et al. (2019) conducted semi-structured interviews with three counsellors who had experienced the menopause. Participants highlighted confusion around biological and psychological changes of the menopause. Some participants also spoke of an impact on self-concept, loneliness, embarrassment and concern about their capacity to practice clinically. In terms of client work, participants could experience a ‘disconnect’ in sessions (e.g. during hot flushes), through to decisions about ceasing therapy work. Experiences of limited discussion of the menopause, fears around negative external evaluation, and the topic being ‘taboo’ is argued to be present within the counselling profession itself. This highlights the need for the profession to tackle shame and promote knowledge and awareness. This could include the menopause being incorporated into training curriculums, CPD and offering improved support.

Calow et al. (2023) proposed that menopause education is delivered to undergraduate and pre-registration programmes for healthcare professionals in academic institutions, and that it should combine both theoretical knowledge and clinical experience. This is supported by other research advocating for the pedagogy of menopause education to acknowledge the complexity of the experience (MacPherson &Quinton, 2022). This arguably emphasises the role of wider systems in promoting training and knowledge, and therefore, moves away from individual level blame or accountability alone.

### 1.7 Literature Review: A Systematic Review of the Evidence for CBT for Symptoms of Depression in Menopausal Clients

The Women’s Health Strategy (Department for Health and Social Care, 2022) seeks to improve the care of women across the lifespan, and the menopause has been highlighted as one of the priority areas. Depression has been selected for this review as women experience a significantly increased risk of depression during the menopause transition, with recent research suggesting a 40% increased risk when compared to premenopausal populations of women (Badawy et al., 2024). In England, NICE (2015) recommends CBT for symptoms of low mood during the menopause, and so a systematic review will be conducted to understand more about the current state of evidence. This is also important as health services often refer to NICE guidelines when designing treatment pathways. There is a need to review current evidence to raise awareness and to explore if appropriate care is being delivered. Therefore, this review could contribute to an understanding of the efficacy of CBT for this population of women.

### **1.7.1** ***Introduction***

Research has identified the perimenopause as a *"window of vulnerability"* for the onset of depression and major depression, and is present for women who also have no history of depression (Maki et al., 2018). This aligns with research which highlights that oestrogen has protective properties for mental health, and that reproductive events such as the postpartum period and menopause transition are linked with mood disturbances for this reason (Georgakis et al., 2016; Soares, 2019). Possible risk factors for depressive symptoms during the menopause include prior history of mental health difficulties, history of reproductive related mood disturbance, psychosocial stressors (e.g. financial difficulties, adverse life events, lack of social support), sociodemographic factors (e.g. being of black race, younger age) and the type of menopause symptoms experienced (e.g. sleep disturbance) (Maki et al., 2019; Natari et al., 2018; Weber et al., 2014).

Surprisingly, there is a paucity of evidence on women with a history of Severe Mental Illness (SMI) (e.g. psychosis, bipolar disorder). Recent evidence suggests that changes in oestrogen levels during reproductive events, such as menstruation (Reilly et al., 2020), post-partum period (Bergink et al., 2016) and the post-menopause period (Riecher-Rossler et al., 2018), are related to changes in mental health and experiences of psychosis. Other evidence suggests that the menopause may impact on the illness course in Bipolar Disorder (BD), with depressive symptoms being the most common and most likely to relapse (Perich et al., 2017; Perich et al., 2017a). Despite limited research on such populations, some evidence advocates for a gender-specific approach to treatment due to the possible worsening of psychotic symptoms and depression at the time of menopause (González-Rodríguez et al., 2021), and the possible impact of the menopause on the effectiveness of antipsychotic medication (Seeman & Gonzalez-Rodrıguez, 2018), although more research is needed.

NICE (2015) guidelines for the management of the menopause recommends CBT for low mood and anxiety. CBT has developed a strong evidence base for anxiety and depression in adults (Thoma et al., 2015) and it's interventions have shown promise for women during menopause, such as for functional impairment associated with vasomotor symptoms (Hunter & Mann, 2010; Hunter & Chilcot, 2021; Hunter, 2021), sleep (Arico et al., 2016; Bei et al., 2014), depression (Green et al., 2015), anxiety (Spector et al., 2024) and natural and treatment induced menopause (Ye et al., 2021). However, a lack of research, methodological issues in studies, and the need for further research on psychological therapies other than CBT (e.g. Interpersonal Psychotherapy, Mindfulness-Based Cognitive Therapy), mean that many knowledge gaps remain (Maki et al., 2019; Soares, 2017). Moreover, although there may be similarity in CBT interventions for reproductive events, there are some differences. For instance, the postpartum period can be linked with the onset of depression, which can have systemic implications for women's relationship with their child (e.g. Batt et al., 2020). Interventions for the menopause involve addressing women's lifestyle, beliefs, cognitive appraisal of symptoms (e.g. hot flushes and night sweats) and behavioural responses (Hunter & Edozien, 2017; Hunter & Mann, 2010). In this sense, there is overlap in the both postpartum period and the menopause being periods of transition and influenced by hormones, and there is utility in the use of cognitive strategies and behavioural change methods for both. However, there are some differences between both transitions. For instance, some menopause research has highlighted the sense of loss and grief due to the end of reproductive ability, with consequences for individuals' sense of 'womanhood' (Cronin et al., 2023). In contrast, the postpartum period may involve addressing specific cognitions around motherhood (e.g. being a 'bad' mother), and an interpersonal component focussed on a change to a couple's relationship and on the mother and infant (Batt et al., 2020; Branquinho et al., 2024). Therefore, further research is also needed to explore how depression in the postpartum period differs to other experiences of depression outside this period (Batt et al., 2020), and arguably, how it differs to experiences of depression during the menopause transition.

In terms of the evidence for depression for menopausal women, whilst one systematic review of CBT for menopausal symptoms did not include depression (see Van Driel et al., 2019), another review by Mollaahmadi et al. (2019) assessed the effectiveness of different CBT delivery formats on multiple menopausal symptoms and did include depression and found both individual and group CBT (GCBT) were effective. However, as the format of interventions was the focus and not depression, a number of unanswered questions remained about the methodological rigour of studies targeting depression. For instance, the current author notes that included studies had participants with sub-threshold symptoms of depression, and one included study did not directly corroborate if participants were menopausal. In addition, a recent systematic review by Spector et al. (2024) had included depression but commented that some included studies had not checked the menopausal status of participants.

The current review will focus on CBT and its evidence for symptoms of depression in menopausal participants who experience the menopause naturally. It aims to be unique in only focusing on studies with participants in the clinical range for depression (on or above cut-offs) on assessment/outcome measures and/or classed as depressed with reference to diagnostic frameworks in studies. As NICE (2015) recommends CBT for low mood in menopausal women, evidence from participants from across the mental health spectrum will be welcomed (i.e. including those with SMI), as long as depressive symptoms are within the context of the menopause transition and are an outcome being measured. This review will only focus on studies where menopause status has been confirmed (e.g. self-report, medical assessment). The trustworthiness of evidence, the populations studied and implications for practice will be explored.

Studies including medically induced menopause will not be included in this review. This is not to dismiss or minimise this experience. In the author's opinion, it is important not to 'collapse together' or homogenise menopause experiences, particularly when causes of symptoms at the outset for women differ and can also be linked with nuanced experiences (e.g. see Ayers et al., 2010). Therefore, it is felt that this population require an in-depth enquiry in their own right.

### 1.7.2 *Method*

The conduct and reporting of this review was in accordance with the Preferred Reporting Items For Systematic Reviews And Meta-analysis (PRISMA) statement (Page et al., 2021).

#### 1.7.2.1 *Eligibility Criteria*

Studies were included if they satisfied the following criteria: Controlled and uncontrolled trials using CBT to treat symptoms of depression in the context of the menopause transition; menopause status confirmed directly with clients (i.e. not researcher assumption); quantitative evidence; academic journal articles; adult participants; depressive symptoms on or above cut-offs on measures and/or in reference to a diagnostic frameworks; varied CBT delivery formats are accepted (e.g. group, individual, self-help); depression as an outcome with a minimum of two reported measurements (before intervention and after); global evidence but available in English; full text articles available to enable risk of bias assessments.

#### 1.7.2.2 Search Strategy

The search was performed on 27th May 2024 using the following databases: APA Psych Info, APA Psych tests, APA Psych Articles, CINAHL Ultimate, E-journals, and MEDLINE Ultimate. The search was not limited to English only articles in case translations were available. No limits were placed on the years searched, but limits were made to academic journal articles only. Titles and abstracts were searched using search keywords, associated synonyms, and truncation filters. Please refer to Table 1 (p. 31) below.

#### 1.7.2.3 Data Items and Extraction

Data was extracted using Population, Intervention, Comparison, Outcome (PICO) criteria (Thomas et al., 2021).

#### 1.7.2.4 Risk of Bias and Quality Assessments

Assessments were conducted by the author independently. The Critical Appraisal Skills Programme (2021) (CASP) checklists were used to assess quality. Risk of bias was assessed using the Risk Of Bias Tool For Randomised Trials (RoB-2) (Sterne et al., 2019), as recommended by Cochrane (Higgins et al., 2021), and Risk Of Bias In Non-Randomised Studies Of Intervention Tool (ROBINS-I) (Sterne et al., 2016).

**Table 1**

*Search Strategy*

| Term | Search Strategy |
|---|---|
| Menopause | Perimenpaus* OR menopaus* OR climeractic |
| | AND |
| Depression | depression OR "low mood" OR depressive OR “well-being” |
| | AND |
| CBT | "Cognitive behavioural" OR CBT OR "Cognitive behavioral" OR “cognitive therapy” |

### 1.7.2.5 Synthesis Method

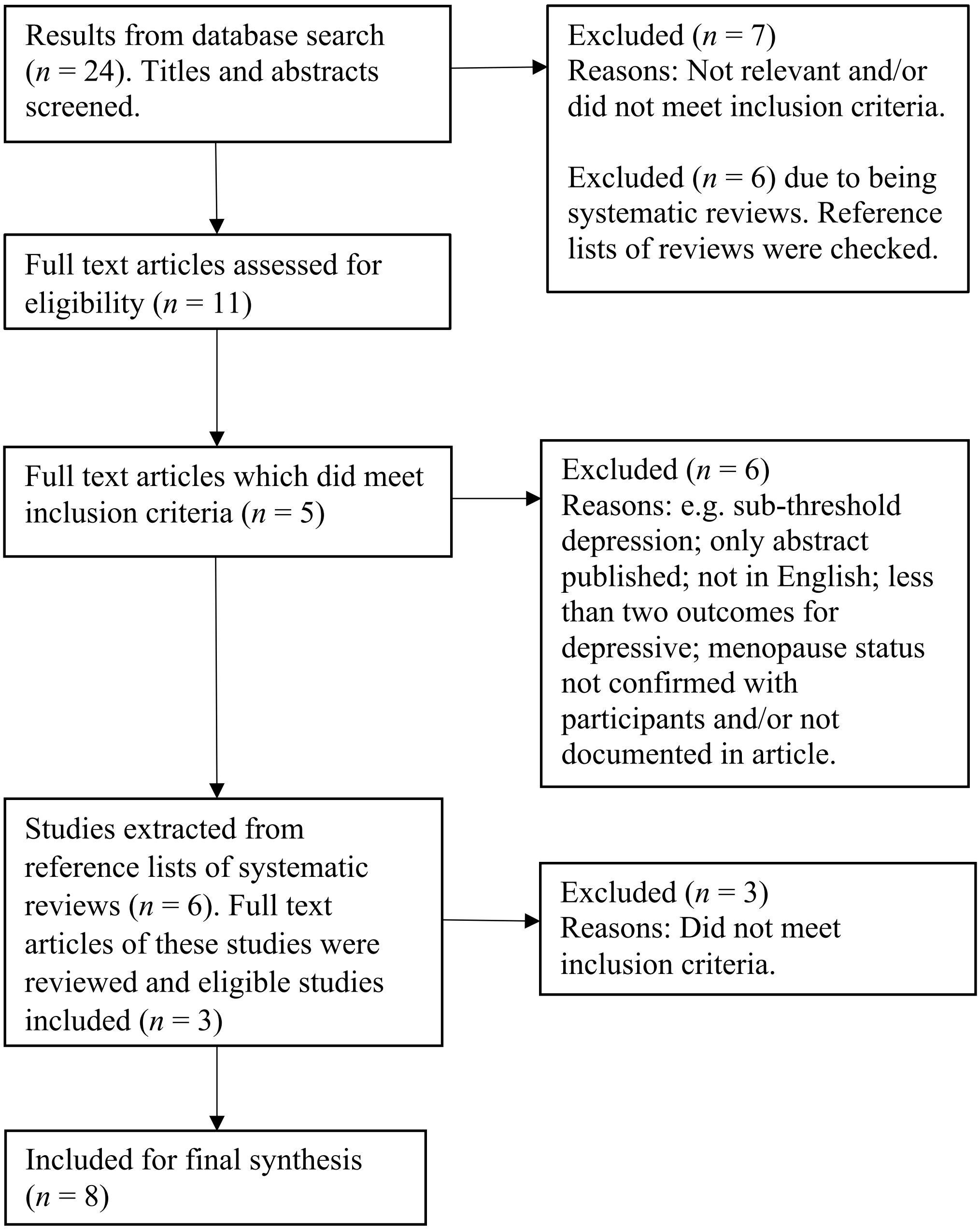
A meta-analysis was not conducted due to the diversity across the studies in research design, use of outcome measures, sampling, severity of depression, and varying formats and content of CBT interventions. A narrative synthesis was conducted with reference to the Cochrane guide (McKenzie et al., 2021) and the ‘Synthesis Without Meta-Analysis’ (SWiM) guideline, also endorsed by Cochrane (Campbell et al., 2020).

### 1.7.3 *Results*

The search produced 24 results. Titles and abstracts were screened, and 6 articles were removed as they were systematic reviews, and 7 were either not relevant or eligible. Full text articles of 11 studies were then reviewed and studies were rejected if they did not meet the inclusion criteria. From this, 5 studies met the inclusion criteria. The reference lists of the six systematic reviews from the search were then manually checked and six studies were extracted. The full texts of these six articles were then reviewed, and three studies met the inclusion criteria. In total, 8 studies were included for the final synthesis. An overview of the search is illustrated in the PRISMA flow diagram in Figure 1 (p. 32) below.

**Figure 1**

*PRISMA Flow Diagram*



### 1.7.3.1 Study Characteristics

Characteristics of included studies are presented in Table 2 below. As the current review focuses on depression, only related outcome measures are noted.

**Table 2**

*Characteristics of Included Studies*

| Study | Sample | Study Information | Measurements for Depression |
|---|---|---|---|
| Khoshbooii et al. (2011)<br>Randomised Control Trial (RCT) | Community sample, Iran. | Experimental: *N* = 25 / Control: *N* = 25<br>GCBT (16 sessions twice weekly, two hours per session)<br>(6 non-completers)<br>Follow up: Yes (missing details)<br>Content: Cognitive therapy for depression and menopause education. | Beck Depression Inventory II<br>(BDI-II; Beck et al., 1996) |
| Brandon et al. (2013)<br>Clinical Trial | Community sample, USA. | Perimenopausal *N* = 57 (19 non completers)<br>Post-menopausal *N* = 91 (17 non completers)<br>Individual cognitive therapy (16-20 therapy sessions over a maximum of 14 weeks, length of sessions not stated).<br>Content: Cognitive therapy for depression. | Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960) |
| Green et al. (2013)<br>Pilot study | Community sample, Canada. | *N*= 8 (4 per group)<br>GCBT (two, 10-week pilot groups, 2 hours per session, 4 participants per group)<br>Content: psychoeducation on the menopause, cognitive and behavioural interventions for anxiety, panic attacks, depression, urogenital complaints, sexual concerns and sleep hygiene. | Greene Climacteric Scale (GCS; Greene, 2008); Montgomery-Asberg Depression Rating Scale (MADRS Montgomery & Åsberg, 1979) |

| Study | Sample | Study Information | Measurements for Depression |
|---|---|---|---|
| Green et al. (2019)<br>Single blind RCT | Community sample, Canada. | Experimental: *N*=28 (9 non-completers) Control: *N*=21 (15 non-completers)<br>GCBT (12-weekly 2-hour sessions, up to eight participants per group; range 5-8).<br>Follow up: 3 months<br>Content: manualised treatment - psychoeducation, CBT for VMS and depression, anxiety, sleep difficulties, and sexual concerns, relapse prevention. | BDI-II (Beck et al., 1996)<br>MADRS (Montgomery & Åsberg, 1979) |
| Reddy et al. (2019)<br>RCT | Community sample, India. | Experimental: *N* = 40 (11 non-completers)/ Control: *N* = 40 (11 non-completers)<br>GCBT (six weekly group sessions lasting between 50–60 min)<br>Follow up: 1 month and 6 month<br>Content: psychoeducation, relaxation, CBT for depression, cognitive, problem-solving, coping with hormonal changes. | Center for Epidemiological Studies Depression Scale (CES-D; Lewinsohn et al., 1997) |
| Conklin et al. (2020)<br>Prospective single arm study | Community sample, USA. | *N*= 59 (1 non-completer; 6 lost to follow up)<br>GCBT (6 weekly, 90mins sessions). Eleven groups of 4-7 participants,<br>Follow up: Yes (missing details)<br>Content: Manualised treatment - Psychoeducation, stress management, managing VMS, improving sleep, relapse management. Optional topics: weight, sexual functioning or cognition. | Snaith-Hamilton Pleasure Scale (SHAPS; Nakonezny et al., 2010); The Quick Inventory of Depression Symptomatology-Self Report (QIDSSR-16; Trivedi et al., 2004); MADRS (Montgomery & Åsberg, 1979). |
| Ham et al. (2020)<br>RCT | Community sample, South Korea. | Experimental: *N* = 28<br>One 2 hour group and 4 individual sessions of CBT for Insomnia (CBT-I) | CES-D<br>(Lewinsohn et al., 1997) |

| Study | Sample | Study Information | Measurements for Depression |
|---|---|---|---|
| | | lasting 30-60mins, and CBT-I self-help booklet given during treatment.<br>Control: *N* = 30. One 2 hour group session & CBT-I booklet.<br>Follow up: 12 months | |
| Khoshbooii et al. (2021)<br>Mixed methods embedded RCT | Community sample, Iran. | Individual Culturally Adapted-CBT (CA-CBT): *N*=22 ( 8 x 1 hour sessions over 8 weeks)<br>Group CA-CBT: *N* = 22 (16 sessions over 8 weeks, 24 hours total)<br>Control (waitlist) = *N* = 20<br>Follow up: 32 weeks<br>Content: psychoeducation, cognitive and behavioural interventions for depression; integrated Quran verses. | BDI-II<br>(Beck et al., 1996) |

### 1.7.3.2 Population

Participants were identified in studies as women and a total of 516 participated in all conditions across studies. Participants were from community settings in the United States of America, Canada, Iran, South Korea and India. Experimental sample sizes within studies varied from 8 to 91, and the age ranged from 30 to 65 years, although Brandon et al. (2013) identified the top age bracket as “60+”. Amalgamating studies from India, Iran, and South Korea increased diversity in the entire sample, but individually these study samples lacked diversity, compromising external validity. Some studies had additional exclusions; Conklin et al. (2020) only included white and black participants to explore diversity, and Khoshbooii et al. (2011) only recruited married women. Khoshbooii et al. (2021) used CA- CBT integrating Quran verses, and whilst this may be useful to test this adaptation, it may be difficult to generalise the findings beyond this population.

#### 1.7.3.2.1 Menopause Status

Menopausal status was confirmed via self-report (e.g. screening, outcome measures), except for one study (Khoshbooii et al., 2021) which used gynaecological assessment. Although Brandon et al. (2013) confirmed menopause via self-report (e.g. 12 months of no menstruation) in the post-menopausal sample, perimenopausal status was inferred by age, thus producing confounds in this study. Despite this discrepancy in how participants were assessed within the study, it was included in the current synthesis as a large sample within the study did have their menopause status confirmed (*n* = 91) and were compared in analyses to other women, which may help answer the review question. However, this represents the conflicting methods used to assess participants' menopause status and methodological issues in menopause research (Soares, 2017).

Four studies included samples of both perimenopausal and menopausal participants (Brandon et al., 2013; Conklin et al., 2020; Green et al., 2019; Ham et al., 2020). However, there were unequal samples of each group within studies, and in randomised studies only Ham et al. (2020) and Brandon et al. (2013) commented on the proportions of each in the experimental and control conditions. Two studies only recruited perimenopausal women (Khoshbooii et al., 2011; Khoshbooii et al., 2021). Menopausal staging in two studies was vague, with Green et al. (2013) recruiting participants in "menopausal transition" or "post-menopause", and Reddy et al. (2019) recruiting "menopausal clients". Terms such as "menopause", "perimenopause" and "post-menopause" are used interchangeably in some research, which is problematic (Soares, 2017). Only three studies (Conklin et al., 2020; Green et al., 2013; Green et al., 2019) used formal guidelines; Staging of Reproductive Aging Workshop (STRAW) criteria (Harlow et al., 2012).

#### 1.7.3.2.2 Medication

HRT and psychotropic medication act as modifiers and potential confounds. Three studies excluded participants on HRT and antidepressants (Khoshbooii et al., 2011; Khoshbooii et al., 2021; Reddy et al., 2019). Conklin et al. (2020) excluded those on HRT, and psychotropic medication doses had to be stable for a minimum of 8 weeks prior and during the study. In Brandon et al. (2013) information about HRT was not collected and only historic non-responders to 6 weeks of Fluoxetine 40mg were excluded. In Ham et al. (2020), women on psychotropic medication were excluded, and information on HRT was not documented. In two studies (Green et al., 2013, Green et al., 2019) women on HRT and antidepressants were included as long as they were on medication 3 months prior and the dose was stable during the study.

#### 1.7.3.2.3 Symptoms of Depression

Three studies (Brandon et al., 2013; Conklin et al., 2020; Green et al., 2013) used interviews and formal diagnostic frameworks (e.g. Diagnostic and Statistical Manual of Mental Disorders 5th Edition; American Psychiatric Association, 2013). All studies used varied outcome measures for depression, and samples were at cut off and above (please refer to Table 2, p. 33-35).

Samples varied in depression symptom severity, co-morbidity and chronicity. Two studies (Khoshbooii et al., 2011; Khoshbooii et al., 2021) excluded participants on psychotropic medication and who historically received CBT, and so it is possible these samples represent less chronic presentations of depression. In comparison, Brandon et al. (2013) included chronic presentations of depression (recurrent depressive disorder, dysthymic disorder) but excluded participants who did not respond to 8+ sessions of cognitive therapy in the past. The remaining studies did not exclude participants based on historic therapy. One study (Green et al., 2013) included participants with depression who had co-morbid anxiety disorders. All studies excluded participants with severe depression, active suicidal ideation, significant physical illnesses and substance misuse. Conklin et al. (2020) was the only study to include eleven participants with SMI (Bipolar Disorder) with depressive symptoms related to the menopause transition.

### 1.7.3.3 Intervention

Five studies used a group format. Khoshbooii et al. (2021) compared group and individual CBT against a control group within one study. One study only implemented individual CBT (Brandon et al., 2013), and one study (Ham et al., 2020) used the first session as a group intervention followed by individual sessions. All interventions were delivered face to face, although Conklin et al. (2020) delivered telephone 'catch up' sessions to participants who missed sessions. The number of group sessions varied from 6 to 16, lasting 50 minutes to 2 hours. Individual sessions ranged from 4 to 20, lasting 30 minutes to 1 hour. Length of individual sessions is not stated in Brandon et al. (2013). Six studies had follow-up ranging from 1 month to 1 year, although there were missing details in two studies.

#### 1.7.3.3.1 *Intervention Approaches For Symptoms Of Depression*

Methods could be categorised as *'indirect interventions'* such as Ham et al. (2020) where the intervention's primary focus is targeting insomnia, and decreased symptoms of depression were a consequent outcome which was measured. *'Direct interventions'* explicitly focussed on depression and included Khoshbooii et al. (2011) and Reddy et al. (2019). Brandon et al. (2013) focussed on depression and whether treatment response was modulated by reproductive status. Conklin (2020) targeted women with chronic, recurrent and relapsing mood disorders who may or may not have problematic vasomotor symptoms. Khoshbooii et al. (2021) targeted depression and sexual satisfaction to explore a '*bidirectional'* link. *'Generalised'* approaches included Green et al. (2013) and Green et al. (2019) who targeted a multitude of menopausal symptoms, and changes in depression are an outcome.

#### 1.7.3.3.2 *Content of Interventions*

Similarities and differences were evident (see Table 2, p. 33-35). All implemented psychoeducation on the menopause, cognitive interventions and behavioural strategies. Studies used interventions on depression, sleep, stress, anxiety, panic attacks, problem solving, managing vasomotor symptoms, sexual functioning, urogenital complaints, hormonal changes, weight changes and relaxation. Depression was directly listed in 6 studies. Khoshbooii et al. (2021) integrated Quran verses into cognitive interventions.

### 1.7.3.4 *Comparators*

Five studies used a control group. Controls involved no intervention, although in Ham et al. (2020) the control received an education session on CBT-I and a self-help book. Khoshbooii et al. (2011) documented a control but with no details. Three studies compared clients based on their menopausal stage: Khoshbooii et al. (2011) compared results between pre-menopausal with perimenopausal clients; Green et al. (2019) used menopause stage as a covariate; Brandon et al. (2013) compared the results of pre-menopausal, perimenopausal and post-menopausal women in terms of non-response rates, remission rates, and symptom reduction.

### 1.7.3.5 *Outcomes of Interventions*

Table 2 (p. 33-35) highlights the heterogeneity in the use of outcome measures. Self-report measures were used in all studies and included: BDI II, HRSD, CES-D, GCS, QIDSSR-16. The most used measure was BDI II, used in three studies. Clinician rated measures (MADRS, SHAPS) for depression were used in three studies.

As this review focusses on depression, the relevant findings for this within included studies will be the focus. To prevent unintentional vote counting based on statistical results alone, discouraged by Cochrane in systematic reviews without meta-analysis (McKenzie et al., 2021), findings are summarised with added reference to risk of bias assessments. CASP

(2021) checklists were also used to review evidence. Please refer to Table 3 below and Table 4 (p. 41). Risk of bias assessment scores can be found in Appendix A.

**Table 3**

*Summary of Findings (Randomised Studies) and RoB2 Assessments.*

| Author | Findings for Depression | Risk of Bias |
|---|---|---|
| Green et al. (2019) | Significant reduction in depressive symptoms (BDI-II) (*p* = 0.001). Group x time interaction for the clinician-rated measure MADRS was not significant (*p* = 0.53). Menopause stage was not a covariate in ANCOVA analyses. | Low |
| Khoshbooii et al. (2021) | Significant reduction in depression symptoms (BDI-II) for group CA-CBT (*p* = 0.001) and individual CA-CBT (*p* = 0.001). | High |
| Ham et al. (2020) | Insignificant results (CES-D) (*p* = 0.937). | High |
| Reddy et al. (2019) | Significant decrease in depression symptoms (CES-D) (*p* = 0.000) | High |
| Khoshbooii et al. (2011) | Significant decrease in depression symptoms (BDI-II) (*p* = .001). No statistical differences in outcomes between pre-menopausal and perimenopausal groups (*p* = .15). | High |

**Table 4**

*Summary of Findings (Non-Randomised Studies) and ROBINS-I Assessments.*

| Author | Findings for Depression | Risk of Bias |
|---|---|---|
| Green et al. (2013) | Reduction in depressive symptoms on measures; MADRS ($p < .01$), and on depression subscale on GCS ($p = .04$]. | Low |
| Brandon et al. (2013) | No differences in non-response rates ($p = 0.799$) between perimenopausal and post-menopausal sample. No statistical differences in remission rates ($p = 0.630$), and rates of 50% symptom reduction on HRSD ($p = 0.931$) between pre-menopausal, perimenopausal and post-menopausal samples. | Critical |
| Conklin et al. (2020) | Significant reduction on SHAPS ($p = 0.001$), QIDSSR-16 ($p < 0.001$), but scores on MADRS did not change ($p = .10$). | Critical |

Tables 3 (p. 39) and Table 4 above show favourable statistical outcomes, with exception to Ham et al. (2020) where the context of threats from North Korea are argued to have influenced results. Positive outcomes were irrespective of menopausal stage, or severity/chronicity of depressive symptoms. However, reasons for some inconsistent results with clinician rated measures were not elaborated upon.

### 1.7.3.5.1 Risk of Bias Assessments

In randomised studies, key issues included lack of information on randomisation, lack of blinding and important confounders. Khoshbooii et al. (2011) reported 6 non-completers, but there was missing information on which condition this was from. In non-randomised studies, issues included lack of blinding and problematic confounds (e.g. no information about HRT use, perimenopausal status assumed by age, one study reported missing information about concomitant psychotherapy as a limitation). The most trustworthy included Green et al. (2019) which is a single-blind RCT; a design closer to the ‘gold standard’. Green et al. (2013) is a pilot study and managed potential confounds of HRT and antidepressants well. Both studies give preliminary efficacy for CBT for depressive symptoms in menopausal women and targeted depression in a more ‘generalised’ approach.

### 1.7.4 *Discussion*

There is promising evidence for CBT for symptoms of depression in menopausal clients. There were differences in the format and content of CBT interventions, and the ‘route’ to which they treated depressive symptoms, highlighting the flexibility of this model. Whilst some treatments directly targeted depression, other studies reduced symptoms of depression via interrelated symptoms. Given this variability, formulation of a menopausal client’s depressive symptoms will be crucial in understanding how their symptoms should be treated. There was no evidence that menopausal stage affected the results of interventions, although studies exploring this were limited. However, high risk of bias in a majority of the studies and problematic confounds mean that results should be cautiously interpreted.

Although caution is advised, findings of this review are supported by another review by Van Driel et al. (2019) who compared CBT, Mindfulness and Behavioural Therapy for menopausal symptoms, although this review did not include depression. A majority of the synthesised studies used group formats, which was also found in a review by Mollaahmadi et al. (2019). Whilst group formats are cost effective, more trials on individual CBT are needed for balanced comparisons. Khoshbooii et al. (2021) noted some participants found discussing sexual satisfaction difficult in a group, so formulation factors should be considered when allocating treatment. It may also be useful to consider whether other therapeutic approaches may be useful when considering relational factors linked with symptoms of depression. Nonetheless, the included studies from Iran in this review provide cross-cultural insights into CBT applications to non-western populations, and additionally, indicates that there are ways that CBT can be culturally adapted for women experiencing the menopause. This is important given racialised minorities are under-represented in menopause research (BMS, 2023).

The current review notes that few studies focussed on depression alone, and so it is possible that some presentations or symptoms are neglected by researchers exploring the efficacy of CBT interventions. Furthermore, methodological issues raised in this review are widely acknowledged within menopause research and require addressing to progress knowledge (Maki et al., 2018; Soares, 2019). Firstly, while conducting the search, the author was surprised to find studies that either had not stated how they had confirmed menopause in their participant group, or perhaps had not elaborated on this procedure in their published article. In the included studies, there was heterogeneity in how studies confirmed menopause status and ascertained specific menopausal staging, which has been cited as a methodological issue in similar reviews (Green et al., 2015; Spector et al., 2024). Future studies should seek to standardise how menopause status is confirmed (e.g. self-report, gynaecological assessment) and terms used for menopause staging to help identify possible mediating variables. For instance, using the STRAW criteria (Harlow et al., 2012) would provide consistency. Furthermore, the studies used different measures for depression, and future studies could also try to standardise measures used for consistency. This is particularly important as there is a lack of menopause specific mood disorder scale (Maki et al., 2018), although new tools are being developed such as the ‘Meno-D’ scale (Kulkarni et al., 2018). Methodology in menopause research could also be improved by blinding, recruiting larger and more diverse samples, and addressing confounds (e.g. HRT, antidepressant use and concomitant psychotherapy).

From this review, further research is needed on the role of menopause staging on depression risk and outcomes using larger samples. Alternatively, exploring whether it is the severity of menopause symptoms that is a possible mediating factor, rather than menopause stage per se, would be of interest. A mediation study would help expand knowledge. Longitudinal research or long-term follow-ups would also help ascertain if effects of CBT interventions are lasting, particularly as the menopause transition and its affects can span years (NHS, 2024).

CBT for depression in menopausal clients could be widely implemented in the UK within services that already offer CBT, such as NHS Talking Therapies (NHS Talking Therapies, 2024). However, research would not just need to be methodologically robust, but also more inclusive for the psychological needs of all menopausal clients to be met. Studies in this review lacked participants from diverse backgrounds who have unique needs when accessing services and can experience poorer therapy outcomes (Alam et al., 2024; National Collaborating Centre for Mental Health, 2023).

NICE (2015) recommends CBT for symptoms of depression in menopausal women, yet not all women from across the mental health spectrum are represented in trials. Participants with chronic/severe presentations and/or SMI are under-represented or excluded in menopause research trials but are present in psychological services. This is concerning given previous history of mental health issues are a risk factor for depression during the menopause transition (Maki et al., 2019). Understanding the utility of therapies for this group is required, especially as people with SMI may struggle to speak to professionals about their menopausal symptoms (Di Lorenzo et al., 2021), and an audit of one UK NHS Trust found low implementation of CBT for people with Schizophrenia (Haddock et al., 2014). As NICE (2015) also recommends HRT, it is also important that research trials do not exclude participants for this reason, but instead account for its affects.

#### 1.7.4.1 Limitations

The search strategy could have been stronger by searching additional databases. The search only produced 24 results, which is unsurprising given the paucity of research in this area, but may have warranted searching grey literature. The review included articles in English and may have missed other global evidence. The eligibility criteria meant studies had to document that menopause status was directly confirmed, but it is unclear if this information in articles was absent because menopause status was not checked, or that it was simply not documented. Additionally, outcome measures cannot diagnose depression in the manner diagnostic frameworks do (e.g. DSM 5, American Psychiatric Association, 2013). Future research could use both diagnostic frameworks and outcome measures. The author also chose to focus on natural menopause in order to not homogenise experiences, and so there is other evidence which has not been included. Evidence from populations with medically induced menopause may have provided further insights. Therefore, it may be useful for future reviews to include both natural and medically-induce menopause in inclusion criteria to examine the evidence for depression to understand the efficacy of CBT, whilst keeping in mind the unique experiences of each of these populations.

As the author completed risk of bias assessments, these could be subjective. This review also focusses on quantitative evidence, but there is contention about rejecting research for not meeting quantitative ‘gold standards’. Qualitative evidence could provide a wider picture of the efficacy of CBT; therefore, the limits of quantitative evidence is not the limits of current knowledge. For instance, in a qualitative study of GCBT with menopausal participants with BD and major depression, Conklin et al. (2021) argued that current manualised treatments require tailoring to these populations; a view reflected by other qualitative research advocating for the treatment needs of menopausal populations with BD (Perich et al., 2017a). Therefore, NICE guidelines should include other types of research evidence and patient’s voices to inform treatment recommendations as part of a more democratic approach (McPherson & Beresford, 2019).

#### 1.7.4.2 Implications for Practice, Policy and Future Research

Considerable research is required in this growing area. Research should include participants with chronic presentations, SMI and from diverse backgrounds. Future research should also compare CBT with other psychological therapies to increase patient choice and challenge current recommendations. Improving research methodology and giving importance to other forms of research would also enable findings to be more meaningful to the clinical context and populations seen by healthcare professionals. The results of the present review also suggest that a variety of interventions are implemented for menopausal clients, but further research is needed to understand how depression during the menopause may differ to depression at other points in an individual's life. This would further understanding of what interventions would be most effective for menopausal women.

Given the current state of evidence, emphasis instead should be placed on how service providers consider the needs of menopausal populations they treat in a personalised care approach (Aninye et al., 2021). The BMS argues that service providers and healthcare professionals should be aware and have knowledge of the menopause (Currie, 2019). Knowledge of this life transition, the current evidence, research gaps, and accommodating the menopause into patient's formulations could help make choices about treatments, or important adaptations. This may mitigate the current gaps in research and reduces the chances of clients experiencing unmet needs within psychological services and poor outcomes. However, research is needed to explore the level of awareness of the menopause among staff within psychological services. Furthermore, as some research indicates that women may struggle to seek help for their symptoms and/or feel stigmatised by their menopause (Aninye et al., 2021; Currie, 2019), research could also explore how therapists respond to such challenges within therapy.

These recommendations could align with socio-ecological approaches. The Socio-Ecological Model (Bronfenbrenner, 1986) argues that health can be impacted by six interacting levels, which includes professionals at the provider level (mesosystem). Consequently, there is a necessity to understand processes within each 'layer' (e.g.

knowledge of the menopause, current clinical practices), in addition to relationships between each level (e.g. government policy) given the current gaps in research, the need to support care decisions and promote positive patient outcomes.

### 1.7.4.3 Conclusion

There are promising findings for the efficacy of CBT for symptoms of depression in menopausal clients. However, challenges in research methodology mean results should be treated with caution. Given the current state of evidence, intervention at the patient, provider, and systems levels are required to address the needs of this population.

## 1.8 Rationale for Current Research

The systematic literature review highlighted a lack of robust research evidence and the need for further research efforts to address methodological concerns raised within the review. This is particularly important as the menopause encompasses both physical and psychological symptoms that require health systems to deliver appropriate care. The current state of research means that there is potentially more need for practitioners in the psychology field to be aware and have knowledge of this transition in order to make appropriate care decisions. Although there has been research into the awareness, knowledge and experience of medical practitioners (e.g. Dintakurti et al., 2022), to the authors knowledge there has been no study exploring this with practitioners who deliver psychological interventions. Given this, a study will be conducted focussing on the awareness, knowledge and experiences of practitioners delivering psychological interventions. This would help understand more about the current state of knowledge and care delivery.  Such research would provide novel insights and help propel further research in this the field. It would also form part of national efforts in the UK to improve the care of women across the lifespan.

### 1.8.1 *Aims and Objectives*

This study aims to understand the level of awareness and knowledge of the menopause among professionals who deliver psychological interventions in statutory services in England. Importantly, the differentiation between ‘awareness’ and ‘knowledge’ has been made as whilst one can be aware of something, it may not in itself mean that one is knowledgeable of that topic. In addition, the study will also seek to understand professionals experiences of working clinically with menopausal clients. The study has the following objectives, as stated in Table 5 below.

**Table 5**

*Study Objectives*

| | Study Objectives |
|---|---|
| 1 | To understand the level of awareness of the menopause among staff who deliver psychological interventions - this includes awareness of what the menopause transition is, its stages and symptoms. |
| 2 | To understand where this knowledge was acquired (e.g. professional training, service training, media, personal experience). |
| 3 | To understand to what extent the menopause transition is discussed within work related training and/or supervision. |
| 4 | To gain an understanding of participants’ experiences of providing psychological interventions to clients in menopause transition (e.g. making adjustments to formulations, or to psychological interventions). Interventions could include direct work (e.g. assessment, psychological therapy, etc) and/or indirect work (e.g. advisory roles within teams, providing supervision). |

# Method

## 2.1 Chapter Summary

This chapter will begin by considering the study's ontological and epistemological positioning. This will be followed by discussion of the researcher's position, the study's research design, procedure, materials used, participant's, method of data analysis, ethical considerations and avenues for dissemination of the research findings.

## 2.2 Research Paradigm

Outlining the ontological and epistemological principles on which the present research is based is crucial as different philosophical assumptions underlie research methodologies (Al-Albabneh, 2020; Trotter II, 2012). Ontology refers to the nature of reality and being (Braune & Clarke, 2021), whereas epistemology refers to the nature of knowledge production (Al-Albabneh, 2020). These philosophical perspectives underpin the research design, the means of gaining knowledge (methodology) and research goals to create a sense of unity and integrity (Al-Ababneh, 2020).

Ontologies include realist positions where one reality exists and is independent of human beliefs or knowledge, compared to relativism positions, which endorses multiple realities (Al-Ababneh, 2020). Epistemological positions include positivism, constructionism, interpretivism, and contextualism. Positivist paradigms propose that knowledge is objective and based on deductive reasoning, cause-and-effect relationships, and is associated with quantitative methods based on principles such as generalisability, replicability and reliability (Maksimovic & Evtimov, 2023); this differs to qualitative research, which is based on principles of credibility, transferability, dependability and confirmability (Ahmed, 2024).

Conversely, constructionist and interpretivist assumptions differ in this view of objectivity, arguing that knowledge is acquired by understanding the inner experiences of different people, such as the meanings and interpretations attributed to events (Cuthbertson et al., 2020). Given the complexity of the world, constructionists argue that value-free research is not possible as post-positivism expects; therefore, these positions are associated with qualitative research (Al-Ababneh, 2020). Contextualism argues that truths exist but is dependent upon the context from which they are made, and therefore, both truth and linguistic meaning are context sensitive (Pynn, 2016).

In contrast, pragmatism offers a philosophical middle position, but holds a stance that there is a single or multiple realities, but does not believe reality can be established precisely as it is dependent upon environment, and instead, knowledge is based on one's social experiences (Goles & Hirschheim, 2000). Furthermore, Critical Realism (CR) combines aspects of positivism and constructionism, and provides possibilities to explain causation of social phenomena and a means of suggesting policy recommendations (Bhaskar, 2020; Fletcher, 2017). CR differs to other ontological and epistemological standpoints, criticising positivism for its *'epistemic fallacy'* (Bhasker, 2013; Bhasker, 2020) where reality is based on what is empirically proven. It argues that both positivist and constructionist paradigms both reduce reality to human knowledge. CR argues that there is a real social world that can be understood through knowledge, but that some knowledge may bring one closer to the reality than other knowledge and can help infer theory and judgement. CR asserts that reality is fluid and dynamic, and exists in a three layered 'iceberg' metaphor, and these domains interact and are part of the same reality: the *'empirical'*, which are events as we experience them and can be measured; the *'actual'* which are events that may or may not be experienced; the *'real'* where causal forces can create events (Bhasker, 2013; Bhaskar, 2020; Fletcher, 2017; Willis, 2023).

The present study followed a critical realist ontology, with an interpretivist epistemology, therefore taking a qualitative approach to data collection. Using a CR ontology acknowledged the reality that each individual's understanding of the topic of the menopause and their experiences of working clinically with this population may uniquely differ to one another. These differences could be attributable to individual life experiences, culture (Alharahsheh & Pius, 2020) and professional experiences. Using an interpretivist epistemology allowed the researcher to obtain a deeper understanding of each participant's experiences and their individual meanings and interpretations, which helped understand the influence of wider social and cultural structures. This helped the author further understand their knowledge on the topic of the menopause, providing rich context when studying a topic which may be complex and potentially emotional. Interpretivism also enabled the author to consider their role as a researcher, particularly one who has insight into the field, may be similarly qualified to participants and consider how this may have influenced analyses. This philosophical positioning and methodological approach maintained conceptual integrity and was arguably useful for the present research to understand the realities of each participant (Willis, 2023) and is important given this is an under researched topic. It is also important as although professionals may work for the same type of service delivering interventions for psychological symptoms, their experiences may not necessarily be the same. Quantitative methods would not theoretically fit, nor would they allow for in-depth or abstract data, and may miss important phenomena. An inductive approach was taken so that the analysis was based solely on the content of the data, rather than a pre-conceived theory.

The researcher had considered using feminist epistemology, which would have been fitting for research focussed on a women's health topic. This may acknowledge the influence of patriarchy, oppression, role of power and marginalisation. However, not all professionals are women, and feminist epistemologies pay particular attention to these voices. In this sense, there is tension between CR which argues that some knowledge is closer to reality than others, and feminist epistemology. Conversely, some argue that there could be links between the two, which requires further research (Gunnarsson et al, 2016). The author believes that the current positioning still allows for the voices of women to come forward in the data. CR can provide an alternative framework to explore gender and mental health topics as it does not dismiss what is already known and aims to go beyond this, and allows for the co-existence of ‘sex’ and ‘gender’ (Bergin et al., 2008). As professionals may also be male, it is felt that these perspectives are also important to pay attention to. The reality of UK statutory services is that teams are not solely female, so the current positioning allowed for opportunities to understand perspectives other than those of women in relation to the menopause.

## 2.3 The Researcher’s Position

The researcher is a mature female of south Asian descent who was born in the UK, who’s socioeconomic background is working class, and values include equality and fairness. The researcher has experience of working in the NHS for over 14 years in various roles in mental health services, primarily with adults delivering therapeutic interventions for depression and anxiety. The researcher has been qualified as a Cognitive Behavioural Therapist since 2012 and is currently a Trainee Clinical Psychologist. This means that the author may have been in similar employed roles to participants, which provides an understanding of how services work, and the strengths and challenges of such services in the current political climate. In addition, whilst the author is pre- menopausal and aware that she will experience the menopause one day and use health services, the author also sits on the ‘other side’ as a professional within services delivering psychological care. This represents a dual position of both potential ‘user’ of statutory services and ‘provider’ of care. There were considerations for how these variables may influence interpretation during the analysis, as well as interactions with participants. The author, being from a minority group, also considered the role this may play in interviews and when analysing the data.

It was important throughout the research for the author to be mindful of their own aspects of identity and how these intersect with participants throughout, including during data analysis. Whilst these aspects of identity are important to acknowledge, this also provided motivation for the author to be open minded and reflexive, which was an important part of conducting the analysis with integrity. The author's personal position can be useful to explicitly reflect on at a later stage following the analysis, and as recommended by RTA guidelines (Braun & Clarke, 2021) and quality measures (Braun & Clarke, 2023).

## 2.4 Research Design

Based on this ontological and epistemological position, designing a study and its sampling methods involved carefully identifying the appropriate methodological approach to data collection based on the research aims (Palinkas et al, 2015). Whilst CR is a theoretical framework, some critics have cited a lack of guidelines for researchers and applied CR informed methodologies, but it is often used in qualitative enquiries (Bhaskar, 2020; Fletcher, 2017). Qualitative methodology was deemed to best answer the current research aims as it enabled the author to gather the information and depth of understanding required to understand the knowledge and experiences of participants. Additionally, it also provided an opportunity for the author to obtain 'information rich' data (Palinkas et al, 2015) particularly given the lack of existing body of research on this topic.

In the present study, qualitative data was obtained from participants using a single-interview-per-participant design, with each interview conducted by the author alone. The interview was semi-structured and conducted virtually via the online platform Zoom and recorded for subsequent transcription and analysis. There was no pre-determined time limit for the interviews in order to obtain as much data as possible from each participant, but it was expected that each interview would last approximately one hour.

### 2.4.1 Reflective Thematic Analysis

Thematic Analysis (TA) is widely utilised within qualitative research as a method of data analysis, and is a theoretically flexible tool rather than a specific methodology. It entails procedures around theme development and allows for both descriptive (on the surface) and latent (implicit) codes to be constructed (Braun & Clarke, 2006; Braun & Clarke, 2021). Nonetheless, as TA encompasses a diversity of methods and not a single one, underpinned by differing theoretical ontologies and epistemologies, it still requires for researchers to consider their own philosophical standpoints to maintain conceptual coherence, particularly when using Reflexive TA (RTA) (Braun & Clarke, 2006; Braun & Clarke, 2019). Braun & Clarke (2023) argue that RTA represents a qualitative, non-positivist method; a ‘Big Q’ approach informed by the values of qualitative research, which differs to ‘small q’ which is more informed by (post)positivist methodology. Therefore, the present study used RTA.

While it is possible that more than one qualitative method would be suitable for the present study, RTA allows for a thoughtful approach to each individual interview, as well as the ability to develop themes laterally across participant interviews (Braun & Clarke, 2020). RTA was chosen over other approaches, such as Interpretative Phenomenological Analysis (IPA) which would involve a focus on language and sense-making. The author was uncertain as to whether participants would have considerable knowledge of the menopause, or much clinical experience working with clients going through the menopause transition. Therefore, RTA was the best fit to whatever depth of data was obtained. Braun & Clarke (2020) also suggest that RTA is more suitable over IPA if the research question is not based on personal experience alone, if the sample size is likely to be larger than typical IPA data-sets, and if the author is curious to look at possible actionable outcomes by reflecting on the themes and subthemes in wider socio-cultural contexts.

In RTA, reflecting on researcher subjectivity and delineating one’s own position to the research topic is a resource, and promotes a sense of *“knowing practice”*; a way to be reflexive theoretically and personally during the analysis, and diverges from a more punitive approach from positivist approaches (Braun & Clarke, 2023).

## 2.5 Participants

### 2.5.1 *Inclusion Criteria*

Purposeful sampling is often used within qualitative research and involves identifying particular individuals and/or groups who are 'information rich', such as because of their experiences, and particularly given the limited resources within research (Palinkas et al, 2015). A purposive sample of carefully selected individuals was used in the present research to answer the study aims.

The study recruited professionals who had experience of providing psychological interventions within statutory services (e.g. NHS, social care, council) in England to adults aged 35 and over. This included a number of professionals (e.g. Psychological Therapists, Psychologists, Psychological Wellbeing Practitioners, Assistant Psychologists, Clinical Associate Psychologists, Mental Health Practitioners, Cognitive Behavioural Therapists etc). The study also recruited professionals in training (e.g. Trainee Clinical Psychologists, Trainee Psychotherapists), as often these clinicians have experiences within other related roles prior to their training. Trainees are also present throughout statutory services and are often part of interventions in packages of care. Therefore, openness to a variety of professionals is important as psychological interventions are delivered by a range of staff members and in a range of formats in modern statutory services in the UK. For example, in NHS Talking Therapies Services, 'low-intensity' treatments for depression and anxiety for adults involve self-help interventions based on CBT, which are delivered with support of Psychological Wellbeing Practitioners (NHS Talking Therapies, 2024).

There was flexibility in terms of where participants would have obtained their experience (e.g. from primary care, secondary care, tertiary care, social care, council). The rationale for focussing on staff with experience in statutory services in England is due to the influence of NICE guidelines for menopause care (NICE, 2015) which applies to England, as there are some differences in devolved nations in the UK. It was important for the researcher to consider to what extent practice reflected the guidelines.

The study accepted participants who are clinicians who work either directly (e.g. assessment, psychological therapy) and/or indirectly (e.g. advisory roles within teams, provide supervision) with clients. This was important as professionals deliver psychological input in a variety of ways within modern services. Participants had to either be currently working within statutory services or have recently left within the last 12 months (e.g. due to a career break, retirement, move to private sector). The restriction of up to 12 months had been set by the author as it was felt that participant's recollections of their work was more likely to be accurate and detailed if their departure had been recent. Participant's clinical experience also needed to be, or have been, in services that would see people who are likely to experience the menopause transition. In the UK, the average age to begin the menopause is 51, but perimenopausal symptoms can begin years prior (BMS, 2021). Therefore, the author specified that participants needed to have worked with people aged 35+. As adult services begin from age 18, it was felt that making this distinction when advertising the study would help reach participants who would be suitable for the study.

Lastly and importantly, the present study was inclusive, and there was no predetermination in terms of the gender identity of the participants, age, ethnicity, beliefs, religion, culture etc. The key factors related to eligibility were the aforementioned criteria.

### 2.4.2 *Exclusion Criteria*

Participants were not able to participate if they did not meet the specified inclusion criteria.

### *2.5.3 Sample Size*

Instead of determining a maximum sample size, the author set a minimum sample size, but aimed to obtain information from participants deemed to be 'information rich' (Malterud et al., 2016) in order to answer the research aims. The author aimed to interview a minimum of 15 participants, but was open to recruiting more participants if there were resources and interest. There is contention within qualitative research about prior determination of sample sizes (Trotter II, 2012; Sim et al., 2018), but it is acknowledged that some argue for more transparency on sample decisions (e.g. Vasileiou et al., 2018). This minimum was set as it was felt that this would provide both rich and potentially diverse data for analysis. For example, this could include professionals from a diversity of services across England, and from diverse backgrounds. Therefore, this delimitation was set based on the author's interest in obtaining as many voices as possible on the topic, and with consideration of available resources and that the research would be conducted by the author alone over a time-set period.

## 2.6 Recruitment

Strategies for recruitment included snowballing and convenience sampling. Participants were recruited in the following ways: (1) personal contacts; (2) advertising through professional bodies; (3) advertising through social media. It was felt that this approach enabled the author to recruit as many eligible professionals as possible and also provided opportunities to recruit a diverse sample. For example, all close contacts were approached, rather than a select few, to avoid any potential bias (e.g. race, gender). Social media groups and professional bodies also comprise professionals from diverse backgrounds who would equally be able to view the study advert and participate in the study if interested.

### 2.6.1 *Personal Contacts*

The study included close contacts of the author who wished to participate. This was justified as the author has over twelve years of experience in statutory primary care mental health services for adults within the London, Essex and the north-east of England regions, and some eligible participants may be known to the author. However, every effort was made to ensure close contacts were made aware of their rights and to avoid the potential for demand. This was achieved by emphasising that participation was voluntary, any views they express should be their own and that there are no 'right' or 'wrong' answers, which was also stated in the Participant Information Sheet (Appendix B). Additionally, if they did not wish to participate that it would not affect their relationship with the author.

The author did not approach personal contacts in person, but sent the study advert to personal contacts (e.g. via their personal email or text) with a message: *"Dear [name], Hope you are well. Here is a poster for a study I am conducting at the moment. I would like to emphasis that participation is completely voluntary. If you are interested and wish to find out more then please contact me on [study email]. If you do not wish to participate and/or are unable to at this time, that is not a problem at all and will not impact you in any way, and you do not need to reply but I thank you for taking time out of your busy week and commitments to read this message. Warm regards, [author name]".* Further information (e.g., Participant Information Sheet; Appendix B) was only provided if participants wished to have this. The use of close contacts was not the primary method of recruitment, as a diversity of recruitment strategies were used.

### *2.6.2 Professional Bodies*

The author aimed to advertise the study through relevant UK based professional bodies, with as many organisations as possible. When approaching organisations during recruitment, a limiting factor was that some organisations asked that the author to pay for membership, or be a member with the appropriate qualification for the organisation. This was not possible due to a lack of budget and/or the author not having the appropriate qualification to be eligible to join the professional body. In other cases, there was no reply to the researcher's request to advertise the study. Organisations where the Study Advert (Appendix C) was published online or in their member magazines included: British Psychological Society (BPS), British Association of Behavioural and Cognitive Psychotherapies (BABCP), and the College of Sexual and Relationship Therapists (COSRT).

### 2.6.3 *Social Media*

This included publishing the Study Advert (Appendix C) in relevant Facebook, Instagram or Twitter groups for practitioners who work in the field of psychology and psychological therapy. These social media groups often include psychological practitioners who are currently working in statutory services, or who have previous experience of working in such services.

## 2.7 Research Procedure

Participants who wished to participate approached the researcher (author) directly via an email address provided in the Study Advert (Appendix C), which was the author's university email address. Participants were given the Participant Information Sheet (Appendix B) which provided an overview of the study and their rights, and if they still wished to participate and they met the eligibility criteria for the study, they were asked to read and sign the Consent Form (Appendix D). Basic information about participants was collected using the Demographic Information Sheet (Appendix E), and each participant was allocated a participant number in ascending order (e.g. 1, 2, 3, etc.).

The researcher scheduled the interview with the participant, which was conducted virtually using Zoom software provided by their university, and was recorded on the online platform for subsequent transcription. Participants had a choice as to whether they wanted to have their own camera on or off during the interview, as the author is aware some may not wish for their faces to be captured in the recording. There was no set time that the interviews were expected to last to allow participants to share as much as they wished, but it was anticipated that they would last up to an hour. Documents with identifiable information and the interview recordings were stored on the author's university personal drive. Only the author, research supervisors and university's Information Technology (IT) department had access to the recordings and documents stored. Transcriptions were anonymised and the data then analysed. Participants were not remunerated in any way, and a budget was not required for this research.

Participants were made aware in the Participant Information Sheet (Appendix B) that participation was voluntary. If they withdrew before or up to two weeks after the interview, their information would be destroyed. However, if they chose to withdraw more than two weeks after the interview, their information would still be used for the study. This caveat had been set because of the resources involved, as transcribing and analysing the interviews takes many hours, and so a lot of work would be lost if information was withdrawn at a later time. However, if the participant believed there was a strong reason why their information needed to be withdrawn after two weeks, they were aware that they could contact the researcher (author) or research supervisors to discuss this further. The author aimed to ensure that participants were fully informed and any concerns were addressed at the outset to avoid the possibility of participants withdrawing after the interview. Following the interview, participants were thanked for their participation and sent a Post-Interview Sheet (Appendix F).

## 2.8 Materials

### 2.8.1 *Study Advert*

An advertisement was used to inform potential participants of the study, and if interested, they made contact with the researcher directly via email (see Appendix C).

### 2.8.2 *Participant Information Sheet and Consent Form*

The Participant Information Sheet (Appendix B) and Consent Form (Appendix D) were used to ensure clients could fully consent to the study and understand their rights. If a participant had visual loss, the researcher planned to be flexible around this (e.g. the participant information sheet and consent form would be read to them and verbal consent would have been sought and recorded online prior to commencement of the interview). The script would be the same as on the written forms in this case.

### 2.8.3 *Participant Demographic Information*

The Participant Demographic Information Sheet (see Appendix E) was used to collect information about participants and was stored securely on the authors person drive with the university. The details collected included personal contact details (name, email address, telephone/mobile number) so that the researcher was able to liaise with them and send the Zoom meeting link. The sheet also requested information about their gender with options (‘male’, ‘female’, ‘non-binary’, ‘do not wish to specify’), age range category (e.g. 20-30, 30-40, etc), ethnicity (blank space left for them to self-identify), and a space was left for participant’s to self-identify their professional title and current employment setting. The final question *‘experience of delivering psychological interventions to clients aged 35+ in statutory services? (or within the last 12 months)’* involved a ‘yes’ or ‘no’ answer for the question

Age was collected within a broader age category as it was felt this would remove any potential anxiety from participants that they may be identifiable. The author wished for participants to self-state their ethnicity as it was felt that if participants were not represented in a pre-determined list, this may have affected engagement and cause hurt, such as by feeling ‘othered’. Participants also had the option of not answering the questions for gender at all. Collecting this information helped understand a little more about the participants themselves and offered insights in later analyses.

### 2.8.4 *Interview Guide*

The Interview Guide (Appendix G) was developed independently for the semi-structured interviews and included a range of open questions, which guided and helped participants expand on aspects of their awareness, knowledge and experiences. There were prompts for the researcher for the interviews, which helped gather relevant information from each participant, but additional prompts could be used with participants as required, depending on their disclosures.

### 2.8.5 *Post-Interview Sheet*

The Post-Interview Sheet (Appendix F) was sent to thank participants for their participation and asked for them to let the researcher know of any wish to have a copy of the results. It also prompted them to contact the researcher if there were any issues discussed in the interview that they were affected by so that support could be arranged.

### 2.8.6 *Research Reflective Journal*

A typed research journal was kept by the researcher to document any relevant field notes throughout the research for later reflection. Notes were anonymised and included reflections on the process, such as what an interview felt like, observations of participants, information for analytic insights and potentially emotional aspects of the research, which is recommended in such qualitative research (Braun & Clarke, 2021).

## 2.9 Method of Data Analysis

Once data had been collected, it was transformed into anonymised transcripts by the researcher alone. Reflexive Thematic Analysis (RTA) was then conducted by the researcher independently. NVivo software was used to support RTA to understand patterns, code data and to transform data into themes and subthemes following thorough reflection (Braun &

Clarke, 2006; Braun & Clarke, 2014; Braun & Clarke, 2019). Guidance for RTA were referred to (Braun & Clarke, 2006; Braun & Clarke, 2019; Braun & Clarke, 2021; Braun & Clarke, 2022; Byrne, 2021), and the methodical manner in which data was approached is detailed below to ensure the analysis was conducted in line with this. This is important in qualitative research to ensure that analysis is conducted with rigour and to ensure trustworthiness of the data (Nowell et al., 2017). Given that the analysis was conducted by the researcher alone, it is important to note that the analysis represents the researcher's subjective perception of themes and subthemes from the data based on what was explicitly said in the data and underlying meanings (Braun & Clarke, 2019).

1. Familiarisation With the Data: Familiarisation with the data began during the interview stage. The researcher kept notes following interviews on their experience of participants, what they reported, and the researcher's impression of the interview itself. Following interviews, recordings were transcribed by the researcher alone. Transcripts were read and reread to ensure accuracy, and written notes were made with reflections and impressions on participant's transcripts.
2. Generating Initial Codes: Transcripts were then uploaded to NVivo software and the researcher developed codes from the data. The codes were reviewed a second time to ensure they were representative and accurate, and to prevent any overlaps. In total, there were 79 codes developed from the data (see Appendix H for a coding example).
3. Searching for Themes: The researcher at times used both Nvivo and written notes to develop themes and subthemes. This was an unanticipated step, but the researcher found it was helpful to see the codes in big writing in from of them and see how they led to a *"broader pattern of meaning"* and *"shared knowing"* to a theme which tells a story about the data (Braun & Clarke, 2021). The researcher

felt this helped with their creativity in order to construct broader themes and subthemes. It was a surprise to the researcher that they chose at points to do this by hand. This related to some long periods on the computer transcribing, some unrelated eye health problems, and a sense of wanting to be with the data in a space and away from a screen. Once finalised, the researcher updated NVivo software.

4. Reviewing Themes and Subthemes: The researcher reviewed the themes and subthemes created and went into a deeper process of reflection of these, and was a process which was challenging at points. Themes do not pre-exist analyses and are found by the researcher (Braun & Clarke, 2022). There were several codes which the researcher found interesting, but the researcher simultaneously had to keep in mind the aims and objectives of the present research, and this involved not including some themes. Letting go of some themes developed was also difficult at points, but was important in order to refine and further define the themes and subthemes. Eventually, the researcher had reached the point where the task was completed and the themes and subthemes were reflections of the codes. It was more challenging than the researcher had anticipated it would be, and involved many breaks and long walks, which helped the researcher ‘recharge’ and come back with renewed energy. Field notes were used at times to motivate, with statements such as *“trust your instincts”* and *“you can do this!”* being used to persist through difficulties in the process. This aluminates Braun & Clarke’s (2021) assertion that the task of TA is not a low-level descriptive task, but an active and deeply interpretive activity that involves the researcher to be thoughtful.

5. Defining and Naming the Themes: It is important for themes to communicate the message of the theme from the data, but also be creatively framed (Braun & Clarke, 2022). This is important when thinking of dissemination and capturing reader's attention. At points, creative energy ran low and breaks again proved helpful here to re-energise. The researcher then finalised the wording of the themes and subthemes, using participants own words where this was possible.
6. Producing the report: The final step involved the researcher then presenting the findings. It was important for the researcher to include the voices of participants from across the sample in the report to demonstrate various expressions that led to theme construction (Byrne, 2021). It was also useful to reflect on Braun & Clarkes (2021) tool for manuscripts, to ensure the write up was clear.

### 2.10 Ethical Considerations

The research was conducted in line with the British Psychological Society's (BPS) Code of Human Research Ethics (2021), which highlights the moral principles which guide researchers. The code includes: respect for the autonomy, privacy and dignity of participants, groups and communities (e.g. culture, gender, age, race, religion, disability etc); scientific integrity to ensure research is of good design and contributes to knowledge development; social responsibility of the researcher to the welfare of participants and to be self-reflective; and maximising benefit and minimising potential for harm.

Ethical approval was required from the University of Essex, which was granted on 5th December 2022 (ETH2122-1481; see Appendix I). Ethical issues were considered for this research study, which have been listed below. It was felt that the benefits of the current research outweighed any potential risks. The findings could be helpful to reflect on the psychological care given to menopausal clients generally. The author did not require NHS ethics for the study as participants were not directly recruited from within NHS services.

Nonetheless, the author hoped that the recruitment process would attract participants with experience from a variety of statutory settings from across England so that the data would not be specific to the practices of one particular setting or geographic location. This would help understand whether there is potential variability in practices across the country, services and/or professional disciplines.

### 2.10.1 *Data*

All information collected was kept securely and stored in line with the Data Protection Act (UK Public General Acts, 1998), which is the UK's implementation of General Data Protection Regulation (GDPR). As the researcher has a secure personal drive with their university, participant data was stored there. This personal drive is only accessible by the author and research supervisors, and in the exceptional circumstances, can be accessed by the IT department in the event that technical help was required. This offered a high level of security of participants information and data. Data did not need to be transported anywhere.

Research data used for analysis would be retained for a period of at least ten years after the completion of the project, at which point data it will be destroyed. Participants who withdrew before their interview, or two weeks after their interview, would also have their data destroyed. The legal basis for processing personally identifying data is that participants have consented to it, and the data controller is the University of Essex (dpo@essex.ac.uk).

### 2.10.2 *Confidentiality*

Transcribed data was anonymised and each participant was referred to by number (e.g. 1, 2, 3, etc). Personal information (e.g. demographics) was stored on the author's university personal drive.

### 2.10.3 *Informed Consent*

Participation was voluntary. Participants were given a Participant Information Sheet (Appendix B) and Consent Form (Appendix D), which ensured participants were fully aware of the research and what their involvement would entail, their rights, how their data would be used and prevents deception. If a participant had visual loss, the Participant Information Sheet and consent form would have been read to them, and verbal consent sought and recorded online prior to commencement to the interview.

### 2.9.4 *Debriefing*

Participants were thanked for their participation and made aware that a summary of the findings can sent to them if they wish through the Post-Interview Sheet (Appendix F). They were also advised that if they felt affected by anything they discussed that they could inform the researcher who would direct them to support (please also refer to 'psychological harm' section below).

### 2.10.5 *Inclusive Stance*

Research has to be non-discriminatory in how it is designed, practiced, analysed and interpreted to avoid bias (BPS, 2021). The study was inclusive of all participants from diverse backgrounds who were eligible to participate.

### 2.10.6 *Suitability of the Researcher*

The researcher (author) is a Trainee Clinical Psychological currently studying a Doctorate in Clinical Psychology at the University of Essex. The researcher is also accredited by the British Association for Behavioural and Cognitive Psychotherapies (BABCP) as a Cognitive Behavioural Therapist from previous training, and has experience of working within the NHS. It was felt that the author's experience in working with a variety of people was beneficial during the interview process.

### 2.10.7 *Psychological Harm*

It was felt that as the interview enquired about participants knowledge and experience at work, that the risk of psychological harm was low. Nonetheless, participants' emotional well-being was monitored throughout their contact with the researcher. Participants were also given a Post-Interview Sheet (Appendix F) thanking them for their participation and prompting them to contact the researcher if affected by the issues discussed. If there was concern about a participant, then they would be directed to support options where they could get further assistance (e.g. GP, Occupational Health, local NHS psychological services, mental health crisis services, etc). This would have been a consideration where participants may be experiencing their own psychological difficulties and/or are affected by the menopause themselves. In the case of the latter, participants would also be directed to their GP and British Menopause Society for support options.

### 2.10.8 *Health and Safety*

The author worked independently, but as the interviews were conducted virtually, there were no concerns around personal safety from lone working. Working virtually with participants also eliminates any risks posed by infection control (e.g. of coronavirus) for both parties.

The author used self-reflection to monitor their own emotional wellbeing. If there were concerns about the impact of the interviews on the researcher, then support could have been obtained from the research supervisors. The author ensured that there was space after each interview to process one's own feelings, and so interviews were conducted with breaks in-between.

## 2.11 Dissemination Plan

Findings will be presented within a doctoral thesis, but given the importance of the potential findings, the research could also be disseminated in other ways. The author remained open minded about which journal to publish the findings of the present study, but a possible option could include ‘Menopause’, which has a wide inter-professional audience. The findings could also be published in ‘The Psychologist’ magazine published by the BPS, or ‘CBT Today’ published by the BABCP, which would reach a number of psychologists and therapists directly. The author is open to any other magazines published for professionals delivering mental health interventions with adults.

There are also other avenues for dissemination, which could help reach other audiences. For instance, the findings could be presented at conferences within the mental health/psychology field, but also events attended by other professionals who work with menopausal clients in services (e.g. General Practitioners). Furthermore, an infographic could be published on websites or social media for the NHS, professional groups, council and charities (e.g. BMS). These are resources accessed by the public and professionals for information. The British Menopause Society are interested in promoting menopause education amongst healthcare professionals, and the findings could be of interest to them as part of their strides to make cultural paradigm shifts in the care of women. By doing this, the findings may also reach service providers through the aforementioned avenues described above. Lastly, findings could reach government agencies as part of the Women’s Health Strategy (Department of Health and Social Care, 2022) and could be disseminated to the appropriate government division.

# Results

## 3.1 Chapter Overview

This chapter will present the results from fifteen semi-structured interviews with participants. Reflexive Thematic Analysis (RTA; Braun & Clarke, 2006; Braun & Clarke, 2019) was conducted by the researcher independently with the use of NVivo software. Illustrative extracts from participant's transcripts will be used to support interpretations made by the researcher. Participants have been referred to using participant numbers (1 to 15) allocated to them, and any personally identifiable information has been removed to protect their identities.

## 3.2 Participant Characteristics

The recruitment phase of the study began in January 2023 and ended in August 2023. In total, 25 people expressed interest in the research and in participating in the study. Of these, eleven were personal contacts of the researcher, of which eight went on to participate in the study, and the remaining did not respond after receiving the Participant Information Sheet. One participant was also known to the researcher but was recruited via 'word of mouth' from another participant (a close contact) who had informed them of the study. There were eleven people who approached the researcher directly after seeing the Study Advert advertised on social media and were not personal contacts. Of these, six participated in the research, four did not return the consent and demographic information forms, and one participant was keen to engage but did not meet the inclusion criteria as they had practiced clinically in Scotland.

Participant numbers are used throughout the chapter to ensure confidentiality, and identifying information has been removed, including information about participants' workplaces or unique aspects of their career journey which may identify them. The length of interviews ranged from a minimum of 21 minutes and 55 seconds, and maximum of one hour and seven minutes, with a mean of 31.9 minutes. Interviews were conducted online via the platform 'Zoom' where the interview was able to be video and audio recorded. Of the sample of fifteen people, fourteen participants consented to having their camera on, and one participant did not wish to be visually captured for personal reasons.

Research participant's ages were captured using age categories (e.g. 20-30, 30-40 etc) to reduce the chances of them being identifiable, and is felt by the researcher to have provided reassurance. The sample ranged between 20-30 years to between 50-60 years of age. One participant stated their age range as 20-30, eight participants stated 30-40, three stated 40-50, and three stated 50-60. Participants included twelve females and three males. The sample included participants from five separate geographic regions across England.

Participants were offered the chance to individually describe their ethnicity. In total, ten identified their ethnicity as "White British", one as "British Indian", one as "British Pakistani", one as "Spanish – White other", one as "Black British" and one as "British Chinese". All participants were able to communicate in English, and one had English as a second language, but was fluent in both spoken languages. Information about other aspects of identity, such as religion and sexuality, were not part of the demographics collected from participants.

At the time of their interview, thirteen participants were working within the NHS, and two had left the NHS within the last year and worked full time within private practice in the same role. The sample included four Trainee Clinical Psychologists, two Clinical Psychologists, seven Cognitive Behavioural Therapists (two in private practice, and one who also identified as a psychotherapist and counsellor, and another who additionally identified as a counsellor), one identified as a Psychotherapist, and one Counsellor working in the NHS.

Of note, participants were often multi-qualified, such as holding other qualifications before their current roles. This could include prior roles such as Psychological Wellbeing Practitioner, Cognitive Behavioural Therapist, Assistant Psychologist, Counsellor or Social Worker. Three participants identified as being in senior leadership positions. Two participants also held positions in academia on taught courses related to their discipline.

All participants had experience of working with adults of menopausal age, including over an extended period and/or currently, with one participant additionally having experience of group work and another of delivering webinars to a large and varied audience. Please see Table 6 (p. 73) for a summary of participant characteristics. Please note, this table has limited available information for each participant deliberately to protect their identities, and therefore, the participants age category has not been presented.

**Table 6**

*Summary of Participant Characteristics*

| Participant Number | Gender | Self-Reported Ethnicity | Professional Role |
|---|---|---|---|
| 1 | Female | White British | CBT therapist |
| 2 | Male | British Chinese | Psychotherapist |
| 3 | Female | White British | Psychotherapist, CBT Therapist (Private) |
| 4 | Male | British Indian | CBT Therapist |
| 5 | Female | Spanish – White Other | Trainee Clinical Psychologist |
| 6 | Female | White British | Clinical Psychologist |
| 7 | Female | White British | Trainee Clinical Psychologist |
| 8 | Female | White British | CBT Therapist |
| 9 | Female | White British | CBT Therapist |
| 10 | Female | White British | Trainee Clinical Psychologist |
| 11 | Female | White British | Counsellor |
| 12 | Female | Black British | CBT therapist, Counsellor |
| 13 | Female | White British | Trainee Clinical Psychologist |
| 14 | Male | White British | Clinical Psychologist |
| 15 | Female | British Pakistani | CBT Therapist (Private) |

## 3.3 Thematic Analysis

Familiarisation with the data began during the interview stage where the researcher kept notes following interviews on their experience of the participant, what they reported, and the researcher's impression of the interview itself. Following completion of the interviews, recordings were transcribed by the researcher. Transcripts were read and reread, and notes were made with reflections and impressions on participant's transcripts. Transcripts were uploaded to NVivo, and Reflexive Thematic Analysis (RTA) was then conducted by the researcher independently to develop codes from the data, which were then developed into themes and subthemes. In total, there were 79 codes developed from the data (see Appendix H for coding example). The analysis below represents the researcher's perception of themes and subthemes from the data. Procedures were followed to ensure that RTA was conducted robustly, as detailed in the Methods Chapter.

## 3.4 Themes and Subthemes

The analysis led to development of five main themes and eight subthemes, as stated in Table 7 (p. 75) below. These will be discussed with excerpts from participant interviews. Consistent with RTA, analytic memos for each theme will be shared with the reader. Due to the recommended format for this thesis, some analytic interpretations are presented in the subsequent Discussion Chapter.

**Table 7**

*Themes and Subthemes Developed From Reflexive Thematic Analysis*

| Summary Of Themes and Subthemes | |
|---|---|
| Main Theme | Subthemes |
| It's a Yes, No and Maybe | A Forgotten Age Group? |
| | Pondering Pedagogy – When It's Good, It's Really Good |
| The School of Life | The Media Moderator |
| | It Has Happened to Me and Those Around Me |
| A Loud Silence in Services | |
| Navigating Uneven Terrains | It's About You, Me and 'Us' |
| | Lead Star, Co-Star or Backstage |
| | It's Not 'One Size Fits All' |
| | It's About Team Work |
| We Need to Hold Space for the Menopause | |

### 3.4.1 *Theme One: It's a Yes, No and Maybe*

This was a strong theme and reflected participants' views of their awareness and knowledge of the menopause transition. Participants all had an awareness of the menopause. However, their level of knowledge varied in the categories of physical and psychological domains of the menopause respectively, indicating that one may have more knowledge of one domain, both, or have gaps in both. Therefore, there was similarity between the participants, such as all felt that there were aspects of the transition that they did not know, which was interesting as they all worked in difference services. Participant 14 felt their current service discussed the menopause comparatively more often as it was a physical health setting. There were differences in how confidently some discussed absences within their knowledge, with one (participant 2) appearing more anxious. This perhaps highlights the costs of silence itself in creating various anxieties about a topic. Excerpts highlight a sense of the topic being the 'unknown', with participants revealing a sense of what is known of a 'secret' and what is not.

> *"…even to me it feels quite unknown….I do believe that there is not much information out there…" (Participant 5)*

> *"I don't know a great deal to be fair." (Participant 11)*

Participant 10 highlights that although they have some understanding of the physical aspects of the change, they felt that they lacked knowledge of the mental health aspect. In comparison, Participant 9 had awareness of the psychological and wider functional impact, but less about the physical changes. Of note, participants 5, 11, 10 and 9 did not work for the same service and all varied in their level of experience within their roles, but all shared a sense of incomplete understanding of the menopause.

> *"...I don't know the ins and outs of the mechanisms of exactly what's going on biologically and at what point, but more of the kind of the effects of it I guess and how it's impacting on people." (Participant 9)*

> *"I don't feel like I know loads about it…it being a transition that affects you your hormones, affects your mood, potentially affect sleep, um maybe there's physical symptoms that women experience as well, when hot flashes or um feeling faint or tired, um obviously the loss of periods… in terms of the transition mentally….I don't think I know too much about the sort of impacts of it…" (Participant 10)*

Participant 6 felt they had adequate knowledge of the transition but spoke of the gaps in knowledge of how the menopause may impact clients with a learning disability. This signalled there may be additional questions about specific populations of women. Interestingly, participant 6 was the only professional within the sample who is an experienced clinician in the field of learning disability.

> *"I don't know if having a learning disability um can sometimes influence hormonal led changes in your body because quite a few of the women that I've known have had early menopause, and I don't know if that's possibly linked to an underlying genetic basis to their LD [learning disability] or whether it's linked with medication or lifestyle factors…" (Participant 6)*

#### 3.4.1.1 Subtheme: A Forgotten Age Group?

This subtheme spoke to the lack of training participants felt they received on the menopause (e.g. CPD, taught professional programmes of training) and how this then creates gaps in knowledge. This signalled to the role of wider cultural and systemic factors within services, which then shapes knowledge held by those that work within it. In particular, some participants spoke about the neglect of this topic, which perpetuated silence and knowledge gaps. Some participants also pointed to the role of patriarchy in relation to the prioritisation of women's health topics in training and academia. These excerpts led to a deeper sense of systemic culpability, citing the role of institutions more specifically in potentially devaluing the importance of the menopause.

> *"...no, not that specifically around that, because I think when I think about when we've we've had teaching around older people, um it's for much older, where it's sort of more around memory and things like that and those kinds of difficulties, I think for the kind of age group which women are when they may have go through the menopause….it's not a forgotten age group, but maybe it is, I don't know, I don't think we've had teaching around the kind of difficulties people face in that, or women face…" (Participant 10)*

> *"…there's no sort of mention of it in the IAPT training, BABCP don't do any training on it…. BPS don't do any training on it, so I would say it's very much something that isn't looked at enough…" (Participant 4)*

Notably, all the above participants worked for different services in geographic locations and ranged from trainee level to experienced practitioners. Some participants also commented on the lack of training on the menopause during professional training and expressed their views about this being a systemic issue in terms of the role of patriarchy and the priority given to women's health topics in curriculums. Notably, these participants shared some similarly as they had either personally experienced the menopause or another condition that required healthcare as a female. This perhaps provided some lived experience and insight into the system and of the gaps in education.

> *"…a lot of the things that are viewed as important and which might be contained within curriculums are probably driven by men, rather than considering the needs of women as well." (Participant 6)*

Some participants expressed how the menopause did not come up during their NHS Talking Therapies (formerly known as IAPT) additional top-up training in long-term health conditions, which is training delivered to qualified staff around working psychologically with clients with physical health conditions (e.g. diabetes, heart failure, cancer, etc). These participants reflected on how a training focussed on the interaction between physical health conditions/symptoms and mental health did not include the menopause. Although this could indicate a biomedicalised view of the menopause, it appeared that participants expressed this as for them it reinforced the sense of neglect of the menopause more generally.

> *"…when we have had like long term conditions [IAPT] training or things like that, having no mention at all of menopause…" (Participant 5)*

Participant 12 was the only counsellor within the sample, and comments on a lack of prioritisation of the menopause during counselling training, and other NHS training they have received since this time.

> *"...I don't think how we're trained as therapists, even during my counselling training, I don't really remember them talking much about menopause really, it's not something that they usually kind of dedicate much time to, it could be me, or it could be specifically my training that I've had, or maybe I've I've not really taken any notice, but in my mind, I'm thinking that I've not really had much focus on that or training..." (Participant 12)*

Participant 9 comments on how the lack of training on HRT fuels lack of understanding of its pharmacological role within the menopause transition. This appeared to maintain stigmatised ideas about HRT, and a sense of uncertainty.

> *"I think there's been a lot of stigma hasn't there about HRT because of the press in the past and people being misinformed.....is all quite complicated, because we're talking about medication, which I don't really know anything about either.....it's all just hearsay from different people....not from a training that I've attended..." (Participant 9)*

Participant 14 was the only participant who recalled brief references to the menopause during their doctorate in clinical psychology, although they highlighted that it was not in-depth training or the focus of the teaching. This perhaps conveys the sense of importance given to the topic during a training programme designed to work with people across the life span. This participant contrasts this against how often the menopause has presented in their current clinical role now that they are qualified, particularly in their specialised field in a physical health setting.

> *"...in terms of like actual kind of teaching or kind of knowledge, I would say its pretty light kind of through um the various kind of psychology courses that kind of went through, I don't remember a great amount of kind of teaching…. I think there was a few kind of odd nods to it kind of here or there, but um it wasn't something we had a significant amount of kind of teaching on, which I think it's kind of quite telling, considering all of the the vast array of impacts that it can have on um people when they're going through that, that kind of period in their life..." (Participant 14)*

#### 3.4.1.2 Subtheme: Pondering Pedagogy – When It's Good, It's Really Good

This subtheme highlights the experiences of those that did receive menopause specific training/education. Although this was a minority of the sample (three participants), it was felt it provided important insights into the experience of those who had received training. There was similarity between the participants as their training was delivered recently within the last year of the interview. One participant received this from the service they work in as internal training, one sought this themselves from within their NHS trust, and another received this during their Doctorate in Clinical Psychology training. These excerpts highlight the importance of the method and practice of teaching of this subject, how this shapes what is known and attitude to the topic.

Participants 8, 4 and 13 all work for different services in differing geographic regions. Participant 8 spoke of an internal CPD delivered in an NHS Talking Therapies (formerly known as IAPT) following serious case reviews, and the impact this had on their knowledge and practice thereafter. Notably, participant 8 has an interest in women's health and a compassionate stance towards the impact of on women directly. For them, the training led to 'generalised effects', such as exploring other women's health topics (e.g. menstruation).

> *"Yeah it was…with my workplace, um they were raising awareness of menopause related um issues off the back of some some serious case reviews um that happened recently in the local area...It was absolutely brilliant…. I've not heard about a great deal of uh that information before, so quite shocking really just how much was totally um new to me, you'd expect to learn that sort of stuff in school biology…it was really, really interesting, I think after after that training um it really encouraged me to ask a lot more, not just about menopause symptoms but about periods and um symptoms related to periods in general…" (Participant 8)*

Participant 4 spoke about the benefits of training provided, such as increased understanding and making links between menopause and a sense of identity and 'womanhood'. Participant 4 identified as male and had highlighted an interest in women's health following experiences of a female family member, and so had sought to attend the training when it had been offered.

> *"...I think what happened was that (NHS trust) were offering some training on it, um like menopause and mental health, and I saw it… I just think well yeah of course it would, why didn't you think about that before? Then realised oh, I should probably try like have a look at this uh just so I'm more knowledgeable about it ….another really important thing that came with the training was about those physical changes….. the whole loss of identity thing, this idea that because you're not menstruating any more it can feel like a loss of your womanhood…..this idea that you're….no longer a young woman or something else, um which is interesting because I was I always imagined that women saw their period as something that happens, it's a bit of a hindrance, but doesn't really tie into you're a womanhood…like I wouldn't tie my masculinity down to like my genitals….so I know*

> *that that link I never quite made until it was, like I found that really fascinating…." (Participant 4)*

Participants expressed some problems with the quality of the training, such as it being cut short, not fully covering the topic and concerns about the materials used. Participant 13 commented on the knowledge and reactions of others who attended the teaching and how this affected her sense of psychological safety in sharing her own lived experience. Participant 13 used her lived experience of the menopause to evaluate the quality of the training, and their excerpt highlights how teaching staff also used their own lived experience to educate. This perhaps highlights how the menopause can be a personally relevant and emotive topic, particularly given professionals either have or will experience it themselves, which needs to be approached sensitively. This also magnifies how the menopause can blur the personal-professional boundary and create a 'dual position'.

> *"…the lecturers spoke a little bit about their personal experience, um but I didn't really feel it covered any kind of depth or range of symptoms, it's still kind of, it's still kind of portrayed in this really narrow sense of when you get a bit older, you'll get a bit forgetful and you'll have hot flashes, and you might feel a bit moody sometimes, that was…all that was really conveyed, which for me it doesn't doesn't even begin to cover the spectrum of my own experience, never mind family members and people that I've worked with experiences." (Participant 13)*

> *"….just feeling a little bit out of place….it would be good to be collaborative and to share experiences, I wouldn't have felt safe to share my experiences…..because it felt like they [other students in trainee cohort] didn't have the knowledge that they needed to be able to make sense of that." (Participant 13)*

An analytic memo was made for theme one: *I was curious as to what the three male participants would say and noticed how surprised I was that they were keen to discuss the topic. One male participant (participant 2) felt the topic was very important but had no training or experience of a client openly discussing the menopause with them. I noticed how anxious he was at the start of the interview, and it made me consider the challenges particular practitioner groups may have in discussing this topic. In comparison, male participants who had more discussions, either in their personal or professional lives, appeared comparatively more confident talking about their level of awareness. What I was also struck by was that accounts were similar irrespective of whether participants were trainees or experienced professionals. Those participants with lived experience of menopause or had to access services for help with women's health, also spoke passionately about the topic.*

### 3.4.2 *Theme Two: The School of Life*

This theme reflects how participants had acquired their knowledge from sources outside of the formal academic or work contexts. This included from the media, lived experience of the menopause and/or personal experiences through people around them. These factors appeared to moderate their knowledge and linked with a sense of importance of the topic for them.

#### 3.4.2.1 Subtheme: The Media Moderator

This subtheme highlights the wider role of the media and the voices of celebrities in providing knowledge, pointing to it either keeping silence or bringing forward the menopause as a topic of discussion. Participants conveyed how recent media outputs about the menopause had brought it into their awareness, enabling more permission to discuss it and disabling silence. Implicit was a sense of the media being another 'entity', and points to other forces beyond academic and professional environments that hold power in promoting narratives.

> *"… recently I think more people are coming out about the menopause like um there's a few people, Davina McCall….it's all in the public uh Social Media, TV…..Lisa Snowdon…there's quite a few people that have been speaking about the menopause and to me, that's where I think I've gotten most of my my knowledge." (Participant 12)*

Participant 13 expressed concerns about the types of messages promoted and whether these are based on the full reality of the menopause experience, alluding to a sense of the media itself continuing to neglect and/or silence aspects of the experience, such as 'unacceptable' parts.

> *"….I have not read the Davina McCall's book or anything…..and lots of people will say they understand a lot more, you know thanks to Davina, but I still think….she only really presents… the more palatable aspects of it that are put out there and discussed and not the less palatable aspects., so not the the impact it can have on your sex drive, not the kind of physical changes and fluctuations that can occur in your body, and and none of that's really spoken about, we can talk about mood swings, we can talk about hot flushes, we can talk about tiredness." (Participant 13)*

Similarly, participant 12 highlights the media may position HRT as a magical 'cure' for women, when in reality it is not and also cannot be taken by all menopausal clients. Participant 12 briefly referenced a client who she knew could not use such medication. This suggests that the media positions menopause within a dominant medical system and contributes to biomedicalisation, framing it within dialogue as a 'medical condition' with 'treatment'. When compared to participant 13, both seem to point to the media seemingly 'hiding truths', and perhaps implicitly minimising the menopause and maintaining stigmatised narratives. Instead, the media portrays a limited view and promotes a 'cure', and a sense of the experience could be 'removed' or 'dealt with'.

> *"...I think this is displayed in the media as well…….'oh HRT will make all your problems go away', 'oh, yeah, you'll feel so great it just takes away all the symptoms and you'll have a life again', and it's almost like you never were going through the meno, and I know that that it's probably not what's supposed to be conveyed, but to me, it comes across as like HRT is a lifesaver, but what me and my client discussed is like, if you can't take HRT, what what then?" (Participant 12)*

#### 3.4.2.2 Subtheme: It Has Happened to Me and Those Around Me

This subtheme highlights how awareness and knowledge of the menopause also came from participants lived experiences and personal relationships. Participants spoke of these experiences being tangled with themes of silence, shame and embarrassment around the topic, but also provided them with insights into the challenges around bringing this up with others and need for discussion. This led to a deeper sense of a personal-professional dimension and how this nuances a topic for clinicians, perhaps adding to the importance of a subject for participants directly. While accounts differed in terms of whether it impacted them directly or someone around them, it provided participants with an insight into the physical and emotional experience of transition, and the cost of silence and self-silence.

> *"....my mum always talks about um having hot flushes and a bad memory and, but she almost says it in a way that is like, oh, you know, that she's ashamed of it, are embarrassed, and then it's sort of laughed off and it's never, it's never mentioned in a, you know, like constructive way or productive way unfortunately, um I don't know if*

> *that's why women mention it that they want to start a dialogue or they want help...” (Participant 11)*

> *“..I do know more than some people just because of my age and you know my my own peer group..”(Participant 3)*

Participant 6 is an experienced practitioner and spoke about their personal experience of the menopause, including how they applied psychological techniques to themselves to manage their symptoms. They were able to apply these techniques as an experienced clinician, but their lived experience made them curious as to why this information is not widely known, and underneath this, signalled the general lack of information provided to women.

> *“It was when the hot flashes were quite problematic, I read something on the internet about CBT for menopausal symptoms and I was thinking well how would that work, but it was very…simple just saying to yourself um 'this will pass' um 'in a few minutes it will be over' um and saying positive things to yourself while the hot flush was going on, that really helped so yeah, it's just it's a shame its… not more part of general knowledge.” (Participant 6)*

Participant 13 spoke about personal experience of close family member’s symptoms not being believed to be perimenopause, and wrongly being put on mental health medication rather than HRT, and the consequences of this. Like participant 6, both spoke with passion about the topic given their lived/personal experiences, and both expressed the sentiment about lack of information. This included to women directly, but also within systems of care.

> *“…she was peri menopausal very early in her mid 30s, she wasn't believed…. so that had been a good five years of experiencing those symptoms, and just yeah, being all*

> *over the place with her mood swings up, you know, her moods up and down, feeling really fatigued all the time…." (Participant 13)*

An analytic memo was kept for theme two: *I reflect on how women's health topics can be influenced by so many factors: personal experience, media, institutions and socio-cultural forces. I pondered why women's health was so 'controversial'. I generally pondered whether a sense of embarrassment and shame about the topic could become internalised on some level for people, either through the media and/or through witnessing those in their personal life talking about the menopause in such a way.*

### 3.4.3 *Theme Three: A Loud Silence in Services*

This main theme highlights participant's experiences, which encompassed an atmosphere of taboo and stigmatised narratives around menopause. This could influence them as clinicians, the client or both in their work. Some also commented on how these themes arose in interactions within other 'layers' of the wider system, and that underlying the 'fuel' for wider silence was taboo around the menopause. The 'fuel' included ageism, patriarchy and generational factors. It also underpinned, in some cases, a sense of shame and anxiety around the topic, indicating how oppressing forces have shaped schema's around the menopause and its discussion. This suggests that forces at play may not be singular but are multifarious.

> *"I don't think we talk enough about menopause in mental health…and in my experience, as a therapist, it's not something clients tend to talk about or bring up...it may be because of there could be shame associated with it…." (Participant 12)*

> *"…it's quite hard when you know that actually as a…woman who's training, I suppose, we don't just talk about the impact of this, and we might have a safe, we might be a safe thing to talk really openly with other female trainees, 'oh yeah I'm*

> *having a, you know, I'm having a bad, bad time and my cycle', the impact the pain etc, etc, so you can talk about it in a safe space informally, but when it comes to the formality of it I don't know if that shifts…" (Participant 7)*

Participant 4, a male, highlights hesitation around raising the menopause with clients due to a concern about how clients may feel, and also how service-wide menopause is not discussed. They compared this to their experience of discussing menstruation openly with peers in their personal life and brought to light possible generational factors which may be an additional factor. There was a sense of older generations struggling with discussion around women's health, in comparison to younger generations, and points to cultural factors that may affect specific groups directly.

> *"….I don't really prompt it as much um just because….I assume that people probably don't want to talk about it um and then one of the things I've learnt recently that some it's not also discussed among their own peers as well as much….I'm aware that couple of generations down again…they're all so very open about their periods…..it's very well documented and spoken about how it intersects with your mental health where the cost of menopause may be different…..I wouldn't say its something I've been supported supported with, like you know I've got clients in my and colleagues in my team who are older and not one of them have used the word menopause, but got a friend who comes over 'oh yeah I'm on my period', and like it's just not a thing, it's not a drama….what I mean it's such normal conversation…" (Participant 4)*

Participants 10 an 12 identified themes of gendered ageism and how this may perpetuate silence or difficulty around discussions on the menopause. More broadly, this points to an interaction between patriarchy and ageism.

> *"…I feel like probably a loss of youth becoming older, a stigma around what it means to be a woman….traditional narratives that can be quite sort of oppressing for women around sort of the purpose being to have babies..." (Participant 10)*

Participant 1 spoke of the wider system, with a sentiment around the role of patriarchy in determining how important women's health is within services, and how this links with the lack of discussion.

> *"I do notice that it kind of reflects the kind of maybe the wider healthcare system, which is that less funding goes to women's health services, therefore, there isn't much discussion around um I suppose women's um fertility lifecycle, and um when we come out of it and transition out of it…" (Participant 1)*

An analytic memo was made for theme three: *I found myself having a sense of heaviness with this theme. I sensed the layers of silence and considered the dynamics of what occurs within services. I found myself thinking about how a transition so natural can be so subversive to talk about. I pondered my participants, curious as to their participation within my research. I noted the demographics of participants and their experiences. I noted that female participants either would go through the transition one day or have done, and that male participants either had come across the topic of menopause in their work or in their personal circle. I wondered if participants found the act of discussing the menopause and the silence around it with me as some kind of act of 'shattering' silence, or perhaps even 'whistleblowing' of what is happening with services.*

### 3.4.4 *Theme Four: Navigating Uneven Terrains*

This theme covered various aspects of participant's experiences of working clinically with menopausal clients. This was a large theme, capturing various subthemes. Clinical work involves a number of activities and skills, and so this felt unsurprising. This includes forming a therapeutic alliance, formulation dilemmas, providing therapeutic interventions and inter-professional liaison. There was a sense of commonality of there being no guide, or no handbook, and a sense of journeying along a path which has not been walked on. This led to a sense of 'uneven terrain', of facing uncertainties (whether imagined or true) and navigating different clinical hurdles.

Of note, while some may have direct experiences of clients explicitly identifying as menopausal, other participants were aware they had likely had contact with this client group, but that clients may not have explicitly identified themselves as menopausal. This curiously pointed to 'known' and 'unknown' experiences within the sample, given all had exposure to this population within their roles.

#### 3.4.4.1 Subtheme: It's About You, Me and 'Us'

This subtheme identifies participant's views around the therapeutic alliance. Overall, this ranged from the need to consider the intersectional identity of the therapist and the client and how these may intersect, through to considering the features of the therapeutic rapport which may serve to strengthen it or may need to be problem solved. It led to a deeper sense of anxiety, such as 'what is the right fit for this client?' or 'how do we connect?', which may in part be a projection of participants own anxiety.

Participants 2 and 9, a male and female, both identified the gender of the therapist as a consideration. This varied from participants articulating their own assumptions about how engaged male therapists would be, to a male therapist themselves being curious about the impact of being male on clients directly.

> *"...women that might be going through that [menopause] might request to see a female practitioner, they might not want to see a male practitioner...women want to*

> *work with a female, they feel more comfortable talking about those things." (Participant 9)*

> *"…as a male practitioner…I'm not quite sure how to approach it sometimes in in sessions, I guess I worry that I might…negatively affect the the alliance….showing up, showing myself up how how little I know about it, so in addition to that….I worry that it would the perceived as a bit intrusive….I feel I don't pursue it actively very often in sessions, either…" (Participant 2)*

Participant 4 raised how both age and/or being pre-menopausal may be factors to consider in the alliance. Underlying this, there is a sentiment around the interaction of age and gender of the practitioner, which meant that female staff may be more scrutinised for not having the experience, whereas male clinicians are perhaps assumed to 'not know' irrespective of their age.

> *"….generally when people are older they've a complex about whether you can be their therapist or not, um its even worse if you're a young woman compared to a younger man…" (Participant 4)*

Participant 6 highlighted how similarity of menopausal status served as a normalising mechanism when working with a client with a learning disability and may have served to overcome other intersectional differences within this alliance. This perhaps highlights the power of lived experience within the relationship.

> *"I'm thinking of one woman in particular, she responded really positively because I think it was it was a way that she could connect with being like a normal woman…that kind of 'you and me' both know what it's like… because it minimised the differences between us, whereas obviously, so much of you know, the way I am and the way they are, there's big, big differences." (Participant 6)*

Participants expressed other challenges included dealing with their own processes when working with menopausal clients, which highlighted therapist anxiety about the menopause. This could also be conceptualised in a psychoanalytic sense as counter-transference. Such factors are important in understanding possible relational experiences with this population and what arises for clinicians in their work. This also points for the need for clinicians to reflect on their own responses when working with this population. Participant 12 discussed their anxiety, possibly alluding to a defence of denial, whereas participant 11 spoke of the experience of 'bearing witness' to the experience, but difficulties of this.

> *"…will I experience that one day?...and it's almost like…this can really affect people, and I don't think I really wanted to acknowledge that…" (Participant 12)*
>
> *"...I find it really difficult when they talk about feeling like they're going crazy, or that other people around...make that judgement, um it's it's not very nice to feel like that is it, like you feel like you're losing the plot that, you know, um what you thought was your way of life…we all have this, like assumptive world…..ripped from under them…" (Participant 11)*

### 3.4.4.2 Subtheme: Lead Star, Co-Star or Backstage

This subtheme reflects the challenges that can arise around psychological formulation. Participants had varied experiences as to whether menopause was considered within the assessment and formulation process. This included either it not being considered at all, overlaps between menopause and other mental health symptoms that are difficult to disentangle, menopause being the central issue to someone's difficulties, or unrelated.

Participants 9 and 13 expressed a lack of consideration of the menopause from the outset at the assessment stage in services, including in mental health and neuropsychological assessments, and how this may impact how difficulties are formulated. There appears to question whether menopause has a spotlight at all and is 'backstage' inappropriately.

> *"I think we work more with women than men…I think we're not picking up on it in our assessment phase, and therefore, I think that's how it can be missed..." (Participant 9)*

> *"….in neuropsychology…there wasn't any consideration around their age and the fact that their cognitive abilities might be impacted by what was going on hormonally...and that it might, you know, there might be depths, there might be peaks and troughs and their ability because of that, um but I don't think there was any recognition of that." (Participant 13)*

Participant 1 expressed that the effects of the menopause can be similar to other hormonal experiences, and how this can be difficult to disentangle when understanding experiences such as emotional dysregulation in clinical work. There was a sense of further discussion being needed given the overlaps.

> *"….I know that there's a very there's vast majority of different symptoms that come with menopause, but there's a lot that are similar to um really adverse reactions to hormones…having um real mood instability, feeling really low, like, you know, the side effects say depression, um like feelings of mood instability, sometimes suicidality, lack of sleep, lack of eating, you know, a lot of the the dysregulation can be can mimic that, too, so I don't know why we don't discuss a lot of this in general." (Participant 1)*

Participant 15 highlights that the menopause as a process of mental and physical change and how this can 'hook' on to other difficulties, and the need to be aware of this.

> *"…what is a symptom of actually the menopause, or what is really actually this is more about, you know, sort of secondary worry or… really just started to sort of formulate more clearly …" (Participant 15)*

Participant 4 also discussed experiences of formulation and disentangling menopausal symptoms from other symptoms. This excerpt highlights how this can be challenging and requires collaboration with clients, but how psychological difficulties are not always distinctly separate.

> *"…my supervisor said to get them to do like a ven diagram and think about what's what's menopause, what's your anxiety and try to figure out where to go from there, but the client was 'oh how am I supposed to know' like and and that kind of made me think well you can't compartmenalise it, you just kind of have to work with whats there like…" (Participant 4)*

Participant 12 also raises how formulation can be influenced by wider service structures and practices within NHS Talking Therapies (formerly IAPT). This points to the challenges faced by clinicians when conceptualising client difficulties, and the tension between the possible narrow use of psychiatric 'labels' versus holistic psychological formulation.

> *"…in IAPT, when you're working in it, it's very prescriptive….compartmentalise things like, 'okay, this diagnosis, this DSM 5' da da da da da, this protocol da da da da da, and it's all very prescriptive, it's not very integrative. It just feels like okay, you're focusing focus on this thing and do this thing well, work on this work on that, and I have found it challenging with other areas as well in IAPT where everything is so problem focused on a specific need, that if there are more than one problem, you kind of feel like you're compromising, but it's all part of the same thing…..I don't think*

> *it's just with the menopause….I think a good therapist would be able to be a bit integrative in all the sessions, no matter if you're in the IAPT service um working with CBT because a person is made of many parts, and a problem is made up of many parts, and there's contributing factors…." (Participant 12)*

#### 3.4.4.3 Subtheme: It's Not 'One Size Fits All'

This subtheme reflects participant's experiences of working clinically providing interventions. Participants spoke about what they have done in their work with clients, which can happen in various formats (e.g. one to one, in a group, online webinars, signposting to community/peer interventions). Whilst there was a lot of discussion of the use of CBT techniques, which may relate to most of the sample being CBT trained, there were also other psychological approaches presented. This indicates clients may not benefit from one type of therapy alone or one type of format. Participants conveyed a sense of initial uncertainty about the work, but they simultaneously were able to navigate through this, perhaps indicating unconscious competence and transferability of skills. Interventions appeared to focus on tailoring to needs, behavioural changes, cognitive restructuring, normalising symptoms, and creating a sense of acceptance and a more compassionate approach to their difficulties.

Participant 12 spoke about the importance of collaboration and Socratic dialogue when thinking of interventions, and this being integral in the CBT approach.

> *"…I just wondered with the client,…like um Socratic discussions about what she would find helpful and what she needed…" (Participant 12)*

Participant 5 spoke about a group which had included CBT interventions, such as psychoeducation, anxiety management strategies and behavioural activation. Participant 1 also spoke about CBT interventions discussed in an open webinar.

> *"I think for the group actually I do remember that it's for the shared experience and normalising and they were learning from each other….I don't remember clearly, between 10 and 12 [people], or something like that, and and I do remember that it was very engaging group, there was like a bit of journaling, I remember that they will share experiences about the weeks and how if symptoms were there how they impacted and I remember was really meaningful, um but also think like what I took away from it is like the techniques I was doing for like anxiety management…or like behavioural activation, they also find it really, really helpful..." (Participant 5)*

> *"…then we did a session around some CBT strategies about…your anxiety about your flushes can make it worse, and how you're thinking about it and your focus on it can can kind of maintain that vicious cycle…." (Participant 1)*

Participant 14 also spoke about other psychological approaches that can be useful to target client difficulties to address their sense of identity, suggesting flexibility in the approach used with the client group. This included incorporating interventions from Acceptance and Commitment Therapy (ACT) and Compassion Focussed Therapy (CFT). Of note, participant 14 worked in a physical health setting and worked with this population more frequently due to the nature of their comorbid health conditions.

> *"I would it say varies….depending on the client…the main the main kind of like therapeutic models are…Acceptance and Commitment Therapy and the compassion focused kind of therapy as well, um and I maybe use a kind of a mix of different techniques from from kind of each….sometimes compassion focussed therapies that can be quite helpful in terms of thinking about how…women might be approaching themselves…there's a lot of disconnect, self criticism focused around um seeing that kind of menopause as a sign of becoming an old lady or kind of becoming an old*

> *woman and being very critical of them ourselves for this, this kind of transition and critical of themselves, if not maybe being able to cope in that kind of same way, and critical about hot flashes and kind of sweating and um using a kind of compassion kind of approach was was helpful…" (Participant 14)*

Similarly, participant 12 spoke about the utility of behavioural experiments as part of CBT work on cognitive restructuring that focussing on normalising their experience. Both participants 12 and 14 focussed on the client developing a more compassionate approach to themselves, which appeared to serve to dismantle unhelpful narratives of their experience with perpetuated distress.

> *". ….and then being compassionate that came up um, being compassionate with self and recognising that this is a process…… the people who were talking to her and she gave some feedback to the people...and she came back the next day and the scores are gone right down her social anxiety score gone down right now, and so 'I'm being compassionate about it, I'm being compassionate', 'I'm not putting pressure on myself and I know that I'm not alone', and all it's just a simple experiment like that. "*
> *(Participant 12)*

Participant 1 highlighted feedback following a psychoeducational webinar intervention, highlighting the need for interventions to be tailored to the intersectional differences of clients to be more inclusive.

> *"…one of the sessions there was reference to…consultant was talking about libido and sexual desire, and she made reference to men and women rather than being inclusive, and somebody fed back that um you know it would be helpful to not use such traditional stereotypes um because this is this is relevant to, you know, not just*

> *to men and women.....that helped us to think more about the the broader, wider concept…"(Participant 1)*

Participants also spoke about the importance of signposting to additional information and support outside of the therapy space, and this forming part of their clinical work to ensure clients felt supported. This signalled that not all helps exists within 'traditional' therapy context or from the clinician. For participant 5, with a background in delivering psychoeducational interventions, this was about tailoring to the needs of the client so they increased their own knowledge, and attuning to their specific journey. In this sense, participant 5 did not approach the work with a sense of having to know everything, but with an awareness of what was available more broadly to support the client and themselves as a clinician.

> *"I suppose some of the work that I've done is about educating people, um signposting them to the right services, signposting them to our webinars. I suppose, just helping them to get more knowledge and be more informed, to be better informed... I think each person has their own journey, and it means something, you know, each individual's experience of what it means to them is unique.." (Participant 5)*

### 3.4.4.4 Subtheme: It's About Team Work

This subtheme reflects participant's views of inter-professional liaison on client cases. This could include their own supervisors, but also professionals external to the service, but who are part of the clients care in the wider system. Participants expressed mixed views, from expressing that menopause had not been mentioned, that it felt in some ways uncomfortable to raise, feeling liaison with others was helpful, concerns about the usefulness of supervision to discuss cases given the lack of training on the topic, to the role of aspects of supervisor-supervisee identities and the role this has in the discussions around menopause. This subtheme magnified the important needs of clinicians outside of the therapy room. Underlying this was the need for clinicians to feel supported when navigating clinical work, but also obtain a sense of feeling guided by a 'knower' and of being contained within the work they are doing with a client.

Some participants spoke about the importance of liaison and signposting to medical professionals to ensure client's needs are met. This speaks to understanding the holistic needs clients may present with, and a multidisciplinary approach. Participants signalled the importance of effective communication between different parts of the healthcare system. Examples included a pattern of less 'joined up' contact with the GP, and how this may impact upon how referrals are dealt with and how menopausal clients are identified. Participants also spoke about their role as clinicians in mediating the relationship between patient and other professionals.

> *"...I think what's happening now is we do get more self-referrals, I think GPs are telling people .... self refer via the app, the website, so then the person is just going to put down what they...see the problem as or or what they think they should be putting down....I haven't got the data, but I wonder if we get less GP referrals....in the old days, it was really great because we used to work in GP surgeries alongside GPs.... So we don't have that close working relationship with GPs that we used to have any more...." (Participant 9)*
>
> *"...finding GP's unsupportive... being dismissed, feeling that they making a fuss about nothing....lots of women in my experience lots of women find that the the GP's aren't particularly supportive and not particularly knowledgeable" (Participant 1)*

Participants had varied impressions of the clinical supervision space. This included the menopause not arising as a topic of discussion, the competing demands of supervision, to participants querying whether their supervisor would be able to advise on such clients.

> *"....that's not even come up…I've never thought menopause as a topic in the clinical supervision either um all these years" (Participant 2)*

> *"....it's [menopause] just not discussed, it's it's not really, you know, especially in the in the NHS and especially in an IAPT service there's so much to get through in supervision…it's not top of the list of of priorities, it's just, you know, it's it is a bit of that conveyor belt and you're just rushing though getting through what you have to.." (Participant 3)*

Participants also raised aspects of supervisor's identity and whether they had the experience or knowledge to provide support. This indicates there may be some pre-conceived ideas of what clinicians feel supervisors may know or be able to provide them in the space.

> *"...my supervisor herself is isn't going through menopause…" (Participant 4)*

> *"...if I had a male supervisor, it's weird...would I think that this therapist would know anything about it? Like, because it's such a female focussed problem, isn't it? And, again, I'm thinking my assumptions as well coming out, would a male therapist really get a sense of what the client is going through?.." (Participant 12)*

Participant 14 spoke about how it seemed that medical professionals had increased their knowledge, particularly given their role in a medical service context, which did enable more successful team discussion.

> *"...guess it means it's actually an open conversation that's going on with medics, it also kind of really helps in terms of people's kind of awareness….." (Participant 14)*

Participant 10 spoke about raising the menopause within multidisciplinary meetings for clients with learning disabilities, providing a voice for clients with additional needs to help personalise their care. This participant spoke of having to be proactive in bringing women's health into focus and how collateral information is needed to understand whether they are menopausal. This seemed to indicate the necessity of having a 'joined up' approach to support the needs of women, particularly those in vulnerable groups.

> *"…so particularly with women who have a learning disability and communication difficulties….there's been a few times in Learning Disability Services, where it's something that I would tend to raise now if if a woman's kind of from her mid 30s, that actually, like, let's ever think about, could there be something else going on here? You know, can we think about family members? Can we check with mum, you know, when she might have started to become peri menopausal and that might map on to some of the experiences this woman's having." (Participant 10)*

An analytic memo was made for theme four: *I was mindful that I had worked in a number of NHS settings during my career in mental health, am currently an NHS staff member and a racialised female. In some way, it felt that participants were able to 'open up' as they felt I knew about the health system and its strengths and challenges. This perhaps helped build rapport. I am also mindful that I needed to create a clear space to separate my own views of service provision from that of participants in order to reduce any bias. I felt stating in the Participant Information Sheet (Appendix B) that there were no 'right' or 'wrong' answers was really important here, and was about coming back again to the space I created for each person with a sense of curiosity and an inquisitive mind-set.*

*This theme was large, with four subthemes, but they all shared this sense of 'murkiness', or a sense of lack of clarify amongst participants when approaching differing aspects of clinical work. At some points I had considered calling the theme 'Murky Water',* *thinking of how it was hard to see ahead. However, this would not have been a true reflection for all participants, as they were able to use clinical skills to navigate their work when needed. Instead, 'Uneven Terrain' represented for me, perhaps from my times hiking, how some parts of a path can be smooth, and we feel confident proceeding. With other parts of the route, we may feel daunted, anxious and we must consider each step. Therefore, I felt this represented the sense I got from participants when discussing differing aspects of clinical work. I also noticed how participant 14 experienced the menopause as a topic that was discussed frequently, which was interesting as this was from their most recent work within a medical service. However, the remainder of the sample spoke about various aspects of having to navigate their work, and what was interesting is how this was a consistent across participants who work in differing services, professional backgrounds and locations.*

### 3.4.5 *Theme Five: We Need to Hold More Space for the Menopause*

This main theme reflects participant's experiences of wider structures around them, and the sense of change being needed to overcome the perceived status quo to support them in their clinical work and improve current care. This included what they felt was needed individually, from senior staff and on an organisational level. This theme presented differently to previous ones as it engendered a sense of wanting to change the tide and liberate the menopause from shackles, to practically problem solve what is required for change, and be able to speak up. Participants spoke about creating a space within services that holds space for the menopause across clinical spaces they work in, addressing the impact of stigma and taboo. This included some 'antidotes' to create change.

Some participants expressed the need to dismantle the internalised and external stigma to support clients in the therapy context. Clinicians receive training in building rapport, but it is important to understand how to tackle unique struggles that arise in a sensitive and helpful way. There seemed to be a sense of a need for a dual approach of it being raised in the therapy room and more widely within systems as part of a shared movement.

> *"..the only thing I can think of is me showing somehow that I'm open to those discussions… as a wider society starts talking about it more." (Participant 11)*

> *"…there's a challenge with the competing wider systems of how we actually hold space um for how that might actually be adding to um the difficulties that someone's experiencing….so that they don't feel like they need to minimise...." (Participant 7)*

Some participants commented on how it should not just be for those who have lived experience of the menopause transition to be mindful of this transition, and that it is about shared responsibility among professionals within a service. Training needs often are determined based on clients' presentations to services, but that the inverse may need to be done with menopausal clients who may not disclose or present for help in the same way. Participant 3 expressed that this perhaps points to the need for data collection, and that training that should be provided to those within the NHS, and clinicians in charitable and private sectors.

> *"….but I do also think there's this responsibility on where the service you happen to be working in, whether it's NHS or or or charity, or private, you know, to maybe have that training provided as well…for everybody…" (Participant 3)*

Participant 8 spoke about understanding the unique needs of professionals offering psychological interventions. This highlights the need to adapt menopause education/training and curriculums based on the professional group being taught.

> *"….think it'd be really useful to have some training not just on menopause but on…how it affects CBT and um how to do….effective treatment when people are*

> *experiencing the menopause, I don't really…know a great deal of uh research around that, but it'd be useful to to have a better understanding of whether whether there are adaptations to therapy that can be helpful…" (Participant 8)*

Some participants also identified other practical, more concrete, resources that participants felt they would need for their work with menopausal clients. This could include queries about the menopause as part of assessment questions, informational resources and more research about menopausal clients. This offered more practical ways to ensure it is 'unsilenced'.

> *"...you know, going back to that assessment, how that can be placed on the the triage form when assessing,…." (Participant 12)*

> *"Just having some materials as well, and some resources that we could share with clients….maybe some videos from YouTube or something like that, that people could like, you know, psycho educational materials…" (Participant 9)*

Participant 14 spoke about the utility of having a tamoxifen support group for menopausal clients open to oncology services and this being an unmet need for many women. This pointed to the need to tailor interventions and for the menopause experience to not be homogenised. It also highlighted the need for more peer interventions for specific women.

> *"...I would love there to be some tamoxifen support group, because it seems like it's coming up a lot, some sort of group for uh um kind… that would be amazing ...it might be a useful place for people to be able to connect and know they're not the only ones going through that…" (Participant 14)*

Participant 10 reflected on the need to understand the intersectional experience of the menopause and how this may impact clients. This points to the need for systems to understand the needs of all who use their services and how aspects of their identity may nuance their experience.

> *"….depending on the background that women identify from maybe any sort of cultural um things that they there own community might attach to meaning around menopause and bring that that might be quite an individual aspect to working people depending on their culture and their identity, and how they kind of how that might influence how they perceive and relate to menopause.." (Participant 10)*

An analytic memo was made for theme five: *This made me think about how when we hold space for something, we can build compassion and more personalised care. When I considered interview excerpts, I found myself getting images of the suffragettes, and I wondered if this was because it reminded me of a sense of energy, and of people coming together asking for change and equality. I considered how change does not just involve a change in narratives, but the provision of education and practical resources. What women encounter with the menopause are multifarious, and similarly, what is needed for care to improve does not involve one thing.*

### 3.5 Reflective Notes

The interviews left me with a range of feelings, which was important to reflect on during the process of conducting them and during the analyses. I noticed similarity in narratives across interviews irrespective of where a participant worked, which I found interesting. I experienced a sense of pride about doing the research when participants reflected on how this area required more attention, and also found myself feeling frustrated after interviews after hearing some narratives of services.

The most important thing for me during data collection was to create an environment where each participant felt they could be open, and that I 'cleared' myself of any of the emotions related to any previous interviews, ready to be present again with the next participant and what they brought. The use of an online video format for the interviews helped build rapport, and I was pleased that it also allowed me as a researcher to access people that did not live in the same city as me. It made me consider whether the same rapport could be achieved by conducting them on the phone, and my impressions are that phone alone would have been equally as useful in terms of increasing accessibility to participate in the study, but potentially less useful in terms of rapport building. In this sense, being able to see one another provides something unique to the interaction.

I was grateful that some participants felt able to 'open up' about their lived experiences or of experiences with those around them. It helped understand that this topic is not merely a professional interest, but very personal for many. I did also wonder at points if there were things participants struggled to talk about; were there things that could be hard to say? What if someone did feel the menopause was 'no big deal'? However, I felt that participants were able to be open, and that I prepared myself to embrace and understand all voices. I was also mindful that all participants had exposure to menopausal clients in their roles, but not all have had explicitly named this in their interactions with clients, whereas others had done. This meant that some participants had perhaps more depth of information to share in interviews than others. In this sense, there was 'explicit' and 'implicit' experience that professionals held.

I was pleasantly surprised when participants shared their positive experiences of participating in the research towards the end of the interview. It made me consider how discussing this topic can create a reflective space in itself. I felt that these comments, captured on the recording, could have been developed into a theme. However, this is not the intention of this study, but could be useful for future research to understand how professionals experience participating in such research.

Using an interpretivist epistemology helped me understand how participants knowledge and view of the world were based on their experiences and the meanings they ascribe them. For example, this was demonstrated in interview excerpts when participants spoke about personal experiences, either relating to themselves or others, and when they identified wider socio-cultural factors. I also noticed how some participants assertions of what needed to change also linked in with their values around equality, which they may hold personally and professionally. This helped gain deeper insights into the role of socio-cultural structures. Moreover, a CR ontology allowed me to consider how each participants experiences helped me understand a part of reality, but there may be a larger reality 'out there' that remains unexplored, like other undiscovered parts of a story. I felt this aligned with my own sense that there are many realities 'out there', and this approach for me was useful over a positivist approach that focuses solely on a directly observable reality that would negate the role of human experience and societal structures (Wells & Giacco 2024).

I also considered my role as an 'insider-researcher', as I am clinician also. I found myself considering how I could also have been a participant had this research been conducted by someone else. During this research, I remained aware of my dual-role and balanced this personal experience with the importance of keeping academic rigour and integrity. It was important to remain open to all perspectives as not all clinicians are homogenous in their views, and in this sense, knowing that I needed to be responsible when studying my target community. I found myself reflecting on my emotional responses and ensuring that there were no 'power dynamics' or judgements within the research, so that participants felt comfortable. I was mindful that I may have been services longer than some participants, and so it was important that they did not feel scrutinised. In this sense, although I am a clinician and knew the systems being discussed, I positioned myself and 'tilted the weighing scales' towards my researcher identity when interacting with participants– a person wanting to know their experiences and thoughts.

Reflecting on all of these intrapersonal processes was vital in order to manage bias and adhere to Tracey's (2010) '*Big Tent'* criteria for qualitative research, particularly the criteria of 'sincerity'. This involves self-reflexivity, authenticity and honesty, including about one's shortcomings. Additionally, in terms of the criteria of 'rich rigour', it is important for decisions about data and the analytic outputs to be transparent, including about the length of the interviews, notes taken, intrapersonal processes as a researcher, and decisions about the data. Crucially, in addition to making sure the study question and interview questions were not biased, meeting with my research supervisors meant that the process of analysis was reviewed for any potential bias. This was particularly important given I was a novice to conducting a larger scale research project. I was struck by the themes; through the analysis, the themes built upon each other like a stack, almost akin to the SEM (Bronfenbrenner, 1986) model. I started to see the influence of individual level processes, and the increasingly larger picture of services, media coverage and societal influencers.

During the write up, I chose to use participant's allocated numbers when discussing verbatim quotes. I had considered different ways of referring to each participant, such as a pseudonym or geographic locations (Lahman et al., 2015). I realised that I could have stipulated at the start of the research that each participant could decide how they are referred to, and I could have left a box for this purpose on the consent form for them to decide. By changing their number to something else during the write up, it felt like I would be making a change to their identity in some way; would they have liked the pseudonym I gave them? Or the geographic location I assigned them? I also understand that referring to participants by numbers may seem dehumanising. This was not the intention. The participants were aware from the Participant Information Sheet (Appendix B) that they would be referred to by number. It felt important to stay with what they had consented to at the start, as in this sense, they had already communicated to me in some way through their consent and participation that they were fine with this vicariously. Therefore, the use of numbers is not intended to dehumanise or create a mechanistic way of referring to participants, but part of a commitment to respecting them. In the next chapter, the findings will be interpreted further in the context of wider literature.

# Discussion

## 4.1 Chapter Overview

This chapter will discuss the findings in the context of wider literature. There will be discussion of the implications for practice and future research, and critical reflection on the research methodology. The chapter will finish with personal reflections on the research process and a concluding summary.

## 4.2 Revisiting the Study Objectives

It is important to consider now what story the findings tell in relation to the study's four identified objectives, which are summarised in Table 8 (p. 111) below.

**Table 8**

*Revisiting the Study Objectives*

| | Study Objectives |
|---|---|
| 1 | To understand the level of awareness of the menopause among staff who deliver psychological interventions - this includes awareness of what the menopause transition is, its stages and symptoms. |
| 2 | To understand where this knowledge was acquired (e.g. professional training, service training, media, personal experience). |
| 3 | To understand to what extent the menopause transition is discussed within work related training and/or supervision. |
| 4 | To gain an understanding of participants' experiences of providing psychological interventions to clients in menopause transition (e.g. making adjustments to formulations, or to psychological interventions). Interventions could include direct work (e.g. assessment, psychological therapy, etc) and/or indirect work (e.g. advisory roles within teams, providing supervision). |

Fifteen participants took part in the study. All participants had experience of working in statutory settings in England delivering psychological interventions, either currently or within the last year. Two participants had left the NHS within the last year and were working in private practice in the same role.

In relation to the first objective, the study found that professionals were aware of the menopause. However, in terms of knowledge about it, this varied, with most of the sample reporting gaps in their knowledge of physical and/or mental health aspects of the experience.

In terms of the second objective, only a small proportion of the sample had attended formal education/training on the menopause, and knowledge was also obtained from the media, lived experience and personal experiences with others. For the third objective, a large proportion of the sample found that menopause was rarely discussed in training they did receive, in supervision or other inter-professional liaison. This also related to some participants own concerns about raising the menopause with other professionals or in multidisciplinary environments during case consultations. For the final objective, participants discussed a range of challenges associated with working with this population due to the lack of discussion of this topic and training. Importantly, the therapeutic relationship required consideration, as did formulation, but participants who had conducted interventions with women were able to recount experiences of applying a multitude of interventions with this group from their pre-existing skillset despite gaps in knowledge and formal guidance. What participants related to, which also applies to all the objectives, was the need to address wider sociocultural and structural influences.

## 4.3 Summary of the Findings

To the author's best knowledge, there is not a comparable study amongst professionals delivering psychological interventions, and so this research offers novel contributions to the field. Through RTA, five main themes and eight subthemes were identified. The themes will now be discussed, and although this is a growing area of research, the findings will be interpreted in the context of available research.

### 4.3.1 *Theme One: It's a Yes, No and Maybe*

This theme illustrates participant's insights into their awareness and knowledge of the menopause. All participants had an awareness of what the menopause was. However, participants' level of knowledge varied in the categories of physical and psychological domains of the menopause, indicating that one may have knowledge of one symptom domain, both, or gaps in both. Participants also expressed how their lack of understanding may be related to a general lack of discussion of the menopause more widely within services, and more broadly in society. A small proportion of the sample had received formal training/education (3 participants). This led to corresponding subthemes *'A Forgotten Age Group?'* and '*Pondering Pedagogy – When It's Good, It's Really Good'*.

This finding offers novel insights into the current state of menopause awareness and knowledge among professionals delivering psychological care. This sits within the UK socio-political landscape, with the Women's Health Strategy (Department for Health and Social Care, 2022) and 'No Time to Step Back' policy (Department for Work and Pensions, 2024) which highlights the need to prioritise menopause care and improve knowledge within healthcare and workplaces.

Whilst there has not been a similar study on psychological practitioners to directly compare the results, the finding that participants felt they had gaps in their knowledge is echoed by other qualitative research that focussed on female counsellors personal experiences, which subsequently recommended the need for those working within the counselling profession to be educated further (e.g. Bodza et al., 2019; Glyde, 2023). It also aligns with research by Dintakurti et al. (2022) who found that 77.5% of GP's expressed the need for training to improve on menopause in both medical and GP training due to a lack of knowledge. Moreover, although the present study's findings differed to research by Davis et al. (2021) who found that GPs, gynaecologists and pharmacists had good knowledge of the menopause, they were similar in the sense that Davis et al. (2021) also found that there was less knowledge of actual medical management of this transition. This resonated within the current study as it was expressed that more information about HRT is needed. This perhaps indicates that 'level of knowledge' and 'ability to work clinically' could be on rated on separate continuums for each individual professional. The findings also align with cross cultural research demonstrating menopause knowledge gaps amongst healthcare workers in China (Lin et al., 2020) and India (Lathia et al., 2022). There is indirect support for the findings from qualitative research from the UK on service users experiences, which found that women felt that healthcare professionals lacked knowledge of the menopause (Martin-Key et al, 2023), and Cooper (2018) who found that menopausal women experienced challenges with obtaining information from professionals within the other layers of the Socio-Ecological Model (SEM).

The subtheme *'A Forgotten Age Group?'* explored further the lack of training participants received on the menopause and how this created a gap in knowledge. A majority of participants had not received training on the menopause, such as in prior education, current workplace or both. Research has reflected on a similar educational divide and consequent '*menopause management vacuum'* within the medical workforce (Faubion & Shufelt, 2022). This finding in the study points to a possible aetiology for the lack of training participants received, and to the role of culture within wider systems that shapes the knowledge held by those that work within it. This reinforces policy recommendations and literature emphasising the need for more awareness of the menopause (Aninye et al., 2021; Currie, 2019). For instance, in a UK based study, Calow et al. (2023) highlighted limited research exploring the extent of menopause education on health care curricula. A literature review was conducted to understand how menopause education was delivered to healthcare students on medical, pharmacy, paramedic and nursing programmes at Liverpool John Moores University. It was found that little attention was paid to the menopause and that improved education was needed to help students support patients, but also their future colleagues who may also require support at some stage. The study advised that menopause education should combine both theoretical knowledge and clinical experience. Arguably, this should be the case for the psychology and mental health professions also.

Some participants noted that the menopause was not included in the training for working with people with long-term physical health conditions in NHS Talking Therapies (formerly IAPT) services, which focusses on psychologically managing the impact of living with medical conditions (National Collaborating Centre for Mental Health, 2018). Whilst this was not explicitly articulated, it brings to light the question of how the menopause is positioned to professionals. Some researchers oppose the 'biomedicalisation' of the menopause, as identifying the menopause in medicalised terms signifies it as a problem that requires management by an individualised and dominant medical system, and instead it can also be socially shaped (Felice et al., 2021). Therefore, particularly in the context of a primary care mental health service like NHS Talking Therapies (formerly IAPT) which would see a large number of women of menopausal age, one must consider in what context the menopause is presented and discussed.

The second subtheme '*Pondering Pedagogy – When It's Good, It's Really Good'* reflected on the training received by a minority of the participants and the quality of this. Three out of the fifteen participants had received formal training/education on the menopause: two through CPD at work and one via the Doctorate in Clinical Psychology. One participant expressed the training had been useful, and another found it useful but said it had been constricted due to delays. The last expressed that they did not feel the topic was adequately covered, and expressed concerns about talking openly about their lived experience around peers that did not have knowledge and were of a different age. What was interesting is that all had attended training within the last year but had been in the field longer than this. It may align with some literature suggesting increased visibility of the topic due to policy change and changed narratives since 2021 due to the *'Davina effect'* (Orgad & Rottenberg, 2023).

MacPherson & Quinton (2022) advocated for the pedagogy of menopause education, stating that it should acknowledge the complexity of the experience, and that training should include changing language, active interaction with peers and experts and patient stories. This arguably should include taking into consideration the training environment to ensure it is a psychologically safe space, especially as some research suggests that women in their 20’s may be more passive about the menopause, compared to those in their 30’s (Munn et al, 2022). In addition, various approaches should be used to promote knowledge in the long-term as a public health approach, including education at school, on social media, workplaces and public health campaigns (Munn et al., 2022).

Guidance on what constitutes ‘good quality’ education and training could be sought from Calow et al. (2023) who recommended that education include discussion of the physiological aspects of the menopause and its impact, strategies to dismantle shame and taboo, and practical support for healthcare staff. This supports the views of the present study’s participants of the role of wider systems in promoting training, which can link with one’s knowledge, and therefore, moves away from entire individual level blame or accountability.

Higher academic institutions involved in professional training for those who deliver psychological care should also generally promote education on women’s health topics, which impacts wellbeing across the life span. There is also a role for accrediting bodies in creating change in culture. In the current study, there were a larger number of CBT therapists, participants either training or trained as Clinical Psychologists, a Psychotherapist and a Counsellor. For staff trained in CBT, knowledge of the menopause could be integrated into teaching and into Roth & Pilling’s (2007) competency framework for delivering CBT for depression and anxiety. This could also be the case for the British Psychological Society, by ensuring core competencies are met in doctoral training. There are numerous other accrediting organisations who should consider the menopause as part of curricula and competency frameworks.

### 4.3.2 *Theme Two: The School of Life*

This theme identified how participants obtained knowledge from outside formal contexts of education or work, such as from lived experience, personal experiences with friends or family, and personal exposure to narratives in the media. This led to corresponding subthemes *'The Media Moderator'* and *'It Has Happened to Me and Those Around Me'.*

The subtheme *'The Media Moderator'* refers to the media's role in participants being more aware of the menopause, such as through celebrity culture and the *'Davina effect'*, which aligns with research highlighting increased receptiveness to the topic (Jermyn, 2023; Orgad & Rottenberg, 2023). Participants also highlighted that the media may position the menopause in a more 'palatable' way and moderate the level of silence on the topic, such as on the 'unpalatable' aspects. Given the influence of the media, it suggests that one needs to re-examine how *"the face of the menopause"* is shaped through the prism of celebrity and media in the *"menopause turn".* This includes questioning *"real world examples"* and narratives of it being about living ones *"best life"* (Jermyn, 2023). Therefore, for cultural change and to be inclusive, the menopause requires reimagining to understand everyone who comprises 'real world experiences', and to also understand the needs of all women. This also echoes the need for interdisciplinary involvement to understand all the facets involved in the experience (Jermyn, 2023).

The second subtheme *'It Has Happened to Me and Those Around Me'* highlights how the menopause is not an experience that staff will only experience in the therapy room, but indeed will encounter in their own lives. This demonstrates how menopause crosses the professional and personal boundary, and personal experience may be a catalyst for participants wanting to dismantle the silence around the menopause. Personal experiences seemed to create an importance to the topic itself for participants. Some research suggests that there is therapeutic utility to lived experience, with the potential for female counsellors to use personal experience of the menopause to support clients (Bodza et al., 2019). A survey by Munn et al. (2022) also found women would seek information from people around them during menopause, including friends. This reflects again the importance of education for everyone, but also that there is utility in peer support interventions for clients and professionals alike (e.g. UCL, 2024). Conversely, qualitative research by Cronin et al. (2023) noted that women could feel silenced by some family members, particularly older generations of women. This indicates that there is much more complexity to personal/lived experiences. It is possible that the sample in the present study had a more empathic approach to the menopause due to their own experiences, but there may be nuances in the impact personal/lived experience may have on clinicians.

#### 4.3.3 *Theme Three: A Loud Silence in Services*

This main theme illustrated participant's experiences during clinical work, and encompassed themes of taboo and stigmatised narratives around menopause. Participants conveyed how the 'fuel' for silence and taboo included ageism, patriarchy and generational factors. This theme is supported by other literature highlighting experiences of limited discussion of the menopause due to fears around negative external evaluation and the topic itself being 'taboo' within the counselling profession (Bodza et al., 2019) and highlights the need for the profession to tackle the shame around it. Other literature also highlights concerns around ageism and patriarchal ideologies in UK healthcare services, such a UK report of 2,000 working doctors that found there was reluctance to discuss menopause at work due to fears around ageism within a male dominated profession (British Medical Association, 2020). The sense of silence was also mirrored in a study by Cronin et al. (2023), and although this study was on nurses and their experience of the menopause within the workplace, their subtheme of “invisibility as a woman” was associated with a sense of diminished womanhood, grief and loss, and a sentiment of lack of empathy and recognition from workplaces. This aligns with the present study where ideas of systemic silence and lack of recognition of the menopause were identified in a similar manner.

Idea’s around the role of patriarchy and lack of prioritisation of women’s health within the findings suggests that the menopause may be actively suppressed within a patriarchal system of society, and by virtue, academic institutions and healthcare, which has been highlighted in literature (Felice et al., 2021; Orgad & Rottenberg, 2023). This emphasises the importance of understanding the potential forces which underlie the current discourse around menopause within systems of care. It also suggests that there may be a general need to pivot the lens to masculinity and consider how men are socialised, and how patriarchy affects the unconscious at a young age (Phillips, 2006). An important caveat is that feminism can differ globally, and it is important to be mindful of western hegemonic models that advocate for women across the world (Abu-Lughod, 2016).

It is also important to consider what factors may underlie the need to ‘speak up’ more on the menopause. The Women’s Health Strategy (2022) highlights the link between menopause, healthcare and the working lives of women across their lifespan; this demonstrates links between gender politics and the political economy. This also possibly suggests that clinical spaces in services offering psychological care are not entirely apolitical. As an example, the formation of IAPT was based on an economic argument and cost-benefit analyses of psychological therapy (Layard et al., 2007). Some research has highlighted a cost to the economy of the menopause and may be contributory to current discourse and ‘taboo shattering’ (Orgad & Rottenberg, 2023). This is important to consider in understanding the drivers behind shattering taboos, although the author acknowledges that the reasons can also vary between professionals, services and cultures. Nonetheless, current strides and policy changes could help to dismantle such structural factors. In terms of therapy itself, there is also importance in incorporating strategies to tackle shame within therapy to help tackle internalised narratives which keep silence; such strategies for shame-based difficulties are implemented in evidence-based therapies, with a recent systematic review indicating evidence for CBT and mindfulness interventions (Goffnett et al., 2020).

### 4.3.4 *Theme Four: Navigating Uneven Terrains*

This theme covered various aspects of participant's experiences of working clinically with menopausal clients, which in practice are separate but interlinked activities within care. This theme included four subthemes: *'It's About You, Me and 'Us'', 'Lead Star, Co-Star or Backstage', 'It's Not 'One Size Fits All''*, and *'It's About Team Work'.*

The subtheme *'It's About You, Me, and 'Us''* reflected on the therapeutic relationship, such as quality of rapport and the intersectional identities of the client and therapist. Further research is required on this topic in relation to the menopause specifically, but some research has considered the role of intersectional differences between client and therapist. An aforementioned study by Glyde (2023) found that participants felt that therapists needed to acknowledge their queer experiences rather than make assumptions, and that therapists required further training in gender, relationship diverse identities, menopause and hormones. Importantly, this subtheme also aligned with literature suggesting that whatever therapy modality, the most important aspect in psychological therapy is the quality of the relationship itself as the 'core curative element' and tailoring it to the client's needs (Lambert & Barley, 2001). Further research could explore whether this overrides intersectional differences in the therapy room when working with menopausal clients.

The subtheme *'Lead Star, Co-Star or Backstage'* reflected on experiences of the menopause either not being considered or asked about, overlaps between menopause and other mental health symptoms that can be difficult to disentangle, menopause being the central issue or in the ‘background’. Psychological formulation is an integral part of delivering psychological interventions and involves developing an understanding or ‘hypothesis’ of a client’s difficulties to determine what meaningful therapeutic input is needed. Formulation is a key competency for many mental health and psychology professionals and involves a collaborative process, which can have a therapeutic benefit in itself, such as to foster hope (Thrower et al., 2024). There is some contention around the categorical nature of psychiatric diagnoses, which could serve to stigmatise and locate a problem within someone, and so psychological formulation can help understand a client’s narrative on the origins and nature of their difficulties with a more compassionate meta-message (Johnstone, 2018). This finding suggests that this could be a challenge and create dilemma’s for clinicians. This aligns with Maki et al. (2018) who argues that menopause symptoms can complicate, co-occur and overlap with presentations of depression. Assessment tools within services are often used to understand the extent of symptoms experienced by people, and aids formulation development. Although there is no validated menopause specific mood disorder scale to assist clinicians, there are other measures for mood which may assist clinicians (Maki et al, 2018).

Importantly, there are psychological approaches which formulate differently to approaches like CBT. For example, psychodynamic theories focus less on specific symptoms, and more on developmental experiences, trauma and the quality of one’s relationships, and could have utility during the menopause transition (Katz-Bearnot, 2010). Therefore, the extent of the challenge when formulating may also then depend on the model of therapy one is implementing. NHS Talking Therapies increasingly offers a diverse range of NICE recommended therapies, such as IPT and Couples Therapy (Clark, 2018; NHS Talking Therapies, 2024) and it would be of interest to understand the commonalities and differences of experiences when formulating, compared to using a CBT model.

Furthermore, the subtheme *'It's Not 'One Size Fits All''* highlights that even if participants did not receive specific training on the menopause, they were able to apply interventions in a variety of formats. Participants discussed the utility of using Socratic dialogue to engage clients in a collaborative approach in therapy, which is key within CBT (Clark & Egan, 2015). Interventions comprised of psychoeducation, CBT interventions for anxiety and depression, counselling, ACT and CFT approaches, and the sample spoke of positive outcomes in their work. Interestingly, although some participants discussed restructuring cognitive appraisals of menopause symptoms, specific CBT biopsychosocial models for menopausal symptoms were not mentioned (e.g. Hunter & Mann, 2010).

One participant spoke of feedback from a client about a clinicians reference to language focussed on heteronormative relationships. This emphasised the importance of service user feedback (Bombard et al., 2018), and of avoiding exchanges within therapeutic environments where clients may experience sexual orientation micro-aggressions, which could impact engagement and the alliance (Shelton & Delgado-Romero, 2011).

The sample predominantly spoke of the effectiveness of using CBT, which may have been related to a larger proportion of the sample being trained in this modality, but does align with literature on the efficacy of CBT for anxiety and depression in UK services more generally (Clark, 2018). Therefore, although most participants reported some gaps in their knowledge and a lack of training, they were able to make use of transferable skills and interventions in practice. This finding is supported by Dintakurti et al. (2022) who found that even though GPs felt they were not offered enough education on the menopause, they felt they had the tools to work with menopausal symptoms in terms of considering HRT, and had self-directed their own learning through books, online resources and guidelines.

Although NICE (2015) advocates for the use of CBT for low mood and anxiety symptoms, there is evidence accumulating for other approaches. Research demonstrates the potential of other therapeutic models, such as ACT, CFT, and Mindfulness based approaches, although further research is required (Agili et al., 2023; Green et al., 2015; Monfaredi et al., 2022; Spector et al., 2024; Taher-Karami et al., 2018). However, there is a need for more research on approaches other than individualised therapies, which some argue may promote neoliberal ideas of women having to 'fix themselves' (Orgad & Rottenberg, 2023), and to offer choice.

The findings did indicate a need to understand more about intersectional aspects of the menopause experience, although this was discussed at length and was only raised by a minority of participants. This would help understand how therapy should be adapted for under researched groups (e.g. Alam et al., 2024; BMS, 2023; Faheem, 2023; Glyde, 2023) and is important given people from across the intersection are present within statutory services.

Participants also spoke of signposting to community groups and apps for information. This is reflected in research endorsing digital psychosocial and health interventions to support women experiencing anxiety and depression during the menopause (e.g. Cronin et al, 2021). Of note, some researchers also argue that such innovations are part of the commodification of the menopause in a 'burgeoning market' of products (Orgad & Rottenberg, 2023). However, research from other parts of the mental health realm has suggested that smart phone applications are an innovative psychosocial intervention for many areas of mental health, such as for people with severe mental illness. For example, in a feasibility study, a befriending intervention for people with psychosis in the community was delivered over a smart phone with positive results (Pinto Da Costa et al, 2024), although some ongoing work is required to address challenges, such as privacy concerns (Torous et al, 2018). Similarly, UCL's innovative new menopause programme offers an intervention providing education and peer support groups offering the opportunity for menopausal people to feel empowered to manage their health and wellbeing (UCL, 2024).

The next subtheme *'It's About Team Work',* focussed on the role of inter-professional liaison. Supervision can contribute to a sense of self-efficacy in professionals, and adherence to evidence-based interventions (Giannopoulos et al, 2021). Bradley & Becker (2021) describe how the functions of supervision for the provider are to provide formative outcomes (e.g. corrective feedback, role-play, discussing interventions), and restorative outcomes (e.g. around wellbeing). Participants identified concerns about the knowledge held by supervisors, and some assumptions of supervisor's knowledge were based on gender and age. Further research is needed to understand more about supervisee assumptions, the knowledge held by supervisors and the experiences of discussing the menopause in supervision. There would be utility in exploring whether lack of initial education during professional training leads lack of discussion within individual supervision and team discussions, thereby potentially perpetuating the cycle of insufficient knowledge within services. Nonetheless, the findings highlight the importance of this space.

Supporting clients involves partnership working practices with other professionals/agencies, and is important in a multidisciplinary approach (Jermyn, 2023). One participant spoke about the field of learning disabilities and a concern about raising the menopause in multidisciplinary discussions. Research suggests that women with Downs Syndrome reach menopause five years earlier (Seltzer et al, 2001) and there can be difficulty disentangling behaviours due to the menopause from other causes. Psychological practitioners within teams can work to formulate and consider ways to support women and educate staff (Willis et al, 2011). Research is required to understand how to support professionals to raise this topic within teams, and also on specific populations of women.

### 4.3.5 *Theme Five: We Need to Hold Space for the Menopause*

This theme reflects participant's experiences of the wider structures around them as clinicians, and the sense of change being needed to overcome the perceived 'status quo'. This theme presented with a sense of wanting the tide to change, to practically problem solve, to speak up, address the impact of stigma and taboo in clinical work, and providing more resources to practitioners for their clinical work going forward.

Participants spoke about creating a space within mental health services that holds space for the menopause, such as giving menopause a platform by encouraging tailored training for teams, having signposting support, more resources and access to research. This would require addressing different layers within a system. It is important to note that there are pressures in the UK health system, such as funding challenges, low morale, staff retention issues and increasing workloads (Anderson et al., 2021) and would require consideration when instigating change.

Improvements in care should not only be driven by economic arguments about the cost of the menopause to the economy, but also part of a movement to support the mental health of those impacted by the menopause. This is important given the number of women in the workforce, and as part of wider movements addressing staff wellbeing, such as in the NHS and social care sectors (Anderson et al., 2021). Addressing the menopause would arguably help statutory services themselves to retain staff who themselves may be faced with menopause symptoms. It would also ensure that the specific needs of populations are met, such as those on tamoxifen, particularly as one participant stated that they felt there are no support groups for such women who cannot take HRT and experience menopause symptoms.

The other question is - how do we tailor training? Macpherson & Quinton's (2022) recommendations included a more general prioritisation of women's health in education. Furthermore, practice-based evidence would provide additional local information, such as from patient outcome measures, to improve outcomes that providers achieve (Debois, 2020).

This type of evidence should be more sought after given that the menopause is under researched and long timescales for research to be produced. This would allow professionals to share information based on current experience, which could be used to improve client care and tailor training. This further demonstrates the importance for menopause to ‘hold space’ in systems in the absence of necessary research.

Participants spoke about the need to address stigmatised narratives and touched upon the need to understand intersectional experiences. In a systematic review and meta-analysis of quantitative data on self-reported racism and health care utilisation, Ben et al. (2017) reported that race was linked with delayed healthcare, unmet needs and adherence to treatment. However, methodological issues were identified with this review and further research is needed around institutional bias and improving cultural competency. In a scoping review of UK evidence, McDermott et al. (2021) found there was limited research conducted on LGBT+ health inequality, including in mental health, and that research tended to essentialise or ‘homogenise’ groups in to ‘LGBT’ rather than distinguish individual groups, and intersects of oppression and power.

These challenges tie in with other evidence indicating barriers affecting people from racialised backgrounds accessing mental health support. This includes stigma, lack of understanding of how mental health and coping are constructed within populations, lack of competence in teams, how services are viewed, and requires practitioners to be aware of their own gaps and biases (Alam et al., 2024). This is supported by research highlighting clinicians receiving a lack of culturally competent training within NHS Talking Therapies (IAPT), which is typically the first point of contact for people experiencing depression and anxiety (Faheem, 2023). As the menopause is an intersectional experience (Riach & Jack, 2021), it is important that research also addresses the experiences of diverse groups and any disparities in healthcare. In addition, inter-generational and culturally unique considerations have been advocated for within government policy (Department for Work and Pensions, 2024). Research from across the globe would also promote understanding of how the menopause is experienced to avoid western dominance in this field.

Leadership is of vital importance in creating change. There are various models of leadership which promote organisational change. Compassionate leadership approaches in healthcare entail creating a culture in an organisation where both patients and staff feel listened to and cared for (De Zulueta, 2016). Of note, some research has highlighted that an innovative online menopause education intervention delivered to managers was feasible and effective to improve awareness, knowledge and confidence in speaking to women about the menopause (Hardy et al., 2019), and points to links between education, CPD and organisational culture. Evaluation of patient's experiences within services would additionally help inform and improve care, and contribute to service policy (Bombard et al., 2018). Further research would be useful to understand what creates change in the culture around the menopause within organisations and its staff, and patient's experiences of participating in evaluations of psychological support during the menopause.

### 4.4 Implications of the Study

Given the findings of the present study, considerably more research is needed to understand the current level of awareness and knowledge of the menopause amongst staff delivering psychological interventions, and to understand their experiences when working clinically. The findings indicate that more education and training is required, as well as more profession-based tailored support and guidance when navigating clinical work with this population. Participants also identified cultural and structural factors that would also need to be addressed to create change.

NICE guidelines (2015) focusses on CBT as an intervention for psychological symptoms, which many participants implemented in varying formats of delivery. This aligns with research that advocates for interventions to be both digital and non-digital (e.g. Cronin et al., 2023). When reflecting on psychological theory which underlies CBT, the use of CBT techniques by practitioners in the present study has offered some indirect evidence for the effectiveness of CBT for menopausal symptoms, aligning with current literature which has advocated for its efficacy for menopausal symptoms. CBT represents an amalgamation of two distinct psychological theories: cognitive theory and behavioural theory. Participants appeared to utilise cognitive strategies within therapy that focussed on clients approaching their menopause experience from a different perspective, such as through normalising their difficulties, developing more acceptance and self-compassion. It also included challenging the meanings associated with the menopause that impacted self-esteem and sense of identity. This lends support to cognitive theories that focus on restructuring cognitions and approaching triggers/situations with a different mindset in order to create affective change. Furthermore, the use behavioural interventions (e.g. behavioural activation) provided support for interventions advocated by behavioural theories that a change in ones behaviour can lead to changes in environmental contingencies and to improved mood. The combination of both theories within CBT practice appeared to offer therapists some flexibility in the approach they took with clients, offering flexibility and a sense of being able to tailor interventions based on psychological theory and formulation.

One participant mentioned the use of third wave therapies (e.g. ACT) and it is possible that ACT approaches align with cognitive theory through the conceptualisation of working on the meta-cognitive level, or alternatively, as ACT does not restructure the content of cognitions, this simultaneously could also offer evidence for behavioural theory (Early & Grady, 2017). More research is needed to understand what aspects of CBT and/or third wave therapies are most useful when working with this population. This is particularly the case with CBT where there is an amalgamation of two theories into a practice model, as this would help understand what exactly works within therapy, or whether it is a case of shaping interventions according to the client in a personalised approach.

As this study also highlighted that practitioners may integrate principles from other approaches, and so further research is required into the efficacy of CBT, different formats of delivery and other therapy modalities. This includes their effectiveness for clients from across the intersection, particularly as intersectional aspects of identity were not discussed at length within the findings. It would be useful to explore the outcomes of such interventions through measures that assess the effectiveness of treatment, and qualitative measures to understand user experiences. Furthermore, there may be utility in other psychological approaches which have not been raised by participants in this study. For instance, Interpersonal Psychotherapy (IPT) is used for symptoms of depression and focuses on processing emotions around transitions. IPT has been found to be effective for depression and is utilised in UK NHS Talking Therapies services (Clark, 2018), and some research in rural menopausal workers in Nigeria has found efficacy in applying this approach (Tokede, 2022).

Moreover, research on cultural adaptations are needed given the diversity present within the UK population. Culturally adapted psychological therapies have been explored in research for depression following other reproductive events that impact women, such as for maternal depression in British mothers of African and Caribbean origin, with positive results (Jidong et al., 2023; Jidong et al., 2024). There are also approaches that may be less present within statutory services and research, such as non-western approaches, alternative therapies and embodied approaches, which could provide patient choice and require exploration.

It would be useful for future research to focus on professionals from different sociodemographic backgrounds and a variety of clinical settings to get more of a sense of the current state of knowledge and their experiences with clients. This includes professionals who work with populations that are under presented in menopause research trials, such as people with severe mental illness and learning disabilities. Neurodiverse populations also remain under-represented in menopause research (Moseley et al., 2020). Research would be useful on understanding experiences of inter-professional liaison within mental health and psychological professions around the menopause (e.g. supervision, liaison with external agencies), and the facilitators and challenges around this.

It may be useful to consider the implications of the findings through a Socio-Ecological Model (SEM; Bronfenbrenner, 1986), which argues that health is impacted by six interacting levels. In a study investigating socio-ecological factors which impact information seeking on the perimenopause, Cooper (2018) found that women found those around them (microsystem) to be the most helpful, but experienced challenges with obtaining information that they needed from healthcare professionals within the other 'layers'. Cooper (2018) argued there is a need for adult education and health promotion to connect at all levels, with education starting as early as school. This aligns with the present research findings with professionals where further education was needed, and highlights the need for all levels of SEM to be addressed in order for effective care to be delivered to address both physical and mental aspects of the menopause experience. This would leverage arguments that individualised, neo-liberal solutions are being offered to menopausal populations, when there are a number of converging sociocultural factors at play (Orgad & Rottenberg, 2023). Indeed, through the analysis, the themes appeared to build upon each other like a stack, almost akin to the SEM model itself, starting with the individual (practitioner) level's awareness and knowledge based on their experiences, into a building picture of layers of structural influences.

In a study exploring ways to improve the health of military women, Trego & Wilson (2021) found that the SEM model helped understand health through a multi-level perspective, and were able to identify 'leverage points' within the interacting layers of influence that could be targeted to improve health. For instance, although each woman would have their own personal beliefs and experiences prior to military service, the study found that the microsystem, mesosystem, exosystem and macrosystem all impacted upon women's intrapersonal processes and help seeking behaviour. Similarly, in the present study, it is possible to consider that outer layers of the SEM similarly impact upon the intrapersonal processes of psychological practitioners. Of note, the leverage points in the present study were presented by practitioners within the findings for the exosystem (e.g. creating resources, having more clinical practice support and guidance) and macro system (e.g. belief systems, culture). There would be utility in conducting a similar study on psychological practitioners from a SEM perspective to understand the leverage points in more depth.

It is possible that tackling menopause care within the mental health and psychology profession from a multilevel perspective may remedy current gaps in knowledge and care. Liss et al. (2024) identified strategies to enhance menopause education within medical training to break the cycle of lack of knowledge and to improve care. Strategies included enhancing clinical knowledge, having access to clinical skills, promoting evidence-based practice, fostering interdisciplinary collaboration, CPD and cultural curiosity. These strategies link in with participants assertions in the present study, and provide a possible strategy that may have similar utility for the mental health and psychology field.

Although UK policies have been introduced to promote improved menopause care in the 'chronosystem', there is a need for more research globally. For instance, Kamal et al (2024) highlighted a lack of research on women who have experienced Female Genital Mutilation (FGM) and their experience of the menopause. In a UK study, they explored the unique physical (e.g. increased pain, recurrent urine infections) and psychological effects as the menopause may intensify pre-existing mental health difficulties or lead to new onset difficulties for women. Barriers to accessing care were identified (e.g. taboo, fear of FGM status being officially reported and the implications of this), and care should entail culturally sensitive care, interpreting services, education and community empowerment. This demonstrates the utility of research efforts to support understanding, tailor care pathways for women and engage communities.

### 4.5 Recommendations

There are recommendations that can be made based on the present findings. Using a critical realist ontology has permitted the exploration of gender issues within mental health care and allows for numerous explanations to exist (Bergin et al., 2008), and for recommendations and action planning for social problems based on suspected causal mechanisms (Fletcher, 2017). Using an interpretivist epistemology helped the author understand the unique experiences, meanings and perspectives of each participant. The present research findings could therefore make recommendations for systems providing psychological care.

Firstly, that menopause education is included in professional training programmes for mental health/psychology staff. Secondly, for those already qualified in practice to receive regular CPD on the menopause and opportunities for skills sharing. Thirdly, an increase in research is required to evaluate the effects of training and education, and to ensure that guidelines on therapeutic interventions reflect what is truly helpful, rather than the only research ‘out there’. A holistic approach of including quantitative, qualitative evidence, patients voices, and practice-based evidence would ensure that current knowledge is fully utilised. In this sense, it would be advisable that NICE include other forms of evidence aside from gold standard RCTs. Therefore, to truly improve care, a diversity of evidence is needed in the development of NICE guidelines (McPherson & Beresford, 2019). Fourthly, for services to make logistical and/or technological changes to ensure that menopausal clients can be identified at referral and their care monitored. This would support further research by accumulating data to monitor engagement and outcomes for this group, and help shape care pathways. Lastly, supervisors and leaders within services should create a culture that holds space for the menopause to counter unhelpful narratives, which arguably have consequences on care.

The above changes are more likely with socio-political movements of the Women's Health Strategy (Department for Health and Social Care, 2022) and 'No Time to Step Back' policy (Department for Work and Pensions, 2023). However, it may require addressing different layers within the system.

### 4.6 Strengths and Limitations

It is important to consider the strengths and limitations of the current study. In terms of strengths, the study is a novel exploration and could propel further research to understand what the mental health/psychology profession in England requires. Secondly, the selection of a qualitative paradigm meant that there was depth to the data and allowed the researcher to develop rich themes and subthemes, which would not have been possible with quantitative methods. This depth allowed the researcher to understand participant's views about wider social, cultural and systemic factors outside of them individually as practitioners, which allowed for more in-depth thinking about the research question. This led the author to consider recommendations for services and practice to improve care.

Thirdly, the researcher took steps to ensure that participants felt as safe as possible to participate. This was important as the topic revolved around their knowledge, practice, and the systems in which they work. Admitting to gaps in one's knowledge or own practice may not be easy, and so it was important for the current author to engender trust during the interviews. The manner in which demographic data was collected may have contributed to participants being willing to engage and experience a sense of psychological safety. In this sense, the study sought enough data to ensure participants were suitable for the study, but avoided detailed inquiry into their professional careers, which may have increased anxiety and affected engagement. Fourthly, although there were a number of CBT therapists in the study, the sample did include professionals from varying professional backgrounds and modalities, and in itself provides novel insights.

A further strength is that the study included a multitude of recruitment strategies, as one method may have biased the type of population recruited. For instance, had the author relied on close contacts alone, this may have meant that the data may have been from particular geographic locations. Instead, the use of social media allowed for the recruitment of participants unknown to the researcher, and from varying parts of the country, different programmes of training and different statutory services. Therefore, when considering the themes from the data, they emerge not from the practices of services in one area, but potentially indicate a broader pattern across services and academic programmes. Another strength of the recruitment strategy was a deliberate choice to invite professionals who had worked in services within the last year but had left within the last 12 months, such as to go into private practice, retirement or career breaks. This allowed for the researcher to capture the views of participants who also have a wealth of experience but were outside of the statutory sphere. This openness was important, particularly given ongoing staff retention issues and vacancies in the health system (Anderson et al., 2021).

In hindsight, there may be things that could have been different. It is typical for qualitative methodologies to use smaller samples, but it is possible that the findings are also limited to the knowledge and experiences of the participants interviewed. The sample spoke of their experiences within the NHS, and there were no participants from other forms of statutory services, and so the findings may only relate to the practices within the NHS. A caveat is that the NHS is the largest provider of psychological interventions in England, such as within NHS Talking Therapies (Clark, 2018), and this may simultaneously be a strength.

Quantitative methodology may have been useful to obtain more breadth of data. For example, the study could have created an online questionnaire that could have been disseminated via a link to participants. This could have included asking professionals to rate their level of awareness and knowledge using likert rating scales. In addition, information about their experience of working with menopausal clients directly could have been sought by asking questions eliciting a 'yes/no' answer, or a rating scale. This would have allowed participants to complete the questionnaire in their own time and may have been more convenient. Such online surveys have been utilised by Munn et al. (2022) and Harper et al. (2022) to obtain an understanding of the level of knowledge amongst menopausal women themselves. This may have felt more preferable for some participants who did not wish to directly contact a researcher for a 'formal' interview. It would be interesting to see whether this would attract a more diverse sample of professionals, such as more male participants, more participants from minority groups and from more service settings.

Perhaps a further option could have been a mixed methods approach. Although this involves opposing epistemologies, some argue that this approach can be powerful if correctly designed in order to obtain the strengths of both approaches, and reduce the limitations that each have (Trotter II, 2012). This could have included utilising the online questionnaire, but incorporating comment boxes for participants to expand on their answers. This would provide the possibility of both a larger sample size of professionals, with qualitative insights. Although a quantitative or a mixed method approach are options, quantitative methodologies emanate from a different epistemic and ontological stance and are in contention with qualitative paradigms. Qualitative methods enable more self-reflexivity during the research process, although conversely, some argue that self-reflexivity is helpful even in quantitative or mixed method approaches to 'centre' the researcher and their biases (Jamieson et al., 2023).

There was a limitation in the study with the eligibility criteria of participants having worked with clients aged 35+, which was stated in the advert. This was set with the intention of getting participants who had worked with clients aged 35+ and based on guidance when perimenopause is likely to begin (BMS, 2021). However, this specification in hindsight was unnecessary. Participants reading the advert may have assumed they may have needed to work in services with this client group specifically, and may have led to misunderstanding. The title of the thesis had also altered during the course of the study, and so it is unclear if this in anyway impacted engagement with the study. Another limitation was that the author was working alone. It would have been useful to have a second researcher who was unknown to close contacts who could have conducted those interviews, and this would have mitigated any potential influence of the researcher.

There were some issues with the Participant Demographic Information sheet (Appendix E). This had an error where age categories overlapped (e.g. 40 to 50, 50 to 60), although on this occasion only impacted one participant who was aged 50 and had commented on this. In future research, if such categories are used, then this should be stated as 40-49, 50-59 and so forth. It may also be useful to collect more data from participants in future research, but there would need to be a rationale. For instance, it may have been useful to consider years of experience, but participants were often multi-qualified and may depend on if one is asking about their current role or total experience. It may also be useful to collect more sociodemographic information (e.g. religious beliefs, culture, sexuality) to understand any potential differences between professionals. This could provide more context and help understand nuances in the findings. It additionally could help ascertain any links between these participant variables and attitudes towards the menopause. Recent research has argued that cultural curiosity is vital within curriculums for menopause education and for culturally responsive menopause care. Cultural values can impact perceptions of the menopause and link with cultural silences (Williams, 2024). Equally, the same cultural curiosity should arguably be paid to professionals within research when exploring their knowledge of the menopause and clinical experiences to understand any role this may play.

A further limitation is around the lack of diversity within the sample. This consisted of a lack of diversity in type of practitioners recruited, and a lack of participants from across the intersection. For instance, despite efforts during recruitment, there were no participants who worked in services such as social care or secondary care services (outpatient and inpatient). This would have provided insights from professionals who work with patients diagnosed with severe and enduring mental health difficulties. There is difficulty in knowing what impact these additional accounts would have had and would require further research. Of note, the study did include trainee and qualified psychologists who would have had some experience in such settings during their training, but mostly included professionals in primary care. In terms of the participants intersectional identities, the sample lacked diversity as a whole as it mostly consisted of participants from Caucasian backgrounds. This was despite efforts to advertise online with professional bodies and in social media groups that had members from a range of diverse backgrounds.

It would be useful for future research to consider if there are any factors affecting particular participants engagement in this form of research. Future research should consider more ‘offline’ methods of recruitment and targeted efforts to attract a range of practitioners and a more diverse sample. In hindsight, it may have been useful for the present study’s advert to have included information about the researcher and a picture so that participants had more information about who they would be speaking to. Offline methods and adapting the advert may have allowed the researcher to build more of a relationship with participants to support engagement. This may have also helped as some research has also shown that having a researcher from a minority group may improve engagement of under-represented groups

(Carter et al., 2023). It may also be useful for future research to actively promote the study in forums where practitioners from diverse groups and specialist clinical fields may congregate. Such forums can also be used for consultations when initially designing a study to consider how to improve recruitment of practitioners and the sociodemographic nature of the sample.

An important acknowledgement is that the study interviewed professionals and spoke of their perspective of client work, and the study did not include client's voices directly, and so further work is needed to understand the experiences of clients. The research was also conducted on professionals in England because the present study wished to compare practice against NICE (2015) guidance, but further research would be useful to explore the knowledge of psychological/mental health practitioners across UK nations and other countries. In addition, the interventions that were discussed in the interviews are from western models of psychological intervention, and it is important to acknowledge that research has not often considered non-western approaches. It would have been useful at this point to reflect again on redesigning the study advert which had "psychological interventions" stipulated, as this formalised language may be reminiscent of medicalised language for some individuals.

It is useful to reflect on Tracy's (2010) eight *'Big Tent'* criteria for excellent qualitative research marked by: (1) worthy topic, (2) rich rigor, (3) sincerity, (4) credibility, (5) resonance, (6) significant contribution, (7) ethics, and (8) meaningful coherence. The study has many strengths when reflecting on this model. The study could have been strengthened by incorporating another 'layer' to strengthen 'credibility'. This could have been achieved through multivocality, such as by including different stakeholders and member reflections, and should be considered in future research. It may also be useful to consider patient participatory elements, which is an increasingly important aspect of current patient agendas within health services (Bombard et al., 2018; Smith et al., 2022). This could have included coproducing the interview guide, participation in data analysis and in making recommendations.

### 4.7 Reflective Notes

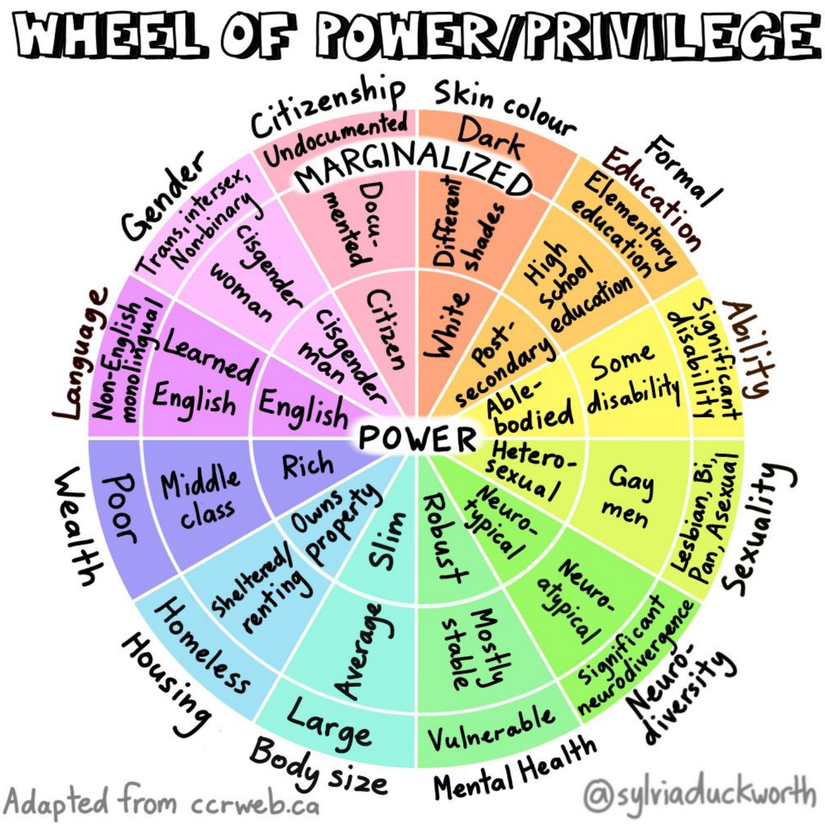
Self-reflexivity involves critically reflecting on one's belief systems and positionalities (Jamieson et al., 2023). Field notes were kept to understand the decisions and experiences during the research for transparency.

When I started this journey in 2021, I mentioned the topic of this thesis to a female colleague and her response was one of confusion and surprise and *"why did you choose that?"*. Since that time, I noticed the menopause gaining more traction in the media, products started appearing in my local pharmacy and health shop, social media posts and podcasts proliferated on the subject, and people responded to my thesis topic with new intrigue. I saw the changing attitudes to the menopause 'live' through my thesis journey. It made me wonder what narratives will surround the menopause in another three years.

Moreover, I have also found it helpful to engage in intersectional reflexivity (Rodriguez & Ridgway, 2021), particularly as a researcher from a minority group. The Wheel of Power and Privilege (Duckworth, 2024; see Figure 2, p. 140) has been useful to consider aspects of power and privilege.

**Figure 2**

*Wheel of Power and Privilege*



My identity intertwines with the topic of the menopause, but also intersected with participants. I was mindful that I was interviewing participants about a subject I had not experienced myself. I also consider whether aspects of my identity may have made it easier or ‘safer’ in some way for participants to talk to me about themes, such as patriarchy and ageism. It is possible that it could have had the opposite effect. It is a useful consideration for future research to consider aspects of researcher identity and whether this impacts disclosure in menopause research. I also consider people going through the menopause and how I have privilege. I now work in a profession that is more financially remunerated than other professions, and means that I could potentially afford private health interventions if required, which is not an option for everyone.

Jamieson et al. (2023) proposes a question for researchers: *"What did I gain from this research?".* I was able to develop my skills as a researcher in a topic of interest for me. Equality is an important value for me, and it has made me consider how I view both younger and older women as important and of value. It perhaps underscores my interest in undermining the silence around the menopause. In this vein, I have found it interesting to see some differences in societal narratives in cross-cultural research (e.g. Dhanabalan et al., 2023) and hear the perspectives of my participants.

Following the completion of the interviews, I experienced personal challenges that led to an experience of stress and associated hormonal and autoimmune symptoms. I saw for myself the role of hormonal dysfunction, and the emotional and physical impact it can have both physically and mentally. This was on top of the demands of work, academia and a busy personal life. It brought home the importance of education in women's health, and how important it is for everyone in a team delivering psychological care.

After finishing my analyses, I experienced some age-related micro-aggressions in the workplace in a psychology service context. This was the first experience in my life of this type of discrimination and made me ponder the challenges for women as they age at work. Would I have wanted to mention the menopause if I had someone at work like this? There is so much complexity in this sense of psychological wellbeing at work. As a female from a minority group, it reminded me of other discriminatory experiences in my life and was very difficult. At times, it led me to retreat into myself and lose confidence. The topic is a passion for me, and involves acknowledging the value of all women, and the intersectionality of people that experience menopause. I maintained my passion for my research by linking into my own personal values. Certainly, reading material for this write-up about gendered ageism was very difficult, and I stepped away from my work many times. I remembered to look after myself by having breaks to ensure I was centred again. I also managed all these experiences through avenues of professional and personal support around me, and people new to my life who shared their wisdom in emotionally managing such types of comments. In retrospect, this perhaps highlights the emotional costs involved in research, particularly for minority researchers (Rodriguez & Ridgway, 2021), but simultaneously made me more empowered to continue.

### 4.8 Conclusion

To the author's knowledge, this is the first study which has sought to understand the current level of awareness and knowledge of the menopause amongst professionals in statutory services who deliver psychological interventions, and to understand their experiences of working clinically with menopausal clients. Fifteen participants took part in the study. Reflexive Thematic Analysis was used to analyse the data and led to the development of five main themes and eight subthemes. Findings indicated gaps in the awareness and knowledge of the menopause, a lack of formal training and education on the menopause, the role of stigma and silence in services, strengths and challenges in clinical work and inter-professional working, and the need for the menopause to hold more space in systems of care for change to occur.

The study's findings offer novel insights, which could propel further research within the mental health and psychology profession. Recommendations include intervention at the practitioner, provider and systems levels to support staff and address the psychological needs of people experiencing the menopause. This can contribute to wider national efforts in the UK to improve the care of women across the lifespan.

The menopause arguably applies to everyone: those who will or currently are journeying through it, professionals involved in care, family, partners and friends. It is for this reason that the menopause should have more of a spotlight in services offering psychological care.

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# Appendices

## Appendix A - ROB-2 and ROBINS-I Risk of Bias Assessment Scoring

ROB-2 Risk of Bias Assessment Scoring

| Item | Khoshbooii et al (2011) | Green et al (2019) | Reddy et al (2019) | Ham et al (2020) | Khoshbooii et al (2021) |
|---|---|---|---|---|---|
| 1.1 | PY | Y | Y | Y | PY |
| 1.2 | NI | Y | NI | PN | PN |
| 1.3 | N | N | PN | N | PN |
| 2.1 | NI | N | PY | PY | Y |
| 2.2 | Y | N | PY | PY | Y |
| 2.3 | Y | N | NI | NI | PN |
| 2.4 | PY | - | - | - | - |
| 2.5 | PN | - | - | - | - |
| 2.6 | PY | Y | PY | PY | PY |
| 2.7 | PN | N | - | - | - |
| 3.1 | NI | Y | PY | PY | PY |
| 3.2 | PY | - | - | - | - |
| 3.3 | NI | - | - | - | - |
| 3.4 | NI | - | - | - | - |
| 4.1 | N | N | PN | PN | N |
| 4.2 | NI | N | N | N | N |
| 4.3 | PY | N | Y | N | Y |
| 4.4 | PY | N | PY | PY | PY |
| 4.5 | PY | N | PY | PY | PY |
| 5.1 | NI | PY | PY | PY | Y |
| 5.2 | N | PN | N | PN | PN |
| 5.3 | N | PN | N | PN | PN |
| Overall Risk of Bias Judgement | High(MI)* | Low | High | High | High |

ROBINS-I Risk of Bias Assessment Scoring

| Item | Brandon et al (2013) | Green et al (2013) | Conklin et al (2020) |
|---|---|---|---|
| 1.1 | Y | N | Y |
| 1.2 | NI | - | NI |
| 1.3 | N | - | PN |
| 1.4 | PN | PY | PN |
| 1.5 | - | PY | PY |
| 1.6 | NI | NI | NI |
| 1.7 | PN | PY | PY |
| 1.8 | - | PY | NI |
| 2.1 | N | N | N |
| 2.2 | - | - | - |
| 2.3 | - | - | - |
| 2.4 | NI | Y | NI |
| 2.5 | NI | - | PY |
| 3.1 | PY | Y | Y |
| 3.2 | PY | Y | Y |
| 3.3 | PY | PY | PY |
| 4.1 | PN | N | N |
| 4.2 | - | - | PY |
| 4.3 | NI | NI | NI |
| 4.4 | PY | Y | Y |
| 4.5 | PY | Y | Y |
| 4.6 | PN | PY | PY |
| 5.1 | PY | Y | PY |
| 5.2 | NI | PN | N |
| 5.3 | NI | PN | N |
| 5.4 | NI | - | NI |
| 5.5 | PY | - | PY |
| 6.1 | PY | PY | PY |
| 6.2 | Y | PY | Y |
| 6.3 | Y | Y | Y |
| 6.4 | PN | PN | N |
| 7.1 | N | PN | N |
| 7.2 | N | PN | N |
| 7.3 | PY | N | PY |
| Overall Risk of Bias Judgement | Critical risk of bias | Low risk of bias | Critical risk of bias |

## Appendix B - Participant Information Sheet

### Title of Project: An exploration of the potential barriers and facilitators to delivering evidence based psychological care to menopausal clients

My name is Kirat Virdi and I am a Trainee Clinical Psychologist carrying out this study as part of a Doctorate in Clinical Psychology with the Department of Health and Social Care at the University of Essex. This study will form the basis of a doctoral thesis.

Thank you for expressing interest in participating in this study. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. If there is anything that is not clear, or if you would like more information, please feel free to contact me on the details at the end of this information sheet.

**What is the purpose of the study?**

The study aims to interview professionals who deliver psychological interventions to people aged 35+ and explore how aware they are of the menopause. The study is also interested in experiences of working with people experiencing the menopause transition directly. The study aims to explore what is working well, and possible areas for development in the care of this client group.

**Who can take part?**

You have been invited to take part in this research study as you are a professional who has delivered psychological interventions to people aged 35 and over within statutory services. Alternatively, you may have worked in this type of role within the last 12 months. We are looking for people who would be willing to help with this research and take part in a one-off interview, which will be carried out online.

**What will happen if I decide to take part?**

After reading this information sheet in full, if you decide to take part you can contact the researcher by email (hv21654@essex.ac.uk) and will be asked to provide some basic information about yourself. If you are eligible and wish to continue, you will be asked to read and sign a consent form and to return this by email to the researcher. By signing the form, you are giving your consent to take part in the study.

Next you and the researcher will arrange a one-off interview on an online platform (Zoom) at a convenient time, and the interview will be recorded. You can decide whether you would like to have your camera on or off during the meeting. The interview will be carried out by the researcher. The researcher is interested in hearing about your experiences from your point of view – there are no right or wrong answers. If you are asked a question you would prefer to not answer, you can just let the researcher know. The interview may last up to an hour, or as long as you feel you need to answer the questions.

At the end of the interview, your participation will be finished and you will not be contacted again by the researcher (unless you would like to receive a copy of the results of the study, in which case this will be emailed to you at a later date). After the interview, the recording will be fully transcribed so that we have a written account of the interview. We will use this information to conduct analyses that will help us to identify themes that appear to be important to you and other participants in the study.

### Do I have to take part?

No. Your participation in this study is entirely voluntary. If you do decide to take part, you will be given this information sheet to keep and be asked to read and sign a consent form.

### Can I change my mind?

If you change your mind once you have agreed to take part in the research, you can leave without having to give a reason or an explanation. Please let the researcher know if you do not wish to continue by contacting them. You can find their details at the bottom of this information sheet.

You are welcome to withdraw your information within two weeks of the interview. All you need to do is contact the researcher to let her know. If you withdraw ***before*** **or** ***up to two weeks after*** **the interview**, your information will be destroyed, and you will not be contacted again. If you choose to withdraw ***more than two weeks after*** **the interview**, you will not be contacted again, but your information will still be used for the study. However, if you believe there is a strong reason why your information needs to be withdrawn after two weeks, please contact the researcher or her supervisor to discuss further. This is because typing-up and analysing the interviews takes many hours, and so a lot of work would be lost if information was withdrawn at a later time.

### What disadvantages or risks should I consider?

Research can help expand knowledge, but sometimes talking about the mental health of people we work with can be challenging for us too, as some of the difficulties may resonate with us. Should you feel affected by anything we discuss, we can signpost you to organisations and services that can assist you. Your wellbeing is monitored throughout the study and we welcome any questions or concerns you may have about the process.

### What are the possible benefits of taking part?

Some benefits can include taking part in a study which can help understand more about a subject, and potentially progress knowledge in the field. Research can help highlight issues or gaps in the field, which future research could address.

### Will my taking part in this study be kept confidential?

Absolutely. All information collected will be kept securely and stored in line with the Data Protection Act 1998. A list may be kept linking participant numbers to names, but this will be kept securely and will only be accessible by myself and my supervisors. Some word-for-word quotes from your interview may be used in the study report, but any identifying details will be removed or replaced with false details. A copy of the information which we record about you, but not other participants, will be provided, free of charge, on request. The only circumstances under which confidentiality *would not apply* is if something you told the researcher made her concerned that you or someone else was at a high risk of serious harm. In the rare event of this happening, the researcher would tell you this was the case, and would let you know what action she would have to take. Research data used for the study will be retained for a period of at least ten years after the completion of the project, at which point your data will be destroyed.

Our legal basis for processing your personally identifying data is that you have consented to it. The data controller is the University of Essex. Essex University's Data Protection Officer can be contacted on dpo@essex.ac.uk.

**Will the use of my data meet GDPR rules?**

Yes. GDPR stands for the General Data Protection Regulation. In the UK, we have to follow the GDPR rules and the Data Protection Act. The researcher will have access to and manage your data, and ensure GDPR rules are maintained throughout. The legal basis for processing personally identifying data is that participants have consented to it, and the data controller is the University of Essex (dpo@essex.ac.uk).

**Who has reviewed this research?**

This research study has received ethical approval from the University of Essex. The research is supervised by two supervisors at the University of Essex who oversee its conduct.

**Who is funding this research?**

The research is not being funded by any agencies or organisations.

**Will I be reimbursed for taking part?**

There are no financial reimbursements for taking part, but we will try and accommodate your availability so it does not affect your other commitments.

**What will happen with the results of the study?**

The study is part of a doctoral thesis in clinical psychology. The findings will be presented in a thesis, but may also be presented in academic journals, magazines, online platforms and conferences. Your data is anonymised and you will not be identifiable in any report, publication or presentation.

**Can I find out about the results of the study?**

Yes. If you like, the researcher will send you a summary of the results at the end of the study. If you would like to see the full dissertation report, you can contact the researcher to request a copy.

**What if there is a problem?**

If you wish to make a complaint, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, you should contact the researcher Kirat Virdi (hv21654@essex.ac.uk).

If are still concerned, or you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach her, please contact the Director of Research in the department responsible for this project, Professor Camille Cronin (email: camille.cronin@essex.ac.uk). If you are still not satisfied, please contact the University's Research Governance and Planning Manager, Sarah Manning-Press (email: sarahm@essex.ac.uk). Please include the ERAMS reference which can be found at the foot of this page.

**What happens next?**

The researcher will email you in about a week using the contact details you provided to ask you if you would like to take part. If you do not, simply let her know that you'd prefer not to be involved.

**Name of the researcher and research supervisors**

Researcher Name: Kirat Virdi
Role: Trainee Clinical Psychologist, Department of Health and Social Care, University of Essex.
Email: hv21654@essex.ac.uk

Research supervisors:

- Dr. Frances Blumenfeld, Department for Health and Social Care, University of Essex (email: fblume@essex.ac.uk)
- Professor Camille Cronin, Department for Health and Social Care, University of Essex (email: camille.cronin@essex.ac.uk)

If you decide to take part, we suggest you keep this information sheet for future reference.

ERAMS reference: ETH2122-1481
Version 1 (June 2022)

## Appendix C - Study Advert

# Are you a professional delivering psychological interventions to clients aged 35 and over in statutory services? Or have done so within the last 12 months?

# Would you like to contribute to a research project?

### What is the study about?

My name is Kirat Virdi and I am a Trainee Clinical Psychologist. I would like to invite you to take part in a research study which aims to understand how aware professionals are of the menopause, and their experiences of working with clients experiencing the menopause transition. This study is part of a Doctorate in Clinical Psychology with the University of Essex and will form the basis of a thesis.

### What would be involved?

It will involve attending a one-off interview which will be online. If you are interested and would like to find out more, then please email me at hv21654@essex.ac.uk for more information about the study.

## Appendix D - Consent Form

ERAMS reference Number: ETH2122-1481

Participant identification number:

(If you agree please initial the box)

| | |
|---|---|
| I confirm that I have read the information sheet (version 1, June 2022) for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | |
| I understand that my participation is voluntary and that I am free to withdraw without giving any reason. I understand that if I withdraw ***before*** **or** ***up to two weeks*** *after* the interview, my information will be destroyed. If I choose to withdraw ***more than two weeks*** *after* the interview, I understand that my information will still be used for the study. However, I understand that if I believe there is a strong reason why my information needs to be withdrawn after two weeks then I can contact the researcher or her supervisor to discuss this further. I understand that any data that is retained and used for the study will be destroyed after a period of 10 years after the project's completion. | |
| I understand I will not gain any financial benefit from my participation. | |
| I agree to my interview for this research to be recorded, for my data to be made into transcripts and for the use of anonymised quotes in research reports, publications and presentations. | |
| I agree to take part in the above study. | |

| | | | |
|---|---|---|---|
| Participant name (please print): | Copy of consent received?<br>Yes / No | Date: | Signature: |
| Name of person taking consent (please print): | Copy of consent in possession?<br>Yes / No | Date: | Signature: |

## Appendix E - Participant Demographic Information

| | |
|---|---|
| Allocated Participant Number: | |
| Name: | |
| Telephone/mobile:<br>Email address: | |
| Gender (delete as appropriate) | Male<br>Female<br>Non-binary<br>Other (please specify)____________<br>Do not wish to specify |
| Participant age (delete as appropriate) | 20-30<br>30-40<br>40-50<br>50-60<br>60+ |
| Ethnicity: | |
| Professional title (s) | |
| Current employment setting: | |
| Experience of delivering psychological interventions to clients aged 35+ in statutory services? (or within the last 12 months) | Yes / No |

# Appendix F - Post Interview Sheet

We would like to thank you for taking time to take part in this research.

This research study will be written up formally as an academic assignment as part of a Doctorate in Clinical Psychology with the Department of Health and Social Care at the University of Essex. It will also be submitted for publication in the public domain and may also be used in academic teaching and presentations. Key findings and anonymised quotes from the interviews will be used in publications and in promotional material. Please let the research know if you would like to receive a summary of the evaluation findings.

Research can help understand more about a subject, and potentially progress knowledge in the field. However, should you feel affected by anything you discuss, you can inform the researcher (Kirat Virdi) who will be able to direct you to relevant support.

# Appendix G - Interview Guide

Can you tell me a bit about your work experience?

- Professional qualification(s)
- Types of service experiences (i.e. private, statutory services)
- Current/previous role, duties, population worked with

What do you know about the menopause transition and its symptoms?

- Where did you obtain this knowledge?

Have you had any formal training related to the menopause?

- If so, what and where was it?
- Was it helpful? If so, how?

Can you tell me about your experiences of working with clients who have been going through the menopause transition?

- Details of client group
- What did you do? What was the intervention? How often was this delivered? What were the outcomes?
- (indirect work) What were the steps in providing care? Who did you have to liaise with? What were the outcomes?
- Were there any important learning points?

Would anything help/have helped you when working with this client group?

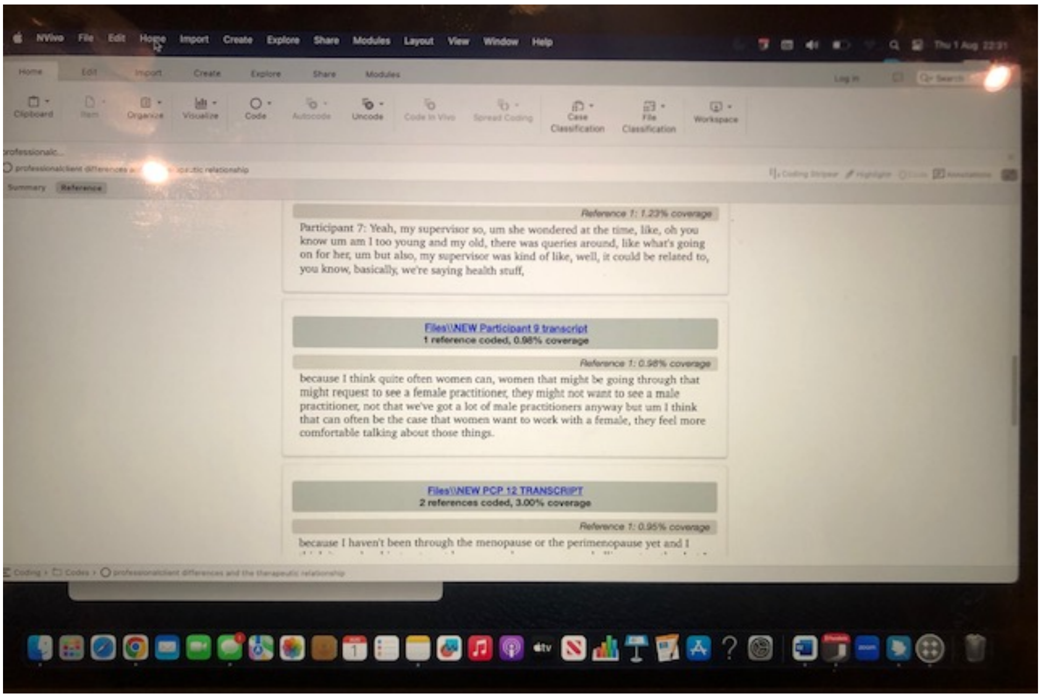
Would anything else support you in your work with menopausal clients going forward?

- Including practitioner level, service/structural level

Were there any challenges that came up during your work?

Do you have anything else you would like to add?

# Appendix H – Coding Example From NVivo Software



Reference 1: 1.23% coverage

Participant 7: Yeah, my supervisor so, um she wondered at the time, like, oh you know um am I too young and my old, there was queries around, like what's going on for her, um but also, my supervisor was kind of like, well, it could be related to, you know, basically, we're saying health stuff,

Files\\NEW Participant 9 transcript
1 reference coded, 0.98% coverage

Reference 1: 0.98% coverage

because I think quite often women can, women that might be going through that might request to see a female practitioner, they might not want to see a male practitioner, not that we've got a lot of male practitioners anyway but um I think that can often be the case that women want to work with a female, they feel more comfortable talking about those things.

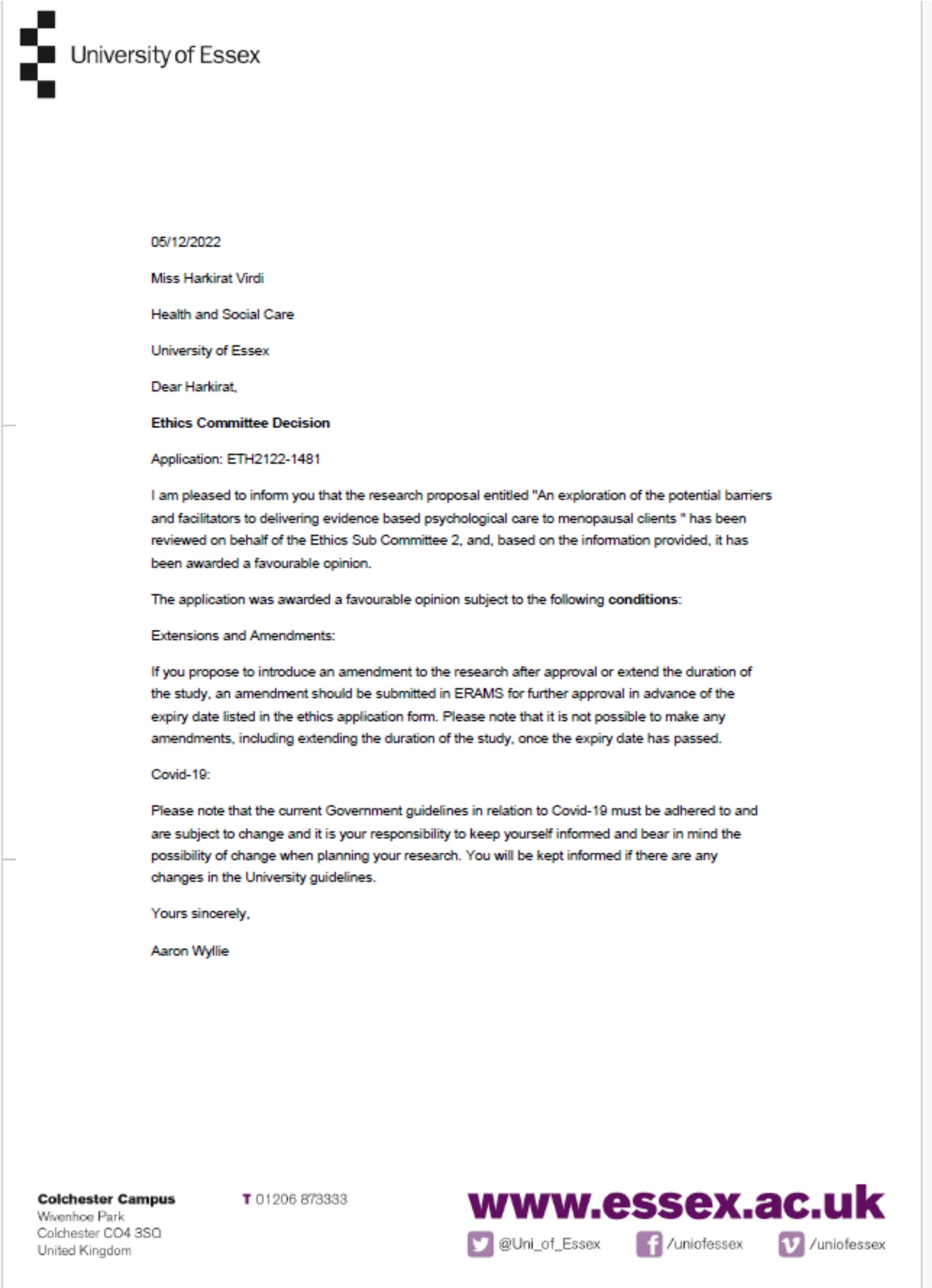
Files\\NEW PCP 12 TRANSCRIPT
2 references coded, 3.00% coverage

Reference 1: 0.95% coverage

because I haven't been through the menopause or the perimenopause yet and I

# Appendix I

## Ethical Approval



University of Essex

05/12/2022

Miss Harkirat Virdi

Health and Social Care

University of Essex

Dear Harkirat,

**Ethics Committee Decision**

Application: ETH2122-1481

I am pleased to inform you that the research proposal entitled "An exploration of the potential barriers and facilitators to delivering evidence based psychological care to menopausal clients " has been reviewed on behalf of the Ethics Sub Committee 2, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

Aaron Wyllie

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