The meaning of menopause in the consulting room and psychoanalytic thinking on a menopause life stage

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Summary

The subject of this enquiry is menopause and can it be thought of as a life stage through a psychodynamic lens. Having a psychoanalytic way of thinking about menopause will help to support clinicians in their work with clients and contribute to psychosocial thinking. Little attention has been given to menopause in psychoanalytic writing so, building on the literature from Freud, Deutsch, Benedek, and others this research will consider the current thinking. Reflexive Thematic Analysis is used as a qualitative enquiry. Research participants were four females who trained psychodynamically as clinicians who presented their clinical work with, in total, 11 clients who had experienced menopause. Reflexivity was integral to the process of this qualitative inquiry with a focus on researcher, participants and data. Six overarching themes were identified: loss, body and psyche, loss of fertility, client defences, therapist defences, and creativity. These themes show the psychic impact of bodily changes, the defences used by the clients and therapists along with the potential for self-integration and creativity once the mourning process has been explored and worked through. Results also highlight the influence of the therapist's position on menopause and the effect on their clinical receptivity. Importantly, the study suggests that menopause can be considered as a transition from one life stage into another characterised by improved integration, a sense of freedom, and creative potential. Menopause can be identified as a transition rather than a single event with the progression through mourning to creativity. This research contributes to psychoanalytic thinking by placing menopause as a meaningful developmental stage rather than simply a biological, physical, or medical occurrence. Clinically, it demonstrates the importance of therapists providing an analytic space for exploration.

Chapter 1
Introduction and Background

1.0 Overview

This research project, entitled 'The meaning of menopause in the consulting room and psychoanalytic thinking on a menopause life stage', began with my observations in the consulting room with clients who talked about the menopause and the psychological impact from a psychoanalytic perspective. I will explore how the menopause manifests in the consulting room and how this can be thought about in relation to a psychoanalytic theory of the menopause as a life stage. I suggest this exploration of what female clients bring to the consulting room and it's meaning, is needed to help move away from thinking of the menopause as a purely physical or biological occurrence. I consider how psychotherapists can support the therapeutic process in which a psychoanalytic lens can help to think about this stage. By bringing this stage of the female life cycle into the spotlight, and the implications from a psychoanalytic perspective, I will consider a theoretical framework to support clinical thinking when working psychodynamically with females going through this pivotal life stage. I will refer to this stage as a *menopause transition* when women go through the stages of menopause from perimenopause, menopause and post menopause.

1.1 Background and Context

Menopause is a natural and inevitable bodily transition for natal females, yet within psychoanalytic theory it has received relatively limited attention. While psychoanalysis has offered rich thinking in other areas of development and psychic change, the specific psychological meaning of menopause has remained comparatively under-theorised. In contrast, medical literature and research have been growing and developing for some time, offering a

wide range of treatments, although most commonly through hormonal replacement therapy (HRT). On various platforms across the media in the United Kingdom, the dominant discourse has been one of symptom management, risk reduction, and pharmacological intervention, which seemingly has been influential in the surge of medical research. For instance, GP training had no requirement to include menopause training, with more recent, specific training created and offered by private menopause consultants to enable each surgery to have at least one practitioner specifically trained in menopause. While this recent medical research is essential and has significantly improved the quality of life for many women, the emphasis on biology can overshadow the psychological and symbolic aspects of this transition. Within the psychoanalytic profession, menopause has more often appeared as a passing reference with limited specific papers rather than being examined as a developmentally significant period when identity and embodied experience can be explored. Noticing this imbalance between medical visibility and psychological reluctance one cannot help but question the lack of analytic theory and which life transitions have been privileged within psychoanalytic traditional theory. From a feminist perspective, the minimalization of menopause within analytic theory echoes wider cultural tendencies to render aging female bodies less visible or less symbolically valued. The absence of psychoanalytic engagement with menopause therefore seems not simply an oversight but suggests a broader pattern in which certain aspects of women's lived experience and reproductive functions have remained insufficiently explored within the analytic tradition that claims to be concerned with the depths of psychic life.

This research project began with my observations in the consulting room with female clients between the ages of 45 to 55. In psychotherapy sessions I noticed that some of my clients were talking about their psychological emotional disturbances and the physical changes in their

body, while going through the menopause. Some clients made comments in their initial sessions which came up repeatedly throughout the work. These include comments such as, “I look in the mirror and I don’t recognise myself”, “I just don’t know the person staring back at me” or “I really don’t know who I am any more” and the statement that seems to carry the most distress, “I have no idea what is happening to me and I feel so out of control”. When explored these comments can be connected to feelings of things being out of control such as changes in body shape, fatigue, mood swings and aging skin. These clients have been at varying stages of menopause when they started working with me. It is important to note that women will have different physical and psychological experiences of menopause. In research by Huang et al (2023) they account for psychological symptoms being prevalent in 72.4% of participants with low or depressed mood in 66.6% being most common, followed by anxiety or panic attacks in 59.7%. In a study by Aljuman, Phillips and Harper from UCL (2023) they report 38.1% of women felt that the menopause was ‘difficult’, 24.6% felt it was ‘very difficult’ and 20.7% felt it was ‘fine’. So, if these figures are reflected in the female clients who engage in psychotherapy or analysis, then this is something worth considering. In my clinical experience the awareness and thinking about clients’ individual experiences in the clinical work seemed to give some relief quite quickly whilst they explored wider issues relating to this period. Often clients access hormone replacement therapy (HRT) or alternatives to relieve the physical symptoms which provides relief of those symptoms, but they are still faced with what some clients I have worked with in the clinical setting have described as “the stranger in the mirror” and of “not feeling connected to how they look”. This is where I have found the psychological impact of moving into the next stage of the life cycle can become the main theme of the work. In 1950 Therese Benedek wrote of HRT, ‘they do not resolve the emotional conflicts without adequate psychotherapy’ (Benedek 1950 p13). HRT can be highly effective in the reduction of most physical symptoms, but that it is not enough on its own.

Through my own *menopause transition*, it was noticeably clear to me that I had complicated feelings about what was happening to me that was very much out of my control. There are papers and books where menopause is referred to or given consideration, however there were few that attach any theoretic understanding or offer a framework to inform clinical work. In psychoanalytic literature this stage is also often referred to as 'Climacteric' or 'Climacterium' which restricts results when searching. Freud (Freud 1894, p.101) considered the 'Climacteric' stage in his theory of anxiety neurosis presenting in both male and female patients connecting it with age. The word 'Climacteric' is a loose translation of the round of the ladder, so it is a period of getting to the top of the ladder of life. Freud explains in Analysis Terminable and Interminable (Freud 1937, p.226) that anxiety neurosis can arise during this 'Climacteric' period, even for those who have no history of anxiety. Freud did not write much on this, which I will consider further, as this could be helpful in thinking about why it can be so distressing for females who have never been in an anxious state before, suddenly find themselves almost disabled by it. I suggest it is the 'emotional conflicts' that Benedek (1950 p.13) spoke of which require a psychoanalytic framework however, it was not a theory of menopause in women. I am going to suggest a life stage which is specifically female and related to the *menopause transition*. I will also explore whether the life stage of menopause can be related to puberty.

In Erikson's (1980) eight life stages he considers stages beyond the age of 12 which allows for further development throughout life until death. Increasingly, as he himself aged, he continued to review his work which his wife continued after his death. Joan Erikson (1998) published an extended version with the addition of a ninth stage to encompass the ninth decade of life, after their experiences showed them that it was a stage they had been unprepared for. The review was based on age and not on the diversity of experiences that comes with gender. There was no difference between men and women's experiences in any of the stages and no mention of menarche or menopause nor how these specific transitions might have an impact on the life

stages for women. In this research, I will consider the life stages of Freud and Erikson and to suggest how menopause could be thought about in these terms.

During my lifetime I have heard women's reproductive health described in negative terms with menstruation referred to as 'the curse' and menopause referred to as 'that time of life'. I have often observed when women act in a certain way, stressed, anxious, angry, challenging, they can be dismissed and thought to be 'hormonal'. When clients talk about these feelings in the analytic setting, they might explain them by framing them in the context of 'having their period' or 'it's just menopause' and it does not always get explored from a psychoanalytic perspective. In this research, I am seeking to foreground the *menopause transition* as a life stage; its meaning for clients, how it can be thought about, not simply in terms of the experience but what that experience actually means, and how that can be more fully understood for each individual female as they will experience menopause in a different way, and it will have a different meaning for all, with my conceptual framework through a psychoanalytic lens. While it is important to note that not every female will experience symptoms either physically or psychologically, for those who enter the clinical setting, searching for understanding menopause is important, and to be able to offer an analytic environment where they can access an experience that will be meaningful.

There have been a number of authors who have written about their observations from a theoretical perspective in relation to the menopause which I will be looking at in the literature review. I will review theories and presentations from the clinical setting investigating the transferential dynamics between client, therapist and researcher where I will also be thinking about this stage in relation to life stages to create a psychoanalytic theoretical framework.

1.2 Research Title

My research title is: 'The meaning of menopause in the consulting room and psychoanalytic thinking on a menopause life stage' I hypothesise that there are disparate elements of going through the menopause that some female clients may experience which can be thought about analytically to create a theoretical framework, and propose an addition to the life stages.

1.3 Research aims and objectives

In psychoanalytic writing menopause is underrepresented, with little or no research of therapists and their experiences of clinical practice working with female clients who experience menopause whilst in therapy. Any natal female born with a uterus will go through menopause, either naturally or surgically. It therefore seems essential to be considering what those clients may be presenting with and that professionals are prepared to be able to explore the impact of menopause effectively.

1.4 Significance and contribution

This research will contribute to the profession and psychoanalytic community as it will introduce new ways of thinking about this demographic of the client base. This contribution to current thinking will be to foreground the relevance of exploring in depth the personal and individual meaning of menopause for each client. In psychoanalysis there is little offer of a theoretic framework to work with those who experience an emotional impact when they go through the *menopause transition* and there is no specific life stage which has relevance for the client who cannot regulate her psychological, emotional stress along with the physical and biological aspects of it. This research has the potential to widen the conversation on how females are thought about psychoanalytically when traditional theories such as castration anxiety and penis envy can be seen as phallocentric and life stages are limited to generalised

thinking based on age with no specific consideration given to gender. In a recent review of NICE guidelines on the treatment of menopause there was no representation on the panel from a psychoanalytic or psychodynamic body which makes it difficult for the conversation of which therapeutic treament is most effective, resulting in CBT being the recommendation for treating the symptoms rather than the meaning of it.

1.5 Brief methodological overview

In Chapter 4 (see p56) I discuss my preference for a qualitative approach to understand meaning and give results that I could consider against my Conceptual Framework from Chapter 3 (see p37), I discuss my choice of Reflexive Thematic Analysis (Braun and Clarke 2006, 2022) as a methodology to explore the understanding and meaning of other therapists' work, what their clients presented consciously or unconsciously and the transference dynamics between researcher, research participant (therapist) and client.

1.6 Thesis Structure Outline

In the next Chapter, I discuss the literature available on menopause, taking into consideration writings from Sigmund Freud and his thoughts on anxiety neurosis and his limited ideas of menopause. I consider the progression in the writings of Helene Deutsch, Terese Benedek through to the more modern writers such as Sandra Bemesderfer, Anne Zakary, Susan Kolod, Dinora Pines, Ruth Lax and Sarah Bemesderfer. While the writings and ideas were indeed progressive and did put a spotlight on the lack of women in psychoanalytic theory, there was no formulation of a framework on which to build this work, with no consideration of how limiting the life stages have been. In Chapter 3 (see p37) I create my Conceptual Framework based on psychodynamic and psychoanalytic thinking and suggest a parallel life stage that would locate the female experience of menopause. Considering theories from the works of

Freud, Klein and Bion, I use my experiences of clinical practice with some subjective experiences to suggest a way of using transference and countertransference along with curiosity and taking into consideration the wider social and cultural contexts that can be relevant to particular clients. In Chapter 4 (see p56) I discuss the methodology used in this research. In Chapter 5 (see p71) I present the results of my findings using data of verbatim excerpts from the transcripts of each interview and how they relate to specific sub-themes. In Chapter 6, I set out my sub-themes and overarching themes as determined from analysis of the dataset. In the following Chapter 7 (see p119) I analyse the results presented in chapter 6, discussing the themes, results, and how they relate to my original conceptual framework. I explore my findings and how they demonstrate the need for a theoretical framework, which I proceed to explore linking to analytic theory. I consider the life stages and how a parallel life stage specific to women can be thought about.

In the closing Summary Chapter (see p143), I give a brief synopsis of the research, drawing together the chapters and summarising the conclusion. I finish with suggestions for two potential future research projects based on this research, which would allow for fuller exploration in more details of ideas and thoughts that emerged from the results and discussion chapters.

Chapter 2

Literature Review

2.0 Introduction

In this chapter I will review literature that relates to this study of how menopause manifests in the consulting room and how this can be thought about in relation to a psychoanalytic theory and life stage of the menopause. I suggest that there can be a psychoanalytic way of understanding this stage in a female's life which may be utilised when working within a clinical analytic setting.

There has been a great advance in thinking about women's health and well-being in relation to the menopause, however, evidence shows that not much has appeared in the psychoanalytic world. I have noticed in my clinical practice that often clients going through the menopause access HRT or alternative supplements to relieve the physical symptoms and some anxiety or low mood which helps for a while, but they are still faced with the stranger in the mirror and what some report as the stigma of "being old". As Benedek (1950 p14) states, 'While hormones usually alleviate the Vaso-vegetative symptoms, they do not resolve the emotional conflicts without adequate therapy.' And I suggest it is these 'emotional conflicts' which require a psychoanalytic framework. NICE guidelines which were reviewed in November 2024 recommend 6-8 sessions of CBT and while they were reviewed in 2022 it was somewhat restrictive in only reviewing the use of different modalities of CBT with no discussion about the efficacy of CBT in comparison to other modalities of therapeutic interventions. There was also no representation from any of the psychoanalytic professional bodies.

While there appears at first to be little written about the psychoanalytic understanding, there have been a number of authors who have written about their observations from a theoretical perspective in relation to the menopause, which I will be looking at in this literature review chapter. In reviewing these theories, and considering presentations in the clinical setting from female clients who are going through the transition of menopause, I aim to create a way of thinking based on psychoanalytic theory. It seems that some literature confuses and combines or uses the term climacteric and menopause interchangeably and I shall do some analysis on this. I suggest that an understanding of the climacteric stage is necessary to be built on and how this can be seen as relating to the menopause as a life stage. I am going to be suggesting my own conceptual framework for thinking about a definition relating to the *menopause transition* that I will outline in the next section. I begin this section thinking about Freud's concept of the climacteric and menopause as stages, what this means and consequent writing on these stages. I will then discuss Erikson's life stages and their relevance to this study. In addition, I will explore if this life stage of the menopause can be related to puberty and other stages of development. Michaela Chamberlain (2024) challenges misogyny in psychoanalysis in her recent book and while there is no mention of menopause, she does dedicate a chapter to 'the missing period in psychoanalysis'. Other authors have made such challenges such as works written by such pioneers as Rosemary Balsam, (Women's Bodies in Psychoanalysis 2012) , Ruth Lax (Becoming and Being a Woman, 1997), Helene Deutsch (Psychoanalysis of the Sexual Functions of Women edited 1991) who first published The Psychology of Women vol1 in 1944 with vol 2 in 1945. In 2010 Dinora Pines published A Woman's Unconscious Use of her Body: A psychoanalytic perspective, with one chapter dedicated to menopause while in 1990 Ruth Formanek edited The Meanings of Menopause: Historical medical and clinical perspectives with contributors from the fields of psychology, psychiatry, nursing and psychoanalysis. Therese Benedek published a volume of papers, Psychoanalytic Investigations,

(1973) based on her work and research considering the relationship between hormones and emotional states in women from her psychoanalytic perspective.

2.1 Climacteric

In the psychoanalytic world, the climacteric stage has previously been referred to in more generic terms in regard to thinking about men and women's experiences, for example, Freud (1894) makes reference to it in both males and females as an anxiety neurosis that occurs at a certain age, an age he does not specify. Gender specificity has been completely overlooked in Erikson's psychosocial stages neither does he include a stage that refers to the climacteric. The word climacteric can be translated from Greek word 'klimax' as 'the round of the ladder', that is the 'top', so it is a period of having got to the top of the ladder of life and now looking down; or from another Greek word 'klimacter' as a 'critical period' depending on where you source the meaning. This word climacteric is important to hold in mind because it is used interchangeably with menopause in psychoanalytic literature, but it does not specifically speak to the female experience and the change in fertility, or the meaning related to that. Menopause can be translated from the Greek words 'menos' translating as 'month' and 'pausis' meaning 'cessation or pause'.

Both terms have been used to discuss this stage, but it is important to keep in mind that normal menopause usually occurs in mid-life when it is considered females transition through a life stage referred to as the climacteric stage. Susan Kolod (2010, p82) is more definite in her assertion that, 'the psychoanalytic term for menopause was the climacteric or top step of the ladder'. Ruth Formanek (1990, p5) who adheres to the meaning of 'cessation' of 'monthly' periods makes a clarification with her definition of menopause as the 'final cessation of menses within the climacteric phase'. This definition can be deceptive, as while menopause usually

occurs between the ages of 45 and 54 with peri menopause starting possibly in the early forties, premature menopause happens from late 30's and surgical menopause is non-age related. So, here I will refer to the *menopause transition* rather than using the term climacteric or refer to any of the specific stages of menopause.

2.2 Freud's concept of the Climacteric and Menopause

I will begin by looking at Sigmund Freud's original psychoanalytic conceptualisations of both climacteric and menopause in his writing, and how these will form the foundation of my study of a conceptual framework of working with female patients in psychic distress in menopause, from a psychoanalytic perspective.

In Incidence and Aetiology of Anxiety Neurosis (1894, pp99-106) Freud first mentions climacteric 'as anxiety in the climacteric during the last major increase of sexual need' in his theory of anxiety neurosis where he suggests 'it will be advisable to consider males and females separately'. This is an interesting observation that while the climacteric can be a concept applied to both men and women's experience; they will both have a different presentation and be considered in diverse ways. The use of the term for males and females suggests the climacteric is not specific to females and therefore not specific to menopause.

In general, Freud's basic theories did not appear to have a gender specificity however, here he does introduce the thought that the female and male psyche require viewing through a different lens. What I am concentrating on in this study, is making a clear distinction between climacteric and menopause, and that the stage of menopause is a specifically female experience which is not always specific to an age-related time in their life. A stated earlier, women can be pushed into menopause due to a surgical intervention, or some treatments of cancer can also cause an

early menopause. Freud's first mention of menopause appears in Types of Onset of Neurosis (Freud 1912a p236), where he relates to a libidinal increase which seems to infer an increase of somatic or sexual excitation, 'It is well known that more or less sudden increases of libido of this kind are habitually associated with puberty and the menopause with the attainment of a certain age in women'. There is no reference to how 'well known' this theory was nor any explanation of the introduction of considerations on the linking menopause to puberty. However, here he is making a link between puberty and menopause, along with his thinking of the female's biology at any age causing their neuroses. This is a valid point in linking the two stages in the female life cycle and I will explore this further. While I accept there is a link that can be made to the effect hormones can have on the psyche, I am not in agreement that the sole cause of psychological distress is the result of biology and I suggest the link between puberty and menopause is more to do with the transition from one life stage to another. Freud (1917a) goes on to include menopause again in his lecture on Anxiety, in his General Theories of Neuroses Series, with a similar theory based on an episode of increased libido being replaced by anxiety (Freud 1917a p403) linking to puberty and menopause states.

He states in the Question of Lay Analysis (Freud 1926) that a neurosis caused by an 'enfeeblement of the ego' can appear as a result of an illness quoting menstruation and menopause as such an illness. He states,

> if the relative feebleness of the ego is the decisive factor for the genesis of a neurosis, it must be possible for a later physical illness to produce a neurosis, provided it can bring about an enfeeblement of the ego……. The normal model of such processes is perhaps the alteration in women caused by the disturbance of menstruation and menopause". (p242)

He seems here to be suggesting the neurosis is due to an illness rather than a life stage transition. I do not agree that menopause or menstruation are illnesses. In retrospect, in 1926 the studies and development of women's biology and health matters were considerably less than today so we must take these theories in the context of their time, societal views and culture of how women were regarded.

Freud's seemingly final mention in publication of menopause along with puberty is in Analysis Terminable and Interminable (1937) regarding a diminished, 'enfeebled' ego resulting in a reaction that cannot be managed in the manner it would usually. He states,

> in a normal person any solution of an instinctual conflict only holds good for a particular strength of instinct, or, more correctly, only for a particular relation between the strength of the instinct and the strength of the ego. If the strength of the ego diminishes whether through illness or exhaustion, or some similar cause, all the instincts which has so far been tamed may renew their demands and strive to obtain a substitutive satisfaction in abnormal ways. (p225-226)

I pick up this theory of anxiety and use this as the basis for what may be happening in that transition between life stages with the struggle of the ego in the management of a disturbance in general rather than specifically of a sexual nature. In this chapter of Analysis Terminable and Interminable, Freud (1937) is reviewing theories, and of particular interest to me in this study, the idea of 'permanently disposing of an instinctual demand' (p226) which he states is impossible and in fact it can only be 'tamed'. He states that,

> Twice in the course of an individual development certain instincts are considerably reinforced: at puberty, and, in women, at the menopause. We are not in the least surprised if a person who was not neurotic before becomes so at these times (p226).

I suggest he is saying that during these transitional times for a female in particular, instincts that have been manageable previously become less manageable due to the ego becoming 'diminished' from a change in the balance of hormones, therefore being applicable to both the stage of puberty and menopause and not directly relating to age. These theories will form the basis of my study into building a conceptual framework to base clinical psychoanalytic work with female patients at the stage of menopause as it relates to an initiation in hormonal decline and not related to climacteric age-related stage.

From what initially appeared as Freud not writing very much on the climacteric stage or menopause, I put forward that he did have the basis of a theory and I will consider this further, and how this could be helpful in thinking about why it can be so distressing for females who have never been in an anxious state before and suddenly find themselves almost disabled by it. I will be drawing upon these ideas in my study to how psychoanalytic theory can be considered in the work with female clients who experience psychological distress due to menopause.

2.3 Erikson's life stages

Erikson's life stages have been of interest in looking at his view of this stage of adulthood and his definition of some of the benefits along with the difficulties. Although he has the life stage of aged 40 to 65 years as one of 'Generativity vs. Stagnation' (Erikson 1980), there is little detail in this, and it lacks any theory around the type of experiences that I have observed in clinical work. Erikson's life stages completely overlook the menopause stage for females. In his stages he gives little consideration between gender or the intricacies of this stage of life in particular. So, while they can be helpful in thinking about stages of life they are limited and are perhaps more related to sociological perspectives. It can be considered as he often reviewed his eight stages that he may have come to consider more work was required with the gender

differences. Joan Erikson (1998) published a new edited edition of the stages of the life cycle adding a ninth stage as both her and Erik themselves experienced their eighth and ninth decades giving them insights and a lived perspective they had not considered previously. Interestingly it was only through doing this research that I found this book and realised that the original stages had been created by Erikson and his wife.

2.4 Post-Freudian

I will now look at contemporary concepts of the menopause, to take these into consideration as a source of data that I can draw on when considering a psychoanalytic theory of the menopause stage within which I will suggest are substages that females can inhabit as positions. The search for literature was difficult as there has not been much published and of the material found, menopause was at times only referred to in passing. Also, the interchangeability of the words menopause and climacteric necessitated in a full search for both with little outcome in results for either word. This lack of study has been discussed in some of the literature with possible or assumed reasons being the feeling of the topic being taboo, females feeling shame, or cultural and societal misogyny. Whatever the reasons may be, it appears to be important to be thinking about this now that the topic has a public focus and no longer carries the taboo aspect of it. I consider it important to not just write about the topic but to create a meaningful psychoanalytic framework that will be of use going forward bringing the topic into the foreground of the psychoanalytic world.

2.4.1 Helen Deutsch

Deutsch was the first female psychoanalyst who wrote about female psychology in a book published by Freuds publishing house in 1925, which Freud cited on two occasions (Deutsch & Roazen 1991 xi-xii). The collection of papers in her book has been edited and translated in

1991 in which Deutsch commits a chapter to menopause (Deutsch& Roazen 1991). She stated her theories as,

> the vagina gives up the struggle, and a regressive re-cathexis of the clitoris as the centre of excitation, there is a regression to the phallic phase, or to that first period of puberty in which the vagina has not yet assumed the leading role (p109).

Again, here we have a theory linking the menopause to the stage of puberty, and how well or not the anxiety was manged then as she states, 'I have the impression that menopause is more easily coped with the more successfully puberty was coped with' (p109). Her relating sexualised excitation remains close to Freud's ideas which she develops with a focus on the female anatomy.

Deutsch (1991) makes links to the Oedipus complex where the focus of fantasies changes to the mother's relationship with the son rather than the son's relationship with the father seeing it as 'it is really an altered, modified new edition of the latter, or, let us say, an epilogue' (p112).

2.4.2 Therese Benedek

In 1950 Therese Benedek wrote of hormone replacements 'they do not resolve the emotional conflicts without adequate psychotherapy' (Benedek 1950 p13). In recognition of the facts that the physical symptoms can be altered with medication but not the psychological disturbances. While she defends the use of the term 'climacterium' she does discuss the term interchangeably with menopause. For much of this paper she focusses on the menstrual cycle citing the link between the 'psychic adaptations' in both instances. Much of Benedek's clinical work was with female patients referred from gynaecology (Kolod 2010 pp86-87). It is reported that she could tell by their reporting of dreams where in their cycle they were. In her work she states how the lack of hormones reduces the ability of the ego to 'adapt' to stresses which is seen in the monthly cycle and even more evident in menopause. This is in line with what Freud spoke of

across his many lectures and written work in the ego's reduction in functioning and 'adaptability'. To finish, Benedek discusses the more optimistic 'other side' of menopause when the woman successfully after psychoanalytic investigation makes the transition to a more mature self, becoming more social, engaging in more interests and achieving goals previously not considered. I was still left uncertain regarding the difference between her definition of climacteric and menopause. While I found the paper interesting, the focus was directed to her work with patients and their menstrual cycle although the connections she makes are valid. I accept there may be links, but I am searching for specific theory relating to the menopause and clarity between the menopause and the climacteric stage.

2.4.3 Sandra Bemesderfer

Bemesderfer (1996b) is clear in her position of,

> menopause is a developmental phase during which significant changes in physiology imply concurrent changes in conscious and unconscious self-assessment and fantasy…. the emotional experience of menopause typically involves two types of castration fears, both the classical phallic castration complex and the feminine castration anxiety (p352).

She proposes in the castration complex experienced by girls they have a belief that they have lost their penis. She sees the traditional castration complex view of the girl accepting this as a loss finding solace in replacing the penis in identifying with mother and the ability to have a child i.e., giving birth; with an alternative view of the feminine castration anxiety in that the girl finds solace in becoming womanly with menstruation i.e., the ability to get pregnant. Hence menopause gives cause for 'an unconscious reworking of aspects of her maternal identification' (p358) resulting in the reappearance of the feminine castration anxiety with the loss of being able to get pregnant. In her case study she concludes that in working through these complexes relief from emotional distress can be found, with a 'reassessment of one's role as a woman…

feeling states and related fantasies about one's body and one's sexuality' (p368). Perhaps as the original complexes had losses which were able to be managed by ego this stage will require the same working through of the mourning of what had been previously gained has now been lost.

These texts from Freud, Deutsch and Benedek are the most cited in the research I have undertaken for this study so to summarise so far, I suggest there is a building upon Freuds theory of the 'enfeebled ego' and Benedek's 'adaptive ego' and the ego's struggle with increased sexual excitation which Deutsch proposes comes as a prelude to the pubertal and menopausal hormone changes. Bemesderfer appears to propose that the working through of the loss of the replacement penis which in childhood is the childbearing ability and menstruation in teenage years, and the space it leaves when menstruation ceases, to be filled with a new creative identity.

2.5 Contemporary Concepts

2.5.1 Anne Zakary

Anne Zakary (2002) places her attention on envy and the 'awareness of the inevitability of death' (p27). In her clinical examples of clients from clinical practice she explores 'what lies at the root of her suffering is the intense envy she cannot face' and 'progressing… inevitably involves loss and particularly so at the menopause when the direction is involutional' (p30). She relates to the word 'luggage' frequently as a metaphor for what the clients feel to be 'carrying around' and a feeling of resentment of having to relieve themselves of this luggage. At each stage of the reproductive cycle, she sees 'an opportunity to confront one's own death because of the loss involved' (p33) but with this loss she acknowledges there appears the chance for a new beginning. This is a more positive view of coming through to the other side of menopause after the intense work has been done.

2.5.2 Susan Kolod

Susan Kolod (2010 p79) considers self-states as a way of thinking about the hormonal experiences quoting Bromberg (1998 p245) 'a self-state is an internally coherent aspect of the self… with its own narrative, its own memory configuration, its own perceptual reality, and its own style of relatedness to others'. Kolod's ideas of self-states brings an interesting focus to working with the fluctuations of hormones and the psychological responses to them. This has been evidenced with Benedek's work and here Kolod also discusses the work of Katharina Dalton (1964) which confirms agreement with Benedek in the effect the fluctuations of hormones in the female body do have a direct influence on the psychological experiences. She concludes 'the premenstrual phase is a time of increased vulnerability and fragility – both physically and emotionally'. I am suggesting here the evidence presented in past research that points to the connection between the body and mind can be included as a subject of psychoanalytic enquiry in the conceptualisation of a psychoanalytic framework, for working with female patients going through the *menopause transition* from the peri-menopause stage to post-menopause.

2.5.3 Dinora Pines

Dinora Pines writes on the work between female clinicians and female patients in her book of presented papers (Pines 2010) although only one chapter is given to menopause. Coming from an object relations perspective she considers the relationships between mothers, mothering and daughters and the losses that are experienced with the changes occurring in those relationships along with the relation with one's own mortality. Some of these outward physical symptoms can be managed with HRT, such as managing hot flushes, bringing vitality back to skin, reducing hair loss and ease joint pain which can help however, the psychological impact of loss

was key in her thinking. The anxiety of adolescence returns as they are triggered by the fluctuation of hormones and the mourning that is experienced when faced with having to let go of, moving out and leaving behind one life stage before being able to move successfully into the next new life stage. Pines (2010) states an optimistic view in

> adult psychological growth continues throughout life and is bound neither to biological development or decline. The experience of loss and mourning for an earlier phase of development can therefore eventually be liberating. (p128)

Interestingly Pines was the first author who spoke of transference in the work (p135), and countertransference (p138) which does not seem to have been considered previously. In my opinion this is an important aspect to include in the creation of a framework as such an integral part of psychoanalytic thinking informing the unconscious communications of what cannot be put into words. She describes a patient reporting in a clinical case that 'middle-age felt like a masquerade. Beneath the mask of her aging face and body there still lay the young woman of her earlier body image' and the working through these difficult feelings to the point of 'new possibilities of sublimation and creativity gradually appeared, and the deep pain and mourning came to an end'. I agree with Pines' theories of loss and envy and her conclusion that 'such mourning, if it can be worked through and completed, may lead to fresh areas of creativity' (p138).

2.5 4 Laura Wolf de Souza Mondrzak et al.

As one of the more current pieces of literature, this group (de Souza Mondrzak et al. 2021) has a predominant focus on Freud, Deutsch and Laznik. They consider the importance of the Oedipus complex from the perspective of Deutsch seeing it as the third time this is experienced and although they do not say it is specific to females, I suggest it does present in men at this age-related stage in life. They say it is

> a reprint of the... Oedipus complex, initially described by Freud, but with some modifications… the menopausal woman, once a mother, would revive the oedipal complex with her son, in a position that would imply incest. (p145)

They go on to consider Laznik's writing (ibid 2021 p149) and his ideas of Jocasta's 'turning a blind eye' to the fact that Oedipus was in fact her son. The theory seems an interesting one that puts Jocasta in the light of a main character rather than a supporting one. As we have read from earlier authors the idea is not new that women, in an attempt to hold onto youth and beauty. become interested in younger men (which we also see in men shifting focus to younger women for the same reasons) however this is an interesting association to Jocasta. The study proceeds to consider the fragility of narcissism and the feminine identity which is much in line with what has been said before, so while it is interesting there is not suggestion of a framework for this analytic work.

2.5.5 Sarah Benamer

Sarah Benamer (2021) writes about menopause and hysterectomy from a personal perspective which she is very transparent about, and this gives the writing a different feel to it. She suggests menopause can often be ignored or not picked up in the work as it may not be the presenting problem,

> if you listen carefully the menopause comes through in fearful asides about the future, the recapitulation of stereotypes; anxiety about bodily change, self-denigration and blame; the request for a fan in the room, feelings of physical and psychological loss, relief at the absence of periods or menstrual pain, no longer having to use contraception, or confusion at a female partner changing (p244)

and that the work is about giving 'support to process the meaning of these experiences.' She claims what is required for females at this stage is to,

> map what gender means for them, bodily and emotionally, and to hold a tension that allows them to explore possibility beyond biological determinism as well as recognise the influence that these ideas have had upon them…. To restore unity of self through integrating body narrative in relationship with a trusted other (p247).

This is the closest I have read of an author thinking of a particular way of working with the menopause stage. Benamer concludes with what I seemed to respond to from my own countertransference to her paper as a call to arms which in itself may appear to be a strange reaction but perhaps a reflection of my sense of need to undertake this research at this time. She states,

> To break the taboo of menopause and shatter some of the stereotypes that haunt or caricature women… metabolise the 'not-knowing', regret, anger and shame…. not to scapegoat hormones…we will not foreclose on the creativity of their meaning making in favour of stereotype or clever interpretation…. To empower them to put a voice to what is already known (p251).

Here we have Benamer's confirmation of the need for a specific theoretical framework for this patient group.

2.6 Menopause and a conceptual framework of psychoanalytic theory

I recognise from my own work with female clients in my clinical practice who talk of their increase in anxiety while transitioning through the menopause, the need for deeper exploration of the current literature, a proposal of a way forward and to suggest a theoretical framework for this work should it present itself in the consulting room of other practitioners.

I suggest the following theories are important in the creation of a new framework; the exploration of the link between bodily hormonal changes and the impact they have on the psyche; links between puberty and menopause rather than specific age-related issues;

considerations given to revisiting the Oedipus complex with a new focus on Jocasta as the main character in this revisitation; loss and mourning the previous life stage; moving on from the envy of others who still have youth and fertility, and the development of a new identity. The working through of these difficulties will include the considerations and theories of anxiety, castration complex and feminine identity and what meanings they have in todays practice; the idea of revisiting of the Oedipus complex with a new focus on Jocasta; Ego strength, the diminishment of the ego, enfeeblement of the ego and the ability one had in managing excess excitation in the past and the impact on the present management of anxiety or adaptivity to an increase of it; the understanding of one's own identity and envy of others and what it means to be female in our society, culture and personal circle of family, friends, colleagues and most importantly one's self. To create a psychoanalytic framework, I will study a number of theories including those from Freud, Klein, Bion and Winnicott. To begin with I will consider Freud's theories of anxiety neurosis, castration anxiety, and the Oedipus complex with a focus on Jocasta, in addition to his theory on the reality and pleasure/unpleasure principle and how these theories relate to current thinking and practice specifically regarding work with females in a life stage of menopause. I will consider Freud's psychosexual stages along with Erikson's psychosocial stages of the life cycle and how menopause can be thought about as a transitional life stage. I will consider Melanie Klein's view on anxiety, identity, envy, paranoid schizoid and depressive positions as theories of interest with the disturbance the reality principle brings, as it throws the client into a paranoid schizoid position when in the emotional distress of this stage. Following on from Klein I will examine Bion's writings on linking, thinking, and 'containment' which I suggest will be of use in helping clients think from a new perspective and in them learning how to think when in a place of being flooded by beta elements. Also, I suggest the exploration of thinking may help patients become creative about the transition into their future 'self'. And finally, I will explore Winnicott's thinking on identity, and his writing

on ego distortion and true and false self, as theories of the development of self-worth to consider when working with the female clients who have unmanageable anxiety at this stage of menopause.

2.7 Conclusion

In this chapter I have reviewed the psychoanalytic literature relating to menopause and the climacteric in order to establish the theoretical ground upon which this study is built. While menopause has been referenced across psychoanalytic writing it has rarely been developed as a distinct conceptual focus. Freud's discussions of the climacteric and menopause, particularly in relation to anxiety neurosis and the "enfeeblement of the ego", provide an early foundation for thinking about transitional periods in which instinctual demands intensify and ego capacity may temporarily diminish. Although brief, these ideas offer a basis for understanding the psychological disturbance that can accompany hormonal change.

Post Freudian authors including Deutsch, Benedek and Bemesderfer develop aspects of hormonal change, castration anxieties and the reworking of maternal and feminine identifications. More contemporary writers such as Zakary, Kolod, Pines, de Souza Mondrzak and Benamer further explore themes of loss, envy, narcissistic vulnerability, regression, identity disturbance and the potential for creativity following mourning.

Despite these contributions there remains no cohesive psychoanalytic framework that brings these strands together for consistent clinical application. It is this absence that the next chapter seeks to address through the development of a conceptual framework grounded in psychoanalytic theory.

Chapter 3

A Conceptual Framework for thinking about the Menopause.

3.0 Introduction

In Chapter 1 (see p12) 'Introduction and Background' I have presented the background and introduction to this research project, and in the previous chapter (see p20) 'Literature Review' I presented a literature review of available texts from a variety of theorists and clinical practitioners that are important to consider. In this, I consider the menopause as a life stage that has a specific feminine element to it and explore how that can be thought about in relation to Freuds psychosexual stages and Eriksons psychosocial stages of the life cycle. I put forward key concepts and theories of Sigmund Freud, Melaine Klein and Wilfred Bion upon which I build a conceptual framework for thinking about the menopause within a clinical setting. I will then draw connections with my clinical experiences of working with female clients who have discussed their emotional distress while going through the menopause transition. The clients will be disguised and referred to as Client L, M and N and have given consent in line with the Ethics Approval process.

To create a psychoanalytic framework, I put forward a number of theories including those from Freud, Klein, and Bion. I consider the use of Freud's theories of anxiety neurosis and his idea of an enfeebled ego and how these theories relate to current thinking and practice specifically regarding work with females in the life stage of menopause. I consider Melanie Klein's view on envy, the defences of splitting and projection as the *menopause transition* seems to throw the client into a paranoid schizoid position when in the emotional distress of this stage. Following Klein I consider Bion's writings on thinking, the building or strengthening of the

client's thinking apparatus to assist the client's ability to process thoughts and regain the ability to think for themselves when in a place of being flooded by overwhelming feelings.

While Freudian, Kleinian, and Bionian theories differ in many areas, including socially, culturally, and psychologically, they are intentionally chosen to consider how menopause can be identified and worked with in psychoanalytic terms in this study. Freud offers an account of anxiety and ego disturbance at key developmental junctures in which he includes puberty and menopause; Klein illuminates defences and transferences as they are demonstrated in the clinical material discussed here; and Bion provides a framework for understanding how thinking can become compromised and subsequently restored within the analytic relationship. The use of multiple theorists and theories can be seen as cherry-picking; however, each provides a sequence and function that reflect the multi-layered nature of the menopausal experience as it has appeared in the interview data and in my clinical practice.

In acknowledging the differences between developmental and psychoanalytic models in this research, developmental thinking is referred to in the exploration of recognising menopause as a developmental stage, one that can be experienced as traumatic. I am not considering developmental theories in the creation of a psychoanalytic framework to aid therapists in their work with women who experience menopause in such a traumatic way.

3.0.1 Contextualising theories presented

In this study I will use the terms 'transference' and 'countertransference' in their psychoanalytic sense as forms of unconscious communication that emerge within the therapeutic relationship. Transference refers to the ways in which a client brings their internal world into the room and locates it in the relationship with the therapist. While this includes

the repetition of earlier patterns of relating, in the context of the menopause transition I suggest transference also can be seen as a way of managing what cannot yet be thought or spoken about: experiences of loss, disconnection from the self, and anxieties linked to bodily changes may be brought inot the relationship unconsciously through projection and projective identification (Klein, 1946) The therapist can be seen as if they are the needed object – an explanatory, maternal or containing presence – through whom the client attempts to restore agency and meaning during a period of psychic disequilibrium. Countertransference refers to the therapist's emotional, bodily and cognitive responses to the client and the therapeutic situation. In line with Heiman's (1950) view, I understand countertransference not only as a likely disruption but as a central clinical instrument; the therapist's feelings can provide access to what the client cannot symbolise. In Bion's terms, when the client's capacity to think is compromised and unprocessed "beta" elements take over, the client may require the therapist's mind as a temporary thinking apparatus; the therapist's task is to contain, metabolise and give back the experience in a more manageable state, supporting and strengthening the client's capacity for thinking and integration (Bion, 1962/ 1970). Where countertransference remains unexamined, therapist and client may collude with denial or avoidance, particularly in relation to the emotional meaning of menopause; where it is thought about, it supports linking, mourning and the gradual reintegration of split-off aspects of the self. In this study I therefore treat transference and countertransference as key routes through which the psychic meaning of menopause enters the room, sometimes directly, and sometimes through acting out, disruptions in thinking, or relational pressures that signal what cannot yet be acknowledged.

3.1 Thinking of menopause in terms of a life stage

If one thinks of a natural menopause as a life stage it can be seen as part of human development and part of the changes that occur naturally as a prelude to the stage of older age. As menopause is a natural part of the ovulatory cycle that anyone born with a uterus will go through, it can therefore be thought of in relation to puberty: In puberty, menstruation begins as the body develops to become fertile and in menopause it ends with a loss of fertility. Both processes take varying lengths of time to go through and vary in severity of symptoms and individual psychological meaning.. Instead of viewing menopause as a distinct new stage of life, it may be more helpful to think of it as a significant developmental transition. Similar to the experience of puberty, menopause brings an intensity that can unsettle established ways of being, in terms of identity and how one experiences the body and relationships. The changes that occur can reactivate earlier conflicts and unsettle what once felt familiar and stable, but they also open up the possibility for new ways of integrating body and mind. In this way, menopause is less a separate stage and more a point where earlier patterns are brought back into focus and worked through, this time within a body that is itself changing.

One of the strong concepts that has come out of this research is that as individuals the stages as they have been considered can be seen as restrictive and do not always allow for individuality especially gender. Bemesderfer (1996a) takes a similar position that ‘menopause is a developmental phase during which significant changes in physiology imply concurrent changes in conscious and unconscious self-assessment and fantasy’ As discussed in Chapter 1, an early menopause can occur as the result of surgery or a particular treatment for cancer so it may not follow the natural flow through into the next expected life stage, but one can be thrust prematurely into an unexpected and unprepared for menopause. So, while thinking from the perspective of this life stage for those premature menopausers there will be additional complexities as they will not be following the ‘natural’ flow through the life stages.

3.2 Freuds psychosexual stages

I am suggesting the importance of considering both Freud's Psychosexual Stages and Erikson's Psychosocial Development Stages and the connection I am making to the menopause stage. Freud's Psychosexual Stages were introduced in the Three Essays on Sexuality (Freud 1905) which he continued to repeatedly review; however, they still have clear limitations. I see two impediments in his Genital Stage ranging from puberty to death: One is he did not consider nor name the differences between male and female experiences throughout the stages along with the gender specific changes that occur except for the Oedipus Complex. The second point being that he promotes that we would be sexual beings until death when in fact menopause and the decline in hormones can cause a severe reduction or disappearance of libido for many women. I acknowledge here that some men can experience a decline in sexual interest with decreasing levels of testosterone over a longer time and a more gradual process which can lead to erectile dysfunction due to the male Andropause, however this cannot been considered in any depth in this project due to the focus here on menopause. Here we can keep in mind that when Freud was creating his theories, they were referring to psychosexual development and therefore there are distinct aspects of importance to consider. It is during the Latency Stage from the age of six until puberty, that the superego continues to develop while the id's energies are suppressed. I see in clinical settings clients in perimenopause presentation of the ego becoming enfeebled and the id has regressed. In latency, children develop social skills, values, and relationships with peers and adults outside of the family. This is a time of exploration in which the sexual energy is repressed. This energy is still present, but it is sublimated into other areas such as intellectual pursuits and social interactions. Once in post menopause when the id energy expands rather than disappearing it includes other interests such as creative activities or academic ventures whilst also still having an investment in sexual activities for many women.

For children in latency, this stage is important in the development of social and communication skills and self-confidence, similarly with those in menopause, there is an increased interest in widening social activities and once the new sense of self has been located a new confidence can appear. Following Latency is the Genital stage, of psychosexual development, from puberty to end of life, when the individual develops a strong sexual interest in the 'opposite sex' which raises a further limitation and would require revision for today's society to be more inclusive of all choices.

3.3 Erikson's psychosocial development stages

Erikson published his life stages much later than Freud in his 1994 book Identity and the Life Cycle (Erikson 1994). The stages I am including in this conversation are Industry v Inferiority and Generation v Stagnation. Erikson's stage of Industry vs. Inferiority echoes Freud's latency stage beginning at the age of six years ending at twelve years old. During this stage, children learn to be productive and to pursue personal interests. Failure and criticism from adults in mastering their own potential may lead children to feelings of failure and inferiority. Children who are encouraged to pursue these activities will experience a sense of accomplishment that usually outweighs the failure. While Freud did not have any later stages seeing the Genital stage ranging from puberty to death Erikson continued with his stages until old age. Erikson's Generativity vs Stagnation stage from age 40 to 65, middle-aged adults strive to create or nurture things that will outlast them. People who have positive relationships with others, decent quality health, and a sense of control over their lives often feel more productive and satisfied. Generativity refers to 'making your mark' on the world by caring for others, as well as through creating and accomplishing things that make the world a better place. Stagnation refers to the failure to find a way to contribute. Stagnant individuals may feel disconnected or uninvolved with their community or with society as a whole.

3.4 Puberty and Menopause

Therese Benedek's (1950) psychoanalytic investigation in her work with women experiencing gynaecological difficulties proposes in menopause there is a transition to a more mature self, becoming more social, engaging in more interests, and achieving goals previously not considered. Dinora Pines (2010) advocates that in menopause the anxieties of adolescence returns as they are triggered by the fluctuation of hormones and the mourning that is experienced when moving out and leaving behind one familiar life stage before being able to move successfully into the next new life stage which may be experienced as unfamiliar at first and too soon. Freud first mentions menopause in Types of Onset of Neurosis (Freud 1912a p236) where he makes a link between puberty and menopause along with his thinking of the female's biology at any age causing their neuroses making a link to the effect hormones can have on the psyche. So, I suggest there is a link between puberty and menopause experiences as they are both affected by fluctuations of hormones and that any distress of an anxious nature is a result of the transition from one life stage to another and what meaning that may have for the client. Client L would go into the toilets and cry hiding until she was able to gather herself and return to her desk after feeling unable to function as well as usual due to brain fog and memory blanks. In the therapy she was able to think about what starting periods was like for her. She talked about her early teenage years in school being distressed that she had developed breasts before others in her class and had her period early. Her mum had not explained what was happening and she felt very scared thinking she was bleeding because something was very wrong with her. It happened in school, and she was found crying in the toilets by a teacher who took time to explain and give her products to use until she got home. The therapist experienced a countertransference of feeling protective and motherly wanting to explain what was going on like her teacher. The client was able to explore that she had been re-experiencing an

exceedingly challenging time when her body was changing, her not understanding the process and feeling unprepared for those changes and perhaps she wanted her therapist to be like her teacher and explain it to her. She began to see that her feeling a lack of control and agency over what she was going through was how she felt as a child but with therapy she did have a better sense of her feelings in the here and now. Her body changes, mood swings with her lack of understanding and preparedness of puberty were similar to her experience of perimenopause. We can see in this example the importance of exploring how puberty was experienced to give us clues as to how the transition through perimenopause to post menopause can be thought about. Therese Benedek (1950) was explicit that women at times of menstruation and menopause a lack of hormones reduces the ability of the ego to 'adapt' to stresses seen in the monthly cycle and even more evident in menopause. This is in line with what Freud spoke of across his many lectures and written work in the ego's reduction in functioning and 'adaptability'. As we have seen evidenced with Benedek's work, so too Susan Kolod (2010) confirms agreement with Benedek in the effect that the fluctuations of hormones in the female body do have a direct influence on the psychological experiences. With early suggestions of links between puberty and menopause rather than specific age-related issues from both Sigmund Freud (1917a, 1926, 1937) and later Helene Deutsch (1991), and how well or not the anxiety was manged then, Deutsch states, 'I have the impression that menopause is more easily coped with the more successfully puberty was coped with' (p111) which may or may not be the case however it would follow that exploring how puberty was managed would be of benefit in understanding this stage of menopause.

3.5 Themes relating to working with menopause in the consulting room

I will introduce examples to show where my themes have originated after which I will go into more detail about theories later in this chapter. The working through of the difficulties

experienced during the menopause journey from perimenopause through to post menopause will include the considerations and theories of anxiety, ego strength, and the enfeeblement of it especially if the client had the ability to self-regulate in the past but unable to in their current crisis. It has been valuable, in my experience, to examine the client's understanding of their own identity, envy of others and what it means to be female in our society, culture and personal circle of family, friends, colleagues and most importantly oneself.

3.5.1 Feeling lost and disconnected from the self

A common theme in the presentations of clinical material is speaking of feeling lost, as they are no longer the younger version of themself and cannot yet connect with the newer version. As with any transition there is a process of mourning the loss of the known before progressing into the unknown and so it is with puberty and menopause. To be able to mourn it is necessary to accept what has been lost. This can bring about an envy of others who still appear to have youth and fertility or indeed their apparent ability to manage menopause without feeling overwhelmed. This process can be difficult to manage without an external 'other' who can offer containment and promote thinking. A brief example of this was a Client M who filled the sessions with feeling lost at work, about colleagues of a similar age who 'had it easy' as she had a higher workload than they had and younger colleagues who wore inappropriate clothes in work and weren't 'as professional as they should be'. Payments for sessions started to be forgotten and needed to be reminded of and the therapist found themself more considered about their own clothes while in their countertransference they realised a feeling they were under assessment. An exploration of the client's feelings of others including fantasies about the therapist and what their feelings might be toward them helped to expose the envy and allow a space to think together and come away from a defensive position of splitting and projecting

into others. The client was then able to appreciate her own value and that of others which helped her to feel less lost.

3.5.2 Menopause stages

Perimenopause is the beginning of menopause and can last from a few weeks to up to ten years. Menopause is a one-day event which is the one-year anniversary of the last menstruation. Once this anniversary has passed the woman enters the post menopause stage. I use the term *menopause transition* to cover all three stages. In my experience I have found that once the menopause can be thought about and the meaning understood there can be a positive outcome with an ability to be playful, creative, and expansive in ways not possible previously bringing a greater sense of self. As with Client M who was able to think about her workload and how it could be managed differently, how she could be more adventurous with how she dressed and how she could be more expressive and playful with innovative ideas in her sessions. This outlook promotes wider social interaction, being creative with new interests or hobbies which interestingly are often from childhood that have been forgotten about in a busy life with studies, work or family commitments and more integration into the community. Many participants described how the psychological work involved in the menopause transition gradually opened up new ways for once constrained energies to find expression, particularly in creative, relational, and intellectual areas. As they worked through the changes, what had at one time felt blocked or unavailable started to appear in new forms, suggesting a change in how energy could be invested.

3.5.3 Sublimation

Participants spoke not only of loss and disorganisation but also of a gradual emergence of renewed sublimatory activity. Drawing on Freud's (1905) idea of sublimation as redirecting

instinctual energy into valued pursuits, it became clear that some clients were able, over time, to re-invest psychic energy that had previously been tied to reproductive identity and relational roles. This process was rarely immediate; it often followed periods of mourning and feeling unsettled. Where there was enough containment, clients began to notice new or previously dormant creative, intellectual, and relational interests coming to the fore. In this way, the menopause transition could be seen as not only a time of loss but also as an opportunity for reorganisation, where energy could be invested in forms of expression less centred on fertility and more open to symbolic and creative possibilities.

This renewed capacity for sublimatory investment also connects with Erikson's (1994) idea of generativity, where development in mid- to later-life involves turning psychic energy toward creativity, contribution, and social engagement that reach beyond earlier identity anchors.

3.5.4 Dreams and Unconscious Communications

When we work with dreams we are working very much with unconscious material which can be extremely helpful and if progestin is prescribed as part of HRT treatment it can increase the dreaming experience. Clients often present dreams that appear to be more vivid than usual with more frequency and often with distinct menopausal themes such as losing something, feeling empty or being chased mirroring the anxieties that come up repeatedly in the work with clients going through the menopause. Freud (1900) in The Interpretation of Dreams stated,

> In waking life, the suppressed material in the mind is prevented from finding expression and is cut off from internal perception…; but during the night… this suppressed material finds methods and means of forcing its way into consciousness. (p608)

As Bemesderfer (1996b) discusses, dreams can be important in the exploration of the meaning of menopause especially when there can be an abundance of material. Client N had a distressing

dream of trying to fill the bath with no plug using sanitary pads to stop the water going down the plug hole. She was feeling her fertility draining away leaving her empty like the bath with no way of stopping the flow. The feeling of emptiness was overwhelming and frightening and once it could be brought into awareness it could be understood. Other ways of working with unconscious material is through transference and countertransference. Pines (2010) was the first author who spoke of transference in the work (p135), and countertransference (p138) which does not seem to have been considered previously. This is an important aspect to consider as such an integral part of psychoanalytic thinking informing the unconscious communications of that which cannot be put into words. As with both Clients L and M in the previous examples, the therapist was able to make use of their countertransference to bring the work to the relationship between the client and therapist to help unpack and understand the dynamics inside and outside the room.

3.6 Psychoanalytic theory related to themes in the work when working with menopause in the consulting room

Now I will discuss the theories presented in the themes in more detail. I start with Freud and his theories of anxiety and mourning. Next, I consider Melanie Klein's theories of envy, splitting, and projection. Following Klein, I focus on Bion's ideas of thinking and containment. While these theoretical perspectives are outlined here in sequence, in practice they are deeply interconnected. Freud's idea of ego vulnerability during times of biological transition sets the stage for understanding how Kleinian processes such as splitting and envy can become more pronounced. What stands out in this research is how Bion develops Kleinian thinking further, shifting attention from what is being defended against to the ways in which the capacity to think about experience can falter. This progression—from Freud's focus on ego strain, through Klein's emphasis on defensive fragmentation, to Bion's concern

with breakdowns in thinking and the need for containment—reflects the clinical patterns that emerged repeatedly in the material.

The theoretical framework guiding this thesis is rooted mainly in contemporary Kleinian and post-Bionian psychoanalytic thinking, with Freud offering the underlying psychoanalytic concepts for understanding anxiety, mourning, and the vulnerability of the ego during periods of biological change. Erikson's developmental ideas are used more as a way to explore issues of identity and generativity that arise in midlife. Throughout the clinical analysis, a Bionian perspective is central, particularly in considering how disruptions in thinking, containment and the gradual restoration of a thinking process unfold within the analytic relationship.

3.6.1 Sigmund Freud, Menopause and the enfeeblement of the ego

As discussed in Chapter 2 Freud's theories of anxiety did not appear to have a gender specificity however he does introduce the thought that the female and male psyche require viewing through a different lens. Freud (1917a) states in his lecture on Anxiety in his General Theories of Neuroses Series and in the Question of Lay Analysis (Freud 1926, p242) he considers a neurosis caused by an 'enfeeblement of the ego' can appear as a result of an illness quoting menstruation and menopause as such an illness although neither are now considered to be an illness. Freud later mentions menopause along with puberty in Analysis Terminable and Interminable (1937, p225-6) regarding a diminished ego resulting in a reaction that cannot be managed in the manner it would usually. I pick up this theory of anxiety and use this as the basis for what may be happening in that transition between life stages with the struggle of the ego in the management of a disturbance. He states that,

> Twice in the course of an individual development certain instincts are considerably reinforced: at puberty, and, in women, at the menopause. We are not in the least surprised if a person who was not neurotic before becomes so at these times (p226).

I suggest he is saying that during these transitional times for a female in particular, instincts that have been manageable previously become less manageable due to the ego becoming 'diminished' from a change in the balance of hormones, therefore being applicable to both the stage of puberty and menopause and not directly relating to age. In the examples here the clients all experienced a feeling of being overwhelmed and in an anxious state when their ego could not function as it had been leaving them in need of an external thoughtful mind to restore thinking. There has been a feeling of loss of the person they once were therefore a mourning process is necessary to be able to move on. A general theme that comes up often is the tension between feelings of relief of no longer having periods and feelings of loss at no longer having the regularity in life of a monthly cycle and the meaning of that which varies for each individual. The mourning can be greater for those who have not had children as a choice but when the choice is removed it can have an unexpected profound impact of loss and a grieving for the children they did not have. Freud (1917b, p246) makes the distinction between normal mourning and a more severe melancholia "in mourning it is the world which has become poor and empty; in melancholia it is the ego itself". While menopause can bring on a depressive mood linked to the loss of a part of their identity but not the ego which is in an enfeebled state but not missing altogether and therefore not melancholic.

3.6.2 Klein Splitting as a defence against Envy

Envy in the Kleinian (1946) sense is associated with the relationship that the individual has with their internalized objects. Emotionally destructive feelings such as envy contribute to self-dislike, guilt, and the fear of aggression from the other. The feelings of envy and the consequent

splitting off feelings from a paranoid schizoid position can become stuck without a containing thoughtful space where the ego can be strengthened as Ignes Sodre (2018) states,

> Interpretation of envy was meant to alleviate mental suffering by leading to greater integration and a strengthening of the ego—though, of course, insight connected to having to acknowledge in oneself a wish to attack goodness cannot but be extremely painful. (p20)

Clients often bring their distress of an inability to manage the changes that are not welcome such as looking in the mirror and not being able to connect to the image they see. This is disruptive in their relationship with internalized objects which is unmanageable creating an inner chaos bringing about a retreat to a paranoid schizoid position. To return to a more manageable, less chaotic depressive position they employ the defence of splitting what they see as all-bad versus the all-good in the ideal image of what they want to see. Entrenched in a paranoid schizoid position, splitting helps bring order to their chaos. With interpretation, thinking and mourning a depressive position can be regained. Zackary (2002) states,

> what lies at the root of her suffering is the intense envy she cannot face…..progressing… inevitably involves loss and particularly so at the menopause when the direction is involutional. (p30)

As in the case of Client M it was difficult to think about her envy of others and the therapist as she was being carried along through the *menopause transition* for which she was unprepared for. In addition to the loss of fertility and youth it was seen as a step closer to old age and death.

3.6.3 Bion - Thinking and Containment

The concept of Bion's theory of containment (1970), provides us with a framework for understanding and navigating the workings of primitive mental states that may pose challenges in the process of mentalization. This concept goes further than solely aiding in the

understanding of early infancy and child development; it extends to encompass the complexity of numerous clinical dilemmas faced by adults as well. Bion's insights on the connection between containment and mental states prove helpful considering this in working with female clients in the *menopause transition*. When the client experiences a breakdown in the alpha function or ability to process thoughts, leading to a state of fear, the object of their focus which can be their sense of self, becomes a source of overwhelming anxiety, effectively immobilizing them. This renders the client susceptible to the repression of unintegrated beta elements or thoughts. Consequently, the client finds themself overwhelmed with unbearable sensations rendering their capacity for logical thought and rational cognition impossible. Symington describes (2004) the feelings as,

> They are undigested and feel like things-in-themselves, as foreign bodies in the mind. They are suitable only for evacuation because they cannot be thought about. If persecuting, they feel like debris of which the mind wants to rid itself; according to the pleasure principle, that which causes discomfort is expelled. The expulsion takes place through projective identification into the body, or into the external world. (p62)

Bion (1997) drew links with Freuds (1911) concept of the discomfort of the reality principle in his paper 'Formulations on the Two Principles of Mental Functioning' and the urge to return to pleasure. In Klein's paper 'Notes on Some Schizoid Mechanisms' (Klein 1946), the theory of splitting off and projecting elements felt to be dangerous or unmanageable into an external object is a defence from the schizoid position. If the process that can be made sense of using Bion's (1967) 'Theory of Thinking', containment aids the client in the ability to think. In all of the clinical examples there is a common thread of the enfeeblement of the ego and how the client used the mind of the therapist as a 'borrowed' thinking apparatus; the client splits off the unmanageable thoughts into the therapist's mind where they can be thought about and

processed before being reintrojected by the client in a more manageable form with a strengthened ego and return to a more depressive position.

What became more and more apparent in both the clinical work and the research interviews was that the difficulty was not located solely within the client's mind. At times, the therapist's own capacity to think about menopausal material could become subtly compromised. Bion's formulation is particularly helpful here, as the analytic couple may both be subject to an inabilty to think when the material touches culturally under-thought aspects of female ageing, fertility, loss and bodily change. In several instances I became aware of a pull either to over-explain, prematurely reassure, or momentarily lose analytic curiosity. Conceptualising these instances through Bion's lens allowed me to understand them not simply as countertransference reactions but as pressures on the containing function itself. This confirmed the importance of the therapist maintaining a capacity for reverie so that the client's unmentalised experience could be engaged with rather than defensively colluded with or avoided.

3.6.4 Conceptual Spine of the Framework

Taken together, the theories discussed in this chapter form a developmental sequence through which menopause can be understood psychoanalytically. The menopause transition introduces a period of biological and psychological upheaval that may precipitate anxiety and a temporary weakening of ego organisation, in line with Freud's observations on transitional states. Under such strain, the individual may retreat to more primitive defensive structures characterised by splitting, projection, and envy, as described by Klein. When these anxieties intensify, emotional experience may become difficult to symbolise and instead be communicated through somatic disturbance, relational tension, or a disruption in the capacity to link thoughts and feelings, echoing Bion's account of attacks on thinking. The client may

feel overwhelmed, fragmented, or estranged from a previously stable sense of self. Within the analytic relationship, however, the therapist's capacity to contain projections, tolerate uncertainty, and continue thinking in the face of confusion offers the possibility of transformation. Through the process of mourning what has been lost and gradually restoring the ego's capacity to think, a more integrated internal position can be regained. Menopause can therefore be conceptualised not simply as a biological event or symptomatic episode, but as a transitional developmental process in which anxiety, defensive reorganisation, containment, and reintegration unfold within relationship and meaning.

3.7 Conclusion

In this chapter, I have discussed my suggestion that menopause resembles the experiences of puberty when the body changes in ways that are not fully under conscious control, identity must be renegotiated in relation to altered embodiment, and a shift in response to perceived changes in desirability, potency, and generativity. However, unlike puberty, menopause involves not the acquisition of reproductive capacity but its transformation, requiring a different understanding of its significance.. I propose theories of importance are those of Freud's theories on anxiety and mourning, Klein's theories on envy and splitting, along with Bion's theory on thinking and containment and I have given examples from clinical work in general.

In the next Chapter 4 'Research Methods' I discuss the methodology for this project which included a full explanation about Reflexive Thematic Analysis as conceptualised by Braun and Clarke (2006, 2022). I showed how my results have been informed reflexively by my own clinical experience and thematic and theoretical ideas that I will outline in this chapter when approaching the research data from the transcripts of the interviews with the research

participants. As Braun and Clarke suggest, it is important to show where reflexive influences of one's clinical experience and background theory are an important contribution when coding the data.

Chapter 4

Methodology

4.0 Introduction

In this chapter I will discuss the methodology used in this research project. I will outline the rationale for using Reflexive Thematic Analysis, the interview process, data collection, and naming themes.

4.1 Background considerations to the project design and outline of the project

My first decision on methodology was to use a qualitative method due to psychoanalytic practice being more of a qualitative process rather than reducing participants feeling and thoughts to a numerical outcome. There were two options I explored before making a final choice. The first option was using Operationalisation to create a theoretical analytic framework. The process would require gathering clinical data, analyse and gather themes which would produce theories to create a framework. In my search through clinical and personal notes, I realised there was insufficient material to give substance to the research, and I could not use material gathered from current work as it would be convoluted and not impartial. The likelihood of the work having a strong focus on menopause would be too intense resulting in a dynamic between myself and the client form the outset as I would have to disclose my intention to use the material in research. The risk would be in seeing everything as relating to menopause and as it is specific subject area even if a client was within the age range, they may not be experiencing any anxiety or stress around their menopause but may feel they have to talk about it as that is what my project is about. Another consideration was that my private practice was located in an area where ethnicity and diversity is low may or may not have an impact, but I would like to sample a more diverse range of participants and clients to add depth to the data

and the research. Reading back through my research journal I can see that I was bringing my own feelings about the underrepresentation of the study of menopause in analytic writing not just what I was seeing in the clinical setting. In my early stage of considering Operationalisation, I gathered all the notes I had made and started to colour code the themes then completed the same colour coding process on the theories I used to think about the material. If I were to use the clinical data gathered from three clients in private practice this would limit content and include my own bias as I was working through my own conflicts in my personal therapy around my journey thorough the *menopause transition*. In keeping with a qualitative approach, my alternative option was to use Reflexive Thematic Analysis as a methodology which I chose to use this as my methodology because I would be able to explore the understanding and meaning of other therapists' work, what clients presented consciously or unconsciously and the transference dynamic between therapist and client. Using Reflexive Thematic Analysis I decided to interview therapists about their work with female clients who are going through menopause rather than using data taken from past clinical material from my own private practice with three female clients transitioning through this life stage whilst in therapy. The preferred methodology would produce a broader and more diverse dataset, more confidentiality as the therapists will anonymise their material before we meet and reduce my personal bias. My position of interviewer will give triangulation of the transferences in the work between the client and therapist in using a hermeneutic approach (Steele 1979).

As I thought about my initial efforts to operationalise clinical material, I became increasingly aware of what Braun and Clarke (2022) refer to as the researcher's 'pressure to find.' I became attracted to the idea that menopause appeared both under-theorised and analytically significant, which shaped the way I approached the material. However, I also recognised that this internal drive risked narrowing my perspective, and to 'prove' that there is a need to open

this discussion, perhaps limiting what I was able to see. This realisation was significant, as it caused me to consider how my own expectations could be affecting the process. By deciding to interview other clinicians, I was able to expand the scope of the data and, importantly, to disrupt my own tendency to locate menopause in every clinical encounter. Moving toward Reflexive Thematic Analysis became not just a methodological choice but a reflexive one, providing a framework to contain and challenge my own anticipatory thinking.

4.2 Data Source

My research involved undertaking semi-structured interviews with qualified psychodynamic counsellors, psychodynamic psychotherapists and psychoanalysts based on their experiences of working with female clients who are at varying stages of menopause. They were all currently working in private practice engaged in regular supervision and adhered to their professional body ethical framework. I analysed the transference and countertransference between the therapist and client along with the transference and countertransference between myself and the therapist as they talk about their work. Working with transference and unconscious processes are the foundation of how we understand not only the client's internal world (Freud 1912b) but how it communicates and affects the internal world of the therapist (Joseph 1985, Heiman 1950) and in this project with me (Holmes 2014).

Any clinical material the participants brought to the research was anonymised prior to the interview and was work they had engaged with in their private practice setting working either online or face to face with female clients between the ages of 40 and 60 years old. Menopause usually is recognised between 45 and 54 however some can enter peri menopause from the age of 40 and some continue their journey until their early 60's. I did not advertise in either the

private practice agency or the charity service that I worked in. In taking this decision I avoided difficulties with boundaries of multiple roles and relations that I might have had with prospective participants at the time of the interview which may have had an effect on their presentation of material, the dynamics between the client, therapist and myself as the researcher and the analysis of the data. I investigated the relationships between the client and therapist through the hermeneutic lens of transference, countertransference and unconscious processes; therefore, I used semi-structured interview questions which allowed for more flexibility in the exploration of material while keeping a degree of structure and ensuring a coherence between all interviews. Reflexive Thematic Analysis research uses the exploration of my own response to the data at source in interview and in the various stages using myself as an integral part of the analysis and in the reviewing of created themes. This way of working is integrated into how I work in a clinical setting using myself and my responses to clinical material and the client themselves then using supervision to triangulate the material and transferences making this methodology consistent from an epistemological perspective. Consideration was given to the impact of the engagement in this research on the participant. On one hand they may have wanted gain insight of processes they had not considered or noticed previously through answering the questions however, on the other they may have been left feeling scrutinised, exposed or vulnerable at seeing their work through another's eyes. As they were practicing therapists it was considered they would have had an arrangement of provision of their own personal therapy or would have been open to engaging in therapy should they be feeling any of these aftereffects. This was referred to in the consent form.

Alongside recording countertransference responses after each interview, I kept a reflexive research journal in which I documented immediate affective reactions, moments of resonance, irritation, defensiveness, or excitement. Particular attention was given to instances where I felt aligned with a participant's theoretical stance or clinical interpretation, as these

moments carried the risk of premature thematic consolidation. Supervision functioned as an additional reflexive space in which my interpretations were questioned and, at times, unsettled. In this way, reflexivity was not a retrospective exercise but an ongoing analytic discipline throughout the research process.

4.3 Ethical Approval process considerations

Ethical approval was applied for via the University. To do this I prepared an advertisement, an information sheet for participants and a consent form for participants to sign in interest of transparency. Questions were prepared that would form the semi-structured interview along with a structure of the stages of data gathering, coding, creating, refining and naming themes followed by the writing up and if appropriate creating an analytic theoretical framework. Once approval had been granted, I engaged participants by posting the advertisement on my professional body website, local psychotherapy groups' websites and I sent an email to be distributed to teams within local psychotherapy practices. The information sheet was sent to any interested parties at which point they were offered an opportunity to discuss in more detail the process they would be involved in should they wish to take part. For those who proceeded, they had to agree, sign and return the consent form. Participant's identity was anonymised, and they agreed to anonymise client material prior to the interview. Participants were referred to as Research Participant 1 or RP1 and so forth, with clients being identified with a letter, such as Client A, Client B, Client C keeping information to the minimum. My own bias is identified in the reporting of analysis of the material and in the reflections and reviewing of themes. It was important to consider the reason for therapist's engagement in the research as it formed part of the dynamic between them, myself and the research itself. I have already discussed how I endeavoured to avoid a dual or previous role situation with any participant which was important to be fully transparent about at the initial discussion about their engagement. In the analysis of

the data I maintained a focus on unconscious process, participant bias and personal bias, whilst also taking into account any of the participant's personal experience along with my own personal experience with the transition through menopause and the impact that will have on the bias we all brought to the work. I was curious and interested to see how many male therapists engaged in the research from the advertisement as they would have introduced a different position and bring diversity and rich perspectives that would be missing if all participants were female. Unfortunately, there were no male therapist who registered an interest in being involved meaning that element of diversity was lost. The participant's theoretical knowledge and level of training introduced another dimension to be considered in the analysis of data as there can be a sense of hierarchy within the therapeutic profession. It may be considered that a psychodynamic counsellor would not be thinking as analytically as a psychoanalyst however this study is not about the depth of work engaged with it is about which therapies have been used to help identify meaning and understanding of the material that clients present in the clinical setting.

4.4 Interviews

I offered a one-off interview with each participant, with each interview lasting no longer than 90 minutes. The interview was semi-structured in nature to allow participants the ability to explore the material, their transference responses, their thinking, their curiosity and where they found support then I was able to explore particular areas based on the transferences between myself and the participant. I would have preferred to undertake all interviews face to face in the therapists clinical setting, which would enable the participant more comfort in their own surroundings and possibly provide a richer environment to notice unconscious communication and body language. However, due to location restrictions, I could only offer interview using the online platform Zoom which still allowed the participant to be in their own surroundings..

The questions asked were based on seeking to understand what clients presented in the clinical setting, how they presented it, was it specifically related to the menopause or did it become clearer with investigation that it was linked to menopause, how the research participant made sense of these phenomena and what reading they were able to access to support their thinking. During the interview I was able to explore what came up for the participant during their work with the client, the meaning it had for them at the time and the meaning it had for them with hindsight using their transference relationship with the client, their supervisor and with myself during the interview. After the interview I recorded my countertransference as it came up during or after the interview. The questions will not be related to any specific theory unless the participant introduces a theory which they found that linked to the work. It was interesting to understand where they sought help from papers, CPD workshops or other avenues for example supervision, peers or reading groups and what it was that they found to be of use. My aim was that in the final analysis of the themes created from the interviews I would be able to answer the research question of the possibility of a structure of themes, relating them to theories and my own conceptual framework which could be considered when working with this group of female clients. I did not offer a follow up interview as I thought this would bring in more conscious material as the participant would have had time to think through what they presented at the first interview and possibly contradict the material. From a researcher perspective I would have had time to consider their responses and ask further questions based on my bias and transferences running the risk of altering and misrepresenting the original raw material gathered at the first interview session.

4.5 Questions

With regard to interview, these questions were created which were tested and considered for bias, improvements and expansion then submitted in an application for Ethical Approval and approved.

Q1. What is your reason for taking part in this research?

I wanted to understand something of their position and where they were coming from. It was also a good question to start with to settle both of us into our time together.

Q2. What do you know about menopause or what has your experience been of menopause either directly or indirectly?

I wanted to understand how much they knew about menopause and what the implications of their experience had on how it could be thought about in their clients' material. Their experience may have been their own menopause journey, a friend, a sibling or partner's so it may not have been direct experience.

Q3a. How have clients presented material that you believed to be linked to menopause?

I wanted to know how and when clients made comments that identified that they are in this life stage; was it obvious, dismissive or alluded to and who made the connection to menopause?

Q3b. What was it that made you connect the client statements or material to the menopause?

I wanted to understand the links the client and participant both have made, how and why they were made. To understand if they were made from knowledge of menopause or was it something that the participant got to from thinking in an analytic manner?

Q4. What did the client transference feel like in the room in their presentation of the material?

I wanted to understand the transference between the client and participant. What did it feel like and how did it come about? Was it obvious or subtle?

Q5. What have they noticed in their own countertransference responses to the client when they were talking about menopause?

I wanted to understand if the participant had been aware of projections and links to their own feelings and how that impacted the relationship with what the client was telling them. Was it obvious to them or was it thought about in supervision or when reading something about it?

Q6. What are they noticing about talking about this material with the benefit of hindsight?

I wanted to explore if it helped to develop their understanding when they looked at the work with several clients through the lens of menopause and drawing together ideas and thoughts rather than looking at each client in isolation (as I expected the clients would have been in therapy at different times although maybe not, so this was something to clarify).

Q7. What do they think has been the impact on their clients when they have engaged in working through this as a life stage?

I wanted to understand how the client benefited or did not benefit from considering the menopause as a life stage that can be transitioned through. Was this identified specifically by the client or was it felt in the transference dynamic?

Q8. What support has helped, where and how did they find it?

I wanted to understand the current support and what was lacking if anything. How did they access support, how easy or difficult was it and what was helpful?

These questions were tested on psychotherapists not to have them answered as they will be for the research but for their thought on how easy or difficult, they would be to answer and what answers I may receive. Also, if they are relevant to the aim of the research and will they achieve the goal of collecting the appropriate data for analysis.

4.6 Methodology for Data Analysis

Reflexive Thematic Analysis is a qualitative data analysis. This is a flexible subjective methodology which uses the researcher's self-awareness, self-reflection and self-reflexivity in the analysing of complex data produced in the analytic setting, exploring and highlighting the meaning and understanding of emerging themes (Braun and Clarke 2022). The meaning and understanding are enriched further by the researcher reflecting on their subjective experience and biases and looking for connections between those and the themes. This method is suited to the study of analytic clinical material because of the strong focus on self-reflexivity and connecting all aspects of the data, themes and individual experiences. Using semi-structured questions, I gathered data and coded themes as Braun and Clarke (2006) define in their description of reflexive thematic analysis. I defined and named themes then reported the findings then I studied the themes in relation to my conceptual framework to propose a way of thinking about menopause as a life stage that can be used in the clinical work with female clients transitioning through menopause. As the researcher I generated, explored and developed themes from the data I gather from the interviews then I coded and organised them into themes based on my ontological and epistemological position. A particular reflexive challenge concerned the anticipation that certain themes — such as loss or regression — would inevitably emerge. Given my conceptual framework, there was a risk of privileging data that aligned with psychoanalytic developmental theory while overlooking data that complicated or contradicted it. To counter this, stepped away for a few weeks before returning to review the transcriptions.

Then I deliberately examined extracts that did not initially fit emerging themes and asked whether I was dismissing them because they unsettled my expectations. Some of these extracts later became significant subthemes. This process of interrogating what I was drawn toward — and what I was inclined to bypass — was central to maintaining analytic integrity. What also came up was a pressure to find something revelatory and novel which after thinking this through in supervision I was able to set aside and maintain focus on what I found in the data. This process allowed for outcomes that were unique to my processing, so it was of importance to fully explore and declare these subjective elements throughout the process of refining and defining the themes that I created. Braun & Clarke (2006) state six phases of the analysis:

- 1 Familiarise yourself with the data – Listening to, watching the recordings, and writing up the transcripts was fruitful as I was more able to immerse myself in the data and got to know it well. I went through it many times looking at it in different ways to ensure any countertransference was recorded.
- 2 Coding the data – I used colour coding after picking out statements from the participants that were linked to things I recognised from my own practice or things that were new to me that made me curious As I am a visual person I found the colours were a good visual representation of the emerging themes.
- 3 Generating themes - creating themes for the data set has been referred using the pantry method – the codes are the ingredients and themes are recipes (DRM PsySSA. 2022) taking the topics from the coding (ingredients) and arranging them into themes (recipes). The subjectivity brings richness in the same way if different people may have the same ingredients but make different recipes based on their individual ideas about food, their likes and their dislikes.
- 4 Developing and reviewing themes – once the themes have been created they needed to be reviewed checking for biases using reflexivity to analyse at a much deeper level

using the researcher subjectivity only then could they be developed into more sophisticated themes

- 5 Refining, defining and naming themes – I further refined and scrutinised to lead to the final naming of the proposed themes always keeping in mind the main question to be answered.. The themes found were arranged into a framework.
- 6 Writing up – the writing up of the analysis of data and results, the discussion of the results and what might be future research opportunities.

I fully expected the process would not be linear and there was some back and forthness to the phases. Starting with a set of sample questions I worked toward creating the final set as discussed running a pilot interview for final testing. This was considered to be an important task to assess for any assumptions or when I may be leading the participant to talk about themes I have in my own mind. Once the questions had been tested and corrected, I arranged the live interviews. I believed it would be best to do all interviews the same way to maintain congruency throughout as transferences can be different when using online platforms to in person experiences. I did have some reservations, as I had not undertaken research at this level using interviews before, so I was new to the interviewing process, and my participants turned out to be new to being interviewed. This was interesting in my countertransference as some participants stuck to the questions in a more structured way, where others tended to speak more to their work, which did cover all the questions, but in a less linear way.

Due to time constraints and the logistics of travel all interviews were be completed using Zoom and transcribed. Once I gathered the data from the interviews, I started to code the transcripts. When the coding was complete, I organised the data into codes looking at what is beneath the surface at the things that may not be obvious at first, only becoming known after refining multiple times. I was able to use my clinical experience along with my conceptual theoretical

framework as a helpful tool in naming themes. It is worth noting that the framework I started to create may not relate to what I find in the analysis of the data gathered from the interviews. I was concerned that my bias might draw me toward wanting to match my framework to the themes I create so it was necessary to check on biases at phases four and five. I did however find that investigating the material that I did not immediately choose as a theme I found to be interesting that I had not experienced in my own clinical practice, and they became new themes I had not considered originally. I believe this to be one of the benefits of using this methodology. Semi structured interviews kept the interview on topic while allowing the participant flexibility and freedom to bring the material in their subjective way of their perception and experience. Other benefits of Reflexive Thematic Analysis are that it considers the meaning and experience of the client, the participant and the subjectivity of the researcher making for rich nuanced analysis.

4.7 Potential difficulties and issues to overcome

I have discussed the difficulties that may have arisen regarding not gaining enough interest and engagement from participants who fit the criteria specified. I had considered 10 to be a suitable number however it was necessary to accept four participants who each spoke of two to three clients giving data in total of 11 clients. These have all been things to consider and the effect they had on the project as a whole. On reflecting upon what it meant to drop the number of participants I feel while it would have been good to have more diversity of the participants I have a good amount of material to give a generous amount of data.. Although a larger sample might have introduced more demographic variation, the aim of reflexive thematic analysis is not to generalise but to explore depth and nuance of meaning. Working with a smaller number of transcripts meant I was able to engage more closely with each participant's account, which in turn deepened the reflexive process between myself and the

material. I feel this sense of containment did not limit the analysis; instead, it allowed for a more focused and thoughtful exploration of the data, sharpening the insights that emerged.

Undertaking all interviews on Zoom had not been my preference however on reflection I felt it did not interfere with the level of engagement of the participants and provided a rich source of transference. I had not interviewed therapists before as research participants, so this was a unique experience in understanding how to keep control of the interview but also to allow space and freedom for the participant to explore the questions and give their answers. The entire process was new, and I expected difficulties to arise as I learned how to find my way of coding and creating themes. None of the participants had taken part in research previously so they found it difficult to know what to present, so while the semi structured questions were helpful in some ways, some commented they would have liked to have had more specific questions and to have seen them in advance of the interview. I had considered this, but it was decided that they would have not been a spontaneous in their responses and it seemed important to be able to collect material that had not been 'prepared' in advance.

4.8 Conclusion

In the engagement of this research, I remained reflective and reflexive of my bias, expectations and desires. As a clinician I am attentive to these processes, and Reflexive Thematic Analysis suited this research whilst aligning with my personal way working. Ethically I am used to considering confidentiality and the method of interviewing other psychotherapists as research participants about their experiences protects the confidentiality more than if I used my direct clinical data. It was beneficial to consider two methodologies which brought clarity of the scope of the research and to engage with a wider set of data. The theories from my conceptual

framework in Chapter 3 (p33) will inform the codes and themes in my data collection from the research interviews and my analysis of the data.

Chapter 5

Results and Findings

5.0 Introduction to the Results and Findings

In this chapter, I explore the findings from four semi-structured interviews with psychodynamic and psychoanalytic clinicians. The interviews were shaped by eight broad questions that invited participants to reflect on their motivations for taking part, their knowledge and experience of menopause, and the ways in which client material was linked to menopausal themes. Participants also spoke about their experiences within the transference and their awareness of countertransference, as well as the insights that emerged through hindsight. Further, they considered the impact on clients when menopause was addressed in the work and reflected on the sources of support or training that informed their practice.

While the interview schedule offered a framework, participants' responses often unfolded in a more fluid and interconnected way. Reflections that began with one question frequently led into considerations of transference and countertransference and were then revisited through the lens of hindsight. Motivations for taking part were often intertwined with reflections on knowledge, experience, and perceived gaps in training or professional discourse. In keeping with the principles of Reflexive Thematic Analysis, the findings are therefore organised around themes that emerged from these recurring patterns of meaning, rather than following the structure of the interview schedule.

Throughout the interviews, menopause was not experienced as a single, isolated topic but as a disturbance that was threaded through the work. Participants spoke of clients grappling with

losses—of youthfulness, bodily familiarity, fertility, and previously dependable ways of managing emotion and self-regulation. These losses often surfaced in the clinical material and became emotionally charged within the transference and countertransference. When menopause was brought into the therapeutic space, rather than being split off or reduced to a medical issue, clients sometimes found new ways to integrate these experiences and create meaning. These processes were shaped not only by the client's history but also by the therapist's own developmental position, which became particularly evident as participants reflected on their knowledge and hindsight. To preserve the unique clinical and relational texture of each account, the material is first presented from the perspective of each participant.

5.0.1 The Researcher's Process

After transcribing the interviews, I took time to get to know the data. At first, I noticed I was focusing on what I expected to find and started to wonder if I was missing anything. I decided to step away from coding for a while, then came back with a fresh perspective, curious about what I might have overlooked. I was glad to see that my initial coding still made sense. I did feel some pressure to find something new that would challenge my original ideas, and this slowed me down for a bit. After talking with my supervisor, I was able to think through this pressure and return to sorting the codes into themes.

This approach helped me see patterns in the participants' stories, especially about feelings, relationships, and bodily experiences. In psychoanalytic work, these meanings often appear indirectly and across different stories, rather than as direct answers to questions. Grouping the results by theme made it possible to focus on how participants described experiences related to

working with menopause—such as loss, identity, and embodiment—in their clinical work, relationships, and emotional responses, including their thoughts on countertransference.

In this study, I approached countertransference not simply as clinical material but as a source of analytic insight that could deepen understanding of the therapeutic process. Organising the findings thematically enabled me to bring together participants' reflections on feelings such as discomfort, withdrawal, identification, or the urge to retreat from the therapeutic encounter, and to consider these responses as meaningful expressions of unconscious communication and relational disturbance. Had I presented the results according to each interview question, this material would likely have become fragmented, making it more difficult to trace how countertransference experiences emerged and developed across different prompts and clinical situations.

Following both psychoanalytic ideas and Braun and Clarke's reflexive approach, the themes I present reflect my active, interpretative engagement with the data. Throughout the analytic process, I drew on my own thinking mind to make sense of the emotional and symbolic material that emerged in the interviews, much as one would in clinical work. Organising the findings thematically supported a coherent and reflexive account that foregrounds the process of making meaning, recognises my position as a researcher, and resonates with psychoanalytic understandings of experience as layered, relational, and dynamically shaped.

5.1 Introduction to RP1 and Clinical Context

RP1 is a female psychodynamic psychotherapist registered with the BPC, working in private practice for approximately fifteen years and teaching adult students. At the time of the interview, she described herself as being in her early forties and "at the beginning of

perimenopause." Her own developmental position became quietly present throughout the interview, particularly when responding to questions about knowledge and experience of menopause (Q2) and when reflecting, with hindsight, on earlier clinical work (Q6).

RP1 discussed three clients: two current and one past. None had explicitly presented "for menopause," yet across responses to Q3a (how the material was presented) and Q3b (what led her to link it to menopause), it became clear that menopause was embedded in the clinical material of each case. At times it was named by the client; at others it was implicit in symptom clusters, identity disturbances, or relational shifts. In one case, it was only fully recognised retrospectively, when RP1 reconsidered the work through the lens of menopause (Q6, hindsight).

Client A, seen approximately ten years ago, was in her fifties and presented with low mood, anxiety, and a crisis of meaning following her son's leaving home. She referred to feeling "infertile in everything" — not only physically, but in work, relationships, and purpose. At that time, RP1 herself was in her mid-thirties and trying to conceive. This detail, which emerged most clearly in response to Q5 (countertransference) and Q6 (hindsight), later became central to her reflections on therapist defences and possible collusion.

Client B, currently in her fifties, presented with unhappiness in work and marriage and an increasing sense of invisibility as her children became independent. In the early stages of therapy, she foregrounded physical and gynaecological difficulties, which, as RP1 reflected in response to Q3b(link to menopause), made menopause more speakable without immediately exposing deeper psychic pain.

Client C, in her early sixties, presented with chronic insomnia and anxiety that she herself linked to menopause, which she "never fully recovered from." Her material became particularly important regarding Q4(client transferene) and Q5(therapist countertransference), as RP1 described powerful countertransference responses, including a wish to escape the room.

5.1.1 Motivation and Positioning (Q1, Q2)

In response to Q1 (reason for taking part), RP1 positioned the research as addressing an underdeveloped aspect of psychoanalytic discourse. She spoke not only of clinical interest, but of a sense that menopause had been present in her consulting room long before she had adequate language for it. As she reflected, particularly when prompted by Q6 (hindsight), she noticed herself thinking about how many clients over the years may have been speaking from within a menopausal transition that she had not fully recognised.

When invited in Q2 to speak about her own knowledge and experience of menopause, RP1 described how her understanding had progressed. Earlier in her career, she had assumed that menopause was largely defined by hot flushes and poor sleep. Her own early perimenopausal symptoms — anxiety, loss of concentration, brain fog — had unsettled that assumption. Importantly, she did not equate her experience with her clients'; rather, she described menopause as becoming more physically available to her once it was no longer abstract. The interview itself, particularly as she moved between Q2(knowledge of menopause) and Q6(hindsight), functioned as a reflective space in which earlier blind spots became visible.

5.1.2 Loss of Youthfulness as Relational Marker (Q4, Q5)

Across RP1's responses to Q3a (how material presented), Q4 (transference), and Q5 (countertransference), menopause repeatedly appeared organised around loss. This was not always named directly as "loss," but emerged through disruptions to identity, continuity, and relational positioning.

Client C frequently told RP1, "Oh, but you're too young to understand this. You're too young to know about menopause. She often made comments about me being too young to understand." In responding to Q4 (transference) RP1 described how these comments created

distance. Youthfulness became a relational marker rather than a simple physical attribute. The client seemed to position the therapist as existing in a different world — one imagined as untroubled by decline.

RP1 reflected that this dynamic pattern contained both envy and despair. The client's insistence that the therapist could not understand foreclosed intimacy. In Q5 (countertransference), RP1 described feeling momentarily excluded and powerless to reach her. Youthfulness, in this sense, served both as a lost attribute for the client and a dividing line in the transference.

5.1.3 Split Between Internal and External Self (Q3b, Q4, Q5)

When asked in Q3b (link to menopause) what led her to connect the material to menopause, RP1 described Client C's refusal to look in mirrors. The split between how she felt internally and what she saw externally had become "unbearable" as RP1 reflected, "It became unbearable to have that split between who she felt she was and who she saw in her reflection". In the room, this splitting entered RP1's countertransference (Q5) as an impulse to escape:

"I remember wanting to escape from the room and the overwhelming feelings of… eh… not repulsion, but needing to get away from something unbearable".

Through supervision (linked to Q8, support), she came to understand this as an identification with the client's own wish to flee the emerging "new version" of herself. "It (supervision) really helped to see how Client C wanted to get away from the new version of herself that repulsed her so much". The loss here was not only youthfulness, but psychic coherence.

5.1.4 Identity and Role of Loss (Client B) (Q3a, Q7)

In response to Q3a (material presented)–Q3b (links to menopause)and, later, to Q7 (impact), RP1 repeatedly returned to the value of holding body and psyche together. Menopause could

easily be split off as “medical,” particularly when clients were under GP care, yet she described how meaning often lay in the symbolic life of symptoms.

Client B’s distress intensified as her children became independent. In Q3a (material presented), RP1 described how the presenting material focused on work dissatisfaction and relational strain, yet underlying these concerns was the loss of being needed. As she reflected in Q7 (impact), once they worked through this identity shift, the client indicated feeling freer to think about herself saying, “Once we worked through her loss of identity, letting go of the past roles of carer, mother, homemaker and generally the one who did everything for everyone, she felt free to think about herself and was more able to make decisions for herself without the constraints of those roles that had been her focus for so many years”.

RP1 described the therapy as providing a “thinking mind” that contained what had previously been chaotic. Menopause, in this instance, coincided with a reorganisation of maternal identity.

5.1.5 Brain Fog as Meaning (Q3b)

Client B briefly mentioned, “Client B would often zone out, which she passed off as menopause brain.” In Q3b (links to menopause) RP1 described exploring whether zoning out functioned defensively — perhaps protecting against the pain of loss. As they made these links, the client became more able to articulate feelings that had previously been dissociated. Here, a symptom became thinkable, then understood.

5.1.6 Adolescence Revisited (Q7)

RP1 also described Client B feeling “like a teenager again.” Emotional volatility, experienced as regressive and frightening, required containment. In Q7 (impact), RP1 suggested that when this stage was held rather than pathologised, it became more manageable.

5.1.7 "Infertile in Everything" (Q6)

This theme appeared most strongly through hindsight (Q6). Looking back at Client A, RP1 reconsidered their work together saying, "Looking back it could have been more helpful to link the meaning of the loss of fertility and the inability to bring things to fruition so that it could be thought about, owned and seen as less overwhelming than she thought it would be".

Client A repeatedly began projects she could not complete and struggled to sustain therapy. In Q6, RP1 wondered whether these enactments reflected an unbearable confrontation with the end of fertility. At the time, she had not explicitly linked bodily infertility with psychic infertility. Reflecting now, she considered how that avoidance may have been affected by her own wish to conceive (Q5 countertransference).

5.1.8 Insomnia as Defence (Q3a, Q5)

Client C's insomnia, initially framed as a symptom, was later understood (Q3a links) as a defence against the surge of unwanted and painful unconscious material. In Q5 (countertransference) RP1 described sensing that sleep would bring her nearer to unprocessed regret and loss, saying "the insomnia seemed to be a defence preventing the unconscious from being known so that she didn't have to think about the regret of not having children and accepting getting older, becoming infertile and other regrets of not having lived life to the fullest."

5.1.9 Splitting off the Body from Therapy (Client A) (Q5, Q6)

Client A insisted menopause was "about her body and a matter for the GP." While reflecting on Q5 and Q6, RP1 acknowledged how she had colluded with this split, perhaps unconsciously protecting her own fertility wishes.RP1 reflected, "It was easy for me to collude with her avoidance".

5.1.10 Envy of the Younger Therapist (Q4)

In Q4, (transference) RP1 described instances in which her client imagined she was living a carefree life, saying, “There was a sense of losing her ability to enjoy life, and that menopause was a kind of death sentence while I was able to live this colourful life.” Envy protected her against despair, but also limited the connection between them.

5.1.11 Therapist Countertransference (Q5, Q6, Q8)

RP1’s most striking reflections emerged when discussing her own positioning. She spoke candidly (Q5 countertransference) about trying to conceive at the time she worked with Client A, and how that may have made the topic of infertility difficult to hold saying “Perhaps there was something unwelcoming in me and I didn’t take as much notice of the symptoms she was mentioning or what not being able to conceive meant for her”. In Q6 (hindsight), she described this as a form of ignorance, perhaps formed by cultural silence, “I didn’t even consider trying to find what had been written about it as it just wasn’t on my mind”. In Q8 (support), she noted the absence of menopause from training spaces and supervision groups, suggesting that the profession itself may reflect the defensive splitting seen in clients.

5.1.12 Closing Reflections (Q6, Q8)

RP1 reflected that taking part in the interview process had brought the experience of menopause more fully into her awareness. She described Q6 as offering a kind of secondary analytic space that enabled her to return to previous clinical work with greater openness. Through this process, she found herself becoming increasingly attentive to the connections between body and mind in women aged 40 to 60, and more able to explicitly name menopause when it became relevant in her work.

Her account demonstrates that menopause becomes thinkable not only through the acquisition of knowledge (Q2), but also through the lived, embodied experience of both client and practitioner, the relational disturbances that arise in the therapeutic space (Q4–Q5), the opportunity for reflective hindsight (Q6), and the support of containing supervision (Q8).

5.2 Introduction to RP2 and Clinical Context

RP2, a female psychodynamic counsellor accredited with the BACP, works across both private practice and a charity setting. At the time of the interview, she identified herself as being in her mid-fifties and in perimenopause. This positioning within her own life stage subtly informed the interview, shaping her responses to questions about her knowledge and experience of menopause (Q2), and became particularly apparent in the reflective space offered by hindsight (Q6).

RP2 brought two cases, both of which had concluded by the time of the interview. In neither case was menopause named as the presenting issue, yet as she reflected on how the material emerged (Q3a) and what prompted her to make links to menopause (Q3b), it became apparent that menopausal themes were present within the clinical space. It was only through the process of looking back (Q6) that the significance of menopause within the work became more fully recognised and understood.

Client D, in her fifties, attended for eight sessions, which RP2 described as feeling fragmented and intermittent. Client D was balancing the demands of caring for a child with a disability, adjusting to another child leaving home, and negotiating changes within her partnership. Menopause surfaced only briefly, primarily in a medical-biological context. In contrast, Client E, in her early seventies, came with growing anxiety, particularly in relation to travel and driving. Although menopause was never directly named in the therapeutic work, RP2, when

reflecting later (Q6), began to consider whether menopause might have been a silent but organising presence within the clinical material.

5.2.1 Motivation and Positioning (Q1, Q2)

When reflecting on her reasons for participating in response to Q1, RP2 spoke with a noticeable hesitancy, expressing both a wish to contribute and an acute awareness of the limits of her own knowledge. This tentativeness seemed to echo the theme of diminished confidence that would later emerge in her clients' narratives. As the conversation unfolded, especially in response to Q6, it became apparent that her motivation was also shaped by a wish to revisit previous work, recognising in hindsight that a more conscious consideration of menopause might have led to a different approach.

In considering Q2, RP2 reflected on her own perimenopausal experience as something that had heightened her sensitivity to the "destabilising nature of this period". She was careful not to confuse her own experience with those of her clients, but noted that living through menopause herself had made the psychological aspects of this transition more accessible to her. What might once have been understood solely through the lens of anxiety or depression could now be seen in a broader, more nuanced way.

5.2.2 Loss of Potency and Agency (Client D) (Q3a, Q6)

Throughout RP2's responses to Q3a (how clients presented), Q4 (transference), and Q5 (countertransference), menopause was described as a gradual erosion, rather than a sudden or dramatic collapse. The sense of loss was experienced as something that built up over time, often subtle and difficult to pinpoint, yet nonetheless deeply felt.

Client D was described as someone who had, in the past, managed a range of responsibilities—caring for others, volunteering, and maintaining family life—with a sense of competence and

capability. However, as RP2 reflected in Q3a, this capacity seemed to have gradually diminished. The ability to plan and organise became increasingly difficult, confidence began to wane, and challenges that once felt manageable started to feel overwhelming.

Responding to Q3a (how clients presented), RP2 observed that the client's sense of her 'adult part' seemed to have receded, leaving her feeling more vulnerable and unsettled, almost as if she had regressed to a younger, less confident state. RP2 described a sense that the client's agency had faded, making it difficult for her to navigate everyday challenges. "She had been a strong, capable woman, so when she came up against these sudden anxieties and fears, it felt as if she was unable to manage life the way she had been used to. It really threw her and she found herself not knowing how to cope." When reflecting on these experiences in hindsight (Q6), RP2 considered how menopause may have intensified transitions that might otherwise have been manageable, such as children leaving home or changes in relationships, turning them into moments of crisis.

5.2.3 Life as it Was / Regret (Client E) (Q3a, Q6)

With Client E, RP2 described how anxiety seemed to have emerged slowly, almost imperceptibly, over an extended period. The client often found herself reflecting on how she used to be—a confident traveller, independent and capable—and comparing this to her current experience and looking back at past regrets. " Once we were able to engage with her disappointments, she was able to connect to the younger part of herself, acknowledging what had been lost, but also now able to make choices to engage with parts of herself as she is now". While this was initially understood as generalised anxiety (Q3a presented material), RP2 later reflected (Q6 hindsight) on whether the prolonged process of menopausal transition might have contributed to a gradual erosion of the client's trust in herself.

In this case, regret seemed to be more present than in RP1's material, with the client repeatedly questioning, 'why am I like this now?' and quietly mourning the loss of her earlier self. The sense of loss extended beyond fertility, encompassing a previous sense of competence and capability that now felt out of reach.

5.2.4 Ordinary Becomes Crisis (Q3b, Q7)

RP2's material conveyed how menopausal experiences could amplify both physical and emotional responses, with menopause itself often described as intensifying what might otherwise have been manageable.

In response to Q3b (links to menopause), RP2 reflected on how she began to consider menopause as a relevant factor when her client's responses to everyday stressors shifted, with previously manageable challenges suddenly feeling overwhelming and destabilising. The phrase "the rug pulled out" was used to capture the client's sense of internal chaos, highlighting how changes in the body could unsettle her whole sense of being.

Reflecting on the impact in Q7 (impact), RP2 suggested that if menopause had been explored more openly in the sessions, it could have offered a framework for understanding the client's experience. Rather than interpreting the sense of collapse as a sign of something fundamentally wrong, the client might have been able to see it as part of a wider process of transition and reorganisation.

5.2.5 Anxiety About Forward Movement (Client E) (Q3a)

Client E's material was marked by anxieties around travel and driving, which, in RP2's later reflections (Q6), appeared to be connected to deeper fears about moving forward in life. "We were able to think about some things in her life that were changing that she couldn't control, and her feeling of just being on this runaway train and not being able to have any control over

it". The sense of life progressing toward old age, coupled with a body that no longer felt as dependable, seemed to heighten a sense of vulnerability.

Brain fog and forgetfulness emerged not only as physical symptoms but also as experiences imbued with psychological significance. Here, the boundaries between body and psyche became blurred, with each shaping and informing the other.

5.2.6 Diminished Potency (Q3b & Q6)

In speaking about Client D's son leaving home, RP2 reflected (Q3b links to menopause) on how the departure of the "potent son" seemed to coincide with a sense that the client's own potency had gone with him. This interpretation emerged during the interview, demonstrating how Q6 functioned as a reflective space.

Fertility, in this context, appeared to be less about reproductive ability itself and more about a sense of a less tangible potency—the feeling of being needed or of contributing something meaningful. The loss of this capacity seemed to raise questions about identity and self-worth. Once it could be thought about the client was able to explore and engage with a new sense of potency.

5.2.7 Resistance to Depth (Client D) (Q4)

Within RP2's material, defences tended to manifest as avoidance and minimisation, shaping the way clients engaged with both the therapeutic process and their own experiences.

RP2 reflected in Q4 that, although Client D expressed a wish to engage in deeper work, there remained a sense of something impeding the process. Sessions often felt stilted, with a noticeable gap between what was said and what was communicated on a more unconscious level. Looking back at Q6, RP2 considered whether the client's limited capacity for depth at that stage might have been shaped by the destabilising effects of menopause, suggesting that a

greater degree of stabilisation was needed before interpretation was possible. RP2 replied "when I offered interpretations they didn't seem helpful and were avoided; it was as if they were dangerous and to be avoided at all costs."

5.2.8 "Just Get On With It" (Client D) (Q3a)

For Client D, a longstanding coping style of endurance meant that menopause was something to be managed privately rather than spoken about. This defensive stance made it difficult for her to allow herself the space to acknowledge and attend to experiences of loss.

5.2.9 Confusion and Forgetting (Q5)

RP2's responses to Q5 offered insight into her own internal responses within the therapeutic relationship. She described experiencing moments of confusion when working with Client E, at times feeling engulfed by the client's anxiety or unsure how to move the work forward. There were periods when her own thinking felt impaired. "I found myself getting confused and forgetting the names of people in her life". Through supervision (Q8), these experiences became more comprehensible as countertransference, understood as communications of the client's internal chaos.

5.2.10 Naming Felt "Impossible" (Q6)

RP2 noted that naming menopause had felt almost impossible, even when she suspected its relevance. "It felt impossible to be out in the open about it, and that it could be understood. When I was younger, I wasn't as able to link symptoms to what it meant to be going through this stage." In Q6, RP2 recognised this as a possible blind spot, which may have reflected her own level of awareness of this transitional phase.

5.2.11 Grief Opens Possibility (Q7)

In contrast to RP1's material, RP2's extracts illustrated a more distinct movement towards creative renewal within the therapeutic process. With Client E, once grief could be tolerated within the sessions, a subtle shift became possible. In response to Q7 RP2 said, "Once she was able to grieve the regrets and let them go it was possible to challenge the norms and old narratives about who she thought she was and she was able to see that she didn't have to be restricted anymore with expectations that she used to hold for herself." The client was able to reconnect with a long-forgotten desire to paint, beginning to explore this as a hobby. RP2 described this not as a dramatic transformation, but rather as a gentle reclaiming of self. In this way, creativity was able to emerge after the process of mourning, not bypassing the experience of loss but arising from within it.

5.2.12 Closing Reflections (Q8)

RP2 concluded that participating in the interview had heightened her awareness of menopause as a significant clinical factor. She reflected on the importance of incorporating more explicit exploration of menstrual and menopausal history within assessment. In response to Q8, she observed the absence of menopause in training spaces and expressed a wish for further opportunities for continuing professional development. Throughout her interview, menopause was described less as a single event and more as a destabilising transition, one that could amplify existing vulnerabilities, erode ego strength, and challenge established identities. Yet, when these experiences were held and contextualised within the therapeutic relationship, there was also the possibility for reorganisation and renewed investment in self.

5.3 Introduction to RP3 and Clinical Context

RP3 is a BPC-registered psychodynamic psychotherapist in private practice. At the time of the interview, she described herself as in her early fifties and post-menopausal. Her own experience of having moved through menopause shaped the texture of her reflections, particularly in response to Q2 (knowledge and experience) and Q6 (hindsight). There was a grounded quality to her narrative, as though menopause was not only something she had observed clinically but something she had experienced and made some sense of personally. RP3 presented three clients (F, G, and H), all in different phases of the menopause transition. In contrast to RP1 and RP2, RP3's material contained more explicit exploration of periods stopping, fertility, and the emotional meaning of that cessation. In her responses to Q3a and Q3b, menopause was not peripheral; it was more overtly part of the clinical conversation, though still shaped by individual fantasy and defence.

5.3.1 Motivation and Positioning (Q1, Q2)

In response to Q1(reason), RP3 spoke about the lack of attention given to menopause in psychoanalytic literature. She expressed frustration that key stages in women's development are often overlooked, even though they are grounded in bodily experience. For her, menopause was something that happened in the body and inevitably affected the psyche. She described menopause as "an embodied transition that disrupts established ways of thinking and feeling about oneself." In Q2 (knowledge), RP3 reflected that her own experience of menopause had increased her sensitivity in clinical work with clients of a similar age. She was careful to note that personal experience does not automatically lead to analytic understanding, but she found that having lived through the transition changed the way she listened to and thought about her clients. Menopause became something she could recognise and think about more openly in the therapeutic space.

5.3.2 Periods Stopping: Relief, Control, or Finality (Q3a, Q3b)

RP3's material highlighted how the theme of loss was experienced through the specific meaning attached to the end of menstruation. While RP1's focus was on youthfulness and the fragmentation of identity, RP3's accounts explored how clients worked to make sense of what it meant for their periods to stop, and how this process shaped their understanding of themselves. RP3 described how clients responded in varied ways to the cessation of menstruation. For Client F and G periods had been a source of ongoing distress, marked by pain, unpredictability, and a sense of intrusion, so their ending brought a sense of relief and freedom. For Client H, the regularity of menstruation had provided a "predictable rhythm, almost a reassuring structure", so its cessation introduced a sense of finality and a disruption to their internal sense of order. She, as described by RP3, had maintained a strong sense of control by closely monitoring her cycles, and when her periods stopped, this control was quietly but profoundly disrupted. Rather than experiencing immediate distress, the client found herself needing to think differently about menopause, as her relationship to time and her sense of agency had shifted in ways that required new forms of adjustment. Across these accounts, the experience of loss emerged as a complex and individual process, shaped by each woman's personal history with menstruation, the fantasies and meanings attached to it, and the ways these internal experiences influenced the sense of self.

5.3.3 Sense of Self and the Mirror (Q4)

RP3 also reflected on Client H who experienced menopause as a time when the gap between their internal sense of self and their outward appearance became more pronounced. While RP1's accounts focused on fragmentation, RP3's material suggested that clients faced the reality of change, prompting them to engage in psychological adjustment. "Client H felt she had to fit in, to look a certain way, be slim, wear the right clothes, and her children's

accomplishments reflected her sense of self-worth. Once we were able to understand this she could let go and grieve those 'lost' years, allowing her to focus on what she wanted in life."Clients described becoming aware that their bodies no longer reflected how they felt inside, and this recognition required them to work through the challenge of integrating these changes, rather than turning to denial.

5.3.4 Letting go of Self Image (Q3a)

RP3's interview offered detailed accounts of how bodily experiences could take on symbolic meaning for clients. RP3 reflected on how Client H managed the changes in her body and looks. It had been difficult to come to terms with the changes and with what they meant for her. Once the meanings were uncovered and worked through, the client felt relief and released from her investment in looks, "She felt relieved that when her body changed, she was released from the competitiveness with other women".

5.3.5 Fertility as Danger or Value (Q3a)

RP3's material included particularly detailed reflections on the symbolic meaning of fertility. RP3 explained, "Client F experienced fertility as dangerous, she grew up not wanting to be a woman, to stay a little girl forever so that she wasn't in competition with her mother." For this client, menopause brought relief, as the risk of becoming rivalrous or taking on a feared maternal role was reduced. In this case, fertility was linked to risk, and its end brought a sense of safety. In contrast, Client H saw fertility as central to her sense of value. The idea of losing fertility was deeply upsetting. In Q3a, RP3 described how she "felt devastated as her periods were a sign that she had a value as a woman, that she was healthy and life-giving." This client equated fertility with desirability and potency, so menopause felt like a loss of identity.

Client G's experience was more mixed. She felt some relief from the pressures of reproductive potential, but also had to face the reality of time passing. Across these cases, fertility was experienced less as a biological fact and more as something that organised feelings about worth, competition, danger, and creativity.

5.3.6 Competition and Envy (Q4)

RP3 described moments when clients related to her as either similar to or different from themselves in terms of the menopause transition. When clients imagined her as either past or not yet at menopause, competitive feelings sometimes emerged. In Q4, she reflected that these transferential patterns revealed underlying anxieties about ageing, desirability, and maternal identity.

5.3.7 Avoidance of Mourning (Q3a, Q6)

Rp3 reflected on Client F, focused on the practical aspects of menopause — HRT regimes, lifestyle changes — while sidestepping its emotional meaning as she "went straight on to HRT in her wish to not feel anything. When she felt disturbed or tormented about anything, she would go to the GP for a pill to take it all away. It took a long time before she could talk about it". In Q6, RP3 acknowledged that she sometimes colluded with this by prioritising symptom management over symbolic exploration. Only later did she recognise that grief work had been required.

5.3.8 Countertransference and Attacks on Thinking (Q5, Q8)

RP3 described times in Q5 when she found it difficult "to think freely in sessions". She noticed "feeling cautious" about exploring certain topics, especially those related to freedom from

caring roles or mixed feelings about femininity. These areas felt potentially unsettling, as they seemed to challenge established ways of understanding oneself.

Through supervision (Q8), she was able to consider how her own experience of menopause might have influenced what she felt able to explore with clients. In this way, countertransference became an opportunity for learning and growth in her clinical work.

5.3.9 Living a New Life (Q7)

RP3's material, even more than earlier interviews, showed how the menopause transition could open up possibilities for renewal. In response to Q7, RP3 described clients who, after working through grief, began to reconfigure their identity. Client G took up samba drumming and "felt free to connect with other women". Client H invested energy in gardening, describing it as "growing something different and using the fertility of the land". These were not grand transformations but subtle reorientations toward self-defined activity.

Creativity did not serve to deny loss, but rather emerged after it had been acknowledged and mourned. RP3 reflected "Client H had the loss of the false self, which was a relief, but also the loss of who she didn't get to be when she was younger". Once clients had worked through the loss of fertility, they found space for new forms of creativity and growth.

5.3.10 Closing Reflections (Q6, Q8)

RP3 concluded by emphasising that menopause cannot be treated as a uniform experience. The same biological event carried radically different meanings depending on developmental history, relational configuration, and fantasy. In Q8, she suggested that psychoanalytic training would benefit from more explicit engagement with menopause as a developmental transition, rather than leaving it to emerge accidentally in the consulting room.

Across RP3's interview, menopause appeared as both destabilising and potentially liberating. It disturbed established identifications but also offered an opportunity for reorganisation when grief could be sustained.

5.4 Introduction to RP4 and Clinical Context

RP4 is a BPC-registered psychodynamic psychotherapist working in both private practice and an agency setting. At the time of interview she described herself as in her early fifties and recently post-menopausal. Like RP3, she was speaking from the position of having moved through the transition, yet her interview carried a slightly different quality: more emphasis on bodily disturbance, on attacks on thinking, and on her own resistance to engaging the topic.

She presented three current clients (I, J and K). In response to Q3a (how material presented), menopause appeared across these cases in different forms: anger at bodily change, regret narratives, dissociation, and seemingly inexplicable physical symptoms. In Q3b, she reflected on how these phenomena gradually became thinkable as menopause-linked, rather than isolated difficulties.

5.4.1 Motivation and Positioning (Q1, Q2)

In response to Q1, RP4 described menopause as under-researched, noting that while it appeared in some clients' material, it did not feature consistently in clinical discourse. She was cautious not to over-generalise. There was a sense that she was offering clinical observations rather than a theory — remaining tentative about causality, but clear that something important was being missed. In Q2, when asked about her own knowledge and experience, RP4 acknowledged that menopause had not initially been something she had thought about in analytic terms. She described an earlier tendency to see it as largely medical. Only through reflection and through her own embodied experience had she begun to consider its symbolic and relational

dimensions. There was an honesty in her account of having resisted reading or engaging with menopause in depth — a “head in the sand” quality that she later recognised in herself. This became important when considering therapist defences.

5.4.2 Youthfulness as Scaffolding (Client I) (Q3a, Q4)

In RP4’s material, experiences of loss were described as deeply connected to feelings of narcissistic injury and to the sudden acknowledgement of time passing. The shock of bodily changes brought the reality of ageing into focus, making the passage of time something that could no longer be ignored. Client I was described as someone who, for much of her life, had imagined herself as older than her years, identifying strongly with qualities of maturity and wisdom, yet at the same time maintaining a youthful appearance. The arrival of menopause, and the accompanying visible changes in her body, disrupted this internal sense of self. In Q3a, RP4 said” Client, I felt really angry how menopause had ravaged her body and taken these parts (fertility and looks) of her”, highlighting the emotional impact of these physical changes. In Q4, RP4 reflected on how this anger would often be present in the therapeutic space, sometimes emerging as sharpness or irritability directed towards others. Underneath this anger, there was a sense of deep injury, as if the loss of youthfulness—which had served as a kind of psychic scaffolding—was experienced as a direct attack on the client’s sense of identity.

5.4.3 Regret and “What If” Narratives (Client J) (Q3a)

Client J’s material was characterised by a strong sense of regret, with sessions often returning to earlier life decisions and the possibilities that were no longer available. In response to Q3a, RP4 described how the client would repeatedly bring 'what if' and 'if only' questions into the room. Menopause appeared to act as a marker in time, making it clear that certain opportunities had now closed, and prompting a process of mourning for what could have been. “once she

was able to grieve the losses of the past she was able to think about a newer way of seeing this new stage in her life". Whereas RP1's material focused more on experiences of split identity, RP4's accounts placed greater emphasis on the experience of time itself, and the sense that certain changes were now irreversible.

5.4.4 Dissociation and "Out at Sea" (Q4)

With Client I, RP4 described moments in which the client experienced dissociation, often using the phrase 'out at sea' to capture the feeling of being unmoored. "With Client I, she would really struggle with her reflection, she would disconnect from the image and feel out at sea with no anchor. She felt her internal self was floating away from the image of who she saw reflected back". In Q4, RP4 connected this sense of drifting to a loss of internal anchoring that arose when bodily changes felt unpredictable and beyond control. The client's psychological state seemed to mirror the unpredictability of her physical symptoms, resulting in a sense of psychic drift.

5.4.5 Night Sweats and Body Memory (Q3b)

In RP4's interview, there were clear examples of how bodily symptoms could be understood not only as physical experiences but also as carrying symbolic meaning within the therapeutic process. In Q3b, RP4 described working with Client I whose night sweats appeared not only intense but also emotionally charged. As they explored these experiences together, associations began to emerge that linked the night sweats to early childhood experiences of bedwetting and the accompanying feelings of shame. RP4 reflected on whether the menopausal symptoms might be reactivating earlier bodily experiences that had not been fully contained or processed. "once we could talk and think about the connectioin and meaning of it she was more able to regulate her emotional response and to move away from her repulsion of herself." In this way,

menopause was experienced not simply as a set of hormonal changes, but as a process that could reawaken earlier anxieties connected to the body, bringing past emotional experiences into the present.

5.4.6 Hot Flushes and Maternal Themes (Q4)

RP4 described instances where hot flushes occurred during sessions touching on mother–daughter material. In Q4 she reflected on how these bodily eruptions felt communicative — something unspeakable finding expression through the body. “It was as if mother was a hot topic and the heat served as a warning. But also that there was an axiety about becoming mother through menopause”. Rather than seeking to interpret these symptoms in a reductive way, RP4 approached them with curiosity, allowing space within the sessions for meaning to emerge and unfold over time.

5.4.7 Fertility and Value (Q3a)

While fertility was not spoken about as directly in RP4’s extracts as it was in RP3’s, its symbolic significance remained powerfully present throughout the material. For Client I, fertility became closely linked with a sense of desirability, so that as menopause progressed and fertility receded, she began to experience herself as invisible. RP4 described in Q3a how this invisibility was not simply disappointing but felt annihilating, suggesting a profound impact on her sense of self.

Client K, who had been infertile, had a very different experience. “She would feel angry at others who were sad to be losing fertility because at least they had had it. Her loss was grieving the hope she carried that someday the doctors would find something to ‘cure’ her”.

Another client’s wish to bring a new puppy into her life, which she described as 'like having a baby,' was understood by RP4 (Q6) as a way identifying with a life-giving potential that is no

longer possible within her body at a time when these capacities might have felt threatened or lost. Even after fertility was no longer biologically possible, it continued to shape clients' psychic worlds, organising meaning and influencing how they related to themself and others.

5.4.8 Splitting Body and Mind (Q3a)

Within RP4's material, defences frequently emerged in the form of splitting or avoidance, shaping how both physical and emotional experiences were managed in the therapeutic space. Some clients described their experiences of HRT and physical symptoms using only medical language, keeping these aspects separate from their emotional distress. RP4 recognised in Q6 that she too had sometimes accepted this division, rather than inviting exploration of the connections between body and mind within the sessions.

5.4.9 Attack on Thinking (Q4, Q5)

The most striking material appeared in response to Q5, where RP4 described her own difficulty in thinking clearly during sessions with Client I. She found that note-taking became challenging and that her thoughts and ideas felt out of reach, mirroring the client's own struggles. Through supervision (Q8), she came to understand this as identification with the client's own inability to think about what was happening to her. The menopause-linked disturbance had entered the analytic field as an attack on linking — on the capacity to connect body and mind. "Working through this in supervision helped me to realise that she couldn't think about this herself and in my countertransference my thinking became disconnected and cut off. This allowed me to bring it into the work and help Client. I allow the thoughts to be known." This experience resonated with patterns described by RP1 and RP2, where clients expressed a wish to escape, feelings of confusion, and a sense of being engulfed. Across participants, it became evident

that material linked to menopause could disrupt the capacity for thinking within the therapeutic relationship.

5.4.10 Envy (Q4)

RP4 reflected the difficulty in working with Cleint K's envy based on her fantasy about RP4s life. "she assumed I wouldn't be able to understand as there seemed to be envy of me and her friends who 'had it all sussed' and because they had been fertile and had children. What she didn't realise was that I didn't have any children". It was impossible for client K to see others having difficulties that would be equal to hers. This caused an obstruction in the work, which, over time, was able to be resolved and moved on from.

5.4.11 Resistance to Engaging Menopause (Q2, Q6)

RP4 was open in acknowledging her own avoidance in relation to the topic of menopause. RP4 reflected that she had previously minimised menopause as a topic in her work, which may have echoed a wider cultural silence. It was only later that she recognised how her own avoidance mirrored that of her clients. In Q6, her reflections revealed how her own discomfort may have limited what she felt able to explore with clients. The interview itself became a space where she could begin to articulate and work through these feelings.

5.4.12 Reclaiming Visibility (Q7)

Although the material was marked by an intense sense of loss, RP4 also identified moments of renewal and transformation within her clients' experiences. RP4 spoke of Client J's, after years of withdrawal, newfound ability to sing publicly again, something she enjoyed at school. Client I began to embrace a new sense of visibility, no longer needing to be seen as youthful but instead finding a steadiness and value in her own maturity. RP4 described in Q7, "these shifts

only became possible once grief had been acknowledged and allowed into the therapeutic space". Creativity was not a denial of ageing, but rather something that could emerge from its acceptance.

5.4.13 Closing Reflections (Q6, Q8)

RP4 concluded by emphasising that menopause should not be understood as a single psychological event, but rather as a transitional period in which earlier experiences may be reactivated and re-examined. She expressed a wish for more training and opportunities for shared discussion within psychoanalytic spaces (Q8), observing that the ongoing silence around menopause continues to marginalise it in clinical practice. She said, "I do see it in work with some clients and not others, which I find interesting in itself. I don't have any theory to work from, so I just go by my observations from the clients who have brought it into the work". Throughout the interview, menopause emerged as a destabilising force, exposing early wounds and challenging established identifications. Yet, when these experiences could be thought about and attacks on thinking were contained, new possibilities for reorganisation and integration became available.

5.5 Cross-Participant Integration of Themes and Links to Interview Questions

When the four interviews are considered together, menopause emerges not as a discrete topic that clients "bring," but as a topic within which other material intensifies. Across Q3a and Q3b, participants rarely described clients presenting with menopause as the primary complaint. Instead, menopause appeared as a context that sharpened loss, destabilised identity, or amplified anxiety already present. It was often recognised only gradually — and sometimes only in hindsight (Q6).

A striking pattern across all four participants was the centrality of loss. Whether described as the decline of potency (RP2), the split between internal and external self (RP1), the shock of time becoming visible (RP4), or the confrontation with irreversibility (RP3), menopause functioned as a psychic organiser around endings. These endings were not limited to fertility. They included loss of youthfulness, loss of bodily reliability, loss of familiar regulatory rhythms, and loss of certain imagined futures. Importantly, these losses were rarely articulated by clients in symbolic language at first. They appeared in displaced forms — insomnia, anxiety about travel, envy of the younger therapist, regret narratives, dissociation, or complaints about physical symptoms.

Responses to Q4 and Q5 (transference and countertransference) revealed how frequently menopause-linked material was communicated relationally before it could be thought about between therapist and client. Clients positioned therapists as younger, freer, or untouched; therapists experienced confusion, pressure, forgetfulness, or the wish to escape. In several interviews, thinking itself seemed temporarily impaired in the dynamic. Across participants, supervision (Q8) functioned as the place where these disturbances could be brought to mind and understood. Menopause, then, did not simply enter the room as content; it entered as atmosphere, as pressure on the capacity to link.

Another cross-participant pattern concerned the split between medical and psychological discourse. In Q3a, menopause was often introduced by clients through GP consultations, HRT discussions, or references to “menopause brain.” Yet whether that material became symbolically elaborated depended on the therapist’s capacity to hold body and psyche together. In Q6, several participants reflected on moments where they had colluded with a medical split, allowing menopause to remain in the domain of symptom management rather than exploring

its meaning. The interview process offered a lens through which this split could be reconsidered.

Fertility, when viewed across interviews, operated less as a literal reproductive issue and more as a symbolic organiser of potency and value. For some clients (RP3), its loss was relief; for others (RP1, RP4), it signified depletion or invisibility. For RP2's client, potency seemed to migrate outward to the departing son, leaving behind a diminished internal position. These differences highlight that menopause does not carry a singular meaning. Instead, it activates pre-existing beliefs of femininity, rivalry, creativity, and worth.

Creativity appeared in all interviews, but rarely at the beginning of the work. In response to Q7 (impact), participants described shifts only once mourning had been tolerated and worked through. New hobbies, redefined visibility, investment in art or music, renewed attachments — these developments followed rather than preceded grief. Menopause thus appeared as potentially generative, but only when the analytic relationship could contain its destabilising aspects.

Responses to Q1 and Q8 collectively revealed something further: the relative absence of menopause within psychoanalytic training and discourse shaped what therapists felt equipped to notice. Participants repeatedly described menopause as historically "not in mind." Personal experience (Q2) often prompted greater attentiveness, yet even this required supervision and reflection to translate into analytic work. The research interview itself functioned reflexively; several participants described realising, through answering Q6, how menopause had been present but unformulated in earlier cases.

Taken together, the data suggest that menopause operates in the consulting room as a transitional process rather than a discrete event. It intensifies existing conflicts, reactivates earlier bodily and relational experiences, and challenges established identifications. Its meanings are highly individual, yet certain patterns recur: destabilisation of ego functionality, heightened sensitivity to time and visibility, and the need for renewed containment. Where menopause remained unprocessed, work risked stalling or remaining symptom-focused. Where it could be thought about symbolically, clients moved toward greater integration. The integration of these interviews therefore supports the view that menopause is not merely a biological transition that occasionally intrudes into psychotherapy, but a psychologically rich developmental passage that affects both members of the analytic dyad. It requires attention not only to client material but to the therapist's own developmental position.

5.6 Uneven Contribution Across Themes

Not all participants contributed equally to every theme, which aligns with the principles of reflexive thematic analysis. Rather than viewing themes as fixed categories to be filled by each participant, themes are understood as patterns of meaning that emerge through the researcher's ongoing interpretative engagement with the data (Braun & Clarke, 2006, 2021). For some participants, certain aspects of the menopausal experience became the focus of their accounts, often reflecting what felt most immediate or emotionally charged in their clinical work, while others found themselves drawn to different areas of concern. In this way, the distribution of data across themes mirrors the unique meaning, emotional attunement and clinical significance these issues held for each individual, shaped by their own experiences and the dynamics present in their work.

Seen through a psychoanalytic lens, this variation is to be expected. Participants naturally gravitated toward those dynamics that felt most emotionally charged or clinically urgent in their work with clients. As a result, the presence of richer material within particular themes often points to areas where there was a heightened sense of identification, conflict, or countertransference, rather than suggesting any imbalance or shortcoming in the analysis itself. The intention in presenting these themes is not to achieve equal representation from all participants, but rather to build a coherent account that captures the most meaningful patterns emerging from the data. In this context, uneven contribution is seen as an inherent aspect of qualitative depth, reflecting the complexity and individuality of participants' experiences, rather than as a methodological weakness.

5.7 Conclusion

Across the four interviews, menopause emerged not as a single clinical topic but as a psychologically charged transition that reshaped how clients experienced their bodies, identities, and relationships. It rarely appeared in isolation. Instead, it functioned as a background condition that intensified loss, destabilised previously reliable ways of coping, and brought into focus questions of visibility, potency, and time.

In response to Q3a and Q3b, participants described clients presenting with anxiety, insomnia, dissociation, envy, regret, and bodily symptoms that were not initially named as menopausal in meaning. Yet through reflection (Q6), many of these phenomena became understandable as expressions of a deeper disturbance linked to the menopause transition. The material suggests that menopause often enters the consulting room indirectly — through enactment, symptom, or transference configuration — before it becomes symbolically articulated.

The transference–countertransference field (Q4–Q5) proved particularly revealing. Across participants, menopause-linked distress was communicated through competition, idealisation of youth, feelings of being left behind, and at times through attacks on thinking within the analytic space itself. Therapists described confusion, the wish to withdraw, difficulty linking ideas, and, in hindsight, recognition of their own defensive positioning. Supervision (Q8) frequently functioned as the containing third that restored thinking and allowed the therapist to re-enter the material with greater clarity.

The findings also demonstrate that menopause does not carry a singular psychological meaning. Fertility, for example, was experienced variously as relief, danger, loss, or depletion, depending on each client's developmental history and fantasy life. Similarly, bodily symptoms could represent regression, protest, communication, or defence. What appears consistent across the dataset is not a uniform narrative but a shared pattern: menopause unsettles established identities and requires psychic reorganisation.

When the transition could be acknowledged and held within the analytic relationship (Q7), participants described movement toward greater integration. Mourning often preceded change. Creativity and renewed investment emerged not as denial of loss but as its working through. Where menopause remained split off or reduced to medical management, the work appeared more constrained.

The interviews also reveal something about the profession itself. In responses to Q1, Q2 and Q8, participants repeatedly described menopause as historically underrepresented within psychoanalytic discourse and training. Several acknowledged that it had not always been in

mind clinically. The research process itself became a reflective space in which previously unformulated experience could be thought about.

Taken together, the findings suggest that menopause operates as a significant developmental transition within psychodynamic psychotherapy. It is neither solely biological nor purely symbolic, but a transitional field in which body and psyche, past and future, loss and possibility intersect. Next, I present a table that demonstrates the mapping of interview questions to the themes and results. (See Figure 1).

Figure 1. Mapping of Interview Questions to Themes and Results

Interview Question	Analytic Focus	Overarching Theme(s)	Sub-Theme(s)	Illustrative Participant/Client Material	Location in Results Chapter
1. Reason for taking part in the research	Participant motivation; perceived gaps in theory, training, and clinical discourse	Therapist Defences and their Position	Absence of menopause from the therapist's mind	All participants (RP1–RP4) describe menopause as under-researched; participation motivated by hindsight, clinical curiosity, and personal relevance	Sections 5.1.2, 5.2.2, 5.4.2
2. Knowledge/experience of menopause (direct or indirect)	Therapist knowledge, personal experience, and cultural context shaping clinical listening	Therapist Defences and their position	Absence of menopause from the therapist's mind; Fertility and therapist counterinvestment	RP1's limited early knowledge; RP1–RP4 report menopause becoming clinically salient with personal ageing or experience	Sections 5.5.1, 5.1.2,5.3.2, 5.4.2, 5.4.7
3a. Client presentation of menopause-related material	Manifest and latent presentation of menopausal material in therapy	Loss; Body and Psyche; Client Defences	Youthfulness; Sense of self; Symptoms with meaning; Insomnia; Denial; Envy	Menopause presented indirectly through anxiety, insomnia, dysregulation, dissociation, bodily complaints, and identity disturbance	Sections 5.1.1, 5.1.4, 5.1.6, 5.2.3, 5.2.4, 5.2.6, 5.3.2, 5.3.6, 5.4.3, 5.4.5, 5.4.6
3b. What linked client material to menopause	Clinician interpretative process; developmental timing; embodied and affective cues	Body and Psyche; Therapist Defences	Symptoms that have meaning; Absence of menopause from therapist's mind	Recognition via age/life stage, bodily changes, symptom clusters, and countertransference experiences of confusion or overwhelm	Sections 5.1.1, 5.1.3, 5.1.4, 5.2.4, 5.2.5, 5.4.4,
4. Client transference in the room	Relational dynamics; projections and identifications linked to menopause	Loss; Client Defences	Youthfulness; Sense of self; Envy	Clients position therapist as younger, fertile, or "full of life"; competitive, distancing, or idealising dynamics	Sections 5.1.3, 5.1.6, 5.2.6, 5.3.3, 5.3.6, 5.4.3, 5.4.4, 5.4.6

Interview Question	Analytic Focus	Overarching Theme(s)	Sub-Theme(s)	Illustrative Participant/Client Material	Location in Results Chapter
5. Therapist countertransference responses	Therapist affective, cognitive, and bodily responses as clinical data	Therapist Defences	Countertransference; Attacks on thinking; Fertility and therapist countertransference	Confusion, forgetting, urge to escape, reassurance impulses; supervision enables containment and meaning-making	Sections 5.1.1, 5.1.3, 5.1.6,5.1.7, 5.2.6, 5.3.2, 5.3.6
6. Reflections with hindsight	Reflexive learning; recognition of avoidance, collusion, and missed links	Therapist Defences; Client Defences	Denial; Avoidance; Absence of menopause from therapist's mind	All RPs reflect on cases where menopause was not named; learning emerges retrospectively	Sections 5.1.1, 5.1.2, 5.1.6, 5.1.7, 5.1.8, 5.2.3, 5.2.5, 5.2.6, 5.3.2, 5.3.9, 5.4.7, 5.4.9
7. Impact on clients of engaging menopause as a life stage	Therapeutic change; integration of loss and identity	Body and Psyche; Creativity and Potency	Linking body and psyche; Living a new life; Potency	Reduced dysregulation; increased agency, creativity, and self-investment (e.g., new hobbies, identity shifts)	Sections 5.1.4, 5.2.4, 5.2.8, 5.3.8, 5.4.8
8. Helpful supports and how accessed	Internal and external supports facilitating containment and thinking	Therapist Defences; Body and Psyche	Supervision as containment; Medical support	Supervision restores therapist thinking; GP/HRT address physical symptoms; therapy integrates psychological meaning	Sections 5.1.7, 5.1.8, 5.2.9, 5.3.7, 5.3.9, 5.4.9

Chapter 6

Results: Themes and Sub-Themes

6.0 Extended summary of themes and sub-themes

I found that the six themes did not emerge as separate or isolated categories, but rather as interconnected strands running through the material. Loss was a consistent presence in participants' accounts, though it rarely appeared as a direct expression of grief. Instead, it tended to appear as a disturbance in self-experience, in bodily changes, and in the way time was internally experienced. I noticed that body and psyche together formed the space in which these losses were lived and communicated, often through symptoms, shifts in identity, and changes in emotional regulation. The loss of fertility was experienced both concretely and symbolically through feelings of lack of potency, and value, raising questions about the capacity to bring things to fruition. Both client and therapist defences shaped how these disturbances were managed—sometimes split off, denied, avoided, enacted, or held within the transference–countertransference relationship as confusion, pressure, or attacks on thinking and linking. When creativity did emerge, it tended to do so only after some mourning had been tolerated, signalling not a bypass but a movement toward reorganisation and renewed investment in the self.

In bringing these themes and sub-themes together, I have held them as a connected system rather than as discrete categories. Loss was often the first way that menopause became noticeable in clinical settings, with the body and psyche providing the space in which that loss was experienced, communicated, and symbolised. I noticed that losing fertility was not only a real event but also shaped ideas about power, worth, and things that cannot be changed. The

ways in which clients and therapists managed this disturbance—through splitting, avoidance, enactment, or difficulties in linking and thinking within the transference–countertransference relationship—became central to the clinical process. Where creativity appeared, it tended to follow the work of mourning, marking a shift toward reorganisation and renewed energy once loss could be thought about. I will summarise each theme and its sub-themes, highlighting the core meanings that recurred across participants' accounts.

6.1 Theme 1: Loss

Loss was the most consistent organising theme across participants, yet it took different shapes depending on the client's history, fantasy life, and relational context. I understood "loss" here as more than an endpoint; it was the felt experience of something shifting internally that could not be restored by will, effort, or reassurance.

6.1.1 Youthfulness

Youthfulness was often seen as a sign of relationships and self-image, not just a matter of looks. In RP1 and RP4, the mirror became an especially charged site: clients described a disjunction between their internal sense of self and the face or body they saw being reflected back. This gap was not just upsetting. It also put psychological and ego stability at risk. In the transference, youthfulness could also become a dividing line: clients positioned the therapist as "too young," placing the therapist in an imagined idealised and envied world untouched by decline. This created distance and, at times, cut off intimacy. What I was struck by is how quickly the loss of youthfulness could become a loss of recognisability—an experience of not being able to recognise oneself in one's own image.

6.1.2 Life as it was

Participants described clients speaking from a sense that life had become unrecognisable or unmanageable. What had previously been workable—ordinary stressors, responsibilities, transitions—could suddenly feel like collapse, "the rug pulled out," or being "out at sea." This sub-theme held the way menopause can alter the supposed stability of life, creating a before-and-after quality, even when the external circumstances have not dramatically changed. The loss here was not only who they had been, but the loss of confidence that life could be held together in the same way again.

6.1.3 The sense of self

A recurring feature of the accounts was a disturbance in identity: clients struggled to know who they were now, or how to inhabit the new version of themselves. Sometimes this appeared through role shifts (for example, the moving away from mothering or caring identities as children became more independent). Sometimes, it felt like an existential confusion. The old version no longer fit, but the new one had not yet taken shape. This disturbance often entered the therapeutic space as a pressure on linking—difficulty tolerating ambiguity, difficulty sustaining reflection, or the wish to retreat from what could not yet be named.

6.1.4 Regrets of a life not lived

Regret narratives—"what if," "if only," and mourning for paths not taken—appeared most explicitly in RP2 and RP4, but the emotional logic of regret ran through the dataset more

widely. Menopause seemed to function as a marker of time: not only the loss of fertility, but the felt closing down of certain imagined futures. What was being mourned was not only an external outcome (children, careers, relationships), but the internal fantasy of still having time to become someone else.

6.1.5 Periods stopping

Where periods were spoken about directly (especially in RP3), the cessation of menstruation did not seem to carry a single meaning. For some, periods stopping was relief—an end to pain, intrusion, unpredictability, or fear of pregnancy. For others, the rhythm of menstruation had served as reassurance and internal structure; its loss was experienced as finality, and as a disruption to bodily trust. I held this sub-theme as a reminder that the same bodily event can stabilise one client and destabilise another, depending on what menstruation had come to represent psychologically.

6.2 Theme 2: Body and Psyche

All participants described menopause as most clinically meaningful when body and psyche were understood together, rather than separated into medical and psychological categories. Symptoms often emerged as the first way clients could express their experience, but these symptoms often carried relational and symbolic meaning as well as physiological significance.

6.2.1 Changes in the body causing changes to identity

Clients often described bodily changes as deeply connected to their sense of identity: who they

are, and how they are seen. For some, these physical changes threatened identities that had been built around beauty, control, or being the one who is always in charge. For others, the changes in the body coincided with a release from restrictive roles such as mother, carer, or homemaker, and opened up space for a different relationship with the self. In these accounts, the body appeared to require a rethinking of the sense of self that was once maintained by role, appearance, or function.

6.2.2 The personal meaning of periods

Even when menstruation was not the main focus in sessions, its meaning was often present in the background. Periods could represent health, fertility, predictability, or a sense of safety from pregnancy. When cycles became irregular or stopped, clients described a disturbance that was not only biological but also psychological, often experienced as a loss of control, loss of reassurance, or the collapse of a familiar rhythm that had quietly supported their ability to regulate themselves.

6.2.3 Symptoms that have meaning

Participants described symptoms as carrying psychological meaning: insomnia could be understood as a defence, brain fog as a form of dissociation or avoidance, and sweats and flushes as bodily eruptions that became especially charged in relation to particular themes in relationships. Rather than treating symptoms as fixed symbols, I noticed that talking about symptoms often provided a starting point—something that could be spoken about, which then allowed clients to approach experiences that were harder to put into words.

6.2.4 Physical changes to the body and face

Aches, pains, reduced mobility, and visible ageing were not simply described as inconveniences by clients; instead, they often spoke of these changes as carrying a sense of injury to self-esteem and a loss of trust in their bodies. When the body became less dependable, clients described feeling unsettled internally. In some sessions, I noticed this sense of unreliability appeared as a kind of drift, dissociation, or feeling unanchored.

6.2.5 Menopause amplifies dysregulation

Menopause was often described as amplifying existing difficulties: mood swings, internal chaos, or a sense of regression, such as feeling like a teenager again. Participants spoke about how challenges that might once have been manageable now became much harder to contain. Clinically, this amplification was important because it influenced when and how interpretation could be offered; at times and what seemed to be more often than not, stabilisation and containment needed to come before clients could engage in symbolic thinking.

6.3 Theme 3: Loss of fertility

The topic of fertility ran through the interviews as a psychological organiser rather than a purely reproductive fact. Its loss could signify relief, danger, depletion, invisibility, or the end of imagined possibility, depending on the client's internal world.

6.3.1 The unconscious meaning of being a fertile woman

In RP3 especially, fertility held meanings of value, rivalry, danger, desirability, and identity. One client experienced fertility as threatening—linked to competition with mother—and menopause brought safety. Another experienced fertility as central to worth, and its loss felt devastating. Across participants, I saw fertility as a container for different fantasies about femininity, power, and belonging.

6.3.2 Unable to bring things to fruition

In RP1 and RP2, fertility was also described as a symbolic question of potency: the ability to finish projects, to sustain something, or to bring things to fruition. Difficulties with completion, feeling stuck, or experiencing a loss of agency were not simply attributed to menopause, but were understood as enactments that gained meaning when explored through the lens of endings and irreversibility.

6.4 Theme 4: Client defences

Client defences often shaped whether and how menopause could be thought about in sessions. What was being defended against was not menopause itself, but what it represented: loss, envy, ageing, regret, the body's betrayal, and changes in identity and desire.

6.4.1 Insomnia

Insomnia was described as more than just a symptom; it often functioned as a defence against knowing, against the return of regret, grief, and unwanted thoughts. Sleep would bring the

unconscious closer, so not sleeping kept the mind in a vigilant state where deeper feelings could be kept at a distance.

6.4.2 Attacks on thinking and linking

Across accounts, there were moments where linking became difficult. Sometimes this appeared in clients as switching off, confusion, or dissociation. Sometimes it appeared in the therapist's experience or countertransference as impaired thinking, forgetfulness, or difficulty holding the thread. I treated these moments as communications within the analytic field: not failures of technique, but signals that something was becoming unendurable to think about directly.

6.4.3 Denial

Denial often appeared as a split into medical explanations: 'this is just hormones,' 'the GP will deal with it,' or seeing HRT as the only solution. This did not mean clients were indifferent; rather, it often suggested that the emotional meaning was too exposing or too threatening to put into words.

6.4.4 Avoidance

Avoidance could take the form of behaviours such as not travelling, not driving, or not looking in mirrors, or it could appear in conversation as moving away from feelings into management strategies. While avoidance protected clients from pain and fear, it also limited the work until the underlying meaning could be approached more gradually.

6.4.5 Envy

Envy, particularly toward a younger therapist or toward others imagined as freer, more fertile, or less burdened, often recurred as a defensive pattern. While envy protected clients from despair and humiliation, it also created distance in the therapeutic relationship. In this way, envy could keep menopause out of the room by placing the problem in the other's imagined ease, rather than allowing the client to face their own sense of loss.

6.5 Theme 5: Therapist defences

Therapist defences were not understood as shortcomings, but as part of the same analytic field. Menopause appeared to press on the therapist's own developmental positioning, making some thoughts more difficult to hold in mind. Through the interviews, it became apparent how cultural silence, limited training, and personal vulnerability each shaped what therapists were able to notice or found themselves avoiding.

6.5.1 Menopause not being in mind

Several participants described menopause as historically 'not in mind,' which influenced how readily links could be made between symptoms and meaning. In the absence of an internal framework, menopause often remained in the background, even when it was present in the room.

6.5.2 Therapist trying to get pregnant

RP1's account illustrated how the therapist's own wishes around fertility could make it more difficult to think about infertility in the work, and how this could lead to a collusion with a split between body and mind. The openness with which this was described highlighted how therapist defences can emerge when the material feels particularly close to personal experience. While this only appeared with one RP, I wanted to keep it in the subthemes as it was a surprising revelation, showing the diverse reactions within this work.

6.5.3 Therapist's own experience with menopause

For RP2 to RP4, their own experiences of menopause shaped what felt possible to explore in the work. At times, personal experience seemed to increase sensitivity to the material; at other points, it led to hesitancy, avoidance, or a sense of 'putting one's head in the sand,' which was only recognised in retrospect.

6.5.4 Therapist countertransference

Countertransference emerged not only as feeling, but as shifts in the capacity to think: confusion, forgetfulness, pressure, withdrawal, and the wish to escape. In the data, supervision repeatedly restored a containing third, allowing the therapist to metabolise what had been lodged in the relationship and to re-enter the work with greater linking capacity.

6.6 Theme 6: Creativity

Creativity was described as emerging from working through, rather than as a starting point. It tended to follow a process of mourning; once loss could be acknowledged and tolerated, new investments gradually became possible.

6.6.1 New hobbies and being creative

Painting, drumming, gardening, and singing were described as modest but real shifts, rather than dramatic reinventions. Creativity did not erase the sense of loss, but suggested that something had been worked through enough for the ego to strengthen and libido to begin to move again.

6.6.2 Living a new life

This sub-theme described a re-imagining toward the present self, rather than remaining organised around the lost self. Clients began to move away from identities shaped by being needed, being youthful, being fertile, or being in control, and toward an internal position that could accommodate change.

6.6.3 Potency

Potency was reworked across the interviews: as bodily fertility receded, there was space for psychic fertility to emerge. New projects and interests became possible, not as compensation, but as evidence of an internal reorganisation—a capacity to generate and sustain meaning after endings had been faced and worked through.

6.7 Conclusion

Across these four interviews, I have shown how menopause entered the consulting room less as a declared topic and more as a disturbance in the analytic field. It intensified experiences of loss, unsettled established identities, and placed pressure on the capacity to think, both for clients and, at times, for therapists. Through the analytic process, it became clear that menopause does not simply sit alongside other developmental transitions; it reorganises how body and psyche are experienced and linked. Earlier dynamics of rivalry, potency, shame, dependency, and creativity could be reactivated, and the limitations of current theoretical language and professional training were also revealed. In the next chapter, I move from description to interpretation, drawing these findings into dialogue with the psychoanalytic framework outlined in Chapter 3. I consider how concepts from Freud, Klein, and Bion help to illuminate what has emerged here, and where the data invite refinement or extension of those ideas. In doing so, I begin to think more explicitly about menopause as a developmental passage with distinct psychic implications for both members of the analytic dyad.

Chapter 7

Discussion of Findings

7.0 Introduction

In the preceding chapter I presented the findings of the data analysis taken from the anonymised transcripts of interviews with research participants (RPs), each of whom reflected on their clinical work with clients in relation to the clients' experiences of menopause. In chapter 3 (see p37), I developed my conceptual framework based on my own clinical experience, in private practice with female clients. I analysed the data from the anonymised transcripts of the interviews and the themes that are shown in chapter 5 (see p71), then exemplified in chapter 6 (see p107) are the results. The purpose of this chapter is to interpret the findings in relation to my conceptual framework. I will explore how the material confirms, extends or challenges the psychoanalytic theories considered earlier and how the experiences reported by the RPs resonate with or diverge from existing understanding of menopause as a developmental stage. This chapter further includes a reflexive account of my own transference to the project and the of the research project with my clinical and subjective experiences. I also discuss the RP's reflections on their own positioning in relation to menopause.

In this chapter, I clarify the theoretical framework I use to interpret the findings. I see menopause not purely as a physical event, but as a developmental and psychological transition where issues like loss, fertility, motherhood, femininity, identity, and generativity can take on new meaning. I also consider the therapist's own experience, including how close they are to menopause and how they use countertransference, as key to whether menopausal themes can be noticed, explored, and addressed in therapy. These ideas shape the discussion that follows.

7.1 Loss as it was presented in the room, it's meaning and how it relates to clinical theories and life stages

The theme of loss came up repeatedly in the clinical narratives of women navigating menopause. As highlighted in Chapter 6, clients expressed a profound sense of loss – whether of youthfulness, former identities, or the capacity to bear children. RP3 talked about client H (see p94) *"She felt she would be invisible"* and RP4 (see p105) reported client I said, "*she feels really angry how menopause has ravaged her body and 'taken' these parts of her."* This recurrent theme reported by the RPs spoke to clients' experiences of being lost to oneself with a sense of alienation from both the youthful self now mourned and the emergent self not yet consolidated. These findings resonate with Freud's (1917/1957) conception of mourning as a psychic process in which the ego gradually detaches from lost objects. Yet, in menopause, the object of mourning is not a single external relationship but rather a multiplicity of losses: the body as it was, an imagined future, and the sense of a stable identity.

All RPs reported clients talking about the loss of their visible youthfulness as they saw their reflections change in the mirror. RPs reported that client's feeling they have lost an appearance of youthfulness results in some clients feeling invisible and feeling angry at something being taken from them. The loss can be felt as a trauma, losing sight of who they 'are' leading to a sense of being out of control, and a disconnect from their sense of self. The RPs discussed how their clients struggled with connecting who they were on the inside with who they saw themselves as on the outside but also who they used to be and who they thought they were developing into. The transition through menopause is shown to be a conflicting time and a period of disconnection which I expected the RPs would have talked more about from their experiences in the clinical setting. On reflection, I suggest there is a transferential dynamic of

disconnection or denial of the process of transition as RPs found themselves unable to think and make connections between the material and menopause.

In chapter 2, I reviewed Benedek's (1950) (see p28) account of menopause as a psychosomatic process, where a physiological change precipitates psychological disequilibrium. This study extends Benedek's formulation by showing how this disequilibrium is often experienced as fragmentation of the self. RPs described their clients' *loss of youthfulness* in terms of a disjunction between inner vitality and outer appearance. Benedek also states the fluctuations of hormones reduced the ego's adaptability, claiming to know where in the cycle a patient was from the material they would present. So, while there is a biological event it does have an impact on the emotional stability which is where a psychoanalytic theory will assist clinicians in this work. To return to Freud's (1937 p226) (see page41) theory that during transitional times, which he included puberty and menopause as such times, the 'instincts' which have previously been manageable are no longer so. He does not specify 'instincts' however, we can surmise as he is naming reproductive transitions, that they will include a desire to protect the ego from pain or discomfort. While Freuds term 'enfeebled ego' is disagreeable, I suggest Lax (1997) provides a more helpful theory with her view that mature ego functioning is still present and can be accessed in the therapeutic work when she states,

> "even though the depressive menopausal reaction is associated with a loss of self-esteem, a decreased sense of narcissistic well-being, and increased vulnerability, it does not result in a loss of mature ego functions". (p204)

Klein's (1946/1997) (see p50) account of splitting as a defence against anxiety: the ageing body is cast into a 'bad' object position, while the internalised self remains idealised, relieving the pained ego. Such splitting, however, can only be sustained temporarily before dissonance

produces depressive anxieties. It is these anxieties that can cause the splitting off and projecting into the therapist that requires the understanding from the perspective of a menopause 'assault' on the body and psyche. If menopause is not acknowledged then these anxieties can be attributed to other unrelated or related in some way they will not directly explore or link to the transition of menopause and the mourning process that is needed when the sense of self is lost.

RPs reported clients had felt estrange from their own *sense of self*, uncertain of who they were or might become. This recalls Winnicott's (1960) notion of the false self, whereby earlier identifications – such as mother, carer or desirable partner – cease to feel authentic, leaving an absence where a renewed sense of self has not yet formed. The *regrets of a life not lived* intensified in this crisis, as women revisited paths not taken (motherhood, careers, relationships) that are now closed. Pines (2010) argued that menopause often reactivates earlier developmental conflicts, particularly those associated with missed opportunities for generativity. The data here supports Pines' observation but also highlight the defensive function of regret; by focussing on imagined pasts, women may avoid engaging with the demands of present mourning.

The loss of periods itself carried ambivalent feelings. For some, it brought relief, symbolising the end of reproductive anxiety; for others, it confirmed a felt loss. As Lax (1990) observed, menstruation often holds unconscious significance as proof of bodily vitality and feminine identity. Its loss then demands a reworking of what womanhood means to each individual. The ambivalence reported by RPs reflects a mourning process of any nature as the oscillation between denial and mourning is not linear. This oscillation mirrors Klein's (1940) depressive position: the subject must confront both the loss and the ambivalence in their relationship to the lost object which is a further complicated due to the 'object' being a part of the self – an

internal object rather than an external object. The projection of the lost object into another makes it easier to work with the loss.

Bion's (1970) theory of containment (see p51) provides what is needed for the clients who have split off the 'bad object' needing to work it through with an available mind. Once the discarded object can be thought about and managed it can be reintegrated in a manageable way that was not possible in the throes of the menopause transition.

Considering the data within the context of the conceptual framework, the results for the theme of loss suggest that menopause may be best understood as a multifaceted mourning process. Unlike the mourning of a single object, menopausal mourning involves multiple complex losses, both real and imagined. The clinical setting becomes a crucial space in which these losses can be acknowledged and named, contained and gradually integrated. Where such containment is absent, the data showed, as RPs reported, clients frequently engage their familiar, protective defences – insomnia, denial, avoidance – that I will explore later here in 7.4.

7.2 The Body and Psyche as it was presented in the room, it's meaning and how it relates to clinical theories and life stages

The second major theme, *body and psyche*, captures how menopausal experiences were described as both physical and emotional, each element shaping and amplifying the other. All RPs talked about their client's difficulty with changes on a biological (internal) level and on a physical (external and aesthetic) level causing a disconnect with their identity. When the body changes in ways that suddenly cannot be explained or controlled it can lead to distress and feeling out of control. RP 1 spoke of a client not being able to feel in control of her body or

her emotions so when RP1 could think from the perspective of menopause, she was able to think about connecting the changes in the body with the mind (overwhelming emotions) in the sessions so, the client was then able to think about herself, her emotional internal world, and her body in a different way. Then, by accepting the changes, she started investing more in looking after her emotional regulation by increasing the frequency of sessions. Bion's (1967) theories of Thinking and Containing (see p51) enabled the client to think in a different way. RP 2 and RP3 had similar experiences to share; their clients each focussing on how others perceived them from a physical perspective and had no or little sense of self from a psychological perspective if they could not live up to expectations. Once this had been explored and worked through as projections of their own feelings, and expectations that they were trying to live up to, the clients were able to acknowledge value in the body and mind as a whole self. RP 4 reflected on client I who felt her body was attacking her with the changes happening that she could not control. The client reported feeling cut off from her body and was often in a state of dissociation. Once worked through the loss of the previous version of the body they were able to connect to her 'new' body and come back to a state of integration of body and mind. This supports the argument outlined in Chapter 3 (p37) that menopause cannot be understood through a biological or physical lens alone; rather, it involves a reworking of identity and a fragmented sense of self. One RP reported,

> "She would look in the mirror and say, 'That isn't me. That's' an old woman staring back at me'. Inside she still felt 30" (RP2)

This statement illustrates the psychic dissonance between internal and external self-representations. Identity can be thought of as a constant negotiation between inner objects and external realities, so when bodily transformations disrupt that balance, anxieties of fragmentation arise, often defended against by envy and splitting; the inner 'young' self, versus the 'old' body (Klein 1957/1997).

The sub-theme of the *personal meaning of periods* demonstrated how the bodily functions were laden with symbolic weight. For some women, menstruation signified vitality and the ongoing possibility of motherhood, while for others, it represented unwanted fertility or an unwelcome reminder of bodily rhythms. Here the missed period functions as a loss, confirming Lax's (1990) claim that menstruation provides unconscious reassurance of health and femininity. Its cessation can destabilise identity and evoke an anxiety around what it means to no longer menstruate and its relation to femininity.

The data also suggested that some women experienced *menopausal symptoms symbolically*. Hot flushes, insomnia, or mood swings were often interpreted by RPs as expressions of unconscious conflict. This resonates with Freud's (1905) early theorisation of symptoms of hysteria as symbolic communications of repressed psychic material. As one RP put it,

> "her hot flushes seemed to come every time we got close to talking about her mother' almost as if her body was expressing what she couldn't put into words". (RP4)

This also links with Symington's (2004) 'undigested foreign bodies in the mind' that could only be 'expressed' through the pores as heat and sweat. Once this was understood it became a useful symptom to alert the RP and client to something that was stuck unconsciously. It also aligns with Bion's (1962) notion of somatic expressions as attack on linking, where the body speaks when thoughts cannot be tolerated. This can often be identified in the countertransference in the therapist when they find themselves unable to think or make connections.

RPs descriptions of *physical changes to the body and face* also revealed the destabilising effect of visible aging. The onset of aches and pains in strange places, wrinkles, and reduced mobility was discussed as being experienced as a threat to psychic equilibrium, leaving clients feeling

out of control of their body or experiencing their body as foreign. The analytic space becomes the ground for reintegration of the body as part of the self rather than 'other'.

Finally, the sub-theme of *menopause amplifies dysregulating* highlighted parallels with adolescence. Hormonal fluctuations were described as reactivating mood swings, impulsivity, and inner chaos. As argued in Chapter 3 (see p37), menopause can be conceptualised as a transitional process with developmental significance, in some respects similar to puberty, in that it reactivates earlier conflicts. .

> "She said she felt like a teenager again, crying one minute then furious the next. But this time she didn't have her parents to hold her". (RP1)

This connects to what Pines (2010) claims that the menopause reactivates unresolved pubertal dynamics, particularly around separation, individuation and identity formation. Of course, as the menopause transition is a progression from one life stage to the next there is another working through of individual and identity formation.

Overall, these findings demonstrate that menopause cannot be reduced to a biological transition. It is an embodied psychic crisis that destabilises identity, reawakens developmental conflicts, and invites symbolic expression of unconscious material. By linking body and psyche, the analytic setting provides a space in which clients can begin to explore and re-integrate these disavowed aspects of the self.

7.3 Loss of fertility as it was presented in the room, it's meaning and how it relates to clinical theories and life stages

The theme of *loss of fertility* was one of the most emotionally charged dimensions of the interviews. Even when RPs discussed clients who did not explicitly articulate a desire for children, the symbolic weight of fertility permeated their narratives. This evidence supports the view that menopause carries profound psychosocial implications, as reproductive capacity is deeply tied to unconscious representation of femininity. One RP recounted,

> "She told me it wasn't that she wanted to have a child but knowing that she couldn't, felt like something had been taken from her" (RP3)

Here the mourning is not for an actual child but for the fantasy of potentiality. Menopause can often evoke anxieties about the finality of what menstruation, femininity and womanhood has meant for each individual. As I thought more about this theme, I realized that the loss involved is not just about biological fertility, but also about the personal meanings tied to motherhood. For some women, motherhood is something they have experienced; for others, it is a fantasy, an identification, a regret, a refusal, or something that feels impossible. Menopause can bring up not only the reality of infertility, but also a woman's feelings about being a mother, not being a mother, or no longer being able to become one. So, I see motherhood here as more than a social role. It is also a personal reference point that shapes how loss, power, femininity, and identity are experienced.

The subtheme of the *unconscious meaning of being a fertile woman* emerged in varied forms. For some women, fertility symbolised health, vitality, and desirability, while for others it was bound to their sense of womanhood and relational identity. Its loss destabilised the ego and brough about what Klein (1940) described as depressive anxieties – grief for the internal object that could no longer be sustained. The data suggests an internalised experience of the loss of fertility as a psychic void, an unconscious representation of the womb as depleted. Pines (2010)

similarly observed that infertility – whether biological or menopausal, often manifests in fantasies of emptiness or barrenness that are as much psychic as physical.

Not all clients have difficulty accepting this loss. For those who do find it difficult, it can be for a variety of reasons. Loss of fertility was difficult to define in one theme as some clients spoke of it as a loss so the discussion has been recorded in the theme of loss but the meaning of losing fertility also was spoken about explicitly therefore it has been included here with reference to the meaning of it rather than simply the loss of it. RP 2 noticed a repetition of the words “full of life” which she explored with Client D to gain an understanding that she was really talking about fertility and the sense of life it gave her. This helped with thinking about her feeling of how she could go on being full of life without periods which signalled fertility. RP 3 had spoken with all the clients presented about their meaning of fertility. For Client F fertility was dangerous so with the loss of if she felt safe again; Client G saw fertility as something that was not in her control as having children had been difficult for her physically, so fertility removed the fear of becoming pregnant again; Client H saw losing her fertility as something devastating when her ability to conceive was taken away from her, having felt it gave her a sense of security which Bemesderfer (1996b) explored as the feminine castration anxiety in her writing (see p29). RP 4 spoke of Client K who was diagnosed as biologically infertile and felt angry when others saw it as a loss. Linking to my conceptual framework on envy (see p50), her envy of others made it difficult for her to focus on her own final loss and accepting that a miracle was not going to happen for her to recover her fertility. What was also difficult was her feeling she had to give up her envy when all her friends were losing their fertility. RP4 did not go into detail about her work with the envy however, this aligns with Pines (2010) suggestion of the defensive function of distraction from what is too unimaginable to manage with Client K’s envy allowing her to focus on what others possessed in order to avoid

thinking about what she had been deprived of. Once the others lost what their fertility she could no longer envy them and was left with acknowledging the pain of her own infertility in a new way. RP4 expressed more general thoughts based on other clients and her own experience of menopause that fertility brings a sense of power of being able to conceive and that allows a feeling of being desirable which can be experienced as a loss when one loses fertility.

The sub-theme, *unable to bring things to fruition*, highlighted how loss of fertility goes beyond reproduction to encompass creativity and productivity. RPs described clients who had difficulty completing projects or sustaining motivation, echoing Erikson's (1980) developmental stage of generativity v stagnation. When reproductive capacity is lost, psychic energy may struggle to find new outlets, resulting in feelings of impotence. This can also be considered in line with Lax's (1997) claim that menopause can reactivate unresolved narcissistic injuries, leading to a sense of paralysis in work and relationships. Yet as explored later in 7.6 (see p134) on Creativity, these same women often eventually discovered new forms of generativity once mourning was undertaken and psychic reorganisation became possible. The paralysis became part of the study with my own experience of feeling unable to complete chapters going through a period of impotence and lack of creativity.

The findings here suggest that fertility, in psychodynamic terms, operates as a symbolic container for much broader anxieties about potency, creativity, and the continuity of the self. Also to be taken into consideration, although there is no potential to explore further in this study, the societal or cultural meaning of fertility and the impact those meanings have on individuals. I reiterate my suggestion that menopause must therefore be conceptualised as both a biological and developmental transition: while the reproductive body undergoes irrevocable

change, the psyche grapples with reconfiguring its capacity for symbolisation, creativity, and relationality.

7.4 Client Defences as it was presented in the room, it's meaning and how it relates to clinical theories and life stages

The interpretation of client defences is the root of psychoanalytic therapy. It is in working through defences that clients can understand their lives in a deeper sense enabling them to make changes and let go of the maladaptive defences that no longer serve them. Across all interviews, RPs reported the prominence of defences used by clients in response to menopausal changes. Denial, avoidance, and envy emerged as the most salient, consistent with psychoanalytic literature that views defences as attempts to protect the ego from intolerable psychic pain (Freud, 1926/1959).

Denial was the most frequently observed, particularly around the acknowledgement of menopause as a psychologically significant event. RP 1 talked of Client A's difficulty accepting there may be a psychological aspect of menopause preferring to keep it as an exclusively physical, biological issue which was projected into RP 1 who was eventually able to recognise her own collusion with the client's avoidance by not exploring the clients' or her own resistance. RP1 explained,

"*she did not want to talk about it in the room and there was a resistance and probably some ignorance in me. It was easy for me to collude with her avoidance*".

RP 3 considered how Client H was in denial about her menopause as she had used denial so much as a way of coping her whole life,

> *"I thought I was pregnant again or I had cancer or something like that. I thought if I denied it then it wouldn't be happening."*

With a number of RPs describing clients in denial about menopause having any emotional impact the evidence points to Freud's (1926/1959) observations of denial as a mechanism that shields the ego from anxiety-provoking reality. In the menopausal context, denial operates to sustain as illusion of continuity with the pre-menopausal self. Yet, as RPs highlighted, such denial often impedes therapeutic exploration, reinforcing what Bion (1962) called 'attacks on linking' – an unconscious effort to prevent psychic connections that might surface unbearable truths.

Avoidance also surfaced when RPs reported that clients redirected their struggles unto external solutions, such as hormone replacement treatment (HRT), without engaging the psychic meaning of their experience. While medical interventions are valuable and necessary for some, from a psychodynamic perspective, exclusive reliance on them may function as a defence against mourning the symbolic losses of menopause. This mirrors what Pines (1996) describes as the 'splitting off' of psychological dimensions of reproductive change.

Envy, as theorised by Klein (1957/1997), was evident in clients who struggled with comparisons to younger women or their therapist. Envy can serve as a defence against feelings of depletion and inferiority. By devaluing the therapist's or other's perceived youth, the client can avoid confronting her own grief and mourning processes.

These finding suggest that defensive operations in menopause often mirror earlier developmental strategies. Just as adolescents may defend against the overwhelming changes of puberty through denial or projection menopausal women revisit similar psychic terrain. This reinforces my conceptual framework (Chapter 3 see p37), which proposes menopause as a second pubertal moment, marked by comparable defences between reality and fantasy,

connection and disconnection in alignment with Freud (1926), Deutsch (1991), and Pines (2010).

7.5 Therapist Defences as it was presented in the room, it's meaning and how it relates to clinical theories and life stages

Therapist defences are considered deeply in any psychoanalytic setting. In this research the RPs were asked to think about their work and what made it specifically about menopause. The defences I created in this theme have an element that can be related to menopause whilst also being defences that may arise in any psychoanalytic work. The interviews revealed how therapists themselves employed defences when confronted with menopausal material. When I created the sub-theme of therapists' countertransference, I realised it is not so much a defence, but it is part of the unconscious reaction to the client and their material which is why it is included in this theme. It would seem, from the results presented here, that it is important to allow space to consider unconscious material as it relates to menopause rather than something exclusively from the past or previous experiences. The crucial part of the thinking process is to view through a lens of menopause to begin with before assumptions go to what would be interpreted if the client were not in a menopause transition.

RP1 described how she colluded with the avoidance, where her own discomfort mirrored the client's resistance. This illustrates how countertransference, if unexamined, can reinforce avoidance. As Heimann (1950) argued, countertransference is not simply an obstacle but a tool: when therapists reflect on their emotional responses, they can access unconscious communications of the client. In other cases, therapists identified their own denial or minimisation, particularly if they were personally navigating their own menopause transition. One RP admitted,

> "There was part of me that didn't want to face it in myself, so I pushed it away in her too." (RP4)

Here the therapist's defensive retreat highlights the challenge of working at this intersection of personal and professional identities. This supports Balsam's (2012) argument that psychoanalysis has historically marginalised female bodily experience, leaving clinicians with limited conceptual tools to think about menopause without resorting to avoidance or pathologisation. I have come to see that a therapist's own experience is central to this work. It is one of the ways menopausal issues become possible to think about. Whether it is through personal experience, being at a similar stage of life, countertransference, or even pulling away defensively, the therapist's position shapes what gets noticed, what is avoided, and what can be understood in the session. For this reason, I see the therapist's subjectivity as a key part of the analytic process with menopause, not something outside of it. This seemed especially important in my findings, since menopause often showed up less as direct content and more as something noticed in hindsight, or first sensed through the therapist's own struggle to think about it.

Importantly one RP described experiencing 'envious countertransference' when working with a client in menopause reporting her fear that her client's 'barrenness' might 'infect' her own reproductive hopes. This complex projection highlights the porous boundaries of therapist subjectivity, where unresolved personal dynamics can intrude into clinical work. While painful, such enactments offer opportunities for deepening therapeutic exploration if acknowledged (Britton 2003).

These accounts underscore the necessity of reflexivity in analytic work with menopausal clients. As outlined in Chapter 3, menopause challenges not only the client's ego functions but also the therapist's capacity to contain, think, and symbolise. Without conscious engagement, both risk becoming caught up in collusive defences that impede psychic growth.

7.6 Creativity as it was presented in the room, it's meaning and how it relates to clinical theories and life stages

In contrast to the themes of loss or defence, the theme of creativity introduced a hopeful dimension to the findings. Several RPs observed that, once mourning processes had been navigated, clients discovered new forms of creativity and freedom. As discussed in chapter 2, my literature review (see page 20), Benedek (1950) speaks of becoming more social and engaging in new interests, Pines (2010) suggests after the losses have been mourned goals can be achieved and finally Zakary (2002) talks of there being a chance of new beginnings.

For example, one RP noted (see p102),

> *"Client H is now growing things, growing vegetables in her garden instead of growing children. She laughed when we thought about her using the fertility of the land rather than her body to create life. She found this new lease of life and said she felt like she was 11 years old again when she used to love gardening with her grandmother." (RP3)*

This reflects Benedek's (1950) notion that menopause, though initially destabilising, can move toward reorganisation and social generativity. Pines (2010) similarly emphasised that, after loss is acknowledged, many women experience a renewal of creativity and energy, freed from reproductive anxieties and societal role expectations.

From a Kleinian perspective, this movement can be understood as a shift into the depressive position, where ambivalence and loss are integrated, allowing for reparative creativity (Klein 1946/1997). Rather than clinging defensively to the past, clients may internalise a more realistic self-image and channel their energy into new symbolic pursuits. This reflects the transition when a child, after navigating the turbulence of early years, enters a calmer stage of latency. A woman can experience a return to latency, a calmer place to enjoy creativity and freedom but with the benefits of wisdom and experience. The findings tell us the RPs noticed their clients have felt there can be a relief at the end of menopause from external and internalised expectations, such as being the mother, carer, the one who does it all. This relief brings with it a sense of calm or freedom. This links to my own experiences of clinical practice and the clients I have worked with in their experiences of feeling relieved to have made it to the other side when they can prioritise their needs.. Here, libido, once channelled into reproduction and caretaking, can be re-invested or sublimated into personal creativity, relationships, and self-realisation. Erikson's (1980) stage of generativity v stagnation may require reframing in light of these specifically female experiences during menopause, with stagnation often dominating the transition before generativity can re-emerge. As Joan Erikson (1998) explains of her ninth stage, it is possible to put the dystonic element first followed by the syntonic. This would allow for the stage of 'generativity v stagnation' to be reversed for the menopause transition to 'stagnation v generativity'.

On a final note, as Zakary (2002) cautioned, the positive reframing of menopause risks colluding with cultural denial of its painful aspects. Therapist must therefore facilitate both mourning and transformation, ensuring creativity emerges not as premature defence but as authentic psychic renewal.

7.6.1 Sublimation and the reorganisation of potency

While loss and defence were prominent in the data, I was equally struck by moments in which something reorganising took place. These were not dramatic transformations, nor were they universal. Rather, they appeared gradually, often followed by periods of anger, disorientation or grief. What seemed to shift was not the return of the previous self, but a reworking of what potency and fertility might mean once the bodily expression has been altered.

Several participants described clients who, after struggling with invisibility, envy, or bodily betrayal, began to invest differently. RP3 spoke of a client who turned to drumming, forming new social connections with other women and speaking openly about menopause for the first time. Another began gardening, using language of “growing” in a way that felt symbolically significant. RP4 described a client who, having felt rage at the physical change, slowly moved towards a quieter confidence as she dressed differently and let go of organising herself around how others might see her. RP2 reflected on a client who shifted from searching for a solution that would restore her to her former self to engaging with regret, creativity and a more compassionate stance toward herself. In each of these accounts, energy has been tightly bound to bodily potency or relational validation appeared to loosen and find new forms of expression.

Freud's concept of sublimation (1905, 1930) offers a useful way of thinking about this shift. Sublimation involves redirecting instinctual energy from its original sexual or bodily aims towards socially valued or creative pursuits. In menopause, the literal loss of reproductive capacity appeared in some instances to destabilise the organisation of the libido itself. Fertility had not only been biological, but it had also structured identity, desirability, and

value. When the structure shifted, the question became not simply what had been lost but where that instinctual investment might now reside.

What I find clinically significant is that this redirection did not occur in the absence of mourning. Where participants described creative or liberating shifts, these followed acknowledgement of loss. RPs reflected on clients who spoke of sadness at no longer being needed, anger at bodily change, fear of ageing, or despair at perceived invisibility. Only once these effects were tolerated and contained within the therapeutic relationship did something reorganising become possible. Sublimation did not resemble denial or reaction formation. It followed grief. It appeared as a transformation of libidinal investment once the fantasy of regaining something that had been lost was released.

I do not suggest that menopause automatically produces sublimation. Nor did all RPs recount clients who reached this point. However, where ego disorganisation could be thought about rather than defended against, libido did not simply diminish. It reorganised. Potency shifted from being located in reproductive capacity, sexual visibility, or indispensability to others, towards a more internalised sense of self-actualisation. The clients presented spoke less about how they should appear and more about what felt meaningful to them. In this sense menopause may function as a developmental juncture in which instinctual life is required to find new symbolic expression. I suggest therefore that menopause does not merely confront women with loss, but with the task of reassigning psychic energy. Where that task is supported, what initially presents as depletion may give way to a different form of vitality – not the vitality of youth, but one grounded in internal authority and creative self-definition.

7.7 Researcher's Transference to the project

My own transference to the project paralleled themes observed in RPs and clients. On starting the study, I felt enthusiastic with boundless energy for the work this research would bring. In my transference to the actual process of the interviews and analysis of the results I was in a very opposing, infertile place, finding it difficult to engage participants in the research which seems reflective of clients not feeling able to engage with their transition. There were stages when it felt difficult to bring the project to fruition. This mirrors the clients who found themselves stuck and unable to move forward with a sense of agency. They became avoidant or went into denial that there was anything happening that could not be rectified with a pill or patch. When advertising for participants it took a long time to recruit as there were very few applicants and a quarter of the people who did apply withdrew before interview. This was the infertile surroundings I found myself in, an experience I found repeated itself throughout the project. I experienced in my countertransference to the RPs a lack of exploring their material feeling cut off or avoiding a challenge, as if they were fragile. This seemed to reflect a feeling one of the participants spoke of about her apprehension of bringing menopause into the work and felt she had to wait for the client to bring it up. In my personal experience in practice, it is the client who brings the material and steers the direction of the session but when I have been able to hold menopause in mind then I have found that clients seem more likely to bring it up and I watch out for it. Such parallel processes highlight the transferential dynamics between researcher, participants and subject matter in qualitative research.

7.8 Further thoughts in relation to my conceptual framework.

Freud's notion of an 'enfeeblement of the ego' (1926, p.242) feels unsatisfactory in accounting for the psychological turbulence of menopause. While hormonal shifts undeniably affect mood and somatic experience, Lax's (1997) perspective – that mature ego functions persist despite narcissistic vulnerability – better captures the analytic perspective. My

findings support a reformulation that recognises temporary ego disorganisation without pathologizing menopause as an illness. I believe something does happen that causes a psychological reaction when there are hormonal fluctuations of this scale in women. It is observed in puberty also as we can see adolescent girls having a quite distinctly unique experience from boys at that age. For girls there are different hormones which influence the whole body flooding the body although not at the same rate they appear to fall off a cliff at menopause. As I am not medically qualified, I cannot go into detail of the hormonal reactions within the body and cannot speak from a medical perspective but in my experience personally, and from observation of clients there is a connection between hormones and women's moods. Thinking of the ego, I suggest in the sudden loss of hormones an internal chaos is experienced. The superego appears to take over, when clients speak of how they should look, act, or feel, leaving the ego in an underactive position. I cannot say if this is due to the hormones or if it is in reaction to the fluctuations.

7.9 The Research Participant's position on menopause.

All RPs spoke of their awareness of a time when menopause had not been in their clinical consciousness as something to work with from a psychoanalytic perspective, only becoming more salient as they encountered it personally. They did not speak specifically about any clients but did so more in general terms. RP 1 commented,

> " *I was ignorant to it, and it is only in the last 5 years, since I started to understand my own perimenopause, that I have noticed it in the work".*

RP 2 stated,

> "*When I had a personal connection to it (menopause) then it appeared more in the work whereas when I was younger it wouldn't have entered my mind*"

with RP 3 reflecting,

> "*It didn't occur to me that there could be a meaning that would be so different for every client*"

and RP 4 noticing,

> "*So I do think back to those older women I worked with and wonder how much I missed because it wasn't on my radar. Gradually as I got older and started to hear more about it from other women close to me I have started to recognise when clients bring it up or if they don't bring it up then I have some curiosity about that.*"

I was interested in the last comment when RP 4 noted that now if menopause does not come up that it causes curiosity. It seems people are realising that there can be emotional aspects of menopause around loss of fertility, what that means for the client and how they can transition through into the next life stage by letting go of the previous.

An observation of interest was that the two RPs who talked mostly about the theme of Creativity were both post menopausal and had completely stopped periods themselves while the two RPs who were in perimenopause did not talk about it with their clients. All RPs stated their reason for taking part was that they felt the need for more discussion on the topic of menopause and how to work with it in the clinical setting. RP1 (see p80) talked about the number of clients she had not talked about menopause with as part of the work in her many years of working. She put this down to the fact that until she started having symptoms in perimenopause, she was not aware of the impact it can have; RP2 stated,

> "it *feels like a bit of training is missing for me*"

RP3 stated,

> "*There is a real thing happening in the body and if you're not noticing it that's a little bit crazy, isn't it*?"

RP4 reflected that in reviewing her client work presented she has been able recognise patterns in the work and how menopause is brought into the room or kept out and her own reactions with the part they play. This underscores the importance of training that explicitly addresses menopause, ensuring clinicians can recognise its psychic and emotional significance regardless of personal experience.

7.10 Interesting aspects of the female and male perspectives

This study further highlights the androcentric biases embedded in psychoanalytic theory. As Balsam (2012) argues, “Pretending these anxieties can be subsumed under the rubric of ‘castration anxiety now a days has to be a form of defensive reductionism”. She goes on to say (p.26) “One can appreciate that female-to-female dynamics give an altogether different arena from female-to-male dynamics in which to explore how the female body is mentally encoded during childhood, adolescence, motherhood and ageing” to which I would add menopause as a specifically female experience (p24).

Watson (2020) reminds us, ‘to listen to the resonances of desire and facilitate the analysand in hearing the truth in what she is saying. In this, we are scrupulous in our attention to listening out for bits and pieces of meaning and to excesses and residues that point to what is beyond every day and intentional meaning’ (p128). Clinicians are thus tasked with hearing the nuances around menopause, just as they must attune to male clients’ struggles with andropause and diminished potency. Future theory must evolve beyond mid-twentieth-century assumptions about life expectancy and reproduction to accommodate contemporary society.

The female body and the emotional connection to it have been missing from psychoanalytic theory. This research will highlight and start the conversation to bring it into the clinical setting

in the work we do with female clients. This study also demonstrates the case for listening out for material that can often be passed off as a benign comment, but current awareness shows it is important to consider how techniques and concepts created from a traditional perspective when life stages and longevity were vastly different can still be useful in our modern thinking. It is important not the throw the baby out with the bathwater.

7.11 Conclusion

In this chapter I have situated the thematic findings – loss, body and psyche, loss of fertility, client and therapists' defences and creativity - within psychoanalytic theory and my conceptual framework. The analysis highlights how menopause can bring about a sense of an unknown loss, challenge identity, evoke unconscious meaning of bodily change, and mobilise defences, but also how analytic work can facilitate mourning and foster creative re-engagement with life. I have explored the suggestions from my conceptual framework of working with clients offering containment, exploring the unconscious meaning of periods, fertility and identity to give space for ego strengthening and restore a sense of the self. These findings demonstrate that menopause enters psychotherapy less as spoken content and more as a disturbance in thinking, identity, and relational organisation, becoming recognisable primarily through countertransference and retrospectively through the process of containment. The implications of these findings for psychoanalytic knowledge and clinical practice are drawn together in the following chapter.

Chapter 8

Conclusion and Future Research Work

8.0 Introduction

This research project entitled 'The Meaning of Menopause in the consulting room and psychoanalytic thinking on a menopause life stage', originated from clinical observations that while many women transition through menopause without notable psychological disruption, others experience profoundly emotional and identity challenges. My initial impressions, shaped by private practice, was those psychoanalytic theories available in the literature insufficiently addressed the specificity of female hormonal and bodily changes and their psychic impact.

The existing literature is limited. While menopause has been addressed by figures such as Freud (1926), Deutsch (1984), Benedek (1950), Pines (2010), Lax (1997) and Balsam (2012), most accounts derive from individual case studies or theoretical reflections rather than systemic qualitative research. Feminist perspectives (e.g. Orbach, 1983; Alizade, 2018; Benamer, 2021; Chamberlain 2024) have enriched understanding but remain under-integrated with clinical psychoanalytic theory. My literature review in Chapter 2 highlighted this gap, situating menopause as a developmental transition comparable to, yet distinct from, puberty.

Methodologically, this study employed Reflexive Thematic Analysis (Braun & Clarke, 2006, 2022), chosen for its alignment with psychodynamic practice, which values reflexivity and the interpretive role of the clinician. Semi-structured interviews were concluded with the four research participants who were psychodynamically trained, each presenting material from

clinical material from menopausal clients. Notably, no male practitioners applied to participate, nor did any pre-menopausal female clinicians – an absence that warrants future investigation.

The analytic process generated sub-themes that were refined into six overarching themes: loss, body and psyche, loss of fertility, client defences, therapist defences, and creativity. In chapter 3 I developed a conceptual framework grounded in psychoanalytic theory and clinical practice, introducing the idea that menopause operates as a transitional process with developmental significance similar to that of puberty. . Chapters 5 and 6 presented the themes and illustrated them with clinical material, while Chapter 7 situated the findings in relation to psychoanalytic concepts, reflexivity, and clinical implications.

These findings contribute a new psychoanalytic lens for conceptualising the menopause transition as a distinct stage in the life cycle which is specifically female situated. They demonstrate the emotional impact of bodily change, the defences used by both clients and therapists, and the potential for creativity and integration once mourning processes are work through. This chapter consolidates the contributions of the study, evaluates its strengths and limitations, and outlines directions for future research.

8.1 Strengths of the study

This study makes several contributions at both theoretical and clinical levels.

First, the findings confirm that clinicians' own position in relation to the menopause transition significantly shapes their clinical engagement with clients. Clinicians in perimenopause or post menopause demonstrate greater openness to exploring the nuances of the menopausal experience, whereas those with less personal resonance often overlooked

these counter transferential dynamics. This echoes Heimann's (1950) understanding of countertransference as both obstacle and instrument of analytic work.

Second, the study foregrounds the need for a psychoanalytic approach that attends specifically to female embodiment. Traditional male-centric models of development inadequately capture the emotional meaning of the menstruation, fertility and menopause. By demonstrating how clients made sense of their bodily changes through themes of loss, identity disruption, and creativity, this research illustrates the clinical importance of exploring menstrual and menopausal meaning as part of identity work in particular with female clients.

Third, the methodological design – interviewing four clinicians about 11 clients – allowed for a broad scope while still enabling in-depth analysis. This mitigated (thought did not eliminate) the risk of personal bias by triangulating across multiple clinical perspectives. Importantly, the study highlights the relational dimensions; the therapist's stage of life and psychic position in relation to the menopause directly influenced the analytic process.

Finally,. I propose that menopause can be more accurately understood not as a particular life stage, but as a significant developmental transition comparable in intensity to puberty, in which bodily change brings psychic reorganisation and a reworking of identity. Seeing it as a transitional process allows for individuality and accommodates both gradual and premature menopausal experiences. This builds on Freuds' (1920/1955) and Erikson's (1980) developmental models, while responding to Balsam's (2012) call for more female-centred developmental theory. Evidence from this study suggests that, once morning of fertility and youth is accomplished, women may experience a renewed integration of identity, psychic freedom, and creative potential. Clinically, the findings suggest that when clients are offered

and analytic space to explore the meaning of their menopause, they are better able to mourn the loss of a previous self, integrate bodily change, and move forward with curiosity and creativity. This underscores the importance of working with menopause not simply as a medical or biological issue but as a psychodynamic process with developmental significance.

8.2 Limitations of the study

Several limitations constrain the scope of findings and point toward directions for future research.

First, the sample size was small, comprising four female clinicians and their clinical material with 11 clients. While qualitative studies prioritise depth over breadth, the absence of male clinicians and pre-menopausal female clinicians limits the diversity of perspectives. This raises questions about how male analysts and therapists might approach this work with female clients in menopause, or how younger clinicians might overlook or misinterpret menopausal material.

Second, while multiple cases were discussed, the level of detail was necessarily less than that of an in-depth case study. Richer analysis of three to four clients' case material of their menopausal experiences could further illuminate unconscious processes, transference dynamics and long-term outcomes.

Third, the study did not address male developmental transitions, particularly andropause, which involves a hormonal decline, changes to potency, and identity challenges. Future comparative research could examine parallels and divergences between menopause and andropause transitions, broadening understanding of midlife transitions across genders.

Fourth, the hypothesised relationship between puberty and menopause as structurally similar transitions was not fully explored. Although both involve rapid hormonal change and identity reorganisation, this study did not systematically investigate whether women's capacity to navigate puberty predicted their adaptation to menopause. A future comparative study of clinician's case studies with a focus on clients' experiences of both developmental stages would clarify this potential developmental link.

Finally, while reflexivity was integral to the methodology, my own position as a psychodynamic psychotherapist and as a woman experiencing menopause inevitably shaped the analysis. Although I worked to remain critically reflexive, future studies involving interdisciplinary teams would enrich validity.

8.3 Future research work that would further develop the line of my research

Here I explore ways forward with research to help develop knowledge of the female experience through the life cycle at particular times when there is a hormonal impact.

8.3.1 Future study idea I

A case study into the female experience of female clients going through the *menopause transition* whilst in an individual, once weekly psychotherapy treatment from my private practice taking into consideration their experience of menarche.

Proposed rationale for the study

The exploration of four clients' experience of the menopause including the clients' transference and the countertransference of the therapist. This study would give detailed knowledge of the

clinical interactions over a lengthy period and allow for more detailed investigation of transferences, projections and defences from the perspective of both client and therapist.

Proposed setting

The setting would be in private practice either in person treatment or online with a qualified psychodynamic psychotherapist.

Proposed Research participants

The research participants would be four individual clients from my private clinical practice who started the psychotherapy at no particular stage of the *menopause transition*, working through the psychological and emotional difficulties toward post menopause.

Proposed collection of data

Verbatim notes from clinical session would be recorded in addition to notes from supervision concerning my transference or countertransference.

Proposed methodology

Data would be analysed using Operationalisation. A clear hypothesis would be defined from this current study. Operational determinants definitions would be formed into a conceptual framework and used to analyse or test the data from the case study notes. This ‘testing’ of the hypothesis confirms the validity of the conceptual framework.

8.3.2 Future study idea II

A larger scale qualitative study of clinician's experience of work with clients who have gone through the menopause transition whilst in therapy using a multi-disciplinary team of researchers.

Proposed rationale for the study

To gain a wider, more diverse set of research participants, data and analysis.

Proposed setting

The study would be based on interviewing therapists about their work with clients from their private practice setting.

Proposed Research Participants

A large, diverse in gender and age, cohort of more than 20 participants would have worked with women who have experienced the menopause transition while in therapy.

Proposed collection of data

Interviews would be recorded and transcribed. Data would be gathered into codes then themes and subthemes and analysed by a multi-disciplinary team to give a more diverse analysis of data.

Proposed Methodology

Reflexive Thematic Analysis would be used to code the data inductively and deductively. Codes would be developed and defined to generate themes and subthemes which would be interpreted against current psychoanalytic theory.

8.4 Conclusion

This study represents one of the few qualitative psychoanalytic enquiries into menopause, foregrounding female embodiment as central to psychic development. It demonstrates that menopause is not merely a biological or medical phenomenon but a profound psychological transition, with implications for identity, relationality, and creativity.

By integrating practitioners' clinical observations with psychoanalytic theory, I have argued for conceptualising menopause as a distinct developmental transition within the life course with the potential for integration and renewal following loss, while acknowledging the psychic challenges of transition.

Ultimately, this research contributes to a growing recognition of the need to revise psychoanalytic developmental theory to better account for female-specific experiences. In so doing, it invites clinicians to engage menopause more explicitly in their work, enabling clients to find meaning, mourn losses, and embrace possibilities of transformation in midlife and beyond.

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