The big MENOPAUSE – the word just seems wrong!

An Interpretative Phenomenological Analysis of Christian Women's Experience of the Menopause

A thesis submitted in partial fulfilment of the Doctorate in Counselling Psychology at London Metropolitan University

by

Jane Elizabeth Beckford

Student Number: 94D24607

School of Social Sciences and Social Professions

London Metropolitan University

2023

Declaration

I hereby declare that the work submitted in this dissertation is fully the result of my own investigation, except where otherwise stated.

Name: Jane Elizabeth Beckford

Date: February 2023

Acknowledgements

I would firstly like to thank my research supervisor, Dr Angela Loulopoulou, for believing in this project from its inception, and for her support and guidance for its duration. I am grateful for the knowledge she has imparted and for her kind encouragement that has enabled me to persevere. I have greatly appreciated the support of my fellow trainees who have travelled this journey with me - especially Justine, my companion from day one – you have kept me sane! We could never have anticipated the challenges brought by a global pandemic mid-way through the course, and the trials of online learning, but we adapted and survived!

My children, Amy and Adam, have been patient and encouraging on the home front and have provided invaluable IT support. So many supportive friends and family members have tolerated my lack of social contact and cheered me on from the side-lines - I'm sure they will all be relieved I have finally reached this point. Sadly, I cannot thank them in person, but I want to acknowledge my parents, Don and Yvonne, and grandparents, Charles and Margery, who taught me the importance of learning, love, family and faith, and that we all have the potential to make a difference in this world.

Finally, I am hugely grateful to the six participants who willingly gave their time and spoke so openly about their menopause and their faith – without them none of this would have been possible.

Table of Contents

Note: Although some style guides prefer that personal pronouns referring to God are not capitalised, they also allow for author preference (Hudson, 2016). Throughout this study the pronouns for God are capitalised as the style preference of the author; this is as a mark of reverence for God and respect for participants, all of whom have a faith in God and might expect to see this capitalisation.

Abstract

Background

As a universal experience for midlife women, menopause represents a marker of aging and fertility loss that the evidence suggests may have a profound biopsychosocial impact. However, menopause is not well explored in psychological research, particularly in terms of the existential and spiritual questions it may raise for women.

Aim

To address the gap in research knowledge in terms of understanding how women of faith may utilise their beliefs to make sense of menopause, or conversely, how menopause may challenge women's experience of their faith at this stage of life.

Method

A qualitative study investigated the lived experience of six Christian women who were perimenopausal or up to five years postmenopausal. Data was collected by semi-structured interviews and analysed by interpretative phenomenological analysis (IPA).

Findings

Three superordinate themes and nine sub-themes emerged, reflecting a sequence where the impact of menopause on identity and sense of self led to efforts to adjust and respond, which for most involved finding perspective through their faith, but this was not without struggle for some. Overall though, participants identified that their faith brought perspective and resilience to the challenges of menopause and most expressed a sense of hope for the future. The implications of the study for clinical practice and further research are discussed.

INTRODUCTION

Preface

This thesis adopts the standpoint that menopause is not only a biological event, but a biopsychosocial phenomenon that can be profoundly destabilising for women (de Salis et al., 2017). Within an existential theoretical framework, there is evidence that menopause may impact the physical, social, psychological and spiritual dimensions of existence (Stephens, 2001; van Deurzen, 2012). However, spirituality is also found to foster resilience and provide meaning for women at menopause, enabling them to make sense of the challenges in the other dimensions of their lives (Steffen, 2011).

The present study explores how women with a Christian faith respond to the changes and losses menopause may bring, and specifically whether their faith influences how they experience and cope with menopause. Whilst the evidence tends to suggest a positive influence of spirituality (Steffen, 2011; Pimenta et al., 2014; Strezova et al., 2017), the intention is to be open to the possibility of negative effects too, such as menopause causing a crisis of faith. This open stance should enable a full exploration of the possible interactions between menopause and faith for women at midlife.

There follows a reflexive statement and a review of the relevance of the study to counselling psychology. The literature review (Chapter 1) then evaluates the existing research and proposes the research questions. Chapter 2 sets out the rationale for the methodology and describes the procedures undertaken. The analysis (Chapter 3) and discussion (Chapter 4) explore the themes emerging from the research interviews, and

finally, the implications of the study for clinical practice and further research are explicated.

Reflexive Statement

Qualitative research in counselling psychology does not treat data as objective truth, but as the subjective co-construction of reality by researcher and participant (Rabbidge, 2017). As a qualitative researcher, I come with my own understanding and experience of the phenomenon under investigation, and my subjectivity is an important component of the research process (Finlay, 2002). Reflexivity - defined as "thoughtful, conscious self-awareness" - is the means by which I examine and make explicit my assumptions, biases and beliefs, as well as my desires and expectations for the study, as far as possible bracketing these to limit their impact on the research findings (Finlay, 2002, p. 532).

As a woman who has experienced the menopause, I have an emotional connection to the topic that influenced my decision to research it. My experience of menopause was not inconsequential, but neither was it profoundly destabilising, yet it never seemed easy to talk about it with others. Menopause as a subject was not part of normal dialogue in any setting of my life; to broach the subject felt a challenge and my attempts to do so were not always met with encouragement. Therefore, as for many women (see Walter, 2000), my menopause was a private affair. The reticence I initially felt on talking about menopause as my research topic made me all the more determined to "push through the pain barrier" and summon the courage to explore this taboo subject further.

I became intrigued by the hidden nature of menopause - an event every woman goes through and yet is rarely mentioned. As I began to speak more openly with friends who were menopausal, it was clear some had experienced significant change – from feeling vibrant and energetic in their forties, to feeling tired, frumpy, and in some way less valued, in their fifties – with a resulting impact on their identity and selfhood. I began to reflect on the meaning of menopause for me; whilst I recognised some of the feelings expressed by my friends, I also appreciated how this midlife event had spurred me on to positive change, as I launched into a new career and became more determined to remain active and engaged in life – perhaps menopause had been a mixed blessing. The awareness that I have less years of life ahead than behind me has led to a new appreciation of things and a determination to make every day count. This sense of taking stock of life, and the theme of opportunity arising from crisis, guided me to an existential perspective on menopause and an interest in what gives women meaning and purpose at this life stage - this naturally turned my attention to spirituality.

On deciding whether to investigate the experience of women with a specific faith or a more abstract notion of spirituality, I chose the former, feeling it would lead to greater homogeneity of participants in terms of a set of beliefs, and might enable an exploration of the sociocultural influences on women from their faith community. As a Christian myself, this made me aware of the need to bracket any assumptions I might hold on how women of faith would experience menopause. In reviewing the literature, I became aware that most studies found spirituality to be a protective factor, promoting resilience in midlife women (Steffen, 2011; Pimenta et al., 2014; Strezova et al., 2017). This challenged me to be alert to the possibility of alternative discourses, not as yet

evident in current research but which might arise in my own research, in order to be open to the experience of women who may struggle in their faith at this stage of life.

I reflected on my faith: my beliefs and values are central to the way I live my life and the decisions I make; my faith provides me with a sense of meaning and purpose. I have always felt this to be an entirely personal matter and this position informs my stance towards others - everyone's "meaning of life" is constructed very differently, personal to them, and to be treated with the utmost respect. Throughout my long career in nursing, I learnt to carry my faith with wisdom and discernment, almost never discussing it at work. In embarking on a study that explores spirituality, I am acutely aware of the need to bracket my own beliefs in order to explore those of others with openness, respect and sensitivity. Van Deurzen (2011) recommends that in clearing our perspective, we should not discard our beliefs, but make them explicit and scrutinise their essence. This is clearly not a one-off event but will be an ongoing process for the duration of the research.

In embarking on a research study, there are pros and cons to having personal experience of the subject under investigation. On the positive side, the fact that I have been through menopause provides me with a greater understanding of the issues at stake, not least being able to relate to the bodily experience of vasomotor symptoms women may experience. It may also be advantageous for the research interviews that I am a mature woman - a member of what Sergeant and Rizq (2017, p. 198) identify as the "hidden sisterhood" of those who understand, with whom women feel safe to talk about their menopause.

On the other hand, I must recognise that my own experience of menopause is as unique as that of any woman. I need to bracket any assumption that others will experience things in the same way as I did; our experience is only partially sharable (Spinelli, 2005). Whether women have sailed through menopause with no trouble, or found it profoundly disrupting, this must be respected as their subjective experience. In conducting the literature review, I was attentive to my possible bias in wanting menopause to be "brought out of hiding" and taken seriously by the reader. Therefore, I was mindful of the need to attend to all discourses and include all relevant papers, even those that portrayed menopause as an inconsequential event, in order to be as objective as possible in exploring this field of research.

In conducting the research interviews, I was struck by both similarities and differences in participants' accounts. I was aware that to assume or emphasise similarities with my own experience or my expectations for the study, would be to introduce bias into the research. It was important to ensure that I paid equal attention to evidence that disconfirmed, as to evidence that confirmed, my assumptions and beliefs. To ensure that I embraced the diversity of experience and valued all participant accounts equally, I diligently reviewed the evidence for each of the themes I identified and verified their accuracy with my supervisor and two of the participants. This process was aided by maintaining a reflective journal account of the interviews and my reactions and feelings arising from them.

In conclusion, I am left with the sense that my own mixed experience of menopause, as well as my experience of both ups and downs with my faith at this time, leaves me with a curiosity as to the experience of others, rather than any fixed agenda or sense

that I have anything to prove. I feel this is a positive and open attitude with which to approach my research, but will maintain a reflexive stance throughout the project.

Relevance to Counselling Psychology

Counselling psychologists may themselves be influenced by a culture that regards menopause as taboo and pays little regard to its psychosocial impact. It is anticipated that this study will contribute to the growing body of research that emphasises the biopsychosocial nature of menopause (Stephens, 2001; Pimenta et al., 2014; Atwood et al., 2008) and will present an existential perspective on the changes and losses, as well as opportunities, it may bring for women at midlife.

Whether or not menopause is named as the issue that has brought a woman to therapy, practitioners should be aware that it may underlie other midlife issues, such as sexual and relationship difficulties, that women may want to explore in therapy. A sense of aging and decline of mind and body at menopause may impact women's identity and selfhood (de Salis et al., 2017); a search for meaning may bring them to therapy. Moreover, where society adopts negative discourses on menopause that engender shame (Sergeant & Rizq, 2017), the therapeutic relationship can provide acceptance and empathy, enabling women to acknowledge and explore their feelings. The counselling psychologist can challenge negative discourses and suggest alternative perspectives, enabling women to divest themselves of limiting accounts of their lives and bodies and formulate more positive narratives for their later years of life.

Coyle (2010) identifies spirituality as a topic that is rarely routinely explored in therapy and advocates that the counselling psychologist should engage actively with the

spiritual dimension where this is salient to clients' meaning making systems. Indeed, the pluralistic philosophy of counselling psychology requires it to engage simultaneously with many aspects of client experience - such as age, gender, culture and sexuality, as well as spirituality – in order to gain a holistic view of the person and a contextualised understanding of their life (Coyle, 2010; McAteer, 2010). Paying inadequate attention to any part of the client's subjective experience may significantly impact their adjustment, growth and therapeutic outcomes (Coyle, 2010); in the case of menopausal women, this may compound their sense of voicelessness and isolation.

The counselling psychologist may be a member of a multidisciplinary team, with the opportunity to influence other health professionals. General practitioners, often the first contact for women with menopausal symptoms, are likely to refer to the NICE guidance which adopts a biomedical discourse, emphasising the "diagnosis and management" of menopause (National Institute for Health and Care Excellence, 2015). The counselling psychologist may offer an alternative perspective, reframing menopause as a natural life transition that, despite its very real challenges, may bring benefit and growth (Hvas & Gannik, 2008a).

In conclusion, counselling psychologists should be aware of the biopsychosocial nature of menopause and the diverse ways in which it can affect women, in order to provide them with optimal holistic psychological care at this stage of their lives.

CHAPTER 1

CRITICAL LITERATURE REVIEW

There now follows a review of the existing literature on menopause from different theoretical frameworks, focusing particularly on biopsychosocial and existential perspectives and on the interface between menopause and spiritual faith.

1.1 Menopause: A Biopsychosocial Phenomenon

Menopause is a universal experience for women who reach their fifties and have not experienced premature or medically induced menopause. It is defined as the permanent cessation of menstruation resulting from the loss of ovarian follicular activity (Hoga et al., 2015). This biological event signals the end of a woman's reproductive years and a transition into the later stages of life, bringing images of aging, decline and loss (Stephens, 2001; Winterich & Umberson, 1999). Stephens (2001) suggests therefore, that the biological event of menopause should not be divorced from its psychosocial consequences, which will influence the experience of menopause for women. However, a review of the literature on menopause reveals far more of a research focus on the biological than psychological aspects of this transition; a search for articles on *menopause* using the SCOPUS search engine in February 2019 identified 56,460 in medical journals and only 894 in psychology journals, a ratio of 63 to 1. Thus, the psychological understanding of menopause appears to have been marginalised in favour of a biomedical discourse.

The biomedical model constructs menopause as a deficiency disease, amenable to treatment with hormone replacement therapy (HRT) (Rubinstein & Foster, 2012). This

focus on a failing body that needs to be fixed may threaten women's self-esteem. Moreover, it may divert attention from the psychosocial perspective that seeks to explore the impact of menopause on women's wellbeing and identity. Conversely, Stephens (2001) argues that the risk of adopting a purely psychosocial perspective is that the biological reality of menopause for women may be ignored and onerous physical symptoms disregarded. Stephens (2001) warns against a Cartesian dualism – where psychology focuses on a disembodied mind and medicine on a faulty body - emphasising instead the need for a biopsychosocial approach, where women's experience of menopause is both embodied and culturally embedded. Women not only *have* bodies but *are* bodies – they engage in the social world as embodied beings and their body provides their sense of self, which can in turn be threatened by the bodily changes at menopause (Stephens, 2001).

1.2 Introducing an Existential Theoretical Framework for Menopause

Countering the biomedical model, other discourses offer alternative positions and ways for women to respond to menopause (Hvas & Gannik, 2008a). Predominant amongst these is the feminist discourse that resists the medicalisation of menopause and presents it as a natural transition to be embraced (Hvas & Gannik, 2008a; Sergeant & Rizq, 2017). Moreover, the existential discourse explores the paradox of considering menopause both a crisis and an opportunity for growth (Hvas & Gannik, 2008b). This review will present the argument that an existential theoretical framework for menopause presents the possibility of a positive vision of female aging and a sense of retaining control over life – for better or worse.

The study adopts an existential phenomenological approach, where the concern of investigation is existence as it is humanly experienced (Heidegger, 1962). This approach emphasises themes such as freedom and limitation, temporality (awareness of our mortality), engagement and encounter with the world and others, and meaning/meaninglessness (Spinelli, 2005) that are pertinent to the present study.

Moreover, the study adopts a critical realist epistemology, in acknowledging that menopause exists as an objective reality, but that the experience of it will be subjective and not the same for any two women (Willig, 2013). Critical realism therefore recognises the subjective nature of knowledge production, alongside the objective reality of the phenomenon being studied.

1.3 The Literature Search

Searches were carried out using several databases (PsycINFO, PsycARTICLES, Academic Search Complete, Web of Science and PubMed). Searches using the terms *menopause* and *existential* yielded only two published studies, and those using the terms *menopause* and *spirituality* yielded four published studies. In the latter case, participants were either from homogenous Christian denominations (Steffen, 2011; Strezova et al., 2017) or were selected from community populations where spiritual or religious beliefs were not inclusion criteria for the study (Pimenta et al., 2014; Mackey et al., 2014). Further literature searches explored the relationship between *menopause* and each of the six major religious faiths practised in the UK (British Council, n.d.), which yielded a total of 16 further relevant studies (Christianity - 1, Judaism - 0, Hinduism - 0, Sikhism - 0, Buddhism - 2 and Islam - 13). The search was then widened to explore the related areas of *spirituality* and *aging*, and *spirituality* and *infertility*. It

is argued that this gap in current research knowledge justifies the present study on the interaction between menopause and spirituality.

1.4 Menopause Defined: An Overview of Stages and Symptoms

The menopause is comprised of various stages that require definition. According to the American Society for Reproductive Medicine (2006), menopause status is based on the regularity, or otherwise, of menstrual bleeding. *Perimenopause* begins with variations of seven days or more in menstrual cycle length and ends one year after the final menstrual period (FMP). *Menopause* can only be determined to have occurred in retrospect, after a year of the absence of periods. *Postmenopause* describes the period following the FMP (American Society for Reproductive Medicine, 2006). Throughout this study, the term *menopause* will refer to the entire menopausal transition, rather than the specific point in time at which menopause occurs, as this is the term commonly used by women to describe their perimenopause. Within the research interviews, the terms *perimenopause* and *menopause* are used interchangeably by participants, with *menopause* rarely being used as defined above.

There is considerable variation between women in the age they reach menopause, the average being 51 years (NICE, 2015), and in the duration of perimenopause, which may last between 3-9 years (McKinlay et al., 1992). The most common menopausal symptoms, linked to oestrogen depletion, are hot flushes and night sweats – termed vasomotor symptoms – but women may also experience mood changes, fatigue, sleep disturbance, memory and concentration loss (termed “brain fog”), vaginal dryness, loss of libido, headaches, and joint and muscle stiffness (NICE, 2015; Mitchell & Woods, 2001). The evidence suggests symptoms are experienced by around 80% of

menopausal women in the UK, may severely affect quality of life, and may continue for several years after menopause (NICE, 2015).

Brain fog is the commonly used term for the memory and concentration problems that occur in up to 60% of women at menopause (Mitchell & Woods, 2001). Women's poorer subjective memory performance corresponds with poorer scores on objective cognitive testing, but changes are subtle and often transient (Greendale et al., 2011). Declining levels of oestrogen at perimenopause affect memory directly through neural effects, and indirectly through mood, sleep problems, fatigue and stress (Greendale et al., 2011).

1.5 Themes from the Literature

1.5.1 How do Women Experience the Menopause?

Despite menopause being a universal experience, women show diverse responses in terms of how they rate its significance in their lives (Hoga et al., 2015; Walter, 2000). In a UK qualitative study of 48 midlife women, de Salis et al. (2017) discovered three interrelated narratives of *normality*, *distress* and *transformation* emerging from their accounts of menopause. Some women followed a "rite of passage" trajectory, with transformation emerging from loss, shame and struggle, but this was neither inevitable nor complete; women moved between the three narratives and their progress was not always linear (de Salis et al., 2017).

In the narrative of *normality*, menopause was seen as natural and fertility loss as inconsequential (de Salis et al., 2017); however, it is notable that all participants in the study were mothers and findings might be different for childless women. Moreover,

the body was experienced separately from the self, and changing identity was related to other life transitions, such as children leaving home, rather than reproductive status (de Salis et al., 2017). Further studies also find that, despite negative cultural constructions of menopause, many women view it as a neutral or inconsequential event (Ayers et al., 2010; Winterich & Umberson, 1999). Sometimes the menopause was overshadowed by other life events, such as marital crisis, or thrown into perspective by an earlier life-threatening illness, where survival to experience menopause at all was seen as a bonus (de Salis et al., 2017; Winterich & Umberson, 1999). However, there was also a tendency for women to see menopause as something they just had to get on with; yielding to hot flushes and night sweats was seen as an indulgence, or the domain of weaker or more dramatic personalities (de Salis et al., 2017). The evidence therefore suggests that women may normalise menopause and minimise its symptoms as a coping mechanism, to retain their sense of self in spite of the perceived failure of their bodies.

In the narrative of *distress,* the biological and psychosocial worlds were more closely intertwined, so the pain felt on children leaving home was exacerbated by the fertility loss, sexual decline, emotional lability and vasomotor symptoms associated with menopause, with resulting profound challenges to identity and selfhood (de Salis et al., 2017). The menopause may thus provoke an existential crisis, intensified by concurrent life events and the way in which individual women respond to them (Hoga et al., 2015). The relationship between women's attitudes towards menopause and their reporting of menopausal symptoms has been explored. In a review of 13 quantitative studies, Ayers et al. (2010) found women with more negative attitudes towards menopause reported more menopausal symptoms. However, only one of the studies

reviewed had evaluated attitudes *prior* to menopause, so for the other studies the direction of causality was unclear; it is possible women felt more negatively towards menopause *because* of their adverse experience of its physical or psychological effects.

In exploring the narrative of distress, it is worth digressing to review the findings from quantitative research of an association between menopause and symptoms of anxiety and depression. A recent Australian study (n = 711) found that for all women, perimenopause was associated with an increased risk of depression and postmenopause with an increased risk of anxiety (Mulhall et al., 2018). In women without any history of depression or anxiety, both perimenopause and postmenopause were associated with an increase in both conditions (Mulhall et al., 2018). A larger Norwegian study (n = 16,080) found higher scores for anxiety and depression in perimenopause and postmenopause compared to premenopause, with a peak in anxiety during perimenopause (Tangen & Mykletun, 2008). A United States 7-year longitudinal study (n = 266) found earlier anxiety and current life stress were more important than vasomotor symptoms in predicting a first episode of major depression in midlife women (Bromberger et al., 2009). However, the focus of this study on the physical symptoms of menopause seems to reflect a mind-body dualism, ignoring the possible impact of the *meaning* of menopause for women (in terms of fertility loss and aging) and how this may *interact with* current life stress and bodily effects to contribute to depression. In summary, menopause is found to be associated with an increased risk of anxiety and depression, but quantitative studies can only make assumptions about causality. The advantage of qualitative research is that it gives women themselves a voice to describe the nuances of their individual menopausal experience.

A further digression seems useful to explore the sexual problems that may arise at menopause and contribute to women's distress. These result from two main conditions: genitourinary syndrome of menopause (GSM) which involves vaginal atrophy and dryness, leading to painful intercourse; and hypoactive sexual desire disorder (HSDD) which may lead to loss of desire, decreased arousal and inability to reach orgasm (Kingsberg et al., 2019). Sexual health is an important determinant of overall health and quality of life, which may therefore be impacted by sexual problems at menopause (Kingsberg et al., 2019). Moreover, sexual difficulties often contribute to relationship difficulties, although existing relationship difficulties may equally diminish sexual desire (Thornton et al., 2015). A recent large US study (n = 68,131) found 73% of women aged 48-68 years were sexually active and 50% of these reported symptoms of sexual dysfunction (von Hippel et al., 2019). Menopausal sexual problems may be effectively treated, but women are often unaware of this, considering them an inevitable part of the aging process (Kingsberg et al., 2019). Moreover, cultural taboos about sex and views dismissive of the sexual needs of older women may contribute to women's reticence in seeking help with these problems (Kingsberg et al., 2019). In a study showing loss of sexual desire in 35% of women aged 45-60 years, a relationship was found between reduced sexual desire and physical menopausal symptoms and mood changes, including anxiety and depression (Rabiee et al., 2015). Women's distress may therefore be exacerbated by the complex interaction of physical, psychological and sexual changes at menopause.

In the narrative of *transformation*, women were able to accept and move on from the loss and distress of menopause, discovering new beginnings, greater confidence, renewed relationships, and in some cases a re-emerging sexuality; this was framed as

a postmenopausal restructuring of their disrupted identities and biographies (de Salis et al., 2017). Some of the positive framing of menopause focuses on women's liberation from previous family responsibilities, as well as from the restrictions of menstruation. For example, postmenopausal Iranian women felt a greater sense of cleanliness and comfort and were able to take part in religious rituals from which they were previously excluded when menstruating (Hakimi et al., 2016). However, the extent to which women can experience this greater sense of freedom after menopause may depend on their state of health, socioeconomic status, caring responsibilities, and the expectations of how women should behave within their particular culture.

1.5.2 What Influences how Women Experience the Menopause?

The diversity of women's experience of the menopause may be explained by personal factors as well as the extent to which they internalise sociocultural ideas and values - not least among these is the apparent culture of silence that surrounds menopause. Walter (2000) examined the reluctance of women to discuss the menopause with friends or family, finding its connection with female sexuality renders the menopause a taboo subject that is shrouded in secrecy. Women who did initiate conversations about the menopause were often met with others' reluctance to engage in discussion (Walter, 2000). The taboo of menopause and women's vulnerability relating to bodily changes can activate feelings of shame, resulting in the menopause becoming a private, rather than shared experience (Utz, 2011; Walter, 2000). The unspoken social rule of keeping menopause hidden may then allow dismissive narratives to persist (Sergeant & Rizq, 2017). Furthermore, because menopause is not an open topic of conversation, women have no scripts to negotiate it and to know what is normal; this may contribute

to the diverse, sometimes contradictory, views women hold about menopause (Rubinstein & Foster, 2012).

The feminist perspective gives voice to women, countering the silence and shame that surround menopause. Feminism emphasises the control of women's bodies by men, framing menopause as a natural life event that has become medicalised into a condition of deficiency (Stephens, 2001; Utz, 2011). The literature describes the societal pressure of medicalisation, where the pharmaceutical industry, supported by the media, frames natural aging processes as symptoms to be fixed (Utz, 2011). It is argued that medicalisation stigmatises menopause, causing women to feel their bodies have failed them. The feminist position is that women should be allowed to experience the menopause as a natural part of their life cycle, free from medical interference (Utz, 2011). Countering this argument, Stephens (2001) suggests that the feminist construction of menopause as natural and unproblematic may not be helpful to women suffering from, for example, heavy bleeding and sleepless nights; thus, the feminist argument should not be allowed to inadvertently reinforce the position that women should endure the menopause and avoid seeking help with troublesome symptoms.

Sociocultural influences will vary depending on whereabouts in the world women live and the times they have lived through. Lock and Kaufert (2001) challenge the concept of a universal menopause, finding much lower reporting of menopausal symptoms by Japanese compared to North American women. Whilst this may be attributed to the healthier Japanese lifestyle, Lock and Kaufert (2001) also identify the cultural expectation that Japanese women should care for the extended family and not succumb to an illness associated with indolence and luxury; this expectation may contribute to

the lower reporting of menopausal symptoms. Another factor to consider is the societal attitude towards aging; specifically, in cultures where aging is celebrated, it appears that women report fewer menopausal symptoms. Gupta et al. (2006) found that Asian women living in Delhi reported fewer vasomotor symptoms, and attributed fewer symptoms overall to menopause, than Asian women living in the UK. The latter group's experience of menopause was similar to that of UK Caucasian women, possibly due to their having adopted the culture and lifestyle of their country of residence (Gupta et al., 2006). However, the study also found that *both* Asian groups were more likely to believe that menopause could herald a new phase of life, compared to the Caucasian women who expressed fears about growing old (Gupta et al., 2006). The study was small, with each group comprising around 50 participants, but possibly demonstrates conflicting cultural influences on the menopausal experience of Asian women living in the UK that might merit further exploration.

An interaction between biology and culture can thus be seen to influence women's subjective experience of menopause from one part of the world to another. Connected to this is the value societies ascribe to older women, which may determine whether they perceive the physiological changes of menopause as progression or decline; this may in turn influence their lived experience of such changes (Astbury-Ward, 2003).

Changes in the cultural construction of menopause also occur over time, due to social change. Utz (2011) conducted a qualitative study of 11 mother-daughter pairs in the United States. Despite the physical manifestations of menopause being similar across the generations, Utz (2011) found mothers and daughters experienced menopause very differently; the mothers accepted it as an inevitable life transition, but the daughters

were determined to fight both menopause and the aging process with an arsenal of medical and cosmetic interventions. Utz (2011) proposes this is due to the daughters having lived their adult lives with the ability to control their fertility, but identifies a dichotomy between the daughters' perceived control over their bodies and the actual control being exerted over them by the media, beauty and pharmaceutical industries.

Faced with the biological reality of changes in their appearance at menopause, such as weight gain, changes in skin tone and greying hair, women may find it increasingly difficult to match cultural ideals of beauty and sexual attractiveness that in Western society are based on being young and slim. A mixed methods study of surveys (n = 270) and interviews (n = 12) explored the relationship between views on menopause and measures of body consciousness (Rubinstein & Foster, 2012). The study found that higher ratings for body dissatisfaction were linked to negative attitudes towards menopause, and that women who rated highly on self-objectification were particularly concerned about their changing appearance (Rubinstein & Foster, 2012). The study concluded that a woman who focuses more on her appearance and feels she does not live up to cultural body standards is more likely to view menopause as a negative experience than a woman who is less body-conscious (Rubinstein & Foster, 2012).

Lastly, in a grounded theory study of the impact of menopause on identity, an overall category emerged of "Continuing my story while everything changes" (Sergeant & Rizq, 2017). This was influenced by four further categories: "It feels like my body's been taken over by aliens" - women described the challenges of their changing, unpredictable bodies; "Going from one phase of life to another" – the need to renegotiate role and status in the face of narratives questioning women's relevance,

attractiveness and emotional stability; “Keeping it hidden” – a socially-acquired strategy to protect against negative narratives; and “Managing my menopause myself” – the conflict between women’s intention to shape their own response and the pressure to conform to societal expectations (Sergeant & Rizq, 2017). Overall, the study identified the emotional strain for women in negotiating a continuing narrative of their lives through a period of change – both in their body and in their place in the social world (Sergeant & Rizq, 2017). The study lends further weight to the link between sociocultural narratives on menopause and women’s response to their changing bodies, confirming the utility of a biopsychosocial approach to menopause.

In summary, the research evidence indicates that women’s experience of menopause is influenced by their personal journey through the challenges of midlife, as well as by societal attitudes and expectations. The cultural silencing of menopause may be utilised by women as a strategy to carry on as normal but may also lead to a sense of isolation and allow negative discourses to go unchallenged. Menopausal experience varies both by culture and by the extent to which women internalise the values of their culture. It follows that women’s resilience during menopause may be influenced by the extent to which they can resist negative cultural narratives and decide for themselves how they wish to live.

1.5.3 An Existential Framework for Menopause

The argument for positioning menopause within an existential theoretical framework relates to its themes, in Western culture, of aging, decline and loss, and the resulting impact on a woman’s identity and sense of herself in the world. There is also evidence that women themselves connect existential questions on the meaning of life to the

cessation of menstruation (Hvas & Gannik, 2008b). A review of literature supporting this stance will be followed by a description of menopause within the four dimensions of human existence: the physical, social, personal (psychological) and spiritual dimensions (van Deurzen, 2012).

Despite the argument for an existential perspective on menopause, there is a scarcity of literature conceptualising it in this way. Only two published papers were found that directly explored an existential approach to menopause. These papers comprised a two-part study that used discourse analysis to explore how meaning is constructed about menopause – both in written media aimed at midlife women (Hvas & Gannik, 2008a) and in terms of how women themselves talk about menopause (Hvas & Gannik, 2008b). Seven different discourses on menopause were identified, of which the *biomedical* discourse was dominant. The *eternal youth*, *health-promotion* and *consumer* discourses implied more empowered roles for women, but their implicit choices were still dictated by the medical agenda. The *alternative* discourse emphasised the non-medical treatment of symptoms, regarding menopause as a natural transition for which nonetheless women might require some assistance to keep their body in balance. The *feminist/critical* discourse rejected the concept of deficiency and the medicalisation of a natural period in women's lives, promoting a more active, informed role for women in negotiating their menopause (Hvas & Gannik, 2008a). The *existential* discourse permeated most of the interviews when the conversation turned to aging, femininity and self-development, and stands in starkest contrast to the biomedical discourse; here, menopause was uplifted to a process of self-discovery and seen as a catalyst for change and growth (Hvas & Gannik, 2008b). The written media focused on the ability to "take on life" for better or worse, in loss as well as joy.

Menopause was seen as a transition to a new phase of life, with possibilities for greater freedom and enhanced confidence (Hvas & Gannik, 2008a). The authors propose that the existential discourse offers the greatest potential for changing the negative images of deficiency and decay for women at menopause (Hvas & Gannik, 2008a).

1.5.4 Menopause Represented in the Four Dimensions of Human Existence

Existential theory proposes that there are four dimensions of human existence - the physical, social, personal (psychological) and spiritual - through which people encounter and relate to the world (van Deurzen, 2012). In these four dimensions, people find the meaning that enables "a well-lived existence" (van Deurzen, 2011, p. 176). In the physical dimension, individuals relate to the natural world, their health and bodily needs, and their mortality – they find *efficacy* in being able to stand their ground; in the social dimension, individuals relate to their family and culture, and the extent to which they feel a sense of belonging – here they find their *value*; in the personal dimension, individuals create their sense of self and identity and find their *self-worth*; and in the spiritual dimension, individuals create their ideology and find their *purpose* (van Deurzen, 2011). The four dimensions reflect the proposed biopsychosocial approach to menopause, with the addition of a spiritual perspective. Menopause can be mapped onto these four dimensions of human existence, as follows.

In the **physical dimension**, menopause is seen as inextricably linked to aging (Rubinstein & Foster, 2012; Hvas, 2006), therefore an understanding of the meaning of menopause must be considered alongside an understanding of the meaning of aging for women. Menopause brings aging to the consciousness and its physical effects then remind women of the age-related changes their body is going through. Menopause is

a tangible marker of entry into the later stages of life that is unique to women - there is no comparable marker for men. A sense of aging may provoke anxiety for the future, relating to loss of health, vitality, independence, and even fear about death (McCann Mortimer et al., 2008). In existential philosophy, aging relates to *temporality* - the awareness of our mortality (Spinelli, 2005). Yalom (2009) suggests that death and mortality form the horizon for all discussion about aging, bodily changes, life stages and midlife markers - arguably menopause could be included here.

In the **social dimension**, women report a loss of status and social value at menopause, based on how they feel others relate to them – a sense of becoming invisible (Rubinstein & Foster, 2012). Moreover, the sense of self may be challenged by negative cultural stereotypes of menopausal women – seen as being erratic, angry, stupid and forgetful – as well as a lack of older female role models in popular culture with whom women can identify (Atwood et al., 2008). Women at menopause may have as much, or more, of their adult life ahead of them as they have behind them. When their own positive outlook on life is not shared by society, there is a risk they will feel a sense of alienation from, rather than connection to, their social world. Conversely, there is evidence that social roles can provide a protective function at menopause; for example, women who occupied multiple social roles were found to have fewer concerns about their loss of fertility (Strauss, 2013).

In the **personal dimension**, women's identity and self-worth may be challenged by their loss of fertility, perceived loss of sexual attractiveness and declining sexuality. Reproductive ability is seen as a source of power and the loss of this part of the self may be mourned (Rubinstein & Foster, 2012). Women describe feeling they have

outlived their usefulness and productivity; some express a sense of loss of their femininity (de Salis et al., 2017). Even when women had decided against having children, or any more children, the loss of their capability to do so triggered deep feelings of sadness (Astbury-Ward, 2003). Moreover, menopausal sexual difficulties may impact women's self-esteem, relationships, emotional and social functioning, and psychological health (Thornton et al., 2015).

In the **spiritual dimension** lies the possibility for women to make sense of what is happening in their lives at menopause. When the physical, social and personal dimensions feel under threat, van Deurzen (2011) argues that one's ideology of life must come to the fore, to enable sense and meaning to be made of one's experience. Our spirituality helps us define what is essential to us at a time of loss, and from it we derive our sense of truth and purpose. A definition of spirituality is followed by an exploration of how spirituality may influence women's menopausal experience.

1.5.5 Spirituality Defined

In proposing an existential framework for spirituality, Webster (2004) argues that the focus of both spirituality and existential philosophy is essentially an engagement with the meaning of one's life. Existential themes of *thrownness* (the idea that we are "thrown" into the world, into a body, family, culture, and in some cases religion (Spinelli, 2005)) and *choice* become evident in the distinction between formal religion, which provides a culturally acquired worldview, and an individual's freedom to choose which meanings offer the greatest personal significance, and therefore how they relate to these (Webster, 2004).

The following definition allows for a broad conceptualisation of spirituality that could apply to different religions, or to philosophical perspectives that are not religiously based:

> "*Spirituality which comes from the Latin spiritus, meaning "breath of life", is a way of being and experiencing that comes through awareness of a transcendent dimension and that is characterised by certain identifiable values in regard to self, others, nature, life, and whatever one considers the Ultimate".*
> *(Elkins et al., 1988, p. 10).*

The spiritual dimension of existence therefore represents people's ideas, values and beliefs about life, the world, themselves and "the beyond"; it is the dimension where people create meaning and make sense of things (van Deurzen, 2012, p. 174).

1.5.6 The Influence of Spirituality and Faith on Menopausal Experience

A literature search on *spirituality and menopause* yielded only four published papers of direct relevance; two of these were quantitative studies. Steffen (2011) found that in women from the Mormon Church (n = 218), higher levels of spiritual strength were related to lower levels of reported menopausal symptoms – adaptive coping strategies partially accounted for this relationship. Spiritual strength was also related to decreased concern with bodily appearance (Steffen, 2011). A study of perimenopausal and postmenopausal Portuguese women (n = 710) found spirituality to have a positive impact in terms of lower menopausal symptom reporting; this included depression, anxiety, cognitive impairment, vasomotor and sexual symptoms (Pimenta et al., 2014). In this study, spirituality was not defined in terms of a specific faith but was assessed

in a community sample of women, using the Portuguese version of the Spirituality Wellbeing Questionnaire (Pimenta et al., 2014).

The third paper, a qualitative study of Macedonian women living in Australia, found the Christian Orthodox faith to be a dominant cultural factor (Strezova et al., 2017). Deeply religious participants found their faith helped them through the menopausal transition, and that they were as likely to consult a priest as a doctor with any difficulties (Strezova et al., 2017). Religious fasting in some cases eased, and in some cases exacerbated, menopausal symptoms; it was unclear from the paper whether the women attributed any spiritual significance to this finding, or whether it was deemed a purely physical effect (Strezova et al., 2017). The fourth paper, a multi-ethnic, qualitative study, found that women from each of three ethnic groups in Singapore drew strength from their religion and prayer in coping with their menopausal symptoms (Mackey et al., 2014).

The literature search also yielded some unpublished doctoral theses, for example, Jaeger (2004) conducted a phenomenological study that explored the relationship between sexuality and spirituality in midlife women. A pattern of transition was identified, where loss and solitude brought a deepening of spirituality, leading to rejuvenation and empowerment. Spirituality was found to provide women with insight, knowledge, meaning and purpose (Jaeger, 2004). However, few of the theses addressed both menopause *and* spirituality in depth. Those that explored spirituality often did so in the context of midlife rather than menopause per se; participants were selected from a wide age range and some studies included both men and women, so did not concentrate on the menopausal experience. Conversely, there were studies that

explored menopause, but did not consider its interaction with the spiritual dimension in any real depth.

Due to the small number of studies found on spirituality and menopause, further searches were carried out to explore the relationship between *spirituality and infertility* and *spirituality and aging.* These were considered related areas of research, due to menopause bringing an awareness to women of both their loss of fertility and their aging bodies. The search on *spirituality and infertility* yielded ten papers, of which only three were directly relevant. These studies identified two contrasting themes. Firstly, qualitative studies found the challenge of infertility may provoke an existential crisis, impacting all four dimensions of existence, including the spiritual, and causing women to question their meaning and purpose in life (Romeiro et al., 2017). A grounded theory study of Christian and Muslim women facing infertility found this crisis of faith could lead to anger towards God or spiritual leaders (Latifnejad Roudsari et al., 2014). Secondly, it was found that spirituality provided a *meaning-making framework* that helped women manage their emotional response to infertility and find peace through reliance on a higher being, as well as intimacy with God and others (Latifnejad Roudsari et al., 2014). In a quantitative study of 152 couples, spirituality contributed to improved quality of life and reduction in stress relating to the couples' infertility (Casu et al., 2018). Moreover, spirituality was found to help women transcend suffering, develop resilience and regain hope by constructing new meaning and purpose in life (Romeiro et al., 2017).

There was a greater number of journal articles on *spirituality and aging*, however most studies focused on populations from 10-40 years older than the average age at

menopause, therefore already living in old age, rather than at the gateway to it. It was generally found that spirituality fostered resilience in later life. Manning (2012) found the essence of spirituality in older women to encompass: being grateful, engaging in complete acceptance, and possessing a strong sense of assuredness. Spirituality was found to help women confront and adapt to the realities of aging, engendering inner strength, connection and transcendence (Manning, 2012).

Critiquing Rowe and Khan's (1997) model of successful aging, McCann Mortimer et al. (2008) highlight their omission of the positive contribution of spirituality. They propose that successful aging is a multi-dimensional construct, comprising personal agency, which includes spiritual expression, as well as social value derived from generativity, social role and spiritual connection (McCann Mortimer et al., 2008). This multi-dimensional model seems to mirror the four-dimension existential framework, with the omission of the physical dimension; the article suggests that physical health challenges may not be a barrier to successful aging, provided the individual can retain their sense of autonomy (McCann Mortimer et al., 2008). In summary, the evidence suggests that spirituality may enable women to cope better with the challenges of both infertility and aging. This seems to lend weight to the evidence that spirituality may promote resilience for women at menopause.

Further literature searches explored the relationship between *menopause* and each of the six major religious faiths practised in the UK (British Council, n.d.), which yielded a total of 16 further relevant studies (Christianity - 1, Judaism - 0, Hinduism - 0, Sikhism - 0, Buddhism - 2 and Islam - 13). Christian, Buddhist and Islamic studies found that menopause brought a sense of freedom from religious and cultural

restrictions around menstruation (Strezova et al., 2017; Noonil et al., 2012; Mahadeen et al., 2008), resulting in women feeling they could be more visible in public and religious life (Merghati-Khoei et al., 2014). However, women also anticipated that the menopause would represent the end of their sexual lives (Kadri et al., 2007); whilst some viewed this as entirely appropriate, others considered it problematic, expressing the view that older women still have sexual desires (Noonil et al., 2012). Kadri et al. (2007) found that Muslim women's views on menopause originated more from cultural traditions than their religious beliefs. In general, there was a greater focus in this literature on organised religion as an external factor placing expectations on women, than on spirituality as an internal dimension influencing their subjective experience of menopause.

1.6 Summary and Proposed Research Questions

The literature review has explored why women experience the universal biological event of menopause so differently from one another. It has demonstrated that women's subjective experience is shaped by cultural beliefs, as well as their individual (biological, psychological and social) circumstances at this stage of life. The negative cultural construction of menopause as an event associated with aging and decline may challenge a woman's sense of self and identity. The hidden nature of menopause may result in women's distress going unheeded. A biopsychosocial perspective is therefore essential to a full understanding of the issues affecting women at menopause.

The literature review places menopause within an existential theoretical framework that presents a positive vision of female aging, with the possibility of opportunity arising from the crisis that may occur at midlife. The influence of spirituality on

menopausal experience (as well as on the related existential challenges of infertility and aging) was explored; spirituality was found to be a protective factor, promoting psychological resilience and quality of life. Moreover, quantitative studies demonstrated that spirituality was associated with lower reporting of the physical and psychological symptoms of menopause. The possible negative aspects of spiritual engagement, such as menopause causing a crisis of faith, or women feeling invisible or misunderstood in a male-centric faith community, merit further exploration.

With so few studies on menopause and spirituality, in particular relating to Christianity as the dominant religion in the UK, there is clearly a gap in the research knowledge in terms of how women of faith may utilise their beliefs to make sense of menopause, or of how menopause may challenge women's experience of their faith at this often-perplexing time of life. Moreover, many studies recruited participants from white, married, affluent populations - there is a gap in terms of an understanding of the experience of menopause and spirituality for women from more diverse backgrounds.

In identifying a gap in the current knowledge base, a phenomenological study is proposed to explore the research questions:

> "How do Christian women experience the menopause?" and
>
> "How do they experience their faith at this stage of their lives?"

CHAPTER 2

METHODOLOGY

The literature review identified a scarcity of research addressing the psychological impact of menopause; in particular, few studies have addressed the existential and spiritual questions that this life transition might raise for women. The methodology chapter will outline the rationale for a qualitative approach to investigating the topic, specifically using Interpretative Phenomenological Analysis (IPA). It will be argued that IPA is an appropriate methodology for addressing the research questions and is compatible with both the philosophical stance of counselling psychology and my own ontological and epistemological position. The chapter sets out the study design and procedures and addresses ethical considerations. It concludes by reflecting on how the process of implementation may have shaped the results of the study.

2.1 Rationale for a Qualitative Methodology

A qualitative approach was employed for this exploratory phenomenological study. Quantitative and qualitative studies adopt different philosophical assumptions and methods of inquiry (Rafalin, 2010). Whereas quantitative research is based on positivist assumptions that knowledge is fixed and determined by natural laws, qualitative research emphasises 'lived' experience and asserts that non-observable phenomena such as thoughts and emotions can be studied; observations are subjective and filtered through the lenses of both participant and researcher (Kasket, 2013). A qualitative approach, using a phenomenological methodology, was considered the most appropriate to address the research questions. This will enable a detailed exploration of the complexities and nuances of women's menopausal experiences,

allowing their own interpretations to be heard, and elucidating the meanings they attribute to this life transition.

2.2 Ontological and Epistemological Reflexivity

All research is underpinned by assumptions about *what there is to know* (ontology) and *how we can come to know about it* (epistemology) (Willig, 2013). Our ontological and epistemological positions must be acknowledged as such - positions that are taken, rather than self-evident truths (Willig, 2019). Reflexivity enhances the researcher's awareness of the assumptions underpinning their research questions, facilitating the choice of a methodology that is compatible with their ontological and epistemological stance. Reflexivity has enabled me to identify how my way of seeing the world has fluctuated over time, and how the position I have arrived at has informed my approach to the present study.

In my previous academic study in cognitive neuroscience, the emphasis was on positivism and empiricism; knowledge claims were objective, factual and value-free. In my previous career as a nurse, medical colleagues similarly adopted a biomedical, positivist approach to patient diagnosis and treatment – their focus was more often on the condition than the person. However, as nurses, we adopted a more holistic stance, recognising the psychosocial influences on health, and advocating for our patients' best interests. Early in my present training, teaching on the humanistic philosophy of counselling psychology expounded this way of relating as the Rogerian attitude of *being with* rather than *doing to* the person; empathically connecting with another in a way not amenable to causal explanation (Strawbridge, 2016). In my therapeutic work,

I have embraced a commitment to *be with* my client in their distress and uncertainty; entering this therapeutic space has been challenging at times, but also a great privilege.

In a qualitative research interview, *what there is to know* is the person - our participant, and *how we can come to know about them* - their thoughts, emotions and lived experience – is dependent on the quality of our relating to and *being with* that person. According to Merleau-Ponty, knowledge is co-created in the embodied dialogical encounter, thus it arises from the intersubjective space between researcher and participant (Finlay, 2009). Martin Buber (2013) suggested that the very essence of being a person - our existence - consists in the event of dialogue and encounter. Buber defined two types of encounter: the *I-It* relationship, where the Other is an object to be used and experienced, but never truly known; and the *I-Thou* relationship, which requires us to be present, attuned and receptive to the Other, and open to the possibility of being fundamentally changed by the encounter (Buber, 2013). The concept of the Other being *unknowable* was advanced by Emmanuel Levinas, who defined empathy as *the art of not-knowing*, being curious and open to being surprised (Schmid, 2013). This stance of *being with* another and respectfully acknowledging their unknowability underpins my therapeutic practice and has shaped the development of my epistemological position in research.

In exploring menopause as a phenomenon which is an objective reality for all women, I accept that every woman will respond to it differently and attach to it both individual and cultural meanings. Every woman's experience will be unique to her and only possible for others to know in part, based on her interpretation and reporting of that experience (Spinelli, 2005). Thus, even speaking to a small number of women about

their experience of menopause may reveal multiple perspectives on how the world is constructed for women at this stage of life. This pluralistic epistemological position requires us to hold many truths as valid and actively engage with uncertainty; thus, we come to acknowledge the complexity of human experience (Spinelli, 2005).

Accordingly, I have arrived at a critical realist perspective. Critical realism adopts a realist ontology, acknowledging that an objective reality such as menopause exists; however, it also maintains a relativist epistemology, in that the experience of this reality will be different for different women and socially constructed (Willig, 2013). Critical realism therefore recognises both the subjective nature of knowledge production and the objective reality of the phenomenon being studied.

2.3 Rationale for Using Interpretative Phenomenological Analysis

IPA is a qualitative research methodology that gives value to the unique, subjective experience of the individual; it is therefore appropriate for exploring Christian women's experience of the menopause, thereby addressing the research questions. IPA adopts a critical realist approach and is therefore compatible with my epistemological position (Braun & Clarke, 2013). IPA is an approach informed by *phenomenology*, a philosophical approach to the study of lived experience, and *hermeneutics*, or interpretation (Smith et al., 2012). Husserlian phenomenology requires us to step outside our everyday experience to reach the essence of a phenomenon (Smith et al., 2012). Conversely, Heideggerian phenomenology rejects the notion of the detached observer, locating experience in context - in the lived world of people and relationships (Smith et al., 2012). Heidegger emphasises that we are *beings-in-the-world* - we make sense of and interpret the world from our position within it (Smith et al., 2012).

Merleau-Ponty also proposed a view of the person as embedded in the world, but emphasised how we perceive and relate to the world through our *embodiment* (Langdridge, 2013). The ideas of Merleau-Ponty and Heidegger seem especially relevant to the present study, which recognises how women engage in society as embodied beings, and their experience of menopause is both embodied and culturally embedded (Stephens, 2001).

2.4 Characteristics of Interpretative Phenomenological Analysis

IPA explores how participants make sense of their life experience. In doing so, it adopts an *idiographic* stance, in that it does not seek to generalise from individual experience (Smith et al., 2012). Moreover, IPA recognises the impossibility of gaining direct access to the participant's experience but is engaged in a double hermeneutic – the researcher is trying to make sense of the participant, who is trying to make sense of what is happening to them (Smith et al., 2012). Therefore, an understanding of the participant's experience can only ever be partial and is influenced by the researcher's interpretation and the interaction between researcher and participant (Willig, 2013).

Semi-structured interviewing is a data collection method that supports IPA and is compatible with the research aim of exploring participants' experience of menopause. Semi-structured interviews adopt a relational approach, facilitating a deep exploration of personal issues through dialogue between researcher and participant; they provide 'rich data' where participants tell their stories, express their thoughts and feelings, and develop their ideas through reflection (Smith et al., 2012). Moreover, the interview allows participants to provide a detailed, first-person account of the phenomenon under investigation, giving them an important stake in what is covered (Smith et al., 2012;

DeJonckheere & Vaughn, 2019). As part of this method, the influence of the researcher on the research process must be acknowledged and made explicit through reflexivity (Drake & Heath, 2011; Taylor & Hicks, 2009).

2.5 Consideration of Alternative Qualitative Approaches

IPA is one of a number of qualitative methodologies seeking to explore lived experience; from an epistemological perspective, it was deemed most appropriate for the present study.

A grounded theory approach might also have been considered. Like IPA, grounded theory aims to systematically identify themes from a text that capture the essence of a phenomenon (Willig, 2013). However, grounded theory ultimately aims to explicate the *social processes that account for a phenomenon*, whereas IPA is concerned with discerning the *essence of a phenomenon* as understood through the human experience of it (Willig, 2013). IPA is therefore deemed more suitable for the present study.

A further approach that might have been considered is discourse analysis, which studies patterns of meaning within texts to examine how participants use language to construct their world (Braun & Clarke, 2013). It is underpinned by the idea that language creates, rather than reflects, meaning and reality (Braun & Clarke, 2013). However, discourse analysis adopts a social constructionist approach to knowledge acquisition, so would be incompatible with the critical realist approach of the present study. Moreover, discourse analysis tends to use focus groups, so is arguably less appropriate for the study of individual experience.

2.6 Study Design and Procedures

2.6.1 Participants

The inclusion and exclusion criteria for the study are at Appendix A. Strict adherence to the two inclusion criteria, concerning menopausal status and Christian faith, ensured a homogenous sample, as required for IPA (Smith et al., 2012). Six participants were recruited; this is deemed an acceptable number for IPA studies (Smith et al., 2012).

2.6.2 Recruitment

To address the bias of previous studies towards white, married, affluent populations, the plan was to recruit from two churches known to the researcher in an area of ethnic diversity. Both churches have female leaders who publicised the study to women in the appropriate age range, however, only one participant was recruited through this approach. Therefore, further participants were recruited from another church where the researcher had contacts, from a London-wide church event on menopause, and by advertising on social media. Unfortunately, only the first participant was from a minority ethnic group, but there was greater diversity in marital status than found in previous studies, with one divorced and two single participants. Participant demographic information is shown in Table 1.

Women who expressed an interest in the study were sent a participant information sheet (Appendix B); a telephone call was then arranged to answer any queries and confirm that women met the inclusion criteria. Participants were then sent a Patient Health Questionnaire-9 (PHQ-9) depression scale (Kroenke et al., 2001) (Appendix C) and consent form (Appendix D) to complete and return; provided the PHQ-9 score met the inclusion criteria, the interview was then scheduled.

Participant Pseudonym[1]	Marital Status	Age	Menopausal Status	Whether has Children	Ethnicity	Occupation
Katia	Single	54	Post-menopausal for 4 years	No	White Caucasian	Healthcare
Megan	Single	47	Perimenopausal	No	White Caucasian	Healthcare
Connie	Married	50	Perimenopausal	Yes	White Caucasian	Church Ministry
Maya	Married	51	Perimenopausal	Yes	Asian	Church Ministry
Louise	Married	54	Perimenopausal	Yes	White Caucasian	Higher Education
Diane	Divorced	58	Post-menopausal for 4 years	Yes	White Caucasian	Retired from Healthcare

Table 1 - Participant Demographic Information

2.6.3 Interviews

Data collection was by semi-structured interviews lasting around 60 minutes each. One pilot interview was conducted with a Christian colleague of menopausal age, to ensure the questions made sense to her; following this, no amendments seemed necessary. The first interview for the main study was held in a church office, the rest (due to coronavirus lockdown) were held by videoconferencing. The interview schedule is at Appendix E. The schedule provided a loose agenda for the content of the interview, maintaining a focus on the research questions. However, it was used flexibly to facilitate exploration of participants' thoughts, feelings and beliefs (DeJonckheere & Vaughn, 2019). Questions were both descriptive and evaluative, allowing participants to express themselves freely and fully (Smith et al., 2012).

[1] Pseudonyms were used to preserve anonymity

The subject matter of the interview comprised menopause and faith - both sensitive topics that women may not be used to discussing. Consequently, it was important to establish trust and rapport with participants. It was advantageous that the researcher is a woman of a similar age to participants and was able to use her therapeutic skills to create a space where they felt able to talk freely and safely. The final question encouraged participants to reflect on the *process* of the interview, in the hope of gaining insight into the researcher's possible influence, as well as the participant's sense of autonomy; diligent reflexivity of this kind should enable any necessary modification to interview style (Braun & Clarke, 2013; McNair et al., 2008).

2.6.4 Analysis

The stages of analysis were first applied to the transcript of each individual participant. The process started during the transcribing of the interview recording, where the researcher made a note of initial thoughts and ideas (Smith & Eatough, 2016). The transcript was then re-read several times, so the researcher became fully immersed in the data and responsive to what was being said; notes on anything of interest were made in the right-hand margin. It was important to bracket any assumptions about possible findings and be open to whatever the data might yield.

The next step was to condense the notes into salient themes in the left-hand margin, ensuring these reflected and stayed as true as possible to the participant's words (see Appendix F for a section of one transcript with accompanying notes). This stage was interpretative, drawing on psychological concepts to make sense of the participant's patterns of meanings (Smith et al., 2012). It was important to ensure the connection was maintained between the participant's words and the researcher's interpretation.

Themes were then clustered, based on connections between them, each cluster was given a superordinate theme title, and a table was created of the superordinate themes and sub-themes that constituted them (Smith & Eatough, 2016). Key quotations from the participant were used to illustrate each sub-theme (see Appendix G for a table of preliminary themes for one participant). To enhance the validity of the analysis, two participants were invited to comment on whether the themes emerging from their interviews accurately reflected their accounts; both participants confirmed this to be the case.

This process was repeated for all the transcripts and a final table of themes developed that reflected the whole data set (Smith & Eatough, 2016). Themes that did not fit with the emerging structure or did not appear to have a strong evidence base were discarded at this point; this process was inevitably selective (Smith & Eatough, 2016).

A narrative account was then developed, with sufficient extracts from participants to capture the key qualities of their experience of menopause. The account is one of interplay between the participants' accounts of their experience and the interpretative activity of the researcher. Research supervision and reflexivity were used to test the coherence of the interpretation and to identify and challenge the researcher's perceptions and processes (Smith et al., 2012).

In summary, IPA is an iterative, inductive cycle, where the researcher moves back and forth, from the particular to the shared, and from the descriptive to the interpretative, whilst preserving the integrity of participants' accounts (Smith et al., 2012). This

approach maintains an idiographic commitment to individual experience - in this case, participants' experience of menopause in the context of their spiritual faith.

2.6.5 Ethical Considerations

2.6.5.1 Ethical Approval and Standards

Ethical approval for the study was granted by London Metropolitan University Research Ethics Review Panel (see Appendix H). The ethical standards for the study address the principles for research ethics set out by the British Psychological Society (BPS, 2021). Participants' dignity, rights and welfare were protected at all times (Health and Care Professions Council, 2016; London Metropolitan University, 2021).

2.6.5.2 Confidentiality and Data Protection

To protect participant confidentiality, the following measures were in place, in line with the requirements of the Data Protection Act, 2018:

- All written information was kept in locked storage and all electronic data was password-protected.
- Documents that identify participants, such as consent forms, were stored separately from written transcripts, from which all participant-identifiable information was removed.
- Pseudonyms are used throughout the thesis to protect participant anonymity.
- All data will be destroyed five years after final submission of the thesis.

2.6.5.3 Informed Consent

Before the interview, participants were given an information sheet on the study and encouraged to ask any questions before they signed the consent form. Participants were

advised of their right to withdraw from the study up to four weeks after their interview and have their data destroyed (BPS, 2021).

2.6.5.4 Managing Possible Distress

After the interview, participants were debriefed to identify any unforeseen harm or discomfort. They were then sent a debriefing sheet with contact details for the researcher, in case of further concerns (Appendix I). Although distress did not arise, a distress protocol was in place in case needed (Appendix J).

2.7 Methodological Reflexivity

Methodological reflexivity is the means by which the researcher acknowledges how their involvement in implementing the method may shape the results of their study. The recruitment process itself revealed that the study was on menopause and faith and being conducted by a trainee counselling psychologist; this may have generated interest from women for whom the psychological and spiritual challenges of menopause were pertinent, leading to a degree of selection bias. During the interviews, my aim was to be empathic, but to adopt an otherwise neutral stance, so as not to influence or over-identify with participants; it was important to be as open to findings that might disconfirm, as to those that might confirm, my expectations. Similarly, it was important to maintain the role of researcher rather than therapist; this was a challenge when participants expressed the difficulties of aspects of their menopause, and highlights the importance of diligent debriefing to ensure participants were not left with any distress.

The original plan was to conduct the interviews in a church office; it was anticipated this might be perceived as a safe space by participants, who were all church goers. However, it is also possible that a church environment might influence participants' responses or cause them to feel they had to behave in a certain way. In the event, only Katia was interviewed face-to-face in the church office. It is difficult to know whether and how this environment might have influenced Katia in her interview, however she did seem able to speak openly about the challenges in her life.

Discovering that I would need to conduct the rest of the interviews remotely, and would not therefore meet participants in person, was disappointing; this was not how I had envisaged carrying out the research project. I considered how videoconferencing might affect Merleau-Ponty's concept of the intersubjective space where knowledge is co-created (Finlay, 2009). Would I perceive the participants as embodied, three-dimensional beings when they appeared as two-dimensional images on screen? Initially, the interviews felt less natural online - the limited view made it less easy to read participants' nonverbal cues or use my posture to create a sense of empathic attention. However, the participants seemed enthusiastic about the approach, finding it more convenient to be interviewed at home, and it did not seem to prevent any of them from speaking openly about very personal matters.

In the context of the Covid-19 pandemic, a study by McBeath et al. (2020) found psychotherapists felt challenged by online therapy but clients mostly felt comfortable, more empowered and less self-conscious in their own homes; there were reports that clients seemed to "open up" more quickly online than therapists felt they would have done face-to-face. This finding might be advantageous for the research interview as a

one-off encounter. In summary, despite my concern that I would feel less connected to participants online, this was not fully borne out in reality, nor did remote interviewing seem to prevent participants' open discussion of their thoughts and feelings about their menopausal experience.

2.8 Research Quality

Diligence was applied to ensure the methodology met the four criteria for validity in qualitative research, proposed by Yardley (2000): sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance (see Table 2).

Research Quality	
Diligence was applied to ensure the methodology met the four criteria for validity in qualitative research (Yardley, 2000).	
Sensitivity to Context	**Transparency and Coherence**
The study was contextualised in relation to the existing research through the literature review. During the interviews and analysis, an awareness was maintained of both the ethical context, with regard to the sensitivity of the subject matter, and the sociocultural context, with regard to how participants' backgrounds and experience may have shaped their accounts.	The study demonstrates a coherence between the research question, the theoretical framework, and the methods used to collect and analyse the data. The presentation of sufficient data extracts allows the reader to judge the adequacy of interpretations. Through reflexivity, the researcher aimed to bracket her assumptions of what the data might yield, ensuring findings were grounded in the data.
Commitment and Rigour	**Impact and Importance**
These are demonstrated through an in-depth engagement with the topic of menopause – both professionally and personally, as well as through the diligent application of good research principles and practice in the collection and analysis of the data.	The study contributes to a limited existing research base, through its consideration of the possible interaction of menopause and spirituality in midlife women; it is anticipated that this will increase awareness of these issues in counselling psychologists and other psychological therapists.

Table 2 – Demonstration of Research Quality through Adherence to Yardley's (2000) Four Criteria for Validity

CHAPTER 3

ANALYSIS & RESULTS

Interpretative phenomenological analysis of the six interview transcripts led to the identification of three superordinate themes and nine sub-themes (Figure 1 and Table 3). There seemed to be a chronological sequence, from participants realising – often with some disbelief – that they were in perimenopause and aspects of this impacting their sense of self and identity, to adjusting to this in different ways, some finding this a struggle, and lastly, for most of them, finding their faith brought a sense of perspective, resilience and hope. Therefore, the first two superordinate themes relate to the challenges of menopause and how participants sought to adjust to these in the context of life and faith. In the third superordinate theme, participants identify more explicitly how their faith has enabled them to transcend some of these challenges.

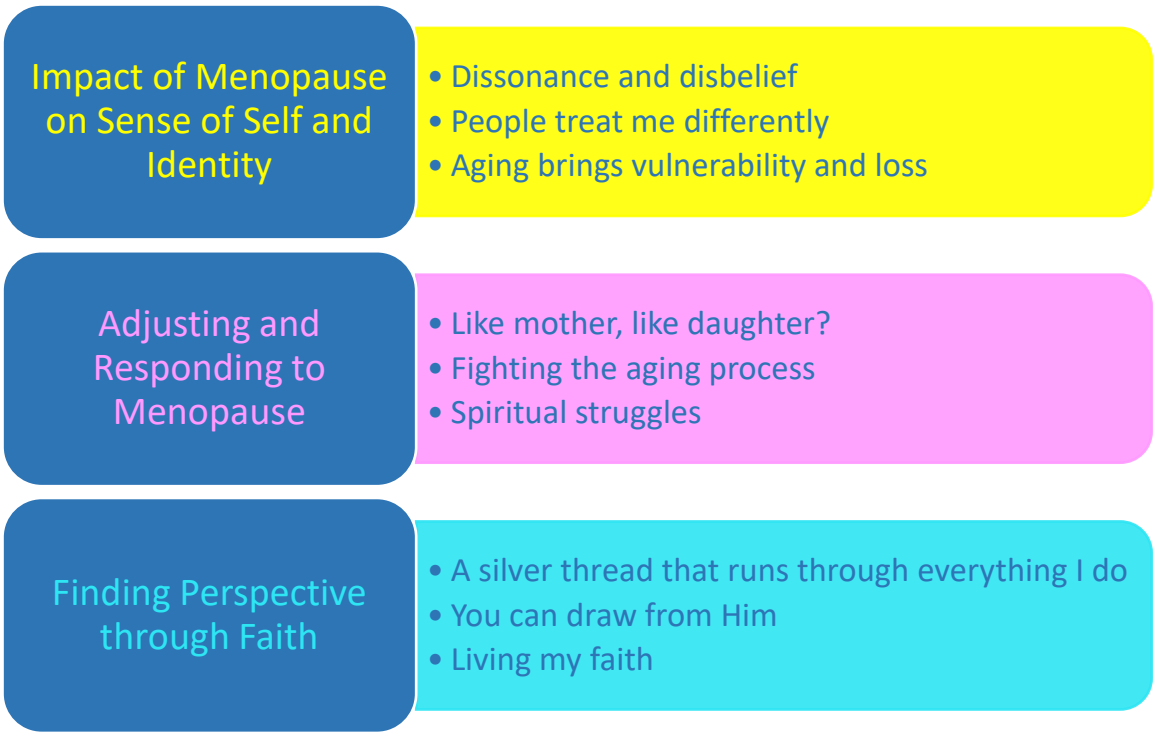


Figure 1 – Diagrammatic Presentation of Superordinate Themes and Sub-Themes

Superordinate Themes	Sub-Themes	Key Quotes
Impact of Menopause on Sense of Self and Identity	Dissonance and disbelief	*"Because in my head I feel young and it feels like now this being like…the big menopause, the word just seems wrong (laughs) … to at this stage be going through this…the word just puts you in an old category...you normally think of, you know, people in their sixties" (Megan; 157-159, 174-175)*
	People treat me differently	*"There is that sort of feeling of becoming invisible…of being less worthy of things.…I really enjoy performing in theatre, but as you get older, you're not so physically able…there were lots of things I had to say goodbye to…the younger girl type characters" (Louise; 226-238)*
	Aging brings vulnerability and loss	*"I do…sometimes worry about the future….in ten years' time…I don't have my own place, you know, I rent and…I don't have a husband, I'm on my own. I think I feel more vulnerable the older you get.... I feel vulnerable at times" (Katia; 505-510)*
Adjusting and Responding to Menopause	Like mother, like daughter?	*"It hasn't been as bad as I thought it could be because, going by my mum's experience which was…quite traumatic …she had it quite bad…. I had the fear that it might happen to me in later years, which it didn't really" (Katia; 10-15)*
	Fighting the aging process	*"I was the heaviest I'd ever been… I thought I have to do something about this, because I was feeling really old, you know, just really yucky about myself. And actually, losing the weight...I've got a bit of a waistline back as well now.…and all of that stuff's quite nice" (Diane; 172-177)*
	Spiritual struggles	*"It's like I've got something stuck in my foot and I'm...ignoring the fact that I've got it stuck in my foot and carry on doing everything…God can't reach you if you barricade yourself into something and so that's letting yourself be aware of that and gentle to yourself" (Maya; 641-648)*
Finding Perspective through Faith	A silver thread that runs through everything I do	*"It's like a silver thread that runs through everything I do. And even if I'm not thinking about stuff explicitly from a faith perspective, I know it's part of my thinking….it has always run through everything…. I think it's an anchor really… a constant that I can go back to" (Diane; 359-367, 379-380)*
	You can draw from Him	*"I think that's what's so beautiful is to know that…the Holy Spirit is saying… that you can draw from me…. that's what I love about knowing God is that you can draw from Him and that I have that expectation - He's seriously going to help me now" (Connie; 452-458)*
	Living my faith	*"I'm looking forward to that time of my life …to do the things my heart wants to do rather than just do the things I have to do…. I feel I can really start to live my faith in a way that I can't always now…. perhaps as I grow older, I'll actually be able to be more of that person I really, really want to be" (Louise; 700-714)*

Table 3 – Superordinate Themes and Sub-Themes with Key Quotes

3.1 Superordinate Theme 1: *Impact of Menopause on Sense of Self and Identity*

Menopause was met by participants with a sense of disbelief and led to a dissonance between how they felt in themselves and how menopause made them feel. It influenced how they perceived themselves and how they felt others perceived them; this was associated for some with a sense of aging and feeling less visible in society. Moreover, the cognitive and emotional effects of menopause threatened participants' self-confidence, as well as their prior sense of a constant, predictable and competent self. For the single participants in particular, the sense of aging that menopause signified brought feelings of vulnerability and loss.

3.1.1 Sub-Theme: *Dissonance and disbelief*

The theme of dissonance and disbelief was connected with the sense of aging menopause brought, as well as its cognitive and emotional challenges; together these impacted participants' identity and sense of self.

Firstly, participants felt that menopause heralded an older stage of life. For Megan, this seemed particularly disconcerting, as she felt she was too young to be going through menopause:

> *"Because in my head I feel young and it feels like now this being like…the big menopause, the word just seems wrong (laughs)...to at this stage be going through this…the word just puts you in an old category...you normally think of, you know, people in their sixties" (Megan; 157-159, 174-175).*

Megan talks about menopause being associated with “people in their sixties” – much older than her; it seems that she feels menopause is not relevant to her because she states that she “feels young” and that the word is “wrong”. There appears to be a dissonance between how Megan sees herself and how she views menopause conveyed by this quote. It may be that she perceives a stigma associated with menopause. Megan talks about an “old category” which could indicate how she thinks society views menopausal women and for her this is a category she does not wish to belong to. A further indication of Megan’s struggle with finding herself in menopause seems to be her use of the word “big” to describe the menopause, and her laughter, as if she cannot quite believe or comprehend that this is happening to her. Menopause seems to represent an unwelcome milestone in Megan’s life, giving her a new, unwanted identity.

Louise, similarly to Megan, identified a certain dissonance, expressed through a discrepancy between her physical age and her psychological age, which seemed to present a challenge to her identity and sense of self:

> *“It is that whole psychological coming to terms with the fact that you're not the person that.... you feel inside, 'cause I…feel personally that…my heart is still the same heart as it was when I was eighteen, twenty, thirty” (Louise; 246-249).*

Louise seems to consider that menopause signifies a certain physical change associated with aging and this does not fit with how she views herself; her identity seems to be tied to how she feels “inside”, which is very youthful, as indicated by the phrase “my

heart is still the same heart as it was when I was eighteen, twenty, thirty". She identifies the "psychological coming to terms with" - perhaps having to accept - the fact she is "not the person" she feels inside, which implies a sense of loss of a younger self. For Louise, it seems that as a menopausal woman she can no longer consider herself young; it is unclear whether this is her own perception or a perception she feels is imposed by society.

As well as the sense of aging, the cognitive challenges of menopause - the memory and concentration problems often termed *brain fog* - presented a further challenge to the sense of self. Katia described how brain fog affected her confidence:

> *"I get my words muddled up and can go round the houses…explaining things, not being succinct…..I sometimes feel that I'm a bit stupid because of the brain fog….it has affected my confidence…. I'm not as bright as other people…. I get muddled up or not able to get my point across very clearly" (Katia; 312-314, 346-349, 354-357).*

Katia seems to convey a general state of confusion that presents itself through an inability to express herself succinctly; this hampers her communication with others. She twice uses the term "muddled up" and describes a convoluted route "round the houses" to make herself understood – there is a sense of a struggle with a brain that is in some ways letting her down. It seems as a result, that Katia perceives herself as "a bit stupid" and "not as bright as other people" – concluding that the cause is a lack of intelligence rather than fluctuating hormones - consequently she describes an impact on her confidence. Interestingly, Katia found it difficult at times to express herself in

the interview and seemed to lose her train of thought, depicting in some way what she had been describing.

Louise described a difficult year, where her mother's death and lockdown had coincided with the onset of perimenopause, manifest primarily in cognitive effects:

> *"My mother died in early February, and we just managed to deliver her funeral and then we got to lockdown and everything... So, the world has been very strange for me this year and I've had to deal with what I now realise was the onset of perimenopause…. I was feeling under par, not able to function, definitely a sort of brain fog…those sorts of symptoms that aren't very physical" (Louise; 5-13).*

Louise describes a "strange world" where life events have been rendered more challenging by feeling "under par, not able to function" – there is a sense of almost literally feeling she is in a fog. The image conveyed seems to be one of Louise trying to find her way through the year to get to the other side. With her mother's death, lockdown and perimenopause, the year seems like a place where she has felt lost and not sure what to hold on to. Her remark that the brain fog symptoms "aren't very physical" may imply that she had a clear idea of what menopausal symptoms would be, and the cognitive effects were unexpected. At the same time, she seems uncertain whether they were just due to perimenopause or linked to her mother's death and lockdown too. All these events made the onset of perimenopause more difficult to recognise, so Louise later talks about how she "rewound" the year, to work out which symptoms she could retrospectively attribute to hormonal changes:

> *"So, I've kind of rewound the year and worked out…okay, that was probably due to the changes in my physical state and the hormonal changes, and that's been really such a relief" (Louise; 108-111).*

Louise identifies that the sense of strangeness and not feeling herself could probably be attributed to her "physical state and the hormonal changes". It appears that recognising the potential effect of hormonal changes on her cognitive ability brought significant relief; there is an implication that Louise feared she was losing her mental faculties. This is further confirmed when she states that because her mother had died of dementia, she feared she was developing the same:

> *"*[It] *made me think I was slipping into a dementia…and that's what my mum died of" (Louise; 40-45).*

Lastly, participants described the emotional effects of menopause - feeling angry, irritable and overwhelmed – and the impact on how they reacted to day-to-day situations; this created a dissonance with their prior sense of themselves as calm, rational and in control. The menopausal effects on mood were rendered more disconcerting by their unpredictability – just as the menstrual cycle becomes less regular in perimenopause, so do any accompanying mood changes – therefore, it was not always easy for participants to identify the reason for their sudden emotionality.

Maya described feeling overwhelmed at times by family life; this was new to her with perimenopause, and she described how it made her feel differently in herself:

"It's just the...kids are fighting, everybody stop...it's just too much. Normally you're...there calming down. I just feel…I can't cope with this…it's normal teenage stuff, it's nothing...the stuff that you defuse.... It just feels like, oh my gosh, I can't cope with this…. with the shouting…or I snap….which is not normally me….inside I'm feeling different" (Maya; 652-664).

Using the present tense which gives a sense of immediacy, Maya depicts a scene of "normal teenage stuff" - a fight that she would normally "defuse". The fact that she states "normally" may indicate that she feels she is failing to cope with something she should be expected to cope with. Her sense of feeling overwhelmed renders her unable to control the situation - twice she says, "I can't cope with this". Her phrase "everybody stop…it's just too much" feels like a cry for help - whether or not she has actually said or felt this in the heat of a family argument is unclear. The alternative response she describes - "or I snap" - indicates a sense of becoming angry with her children which is "not normally me" – she perhaps feels she has not responded in the way she would have liked. Maya finishes by saying "inside I'm feeling different" – implying a dissonance between her normal calm, coping self and the overwhelmed state in which she finds herself.

Similarly, Connie described the perplexity of a sudden, unpredictable onset of anger:

"You almost don't — you don't realise what's happening and then you realise you're just angry…and it's not necessarily something…that you're angry about, instead it's just…to do with your emotions or where the hormones are taking you" (Connie; 113-120).

Connie depicts a sense in which anger comes upon her unawares when she says: “you don’t realise what’s happening and then you realise you’re just angry”. She recognises that there is nothing she is angry about – she is “just angry” and “it’s just to do with [her] emotions” - the word “just” gives a sense of an emotional response unrelated to any problems in her day-to-day life. Connie seems to experience a dissonance between her normal emotional response, connected to life events, and this new experience of seemingly irrational, unpredictable anger that seems to her to be hormonally driven. This impacts her sense of self, as expressed below:

> *“I can start thinking: “Oh I’m an angry person”. I mean, I’m not an angry person, that’s not who I am. God hasn’t set that over me, that’s not my identity” (Connie; 468-470).*

Connie identifies that her anger influences how she thinks about herself – as “an angry person”. However, she does not feel she is like this and expresses that it is incompatible with her identity as a Christian. In “God hasn’t set that over me” there is a sense of resisting the angry identity by asserting her Christian identity, and gaining some perspective on her anger.

3.1.2 Sub-Theme: *People treat me differently*

Participants described how they felt they were perceived or treated differently by other people at the time of menopause. It is unclear how much this feeling originated from other people’s actual behaviour towards them, and how much from participants possibly internalising cultural stereotypes on menopause and female aging, which may have impacted their sense of their value in society.

A perception of being viewed less positively by others was interpreted by participants as becoming less visible or invisible. They expressed a sense of having less social value as they aged, and that more attention was paid to younger women. Diane described this in the context of both church and work settings:

> *"I think what struck me was...I became less visible…. realising when you're in a group of people, it's kind of the younger women who get noticed and you don't…I can't put my finger on a specific event and go: "I particularly noticed it there". It's something that builds, that I noticed over time" (Diane; 96-105).*

Diane describes something that "struck her", that she "noticed over time" – there is a sense of a gradual realisation that she is receiving less attention than others in her social sphere. Her phrase "I became less visible" denotes a sense of fading into the background as the younger women take centre stage. The subtlety of this attentional shift seems to make it difficult for Diane to feel sure her perception is borne out in reality and not just a figment of her imagination. Moreover, she seems quite accepting of the situation as something that happens with age; she does not seem to be offended or feel she is being treated unfairly.

Similarly, Louise described how she felt she had become invisible in the area of amateur dramatics, where she had been forced to give up roles she had previously played:

> *"There is that sort of feeling of becoming invisible…of being less worthy of things.…I really enjoy performing in theatre, but as you get older, you're not so physically able…there were lots of things I had to say goodbye to…the younger girl type characters. In pantomime, over a number of years I've been cast as the cat in Dick Whittington and last year they replaced me with a 15-year-old (laughs). Those sorts of things are really hard to take" (Louise; 226-243).*

Louise equates "becoming invisible" with "being less worthy" - perhaps feeling less valued by others. The loss of theatrical roles she had previously enjoyed should perhaps be considered alongside what they might represent in terms of her self-expression – the role of the cat may denote agility and playfulness, for example. It is unclear whether Louise had really become physically unable to play the part of the cat or whether it was the perception of others that her age rendered her unsuitable for the role; perhaps reflecting a view that it is unseemly for a woman in her fifties to be agile and playful. The loss of this role seems compounded by Louise's sense of being "replaced" – others having seemingly judged her as too old, rather than it being her choice to give up the role. Her laughter appears incompatible with her reflection that this has been "hard to take". For Louise, aging - perhaps more than menopause – seemed to have resulted in the diminishment of an important outlet for her creativity and self-expression, with a resulting impact on her identity and self-esteem.

For Diane, the challenges of menopause had coincided with her recent retirement from an all-encompassing senior nursing role. She reflected on how retirement would impact her identity, wondering whether she would "just now disappear":

> *"I think, actually, it's the retirement with menopause as well…it's that getting your head around and kind of moving you into a different space…. You're not the kind of high-flying chief nurse anymore….all of that adjustment…that's what I was saying about the invisibility…would I just now disappear in terms of the networks I have….Being a senior nurse has defined me for a long time. And so having to think about: Who am I now?" (Diane; 225-239).*

Diane identifies how the combination of menopause and retirement has moved her into "a different space" – a new phase of life perhaps. The transition to retirement raises existential questions for her: in relinquishing the identity of a "high-flying chief nurse", who will she now be? If she no longer exists in the professional networks she has been a part of, will she "just now disappear"? This quote raises questions about how Diane sees herself existing in society. She identifies that she has become defined by her career, and in losing this role seems to fear she will disappear from society altogether. It seems she may wonder whether people will still connect with her if she no longer holds her professional role. Diane talks about "adjustment" and "having to think about" her identity in retirement; thus, she seems to take a degree of control in navigating her way forwards and finding ways to stay connected and visible in life.

Louise does not explicitly talk about people treating her differently in the quote below, but describes how her perception of the impact of brain fog on her verbal fluency makes her *think* people will perceive her differently:

> *"I've started to get less confident about giving my opinions or speaking in a meeting with important people, because I feel that I will stumble on a word…even though I know what I want to say, it doesn't come out as eloquently as I would want it to…. that's impacting my self-esteem" (Louise; 259-264).*

Louise implies that she considers herself to be normally eloquent and that people normally value her opinion, but she seems to worry that brain fog is impacting her eloquence and that as a result people will view her differently. She seems to feel her perceived lack of fluency may affect her status at work, and implies she is holding back from speaking to avoid the risk of being exposed as inarticulate. In this quote, Louise seemed to stumble over her words more than at other times in the interview, as if thinking about stumbling over her words made her do so.

The sub-theme "People treat me differently" seems to relate as much to aging and life transitions such as retirement, as it does to menopause. However, there may be a cumulative impact on the identity where life transitions, such as retirement and menopause, coincide and contribute to women's sense of aging, moving to a different stage of life, and becoming less visible and valued in society.

3.1.3 Sub-Theme: *Aging brings vulnerability and loss*

In recognising menopause as a gateway to their older years, participants reflected on what aging meant to them. This sub-theme covers the experience of the single (never married) participants, who seemed to feel particularly alone and vulnerable. Moreover, they reflected on the sense of loss brought by the end of their reproductive years, where

this removed any possibility of having children and also led to their perception that marriage was no longer a possibility for them.

Katia had no contact with her family of origin and an auto-immune condition, possibly triggered by menopause, sometimes prevented her from working:

> *"I do…sometimes worry about the future….in ten years' time…I don't have my own place, you know, I rent and…I don't have a husband, I'm on my own. I think I feel more vulnerable the older you get.... I feel vulnerable at times" (Katia; 505-510).*

Katia's fears seem focused on a period ten years into the future when she feels she might be less able to provide for herself. She identifies the insecurity of her accommodation when she says "I don't have my own place" but this seems as if it could be a metaphor for her life – a sense of not having found a place of belonging and safety. Her phrase "I don't have a husband, I'm on my own" seems to portray a sense of feeling alone in the world. Katia appears to feel that she can only rely on herself; this leads to the feeling of vulnerability she expresses – a sense of being unprotected.

For Megan, the feeling of aging that came with menopause brought a sense of an uncertain future. She recognised that aspects of her life that had never previously worried her, now brought anxiety:

> *"I do get a bit anxious looking at the future…. I often think about the fact that…I'm here on my own in this house…and it was always fine with my family being so far away, but lately…I really miss them, and it's very scary for me to think* [of her parents getting older] *… the chances of them getting sick…really scares me" (Megan; 511-529).*

Megan identifies certain changes in her thinking brought by menopause and aging. Something that "was always fine" - her family being abroad - now brings a longing for their proximity and a fear for their welfare. Moreover, menopause seems to have heightened Megan's sense of being alone - "here on my own in this house". An awareness of aging seems therefore to bring an awareness of mortality and anxiety about death, primarily for her parents, but arguably also for herself, in recognising that the protection of the older generation will be removed by their passing, leaving her to face the later stages of life alone.

Both participants, not having married or had children, described a sense of lost opportunity on reaching menopause; this contributed to a degree of spiritual struggle.

Katia relayed with some sadness that she felt that God had told her she would marry. She concluded that she must have been wrong and must now come to terms with her life as a single, childless woman:

> *"I didn't marry and..... would have liked to have done…I felt God said that I would do, and it hasn't happened…in my late thirties I felt He said that…. I've got to a point thinking, okay perhaps I've got that wrong and it's coming to terms with that I suppose…also not having children" (Katia; 221-226).*

Katia's focus seems to be on marriage more than children, which arguably is not ruled out by menopause, but she does not seem to hold out any hope that it will happen. Therefore, believing that God had told her she would marry, she concludes that she must have been wrong, rather than that God has let her down or been slow to act. Perhaps it seems easier to her to rule out the prospect of marriage than to hold on to it, consequently she describes "coming to terms with" her singleness. Katia's brief comment "also not having children" does not provide clarity on how much this is an issue for her – whether she had a strong desire for children or merely saw them as something that would come along with marriage is unclear.

Similarly, Megan described a "massive desire" to be married; this caused her to feel angry with God that it had not happened. Like Katia, she seemed to feel that menopause significantly reduced the possibility that it would:

> *"There was definitely some anger about the feeling of why…. being single is such a big thing…that I've struggled to deal with…. The menopause …makes me realise that maybe…I will never…get married because now I'm in an even older bracket" (Megan; 386-393).*

Megan does not identify herself as the subject nor God as the object of her anger when she says "there was definitely some anger" – it seems she does not feel comfortable to own her anger nor to admit directing it at God. Her description of singleness as "such a big thing…that I've struggled to deal with" reflects her earlier description of "the big menopause", giving an indication of how significant in her life these issues are; they seem to define her, and she struggles to transcend them. Menopause, she feels, places her in "an even older bracket" where she seems to feel her hope of marriage is fading. Megan articulated further her struggle with God over her singleness:

> *"It's…this realisation again of where I'm at…It's moments of just being like - argh! … I'm not constantly angry with God…I know it's not His fault…I don't blame Him for everything. I'm annoyed more than angry…because when I think of menopause it…goes to the singleness thing. Then I'm angry about it with Him, like: Why not? What am I not? What don't I have? Or just…Why? (Laughing) Why not me?" (Megan; 432-451).*

Megan describes a "realisation again" of her singleness on reaching menopause – there is a sense of frustration that "where [she is] at" is not where she wants to be. In this quote, Megan plays down her anger, saying she is "not constantly angry with God", that "it's not His fault" and she does not "blame Him for everything". However, this seems incongruent with her belief that God could provide a husband for her, but has not done so. Although she seems uncomfortable expressing anger towards God, Megan does eventually admit "I'm angry about it with Him". She seems to reason with God, asking Him "why not me?" and questioning whether there is some inadequacy in her to explain why she, unlike others, has not been blessed with marriage. Her laughter perhaps indicates her bewilderment with how her life has turned out.

3.2 Superordinate Theme 2: *Adjusting and Responding to Menopause*

Some participants seemed taken by surprise to realise they were in perimenopause, in one case having to have this pointed out by a friend. Perhaps due to the taboo of menopause, they did not seem prepared by having discussed or read about it in advance. This lack of preparedness may have exacerbated the impact of menopause on the identity and sense of self, described in Superordinate Theme 1. In adjusting and responding to menopause, participants sought to discover what they should expect to experience, to try to normalise what was happening to them – their main source of information on this being their mother. Themes were also identified of fighting the aging process - perhaps trying to minimise the impact of menopause on the body - and of spiritual struggles, as menopause challenged participants' faith in different ways.

3.2.1 Sub-Theme: *Like mother, like daughter?*

Participants sought to discover what they should expect from their experience of menopause – what was normal. Their main source of information on this was their mother, based on the assumption that they were likely to experience menopause in the same way that she had. Two participants - both healthcare professionals - believed that genetics would play a significant role in determining their menopausal experience. Participants either sought information by speaking directly to their mother or by drawing on their memory of how things had been for her in their younger years. For some participants, their menopausal experience was a lot easier than their mother's had been, which brought a sense of relief.

Diane explained that, based on her mother's experience, she had anticipated a difficult time with menopause:

"My mum had a very difficult menopause with really heavy periods of bleeding and flooding and all of the physical symptoms, and actually wound up having to have a hysterectomy. So....knowing there's a genetic component to this, I was braced for it being a really difficult time. In actual fact, it was quite straightforward" (Diane; 5-10).

Diane describes her mother's experience as one of difficulty and struggle, leading to a hysterectomy. This is a portrayal of menopause as a range of unpleasant symptoms significantly impacting everyday life, for which the only solution seemed to be the surgical removal of the uterus – the major reproductive organ, seen as the source of the problem. Diane assumed that her experience of menopause would be similar to her mother's; she describes being "braced for it being a really difficult time". Bracing yourself implies a sense of mentally preparing for difficulty, anticipating a worst-case scenario. Diane seemed relieved that her actual experience turned out to be "quite straightforward".

Similarly, Katia expressed the fear that her experience would be the same as her mother's, but in this case, the impact was on mental rather than physical health. She described a frightening time as a teenager when her mother was menopausal:

"It hasn't been as bad as I thought it could be because, going by my mum's experience which was…quite traumatic…she had it quite bad…I was a teenager when she was going through her menopause…. I had the fear that it might happen to me in later years, which it didn't really…. She used to be quite

angry and take her anger out on me and sometimes used to hit me…. have these rages" (Katia; 10-15, 29-31).

In describing her mother's experience as "traumatic", it is unclear whether Katia means the trauma was experienced by her mother or, possibly more likely, herself. She describes a mother consumed by anger and rage, which she took out on her teenage daughter, at times with physical violence. There is a sense of a woman driven crazy and out of control by her hormones – a mother who has become unpredictable and unloving, possibly resenting her newly-fertile daughter. Katia seemed to have internalised this negative representation of menopause, fearing it would become her own reality. Her phrase "the fear that it might happen to me" gives a sense that something else – a hormonal rage – might take her over, causing a loss of control. Katia expresses relief that these fears were not realised in her own menopausal experience.

Conversely, Megan's mother was one of the few people she felt able to turn to when, in her mid-forties, her fairly early menopause took her by surprise and led to embarrassment. In talking to her mother, she sought confirmation that there would be a genetic basis for this, but discovered her mother's menopause had started later than hers:

"I've mentioned it to my mum.....because I've never asked her…if hers was also very early onset…and she said hers was only towards the beginning of her fifties" (Megan; 94-97).

"They sometimes say.... it's genetic…like if your mum goes through it early then you probably will go through it early as well" (Megan; 160-163).

Megan turns to her mother to attempt to normalise an experience she feels is abnormal. She also turns to what she possibly views as the certainty of science to make sense of the situation. To reverse the way Megan expresses it, she assumes that she must be experiencing an early menopause because her mother did. Discovering that her mother's menopause was not so early brings a sense of disappointment in her tone of voice - perhaps feeling a little let down that her mother apparently belongs to the group of women who experience menopause at what she sees as the normal time, thus heightening her own sense of being abnormal and different from others.

Maya made a connection between her easy experience of the physical aspects of menopause and her mother's experience:

"So, I mean...my experience is not having too many symptoms, certainly my mum doesn't remember having too many actual, sort of, you know, having to fan myself or anything like that" (Maya; 36-39).

In this quote, Maya switches seamlessly from talking about herself, to her mother, then back to herself again. Rather than explicitly articulating a genetic argument, Maya expresses a sense of being intertwined with her mother and a firm assumption that the menopausal experience will be the same for both of them, in not having too many problems with vasomotor symptoms.

Louise was still in the first year of perimenopause and considering the possibility of HRT should she feel she needed this as time progressed. It is noteworthy that she refers to her mother's experience of HRT as her point of reference, rather than contemporary medical sources:

> *"I remember my mum, when she was going through it, had quite a bad time and did go on HRT, and in those days HRT…was more brutal perhaps than it is now, and there's lots of different choices now" (Louise; 164-168).*

Louise describes a sense of her mother being caught between the challenges of a "bad time" with menopause or the "brutality" of HRT. She expresses her anticipation that in today's world, HRT will be less brutal, and she will have greater choices in managing her menopause than her mother did.

Using their mother's experience as their main point of reference led to participants' menopausal experience being defined in relation to this – generally being described as either better or worse than their mother's experience. An assumption, based on genetics, that their menopause would be the same as their mother's often seemed unsubstantiated and arguably led to needless worry for Diane and Katia as they approached perimenopause. There was no particular evidence in this study that their mother's experience provided useful information to reassure participants facing the destabilising impact of menopause. However, it is more the place of large-scale quantitative studies to examine the strength of the genetic argument, whilst recognising that biological factors are only one part of the picture, along with psychosocial

influences. The discussion (Chapter 4) will explore participants' prioritisation of their mother's experience over other sources of information.

3.2.2 Sub-Theme: *Fighting the aging process*

This sub-theme relates to the significant efforts some participants made to retain their youthfulness – in terms of either physical fitness or appearance - to try to counter the aging effects of menopause. This seemed important to their self-concept, as well as how they felt others would perceive them. Some described the challenge of maintaining their previous level of physical activity in the face of menopausal fatigue.

Megan described "exercising like crazy" to prove that she was still able to do so:

> *"It's... like this conflict between the fact that I ... still feel young…but then this thing has…put me now in another bracket of old ... I have all these symptoms of getting tired…I am exercising like crazy, and I don't know if this is mentally for me to just kind of….prove to myself that I …can still … do normal exercise like I…used to" (Megan; 133-142).*

Megan identifies the "conflict" between her sense of herself as young, and menopause having put her "in another bracket of old" – almost a sense of being picked up against her will and moved across to another category of womanhood. This seems to be something she feels menopause has done to her and she is fighting back! Her description of "exercising like crazy" gives a sense of strenuous activity to beat her tiredness into submission. She identifies needing to prove she can still function as she used to, refusing to allow menopause to rob her of her physical prowess.

Similarly, Connie had taken up dancing again to challenge herself physically, having reached an advanced level of proficiency when younger. Despite describing herself as physically fit and confident in her body, she still found it "threatening" to walk into a dance class with younger people:

> *"I actually started dancing again…that was quite threatening……I'm walking into professional classes and thinking: Why? I should've never started that…I'm dancing with 20-year-olds, but I'm a 50-year-old. But you can remember how you were…and then you realise you have to be kind to yourself, you're getting older" (Connie; 218-228).*

Connie's use of the word "threatening" may imply a fear of being publicly exposed as someone who, due to her age, should not really be there, does not fit in with the 20-year-olds, or may not be physically fit enough to cope with the class. Walking into the class, she questions herself as to why she is there, whether this is a mistake. She identifies a discrepancy between her skill and enthusiasm for dance and her awareness of her age compared to the others present, implying her body might not perform in the way it had previously. Connie highlights the need to address this discrepancy through being kind to herself and acknowledging her age rather than fighting it.

For Diane, menopausal weight gain made her feel old, which motivated her towards a determined and successful effort to lose the excess weight:

> *"I was the heaviest I'd ever been…. I thought I have to do something about this, because I was feeling really old, you know, just really yucky about myself.*

And actually, losing the weight...I've got a bit of a waistline back as well now …and all of that stuff's quite nice" (Diane; 172-177).

"I say I'm retired, and people say: "Really? You don't look old enough!" ... It's nice to get those compliments…. I think that's what I was saying about the invisibility, you don't get the compliments" (Diane; 189-197).

Diane connects her weight gain to feeling old and "yucky about myself" which seems to imply feeling unattractive. Losing the weight and regaining her shape gave her a boost and made her feel better about herself. This was enhanced by receiving compliments about not looking her age, which reduced the sense of invisibility Diane had previously experienced. The internalisation of societal views connecting weight, age, beauty and social value seems evident in Diane's narrative, summarised as: slim/young/attractive/visible *versus* fat/old/unattractive/invisible. There are also cultural narratives framing slimness as being "in control" and fatness as having "let yourself go" that may play into Diane's sense of achievement at her weight loss.

Participants who had had children later in life identified an incongruity between their sense of their children keeping them young and active, and their struggle against an aging body. Maya linked this to a concern about staying healthy for her children:

"I don't see myself as feeling older, looking older, because I don't think I am. But I'm aware that inside me, you know, my capacity to be existing as a healthy person for my children…is going to be a challenge" (Maya; 195-199).

Maya's self-concept is one of feeling and looking young; however, she anticipates a future "challenge" of maintaining her health and vitality as she ages. Maya describes aging taking place "inside me" whilst outside she looks young. This contrasts with Megan and Louise, who regarded aging as taking place externally whilst inside they felt young. Either way, there is a dissonance between the internal and external self. Moreover, Maya identifies the need to keep healthy for her children, perhaps more than for herself, possibly seeing her mothering role as of the highest priority.

Louise felt that her daughter kept her young and active, but the fatigue she associated with the recent onset of perimenopause made mothering more of a struggle:

> *"I had a child late in life…. these things are quite a challenge…I've always felt that…having a young child keeps me very young, but yet I'm battling against an aging body…and this year particularly, feeling very fatigued" (Louise; 25-30).*

Like Maya, Louise used the word "challenge" relating to older motherhood – on the one hand feeling it kept her young, but on the other hand describing "battling against an aging body" to fulfil the role.

In summary, participants used words such as "challenge" and "battling" to describe their efforts to overcome menopausal fatigue and weight gain. This was either to fulfil social obligations such as parenting, to prove their physical ability, or to feel better about themselves and how others saw them. There was a sense of a struggle to bring their aging body in line with their younger self-concept. Thus, the physical dimension

seemed to be failing to meet the needs of the personal and social dimensions of their lives. The negative cultural stereotypes relating to female aging are again seen to feature in participants' accounts of their struggle.

3.2.3 Sub-Theme: *Spiritual struggles*

Participants described the day-to-day struggle of living according to their faith amid the challenges of menopause. Whilst they identified the strength that their faith provided (covered in Superordinate Theme 3: *Finding Perspective through Faith*), they were also honest about the challenges of finding that faith perspective on a daily basis. For Maya, this struggle was greater when her menopausal mood swings occurred:

> *"It's like I've got something stuck in my foot and I'm...ignoring the fact that I've got it stuck in my foot and carry on doing everything…God can't reach you if you barricade yourself into something and so that's letting yourself be aware of that and gentle to yourself" (Maya; 641-648).*

Maya's account of ignoring "something stuck in my foot" evokes a discomfort that is being disregarded – an itch that is not being scratched, to use another metaphor. She admits that the "barricades" she erects cut her off from God. Maya depicts a sense of stubborn resistance to what she feels will bring her peace. She acknowledges that self-awareness is key to a gentler way of being - perhaps a reconnection with self and God.

Similarly, Megan described times in her menopausal struggles when it was difficult to turn to her faith, but finding when she did so, things became easier:

> *"I have moments where it is difficult to go to the Word* [the Bible] *because you're caught up in…it's almost a Catch-22, because you need to…The moment you go to Him, He's always there for you, but then you have to actually make a decision to go to Him" (Megan; 468-472).*

Megan identifies a Catch-22 situation – the paradox of not doing the very thing that she feels she needs to do. It is unclear from the quote what it is that she gets "caught up in" that makes it difficult to turn to her faith. She says she believes that God is "always there for [her]", but recognises that she needs to take action, for example by reading the Bible, to access the support that He offers.

Conversely, Louise seemed to feel there were aspects of her menopausal experience that were not relevant to God:

> *"I'm probably not so much in touch with my faith during that bit, because that's the bit where I'm getting annoyed with myself rather than thinking it's got anything to do with, you know, there's a part of us that's our human frailty and I see that very much as a human breakdown. I don't really equate it to a faith situation" (Louise; 459-464).*

Louise relates her menopausal brain fog to "human frailty" rather than a "faith situation" where she can seek support from God. This seems to imply a degree of splitting of the physical and spiritual dimensions of her life. Moreover, her use of the phrase "human breakdown" and her feeling annoyed with herself seem to indicate that she may blame herself in some way for her cognitive difficulties. There is a sense of

Louise coping with this challenging aspect of menopause by herself, rather than accessing the support her faith might offer.

In contrast, Connie expressed her sense of God understanding the challenges of her menopause and being able to help her in the moment of her emotionality:

> *"In this moment, it really is a time where I just have to breathe or sometimes* [her husband] *can hold me…he is recognising she just needs to breathe now; this is where maybe hormones are taking her. But allow God to come and just make a moment of His awareness and He can help me in this" (Connie; 458-465).*

Connie expresses a mindful awareness of her emotions when menopausal mood swings occur; she describes taking time to breathe, being held by her husband, and allowing God to come and help her. There is a sense of her slowing down and accepting, rather than resisting, what is happening. This quote indicates a greater cohesion between the physical and spiritual dimensions, and serves as a link to the third and final superordinate theme that describes how participants found their faith gave them perspective amid the challenges of menopause.

In summary, the spiritual struggles at menopause seem to centre on challenges with mood, leading to a resistance to God - participants identified the paradox of not turning to their faith when it could possibly help them. There was also a sense of doubting that God would understand female hormonal problems, perhaps linked to an internalised sense of blame for their failing menopausal body.

3.3 Superordinate Theme 3: *Finding Perspective through Faith*

Participants found their faith provided perspective that enabled them to cope with their menopausal challenges. Three sub-themes emerged from this, relating to: having a broader, deeper perspective on life; sensing God as a resource they could draw from to sustain them; and feeling they had a positive future, where they could "live" their faith by pursuing what they felt were God's plans for their life. Broadly speaking, the three sub-themes could be considered to relate to the three qualities of perspective, resilience and hope.

3.3.1 Sub-Theme: *A silver thread that runs through everything I do*

Participants identified the diverse ways in which their faith provided a perspective that enabled them to cope and see beyond their difficulties. Diane described her faith being "like a silver thread" running through her life – this implies a sense of continuity that might protect against the disruption of a life transition such as menopause:

> *"It's like a silver thread that runs through everything I do. And even if I'm not thinking about stuff explicitly from a faith perspective, I know it's part of my thinking….it has always run through everything…. I think it's an anchor really… a constant that I can go back to" (Diane; 359-367, 379-380).*

Diane talks about her faith as "a constant that I can go back to" – something that is always present in her life and even informs her thinking. There is a sense of enduring continuity when she says: "it has always run through everything". Describing her faith as a silver thread seems to give it value - something precious and yet strong. She also likens her faith to an anchor - suggesting stability, as an anchor holds a boat secure in

a storm. There is an implication through this quote, that Diane's faith holds her life in equilibrium and protects against disturbance. In the interview, this quote was part of a discussion about how changes such as menopause and retirement had challenged Diane's identity and sense of herself as visible and valued; she identified how her faith provided stability in this context.

For Connie, her faith enabled her to adopt a youthful perspective on life:

> *"Realising I am growing older, and I accept that…. But then also speaking that…youth thinking, that renewal of the mind, you know, when you're trusting God…allowing His Spirit to renew your thoughts in how you view life and not to have an old view" (Connie; 256-263).*

Although indicating that she accepts her physical aging, Connie describes how she adopts "youth thinking" rather than "an old view" on life. She attributes this to her trust in God and "allowing His Spirit to renew [her] thoughts". Connie's faith seems to enable her to transcend, rather than internalise, some of the negative stereotypes of aging that had been evoked by perimenopause, retaining her sense of vibrancy and enthusiasm for life.

Katia found that her belief in eternal life gave her a different perspective on her earthly life and the family she did not have:

> *"This world is a temporary world…all these experiences in this world* [are] *…preparing me for the next…having a different perspective… to: What can I have?... I should have had all this in this life…. It's not just about this life, it's about eternity as well" (Katia; 256-264).*

Katia depicts a sense of her life as a preparatory stage for heaven. She seems to denounce any sense of entitlement to the family life that has eluded her when she says: "It's not just about this life, it's about eternity as well". This perspective seems to help Katia to accept being single; a status that had proved a particular challenge at menopause, in terms of accepting her loss of fertility and, in her mind, diminished prospects for marriage. It may also counter any sense of unfulfilled generativity to hold the perspective that this life is not all there is, but that she can be preparing and investing here for the next life.

Maya described how her faith provided a broader perspective when the emotional effects of menopause caused relationship difficulties:

> *"When I pray, God gives me a different perspective and helps me to understand other people's perspectives and take the view on what is happening in a bigger sense…I literally walk away from a situation that's difficult and say: "God, what am I supposed to do? God, I'm really upset. I'm really angry" …. I can be honest … asking God to help me to see it differently. And I've learned over time, the quicker I do that, the quicker God gets to work" (Maya; 745-764).*

Maya describes her prayer as an outpouring of her distress to God and a cry for His help; there seems to be an intimacy in the way she relates to God, as a child to a parent. Her sense of God "[getting] to work" seems to be a broadening of her perspective on the situation, so she can see things differently - the bigger picture. Maya implies that, in the midst of menopausal mood swings, this improved understanding eases her anger and distress.

Katia described how her earlier experience of becoming a Christian had fundamentally changed her perspective on life:

> *"I don't think I'd be here now... I've been at a point where I was suicidal years ago…I don't think I'd be here without God….to get this far is just amazing …I have a sense of contentment within me which I really treasure …I also feel that I know and experience…what love is about. God's love has made a huge impact in my life" (Katia; 447-463).*
>
> *"God has brought me to a place I thought I'd never be because of my background…. I feel now I'm in a place of contentment and acceptance...I'm beginning to feel comfortable in who I am" (Katia; 419-423).*

In these quotes, Katia identifies her relationship with God as having brought complete transformation to her life - from feeling suicidal and that life was not worth living, to feeling contented and loved by God. She describes a self-acceptance when she says: "I'm beginning to feel comfortable in who I am". Katia expresses her astonishment that she has even lived to reach menopause – "to get this far is just amazing". This seems to alter her perspective on menopause from a time of challenge, to one of

achievement and personal growth. This possibly mirrors the more positive view held by non-Western cultures on female aging.

In summary, this sub-theme identifies ways in which faith broadens and deepens perspective; these ways seem as diverse as the participants' lives and experiences, but in each case are identified by them as enabling coping at menopause.

3.3.2 Sub-Theme: *You can draw from Him*

Participants described ways in which they felt able to draw on God to sustain them through the physical and psychological challenges of menopause - in this way, their faith provided resilience. Some identified that they did not always turn to their faith immediately - there was at times an inner struggle before they did so (this links to the sub-theme: *Spiritual struggles*). However, most felt that once they connected with God, they experienced a sense of easing of whatever was troubling them.

In the confusion that she felt with menopausal fatigue and brain fog, Louise described "pulling back" to find the space to pray:

> *"I find that I just pull back, I pray, I offer my problems to God and that helps me, calms me, brings me to an understanding that it will be - one way or another, it will be fine…there'll be a way through…. it's very, very beneficial" (Louise; 490-495).*

Louise describes how she draws on God's help, saying "I offer my problems to God" – a sense of handing things over to Him. She describes how prayer calms her and gives

her the confidence that things will work out; she finds this "very, very beneficial". Louise appears to be someone who likes to feel in control and menopausal brain fog seems to threaten this. It appears that putting God in control enables her to accept the situation.

Connie also saw God as a resource that she could draw from, with the firm expectation of help:

> *"I think that's what's so beautiful is to know that…the Holy Spirit is saying …that you can draw from me…. that's what I love about knowing God is that you can draw from Him and that I have that expectation - He's seriously going to help me now" (Connie; 452-458).*

Connie connects her sense that God is saying "you can draw from me" with her expectation that "He's seriously going to help me now". She depicts a loving, trusting relationship with God in her reflection: "that's what I love about knowing God". For Connie, this need to rely on God became greater when her menopausal fatigue threatened her ability to function at work:

> *"I sometimes just become tired, I'm just like – ugh* [sighs] *- as if my energy has just left me…That's when I realise, I have to draw from this* [her faith] *now. I don't doubt God's ability… I really have to rely on Him and every time He's faithful" (Connie; 436-446).*

Like Louise, Connie describes how she is able to draw from God when menopause drains her of energy and capacity. She describes finding God to be faithful; there seems to be no doubt in her mind that He can and will meet her needs when she is struggling.

Having recently started ordination training, alongside the demands of work, family life and menopausal mood swings, Maya identified her need to rely heavily on God through prayer:

> *"I'm doing ordination training so…I'm on my knees and I'm going to be staying there .... Being in priestly ministry…unless you rely on the Lord for your strength and equipping… you would not do it.…I do struggle with this stuff…. I feel very insecure, and you know: Why me? But I also know that I am called, and this is what I'm supposed to be doing, but I'm not doing it in my own strength" (Maya; 569-592).*

Maya's expression "I'm on my knees [praying] and I'm going to be staying there" denotes an attitude of total reliance on God. She identifies the uniquely challenging nature of the ministry and her own struggle with insecurity regarding her place in it. However, her strong sense of vocation seems to enable her to overcome her self-doubt; she expresses her sense that if God has "called" her to this work, she can draw on Him to strengthen and equip her to do it – they are in this together.

Katia described how she felt God had brought her to her current church where there was a group of single women of her age. She saw this as His provision of a family, providing encouragement in her single life and lessening her sense of vulnerability:

"The friends are actually God's arms…giving me a hug…being that support…a listening ear… becoming family, I suppose" (Katia; 534-540).

With the expression "God's arms", Katia portrays a sense of God supporting her indirectly, through her friends providing the physical comfort of a hug. There is a sense that her friends have become part of the God-resource that she can draw from for support at this stage of life, when she might otherwise feel alone.

In summary, participants identified ways in which they could draw from their faith for resilience to cope with the challenges of menopause and the concurrent demands of midlife. Consequently, they described how fatigue, self-doubt, confusion, loneliness and vulnerability all seemed to diminish in their impact.

3.3.3 Sub-Theme: *Living my faith*

Participants had identified that menopause brought a sense of aging. However, when they looked to the future, most of them described feeling positive, particularly where they felt they were pursuing plans that were in line with God's purpose for their lives.

Louise described feeling positive about getting older. In retirement, she looked forward to having less to juggle and more time to take on new things - primarily in terms of church and voluntary work:

"I can choose to do what I want to do…. all those things I really want to do now, but I just don't have the time for. I'm looking forward to that time of my life ...to do the things my heart wants to do rather than just do the things I have

to do…. I feel I can really start to live my faith in a way that I can't always now…. perhaps as I grow older, I'll actually be able to be more of that person I really, really want to be" (Louise; 694-714).

Louise seems to express some frustration with a life where doing "the things [she has] to do" robs her of the time to do "the things [her] heart wants to do"– there is a sense of compromise, that she is not living her life as authentically as she would like. She seems to long for retirement when she envisages having more time and more freedom in how she spends it. In being able to choose and commit to activities that will enable her to "live [her] faith", Louise seems to anticipate gaining a greater sense of fulfilment in life and a greater sense of alignment with the person she really wants to be.

Having recently retired, Diane already felt the benefit of having more time for herself and more choice in her pursuits. She identified that financial security had enabled this freedom. Diane described a sense of hope for the future, looking forward to enjoying a more rural existence with friends:

"I feel quite hopeful actually. I'm looking forward to what the next few years bring…. I'm going to move out of London…a couple of my friends have done that already, and go and live…out towards them and enjoy that" (Diane; 701-711).

Whereas Louise and Diane seemed to relish the prospect of less pressure on their time and more choice in how they spent it, both Connie's and Maya's future plans involved

a very full sense of commitment to church ministry. Maya spoke about her new vocation:

> *"I think* [ordination] *it's exactly what God is wanting me to do… I am in many levels excited about it. I also think it's going to make me feel complete, in a way that anything else wouldn't...I don't think I'm going to ever regret this" (Maya; 899-903).*

Pursuing what she feels is "exactly what God is wanting me to do" gives Maya a sense of excitement for the future. Although just embarking on her training, she nonetheless anticipates it will bring a sense of completeness "in a way that anything else wouldn't". Therefore, Maya's belief seems to be that aligning her life plan with what she believes to be God's purpose for her life is the way to the greatest fulfilment.

Connie also anticipated continuing in full-time church ministry, working alongside her husband. She described how she felt looking to the future:

> *"I'm excited and daunted (laughs)…. I mean, ministry is daunting and very exciting because we are launching…. a whole new arm of* [their church] *purely online, all over the world…so in that sense it's seriously exciting and it's seriously daunting…. And we know that is our future" (Connie; 636-648).*

Connie identifies a mix of excitement and trepidation for the future, but overall seems to relish the challenge ahead for her and her husband. There seems to be an underlying

confidence coming from her belief that this is God's plan for their lives when she says: "And we know that is our future".

In summary, it seemed that despite the awareness of aging that menopause brought, most participants had a positive outlook for the future, that was enhanced where their plans seemed to be aligned with what they felt were God's purposes for their lives.

CHAPTER 4

DISCUSSION & CONCLUSION

The aim of the study was to explore Christian women's experience of menopause, alongside their experience of their faith at this stage of their lives. From the interpretative phenomenological analysis of the six research interviews, three superordinate themes and nine sub-themes emerged. These themes will now be explored in the context of the current research evidence, and within the existential theoretical framework that proposes that meaning is found through the four dimensions of existence – the physical, social, personal and spiritual. With the topic being a largely unexplored area, recommendations for further research will be made, as well as recommendations for clinical practice. The strengths and limitations of the study will be discussed, followed by concluding remarks.

The superordinate themes followed a broadly chronological sequence comprising menopause impacting participants' identity and sense of self, leading to efforts to adjust and respond, which for most involved finding perspective through their faith. This sequence reflects the findings of de Salis et al. (2017), where some women followed a "rite of passage" trajectory, with transformation emerging from loss, shame and struggle. However, they found this trajectory was neither inevitable nor complete; women moved between the narratives of normality, distress and transformation and their progress was not always linear (de Salis et al., 2017). Similarly, the present study seems to reflect a mixed picture of struggle and transformation, as participants negotiated losses and disappointments in the context of their faith.

4.1 *Impact of Menopause on Sense of Self and Identity*

The impact of menopause on identity and selfhood was manifest through the personal dimension in *Dissonance and disbelief* and through the social dimension in *People treat me differently.* Moreover, the single participants in the study described a seemingly more profound impact on their selfhood, described in *Aging brings vulnerability and loss.*

Most participants identified an unpreparedness for perimenopause - a sense of being taken by surprise that seemed to exacerbate its impact. This failure to engage with the prospect of menopause may be explained by its taboo in Western society (Walter, 2000). However, Pramataroff et al. (2007) identify that some women struggle to accept, or even deny, menopause and fertility loss, possibly due to problems coping with past losses; it is possible some participants in the present study were reluctant to acknowledge the onset of perimenopause because of what it represented for them.

Moreover, in the physical dimension, menopause brings an awareness of aging and mortality, reflecting the existential theme of temporality (Spinelli, 2005). The anthropologist Ernest Becker (2011) describes menopause as a milestone that forcefully confronts women with their degeneration towards death, compelling them to adapt to their mortality, just as men can ignore theirs. Becker (2011) identifies the fear of death as a universal, present in everyone, but effectively repressed for most of the time. It could be argued that if menopause reminds us of our mortality, it may be subject to the same repressive efforts, so that women avoid engaging with it before they are forced to do so.

The *Dissonance and disbelief* sub-theme relates to the disruption to the sense of self brought by three particular aspects of menopause: sense of aging, brain fog and mood swings. Participants identified a dissonance between their prior sense of themselves as youthful, vibrant and coping, and the way that menopause made them feel older, and at times confused or irrational. Their descriptions of their menopausal experiences suggested participants had internalised the prevailing negative cultural stereotypes of older women – often portrayed as being fat, frumpy, foolish, and less valued or visible in society (Utz, 2011; Stephens, 2001; Atwood et al., 2008; Sergeant & Rizq, 2017). For Megan in particular, this may have contributed to her shame and reluctance to share menopause-related feelings with others (Brown et al., 2018).

Menopause was seen by participants as a gateway to their older years. Whilst Delanoe et al. (2012) suggest that connecting menopause with the start of old age is a stereotype women can choose to reject, for participants in the present study, the reality of bodily changes such as fatigue was difficult to ignore and robbed them of their vitality, making them *feel* physically older. Indeed, both Megan and Louise identified a dissonance between an inner self that felt young and vibrant and an aging body that felt exhausted; they expressed disbelief and frustration with this sense of bodily decline, as well as the feeling that menopause was pushing them towards an older identity.

Brain fog also impacted participants' sense of self, but in this case the struggle was with the functioning of their brain rather than their body. The memory and concentration problems described in the literature (Greendale et al., 2011) seemed to be manifest in a sense of confusion and difficulty with verbal fluency that impacted

how participants felt others viewed them and damaged their self-confidence. Their prior sense of themselves as assured and articulate seemed to have been replaced by a perceived inability to express themselves that they found distressing.

The way in which participants made sense of brain fog raises some interesting points. Both Katia and Louise feared their brain fog was an early sign of dementia and expressed relief on attributing their symptoms to a physical (hormonal) rather than mental cause. However, it is conceivable they were settling on one possible cause out of many: Louise was recently bereaved of her mother and found lockdown challenging; Katia described a traumatic early life and complicated grief following the recent deaths of her parents. There is evidence that acute stress, psychological trauma and complicated grief may all have a detrimental impact on cognition, particularly memory and attention scores (Hayes et al., 2012; Hall et al., 2014; Angelidis et al., 2019). It is conceivable that women may experience a cumulative effect, where past and current life stresses augment the impact of hormonal changes on cognition at menopause.

Lastly, mood swings created a sense of dissonance between how participants found themselves acting and how they felt they *should* act in a given situation. Maya and Connie described feeling angry, overwhelmed, and unable to cope in situations where they would previously have felt in control. They recognised that mood swings affected their identity and sense of self, describing feeling "different inside" and acknowledging the incompatibility of their anger with their identity as Christians.

As a reflexive note, I had not anticipated the cognitive challenges of menopause being such a concern to participants, having assumed the vasomotor symptoms would predominate; in the event, these physical effects featured only minimally in participants' accounts. One reason for this might be the selection bias of a study perceived as psychological in orientation, thus attracting participants for whom psychological issues were more prominent. Moreover, brain fog may have a greater impact than physical symptoms on the sense of self, meaning participants prioritised it in their accounts of their menopause.

None of the participants mentioned that they were taking HRT, although Louise said she might consider this in future. HRT use was not specifically asked about, as it was not the aim of the study to investigate decision-making on HRT or how effective participants might have found it. Instead, the aim was to explore women's experience of menopause without any agenda, asking open questions to elicit the issues pertinent to them. This reflects the IPA approach of harnessing the capacity of participants to set their own agenda and talk about their priorities in their own terms (Smith et al., 2012). As HRT did not surface as a prominent issue, my feeling was that possibly none of the participants were taking it. There was no evidence to suggest the subject was being avoided, nor is there evidence of HRT being taboo or disapproved of in Christian circles. However, if the study was repeated, it might be useful to explore Christian women's views on HRT.

The *People treat me differently* sub-theme relates to the social dimension and participants' accounts of how they encounter and engage with other people and society. This reflects an existential phenomenological perspective, where our

experience is seen as situated in the lived world of people and relationships; as *beings-in-the-world* we interpret and make sense of the world from our position within it (Heidegger, 1962; Smith et al., 2012).

Participants reported having noticed a change in how people related to them in social settings. Where once they had felt valued and visible - Diane in a senior career role and Louise on the stage, they now felt that as they aged, they became less relevant, even invisible. There did seem to be some evidence of people treating them differently, for example in Louise's loss of theatrical roles to younger actors. It is also possible that internalised cultural views on aging (Sergeant & Rizq, 2017) may have contributed to how participants perceived themselves in society, which then influenced how they felt others perceived them. One wonders how different these perceptions might be in a culture where aging is valued and venerated.

The impact of life transitions, such as retirement and menopause, that serve as markers of aging seems to underlie the experience participants described. The loss of social roles – whether by choice or not – was seen to impact participants' identity and sense of themselves as valued and relevant in society. Superimposed on this may be societal expectations about how women should behave at a certain age; for Louise, these seemed to preclude certain outlets for her creativity and self-expression. Social roles have been found to provide a protective function, leading to fewer concerns about menopause and fertility loss (Strauss, 2013). However, this raises questions about how women exist in the world at midlife: are they seen purely as wife, mother or work colleague, and what happens when, as for Diane, they lose one or more of these roles and feel they will disappear? When women lose the roles that have defined them -

through retirement, children leaving home, divorce or widowhood - they may need to renegotiate how they exist in the world, perhaps rediscovering their identity as an individual, rather than defining themselves through their roles in relation to others.

A further consideration is how the impact of menopause in the personal dimension – the loss of fertility and perceived loss of sexual attractiveness - may impact how women perceive themselves in the social dimension. Diane's sense of younger women being paid more attention than her may speak not only of her feeling less socially desirable, but less sexually desirable. Where reproductive ability is seen as a source of power, its loss may diminish self-esteem and women's sense of their social impact (Rubinstein & Foster, 2012). Thus, menopause can be seen to have an impact across the physical, personal and social dimensions of existence, reflecting again the biopsychosocial perspective.

Participants also described the direct impact of menopausal symptoms, specifically cognitive challenges, on how they felt they performed in social situations. It was striking that they defined their experience in terms of its impact on their social presentation rather than as a personal struggle: for example, Louise focused on how her colleagues would view her perceived inability to express herself. These findings reflect those of Stephens (2001), who found women described their menopausal symptoms in terms of their impact on social and moral obligations, rather than as accounts of suffering. Stephens (2001) identifies that the physical changes at menopause are experienced in terms of their effects on an everyday functioning self who is wife, mother or work colleague; women interpret these changes as a sign of weakness and a threat to their integrated self. Thus, Stephens (2001) emphasises the

social construction of the bodily experience of women at menopause; women rely on a fully functioning body and mind to fulfil their social roles - when menopause threatens this functionality, they may experience inadequacy and shame.

In *Aging brings vulnerability and loss*, the two single participants identified menopause as an unwelcome milestone, representing the loss of hope for marriage and children. Although objectively menopause does not preclude the possibility of marriage, both Katia and Megan seemed to feel it reduced the likelihood of this happening for them; it could be speculated that they felt their age and fertility loss rendered them less "marriageable". Cultural attitudes towards menopause are a product of the status of women in society and the value attached to their reproductive capacity (Kaufert, 1982); thus, marriage and motherhood convey a certain social status that Megan and Katia may have felt they had failed to attain on reaching menopause. Furthermore, women's generativity (or sense of creating something that will outlast them) can be heavily invested in marriage and parenting (Sorell & Montgomery, 2001). Menopause seemed to present a tangible reminder for Katia and Megan that they had not achieved the perceived accomplishment of creating a family. Megan, in particular, seemed to find it difficult to overcome her sense of loss and envisage a meaningful future as a single woman; she expressed her anger towards God for not meeting her desire for marriage, which seemed vital to her sense of worth.

Similarly for these single women, menopause seemed to heighten a sense of aloneness that was compounded for Katia by the absence of any wider family support, and for Megan by her fear of her parents dying, possibly representing the loss of her "invulnerable self protected from death by an older generation" (Wilk & Kirk, 1995,

p. 238); there was a sense of actual or impending loss of their daughter role, and yet they had not become mothers themselves. Their sense of vulnerability also related to concerns about health and finance in the future, without the buffer of marital or parental support. Kaufert (1982) identifies the economic and social deprivation that women without a family may face at midlife. This concern for the future was unique to the single participants in the study, which seems to emphasise the stress-buffering role that marriage and family may play for midlife women, mitigating the adverse impact of negative life events. Without this support, Megan and Katia expressed their sense of feeling alone and vulnerable to any difficulties their future life might bring.

4.2 *Adjusting and Responding to Menopause*

In this superordinate theme, participants described three very different responses to the challenges and disruption brought by menopause. Faced with its impact on the physical, personal and social dimensions of their lives, a pattern emerged where their initial attempts to adjust focused on the social and physical domains, as illustrated in the sub-themes: *Like mother, like daughter?* and *Fighting the aging process.* It seemed only later in the process of adjustment that participants considered how the spiritual dimension might relate to their challenges. However, as they turned to their faith to make sense of menopause, they identified that finding connection with God was not always easy, as described in *Spiritual struggles.*

In *Like mother, like daughter?* participants turned to their mother, or their recollection of their mother's experience, to make sense of menopause, strongly assuming that their experience would be the same as hers. This reflects a study by Dillaway (2007) that found 69% of 61 menopausal women, unprompted by the interviewer, discussed their

mother's menopausal experience when describing their own. Emphasising the significance of genetic inheritance, they assumed, as did participants in the present study, that they would follow the same trajectory as their mother. Dillaway (2007) concludes that their mother's experience is used by women as a "benchmark for understanding, defining, and manoeuvring this reproductive transition" (p. 91). Similarities with their mother legitimised menopausal experience, bringing understanding and confidence, whereas differences brought confusion and an inability to make sense of what was happening to them (Dillaway, 2007). This is illustrated in the present study by Megan: perplexed to reach perimenopause earlier than she expected, her disconcertion intensified on discovering her mother had experienced it at what she considered a normal age, thus enhancing her sense of her own abnormality. Conversely, for some participants, such as Katia and Diane, their assumption of genetic inheritance arguably led to their unnecessary anticipation of a difficult menopause, when their experience did not ultimately match their mother's and was much easier than hers had been.

Dillaway (2007) identifies the mother-daughter relationship as a contextual social backdrop that influences the meaning and experience of menopause for women. Adult women's sense of self may be inextricably linked to their mother, and over their life course, women may view their own experience, including reproductive experience, through their mother (Dillaway, 2007). One might speculate that this could lead to a sense of disconnection for women who have no contact with their biological mother.

Articulating the feminist perspective, Kaufert (1982) identifies how women turn to female relatives and friends to make sense of menopause. This is borne out by the

present study where, as well as their mothers, participants sought out female friends to normalise and validate their menopausal experience; they found their friends provided camaraderie, empathy, and a sense of shared experience that was comforting. Feminist theory emphasises and esteems the experience of women themselves, or the communal experience of women, in an understanding of menopause; this contrasts with the biomedical approach that prioritises the medical interpretation and control of women's health (Kaufert, 1982). Interestingly, only two participants mentioned seeing their general practitioner regarding menopause, and none mentioned accessing online or other resources. For the married participants, their husbands featured only minimally in their accounts. Therefore, menopause seemed a predominantly female issue, illustrating Sergeant & Rizq's (2017, p. 198) concept of a "hidden sisterhood" of those who understand and with whom women feel safe to talk about their menopause.

Fighting the aging process contrasts with this social response, relating as it does to the physical dimension, where participants described making significant efforts to retain their vitality through exercise and dieting. This may represent an attempt to reduce the dissonance between their youthful mind and aging body, by bringing their body back in line with their self-concept. Megan described "exercising like crazy" in response to her distress at reaching perimenopause, perhaps attempting to minimise its impact. However, participants found exercise a challenge with menopausal fatigue, and one wonders whether they were trying to reach an impossible goal.

Society imposes pressure on women to maintain their appearance as they age; a lack of concern about this is regarded as abnormal. It seems to reflect the hidden nature of menopause in society, that women are seen to be doing well if they skilfully manage

the transition by hiding it completely behind a youthful appearance (Kaufert, 1982). Participants in the present study seemed to demonstrate a sense of responsibility to society, as much as to themselves, to appear youthful, as illustrated by Diane's concern about maintaining her appearance in the workplace.

There is clear evidence of the benefit of healthy eating and physical activity for psychological wellbeing at midlife and reducing the risk of obesity and the chronic diseases associated with menopause and aging (Netz et al., 2008; Khandelwal, 2020; Polotsky, 2010). Whilst it is therefore beneficial for women to maintain a healthy lifestyle during and beyond menopause, there is also evidence of risk associated with taking certain behaviours to excess. Mangweth-Matzek et al. (2013) suggest menopause may present a window of vulnerability for eating disorders, finding perimenopause to be significantly associated with both eating and body image pathology. Hunter et al. (2020) found the perceived anti-aging efficacy of HRT gave women a sense of control over aging that they prioritised over the potential medical risks associated with their prolonged HRT use.

Thus, it is important to distinguish between the benefits of a healthy lifestyle at menopause and the risks associated with certain behaviours to attempt to control the aging process, that may originate from societal pressure on women to appear young and attractive. Utz (2011) identifies a dichotomy between women's *perceived* control over their bodies at menopause and the *actual* control exerted over them by the fitness, beauty and pharmaceutical industries.

In this sub-theme, participants also focused on their mother role, with Maya and Louise identifying the need to stay healthy and active for their children. As discussed previously, this reflects how women may prioritise their role in serving others and fulfilling social and moral obligations (Stephens, 2001).

In *Spiritual struggles*, several participants identified at least an initial difficulty in connecting with God and finding a faith perspective amid their menopausal challenges. This related in particular to mood swings: Maya's metaphor of ignoring something stuck in her foot seems to imply a stubborn resistance to a possible source of relief from her distress. Likewise, Megan described the "Catch-22" of not doing the very thing that she felt she needed to do, in connecting with God. One might speculate that relating to God becomes as difficult as relating to other people when we are full of anger and irritation, but perhaps also unwilling to admit to our vulnerability and pain. Underlying this may be the challenge for participants of reconciling their sense of a loving, constant God, with the momentary loss of their sense of a loving, constant self, when struck by menopausal mood swings.

Louise identifies something different though. In her observation that her cognitive difficulties are not a "faith situation" but an issue of "human frailty", it seems that she splits the physical from the spiritual dimension of her life, that she blames herself in some way for her brain fog or feels it is an aspect of her life that is unimportant to God. It seems that the shame and cultural taboo associated with menopause may not only affect women's help-seeking behaviour in the social dimension, but also the spiritual dimension of their lives, influencing how they relate to menopause in the context of their relationship with God (Cronin et al., 2021).

Various studies have conceptualised personal faith in terms of attachment theory, postulating that people's beliefs about God and connection to Him may be comparable to their adult attachment style (Kirkpatrick & Shaver, 1992). An insecure attachment to God, where He is experienced as distant and abandoning, may result in lower self-esteem and a diminished capacity to connect to God through prayer (Szcześniak & Timoszyk-Tomczak, 2020). Conversely, a secure attachment, where God is perceived as loving, accepting and forgiving, is positively associated with enhanced self-esteem and psychological wellbeing (Szcześniak & Timoszyk-Tomczak, 2020). It could be speculated that attachment style may account for some of the individual differences - seen even in the small number of participants in the present study - in how Christian women respond to menopausal challenges in the context of their relationship with God.

Szcześniak and Timoszyk-Tomczak (2020) describe spiritual struggle as the manifestation of a less secure relationship with God; a type of negative coping that reflects spiritual tension with the divine, others who share our faith, or within ourself. Thus, the struggle may have a spiritual dimension, linked to feeling let down by or angry with God, a social dimension, linked to negative feelings towards the church as religious community, or a personal dimension, when associated with guilt or doubt (Szcześniak & Timoszyk-Tomczak, 2020). In this spiritual struggle, adverse life events may be negatively interpreted as God's punishment; this seemed evident when Megan questioned whether some personal inadequacy might explain why God had not provided her with a husband.

In the present study, participants identified *initial* difficulties in relating to God in their menopausal struggles, more than a sense of menopause having profoundly shaken their

faith. The single participants' experience was perhaps the exception to this, where menopause represented for Katia and Megan the loss of hope for marriage and children, causing them to question God's purpose for their lives. Women who struggle spiritually at menopause may find it difficult to seek spiritual support or guidance where menopause remains a societal taboo; the fact that many church leaders are male may not help with this.

4.3 *Finding Perspective through Faith*

The third and final superordinate theme relates to the perspective and resilience that participants identified their faith bringing to the challenges of menopause, allowing them to transcend some of their difficulties and reflect on a sense of hope for the future. Participants often reached this faith perspective after initial attempts to make sense of menopause through the experience of their mothers or friends, and for some after, or alongside, strenuous efforts to fight the aging process. Moreover, the faith perspective was not reached for some without a degree of spiritual struggle.

In *A silver thread that runs through everything I do,* participants identified how their faith provided a foundational perspective for their life, as illustrated by Diane's description of her faith being a constant to which she could always return; this implies stability countering the potential instability of menopause. Diane's "silver thread" metaphor depicts faith as continuity in the face of disruption. There was also a sense in which faith provided perspective on the aging associated with menopause; Connie observed that a God-given youthful outlook enabled her to reject an older mentality and maintain her vibrant enthusiasm for life. Maya found her faith gave her a more consistent sense of self through her mood swings and a broader perspective on

relationship difficulties. Finally, Katia described how the prospect of eternal life gave her perspective on the missed opportunities of her temporal life. Katia also expressed her amazement at having even reached menopause after going through some tough times when she was younger. She reflected on the contentment and self-acceptance she felt on experiencing God's love; this seems to demonstrate a cognitive restructuring towards a new perspective on her sense of self, as being someone both worthy of love and fully loved by God. This notion is supported by systemic reviews that demonstrate the efficacy of integrating religious beliefs to support cognitive restructuring (de Abreu Costa & Moreira-Almeida, 2022).

The faith perspective described by participants seems to be built on their concept of the identity and character of God - as constant, loving and faithful, as well as on their own identity as Christian women. The biblical concept of womanhood may be distinguished from the secular (Western cultural) notion that prioritises physical appearance, reproductive ability, and social or family role, all of which may be impacted or altered at menopause (Kaufert, 1982; Rubinstein & Foster, 2012). Conversely, biblical texts, on which participants are likely to draw for their sense of Christian identity, provide evidence that Jesus regarded women more holistically, often acting counter-culturally in doing so, for example: treating men and women as of equal value in their faith (Mark 3: 34-35); discussing theology with women (Luke 10: 38–42); validating women whom society despised or marginalised (Luke 21: 1-4; John 4: 7-27); not considering menstruating women as impure, but affirming their worth (Mark 5: 25-34); and showing compassion towards women's emotionality (John 11: 32-33) (*New International Version Bible*, 2011). The Old Testament also describes female identity as amounting to more than physical appearance:

> "*Charm is deceptive, and beauty is fleeting; but a woman who fears the Lord is to be praised*" (*New International Version Bible*, 2011, Prov. 31: 30).

Where women can internalise a sense of self as possessing intrinsic, unconditional value in God's eyes - regardless of their fertility status, appearance or social role - this may enable them to reject the negative constructs of aging and overcome some of the psychosocial challenges of menopause (Meletiou & Meylahn, 2015; Steffen, 2011). Participants in the present study identified that their faith provided this alternative self-perspective. However, Meletiou and Meylahn (2015) identify how the biblical concept of womanhood is undermined by the patriarchy that influences social values and gender norms in church and society. This patriarchy arguably maintains the negative stereotyping of female aging, possibly presenting an ongoing challenge to women's faith perspective on their identity and selfhood.

It should be noted that there are alternative interpretations of the concept of biblical womanhood, apart from that espoused by Meletiou and Meylahn (2015). A prominent example is the complementarian view of men and women developed in the 1980s by American evangelicals, primarily in response to second-wave feminism (see Piper and Grudem, 1991). Complementarianism presents manhood and womanhood as innate, divinely ordained categories of identity, with biblically prescribed roles for men and women in church, home and society (Murray, 2021). Complementarianism has its proponents and its critics, and it is not within the scope of this study to provide an in-depth analysis of this theological position. However, Murray (2021) suggests complementarianism is based more on cultural values than biblical insight, and that it idealises the white, conservative, middle-class American family, thus perpetuating

divisions of gender, race and class. Contrary to this recently developed, arguably "man-made" ideology of womanhood, the present study proposes a concept of biblical womanhood that draws from examples of how Jesus interacted with New Testament women. It suggests that such a model may enable Christian women to develop a self-concept that enables them to resist negative cultural stereotypes of female aging that menopause may bring to the fore.

You can draw from Him relates to the concept of God as a resource that participants felt they could draw from to sustain them through the challenges of menopause and midlife. They described how fatigue, self-doubt, confusion, loneliness and vulnerability diminished in their impact as they presented their problems to God and expressed their reliance on Him. It seemed that their faith provided participants with psychological resilience in coping with the challenges of menopause.

These findings reflect those of the literature review (Chapter 1). Though few studies were found relating specifically to menopause, women facing infertility found their faith provided resilience through improved quality of life and reduction in stress (Casu et al., 2018), peace through reliance on a higher being (Latifnejad Roudsari et al., 2014), and the ability to transcend suffering (Romeiro et al., 2017). Manning (2012) found that in older age, a Christian faith provided meaning, inner strength and the acceptance of mortality. In a study that did explore menopause, Steffen (2011) found that resilience partially accounted for the relationship between higher levels of spiritual strength and lower levels of reported menopausal symptoms.

Resilience is described as the successful adaptation to adversity (Reich et al., 2010). In a study of perimenopause, Süss et al. (2021) identify resilience as contributing to psychological health, milder menopausal complaints and improved life satisfaction. Their study identified the psychosocial variables that contribute to resilience as being optimism, emotional stability, emotion regulation, self-compassion and self-esteem. Süss et al. (2021) suggest these variables could foster psychological wellbeing at perimenopause.

The question that then presents itself is whether and how faith can promote resilience at menopause and into later life, enabling better adjustment to aging. Through the present study, it is suggested that the psychosocial variables that Süss et al. (2021) identify as contributing to resilience at perimenopause may be enhanced for some women through their relationship with God. For example: women's sense of God as compassionate and forgiving may enhance their self-compassion and self-esteem, where they are able to adopt a non-judgmental stance towards self; their sense of God as a secure base and benevolent source of control and provision may enhance their optimism, emotional stability and emotion regulation. Therefore, it is proposed that faith could act as a pathway to successful adaptation, by fostering the psychosocial factors that contribute to resilience at menopause.

In *Living my faith,* most participants envisaged a positive future, enhanced for some by the sense that their plans were aligned with what they believed to be God's purposes for their life - that they would be "living their faith". Louise anticipated that after she retired, she would have more time to commit to activities aligned to her faith, thus becoming "more of that person I really, really want to be". This sense of connecting

with deeper meaning in her life seems to illustrate Heidegger's concept of living authentically (1962, in Sekse et al., 2010).

However, the anticipation of greater freedom and choice in later life, articulated by Louise and Diane, seemed contingent on their pensions; the same anticipation was not expressed by Megan and Katia as single women with fewer financial resources. The extent to which women can enjoy greater freedom in later life may depend not only on their socioeconomic circumstances, but also their health, caring responsibilities, and the possible influence of gender-based cultural expectations (Delanoe et al., 2012). These factors may account for individual differences in how women live at midlife and beyond, reflecting the existential theme of freedom versus limitation: our freedom to live life as we desire is bound by the facticity of our existence – our bodies, our culture, and our place in history (Spinelli, 2005).

Maya and Connie described how they were launching into new ventures in Christian ministry that both expected would bring a sense of fulfilment; Maya anticipated "feeling complete" in obeying her sense of God's calling to ordination. Rather than slowing their pace at this stage of life, these participants expressed a heightened focus on what they wished to achieve in the limited years of working life ahead of them. Silf (2011) identifies how life transitions can be a catalyst for new beginnings and growth, when we choose to embrace a new phase of life, new skills and direction. Writing from a Christian perspective, she talks of trusting that God can be found in the fog and bewilderment of transition and bring out latent possibilities when old certainties are lost (Silf, 2011). The sense that God still had plans for them in later life seemed to underpin the conviction with which these participants approached their new ventures.

Successful aging may be conceptualised as a multi-dimensional construct, comprising personal agency and spiritual expression, as well as social value derived from generativity, social role and spiritual connection (McCann Mortimer et al., 2008). Maya and Connie seemed to be exhibiting personal agency and spiritual expression in their future plans, as well as gaining a sense of social value and generativity from what they felt able to impart to others in their ministry. It was notable that both of them expressed self-doubt in terms of their capability; however, their sense that their plans reflected God's purposes seemed to enable them to persevere, and even to relish the challenges ahead.

Whilst Megan derived support and companionship from her friends, she was the only participant who did not seem able to anticipate a positive future, at least if she was to remain single, expressing her anxiety about the future as "the unknown".

4.4 Recommendations of the Study for Clinical Practice, Church and Society

The only study that could be found on this issue, suggests that only 16% of psychological therapists routinely raise the issue of menopause when working with midlife women (Wilk & Kirk, 1995). Whether or not the situation has improved since this study, it is hoped that the present study will highlight the need for psychological therapists to be "menopause-aware" and may equip them to explore the issues that may be pertinent to menopausal clients. Menopause should be conceptualised as an event that may affect women across all dimensions of their lives, potentially having a bio-psycho-social-spiritual impact; a holistic therapeutic approach will enable an understanding of the breadth of women's lived experience of menopause.

The researcher has been invited to present the findings of the study to two professional training programmes - for counselling psychology and integrative psychotherapy. In addition to pursuing publication of the study in academic journals, its key findings will be shared with the BPS Psychology of Women and Equalities Section, to inform policy development in this area of practice. Moreover, as well as presenting the study to colleagues in a psycho-oncology service, the researcher has developed a psychoeducational group programme for women who have experienced medically induced menopause due to cancer treatment; like the study, the programme adopts a biopsychosocial approach to menopause, but in the specific context of women with a cancer diagnosis. Subject to the success of the pilot study, this evidence-based programme could be shared with other psycho-oncology departments through national networks.

Religion and spirituality are further topics that, despite their prominent role in people's lives, are often unexplored in psychotherapy, possibly due to therapists' discomfort or inexperience with such content (Abernethy & Lancia, 1998). Moreover, societal and professional views on issues of faith can be dismissive: for example, the existential psychiatrist Irvin Yalom (2008, p. 117) describes "death-denying religious myths" as providing a false comfort that the self-aware will reject. Christian women may therefore be reluctant to discuss their faith in secular psychotherapy. Greenidge and Baker (2012) found Christian clients tended to seek therapy with Christian counsellors, being unconvinced that a secular counsellor would fully understand their integration of selfhood and faith. Conversely, therapy with a Christian counsellor was constructed as a powerful three-person encounter, where God could be "involved in the experience of seeking to find" (Greenidge & Baker, 2012, p. 216). However, Christian clients may

not have the luxury of choice in their counsellor if they cannot afford private therapy. If they anticipate feeling misunderstood in therapy, this should be seen as an ethical challenge for the profession. Practitioners should be prepared to reflect on their stance towards people of faith and take any necessary steps to address gaps in their training and skills, in order that clients of any faith can feel confident of an empathic acceptance of their beliefs and worldview when entering therapy.

Beyond the academic and professional worlds, the study highlights implications for the wider society. Menopause reflects the intersection of gender and aging, and as such represents an issue of equality and diversity that has implications for employment law; this has been recognised by the trade union movement which has developed guidance and training on menopause in the workplace (Wales TUC, 2017). In addition, the NHS, as a significant employer of women, has recently produced guidance for managers on how to support their staff through menopause (NHS Employers, 2021). It is hoped that other employers and educational institutions will follow suit, to promote equity and understanding in the places where women work and study. Any such initiatives should not represent lip service but should be rigorously evaluated to ensure they are effectively raising awareness and challenging stigmatising views on menopause. Bringing menopause into the open in this way might also help prepare women for the event and encourage them to seek support with any difficulties (Brown et al., 2018). It is hoped that ongoing societal progress towards gender equality and more women in the public eye speaking about menopause (see: DavinaMcCallonMenopause; MariellaFrostruponMenopause) will help to break its taboo. However, changing societal views and a greater openness towards menopause will need to be matched by increased funding for research on its psychosocial impact. There is a need to address

the significant disparity, identified by the literature review, between the medical and psychological research on menopause.

Within the Christian domain, the findings of the study will be disseminated by the researcher speaking at local churches and women's groups that have expressed an interest in this, as well as seeking publication through national Christian news outlets. This may help to raise awareness amongst church leaders of the issues that may affect midlife women, to enable greater understanding and support within the church.

4.5 Study Strengths & Limitations and Recommendations for Further Research

The study explores the lived experience of menopause for six Christian women. In keeping with most current psychological research on menopause (Hoga et al., 2015; Stephens, 2001), it adopts a biopsychosocial approach to this life transition. However, a particular strength may be its integration of the spiritual perspective, specifically the exploration of how faith may foster psychological resilience for menopausal women. Moreover, the existential perspective adopted by the study seems justified when considering how menopause heightened participants' awareness of aging and their mortality, and raised questions on the meaning and purpose of life. The study has only "scratched the surface" of these significant topics and demonstrates a need for further research on the interaction of spirituality with issues of gender and aging at menopause.

In qualitative research, such as IPA, the small sample size means results cannot be generalised to a larger population, but this is not the objective of an IPA study. Rather, the intention is to reveal something of the experience of the individual through an

idiographic approach that embraces the particular; the detailed exploration and analysis of specific cases illuminates what it is like for a particular person to experience a distinct phenomenon (Dennison, 2019). The new insights produced by IPA studies are conducive to dialogue with other forms of research, adding to current theories (Dennison, 2019). For example, an IPA study such as the present one that illustrates individual experience and meaning making at menopause may contribute to an understanding of the anxiety and depression associated with this life stage, as identified by quantitative studies cited in the literature review.

Adopting an idiographic approach enables researchers to seek an existential understanding of how individuals create meaning in their lives (Dennison, 2019). Smith et al. (2012) recognise that identity often becomes a key concern of IPA studies; in particular, they note that IPA work often centres around identity change associated with major life transitions. This is borne out by the present study, in terms of the challenges that the menopausal transition brought to identity and sense of self.

Criticisms of IPA as a methodology suggest that it is unscientific in lacking adherence to systematic, rigorous steps, and that as a result, numerous ways emerge of using the phenomenological method that lose sight of fundamental principles (Sousa, 2008). Smith (2010) counters that fixed steps do not guarantee high quality research, but that interpretative processes and intuitive insights articulated by the researcher are pivotal. Dennison (2019) acknowledges that IPA is not value free and the researcher plays a dual role in being situated both inside and outside their research; their prior lived experience and taken for granted assumptions will influence their interpretations and bracketing of these can never be absolute. In the present study, the researcher's own

lived experience of menopause was not erased, but every effort was made to acknowledge presuppositions and not allow them to unduly influence the analysis and interpretation of participants' experience.

It is clear that the criteria used to evaluate the quality and validity of qualitative research will differ from those used for quantitative research, but evaluation can and should be applied to each stage of a research study. Smith et al. (2012) recommend using Yardley's (2000) criteria: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance (see Table 2 for an evaluation of the present study using these criteria). In summary, as with all research methodologies, there are both strengths and limitations inherent in the use of IPA; the limitations do not invalidate the strengths, but help to clarify the parameters of its use and the considerations that should be in place.

Despite efforts to recruit from a wider demographic, participants who signed up for the study were mainly white and middle class. They were either married or not in a relationship; alternative relationship models, such as cohabiting or same-sex partnerships, were not represented, but might be less commonly found when recruiting from Christian settings. Nevertheless, a further limitation is that the study does not reflect the diversity of society, in terms of factors such as sexual orientation, gender identity, class, ethnicity and disability, when exploring women's experience of menopause and faith. It is anticipated that any of these factors could influence women's menopausal experience. For example, Delanoe et al. (2012) found different experiences of menopause linked to social class and the degree of male domination, and that a given level of independence and emancipation allowed women a status less

impaired by menopause. Women with intellectual disability appear to have less awareness of menopause-associated changes in their bodies (Willis et al., 2011) and a paucity of understanding about menopause itself (Willis, 2008). Women with physical disability are found to be at higher risk for adverse health outcomes associated with postmenopause (Kalpakjian et al., 2004), and in conditions such as multiple sclerosis, menopause may be associated with disease progression (Zeydan et al., 2020). Menopausal women in same-sex relationships have been found to be less concerned with appearance, more feminist and more sexually satisfied than heterosexual women (Calandra, 2001). However, lesbian women may also face discrimination and misunderstanding in healthcare settings, leading to a reluctance to seek help and poorer health outcomes (Stotland et al., 2007). The scarcity of literature across all these areas indicates a need for further qualitative research studies to understand the particular experiences of these groups of women.

The study did not address the experience of menopause for transgender individuals. There is little on this subject in the existing literature, which may lead to a lack of understanding of menopausal issues for transgender people amongst psychological therapists and other healthcare professionals. Mohamed and Hunter (2019) identify gaps in knowledge generally about transgender health in the UK medical system.

Trans men (who identify as male, but were assigned female at birth) will experience a natural menopause if they retain their ovaries and do not take hormone therapy, and will experience a medically induced menopause if the ovaries and uterus are surgically removed. Menopausal symptoms may be reduced or complicated if masculinising hormone therapy is in place (Wales TUC, 2017). Trans women (who identify as

female, but were assigned male at birth) undertaking feminising hormone therapy will often remain on this for life, and should generally experience limited menopausal-like symptoms, unless hormone therapy is interrupted or stopped (Wales TUC, 2017). Mohamed and Hunter (2019) found that transgender women expressed uncertainty about menopause and questioned its relevance to them. Whilst most expected to avoid menopausal symptoms by continuing with hormone therapy indefinitely, considering this essential to their transition, some expressed concern about the long-term effects of hormone therapy, about which there is little research evidence in the transgender population (Mohamed & Hunter, 2019).

In summary, transgender people may experience at least some menopausal symptoms and these will vary depending on the age at which they transitioned, the level of their transitioning, and the gender-affirming treatment they have received (Mohamed & Hunter, 2019). Lack of understanding in healthcare professionals, or individual reluctance to disclose transgender status, may make it more difficult for transgender people to receive help with any difficulties. There is a definite need for further research in this area.

Participants did not mention any sexual difficulties when asked about the impact of menopause on their lives. On reflection, and as a learning point, it might have been useful to specifically ask about this issue, as the evidence suggests women may want to discuss sexual matters but prefer a health professional to invite them to do so (Sekse et al., 2010; Kingsberg et al., 2019). Thus, the non-disclosure of sexual difficulties does not necessarily mean they were not an issue for participants.

To ensure the required homogeneity for an IPA study, recruitment focused exclusively on women with a Christian faith. The experience of menopause for women of other faiths has therefore not been explored by this study, and is under-explored in the research generally, with some religious faiths entirely absent from the literature search. Since religious faith, as both a personal and sociocultural factor, is found to have a significant bearing on women's lived experience of menopause, it is important that the experience of women of all faiths is captured by future research studies on menopause. As part of this work, it may be useful to explore the differences between organised religion as an external, sociocultural factor placing expectations on women, and spirituality as an internal dimension influencing their subjective experience of menopause. Any such studies could usefully involve faith groups themselves as partners in the research process, by adopting a community-based participatory research (CBPR) approach: an example being a recent study of the menopausal experience of First Nation women by Sydora et al. (2021).

In the present study, the researcher shares the same faith as the participants and has reflected on how this may have affected the research process. Participants may have felt more comfortable with a Christian researcher – a sense of being kindred spirits. Feeling that their beliefs and values would be understood and accepted may have enhanced participants' trust and openness. A parallel may be drawn between the semi-structured interview in phenomenological research and the psychotherapeutic setting, where Greenidge and Baker (2012) found that Christian clients anticipated their beliefs and values would be better understood by a Christian counsellor than a secular counsellor. However, a sense of bonding between researcher and participant, and a shared framework, understanding and language relating to faith, could possibly

suppress curiosity and the need for the researcher to fully explicate beliefs and ideas; similarity might be assumed, and difference overlooked. In conducting and analysing the interviews, it was important to be aware of this risk and to aim for a neutral stance of "outside observer" rather than "inside collaborator" - although it must also be acknowledged in a phenomenological study that the researcher makes sense of the world from her position within it and is involved in a process of co-creation of knowledge with participants in the encounter of the research interview (Finlay, 2009; Smith et al., 2012). The role of completely impartial observer is therefore difficult to achieve, but rather the researcher should attempt to bracket assumptions and engage in a critical examination of her customary ways of knowing (Willig, 2013).

Moreover, it was possible that participants might regard the researcher not only as an expert in the research project but an expert in how to negotiate menopause as a Christian, leading to a power differential with participants feeling they had to present a positive image of their faith and the difference it made to their lives, or not mention things they might consider taboo. It is of course possible they would have felt the need to present their faith positively had the researcher not shared their faith. In the event that the researcher had not been a Christian, the research process and findings may have been different and there may have been a need for greater explication of beliefs and ideas. However, in the clinical setting, it has been found that therapists do not need to share the faith of their client to work effectively with religious content (de Abreu Costa & Moreira-Almeida, 2022); one might conclude that there would be no barrier to a non-Christian researcher conducting a similar study to the present one. It is clear that the findings of the study arose from the unique encounter of this particular researcher with these six participants. Although it is possible common themes may

have emerged, the findings would have been different with another researcher (whether Christian or not) and/or six different participants; this illustrates the idiographic and relational nature of IPA.

4.6 Summary of Key Findings

The study found that participants seemed unprepared for the onset of perimenopause, and then experienced a dissonance between their previous youthful, vibrant, coping self, and a self that now felt tired, confused and irrational. Participants were significantly impacted by menopausal fatigue, as well as cognitive and emotional symptoms, that forced them to confront fertility loss, aging, and even their mortality; for the single participants in particular, this brought feelings of vulnerability and loss. Whilst the negative stereotyping of menopause may have influenced how participants interpreted their experience, it may not be helpful to encourage women to reject stereotyping that seems to match the reality of their experience, thereby potentially denigrating that experience; instead, women should be empathically supported in their lived experience of the challenges of this life stage. Moreover, the loss of social roles at midlife brought identity into question and contributed to participants sensing a loss of their visibility and social value.

Participants responded to menopause by using their mother's experience to understand their own, despite some predictive inaccuracy with this. Other women represented their primary source of information on menopause, and surprisingly in the modern age, they did not seem to access online resources. This construction of the importance of mother-daughter ties demonstrates the interplay between the biological and social contexts of menopause. Participants also responded to menopause with strenuous

efforts to fight the effects of aging through diet and exercise, but this often involved battling through physical fatigue. Spiritual struggles seemed to be based on an inability to conceive of God as being concerned with the failings of the female body, or an inability to reconcile a loving God with the particular struggle or loss they were facing. It is suggested that attachment theory may account for some of the individual differences that were evident in how participants related to God. Overall, it seemed that faith co-existed with challenge, through a mixed picture of struggle and transformation, as participants attempted to adjust and respond to their menopausal experience.

When participants connected with their faith, they identified that it provided stability and continuity against the disruption of menopause. Moreover, a sense of God as loving and constant, and a sense of self as having an intrinsic, unconditional value in His eyes, seemed to enable them to surpass the conditional value ascribed to women by Western society; it is suggested this enhanced self-concept stems from a biblical concept of womanhood from which Christian women may derive their self-worth. Participants further identified God as a resource they could draw from for strength and support; through this sense of connection with a power greater than self, it is suggested that faith may provide a pathway to psychological resilience at menopause.

From an existential perspective, it seemed that the menopausal transition and sense of the passing years prompted participants to identify priorities for the remainder of their lives and connect with deeper meaning; their sense of aligning their plans with God's purposes provided a sense of fulfilment and enabled them to overcome self-doubt.

Participants seemed in some ways to be rediscovering themselves as individuals at this life stage, moving beyond a concept of self focused on obligation to others.

4.7 Conclusion

The aim of the study was to explore the research questions:

> "How do Christian women experience the menopause?" and
>
> "How do they experience their faith at this stage of their lives?"

The essence of an interpretative phenomenological study is that it explores lived experience, hence the study offers insight into how six Christian women have, in their own very different and unique ways, made sense of menopause in the context of their faith. The study confirms research findings that identify menopause as a critical window for biopsychosocial change, but also identifies how a spiritual faith can bring perspective, resilience and hope amid these challenges.

The core existential concerns identified by Spinelli (2005) were evident throughout the study, in terms of: menopause impacting how participants existed in the social world; the interplay between freedom and limitation in later life; awareness of aging and mortality; and questions about meaning in life, that seemed for some to be strongly connected to motherhood. This seems to validate the argument that menopause represents an existential concern for women. Moreover, the sense of vulnerability expressed by the single participants may have an existential as much as a psychosocial basis. Framing menopause within an existential paradigm seemed to facilitate a broader perspective for the study than a focus on menopausal symptoms alone,

allowing issues such as aging, vulnerability and loss to be explored, and creating a sense of opportunity arising from crisis, as participants described exploring new avenues for growth and development. Additionally, for some participants, their spiritual beliefs gave meaning to the existential questions raised by menopause.

Participants spoke willingly and openly about very personal matters in the research interviews. Some had hardly discussed their menopause before, but most said they had found it helpful, and even therapeutic, to have the opportunity to process their thoughts and feelings on the issue and how it related to their faith.

Reflecting on my own learning, the study has increased my understanding of the interface between the psychological and spiritual; these dimensions of life are often siloed by professionals, and yet for people of faith they are closely intertwined in terms of how they make sense of their lives. Where psychological therapy ignores the spiritual dimension, it risks gaining only a partial understanding of the person; this conflicts with the pluralistic philosophy of counselling psychology that emphasises a holistic view of the person. The study has increased my confidence in talking with clients about their spirituality, regardless of whether their understanding and beliefs are aligned with my own.

Conceptualising menopause from a bio-psycho-social-spiritual perspective has provided me with a holistic framework for understanding other life transitions and challenges, such as in my current work with people who have a cancer diagnosis. Specifically, this may involve exploring the impact of physical symptoms and/or a

shortened life expectancy on psychological wellbeing and social functioning, and possibly exploring an existential or spiritual perspective on life.

I appreciate that this study may be read very differently depending on the reader's own spiritual or religious perspective. However, I believe it makes a useful contribution to the existing body of research, primarily through its exploration of the interaction of spirituality with the biological, psychological and social aspects of menopause. It is hoped that this will facilitate a fuller understanding of the lived experience of women of faith at this stage in their lives.

REFERENCES

Abernethy, A. D., & Lancia, J. J. (1998). Religion and the psychotherapeutic relationship: Transferential and countertransferential dimensions. *Journal of Psychotherapy Practice and Research, 7*(4), 281-289.

American Society for Reproductive Medicine. (2006). The menopausal transition. *Fertility and Sterility, 86*(Suppl. 4), S253-S256.

Angelidis, A., Solis, E., Lautenbach, F., van der Does, W., & Putman, P. (2019). I'm going to fail! Acute cognitive performance anxiety increases threat-interference and impairs working memory performance. *PLoS ONE, 14*(2): e0210824.

Astbury-Ward, E. M. (2003). Menopause, sexuality and culture: Is there a universal experience? *Sexual and Relationship Therapy, 18*(4), 437-445.

Atwood, J. D., McElgun, L., Celin, Y., & McGrath, J. (2008). The socially constructed meanings of menopause: Another case of manufactured madness? *Journal of Couple & Relationship Therapy, 7*(2), 150-174.

Ayers, B., Forshaw, M., & Hunter, M. S. (2010). The impact of attitudes towards the menopause on women's symptom experience: A systematic review. *Maturitas, 65*, 28-36.

Becker, E. (2011). *The Denial of Death.* Souvenir Press.

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: A practical guide for beginners.* Sage Publishing.

British Council. (n.d.). *What faiths are represented in the UK?* Retrieved 10 November 2019 from: https://study-uk.britishcouncil.org/moving-uk/student-life/religion

British Psychological Society. (2021). *Code of Human Research Ethics*. Available at: https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf

Bromberger, J. T., Kravitz, H. M., Matthews, K., Youk, A., Brown, C., & Feng, W. (2009). Predictors of first lifetime episodes of major depression in midlife women. *Psychological Medicine, 39*, 55-64.

Brown, L., Brown, V., Judd, F., & Bryant, C. (2018). It's not as bad as you think: Menopausal representations are more positive in postmenopausal women. *Journal of Psychosomatic Obstetrics & Gynecology*, *39*(4), 281-288.

Buber, M. (2013). *I and Thou*. (R. G. Smith, Trans.). Bloomsbury.

Calandra, J. M. (2001). *Body image in menopausal lesbian and heterosexual women* [Dissertation]. Dissertation Abstracts International: Section B: The Sciences and Engineering, 61(12-B), 6698.

Casu, G., Ulivi, G., Zaia, V., Fernandes Martins, M. D. C., Parente Barbosa, C., & Gremigni, P. (2018). Spirituality, infertility-related stress, and quality of life in Brazilian infertile couples: Analysis using the actor-partner interdependence mediation model. *Research in Nursing & Health, 41*(2), 156-165.

Coyle, A. (2010). Counselling psychology contributions to religion and spirituality. In M. Milton (Ed.), *Therapy and Beyond: Counselling psychology contributions to therapeutic and social issues* (pp. 259-275). Wiley-Blackwell.

Cronin, C., Hungerford, C., & Wilson, R. L. (2021). Using digital health technologies to manage the psychosocial symptoms of menopause in the workplace: A narrative literature review. *Issues in Mental Health Nursing, 42*(6), 541-548.

De Abreu Costa, M., & Moreira-Almeida, A. (2022). Religion-adapted cognitive behavioral therapy: A review and description of techniques. *Journal of Religion and Health, 61*, 443-466.

DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health, 7*: e000057.

Delanoe, D., Hajri, S., Bachelot, A., Draoui, D. M., Hassoun, D., Marsicano, E., & Ringa, V. (2012). Class, gender and culture in the experience of menopause. A comparative survey in Tunisia and France. *Social Science & Medicine, 75,* 401-409.

Dennison, M. (2019). IPA: The black swan of qualitative research. *Qualitative Methods in Psychology Bulletin, 27*: https://doi.org/10.13140/RG.2.2.29104.81920

De Salis, I., Owen-Smith, A., Donovan, J. L., & Lawlor, D. A. (2017). Experiencing menopause in the UK: The interrelated narratives of normality, distress, and transformation. *Journal of Women & Aging, 30*(6), 520-540.

Dillaway, H. E. (2007). "Am I similar to my mother?" How women make sense of menopause using family background. *Women & Health, 46*(1), 79-97.

Drake, P., & Heath, L. (2011). *Practitioner Research at Doctoral Level: Developing coherent research methodologies.* Routledge.

Elkins, D. N., Hedstrom, L. J., Hughes, L. L., Leaf, J. A., & Saunders, C. (1988). Toward a humanistic-phenomenological spirituality: Definition, description, and measurement. *Journal of Humanistic Psychology, 28*(4), 5-18.

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research, 12*(4), 531-545.

Finlay, L. (2009). Ambiguous encounters: A relational approach to phenomenological research. *Indo-Pacific Journal of Phenomenology, 9*(1), 1-17.

Greendale, G. A., Derby, C. A., & Maki, P. M. (2011). Perimenopause and cognition. *Obstetrics and Gynecology Clinics of North America, 38*(3), 519-535.

Greenidge, S., & Baker, M. (2012). Why do committed Christian clients seek counselling with Christian therapists? *Counselling Psychology Quarterly, 25*(3), 211-222.

Gupta, P., Sturdee, D. W., & Hunter, M. S. (2006). Mid-age health in women from the Indian subcontinent (MAHWIS): General health and the experience of menopause in women. *Climacteric, 9*(1), 13-22.

Hakimi, S., Simbar, M., Tehrani, F. R., Zaiery, F., & Khatami, S. (2016). Women's perspectives toward menopause: A phenomenological study in Iran. *Journal of Women & Aging, 28*(1), 80-89.

Hall, C. A., Reynolds, C. F., Butters, M., Zisook, S., Simon, N., Corey-Bloom, J., Lebowitz, B. D., Begley, A., Mauro, C., & Shear, M. K. (2014). Cognitive functioning in complicated grief. *Journal of Psychiatric Research, 58*, 20-25.

Hayes, J. P., VanElzakker, M. B., & Shin, L. M. (2012). Emotion and cognition interactions in PTSD: A review of neurocognitive and neuroimaging studies. *Frontiers in Integrative Neuroscience, 6*(89), 1-11.

Health and Care Professions Council. (2016). *Standards of Conduct, Performance and Ethics*. Available at: https://www.hcpc-uk.org/resources/standards/standards-of-conduct-performance-and-ethics/

Heidegger, M. (1962). *Being and Time*. Harper & Row.

Hoga, L., Rodolpho, J., Gonçalves, B., & Quirino, B. (2015). Women's experience of menopause: A systematic review of qualitative evidence. *JBI Database of Systematic Reviews & Implementation Reports, 13*(8), 250–337.

Hudson, R. (2016). *The Christian Writer's Manual of Style* (4th ed.). Zondervan.

Hunter, M. M., Huang, A. J., & Wallhagen, M. I. (2020). "I'm going to stay young": Belief in anti-aging efficacy of menopausal hormone therapy drives prolonged use despite medical risks. *PLoS ONE, 15*(5): e0233703.

Hvas, L. (2006). Menopausal women's positive experience of growing older. *Maturitas, 54,* 245-251.

Hvas, L., & Gannik, D. E. (2008a). Discourses on menopause – Part I: Menopause described in texts addressed to Danish women 1996-2004. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 12*(2), 157-175.

Hvas, L., & Gannik, D. E. (2008b). Discourses on menopause – Part II: How do women talk about menopause? *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 12*(2), 177-192.

Jaeger, D. (2004). *Sexuality and spirituality: A phenomenological inquiry of eleven midlife women* [Doctoral thesis, Saint Louis University]. Retrieved from ProQuest Dissertations and Theses Database.

Kadri, N., Berrada, S., Mchichi Alami, K., Manoudi, F., Rachidi, L., Maftouh, S., & Halbreich, U. (2007). Mental health of Moroccan women, a sexual perspective. *Journal of Affective Disorders, 102,* 199-207.

Kalpakjian, C. Z., Riley, B. B., Quint, E. H., & Tate, D. G. (2004). Hormone replacement therapy and health behavior in postmenopausal polio survivors. *Maturitas, 48*(4), 398-410.

Kasket, E. (2013). The counselling psychologist researcher. In G. C. Davey (Ed.), *Applied Psychology* (Supplementary Chapters: Chapter 4). Blackwell Publishing.

Kaufert, P. A. (1982). Myth and the menopause. *Sociology of Health and Illness, 4*(2), 141-166.

Khandelwal, S. (2020). Obesity in midlife: lifestyle and dietary strategies. *Climacteric, 23*(2), 140-147.

Kingsberg, S. A., Schaffir, J., Faught, B. M., Pinkerton, J. V., Parish, S. J., Iglesia, C. B., Gudeman, J., Krop, J., & Simon, J. A. (2019). Female sexual health: Barriers to optimal outcomes and a roadmap for improved patient-clinician communications. *Journal of Women's Health, 28*(4), 432-443.

Kirkpatrick, L. A., & Shaver, P. R. (1992). An attachment-theoretical approach to romantic love and religious belief. *Personality and Social Psychology Bulletin, 18*(3), 266-275.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606-613.

Langdridge, D. (2013). *Existential Counselling & Psychotherapy*. Sage Publications.

Latifnejad Roudsari, R., Allan, H. T., & Smith, P. A. (2014). Iranian and English women's use of religion and spirituality as resources for coping with infertility. *Human Fertility, 17*(2), 114-123.

Lock, M., & Kaufert, P. (2001). Menopause, local biologies, and cultures of aging. *American Journal of Human Biology, 13*, 494–504.

London Metropolitan University. (2021). *Research Ethics Policy and Procedures*. Available at: https://student.londonmet.ac.uk/media/london-metropolitan-university/london-met-documents/professional-service-departments/research-office/policies-/Research-Ethics-Policy-and-Procedures_Final.pdf

Mackey, S., Teo, S. S. H., Dramusic, V., Lee, H. K., & Broughton, M. (2014). Knowledge, attitudes, and practices associated with menopause: A multi-ethnic, qualitative study in Singapore. *Health Care for Women International, 35*, 512-528.

Mahadeen, A. I., Halabi, J. O., & Callister, L. C. (2008). Menopause: A qualitative study of Jordanian women's perceptions. *International Nursing Review, 55*, 427-433.

Mangweth-Matzek, B., Hoek, H. W., Rupp, C. I., Kemmler, G., Harrison, G. P., & Kinzl, J. (2013). The menopausal transition – A possible window of vulnerability for eating pathology. *International Journal of Eating Disorders, 46*(6), 609-616.

Manning, L. K. (2012). Spirituality as a lived experience: Exploring the essence of spirituality for women in late life. *International Journal of Aging and Human Development, 75*(2), 95-113.

McAteer, D. (2010). Philosophical pluralism: Navigating the sea of diversity in psychotherapeutic and counselling psychology practice. In M. Milton (Ed.), *Therapy and Beyond: Counselling psychology contributions to therapeutic and social issues* (pp. 5-19). Wiley-Blackwell.

McBeath, A. G., du Plock, S., & Bager-Charleson, S. (2020). The challenges and experiences of psychotherapists working remotely during the coronavirus pandemic. *Counselling and Psychotherapy Research, 20,* 394-405.

McCann Mortimer, P., Ward, L., & Winefield, H. (2008). Successful ageing by whose definition? Views of older, spiritually affiliated women. *Australasian Journal on Ageing, 27*(4), 200-204.

McKinlay, S. M., Brambilla, D. J., & Posner, J. G. (1992). The normal menopause transition. *Maturitas, 14*(2), 103-115.

McNair, R., Taft, A., & Hegarty, K. (2008). Using reflexivity to enhance in-depth interviewing skills for the clinician researcher. *BMC Medical Research Methodology, 8*(73): https://doi.org/10.1186/1471-2288-8-73.

Meletiou, C., & Meylahn, J-A. (2015). Deconstructing the cultural confinement of the Western menopausal women towards a spirituality of liberation. *Verbum et Ecclesia, 36*(1): https://doi.org/10.4102/ve.v36i1.1312.

Merghati-Khoei, E., Sheikhan, F., Shamsalizadeh, N., Haghani, H., Pasha, Y. R. Y., & Killeen, T. (2014). Menopause negatively impacts sexual lives of middle-aged Iranian women: A cross-sectional study. *Journal of Sex & Marital Therapy, 40*(6), 552-560.

Mitchell, E. S., & Woods, N. F. (2001). Midlife women's attributions about perceived memory changes: Observations from the Seattle Midlife Women's Health Study. *Journal of Women's Health and Gender-Based Medicine, 10*(4), 351–362.

Mohamed, S., & Hunter, M. S. (2019). Transgender women's experiences and beliefs about hormone therapy through and beyond mid-age: An exploratory UK study. *International Journal of Transgenderism, 20*(1), 98-107.

Mulhall, S., Andel, R., & Anstey, K. J. (2018). Variation in symptoms of depression and anxiety in midlife women by menopausal status. *Maturitas, 108*, 7-12.

Murray, A. E. (2021). *Building biblical manhood and womanhood: White American evangelical complementarian theology, 1970-2010* [Doctoral thesis, Emmanuel College, University of Toronto]. Retrieved from: https://tspace.library.utoronto.ca/bitstream/1807/107417/5/Murray_Allison_E_202105_PhD_thesis.pdf

National Institute for Health and Care Excellence. (2015). *Menopause: Diagnosis and management* (NICE guideline: N23). Available at: https://www.nice.org.uk/guidance/ng23

Netz, Y., Zach, S., Taffe, J. R., Guthrie, J., & Dennerstein, L. (2008). Habitual physical activity is a meaningful predictor of well-being in midlife women: A longitudinal analysis. *Climacteric, 11*(4), 337-344.

New International Version Bible. (2011). NIV Online. https://www.bible.com/bible/111/GEN.1.NIV

NHS Employers. (2021). *Menopause and the workplace: Information on how menopause can affect people at work, and practical guidance for employers on how to improve workplace environments for them.* Available at: https://www.nhsemployers.org/articles/menopause-and-workplace

Noonil, N., Hendricks, J., & Aekwarangkoon, S. (2012). Lived experience of Thai women and their changing bodies in midlife. *Nursing and Health Sciences, 14*, 312-317.

Pimenta, F., Maroco, J., Ramos, C., & Leal, I. (2014). Menopausal symptoms: Is spirituality associated with the severity of symptoms? *Journal of Religion and Health, 53*, 1013-1024.

Piper, J., & Grudem, W. (1991). *Recovering Biblical Manhood and Womanhood: A response to evangelical feminism.* Crossway Books.

Polotsky, H. (2010). Metabolic implications of menopause. *Seminars in Reproductive Medicine, 28*(5), 426-434.

Pramataroff, V., Leppert, K., & Strauss, B. (2007). Denial of the climacteric - A pilot study of a common clinical phenomenon. *Journal of Psychosomatic Obstetrics & Gynecology, 28*(3), 135-139.

Rabbidge, M. (2017). Embracing reflexivity: The importance of not hiding the mess. *TESOL Quarterly*, *51*(4), 961-971.

Rabiee, M., Nasirie, M., & Zafarqandie, N. (2015). Evaluation of factors affecting sexual desire during menopausal transition and post menopause. *Women's Health Bulletin, 1*(3): e25147.

Rafalin, D. (2010). Counselling psychology and research: Revisiting the relationship in the light of our "mission". In M. Milton (Ed.), *Therapy and Beyond: Counselling psychology contributions to therapeutic and social issues* (pp. 41-55). Wiley-Blackwell.

Reich, J. W., Zautra, A. J., & Hall, J. S. (2010). *Handbook of Adult Resilience*. The Guilford Press.

Romeiro, J., Caldeira, S., Brady, V., Timmins, F., & Hall, J. (2017). Spiritual aspects of living with infertility: A synthesis of qualitative studies. *Journal of Clinical Nursing, 26*, 3917-3935.

Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist, 37*(4), 433–440.

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

Schmid, P. F. (2013). The anthropological, relational and ethical foundations of person-centred therapy. In M. Cooper, M. O'Hara, P. F. Schmid, & A. C. Bohart (Eds.), *The Handbook of Person-Centred Psychotherapy and Counselling* (2nd ed., pp. 66-83). Palgrave Macmillan.

Sekse, R. J. T., Raaheim, M., Blaaka, G., & Gjengedal, E. (2010). Life beyond cancer: Women's experiences 5 years after treatment for gynaecological cancer. *Scandinavian Journal of Caring Sciences, 24*(4), 799–807.

Sergeant, J., & Rizq, R. (2017). "It's all part of the big CHANGE": A grounded theory study of women's identity during menopause. *Journal of Psychosomatic Obstetrics & Gynaecology, 38*(3), 189-201.

Silf, M. (2011). *The Other Side of Chaos: Breaking through when life is breaking down*. Loyola Press.

Smith, J. A. (2010). Interpretative Phenomenological Analysis: A reply to Amedeo Giorgi. *Existential Analysis, 21*(2), 186-192.

Smith, J. A., & Eatough, V. (2016). Interpretative phenomenological analysis. In E. Lyons & A. Coyle (Eds.), *Analysing Qualitative Data in Psychology* (2nd ed., pp. 50-67). Sage Publications.

Smith, J. A., Flowers, P., & Larkin, M. (2012). *Interpretative Phenomenological Analysis: Theory, Method and Research.* Sage Publications.

Sorell, G. T., & Montgomery, M. J. (2001). Feminist perspectives on Erikson's theory: Their relevance for contemporary identity development research. *Identity: An International Journal of Theory and Research, 1*(2), 97-128.

Sousa, D. (2008). From Monet's paintings to Margaret's ducks: Divagations on phenomenological research. *Existential Analysis, 19*(1), 143-155.

Spinelli, E. (2005). *The Interpreted World: An introduction to phenomenological psychology* (2nd ed.). Sage Publications.

Steffen, P. R. (2011). Spirituality and severity of menopausal symptoms in a sample of religious women. *Journal of Religion and Health, 50,* 721-729.

Stephens, C. (2001). Women's experience at the time of menopause: Accounting for biological, cultural and psychological embodiment. *Journal of Health Psychology, 6*(6), 651-663.

Stotland, N. L., Stewart, D. E., Munce, S. E., & Ashraf, I. (2007). Obstetrics and Gynecology. In J. L. Levenson (Ed.), *Essentials of Psychosomatic Medicine* (pp. 343-374). American Psychiatric Publishing, Inc.

Strauss, J. R. (2013). The baby boomers meet menopause: Fertility, attractiveness, and affective response to the menopausal transition. *Sex Roles, 68,* 77-90.

Strawbridge, S. (2016). Science, craft and professional values. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.), *The Handbook of Counselling Psychology* (4th ed., pp. 20-37). Sage Publications.

Strezova, A., O'Neill, S., O'Callaghan, C., Perry, A., Liu, J., & Eden, J. (2017). Cultural issues in menopause: An exploratory qualitative study of Macedonian women in Australia. *Menopause: The Journal of the North American Menopause Society, 24*(3), 308-315.

Süss, H., Willi, J., Grub, J., & Ehlert, U. (2021). Psychosocial factors promoting resilience during the menopausal transition. *Archives of Women's Mental Health, 24*(2), 231-241.

Sydora, B. C., Graham, B., Oster, R. T., & Ross, S. (2021). Menopause experience in First Nations women and initiatives for menopause symptom awareness; a community-based participatory research approach. *BMC Women's Health, 21*(1), 179: https://pubmed.ncbi.nlm.nih.gov/33902542/

Szcześniak, M., & Timoszyk-Tomczak, C. (2020). Religious struggle and life satisfaction among adult Christians: Self-esteem as a mediator. *Journal of Religion and Health, 59*(6), 2833-2856.

Tangen, T., & Mykletun, A. (2008). Depression and anxiety through the climacteric period: An epidemiological study (HUNT-II). *Journal of Psychosomatic Obstetrics & Gynecology, 29*(2), 125-131.

Taylor, C., & Hicks, S. (2009). The practitioner-researcher: A critical and reflexive approach to professional practice. In N-J. Smith (Ed.), *Achieving your Professional Doctorate* (pp. 50-84). McGraw-Hill.

Thornton, K., Chervenak, J., & Neal-Perry, G. (2015). Menopause and sexuality. *Endocrinology & Metabolism Clinics of North America, 44*(3), 649-661.

Utz, R. L. (2011). Like mother, (not) like daughter: The social construction of menopause and aging. *Journal of Aging Studies, 25,* 143-154.

Van Deurzen, E. (2011). Reasons for living: Existential therapy and spirituality. In L. Barnett & G. Madison (Eds.), *Existential Therapy: Legacy, Vibrancy and Dialogue* (1st ed., pp. 171-182). Routledge.

Van Deurzen, E. (2012). *Existential Counselling & Psychotherapy in Practice* (3rd ed.). Sage Publications.

Von Hippel, C., Adhia, A., Rosenberg, S., Austin, S. B., Partridge, A., & Tamimi, R. (2019). Sexual function among women in midlife: Findings from the Nurses' Health Study II. *Women's Health Issues, 29*(4), 291-298.

Wales Trades Union Congress. (2017). *The menopause in the workplace: A toolkit for trade unionists.* Available at: https://www.tuc.org.uk/sites/default/files/Menopause%20toolkit%20Eng%20FINAL.pdf

Walter, C. A. (2000). The psychosocial meaning of menopause: Women's experiences. *Journal of Women & Aging, 12*(3-4), 117-131.

Webster, R. S. (2004). An existential framework of spirituality. *International Journal of Children's Spirituality, 9*(1), 7-19.

Wilk, C. A., & Kirk, M. A. (1995). Menopause: A developmental stage, not a deficiency disease. *Psychotherapy: Theory, Research, Practice, Training, 32*(2), 233-241.

Willig, C. (2013). *Introducing Qualitative Research in Psychology* (3rd ed.). McGraw-Hill.

Willig, C. (2019). Ontological and epistemological reflexivity: A core skill for therapists. *Counselling and Psychotherapy Research, 19,* 186-194.

Willis, D. S. (2008). A decade on: What have we learnt about supporting women with intellectual disabilities through the menopause? *Journal of Intellectual Disabilities, 12*(1), 9-23.

Willis, D. S., Wishart, J. G., & Muir, W. J. (2011). Menopausal experiences of women with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 24*(1), 74-85.

Winterich, J. A., & Umberson, D. (1999). How women experience menopause: The importance of social context. *Journal of Women & Aging, 11*(4), 57-73.

Yalom, I. D. (2008). *Staring at the Sun: Overcoming the dread of death*. Jossey-Bass.

Yalom, I. D. (2009). *The Gift of Therapy: An open letter to a new generation of therapists and their patients.* Harper Collins.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*(2), 215-228.

Zeydan, B., Atkinson, E. J., Weis, D. M., Smith, C. Y., Rocca, L. G., Rocca, W. A., Keegan, B. M., Weinshenker, B. G., Kantarci, K., & Kantarci, O. H. (2020). Reproductive history and progressive multiple sclerosis risk in women. *Brain Communications, 2*(2): https://doi.org/10.1093/braincomms/fcaa185

APPENDIX A Inclusion and Exclusion Criteria for the Study

The inclusion criteria required that participants were:

1 Perimenopausal or up to five years postmenopausal

This case definition means that women recruited for the study are likely to be currently experiencing menopausal symptoms or have fairly recently gone through their menopausal transition. Therefore, participants should be able to speak from personal current or recent experience about the physical and psychological impact of the menopause.

2 Spiritually affiliated within the Christian faith

Women recruited should hold an active Christian faith that informs and gives meaning to their day-to-day lives; moreover, they should be a regular attender of church meetings. Sharing a similar set of beliefs and belonging to a faith community should result in a fairly homogenous sample, as required for an IPA study. Although all participants should self-identify as Christian, they may belong to any particular Christian denomination, for example Baptist or Anglican.

Exclusion criteria included:

- Women with a significant, enduring mental health diagnosis (PHQ-9 score should be less than 10, with no indication of suicide risk).
- Women with significant, current physical health challenges, for example undergoing chemotherapy for cancer.
- Women whose menopause was premature or induced rather than spontaneous.
- Women without a good standard of English, or whose capacity to consent and participate in the study may otherwise be compromised.

APPENDIX B

Participant Information Sheet

Research Study: How do Christian women experience the menopause?

My name is Jane Beckford and I am studying for a Professional Doctorate in Counselling Psychology at London Metropolitan University. As part of my training, I will be conducting a research study. This study aims to investigate the experience of menopause for women who have a Christian faith. I would like to invite you to take part in this.

What is known about this subject already and why is the study needed?

Much of the existing research on menopause focuses on the medical treatment of it, rather than how women themselves feel about it. Very little is known about how women of any particular faith or religious background experience the menopause, nor about how they experience their faith at this stage of their life. The aim of the study is to give women of faith the opportunity to share their experience of menopause and midlife, to help broaden the understanding of health and psychology professionals on this subject.

What will my participation in the study involve?

Prior to participating in the study, you will be asked to complete a brief screening form for depression. This is because we would not want to expose anyone who is feeling particularly vulnerable to questions of a personal nature.

Your participation will involve attending a confidential interview with the researcher; this will last an hour or so. At the start, you will have the opportunity to ask any questions and you will be asked to sign a consent form.

The interview will be audio-recorded and later transcribed. The researcher will ask questions and you are encouraged to answer as fully as possible. The interview will include questions of a personal nature that may cause discomfort. You have the right not to answer any particular question, and to request that the interview is terminated should you become distressed. There will be an opportunity for debriefing at the end of the interview, so that you can discuss the experience of the interview and how you are feeling. It is possible that the researcher may need to contact you after the interview if any issues discussed require clarification.

How will my privacy be protected?

All written and audio-recorded information will be stored securely in a locked cabinet, or electronically on a computer that is password-protected. Any data that identifies you will be stored separately from your anonymised interview recording and transcript. After 5 years, all data will be destroyed by the researcher.

The final written report may contain quotations from your interview; however, these will be anonymised so it will not be possible for anyone to identify you from any quotation.

Are there any exceptions to this?

The only circumstance where confidentiality may not be maintained is where the information you disclose indicates any risk of harm to yourself or others.

Can I withdraw from the study?

Your participation in the study is entirely voluntary and you have the right to withdraw from the study for up to four weeks following the interview. If you do withdraw during this period, all the data you provided will be destroyed.

How will this study help anyone?

The anonymised information provided by participants will be reported in a thesis that will be held in the library of London Metropolitan University; this may be accessed by academics and professionals interested in the topic. A shorter version of the study may be published in an academic journal; this should help psychologists, counsellors and other health professionals to gain a greater understanding of how women of faith experience the menopause.

What else do I need to know?

The research study has been approved by the London Metropolitan University Research Ethics Sub-Committee, which exists to ensure research carried out by university staff and students is safe and ethical.

Thank you for considering being involved in this study and please do not hesitate to contact me (Jane Beckford) with any queries, by phone: 07974 745 738, or email: jeb072@my.londonmet.ac.uk

Alternatively, any concerns may be raised with my research supervisor, Dr Angela Loulopoulou, by phone: 020 7133 2667, or email: a.loulopoulou@londonmet.ac.uk

APPENDIX C

Patient Health Questionnaire-9 (PHQ-9)

Initials ……. Date…….....

Please tick (by clicking the mouse) **ONLY** one box per line to indicate your response as it applies to the **last 2 weeks**.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0☐	1☐	2☐	3☐
2. Feeling down, depressed or hopeless	0☐	1☐	2☐	3☐
3. Trouble falling or staying asleep, or sleeping too much	0☐	1☐	2☐	3☐
4. Feeling tired or having little energy	0☐	1☐	2☐	3☐
5. Poor appetite or overeating	0☐	1☐	2☐	3☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0☐	1☐	2☐	3☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0☐	1☐	2☐	3☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving a lot more than usual	0☐	1☐	2☐	3☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0☐	1☐	2☐	3☐

LONDON METROPOLITAN UNIVERSITY

APPENDIX D

Consent Form

Participation in the Research Study: How do Christian women experience the menopause?

I confirm that I have read and understood the information sheet provided for the above study and have been given a copy to keep. I have been given the opportunity to ask any questions about the study and my involvement in it, and have had these questions answered to my satisfaction.

I understand that my participation in the study is voluntary and that I have the right to withdraw from the study for up to four weeks following the interview. If I do withdraw during this period, all the data I provide will be destroyed.

I agree to participate in an interview that will last approximately one hour, which will be audio-recorded and later transcribed. I understand that quotations from my interview (from which I will not be identifiable) may be used in the writing up and publication of the study.

I understand that all the information I provide will be kept securely and confidentially and will be destroyed by the researcher after 5 years. However, I also understand that confidentiality cannot be maintained if the information I disclose indicates any risk of harm to myself or others.

I understand that the interview will include questions of a personal nature that may cause discomfort. I understand that I have the right not to answer any particular question, and that I can request for the interview to be terminated should I become distressed.

I understand that the researcher may need to contact me after the interview, if any points discussed require clarification.

Name of participant _____ Signature of participant_____

Name of researcher _____ Signature of researcher _____

Date _____

APPENDIX E Interview Schedule

1 How would you describe your experience of the menopause / what has it been like to experience the menopause?

Possible prompts: *How would you describe the physical, psychological or emotional aspects? How did it compare to how you expected it to be?*

2 How do you feel about yourself at this stage of your life?

Possible prompts: *How do you experience the sense of your body aging and changing?*

How has it been to sense the loss of your fertility?

Menopause is sometimes called "the change" – what has this change meant to you?

3 What are the particular challenges for you at this stage of life?

Possible prompts: *Have there been changes in your family structure or relationships?*

Are there challenges with caring responsibilities, health or work?

4 How would you describe your faith?

Possible prompt: *How does your faith affect your life on a day-to-day basis?*

5 What does your faith mean to you at this point in time / in your life at the moment? How does your faith come into this / relate to this?

Possible prompt: *How does your faith affect how you make sense of, and cope with, challenges and changes in your life?*

6 Can you describe any particular challenges to your faith over this period?

Possible prompts: *How do you hold on to the hope that your faith provides while all of this is going on? How do you experience God in difficult times?*

7 How do you feel when you look to the future?

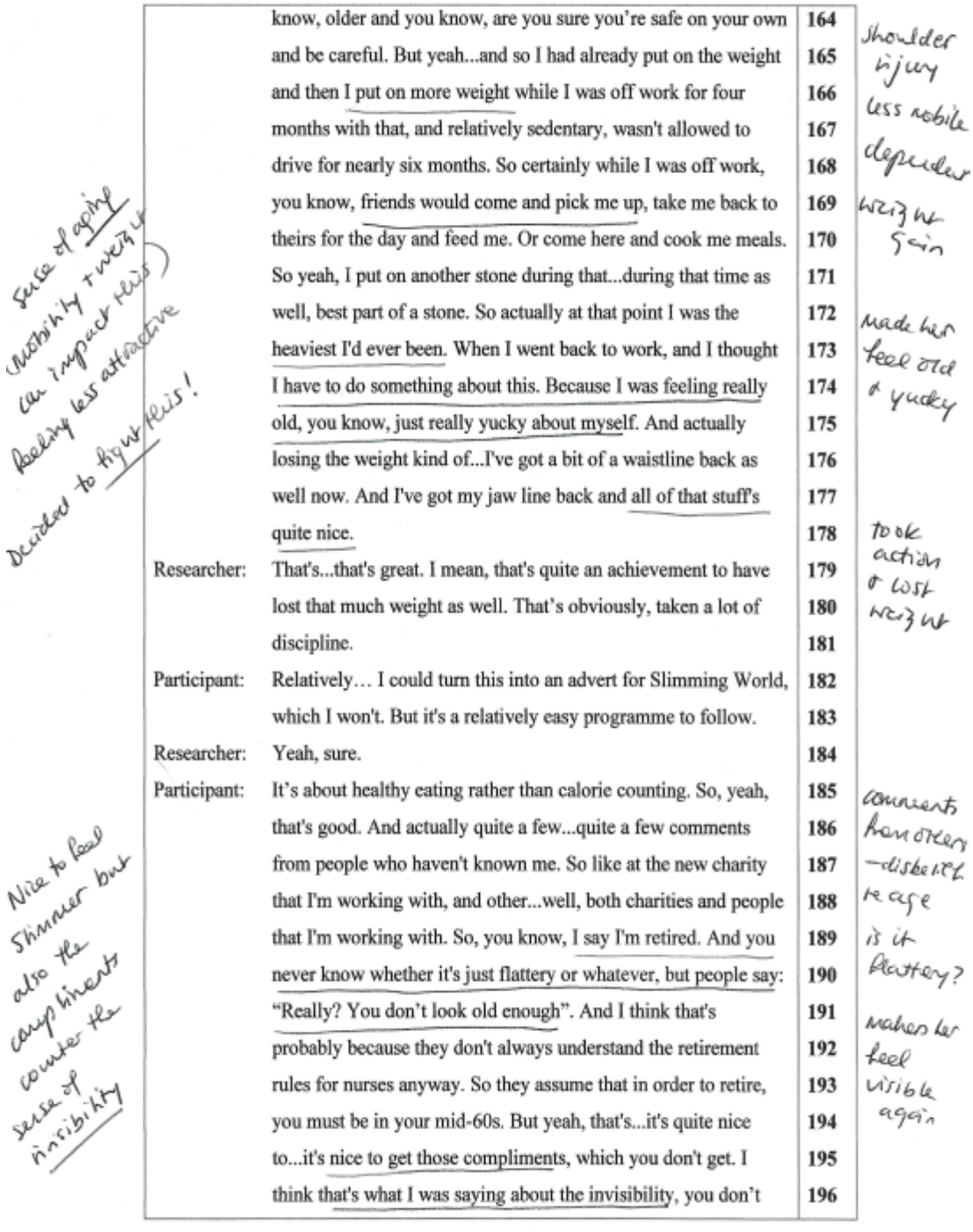
8 Menopause can be quite a private experience. Have you felt able to talk about these issues – to family, friends, church or anyone else - and how was this experience?

9 Is there anything else you would like to mention that we haven't covered?

10 Lastly, could you tell me a little about how you have found the experience of participating in this research interview?

APPENDIX F **Section of One Transcript with Notes**

Diane



	know, older and you know, are you sure you're safe on your own	164
	and be careful. But yeah...and so I had already put on the weight	165
	and then I put on more weight while I was off work for four	166
	months with that, and relatively sedentary, wasn't allowed to	167
	drive for nearly six months. So certainly while I was off work,	168
	you know, friends would come and pick me up, take me back to	169
	theirs for the day and feed me. Or come here and cook me meals.	170
	So yeah, I put on another stone during that...during that time as	171
	well, best part of a stone. So actually at that point I was the	172
	heaviest I'd ever been. When I went back to work, and I thought	173
	I have to do something about this. Because I was feeling really	174
	old, you know, just really yucky about myself. And actually	175
	losing the weight kind of...I've got a bit of a waistline back as	176
	well now. And I've got my jaw line back and all of that stuff's	177
	quite nice.	178
Researcher:	That's...that's great. I mean, that's quite an achievement to have	179
	lost that much weight as well. That's obviously, taken a lot of	180
	discipline.	181
Participant:	Relatively… I could turn this into an advert for Slimming World,	182
	which I won't. But it's a relatively easy programme to follow.	183
Researcher:	Yeah, sure.	184
Participant:	It's about healthy eating rather than calorie counting. So, yeah,	185
	that's good. And actually quite a few...quite a few comments	186
	from people who haven't known me. So like at the new charity	187
	that I'm working with, and other...well, both charities and people	188
	that I'm working with. So, you know, I say I'm retired. And you	189
	never know whether it's just flattery or whatever, but people say:	190
	"Really? You don't look old enough". And I think that's	191
	probably because they don't always understand the retirement	192
	rules for nurses anyway. So they assume that in order to retire,	193
	you must be in your mid-60s. But yeah, that's...it's quite nice	194
	to...it's nice to get those compliments, which you don't get. I	195
	think that's what I was saying about the invisibility, you don't	196

Page 6 of 23

	get the compliments.	197
Researcher:	Yeah. Sure. And obviously, menopause means that fertility is	198
	departing. Has that been an issue for you to sense the loss of	199
	your fertility at all? Does it make you feel differently?	200
Participant:	No, it hasn't actually. And I don't know whether that's	201
	because...well, (A) I have been on my own for years. (B) I was	202
	sterilised after my second son was born, anyway. So that was a	203
	deliberate decision. So I didn't have any of those...any of those	204
	feelings of loss.	205
Researcher:	Right. Sure. And moving on, what are the particular challenges	206
	for you at this stage of life? Have there been changes in your	207
	family structure or relationships? Or have there been caring	208
	responsibilities with the older generation? Issues of health or	209
	work?	210
Participant:	Yeah. Kind of all of the above, really. Yeah, these last few years	211
	I'm in a very different place now than I was five years ago as I	212
	was starting to go into the menopause, you know. So there I	213
	was...I was working full time. You know, the boys were	214
	finishing...well, N. was at university...or, no, just going to	215
	university. A. was starting jobs, but kind of in quite a beginner	216
	phase. And since then, things have...so they both left home for a	217
	while. A. got married. N. went to uni. So I lived on my own for	218
	three years then. N. came back from uni and has been back since	219
	summer last year, because he still hasn't managed to get a	220
	permanent job although he's doing lots of other stuff. Lots of	221
	different stuff, works with a learning disability charity. A.'s	222
	marriage broke up, so he's come back. He's back. He's just	223
	buying a flat in Chelmsford at the moment, so will go again. So	224
	I've retired. And I think, actually, it's the retirement with	225
	menopause as well. But it's that getting your head around and	226
	kind of moving you into a different space, you know. You're not	227
	the kind of high-flying chief nurse anymore for an organisation,	228
	you know, just that all of that adjustment. And I've noticed that	229

losing her fertility was not an issue

Letting loss

life changes

Boomerang kids - leaving then coming back then leaving again

life changes empty nester

Retirement as life event coinciding with menopause

Retirement coupled with menopause

Different place/space

Another space

adjustment not the high flier anymore

	this year, and I think that's about what I was saying about the	230
	invisibility. And would I just now disappear in terms of all of the	231
	net...a lot of the networks and stuff that I have. I mean, that	232
	hasn't proven to be the case.	233
Researcher:	Is that a question you ask yourself, will I just disappear?	234
Participant:	Yeah. As in... you know, I've always been very connected, do a	235
	lot of work through different networks, involved in all sorts of	236
	stuff. And just wondering whether...I think being...being a senior	237
	nurse has defined me for a long time. And so having to think	238
	about who am I now.	239
Researcher:	So it's a lot about identity, really, if I'm not a director of nursing,	240
	then who am I?	241
Participant:	Who am I? I think getting a non-exec director post is brilliant,	242
	because that keeps me connected with the NHS anyway. And I	243
	think other things will...will roll out of that. So yeah, so actually	244
	in the last few weeks, I felt a bit more...a bit more grounded. I	245
	mean, I was before...before the first lockdown it was difficult,	246
	but I was only kind of off work for 10 weeks and then they asked	247
	me to go back to help out. So I went back and I actually covered	248
	one of the senior nursing roles in the organisation. So I worked	249
	for another four months on the bank. But that was really...that	250
	was kind of really good. And I think that helped me transition	251
	my head as well a bit more.	252
Researcher:	So by going back, that helped you to...	253
Participant:	Yeah, I think because I went back into a different role and was	254
	just all of that kind of...Yeah, I'm stepping back from all of this	255
	now. And able to say it very overtly to people while I was there,	256
	which of course while you're still in the role and working to	257
	retirement, you can't go: "Well, I'm stepping back from this so	258
	don't ask me about that because I'm not doing that anymore." But	259
	actually...strangely enough, I found it...I found that quite helpful	260
	doing that. And the being useful stuff, you know. Before I went	261
	back, I was feeling I shouldn't be sat at home here. I shouldn't	262

APPENDIX G Preliminary Superordinate Themes and Sub-Themes

Diane

Superordinate Themes	Sub-Themes	Key Quotes
Impact of Menopause on Sense of Self and Identity	People treat me differently	*"I think, yeah, recognising the kind of different stage in life….and I think I noticed that people started to treat me differently. It felt like...kind of the gateway…a bit like you kind of step through onto the other side of the fence"*
	Becoming invisible	*"I think what struck me was...I became less visible…. realising when you're in a group of people, it's kind of the younger women who get noticed and you don't…I can't put my finger on a specific event and go: "I particularly noticed it there". It's something that builds, that I noticed over time"* *"I think, actually, it's the retirement with menopause as well… moving you into a different space….You're not the…high-flying chief nurse anymore….that's what I was saying about the invisibility…would I just now disappear in terms of the networks I have….Being a senior nurse has defined me for a long time. And so having to think about: Who am I now?"*
Adjusting and Responding to Menopause	Like mother, like daughter?	*"My mum had a very difficult menopause with really heavy periods of bleeding and flooding and all of the physical symptoms, and actually wound up having to have a hysterectomy. So…. knowing there's a genetic component to this, I was braced for it being a really difficult time. In actual fact, it was quite straightforward"*
	Fighting the aging process	*"I was the heaviest I'd ever been… I thought I have to do something about this, because I was feeling really old, you know, just really yucky about myself. And actually, losing the weight...I've got a bit of a waistline back as well now.…and all of that stuff's quite nice"*
Finding Perspective through Faith	A silver thread that runs through everything I do	*"It's like a silver thread that runs through everything I do. And even if I'm not thinking about stuff explicitly from a faith perspective, I know it's part of my thinking….it has always run through everything...I think it's an anchor really… a constant that I can go back to"*
	You can draw from Him	*"It always amazes me, those God incidences that.... you just pick something up and read it…a piece of the Bible...a Bible post on Facebook …and it resonates and speaks into the situation at the time"* *"I used to find it really hard to…create space for God at work …Being at home, that's a lot easier…. I've got back into a rhythm with my daily prayer….I find really useful and comforting….It's that anchor….that kind of grounds the day"*
	Living my faith	*"I feel quite hopeful actually. I'm…looking forward to what the next few years bring…. I'm going to move out of London…a couple of my friends have done that already, and go and live…out towards them and enjoy that"*

APPENDIX H **London Metropolitan University Ethics Application and Approval**

LONDON MET RESEARCH ETHICS REVIEW FORM

For Research Students and Staff

Postgraduate research students (MPhil, PhD and Professional Doctorate): This form should be completed by all research students in full consultation with their supervisor. All research students must complete a research ethics review form before commencing the research or collecting any data and no later than six months after enrolment.

Staff: This form should be completed by the member of staff responsible for the research project (i.e. Principal Investigator and/or grant-holder) in full consultation with any co-investigators, research students and research staff before commencing the research or collecting any data.

Definition of Research

Research is to be understood as original investigation undertaken in order to gain knowledge and understanding. It includes work of direct relevance to the needs of commerce, industry, and to the public and voluntary sectors; scholarship*; the invention and generation of ideas, images, performances, artefacts including design, where these lead to new or substantially improved insights; and the use of existing knowledge in experimental development to produce new or substantially improved materials, devices, products and processes, including design and construction. It excludes routine testing and routine analysis of materials, components and processes such as for the maintenance of national standards, as distinct from the development of new analytical techniques. It also excludes the development of teaching materials that do not embody original research.

*Scholarship is defined as the creation, development and maintenance of the intellectual infrastructure of subjects and disciplines, in forms such as dictionaries, scholarly editions, catalogues and contributions to major research databases.

London Met's *Research Ethics Policy and Procedures* and *Code of Good Research Practice* along with links to research ethics online courses and guidance materials, can be found on the Research & Postgraduate Office Research Ethics webpage:

http://www.londonmet.ac.uk/research/current-students/research-ethics/

London Met's Research Framework can be found here:

http://www.londonmet.ac.uk/research/current-students/research-framework/

Researcher development sessions can be found here:

https://student.londonmet.ac.uk/your-studies/mphil--phd-professional-doctorates/postgraduate-research-training-sessions/

This form requires the completion of the following three sections:

SECTION A: APPLICANT DETAILS

SECTION B: THE PROJECT - ETHICAL ISSUES

SECTION C: THE PROJECT - RISKS AND BENEFITS

SECTION A: APPLICANT DETAILS

A1	Background information
	Research project title: **Menopause and Spirituality: a study of the experience of menopause for Christian women using Interpretative Phenomenological Analysis (IPA)**
	Date of submission for ethics approval: **08.12.19**
	Proposed start date for project: **01.02.20**
	Proposed end date for project: **30.09.21**
	Ethics ID # (to be completed by RERP chair):

A2	Applicant details, if for a research student project
	Name: **Jane Beckford**
	London Met Email address: **jeb072@my.londonmet.ac.uk**

A3	Principal Researcher/Lead Supervisor Member of staff at London Metropolitan University who is responsible for the proposed research project either as Principal Investigator/grant-holder or, in the case of postgraduate research student projects, as Lead Supervisor
	Name: **Dr Angela Loulopoulou**
	Job title: **Principal Lecturer and Programme Director**
	London Met Email address: **A.Loulopoulou@londonmet.ac.uk**

SECTION B: THE PROJECT - ETHICAL ISSUES	
B1	**The Research Proposal**
	Please attach a brief summary of the research project including: • Background/rationale • Research questions/aims/objectives • Research methodology • Review of key literature in this field & conceptual framework for study • References If you plan to recruit participants, be sure to include information how potential participants in the study will be identified, approached and recruited; how informed consent will be obtained; and what measures will be put in place to ensure confidentiality of personal data. **Aim of Study** To carry out a research study using IPA, to explore the menopause and spirituality. Specifically, to answer the **Research Questions**: 1. How do Christian women experience the menopause? 2. How do they experience their spirituality at this stage of their lives? **Objectives of Study** The study proposes that menopause is not only a biological event, but a biopsychosocial phenomenon, which can be profoundly destabilising for women (de Salis et al., 2017). Within an existential theoretical framework, menopause may impact the physical, social, psychological and spiritual dimensions of existence (Stephens, 2001; van Deurzen, 2012); however, spirituality is also found to foster resilience and provide meaning for women, enabling them to make sense of the challenges in the other dimensions of their lives (Steffen, 2011). The study will explore how women with a Christian faith cope with the changes and losses menopause may bring, and whether their faith influences how they experience menopause. Whilst the evidence tends to suggest a positive influence of spirituality, the second research question may facilitate an openness to the possibility of negative effects - such as menopause causing a crisis of faith. This should enable an exploration of any possible interaction between menopause and spirituality for women at midlife. **Background and Rationale** Menopause is defined as the permanent cessation of menstruation resulting from declining ovarian activity (Hoga et al., 2015) - a biological definition for

what is often considered a purely biological event. Indeed, the biomedical model dominates the body of research on menopause. However, many authors argue that menopause should be regarded as a biopsychosocial phenomenon (Stephens, 2001). As a marker of aging, declining sexuality and loss of fertility, menopause may challenge a woman's identity and sense of self. The literature indicates that women experience the universal event of menopause in diverse ways, influenced by both personal and sociocultural factors. Moreover, that negative cultural narratives on female aging may contribute to women feeling silenced, stigmatised and isolated in their midlife difficulties.

Women experiencing the troublesome symptoms of menopause may consult their general practitioner, who is likely to refer to the NICE guidance (National Institute for Health and Care Excellence, 2015) with its focus on the "diagnosis and management" of menopause; this reflects its medicalisation as a deficiency disease requiring pharmacological treatment. There does not appear to be any guidance acknowledging the psychological aspects of menopause. It is possible that the anxiety and depression known to be associated with menopause will be viewed as entirely separate from the biological event itself, reflecting a mind-body dualism; this may not be helpful to women seeking support (Stephens, 2001).

Menopause as a life transition may raise existential and spiritual questions for women. An existential theoretical framework is proposed, which considers the impact of menopause on the four dimensions of existence – the physical, social, psychological and spiritual. It is suggested that the spiritual dimension may provide meaning at this stage of life, enabling women to make sense of challenges in the other dimensions (van Deurzen, 2012). Conversely, an existential challenge such as menopause may arguably provoke a crisis of faith, thereby impacting the spiritual dimension as well.

Literature searching across several databases (PsycINFO, PsycARTICLES, Academic Search Complete, Web of Science and PubMed) revealed only two studies that framed menopause in existential terms and only four studies that examined the relationship between the menopause and spirituality. In the studies on spirituality, participants were either from homogenous Christian church groups (Steffen, 2011; Strezova et al., 2017) or were selected from community populations, where a spiritual dimension to life or a religious faith were not inclusion criteria for the study (Pimenta et al., 2014; Mackey et al., 2014). Further literature searching across the same databases examined the relationship between menopause and each of the six major religious faiths practised in the UK (British Council, n.d.). This yielded a total of 16 further relevant studies (Christianity - 1, Judaism - 0, Hinduism - 0, Sikhism - 0, Buddhism - 2 and Islam - 13).

Overall, a religious faith was found to be a protective factor, increasing resilience for women facing the challenges of menopause (Strezova et al., 2017; Mackey et al., 2014). Christian, Buddhist and Islamic studies found that menopause brought a sense of freedom from religious and cultural restrictions around menstruation (Strezova et al., 2017; Noonil et al., 2012; Mahadeen et

al., 2008), leading to women feeling they could be more visible in public and religious life (Merghati-Khoei et al., 2014). However, women also anticipated that the menopause represented the end of their sexual lives (Kadri et al., 2007), which some viewed as problematic, expressing the view that older women still have sexual desires (Noonil et al., 2012). In some studies, it appeared that women's views on menopause originated more from cultural traditions than their religious beliefs (Kadri et al., 2007). In general, there was more of a focus in the literature on religion as an external factor, than on spirituality as an internal dimension, in terms of influence on women's subjective experience of menopause.

With so few studies on menopause and spirituality, in particular relating to Christianity as the dominant religion in the UK, there is clearly a gap in the research knowledge on how women may utilise their religious beliefs and values to construct meaning at the time of their menopause, or on how menopause may challenge women's experience of their faith at this often-perplexing stage in their lives.

Counselling psychologists who have not themselves experienced menopause and live in a society where it is regarded as taboo, may consider it purely a biological event and may be uninformed of its psychosocial aspects. Moreover, practitioners may feel disinclined to raise the issue of menopause with women, relating as it does to female aging, fertility and sexuality. Additionally, Coyle (2010) suggests that clients' religious and spiritual material is often not routinely engaged with in therapy, advocating that the counselling psychologist should be willing to engage actively with the spiritual dimension where this is salient to clients' meaning making systems. Indeed, the pluralistic philosophy of counselling psychology requires it to engage simultaneously with many aspects of client experience - such as gender, culture and sexuality, as well as spirituality – in order to gain a holistic view of the person and a contextualised understanding of their life (Coyle, 2010; McAteer, 2010). Paying inadequate attention to any part of the client's subjective experience may significantly impact their adjustment and growth (Coyle, 2010); in the case of menopausal women, this may compound their sense of voicelessness and social isolation.

In summary, menopause affects all women at midlife and may bring a sense of aging and loss that interacts with concurrent life events to cause distress. With a scarcity of research framing menopause in psychological terms, counselling psychologists may be ill-equipped to identify and address these issues therapeutically. The value of this study is in giving women a voice and increasing the understanding of counselling psychologists of the complex interaction of issues that may affect midlife women presenting for therapy. The study will aim to create new knowledge to address the gap in a psychological understanding of women at this life stage, specifically how they may use their spiritual faith to make sense of menopause. It is believed that this study may be the first in the UK to explore the relationship between menopause and spirituality.

Research Methodology

The proposal is to conduct a qualitative study to explore women's experience of menopause in the context of their spirituality. Qualitative research emphasises subjective, lived experience and asserts that non-observable phenomena, such as thoughts and emotions, can be studied (Kasket, 2013). Because the study will focus on women's personal experience of menopause, influenced by their sociocultural context, it is argued that a good match is achieved by using a phenomenological approach. This will facilitate an in-depth exploration of the complexity and nuances of the menopausal experience, allowing women's own voices and interpretations to be heard.

IPA as a research methodology explores how participants make sense of their life experiences (Smith et al., 2012). However, IPA recognises the impossibility of gaining direct access to the participant's experience, but is engaged in a double hermeneutic, in trying to make sense of the participant, who is trying to make sense of what is happening to them (Willig, 2013; Smith et al., 2012). Understanding of the participant's experience can only ever be partial, and is influenced by the researcher's worldview (Willig, 2013). Through reflexivity, the researcher should aim to identify the ways in which their own values and standpoints may have shaped the research process and its findings (Braun & Clarke, 2013).

The study adopts a critical realist position, which is compatible with IPA as a research methodology (Braun & Clarke, 2013). Critical realism adopts a realist ontology, acknowledging that an objective reality (such as menopause) does exist (Willig, 2013). However, it also maintains a relativist epistemology, in that the experience of this reality will be different for different women. Critical realism recognises the subjective nature of knowledge production and the objective reality of the phenomenon being studied.

Recruitment

The participant group will comprise 6-8 women who will be:

1. **Perimenopausal or up to five years postmenopausal**

Menopause status is based on the regularity of menstruation. Perimenopause begins with variations of seven days or more in menstrual cycle length and ends one year after the final menstrual period (FMP). Postmenopause describes the time period following the FMP (American Society for Reproductive Medicine, 2006). This case definition should mean that women recruited for the study are currently experiencing menopausal symptoms, or that they have fairly recently gone through the menopause, and are therefore able to speak from current or recent experience about its physical and psychological impact.

2. **Spiritually affiliated within the Christian faith**

The reason for recruiting women who hold an active religious faith, rather than a more abstract notion of spirituality, is that they would share a similar set of beliefs, resulting in a more homogenous sample. They would also be part of a faith community, which would enable exploration of whether or not they have

felt supported by that community at this life stage. Women selected for the study should have a faith that gives meaning to their day-to-day lives and should be a regular attender of church meetings. Moreover, they should self-identify as Christian, but may belong to any particular church denomination.

The inclusion of women who meet both of the above criteria should ensure the required homogeneity for a study using IPA (Smith et al., 2012).

Recruitment strategy

In order to address the bias of previous studies towards a white, affluent, middle-class sample, recruitment will be from a church women's group known to the researcher in an area that is economically deprived and ethnically diverse. Should it not be possible to recruit sufficient participants from this group, snowball sampling will be used to identify contacts of the group at other churches in demographically similar areas. If this combination of sampling methods fails to recruit the required participants, other methods will be used to advertise for women who meet the criteria for the study. These will include wider church networks known to the researcher and menopause support groups on social media.

Informed consent

Before the interview, participants will be given an information sheet about the study and will be able to ask any questions before they consent to participate. Participants will be advised of their right to withdraw from the study, and have their data destroyed, up to four weeks after the interview takes place. Two copies of the consent form will be signed by both participant and researcher, and each will keep one copy (BPS, 2021).

Protection of confidentiality and data security

To protect participants' confidentiality, the following measures will be in place, in line with the requirements of the UK Data Protection Act, 2018:

- All written information will be stored securely in a locked cabinet.
- Data which identifies participants will be stored separately from sensitive data, such as audio recordings and written transcripts, from which any information that identifies participants will be removed.
- All electronic data will be password-protected.
- No participants will be identifiable in the written report of the study.
- All data will be destroyed by the researcher five years after final submission of the thesis.

During the current lockdown situation, it is planned that interviews will be conducted by videoconference using Skype or Zoom platforms

References

American Society for Reproductive Medicine. (2006). The menopausal transition. *Fertility and Sterility, 86*(Suppl. 4), S253-S256.

Braun, V. & Clarke, V. (2013). *Successful Qualitative Research: A practical guide for beginners.* Sage Publishing.

British Council. (n.d.). *What faiths are represented in the UK?* Retrieved 10 November 2019 from: https://study-uk.britishcouncil.org/moving-uk/student-life/religion

British Psychological Society. (2021). *Code of Human Research Ethics*. Available at: https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf

Coyle, A. (2010). Counselling psychology contributions to religion and spirituality. In M. Milton (Ed.), *Therapy and Beyond: Counselling psychology contributions to therapeutic and social issues* (pp. 259-275). Wiley-Blackwell.

De Salis, I., Owen-Smith, A., Donovan, J. L., & Lawlor, D. A. (2017). Experiencing menopause in the UK: The interrelated narratives of normality, distress, and transformation. *Journal of Women & Aging, 30*(6), 520-540.

Hoga, L., Rodolpho, J., Gonçalves, B., & Quirino, B. (2015). Women's experience of menopause: A systematic review of qualitative evidence. *JBI Database of Systematic Reviews & Implementation Reports, 13*(8), 250–337.

Kadri, N., Berrada, S., Mchichi Alami, K., Manoudi, F., Rachidi, L., Maftouh, S., & Halbreich, U. (2007). Mental health of Moroccan women, a sexual perspective. *Journal of Affective Disorders, 102*, 199-207.

Kasket, E. (2013). The counselling psychologist researcher. In G. C. Davey (Ed.), *Applied Psychology* (Supplementary Chapters: Chapter 4). Blackwell Publishing.

Mackey, S., Teo, S. S. H., Dramusic, V., Lee, H. K., & Broughton, M. (2014). Knowledge, attitudes, and practices associated with menopause: A multi-ethnic, qualitative study in Singapore. *Health Care for Women International, 35,* 512-528.

Mahadeen, A. I., Halabi, J. O., & Callister, L. C. (2008). Menopause: A qualitative study of Jordanian women's perceptions. *International Nursing Review, 55*, 427-433.

McAteer, D. (2010). Philosophical pluralism: Navigating the sea of diversity in psychotherapeutic and counselling psychology practice. In M. Milton (Ed.), *Therapy and Beyond: Counselling psychology contributions to therapeutic and social issues* (pp. 5-19). Wiley-Blackwell.

Merghati-Khoei, E., Sheikhan, F., Shamsalizadeh, N., Haghani, H., Pasha, Y. R. Y., & Killeen, T. (2014). Menopause negatively impacts sexual lives of middle-aged Iranian women: A cross-sectional study. *Journal of Sex & Marital Therapy, 40*(6), 552-560.

National Institute for Health and Care Excellence. (2015). *Menopause: Diagnosis and management* (NICE guideline: N23). Available at: https://www.nice.org.uk/guidance/ng23

Noonil, N., Hendricks, J., & Aekwarangkoon, S. (2012). Lived experience of Thai women and their changing bodies in midlife. *Nursing and Health Sciences, 14,* 312-317.

Pimenta, F., Maroco, J., Ramos, C., & Leal, I. (2014). Menopausal symptoms: Is spirituality associated with the severity of symptoms? *Journal of Religion and Health, 53*, 1013-1024.

Smith, J. A., Flowers, P., & Larkin, M. (2012). *Interpretative Phenomenological Analysis: Theory, Method and Research.* Sage Publications.

Steffen, P. R. (2011). Spirituality and severity of menopausal symptoms in a sample of religious women. *Journal of Religion and Health, 50*, 721-729.

Stephens, C. (2001). Women's experience at the time of menopause: Accounting for biological, cultural and psychological embodiment. *Journal of Health Psychology, 6*(6), 651-663.

Strezova, A., O'Neill, S., O'Callaghan, C., Perry, A., Liu, J., & Eden, J. (2017). Cultural issues in menopause: An exploratory qualitative study of Macedonian women in Australia. *Menopause: The Journal of the North American Menopause Society, 24*(3), 308-315.

Van Deurzen, E. (2012). *Existential Counselling & Psychotherapy in Practice* (3rd ed.). Sage Publications.

Willig, C. (2013). *Introducing Qualitative Research in Psychology* (3rd ed.). McGraw-Hill.

B2	**Research Ethics**
	Please outline any ethical issues that might arise from this study and how they are to be addressed. ***NB*** *All research projects have ethical considerations. Please complete this section as fully as possible using the following pointers for guidance. Please include any additional information that you think would be helpful.* • Does the project involve potentially deceiving participants? ***No*** • Will you be requiring the disclosure of confidential or private information? ***Yes*** ***The research interview covers the potentially sensitive areas of sexuality, fertility, aging, religion and spirituality, which are generally considered private to the individual. All information disclosed will be treated with strict confidentiality, as outlined in section B1 above.***

	• Is the project likely to lead to the disclosure of illegal activity or incriminating information about participants? ***No*** • Does the project require a Disclosure and Barring Service (DBS) check for the researcher? ***No*** • Is the project likely to expose participants to distress of any nature? ***Yes*** ***Discussion during the interview of topics of a sensitive nature may cause distress, however, it is not anticipated that any distress would be extreme in nature. In order to mitigate the risk of distress, the study will exclude participants with a significant mental health diagnosis and those who lack capacity. Mental health state will be assessed using the Patient Health Questionnaire-9 (PHQ-9), where the overall score should be less than 10 and question 9 should indicate no suicidality. Should the PHQ-9 raise any concern, participants would be excluded from the study and signposted to their general practitioner for further support. Clear explanation will be given of the interview topics prior to obtaining consent, and the researcher will adopt an empathic questioning style, allowing participants to determine the information they disclose. Following the interview, debriefing will be conducted, and the participant offered follow-up support. Furthermore, a distress protocol will be in place.*** • Will participants be rewarded for their involvement? ***No*** • Are there any potential conflicts of interest in this project? ***No*** • Are there any other potential concerns? ***No*** **If you answered yes to any of the points above, please explain.**
B3	Does the proposed research project involve: • The analysis of existing data, artefacts or performances that are not already in the public domain (i.e. that are published, freely available or available by subscription)? ***No*** • The production and/or analysis of physical data (including computer code, physical entities and/or chemical materials) that might involve potential risks to humans, the researcher(s) or the University? ***No*** • The direct or indirect collection of new data from humans or animals? ***Yes*** ***The project involves the direct collection of new data from humans. Participants will be asked questions, their responses to which will represent new data which will be analysed in order to answer the research questions. Safeguards will be in place to protect participant confidentiality and manage any risk of distress, as previously outlined.*** • Sharing of data with other organisations? ***No*** • Export of data outside the EU*?* ***No***

	If you answered yes to any of the points above, please explain.
B4	Will the proposed research be conducted in any country outside the UK? ***No*** If so, are there independent research ethics regulations and procedures that either: • Do not recognise research ethics review approval from UK-based research ethics services? ***No*** and/or • Require more detailed applications for research ethics review than would ordinarily be conducted by the University's Research Ethics Review Panels and/or other UK-based research ethics services? ***No*** **If you answered yes to any of the points above, please explain.**
B5	Does the proposed research involve: • The collection and/or analysis of body tissues or fluids from humans or animals? ***No*** • The administration of any drug, food substance, placebo or invasive procedure to humans or animals? ***No*** • Any participants lacking capacity (as defined by the UK Mental Capacity Act 2005)? ***No*** • Relationships with any external statutory-, voluntary-, or commercial-sector organisation(s) that require(s) research ethics approval to be obtained from an external research ethics committee or the UK National Research Ethics Service (this includes research involving staff, clients, premises, facilities and data from the UK National Health Service (NHS), Social Care organisations and some other statutory public bodies within the UK)? ***No*** **If you answered yes to any of the points above, please contact your faculty's RERP chair for further guidance.**
B6	Does the proposed research involve: • Accessing / storing information (including information on the web) which promotes extremism or terrorism? ***No*** • Accessing / storing information which is security sensitive (e.g. for which a security clearance is required)? ***No*** **If you answered yes to any of the points above, please explain. To comply with the law, researchers seeking to use information in these categories must have appropriate protocols in place for the secure access and storage of material. For further guidance, see the Universities UK publication** Oversight of Security Sensitive Research Material in UK Universities **(2012).**

SECTION C: THE PROJECT - RISKS AND BENEFITS	
C1	**Risk Assessment**

Please outline:

- the risks posed by this project to both researcher and research participants
- the ways in which you intend to mitigate these risks
- the benefits of this project to the applicant, participants and any others

Risk to research participants: psychological distress

The participants in this study are not likely to be particularly vulnerable, as defined by the BPS (2021), but the interview questions cover sensitive topics (gender, sexuality, fertility, aging, religion and spirituality) that could cause psychological distress. The following measures will be in place to mitigate this risk:

- Clear explanation will be given of the interview topics prior to obtaining consent.
- The researcher will adopt an empathic, non-intrusive questioning style, allowing participants to determine the information they disclose.
- Exclusion criteria will include women with significant current physical or mental health challenges, as well as those without a good standard of English, or whose capacity to consent and participate in the study may otherwise be compromised. Mental health state will be assessed using the PHQ-9, where the overall score should be less than 10 and question 9 should indicate no suicidality. Should the PHQ-9 raise any concern, participants would be excluded from the study and signposted to their general practitioner for further support.
- Debriefing will be conducted after the interview to identify any unforeseen harm and the participant offered follow-up support.
- A distress protocol will be in place.

A further risk of psychological distress may be presented by any possible breach in data security or confidentiality. This risk will be mitigated by the steps outlined in section B1.

The project will adhere to the ethical guidance produced by the BPS (2021) and HCPC (2016), as well as the Data Protection Act, 2018 (the UK law that is equivalent to the EU General Data Protection Regulation, 2016).
It is not anticipated that there will be any further risks to participants.

Risk to researcher: physical harm

The risk to the researcher's safety in conducting the interviews will be mitigated by ensuring lone working is avoided. It is anticipated that interviews will take place in confidential offices at two churches known to the researcher and that a member of the church staff would always be present (within the building, but not in the interview room). The church buildings comply with all statutory regulations for fire and health & safety.

During the current lockdown situation, it is planned that interviews will be conducted by videoconference using Skype or Zoom platforms. It is not anticipated that there will be any further risks to the researcher.

Benefits of the project to applicant, participants and others

The project is a research thesis which is key to enabling the applicant to progress to qualification with the professional doctorate in counselling psychology.

Participants may benefit from being given a safe space to talk about their menopausal experience and their faith; this may enable them to process and reflect on the challenges of midlife. Should any participant then feel that they may benefit from psychotherapy, the researcher will be able to provide them with details of local free or low-cost counselling services.

It is anticipated that the project may benefit counselling psychologists, as well as other therapists and healthcare practitioners, by increasing their understanding of the psychosocial aspects of menopause and the complex interaction of issues that may affect midlife women. This should facilitate better support for women in processing the changes and losses of menopause and their effects on the self and identity, as well as the physical challenges of menopause. At a sociopolitical level, the study will aim to confront the stigma of menopause by giving a voice to women going through this life transition; it is hoped this will promote alternative, less pathologising discourses to the prevailing biomedical one.

References

British Psychological Society. (2021). *Code of Human Research Ethics*. Available at: https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf

Health and Care Professions Council. (2016). *Standards of Conduct, Performance and Ethics*. Available at:https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-conduct-performance-and-ethics.pdf

PSYCHOLOGY: PROJECT CHECKLIST

Delete either **NO** or **YES** to the following statements:

1.	Will the participants be required to experience unpleasant stimuli or unpleasant situations above the normal level of unpleasantness expected in everyday life?[2]	**NO**
2.	Will any relevant information about the nature, process or outcome of the experiment or study be withheld from participants?[3]	**NO**
3.	Will participants be actively misled or deceived as to the purpose of the study?[4]	**NO**
4.	Will participants receive any inducement or payment to take part in the study?	**NO**
5.	Does the research involve identifiable participants or the possibility that anonymised individuals may become identifiable?	**NO**
6.	Will any participants be unable to provide informed consent?	**NO**
7.	Might the study carry a risk – above the normal risk expected in everyday life – of being harmful to the physical or mental well-being of participants?	**NO**
8.	Might the study carry a risk – above the normal risk expected in everyday life – of being harmful to the physical or mental well-being of the researcher in carrying out the study?	**NO**

If you answered **YES** to one or more of the above questions, explain how you will address the corresponding ethical concern(s) in the study protocol (no word limit).

[2] If required to experience unpleasant stimuli or unpleasant situations, participants should be informed beforehand and possibly screened for suitability. Finally, depending on the level of unpleasantness, it may be appropriate to use the distress protocol immediately after data collection.

[3] If information is withheld, the participants will need to be debriefed after the data collection. In addition, a second informed consent to use the data should be obtained after debriefing the participants (attach the second consent form as an appendix to this document). Finally, the distress protocol should be used immediately after data collection.

[4] If the participants are actively misled or deceived, they need to be debriefed after the data collection. In addition, a second informed consent to use the data should be obtained after debriefing the participants (attach the second consent form as an appendix to this document). Finally, the distress protocol should be used immediately after data collection.

Please ensure that you have completed Sections A, B, C and the Psychology Project Checklist, and attached a Research Proposal before submitting to your Faculty Research Ethics Review Panel (RERP)

http://www.londonmet.ac.uk/research/current-students/research-ethics/

Research ethics approval can be granted for a maximum of 4 years or for the duration of the proposed research, whichever is shorter, on the condition that:

- The researcher must inform their faculty's Research Ethics Review Panel (RERP) of any changes to the proposed research that may alter the answers given to the questions in this form or any related research ethics applications
- The researcher must apply for an extension to their ethics approval if the research project continues beyond 4 years.

PSYCHOLOGY: SUBMISSION

You must submit your Psychology Project Proposal and Ethics Application Form **in electronic form** (only) as follows:

1. Prepare **a single MS Word file**, including all attached material (if any) at the end of it;
2. **Sign it**, and **make your supervisor sign it** (signatures can be picture files of scanned signatures);
3. **Rename the single MS Word file** using the following convention and format: Ethics_Course Code_Student Surname_Student ID number
4. e.g., Ethics_MPhil-PhD_Bond_0000007 or Ethics_Staff_Bond
5. Submit the single and renamed MS Word file via Weblearn on *Psychology Research Ethics Community* (visible under *My Organisations*), **using the course-specific submission link**.
6. **Alert** the Chair of the Psychology Research Ethics Review Panel (RERP) by email.

The Psychology Project Proposal and Ethics Application Form must be complete and signed. Incomplete and/or unsigned forms will not be assessed and will require resubmission at the next opportunity.

The researcher must inform the supervisor of any changes to the proposed research that may alter the answers given to the questions in this form or any related research ethics applications. The supervisor will then either approve the changes or ask the student to resubmit the Project Proposal and Ethics Application Form.

Declaration

I confirm that I have read London Met's *Research Ethics Policy and Procedures* and *Code of Good Research Practice* and have consulted relevant guidance on ethics in research.

	Name	Signature	Date
Student	**Jane Beckford**		**08.12.19**
Supervisor	**Dr Angela Loulopoulou**	**Verbal approval given to submit**	**05.12.19**
Principal Investigator			

PSYCHOLOGY: REVIEW

Reviewer

Enter **X** in correspondence with one and only one of the following statements:

C	Clear without amendment.	
M	Clear conditional on the requested changes being made (minor modifications).[5]	
R	Revise and resubmit (major modifications).[6]	

Comments (required for M and R referrals).

	Name	**Signature**	**Date**
Referee			

Final judge (if one was appointed)

Enter **X** in correspondence with one and only one of the following statements:

C	Clear without amendment.	
M	Clear conditional on the requested changes being made (minor modifications).[7]	
R	Revise and resubmit (major modifications).[8]	

[5] The project must be revised. The revised project has to be approved by the supervisor **only**. The revised project, signed by both student and supervisor, must be submitted, for auditing purpose, via the **Minor Modifications Archive** submission link.
[6] The project must be revised, signed by both student and supervisor, and resubmitted via the ordinary submission link as if it were a new submission.
[7] The project must be revised. The revised project has to be approved by the supervisor **only**. The revised project, signed by both student and supervisor, must be submitted, for auditing purpose, via the **Minor Modifications Archive** submission link.
[8] The project must be revised, signed by both student and supervisor, and resubmitted via the ordinary submission link as if it were a new submission.

Comments (required for M and R referrals).

	Name	Signature	Date
Final judge			

Feedback from Ethics Review Panel

	Approved	*Feedback where further work required*
Section A	Yes	
Section B	Yes	
Section C	Yes	
Date of approval		29/1/20
NB: The Researcher should be notified of decision within <u>two</u> weeks of the submission of the application. A copy should be sent to the Research and Postgraduate Office.		
Signature of RERP chair		Professor Mark Wheeler

JANE ELIZABETH BECKFORD 23/04/20 16:56
Ethics application has been fully approved but amended in view of lockdown to request permission to conduct interviews by videoconferencing (Skype or Zoom) as highlighted. No other changes. Thank you
Feedback to Learner 29/04/20 16:05
that's fine

Ethics form fully approved

Inbox ×

Angela Loulopoulou <A.Loulopoulou@londonmet.ac.uk> 30 Jan 2020, 09:40

to me

Dear Jane,

please find fully approved the ethics form attached. You can proceed now in recruitment or further ethics applications (external to London Metropolitan) if required.

Kind Regards,

Angela

Dr Angela Ioanna Loulopoulou, PhD; AFBPsS; FHEA

Principal Lecturer in Counselling Psychology
Programme Director of the Professional Doctorate in Counselling Psychology
School of Social Sciences
Chair of Subject Standards Board for PG Psychology
Chair of Ethics Review Committee for PG Psychology

Office hours 9.30-17.00 Tuesday to Thursday

Please email me if you would like an appointment, as I am not often at my desk.

Read my article at: http://www.tandf.co.uk/journals/banners/readmyarticle/ccpg.gif

Contact address:

London Metropolitan University
Room TM1-65
Tower Building
166-220 Holloway Road
London N7 8DB
Tel: 0207 133 2667

APPENDIX I

LONDON METROPOLITAN UNIVERSITY

Debriefing Sheet

Participation in the Research Study: How do Christian women experience the menopause?

Thank you for participating in the research interview. Your willingness to talk about such sensitive topics as your menopause and your faith is appreciated and valued. I would take this opportunity to remind you that the information you have disclosed will be kept securely and confidentially, and also that no data that identifies you personally will be included in any written report or publication.

Should your participation in the study have raised any concerns, or if there is anything you would like to discuss further, please contact me by phone: 07974 745 738, or email: jeb072@my.londonmet.ac.uk

Alternatively, any concerns may be raised with my research supervisor, Dr Angela Loulopoulou, by phone: 020 7133 2667, or email: a.loulopoulou@londonmet.ac.uk

If you should feel distressed or feel that you have further issues that have not been addressed, you may wish to contact your GP or phone the Samaritans on 116 123. Should you wish to access psychotherapy, information on how to do this may be found at: https://www.bacp.co.uk/about-therapy/we-can-help/

You may request a copy of the completed thesis. Please indicate your interest for this now or email me at the above address.

Many thanks
Jane Beckford

APPENDIX J Distress Protocol

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in the research study on menopause and spirituality. There follows below a two-step protocol detailing signs of distress that the researcher will look out for, as well as action to take for each step. It is not expected that extreme distress will occur, as the study will exclude participants with any significant mental health diagnosis and the sample is a non-clinical one.

Mild distress - Signs to look out for:

1 Tearfulness

2 Voice becomes choked with emotion / difficulty speaking

3 Participant becomes distracted / restless

Action to take:

1 Ask participant whether they are happy to continue

2 Offer them time to pause and compose themselves

3 Remind them they can stop at any time they wish, should they become too distressed

Severe distress - Signs to look out for:

1 Uncontrolled crying, inability to talk coherently

2 Panic attack, for example hyperventilation, shaking, fear of impending heart attack

3 Intrusive thoughts, for example flashbacks to a traumatic event

Action to take:

1 The researcher will terminate the interview and the debrief will begin immediately

2 Relaxation techniques will be suggested to regulate breathing and reduce agitation

3 The researcher will recognise the participant's distress and validate their emotional response

4 If any unresolved issues remain, the researcher will suggest the participant discusses these with their GP and will remind the participant that the research interview is not intended as a therapeutic intervention

5 Details of free or low-cost counselling services will be offered to the participant

Should the researcher feel these steps may be inadequate, further actions may include providing the participant with contact details for the Samaritans or suggesting they attend the local A&E Department and ask for the on-call psychiatric liaison team. The researcher would follow up on any action taken and ensure the participant could access relevant ongoing support, for example from their GP. Any concerns or adverse incidents would be reported to the research supervisor and, if appropriate, via the incident reporting procedures of London Metropolitan University.

Adapted from the Distress Protocol, Chris Cocking, London Metropolitan University, November 2008