Menopause in Psychotherapy:
A Thematic Analysis

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Contents

List of Tables

List of Figures

Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning"

Signed:

Margot Hinton

Date: 20 November 2013

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Abstract

Menopause is the natural and unavoidable ending of a woman's procreative capability. An inter-play of biological, psychological, social and cultural influences is thought to shape each woman's understanding and experience of menopause.

There are relatively few psychotherapeutic studies on menopause in comparison to other significant life transitions, and even fewer that address what happens in therapy between the client and therapist when either or both are transitioning through menopause.

This study examines menopause in the context of psychotherapy. A thematic analysis of eleven pieces of data, i.e. literature, revealed five themes of; silence; loss and fear of loss; challenges of relational interplay; disentangling of tensions; and renewed sense of self – and the core conceptual theme of impotency/potency.

The discussion of the findings highlighted the relevance of menopause as a topic for therapeutic exploration, and synthesizes for clinicians understandings of how menopause may manifest in psychotherapy. The discussion also describes matters that may need to be considered and worked through when either a menopausal client and/or a menopausal therapist are engaged in a therapeutic relationship and how menopause might influence the psychotherapy.

Introduction

Menopause is the natural and unavoidable ending of a woman's procreative capability. It is, however, often labelled a deficiency disease and menopausal women are branded as unstable and crazy. While some women experience the menopause as a time of stress, for others it can be a positive experience, a time of growth, freedom and discovery. An inter-play of biological, psychological, social and cultural influences is thought to shape each woman's understanding and experience of menopause. Contemporary studies from a range of sociological and psychological fields show that disruptions to physical and psychological equilibrium and social functioning during the menopause, while common, are not necessarily part of every woman's menopausal experience (Atwood, McElgun, Celin, & McGrath, 2008; Huffman & Myers, 1999). What is certain is that most women surviving into midlife will experience the menopause transition and therefore it is likely to be present either consciously or unconsciously in therapeutic work with this client group. In New Zealand alone, the September 2012 National Population Statistics estimated that there were 418,590 women aged 45-59, (the most common age for menopause) constituting 10.24 % of the total population (Statistics New Zealand, 2012).

Studies from within the social and biological fields, although useful to frame and contextualise menopause, do not provide therapists with theoretical psychotherapeutic understandings or clinical perspectives relevant to psychotherapy (Mendell, 1988). The comparatively sparse psychotherapeutic literature on menopause consists predominantly of individual therapists' ideas on menopause which are sometimes accompanied by case illustrations. Broadening out from singular therapist experiences and interpretations of menopause, this dissertation takes a selection of the existing literature and explores specifically those parts of the texts that describe what occurs in the therapy in the presence of menopause. The aim is to unearth menopausal themes noticeable in psychotherapy across the range of texts (Attride-Stirling, 2001).

My Interest in the Topic

My interest in this topic arose from my clinical work within the public mental health system. I have been working with a range of clients, including middle-aged women who present with a range of severe and distressing emotional states. I have become increasingly aware of how any psychological issues associated with these clients' transitions through menopause could easily be overlooked. King Palenscar

(2007) highlighted the challenge clinicians' face in "distinguishing psychological disorders from normative psychological reactions, including those states occurring within the context of developmental transitions" (p. 1).

Additionally, as a 46 year old female psychotherapist, my curiosity is fuelled by the realisation that the experience of menopause has become a topic of conversation among my peers and that menopause is the next developmental stage ahead of me. Perhaps my interest in this subject is, as Zachary (2002) described, "a reaction formation of being prepared" (p. 21), and/or it may also represent a healthy curiosity about forthcoming change.

I am particularly interested in the therapeutic relationship and wonder how matters related to menopause may be presented, thought about and worked through, in the everyday practice of psychotherapy. What are the most common transference and countertransference dynamics and do different dyads respond and react differently to this phenomenon? Furthermore, as a female therapist who will soon be entering this developmental stage, what significance will my own menopausal status have in my practice of psychotherapy? In this introduction I offer a brief literature review as a lead into my research question and the aims of the study.

Brief Review of the Literature - A Historical View

Indigenous and non-Western views

Many non-Western indigenous cultures have observed menopause as an important rite of passage. In some Indian (Flint, 1975) and Native American (Chornesky, 1998) cultures, the end of fertility signifies an increase in authority, power and wisdom. Women in these cultures typically report fewer problematic menopause-related symptoms (Chornesky, 1998) and view menopause as a liberating experience, offering positive opportunities for personal growth and access to esteemed social roles.

In Māori culture, menopause has traditionally been accepted as a normal transition within the life cycle that is accompanied by a change in status (Ferro & Wolfsberger, 2003). Following the passage through menopause, a Māori woman becomes a *kuia* (a female elder) who is recognised for her experience and wisdom, gains high status within her community, and is now qualified to perform various rituals on the *marae* (a communal or sacred place that serves spiritual and social purposes) that are denied to younger women (Coney, 1994). In contrast, Western constructions of menopause and views of menopausal women throughout history have usually been negatively framed (MacPherson, 1981): Western women were thought to become

mentally and physically feeble and emotionally less stable during this transition and often experienced a loss of power and status.

Western historical overview

The association between menopause and its effect on a women's psychological health was established in the early 18th century. Women in this life stage were believed to be irritable, depressed and prone to hysteria, developing, what physician Thomas Sydenham, in 1701 called "hysterick fits" (Atwood et al., 2008, p. 153).

In the mid-19th century, "Victorian physicians viewed menopause as a sign of sin and decay" (McCrea, 1983, p. 111). They believed that the symptoms of menopause were a result of abnormal blood flows, a suppression of menstruation, rather than a natural cessation as the result of aging. Blood, normally dispelled during menstruation was thought to rush through the body and enter the brain causing insanity, nervousness and hot flushes (Formanek, 1990; Lax, 1997). Throughout the 18th and early 19th century treatments involved blood-letting (Atwood et al., 2008; Formanek, 1990) or the use of leeches to alleviate these symptoms (Lax, 1997). Additionally, with a life expectancy of 50, women in this era often experienced menopause shortly before their death, as a consequence, menopause was thought to be a foretelling of death (Atwood et al., 2008).

This linking of a woman's physical ailments with her mental state during menopause continued throughout the 19th century, culminating in Kraepelin's early 20th century diagnosis of involutional melancholia to describe women's agitated depression (Kraepelin, 1909, cited in Formanek, 1990).

Formanek (1990) described the influence of a changing social, technological and economic society upon traditional ways of life and the perceptions of menopausal women. As middle-class women in the mid-19th century lost their work to machines, a greater emphasis and value was placed on the role of motherhood. At the same time, the increasing value placed on productivity and self-sufficiency lead to a decline in respect for the aging, unproductive population. Thus, the menopause posed a significant threat to a woman's worth. A more specific definition of femininity and delineation of gender roles occurred concurrently with a mainstream medical perception of the physically and psychologically unstable menopausal woman (Huffman & Myers, 1999).

Medicalisation of menopause

Medical discoveries in the early 1920s furthered understanding of the physiological changes occurring at the menopause (Lax, 1997). These findings positioned menopausal women in terms of physical and mental ill health (Formanek, 1990). Diminishing levels of the hormone estrogen rendered menopause an endocrine deficiency disease rather than a natural life occurrence (MacPherson, 1981). Low levels of estrogen were linked with menopausal symptoms such as night sweats, hot flushes, depression and tiredness, which in the 1960s led to the implementation of Hormonal Replacement Therapy (HRT) to correct this deficiency (Dillaway, 2005). At this time, gynecologist Robert Wilson postulated that the menopause symbolised the end of a woman's femininity. He claimed HRT was useful, not only for the relief of menopausal symptoms, but would help prevent other potential health issues such as cancer; prolong youth and beauty by staving off visible signs of aging; and smooth turbulent relationships by ensuring that women would again find sexual intercourse comfortable (Wilson, 1962, cited in McCrea, 1983). Untreated estrogen deficiency was also thought to also be responsible for osteoporosis (Goodman, 1990; Meyer, 2003), cardiovascular problems and depression (Huffman & Myers, 1999).

Negative views of menopause and the menopausal woman have prevailed. Dickson (1990) asserted that the "sanctity of science and the authority of the medical 'expert'… reinforce society's expectations and stereotypes of menopausal women" (pp. 16-17). The combination of biomedical and sociocultural discourses, therefore has situated the menopausal woman in a challenging environment (Greer, 1991) influencing her experiences and expectations of this life event.

Contemporary views

The biomedical view of menopause as a deficiency disease has been strongly contested by feminist theorists. Feminism generated a proliferation of research on the topic from the 1970s onward, defending menopause as a natural event in a woman's life cycle (Parlee, 1984) and offering women alternative views and understandings in hope of wresting control of menopause from the medical profession and returning it to women (Breheny & Stephens, 2003; Leng, 1996). Studies challenged some of the beliefs and expectations generated and generalised by the medical fraternity, including; the pejorative language used by the medical fraternity to describe the bodily processes occurring at the menopause (Derry, 2004); the medical description of the physiology of menopause and its standard treatments, (Avis & McKinlay, 1995; Derry, 2004; Meyer,

2003; Prior, 2006); and the assertions that psychological disorders such as depression are part of the menopause transition (Avis, 2003; Judd, Hickey, & Bryant, 2012; Pearce, Hawton, & Blake, 1995).

Numerous studies of women's subjective experience, offering women alternative views and understandings on menopause were undertaken. These revealed that; menopause may be a benign event (Matthews et al., 1990); a time of distress (Derry, 2004); or, for some, a positive life occurrence (Hvas, 2001). Positive experiences were related to a sense of freedom from periods, premenstrual tension and contraception (Hvas, 2001; Minkin & Wright, 2005); a better sex life (Hvas, 2001); an increase in energy (Dickson, 1990) or new found opportunities for personal focus and growth (Dillaway, 2005; Hvas, 2001). Differing experiences were thought to derive from a range of biological, psychological, social and cultural influences individual to each woman.

Cross cultural studies on menopause further challenged the medical model and Western perceptions of menopause (Guillemin, 2000). Findings indicated that although physiological processes of menopause are universal, women's experiences of this transition are not (Lawton, Reid, Cormack, Dowell, & Stone, 2001). These studies offered alternative understandings of menopause, showing that women's physiological and psychological experiences are impacted by cultural attitudes (Gannon & Ekstrom, 1993; Huffman & Myers, 1999; Kaufert, 1982). However, Melby, Lock and Kaufert, (2005) caution that although these studies indicate that women identify with cultural generalisations of menopause as a way of understanding the phenomena, again, broadly identified views do not necessarily indicate an individual truth.

History of psychoanalytical/psychotherapeutic theory

The early psychoanalytic literature on menopause and women's menopausal experience, although sparse in comparison with the wider literature on menopause, both reflected and contributed to Western cultural beliefs of the time, augmenting negative stereotypes, rather than normalising the natural developmental process (Spira & Berger, 1999).

Freud's conception of menopause as an anxiety neurosis contributed to the belief that personality disorders were related to the menopause (Patterson & Lynch, 1988). The classical psychoanalytic view utilised a psychosexual developmental model to explain the meaning of menopause (Harris, 1990) that painted a bleak view of this life-stage (Holmes, 2008). Menopause was described as a narcissistic wounding which

reactivated drive instincts and castration anxieties in women resulting in a regression to penis envy and depressive and aggressive changes in character (Deutsch, 1925/1984). Women at menopause were considered physically and emotionally impaired. Menopause was considered to be the end of sexual functioning and the beginning of emotional instability. Freud (1913/1958) described menopausal women as follows:

> After women have lost their genital function, their character often undergoes a peculiar alteration, they become quarrelsome, vexacious, and over-bearing, petty and stingy, that is to say that they exhibit typically sadistic and anal-erotic traits which they did not possess earlier during their period of womanliness (pp. 323-324).

Deutsch (1925/1984) shared some theoretical commonalities with Freud and, although less disparaging about menopausal women, was no more optimistic. She did conceptualise menopause as a normal part of a woman's development, stating that a woman was more than "a machine for bearing children" (Deutsch, 1945, as cited in Spira & Berger, 1999, p. 261). However, she also considered that life became pale and purposeless at the menopause.

Horney (1926), and later others (Greenarce, 1950; Stoller, 1976), challenged Freud's psychology of female development as a deficient variation of male development. They also argued that Freud's theory lacked consideration of any social or cultural factors that may impact on development. They revised the view of female sexual development, emphasising women's primary femininity (central sense of femaleness). However, the next significant study to expand perspectives on menopause specifically, did not appear until 1950.

Benedek (1950) explored the body's response to hormonal changes occurring during menopause and considered the significance of cultural context on feminine identity at this time. She believed that menopause was feared in cultures where women were valued primarily for being sexually reproductive. She argued that the manifestations of menopause were also influenced by a woman's previous history and that some symptoms of menopause arose from pre-existing pathologies that were reactivated by the internal changes occurring at this time. Benedek was sympathetic to the difficulties associated with viewing the involutional process of menopause as development, if viewed from a purely biological perspective. A psychodynamic perspective, she suggested, would say that the decline in hormone production activated a regression of the ego's integrative capacity. In contrast to Deutsch, Benedek conveyed more hope for women post-menopause. She believed a woman's progressive

ability to overcome feelings of inferiority associated with loss of functioning was an adaptive process of maturation which paved the way for a zestful, productive and creative life. Erikson (1963) named this positive developmental outcome "generativity" and described the antithesis of this phase specific development as self-absorption or stagnation.

Lax (1982) supported Benedek's view that multiple influences shape a woman's menopausal experience. She positioned the climacteric as a significant event amongst other mid-life changes and contended that internalisation of a youth oriented culture implies a negative cultural stereotype of aging which may, for some women, not only create fears of this life stage, but also generate feelings of shame and diminished self-esteem.

Some traditional psychoanalytic ideas continue to function as a backdrop to therapists' understanding, but are considered in conjunction with new understandings of female development and the influences of the socio-cultural environment on menopause. Mankowitz (1984), a Jungian analyst, also explored the socio-cultural influences that shape women's experience and thereby furthered understanding of the symbolic representation of women's unconscious processes relevant to this transitional life-stage.

Mayer (1985) proposed new psychoanalytic ideas about primary feminine identity, proposing that a girl may suffer female castration anxiety if she fears loss of female capacities (Renik, 1994). This in turn is thought to thwart her ability to identify with mother and validate expectations of adult femininity. Bemesderfer's (1996b) psychoanalytic view of menopause was derived from both Mayer's (1985) concept of "primary feminine identity" and aspects of traditional psychoanalytical developmental theory. Bemesderfer discussed menopause as a time of physiological challenges that entailed a reworking of maternal identifications. She asserted that normal menopause, like the onset of normal menstruation, is a "confirmation of primary feminine identity" for most women, (p. 358). She added that menopause for women who experience significant difficulties can involve an interplay of both "phallic castration anxiety", i.e. "enactments of wishful fantasies in response to depressive affect" (Renik, 1994, p. 235) and "female castration anxiety" wherein the lost capacity to create evokes fears of losing valued feminine attributes and anxieties about how to fill the painfully empty internal space created by menopause.

There has been a significant shift over time within the psychoanalytic/psychotherapeutic literature describing menopause, from a focus on

depression, narcissistic depletion and loss, to a conceptualisation of menopause as a normal developmental event requiring a reworking of feminine identifications and an integration of psychological and physiological changes that are unique to each woman's experience and context.

This brief literature review on the history of menopause summarises and synthesizes background and contextual information providing a genealogical understanding of menopause as relevant to this study. It has provided a review of important theoretical perspectives that have been influential to psychotherapeutic understandings of menopause. What has been less evident in this historical literature review is the role of psychotherapy practice in providing a useful bridge to integrate the physiological, sociocultural issues with the emotional challenges faced by women during menopause. Also less clear is how issues related to menopause may be presented, thought about and worked through in the everyday practice of psychotherapy.

Research Question and Aims

The purpose of this study is to undertake a thematic analysis to explore themes in the literature on menopause as it relates to the clinical setting and the therapeutic relationship.

Harper (2012) stated that a clinical qualitative research question needs to be "broad and open-ended but of sufficient clarity and specificity" (p. 85). Moreover, as questions mostly align to the language of the methodological approach (Creswell, 1998), following a phenomenological viewpoint, my question is one that searches for meaning: *"From the perspective of the therapist, what happens when therapist, patient and menopause meet?"*

Through a discussion of the findings, the study also aims to identify clinical and practice implications for supporting menopausal women in therapy and practicing psychotherapists who are transitioning through menopause.

Clarification of Terms and Style

In this dissertation, I use the terms "menopause", "menopause transition" or "menopausal" to encompass the entire phase from the initial symptoms of the "peri-menopause" through to the "menopause"; the permanent cessation of menstruation. Here I note specific phrases and alternative terminologies that arise throughout the study.

- **Menopause** is defined as the permanent cessation of menstruation recognisable after 1 year of amenorrhea for which there is no other pathological or physiological cause (World Health Organization, 1996). It is a natural and gradual process brought about by aging ova in response to shifting hormonal levels (Zachary, 2002).

- **Peri-menopause** precedes menopause and describes gradual biological changes and irregularities in menstruation and the menstrual cycle. This is the time when distressing symptoms associated with menopause may be experienced i.e. hot flushes, night sweats and vaginal dryness during which the psychological adjustments to this life change begin (Derry, 2004; Huffman & Myers, 1999).

- **Post-menopause** is defined as the time dating from the final menstrual period.

- **Climacteric** is a less familiar clinical term derived from the word "climacter" meaning the top rung of the ladder. In reference to the menopause "climacteric" represents a women's transition from the reproductive phase to the non-reproductive state and includes the physiological and psychological processes that occur (Bemesderfer, 1996b; Derry, 2004).

- The **menopause transition** is another term for the climacteric, commencing with the first menstrual irregularity and ending with menopause; the final menstrual period (Judd et al., 2012).

- As I do not want to reinforce the medicalisation of the menopause, I refer to those women transitioning through menopause and who are engaged in psychotherapy as **clients**.

- For reasons of consistency and clarity in this dissertation, and encompassing the international and interdisciplinary scope of the data set, I use the term **therapist** to represent counsellors, psychotherapists, psychoanalysts and social workers. I also use the terms **therapy** and **psychotherapy** to denote the practice of psychoanalysis, psychotherapy, counselling and psychotherapy undertaken in the context of social work and psychology.

In this dissertation, and following AUT University (AUT) protocol, I have adopted the American Psychological Association (APA) academic format style with some exceptions for readability: I do use bullet points, emboldened text, modified heading styles, i.e. or e.g., and I use the first person voice when referring to my own process.

Dissertation Outline

Following the introduction, this dissertation comprises four chapters. **The Introduction** presents an introduction to the research topic and provides some background on my choice of topic. It documents a brief literature review on the history of thoughts/ideas about menopause placing this topic in context. The purpose of the study and the research question are defined. The clarification of key terms and presentation style is followed by an outline of the dissertation. **Chapter 1** describes the design of the study. It explains the ontological and epistemological underpinnings of the research and discusses the theoretical and methodological approach guiding the method of thematic analysis. Chapter 1 also explains the process of data collection and the procedures employed to ensure validation of the research. **Chapter 2** explains how the thematic analysis was conducted and offers reflection on the process and my learning from it. **Chapter 3** presents findings of the common themes, subthemes and underlying patterns with supporting quotations from the literature on menopause.**Chapter 4** is a summary of the findings and provides a discussion on these with reference to the research question and other literature. It also provides an overview of the study's limitations, recommendations for future exploration and concludes the study.

Chapter One: Research Design

Introduction

This chapter explains the research design. Concepts of ontology, epistemology, qualitative research and thematic analysis are discussed and related to the aim of the study. The thematic analysis process will be explained and a detailed description of the data collection process described. Finally, the verification strategies that were employed to ensure reliability and validity of the study are presented.

Ontological and epistemological positioning

This section describes the operating paradigms that influenced the methodological and method choices of this study. They incorporate my views concerning relativist ontology and social constructivist epistemology.

Ontology is concerned with theories about the nature of reality and being (Ponterotto, 2005). My beliefs about reality and being are located in relativism: a relational concept which searches for subjective meanings and understands that individuals have different realities evolving from culture and experience (Drummond, 2005). This differs from a scientific realist view which believes that the truth exists (Ponterotto, 2005). A realist philosophy values the verification of objective truth through examination and observation and disregards the feelings and mental constructions of reality (Crossan, 2003) that are relevant to the study of psychotherapy.

Epistemology is concerned with the nature of knowledge. My epistemological approach is social constructivism (Creswell, 2007). Constructivism theory views an individual as engaged in a continuous cognitive process of making meaning of the world in which they live (Crotty, 1998). This theory includes aspects of social constructionism, which is the view that knowledge and reality are constructed rather than discovered and are dependent upon continuing interactions between human beings with and in their world. Social constructionism believes that there is no true meaning to be discovered and objects do not have inherent meaning (Crotty, 1998). This research assumes the overlap of these two positions, that is: the meanings and experiences of both menopause and psychotherapy are constructed and exist both in the mind of individuals and in the culture, and that the various interpretations of psychotherapy and menopause are all valid (Creswell, 2007). As a social constructivist researcher, I also focus on the processes of interaction between individuals including the therapist and the client.

Theoretical perspective and methodology

Methodology is the strategy, process or study design underlying the research process, whilst the method refers to the specific techniques and procedures used by the researcher for data collection and analysis (Crotty, 1998).

The theoretical perspective underpinning this research methodology is interpretive. An interpretive paradigm uses "methods that try to describe and interpret people's feelings and experiences in human terms rather than through quantification and measurement" (Terre Blanche & Kelly, 1999, p. 123). In contrast to a positivist approach, researchers using interpretivist thinking are curious about the various ways that people understand human phenomena and believe that numerous realities are valid (Paterson & Higgs, 2005). Within this paradigm, the relevant literature in this study was reviewed to ascertain the various ways in which the phenomena of menopause in psychotherapy has been engaged with and understood: "This approach can assist the researcher in remaining open to multiple perspectives and unexpected responses, and reflects the philosophical assumption that truth is contextual and subjective" (Poulin, 2007, p. 442).

Interpretive research is often referred to as qualitative (Creswell, 2007; Grant & Giddings, 2002). Geddes (2000) postulates that qualitative research is usually applied to psychotherapeutic study as it is difficult to quantify the emotional, thoughtful, humanness of the psychotherapeutic experience. A qualitative research design has been chosen as the most suitable for this study, as its intent is to describe and explain people's "experiences, behaviours, interactions and social contexts" (Fossey, Harvey, McDermott, & Davidson, 2002, p. 717). The process of inquiry offered by qualitative research enables events to be understood as they inherently unfold within their own context (Humphris, 2005). This study is a process of inquiry exploring how the phenomenon of menopause unfolds within the context of psychotherapy.

The choice of the interpretive paradigm for this research allows a focus on uncovering contextualised, professional knowledge, personal experiential knowledge, and understandings about the phenomenon of menopause in psychotherapy practice from the practitioners of psychotherapy (Paterson and Higgs, 2005). According to Creswell (2007) the researcher's interpretations of what they find are shaped by their own personal, cultural and historical experiences. Thus the interpretations of menopause offered by this study are influenced by my lived experiences and encounters with others in the world, including my engagement with psychotherapy. More specifically, my personal psychotherapeutic journey, psychotherapy training, theories

and work experience influenced my choice of an interpretative/constructivist research paradigm and contribute to the outcomes of this research.

Similarities between the aims and processes of psychotherapy and qualitative research further illuminate my research choices. Similar to qualitative research, psychotherapy is often described as a project of making meaning (Bondi, 2012). New meanings are constructed, described and seen in the encounter between the therapist and the patient as they are "between the 'knower' [the therapist/writers] and the 'would-be-knower' (the researcher)" (Ponterotto, 2005, p. 130). Other similarities between qualitative research and psychotherapy include:

- The use of interpretation to support and progress the meaning-making process (Bondi, 2012).
- The work occurs within a frame; stories are told or explored within either a research or a psychotherapeutic frame (Bondi, 2012).
- The work aims to deepen understanding of self and other (McLeod, 2011).
- Both psychotherapist and researcher practice reflexivity to clarify the processes in which they are both immersed (Bondi, 2012; McLeod, 2011).

Within the interpretive paradigm, I employ a hermeneutical phenomenological attitude for exploring the data. Together phenomenology and hermeneutics help the researcher to understand and to describe experience. This is not a prescriptive process (Van Manen, 1990), but a creative engagement with language that attempts to make explicit what is implicit, or give fresh meaning to what is written (Crotty, 1998). A phenomenological attitude focuses on gaining a deeper meaningful understanding of everyday experience (Lindseth & Norberg, 2004). "Using this attitude, the researcher strives to be open to the 'other' and to attempt to see the world freshly, in a different way" (Finlay, 2009, p. 12). This perspective embraces the view that the body is an objective physical entity being subjectively shaped by interactions with others and the world. This has relevance to the study of menopause phenomena as women undergo physical changes and sensations and make meaning of these changes through their lived experience. In the context of phenomenology, intersubjectivity is inherent in experience and is applicable when "determining the relationship between self and other, how self obtains knowledge about others, and the impact of others on self's experiences of both self and other" (Thompson, 2005, p. 29). Similarly in the context of psychotherapy, intersubjectivity refers to the interplay of two "differently organized subjective worlds" (Stolorow, Atwood, & Orange, 2002, p. 9), that is, of the worlds of both therapist and

client. Intersubjectivity informs the research question of this study as relevant texts are analysed in order to ascertain what happens when therapist, patient and the menopause meet.

Phenomenology then, addresses lived experience, whereas hermeneutics interprets texts (Van Manen, 1990). Hermeneutics is described as the art of interpretation to gain insight and meaning from information (Dowling, 2004) and is inherent in an interpretive paradigm. In phenomenological study, Gadamer (2004) posited that the whole can only be understood by the examination of its parts, the synthesis of which involves the researcher's continued and often repetitive 'play' or engagement with the content of data and their interpretations of it, resulting in the emergence of renewed understandings. He referred to this process as a hermeneutic circle.

Fossey et al, (2002) stipulated that "good quality research is characterised by congruence between the perspective (or paradigm) that informs the research question and the research methods used" (p. 731). As such, I have chosen the method of thematic analysis to link my philosophical approach in a transparent and structural way to the practical work of analysing the data of this qualitative study. The following section delineates thematic analysis (TA) and outlines the applications and process of this method. Thereafter, details of the data gathering process are described.

Method

"Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data (Braun & Clarke, 2006). It is a search for themes that show themselves as being important to the description of the phenomenon (Daly, Kellehear, & Gliksman, 1997). In this study TA is a relevant method to identify patterns of commonalities in therapists' descriptions of menopause in psychotherapy.

A TA involves a process where researchers review their data, make notes and begin to sort it into categories. In analysing the data, the researcher is helped to move their analysis from a broad reading of the data towards discovering patterns and developing a limited number of candidate and subthemes which adequately reflect the literature (Braun & Clarke, 2006). It is a process that depends on "constant comparative analysis processes to develop ways of understanding human phenomena within the context in which they are experienced" (Thorne, 2000, p. 69). "In this sense" and in keeping with a phenomenological attitude, "thematic analysis procedures focus on

developing categories, derived inductively from the data itself, rather than from a priori theory, to enable systematic description" (Fossey et al, 2002, p. 729).

Although there are a number of qualitative research methods, thematic analysis was chosen for several reasons. Firstly, there is a paucity of literature on menopause that specifically addresses the research question. Without an abundance of literature, with which to compare and contrast differing points of view or experiences, as one might in a systemic literature review, the research method of TA was chosen to allow an in-depth engagement with the existing literature. Secondly, TA can be useful for summarising key features from a broad range of data; it can highlight similarities and differences across the data set and generate unexpected perspectives and insights. As such, this method has the potential to bring forth less overt and less directly studied aspects that exist within the data set, that are of relevance to the study question. Thirdly, and in line with an hermeneutic approach, Braun and Clarke (2006) stipulated that themes do not emerge from data, as if residing there waiting to be found, but develop through the active role of the researcher who finds meanings and associations within the data. Through the "careful reading and re-reading of the data" (Rice & Ezzy, 1999, p. 258) and by analysing and reporting on patterns (themes) within the available data (Braun & Clarke, 2006) I aimed to bring to light rich and insightful meaning and information important to the description of the menopause phenomena as it relates to the context of psychotherapy.

Both TA and interpretative phenomenological analysis (IPA) involve coding and theme development. I might have chosen IPA as it fits my theoretical framework (hermeneutic phenomenology) and it focuses on a small sample size. However, I was encouraged to use TA, and in undertaking a comparative exploration, it proved an appropriate choice. This study is an analysis of existing literature which fits less well with the more prescriptive methodological framework of IPA (Braun & Clarke, 2006) which advocates for an analysis of a small number of semi-structured interviews or first-person accounts of personal experiences (Smith & Osborn, 2003). Additionally, in IPA, themes are developed from the analyses of the first text, with subsequent texts examined in relationship to the first, reflecting an idiographic focus that characterises this approach (Braun & Clarke, 2006). In comparison, the process in TA is to code across the entire data set before progressing into theme development. As this study focuses primarily on seeking patterns of meaning across the whole data set, TA is an appropriate method, offering the flexibility suitable to meeting the requirements of this study.

Process of thematic analysis

For this dissertation, the thematic analysis of the literature uses Braun and Clarke's (2006) six phases of thematic analysis as a structural guide (see Table 1).

Table 1.

Phases of Thematic Analysis

Phase	Description of process
1. Familiarising yourself with your data	Texts are read and re-read for familiarity. Preliminary notes including associations, ideas, connections, or summaries are recorded.
2. Generating initial codes	Data is coded in a meaningful and systematic way. Focus is on coding segments of the data relevant or interesting to the research question. Codes are developed as the researcher moves through the coding process.
3. Searching for themes	Identified codes are examined and gathered into possible themes. The researcher ensures links between themes are identified and clusters are noted. Tables or mind-maps are developed to support this process
4. Reviewing themes	The original data is revisited to check that the developing themes fit with individual data as well as the entire data set. The confirmation of meaningful and sufficient data and the reworking of themes to ensure that there is discernable distinctions between themes characterise this phase. A thematic map of the analysis is developed.
5. Defining and naming themes	The refinement of each theme continues, the researcher identifies the essence and ensures the relevance of each theme to the overall picture of analysis. Themes are given clearly-defined names.
6. Producing the report	The report includes extracts of individual pieces of data to support elements of the themes. The themes are woven and synthesised back to the overall literature and the original research aims. The academic account reflects an "active" process of analysing and interpreting data to address the research question.

Adapted from Braun and Clark, (2006, p. 87)

Establishing the data set for thematic analysis

Interpretive research methodology typically uses qualitative methods such as people's words, observable behaviours, clinical material and various texts. Usually a thematic analysis would utilise transcripts of either interviews, or clinical vignettes. These approaches were beyond the scope of fulfilling the requirements of this dissertation; instead information and understanding were gleaned by undertaking a thematic analysis of the literature which was comprised of case studies, personal experience, expert opinion, discussions written by therapists and some vignettes.

To address the dissertation question, a comprehensive search of literature was undertaken through a review of abstracts in the following electronic databases: The American Psychoanalytic Electronic Publishing Library (PEP), PsycINFO, ProQuest Central, Psychology and Behavioural Sciences Collection (PBSC). In addition I searched published works which had been printed or were accessible online. A manual search was also carried out and included relevant information available in books and articles. Literature that was unavailable was ordered on-line through the AUT library inter-loan system. I used email to contact recent authors in the field for leads to less accessible literature that related to the research question. I also attended workshops on menopause and asked presenters for their list of references.

I began my preliminary search using variations of the terms "menopaus*", "perimenopaus*" and "climacteric" (see Table 2). This search was far-reaching and not specific to my research question. However, it afforded me the opportunity to contextualise menopause in a range of medical, psychological and sociological discourse and gave me a sense of which discourses are dominant in studying and reporting on menopause (see Introduction). I also gained an awareness of the scarcity of psychotherapy-related literature on the topic. This search provided a backdrop to my understanding about menopause and how it is considered in the literature.

Table 2 lists the key terms used in each round of the literature search. Combinations of key terms resulted in material specific for thematic analysis; further key terms were identified and used in consecutive combinations to locate further useful data.

Table 2.

Terms and Rounds of Database Search

Terms	Round One	Round Two	Round Three	Round Four
Variations and combinations of these terms were used	Climacteric Menopaus* Perimenopaus*	Psychotherapy Psychoanalysis Psychology Counselling	Psychodynamic Self Psychology Object Relations Humanistic Existential Psychoanaly*	Menopausal client/patient Menopausal therapist/analyst Countertransference Transference Identification Therapeutic alliance Intersubjectiv* Male/female therapist/patient

All abstracts resulting from each round of database search and citation references were scrutinised to determine their relevance to the research question. At this point certain categories of papers were excluded (see section: Exclusion Criteria for Data Set, page 19).

Between Round two and three, I considered broadening the search to include the term "midlife" in order to find more relevant relational aspects of the therapy with women transitioning through menopause. However, although I found an increase in the number of articles that focused on countertransference and transference with midlife clients, few made specific reference to menopause. At this point supervision was helpful in clarifying the scope of this study. The attention to "midlife" was becoming too big and seemed to distract from the research's focus on menopause. Whilst related, and menopause is often seen as a "marker" for midlife, I felt that the specific meaning of menopause and issues specific to this physiological transition might be overshadowed. I decided to narrow the search again to focus on menopause and recorded only those 'midlife' readings that specifically drew attention to the menopause.

Overall 3,625 abstracts were examined and 276 references were identified for further detailed evaluation. With each round, further exclusion criteria were established and a refinement of the inclusion criteria followed. By the end of the fourth round, the data evolving from the searches was repetitive and no new data relevant to the study was emerging. This fulfilled the saturation requirement (Creswell, 1998).

Most of the references examined were excluded for not meeting the inclusion criteria. After this process, and the removal of duplicate articles, 11 articles were retained for data extraction as outlined in the data selection process shown in Figure 1.

Inclusion Criteria

The inclusion and exclusion criteria were determined by several factors. A practical determinant for inclusion was literature written in English and available through library databases and inter-loan services. Further inclusion criteria included: the manifestation of the phenomenon of menopause in the clinical setting, the therapeutic relationship, the internal experience of the client or therapist regarding the phenomenon, and therapist reflections on the therapy.

Exclusion criteria for data set

The following literature was excluded:

- That which was not written in English
- That which focused solely on the biological processes and treatment of menopause without reference to psychological aspects
- Literature where the main focus was on other major illnesses
- That which focused on medical trials for women with physical menopause symptoms
- That which was published prior to 1995, to ensure the relevance of the study to the current social and cultural context, and views on menopause.
- That which focused on male menopause.
- Literature where menopause was the result of medical treatments or surgical procedures
- That which focused on midlife but did not pay attention to menopause
- That which did not include case illustrations
- That which included case illustrations but did not meet other inclusion criteria

Whilst, as a result of my training, my focus and interest is on psychodynamic psychotherapy, there was so little literature relevant to my study focus that I chose not to exclude non-psychodynamic literature.

Round 1
"Menopaus*" "Climacteric" "Perimenopause"
Total references identified

Database	In the body text	In the abstract
PEP	432	34
psychINFO	8289	4190
PBSC	1217	899
proQuest	265654	17051

Round 2   887
"Psychotherapy"
"Psychoanalysis"
"Clinical psychology"
"Counsel*ing"

Midlife
PsychINFO   **110**
Relevance to menopause   **26**

Round 3   1228
● Types of therapy

Round 4   1484
● Relevant clinical terms
● Therapists/clients

Abstracts screened for evaluation   3625

Exclusion 1
● Non English
● Medical treatment focus
● Male menopause
● Major illness focus
● Surgical or medically induced menopause
● Drug trials
● Biomedical with no psychological
● Midlife, no mention of menopause

Manual Search   **26**

Inclusion 1
● Psychotherapy literature
● Literature from other fields that use psychodynamic theory in practice
● Articles written by therapists from any field who discuss their own experience of menopause

References for detailed evaluation   **276**

Duplicates removed   **137**

Exclusion 2   **116**
● Mere mention of menopause
● Exclusion of works prior to 1995

Exclusion 3   **11**
● Psychotherapeutic theory, only, no case illustration

Inclusion 2
● How phenonomena is expressed or experienced in clinical setting
● Internal experience of therapist or patient.
● Transference or countertransference
● Interventions

Exclusion 4   **12**
● Psychotherapeutic theory, case illustration, no intersubjective experience

Data Set   **11**
Clinical case material
Therapist personal experience
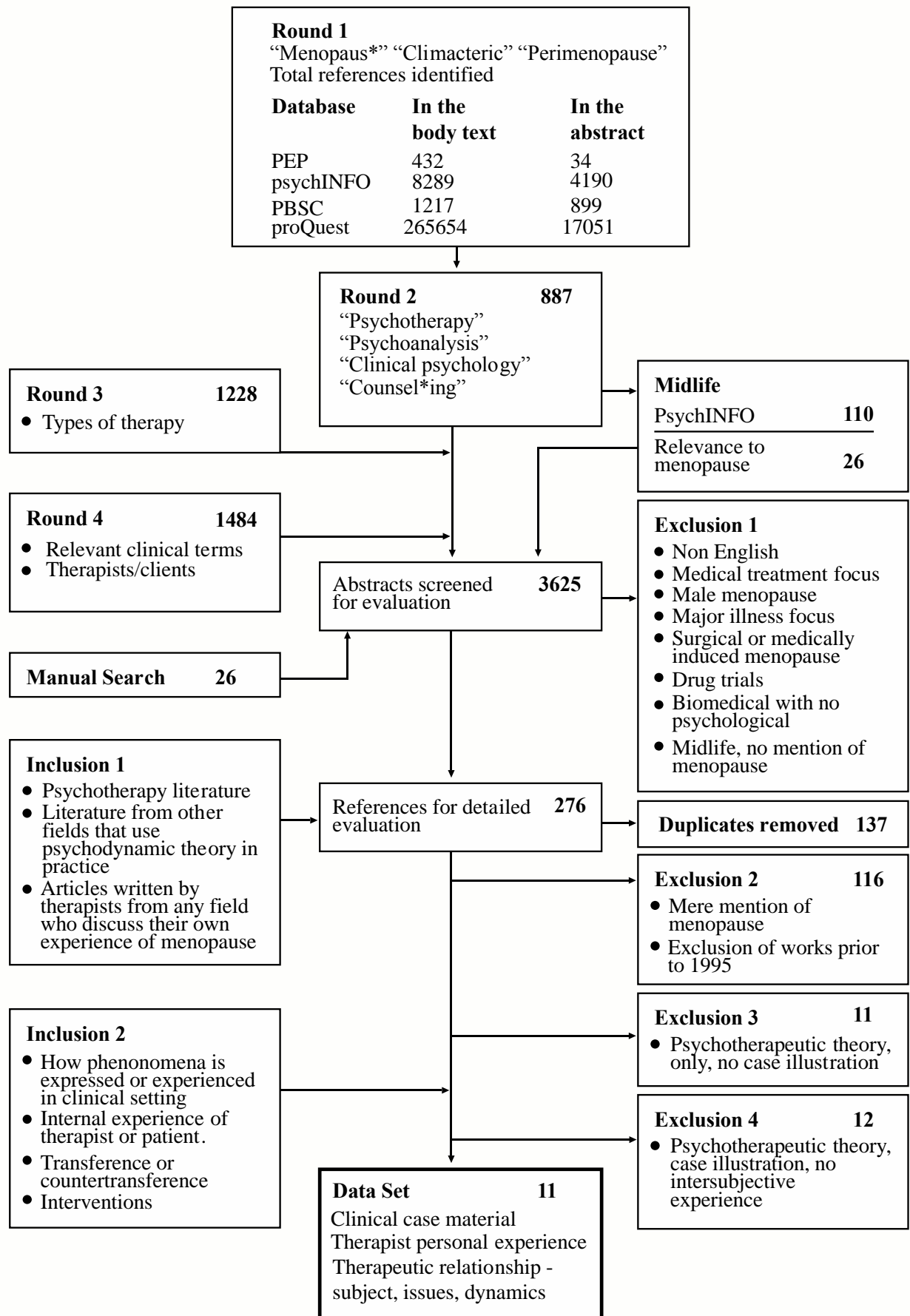Therapeutic relationship - subject, issues, dynamics

Figure 1. Data gathering process

The number of papers reduced markedly during this process, exposing a gap in the literature (See Figure 2).

Bio-psycho-social
Subjective Experience

Psychotherapy theory
and menopause

Clinical setting
Case material of
menopausal client

GAP in literature

Final Data Set

Clinical setting
Menopausal therapist
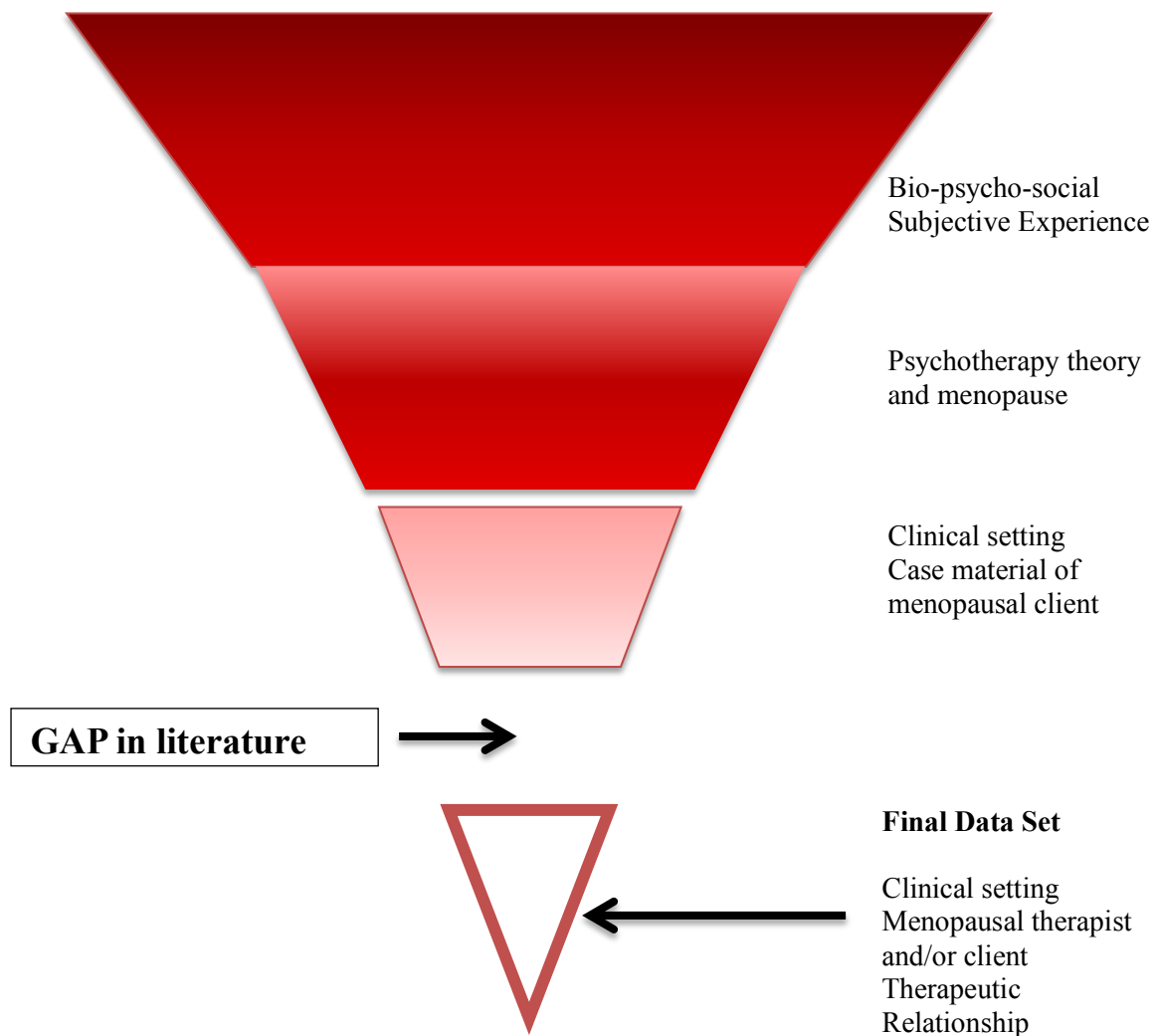and/or client
Therapeutic
Relationship

Figure 2. Menopause in the literature

Why the gap?

The gap in the data set is the scarcity of any direct discussion of the study question, specifically how menopause influences the therapeutic relationship. As a researcher I was curious as to why this gap existed and what it could mean. Several points of interest came to light that limited the data resources available. Firstly there is a surprising amount of literature that discusses midlife yet only briefly, if at all, mentions menopause. Secondly, of the literature that does speak of menopause, very few studies deliberate on the therapeutic relationship. Two examples highlight how this has been overlooked. For instance reviews of Pines' (2010) *A Woman's Unconscious Use of Her Body: A Psychoanalytic Perspective* highlight the author's attention to

transference-countertransference patterns and responses throughout the book (Dunbar, 2011; Schachter, 2011), yet the therapeutic relationship in the chapter on menopause features minimally compared to the other chapters in the book. Similarly, in Lax's (1997) book entitled *Becoming and Being a Woman,* the informative chapter on menopause does not discuss the therapeutic relationship, i.e. the author does not directly explore transference-countertransference from her own experience of working with menopause in the clinical setting, she merely restates a previously published countertransference illustration in an addendum to the chapter.

Because the therapeutic relationship is an important part of my research focus, the gap in the research highlights the need to make the most out of a very limited data set. The final data set includes articles about menopause in psychotherapy that contain any reference to the transference and countertransference phenomenon.

Table 3 presents a breakdown of the style and theoretical field of the data selected for thematic analysis (a list of the final articles are noted in Appendix A).

Table 3.

Data Gathered for Thematic Analysis by Theoretical Field and Type of Publication

Theoretical Field	Number of publications
Psychodynamic Social work	1
Psychoanalytic or psychodynamic	7
Psychotherapy theory undefined	2
Psychology	1
Total	11
Type of publication	Number of publications
Case study/expert opinion	7
Survey and expert opinion	1
Therapist experience	1
Therapist experience and discussion or professional development with other therapists	2
Total	11

Quality of research

Verification is a process where researchers take responsibility for reporting information about the study so that readers can verify the data, its analysis and interpretation (Cohen & Crabtree, 2008). According to Creswell (1998), verification as

a process takes place in all phases of the study from data collection and analysis to report writing. Verification is thought to shape the whole research process (Morse, Barrett, Mayan, Olson, & Spiers, 2002). Lincoln and Guba (1985) used the term trustworthiness and proposed four criteria of trustworthiness; credibility, transferability, dependability and confirmability. Drawing from the criteria of Lincoln and Guba (1985) and other views of verification studied, Creswell (1998) summarised eight verification procedures that are often discussed in the literature; (1) prolonged engagement and persistent observation; (2) triangulation; (3) peer review or debriefing; (4) negative case analysis; (5) clarifying researcher bias; (6) member checks; (7) rich, thick description; and (8) external audits. He recommended that researchers engage at least two of these procedures to establish verification of their study. Below I briefly illustrate how I have engaged some of these procedures to ensure the validity of this research.

Peer review and debriefing

Debriefing and peer review offer opportunities for continued verification as the researcher's thinking and process come under scrutiny by others (Shenton, 2004). Throughout the whole research process I met frequently with my supervisor to; clarify my understandings of the research process, test ideas and interpretations, develop research techniques, consider other possible procedures, voice concerns, ensure my process continued to align with my chosen methodologies, have my interpretations assessed to ensure they reflected the data and to recognise when my own perceptions or bias may be hindering or overcommitting to the process.

During the data collection and thematic analysis stages particularly, I met regularly with colleagues and peers. These meetings were supportive in maintaining the motivation and momentum for study and were useful in providing feedback and critique of my research technique and process. Most importantly these meetings provided opportunity for discussion and debate which furthered learning related to research methodologies and methods. Having established methodologies, methods, the data set and techniques for thematic analysis, I presented my progress and process to fellow students and university staff and received feedback on the development of my research. Revisions were made accordingly.

Rich, thick description

Detailed description is thought to be an important requirement for promoting credibility (Shenton, 2004). In Chapter 3: Findings, I have included many extracts from

and links to the data in order to illustrate the links between my results, analysis and the data set. This allows the reader to determine whether the themes and interpretations reflect the data (Shenton, 2004) and assess whether the findings can be transferred (Creswell, 1998).

Clarifying researcher bias

It is difficult to ensure neutrality as to some extent the researcher and the material are inextricably intertwined and bias is inescapable (Poulin, 2007; Shenton, 2004). It is important the researcher establishes that their findings are reasonable in order to meet the demands of confirmability (Lincoln & Guba, 1985). To establish that my findings are reasonable, I have ensured that the reader understands my position and any biases or preferences that may impact the inquiry. I have articulated that my training and work as a psychotherapist and my experience as a woman, whose next developmental stage is menopause, will have likely shaped the interpretation and approach to this study (Creswell, 1998). I have discussed my beliefs that underpin the chosen methodology and provided an "audit trail" (Shenton, 2004, p. 72) by way of a step by step account of research procedures and decisions.

Verification procedures are evident throughout each phase of the study.

Summary

The purpose of this chapter was to describe the interpretivist paradigm positioning with respect to a social constructivist epistemology. A hermeneutic phenomenological approach for exploring the subject was explained and the rationale for thematic analysis as the main research method was described. An outline of the process of the thematic analysis was given along with a detailed description of how the data for the study was collected. Finally the chapter discussed the verification processes employed to ensure the quality of research. The following chapter delineates the thematic analysis of the data.

Chapter Two: Thematic Analysis

Introduction

This chapter explains how I conducted the thematic analysis (TA) guided by Braun and Clarke's (2006) six step model and the writings of Meier and Boivin (2000) and Attride-Stirling (2001). At the end of each phase I offer some reflection on my learning, specifically, how my engagement with one phase supported the next and how I learned more about a particular phase as a result of my engagement with the subsequent one.

Phase 1: Becoming Familiar with the Data Set

I began the process of a thematic analysis by familiarising myself with the data. During this phase, reading and re-reading the texts aims to hasten researcher familiarity of the topic and initiate the identification of semantic (explicit) or latent (implicit) themes which may later be explored (Braun & Clarke, 2006).

I used two processes to develop my knowledge of the data content. Firstly, I identified the salient points of each text by reading and making notes (associations, key words, preliminary codes) in the margins of each text. Secondly, I lifted broad sections of each article into the Evernote programme (a web-based suite designed for note-taking and archiving). I tagged these chunks of the text with summarising key words. The Evernote system allowed me to view the range of tags and also those that were prevalent, thus I became familiar with the depth and breadth of content in the data set. Both processes enabled me to become aware of commonalities and differences across the texts.

Reflection

As I entered the coding phase, I realised that although I had familiarised myself with the texts, by focusing on the entire data set, my approach had been too broad. As the aim of this research was to understand what happens when therapist, client and menopause meet, I refocused my attention on the parts of texts that were relevant to the study focus using the inclusion criteria I had established in the "gathering the data set" phase. I returned to the literature set, skimming the pages of every article and marking sections of the text that I considered were related to the study. I repeated the familiarisation processes in preparation for the following phase of coding.

Phase 2: Generating Initial Codes

According to Braun and Clarke (2006), codes identify a semantic or latent feature of the data that is interesting to the researcher and meaningful in understanding the phenomena being studied.

The coding of this study was "data-driven" (Braun & Clarke, 2006, p. 83). I used the process of bracketing my own views (Moustakas, 1994) of menopause in order to minimise their interference with the coding process, instead remaining focused on and open to what therapists/writers described of their own experience and what they understood of the patients' experience.

As I became more familiar with the data I became more discerning about which parts of the text I coded. Articles featuring case material usually required me to code the whole case illustration (including the therapist's thinking related to the process of treatment). In all articles, the relevant text was broken down into meaning units. Each meaning unit consisted of one, two or three sentences. As illustrated in Table 4, each meaning unit was cut and pasted into a Word table and a coding procedure was created.

Coding was performed manually in three ways. Firstly, a meaning unit was broken down into 'close to text' codes, this involved paraphrasing the meaning unit into key points utilising the text language. Secondly the "close to text" translations were synthesized and codes were created inductively to capture the meaning and content of each meaning unit. The focus here was to capture the essence of the data. Every meaning unit had at least one code applied, and most had several. In line with Braun and Clarke's (2006) suggestion to "code extracts of data inclusively" (p. 89), attempts were made to ensure that the context of the code was not lost. Thirdly, before completing this stage of the synthesis, attempts were made to write an interpretation of the code in the far right column of the table. Stepping from behind the "bracketing", I, as the researcher, drew on prior knowledge or experience and used this column to make links to other texts or wider psychotherapeutic concepts or theories in case these became useful at a later stage.

Table 4.

Example of Coding Procedure

Meaning Unit	Author	Page	Meaning unit	Close to text	Synthesised Codes	Unbracketed interpretations/ links to other sources
8	Spira and Berger (1999)	p. 263	"Raini wondered if now she was going crazy and she had concerns of the impact of her behavior on her marriage and children.	Wondered if she was going crazy Concerned her behaviour would affect children Concerned her behaviour would affect marriage	8. MP. Thoughts of going crazy 8. MP. Concerned about behaviour 8. MP. Concerned for family	8. Identification with internalised mother 8. Menopause means going crazy 8. Menopause something to be frightened of
9	Spira and Berger (1999)	p. 263	R: 'I am so scared of how all this will come down on my family. I don't want to scare my children'".	Fears impact of behaviour on family	9. MP. Fears scaring children with behaviour	9. MP-Fears she will impact on family as her mother did
10	Spira and Berger (1999)	p. 263	"T: 'This must be pretty scary to you, too—'"		10. T. Inter-redirects patients fear for others back to self	
11	Spira and Berger (1999)	p. 264	"R: 'I guess, but shouldn't I worry more about them— they already don't need me— and if I am out of control, for sure they have no use . . .'"	Thinks she should worry more for others than for self. Does not feel needed by family Believes loss of control will result in rejection	11. MP. focused on needs and wellbeing of others 11. MP. feels unneeded by family 11. MP. loss of role identity in family 11. MP. fears rejection if out of control.	11. Self as belonging to others vs belonging to self 11. Usefulness vs uselessness 11. Menopause means loss of control 11. Struggling with changing family dynamics 11. Disruption to narcissistic equilibrium based on social roles

In this phase labels were attached to the codes (MP, PMP, CMP, T, MT) to acknowledge the source of the code, i.e. who was experiencing or thinking or saying what in the text. Table 5 shows the description of the labels. This was done in case it became useful in later analysis to discern characteristics of either the client or therapist. Similarly at times, a second level label was added to distinguish what was, for example, either said, thought, felt interpreted, dreamed, fantasied or reflected upon throughout the therapeutic process.

Table 5.

Description of Labels Used in Coding the Data

Labels	Referrent
MP	Menopausal Patient
PM	Peri-menopausal Patient
CMP	Childless Menopausal Patient
T	Therapist
MT	Menopausal Therapist
Second Level Labels	
CT	Countertransference
Trans	Transference
TCE	Therapist Clinical Experience
TF	Treatment Focus
TI	Therapist Interpretation
Dream	Dream
Dm Ass	Dream Association
Inter	Intervention by therapist
Life event	Life event

In all cases, the process of coding entailed a continuous reading and re-reading of texts to extract the meaning. Verification took place using supervision. I would select an assortment of coded meaning units for review. Feedback from and discussion with my supervisor developed my coding technique.

Verification by fellow researchers also provided an external check for this part of the research process. I engaged peers to support and challenge me when I experienced coding fatigue. They provided fresh eyes to determine the quality and consistency of my coding.

Reflection

Precision in coding in order to capture the essence of the meaning unit without losing the context within which it is written, is a particular skill. This was a lengthy and arduous process. On reflection, I did not always find it easy to decipher the meaning of my own coding when separated from the text, and often found myself having to return to the text to recode. What I did find useful in my original coding process was entering ideas in the interpretation column. This became useful in searching for themes and when looking at "the overall story of the analysis" (Braun & Clarke, 2006, p. 87).

Phase 3: Searching for Themes

A theme draws features of the data into focus relative to the research question, helping to reveal and interpret both semantic and latent content (Braun & Clarke, 2006). This phase involved stepping back from the micro process of coding to look at the bigger picture of what the codes were illustrating. It involved distributing the coded data into potential themes within the phenomena of menopause in psychotherapy. Themes were generated through a reduction process that involved comparing descriptions and experiences portrayed in the texts, then combining relevant codes into a provisional structure.

Firstly, the synthesised codes were numbered to align with the meaning unit so they were traceable; (see Table 4) the codes were then copied from the table into a new document and enlarged for printing. The codes from each article were printed out on different coloured paper. This was done for two reasons:

1. To allow the researcher to identify the author of the coded piece
2. For verification purposes. The range of coloured codes present under a theme would determine whether (or not) the theme was a fair representation of the data set.

The codes were then cut up in preparation for the process of finding potential themes. This process involved two rounds of development.

Round one: Description

The process of Round 1 is illustrated in Table 6. Initially, selections of codes from each article were organised into broadly categorised piles. Categories were formed on the basis of recurring descriptions and issues regarding menopause in psychotherapy.

Table 6.

Searching for Themes, Round One: Categories and Descriptors

Category	Descriptors
Death	Fear, denial, aloneness, impotence, depression, loss
Ageing	Loss of youth/beauty, fear of ageing, death closer, denial, acceptance, awareness, gains, depression, impotence
Physicality	Symptoms of menopause, body image, attractiveness, unconscious connection to hormonal body, loss of reproductive capacity
Menopause Awareness	Client awareness, midlife vs menopause, menopause as illness, not discussed, topic avoided, cultural influence, not considered, unknown, mind/body split
Description of patient experience	Impotency, uncertainty, childlessness, decline, envy, aloneness, seeks aloneness, loss of sexual desire, fears related to sexuality, loss of control, usefulness/uselessness, increased libido, denial, emptiness, freedom, no feeling, undesirable, loss of self, loss of meaning, loss of confidence, dreams, loss of pregnancy/childbearing, pregnancy desires
Childhood/ Adolescent Experience	Uncelebrated, impotent, envy, usefulness/worthiness, shame/humiliation, powerlessness, unspoken
Therapy Outcomes	Mother/daughter relationship reworked, increased self-worth, focus on self vs other, pursuit of creativity, freedom, redefining roles, acceptance.
Therapist Thinking	Dependency, envy, identity issues, cultural roles, family roles, expulsion of introjects, manic defence, other defences
Relationships	Menopausal patient and her mother, menopausal patient and her daughter, father, son, husband, children
Therapy focus	Current relationships, early relationships, meaning making, working through transition
Relational Interplay	Therapist impotency, mis-attuned, positive/negative mother transference, envy, therapist as dangerous, difficulties in therapy, therapist identification
Menopausal Therapist	Managing physical symptoms, disclosure, concern for therapy, envy/competition, identity, therapeutic frame

All codes within each category were re- read and re-distributed into piles of commonality forming "descriptors". This provided on-going verification of coherence within the initial categories. Whenever a code proved difficult to understand it was traced back to the text and recoded to clarify the meaning. This process of categorising and developing descriptors continued until all codes from all articles had been considered and distributed. Codes that did not fit into a descriptor were placed together

as miscellaneous and set aside for further thought. This process resulted in 12 categories and 97 descriptors.

This first stage represented a classification of codes into categories at a descriptive level. These categories and descriptors were not sufficient to construct a meaningful summary or model of the experience of menopause in psychotherapy. According to Bazeley (2009), "description *is* part of the analytic journey... but description alone is not sufficient. The data must be challenged, extended, supported and linked in order to reveal [its] full value" (p. 8*).* Further analysis was required to ascertain themes which would describe integrating, relational ideas from the data (Richards, 2005 as cited in Bazeley, 2009).

Round two: Subthemes and themes

Now that the 1,615 codes were distributed into broad categories and descriptors, I had a structure from which to further analyse the data. I noticed interrelatedness and subtle differences within and between the descriptors which evoked discussion with my supervisor and colleagues of the possible ways to rename, reorganise or combine certain descriptors. The 12 categories and 97 descriptors were regrouped into 5 thematic clusters on the basis of the following criteria; (a) "related conceptual content" (Attride-Stirling, 2001, p. 395), (b) the commonality of the thematic content among the data set and (c) the relevance of the theme to the study question. This regrouping took place in several ways.

I reclassified some codes and/or descriptors into initial themes and subthemes. For example, codes that represented menopause as unspoken, not discussed, avoided, not considered and unknown, were grouped with codes of hesitancy, default to midlife, negative cultural stereotypes and deficiency disease or illness. This new cluster was restructured into the potential theme of "silence" with subthemes of unknown, unconscious, unspoken, unrecognised and undervalued.

Some categories like "relational interplay" did hold together as a theme, with only a minor reworking of subthemes, whilst other categories were combined. For example, the descriptors in the category "description of patient experience" were redefined and separated into subthemes of loss of youth, loss of ego, loss of identity, loss of reproductive capacity, loss of life, loss of sexuality and loss of power. To illustrate this process: the code "sense of self as a barren woman" was initially categorised in "description of the patient" under the descriptor of "emptiness". This descriptor was placed with other descriptors that focused on women's feelings and

reactions specifically related to their inability to bear children. This selection of descriptors became the subtheme, "loss of reproductive capacity", under a theme of "loss". Other groups or descriptors were imported into the theme of "loss". For example, the descriptors in the category of "death" were incorporated under a subtheme entitled: "loss of life".

A vast number of codes were generated in the subtheme "reworking relationships" This subtheme might have been named a theme in its own right. However, in considering how subthemes and themes combine in the process of thematic analysis (Braun & Clarke, 2006), I positioned it as part of a greater theme (Attride-Sterling, 2001) "deepening into self" as the codes within this subtheme appeared to suggest that by reworking relationships, the menopausal client was further understanding herself.

In this re-ordering process, descriptors were interpreted into subthemes from which the themes were deduced. These provisional themes and subthemes were given interim labels; silence, loss etc. (see Figure 3).
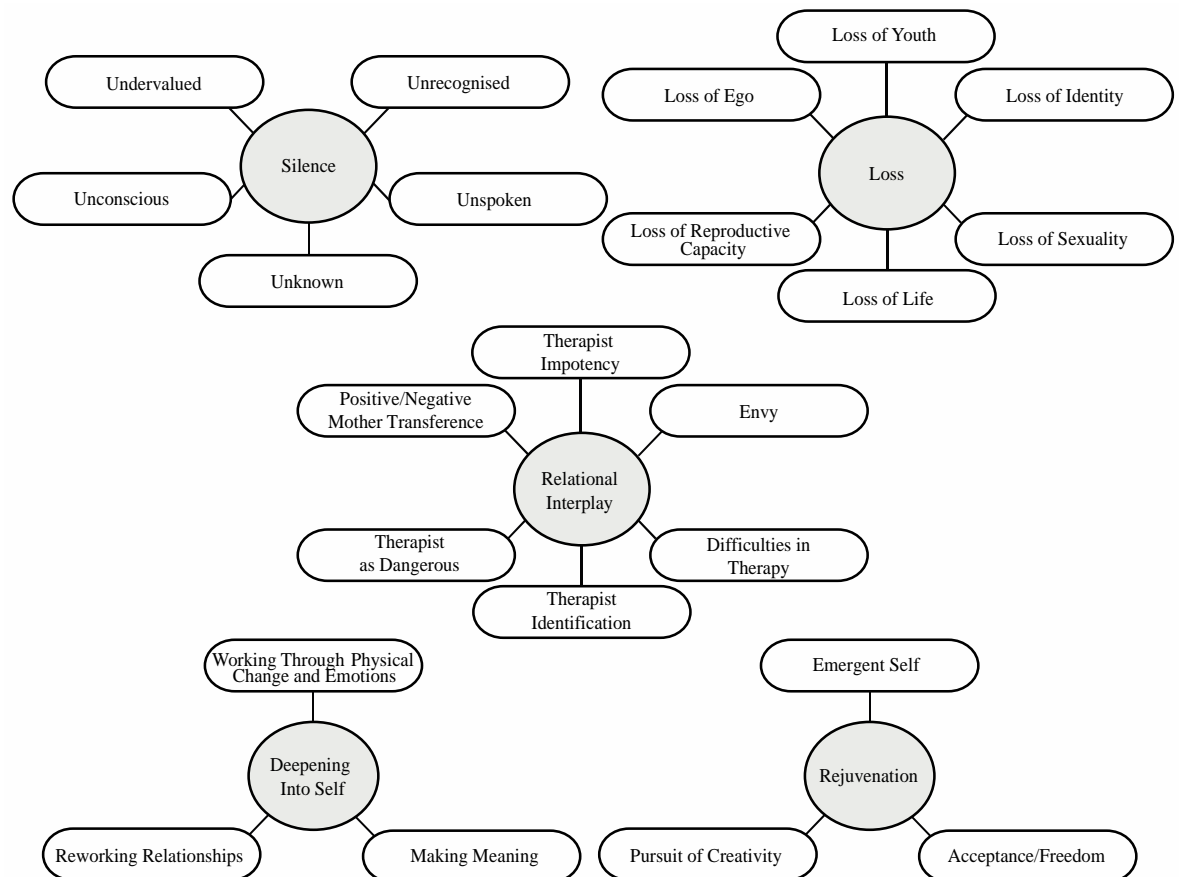

Figure 3. Initial thematic clusters

Reflection

The process I used in the "searching for themes" phase was a creative adaption of the procedure described by Braun and Clarke (2006). I found the development of initial broad categories and descriptors useful in beginning to organise the 1,615 codes into themes. I discovered an article by Attride-Sterling (2001) which I found useful in this phase and helped in the final write up. This author's approach to thematic analysis, differed from mine in regard to terminology and coding technique, yet similarities were found within the process of theme identification and the construction of thematic networks. I learned that although my approach differed, it was still an effective strategy for the data reduction necessary for reaching the research outcomes (Attride-Sterling, 2001).

Phase 4: Reviewing Themes

I was now at the stage of reviewing the themes, which, according to Braun and Clarke (2006), involves the refinement of themes with the aim of constructing a practical framework that illustrates how the themes fit together and convey the overall story of the phenomena of menopause in psychotherapy. This process involved two levels of review to ensure that themes were "(i) specific enough to be discrete (non-repetitive), and (ii) broad enough to encapsulate a set of ideas contained in numerous text segments" (Attride-Sterling, 2001, p. 392).

Level (i): Specific enough

Once the initial themes were determined, the codes that had not been distributed were reconsidered. If they were still difficult to place I went back to the original text and meaning unit for clarification and to ascertain relevancy. The code was either clarified or, if deemed to be irrelevant, discarded.

The data within each theme was scrutinised to ensure meaningful cohesion, whilst making certain there were clear and identifiable distinctions between each of the themes (Braun & Clarke, 2006). This involved re-reading the codes in each subtheme to ensure that the content spoke specifically to the theme. In this process subthemes were condensed or refined. For example, the theme of 'silence' was reduced from five subthemes to two as it became apparent that the content within the initial subthemes of 'unconscious', 'unknown' and 'unspoken', depicted menopause as being overlooked. These subthemes were collapsed into a new subtheme titled; 'unconsidered' which felt to be a better representation of the selected codes. The subtheme 'unrecognised' was subsumed in the subtheme 'undervalued' as similarities were recognised.

The theme of loss was further reconsidered, resulting in a reduction from seven to four subthemes. This process involved a reorganisation of the data codes within the theme, and included the export and import of data codes to and from other subthemes. For example, the subtheme of "loss of life" was now subsumed under the subtheme "loss of youth".

Having re-read the texts and refined ideas about areas of interest relevant to the research question, I was ready to proceed to Level (ii).

Level (ii): Broad enough

Ensuring the themes were an accurate reflection of the data set was undertaken in two ways. Firstly, as each article's codes were printed on different coloured paper it was easy to discern that each theme was represented by a range of authors. Secondly, I returned to the literature set and re-read each article in full, ensuring the overall thematic representation accurately depicted the meanings portrayed in the texts.

Table 7.

Thematic Representation Across the Data Set

	Silence	Loss	Relational Interplay	Deepening meaning	Rejuvenation
Article 1	√	√	√	√	√
Article 2			√		
Article 3	√	√	√	√	
Article 4		√	√	√	√
Article 5	√	√	√	√	√
Article 6	√	√	√		
Article 7	√	√	√		√
Article 8	√	√	√		
Article 9		√	√	√	√
Article 10		√	√	√	√
Article 11	√	√	√	√	√

Although each theme was clearly representative of the data set as a whole, decisions to exclude or include specific descriptors that were denoted by single authors were based on the following criteria; (1) the relevance of the descriptor to the research question and (2) whether I felt the lack of reference across the data texts signified something in itself. For example, whilst the descriptor of "menopausal therapist self-

disclosure" in the subtheme of "therapeutic frame" under the theme of "therapeutic relationship" cannot be regarded as a prevalent theme, it may nonetheless be significant. The aim of a TA "is to reflect a balanced view of the data, and its meaning within a particular context of thoughts, rather than attaching too much importance to the frequency of codes abstracted from their context" (Joffe, 2012, p. 219). Using the established criteria; this descriptor has relevance to the study question; *"From the perspective of the therapist, what happens when therapist, patient and menopause meet".* Codes within this descriptor related to the therapist's experience of her own menopause in the practice of therapy and in particular, how her menopausal experience influenced the therapeutic relationship. The presence of menopausal therapists discussing issues of self-disclosure was not found elsewhere in the literature; as such I felt it important for this study to bring the notion to the fore. With evidence that the thematic map represented the data set, I was ready to move onto Phase 5.

Reflection

During this phase I learned the significance of creating a system for physically managing the paper codes, which had been grouped into descriptors within subthemes and themes so that I could easily return to review or reorganise them as required. As I proceeded into Phase 5, I learned the importance of recording "all" of my process and thinking associated with reviewing the themes. There were occasions when I needed to return to Phase 4, and re-decipher the reasoning behind my actions.

Phase 5: Defining and Naming Themes

This phase involved a much more detailed process of: (1) describing the themes with supporting examples from the text, (2) identifying and clarifying the essence of what the data in each theme captures, and (3) naming the themes. In this process notes and diagrams were transformed into a written account which shaped and conveyed the essential features of the themes as they related to the study focus. This process enabled me to evaluate the content of each theme and make adjustments. For example, on writing the narrative on the theme of "loss", it became evident that "loss of ego" and "loss of identity" were central to the subtheme "loss of power", as such they were subsumed into this subtheme. It also became evident to me that the theme of "loss", focused not only on what was felt to be lost at menopause, but also what woman feared would change or be lost. Thus the theme was renamed "loss and fear of loss". The extraction of quotes to support my thematic descriptions also characterised this phase, as illustrated in Table 8.

Table 8.

Example of Theme "Loss and Fear of Loss" with Extracts

Text Extract	Example of code relevant to this theme	Descriptor	Subtheme	Theme
"I'm not afraid of dying, I just don't want to lose it" (Wilk & Kirk, 1995, p. 239).	MP. Fear of mental deterioration	Fear of decline, helplessness against aging		
"She believed menopause meant withdrawal, decline and death" (Wilk & Kirk, 1995. p. 239).	MP. Menopause foreshadows death	Proximity to and fear of death	Loss of Youth	Loss and Fear of Loss
"…staring into the mirror every morning, mortified at how quickly the young attractive woman I used to be was disappearing" (Brayne, 2011. para. 11).	MT. Mortification at fading youth and attractiveness	Youthfulness, beauty		
"My clinical experience leads me to believe that though a woman may have made a conscious decision to have no more children some time ago, there is always the possibility of a new baby in her mind until the gradual onset of menopause and its unavoidable physical signs destroy her hopeful fantasy" (Pines, 2010, p. 127).	TCE. Menopause onset destroys unconscious childbearing fantasies	Maternal deprivation		
"Because really I'm just a big blank, a meaningless void at bottom" (Holmes, 2008).	MP. Feels empty MP. Feels devoid of meaning	Emptiness	Loss of Fertility	Loss and Fear of Loss
"Pregnancy became an enormous challenge for her, a way of overcoming the limitations of age, which she unconsciously experienced as a foreshadowing of death" (Kogan, 2010, p. 86).	PM. Pregnancy postpones aging and facing death	Postponement		
"Her apprehension was that menopause would deprive her of the only tools which made her important to others" (Spira & Berger, 1999, p. 265).	MP. Fears loss of valued sexual/feminine self	Sexual insecurities		
"She had had a selfless career in a helping profession and was known for her sweetness and capacity to give. She was horrified by her depression and suicidal feelings at this time in her life" (Zachary, 2002, p. 32).	MP. Feelings incongruent with sense of self	Loss of certainty, uncertainty	Loss of Power,	Loss and Fear of Loss

Following Braun and Clarke (2006), I returned to the extracted meaning units within each theme to further refine and clarify the organisation of each thematic network. This entailed clearly describing the meaning of each theme, noting any underlying patterns that appeared and finalising the title of each theme. The theme name of 'silence' was retained to signify the avoidance, neglect and taboo that the data indicated. It encompassed women's menopausal experience as forgotten or somehow suppressed and concealed and captured the evasion, omission and absence of discussion related to menopause.

The theme 'relational interplay' was renamed 'challenges of relational interplay' as it became apparent when conveying the essential features of the theme, that the descriptors and subthemes depicted the interpsychic tensions that evolved when menopause was present in the therapy.

The theme of 'deepening into self' was renamed 'disentangling of tensions' when it became evident that a process of sorting out and making meaning of the tensions of women's menopausal experiences, dominated this theme. Disentangling of tensions more accurately describes the work of therapy depicted in the data.

When writing the narrative on the theme initially called 'rejuvenation', the name did not sit right, as it refers to a process of repair or the quest to restore youth. The essence of the data in this theme was about representing the menopausal women's potential. Rather than a rejuvenation of self, a renewed sense of self. The theme name 'renewed sense of self' better describes the emergence of acceptance, freedom and self-determination.

The core theme of impotency/potency (Figure 4), which is the difficulty in feeling potent with self and others, was a central pattern that I deduced from a deeper exploration and reduction of the themes. According to Meier and Boivin, (2000) a core them is conceptual and is "considered the central phenomenon around which all the other themes are integrated" (p.59). The core theme came to my attention early in the process of analysing the data as the sub-themes and themes were developed. The silence surrounding menopause, loss and fear of loss and the inability to reverse the physiological changes of menopause seemed to me to engender a sense of impotency. However, potency was generated when women disentangled and made sense of internal and external tensions and affirmed this inevitable change. This core theme is discussed more fully in Chapters 3 and 4.

Throughout this phase I sought regular support and verification from my supervisor to ensure I was staying aligned to my methodology and following processes that ensured the themes were a fair representation of the data.

This phase was concluded with the naming of the themes. The thematic map was now defined. (See Figure 4, in which the numbers represent the amount of codes that form each descriptor and subtheme).

Reflection

In the early stages of this phase, I began making sense of the data, utilising the thematic map and the codes that sat within the descriptors. This promptly proved to be an insufficient process, because I found that some of the subtle meanings I deduced could not be supported by the texts, "even though this is not an intentional process [it] constitutes the unintentional, unconscious 'seeing' of data that researchers expect to find" (Fereday & Muir-Cochrane, 2006, p. 7). I quickly learned that the thematic map is a tool in analysis (Attride-Sterling, 2001) and that going beyond the specific content of the texts to identify underlying patterns and make meaning of them required me to continuously and rigorously return to the data set to explore the themes and ensure the trustworthiness of my interpretations.
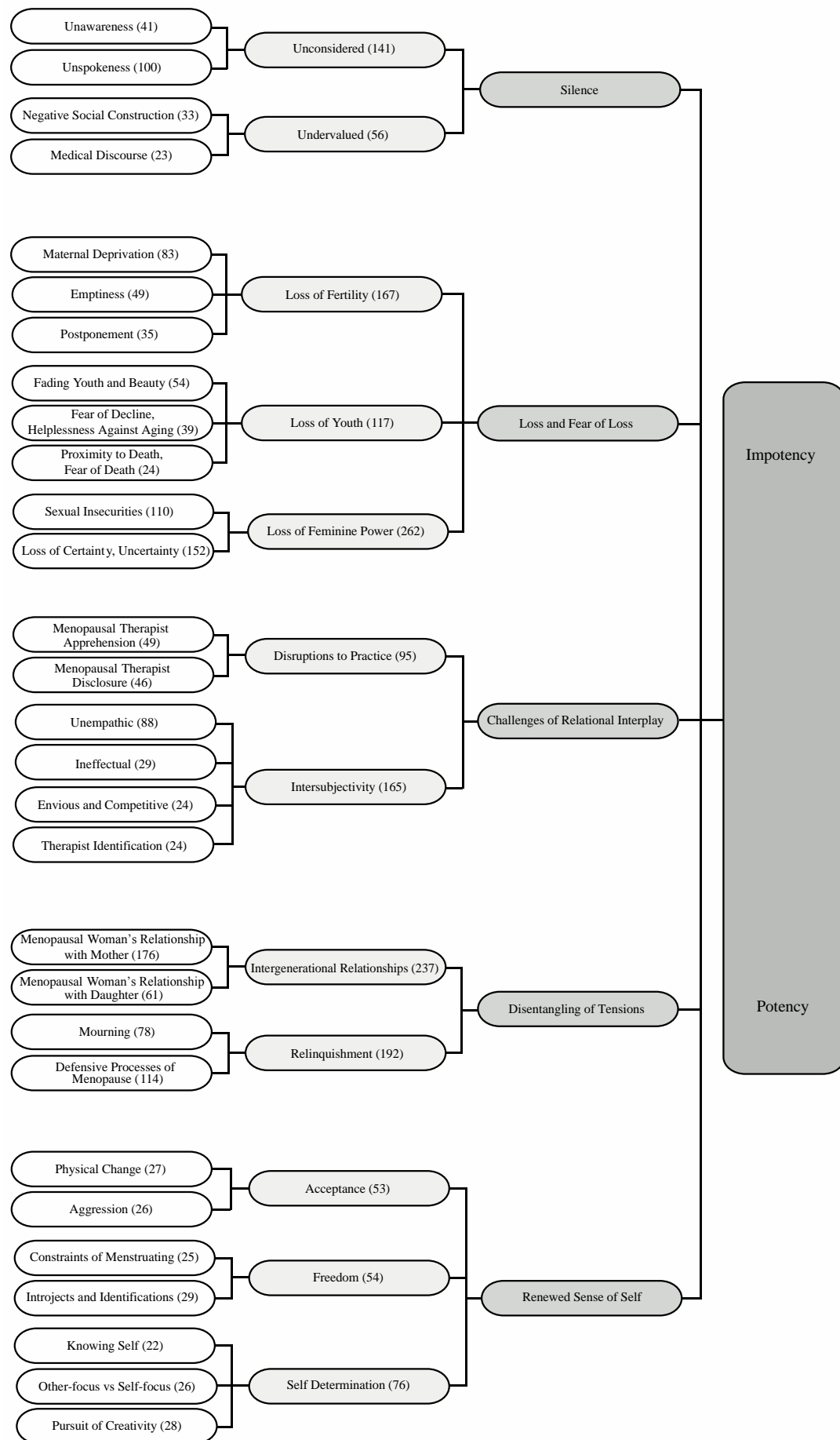
Figure 4. The relationship between descriptors, subthemes, themes and core theme derived by thematic analysis: Producing the final thematic map

Phase 6: Producing the Report

The aim of the final report is to move from description to interpretation of the data. The thematic map is described, and my findings justified using extracts from the data. In the discussion chapter, I create an argument for the findings in relation to the research question. I returned again to the texts and further grappled with the meanings of my findings and contextualised my analysis in relation to existing literature (Azar, 2006). I also included the annotated notes I had generated in the "unbracketed interpretation" column of the original coding procedure in Phase 2, recalling notions and reflective insights. Having thoroughly looked both within and across the themes in these ways I have endeavoured to give a "concise, coherent, logical and non-repetitive account of the findings" (Braun & Clarke, 2006, p. 93).

Reflection

In writing the final report I was faced with challenges. In every study session I gained a deeper understanding of the research process and the meanings embedded in and across the themes. This faced me with consistency issues in report writing and I was continually refining my previous writings in light of this new knowledge. It also confronted me with the need to be discerning when selecting discussion points ensuring I chose those most relevant to the research focus. The reporting of the thematic analysis involved many revisions and drafts as I considered how the analysis and narrative could be improved. I learned through experience that a thematic analysis is not a simple process of moving from one phase to the next. It was instead, as Braun and Clarke (2006) described a continual "recursive process, where movement is back and forth as needed throughout the phases" (p. 86).

Summary

This chapter has created a transparent trail by providing a step-by-step account of the systematic approach used in this thematic analysis. It has described and illustrated, with original evidence, the process involved in working reductively from the peripheral categories inwards to the themes. Reflections on each phase of the TA provide further disclosure of the process undertaken. The following chapter provides a thorough exploration of each theme.

Chapter Three: Findings

Introduction

The thematic analysis produced twenty nine descriptors which were reduced to twelve subthemes, five main themes and a conceptual core theme. These are illustrated by the thematic map (Figure 4). The thematic map represents an exploration of the menopause phenomena with a particular population of menopausal women: those participating in psychotherapy, either as client or therapist. What follows is a detailed exploration of each theme.

Theme One: Silence

The theme of silence comprises of two subthemes and four descriptors and represents an exploration of silence in the context of the broader discussion on menopause in psychotherapy. The thematic network (Figure 5) illustrates concisely the key subthemes of "unconsidered" and "undervalued" to which silence was anchored. Discussions of silence relate to therapist and client unawareness of, and inattention to, menopause as a relevant topic when exploring psychological difficulties of, or as, a midlife woman. The theme of silence is shaped by sociocultural influences and is characterised by the neglect of women's psychological experience. In this sense silence represents a dualistic split between mind and body.
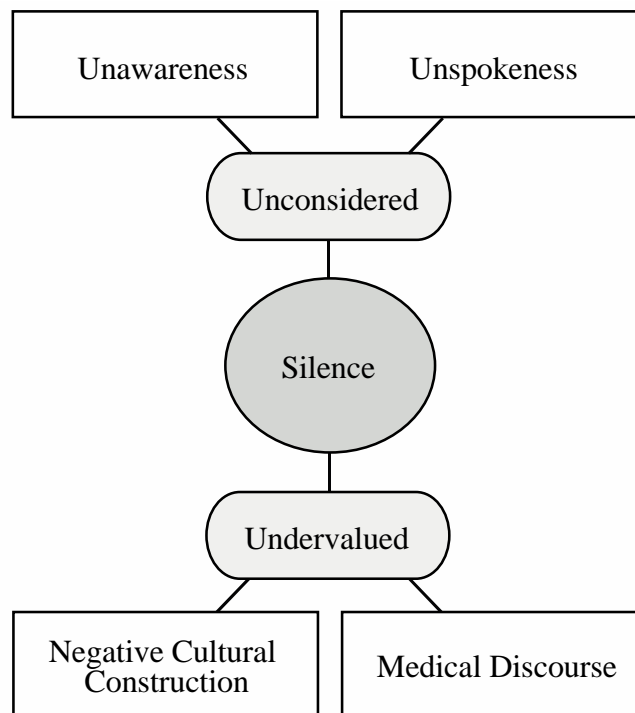

Figure 5. Thematic network for "Silence"

Unconsidered

This subtheme concerns menopause as an often overlooked topic of significance in therapy. The notion that menopause is "unconsidered" evolved from experiences or descriptions of therapists and clients that referred to the; (1) unawareness; and (2) unspokeness of menopause.

Clients described in the literature were unaware, sometimes literally, that they were in or entering menopause and those that were aware seldom contemplated a relationship between issues they experienced and their menopausal status. Similarly, in one survey most therapists did not automatically think of menopause as a possible reason for a midlife woman to enter therapy (Wilk & Kirk, 1995). Likewise, in providing professional development for therapists on the topic of menopause, Brayne (2011) reported that therapists were not aware of possible connections between menopause and the range of physical, social, emotional and existential challenges faced by these women.

The descriptor of "unspokeness" provides further insight into people being unaware of menopause. It captures therapist/writers' reflections on how seldom, if ever, menopause was discussed within psychotherapeutic circles such as in psychotherapy training (Brayne, 2011), with supervisors (Frost, 2006), or with colleagues (Wilk & Kirk, 1995) – let alone with clients. For example, in questioning their own practice, Wilk and Kirk (1995) commented that; "[a]lthough we had in the past heard clients' references to menopause, neither of us had ever pursued those references…. We also realised that we had never discussed the subject with other colleagues" (p235).

The absence of conversation about menopause in therapy-related settings, was firstly attributed to fears, examples of which are female therapists' countertransferential fears (Bemesderfer, 1996b; Wilk & Kirk, 1995) and their embarrassment in discussing their menopause with male supervisors (Frost, 2006). Secondly, there is a sense that menopause is a taboo topic (Spira & Berger, 1999; Wilk & Kirk, 1995).

This unspokeness was thought to contribute to a lack of awareness of menopause in psychotherapy (Wilk & Kirk, 1995) perpetuating the menopause as an unconsidered topic, whereby "therapists can fail to make important connections between a woman reaching menopausal age and the emotional difficulties she is – or they themselves might be experiencing" (Brayne, 2011, para. 5). Thus, menopause is maintained as a "silent realm" (Bridges, 2011, para. 2) for both menopausal therapists and clients who enter menopause often unaware of ways others have dealt with

associated changes and loss. Reasons underpinning the "unawareness" and "unspokeness" of menopause are explored in the following subtheme.

Undervalued

This subtheme sheds light on why menopause is often consciously or unconsciously overlooked as a topic of significance. It refers to the influence of; (1) negative cultural constructions; and (2) medical discourse on therapist and client beliefs and responses to menopause. The first descriptor captures experiences where therapists and clients were described as susceptible to internalising and identifying with the prevalent negative social constructions of menopause. One such construction depicted in the literature equated menopause with "getting old". This carried connotations that menopausal women become difficult, incompetent, unattractive, unfeminine and unwanted. In identification with the cultural preference for youth and beauty, some menopausal women silenced their menopausal status and experiences to avoid negative retribution (Brayne, 2011; Bridges, 2011; Frost, 2006; Wilk & Kirk, 1995). Experiences of, or a fear of shame, judgement, rejection or ridicule evident in the literature is captured by a menopausal therapist in the following statement:

> My own experiences certainly prompt me to concur that this is indeed a silent realm, a silence perhaps understandably perpetuated by those of us who do not wish to be perceived negatively, or to feel humiliated by the 'mocking attitude' evident within our society (Bridges, 2011, para, 2).

The internalisation of these social constructions generates a resistance or tentativeness in both menopausal therapists (Bridges, 2011; Frost, 2006) and clients to discuss menopause. Wilk and Kirk (1995) and Bemesderfer (1996b), suggested that in general, therapists (menopausal or not) may unconsciously collude with the client and neglect to explore the unique experience and the meanings each woman assigns to her menopause.

A further illustration of menopause as a social construction is represented in the descriptor of "medical discourse". Therapist/writers reflected that the biomedical construct of menopause as a deficiency disease exists for some clients. Examples include, those clients, who deferred to an external "all knowing" medical other; as the expert on their body (Pines, 2010; Spira & Berger, 1999); and/or to search for symptom relief (Wilk and Kirk, 1995; Bemesderfer, 1996b). The medical response to menopause as merely a physiological problem "to be fixed" privileges the physical experiences of menopause over psychological experiences and illustrates the mind-body tensions that appear to underlie a women's menopause transition. It was often dreams or symbolic

material brought by the client into therapy that penetrated the silence of menopause, bringing for the client and/or therapist a conscious connection to changes in a woman's physical body and her feelings associated with this change.

Although not overtly evident, culture and mind/body dualism, play an underlying part in all other themes.

Theme Two: Loss and Fear of Loss

The theme of loss, and fear of loss, comprises three subthemes and eight descriptors and represents an analysis of women's experiences of menopause as conveyed or felt in psychotherapy. The thematic map (Figure 6) illustrates the key subthemes of "loss of fertility", "loss of youth" and "loss of feminine power" to which the theme "loss, and fear of loss" was determined. Discussions of loss relate to the physical and emotional changes women negotiate at the menopause and the meanings they attach to them. The theme of loss is underpinned by existential issues and feelings of impotency and further reflects the influence of society, culture and mind-body tensions faced by women transitioning through this stage of life.
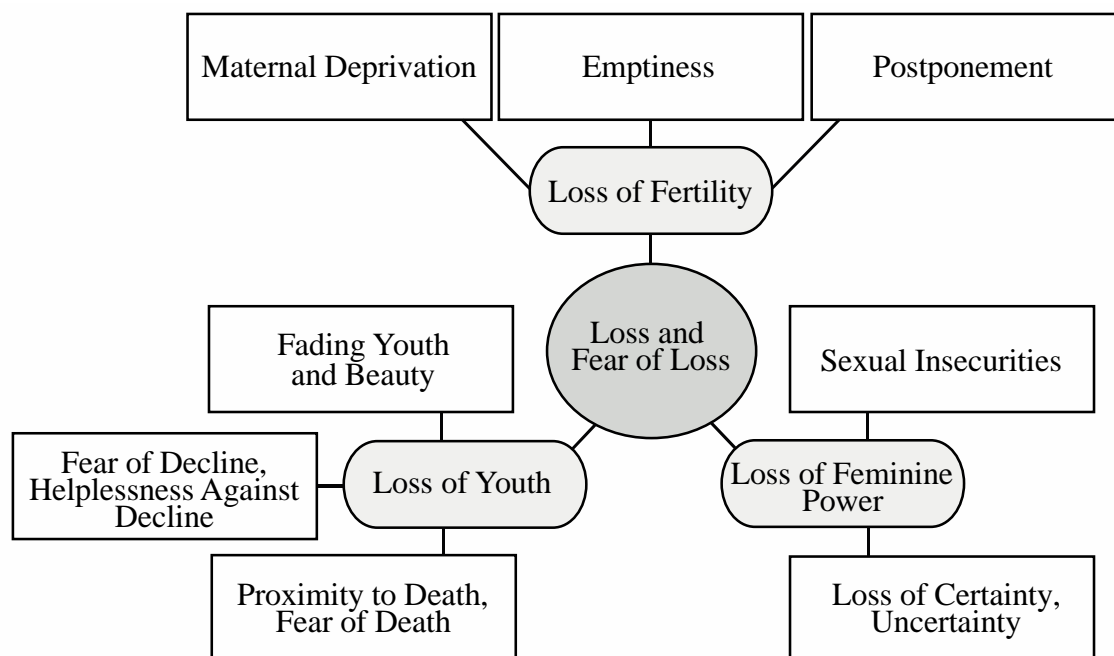

Figure 6. Thematic network for "Loss and Fear of Loss"

Loss of fertility

The subtheme, loss of fertility, captures experiences in which female clients either overtly acknowledge the end of their childbearing years or latently communicate through dreams or preoccupations with pregnancy their struggle to come to terms with

an incapacity to procreate. The descriptors of this subtheme are; (1) maternal deprivation; (2) emptiness; and (3) postponement.

The first descriptor; "maternal deprivation" concerned experiences of women, who upon becoming aware of their menopausal status, experienced an awakening of unconscious childbearing desires. Often the longing for a baby emerged through dreams that were shared in the therapy. A state of anxiousness was apparent as both women with children and those without (Pines, 2010; Zachary, 2002) realised their longings to bear children were accompanied by the diminishing freedom to choose (Pines, 2010).

With or without this longing, the descriptor of "emptiness" represents experiences of meaninglessness, aloneness, loneliness, lacking in direction or purpose, being devoid of feelings and being apprehensive about how to fill the physical and psychic void that are felt to accompany the end of reproduction. In this sense menopause was associated with anxieties and the fear of "being rendered unproductive" (Bemesderfer, 1996b, p. 366).

For some women, these feelings were unbearable. The third descriptor "postponement", refers to descriptions of women who actively defended against their internal reality with attempts to postpone the end of reproductivity. Some became obsessed with becoming pregnant as a conscious attempt to delay reality (Kogan, 2010; Pines, 2010). For example, a therapist reported that her client: "expressed doubts about whether this baby would ever be able to fill the 'void' that she felt in her soul, but [was] 'a concrete solution…[that] just postpones dealing with aging and death'"(Kogan, 2010, p. 91). Failed attempts at conception or miscarriages were thought to evoke feelings of resentment for childless menopausal women (Zachary, 2002; Pines, 2010) and posed further grieving difficulties for "all" women as they faced diminishing pregnancy probabilities. The attempt to postpone infertility also served to maintain the illusion of youthfulness, in this way serving as an avoidance of mourning the pain and growth of change.

Loss of youth

For many women described in this study, the loss of fertility signaled a "loss of youth". In this way, menopause was seen as a demarcation between youth and old age. This subtheme derives from three descriptors; (1) fading youth and beauty; (2) fear of decline and helplessness against aging; and (3) proximity to death and fear of death.

The first descriptor, "fading youthfulness and beauty" refers to a range of experiences incurred as women in menopause observed their disappearing youthful reflection and relinquished their place within youth culture. Women found it difficult to reconcile how they felt with how they looked. Pines (2010), describes this as a "discrepancy between the subjective youthful body image and the objective older image" (p. 128).

Concerns with fading youth had strong associations with the descriptor "negative cultural constructions". With the loss of the culturally valued characteristics of youth and beauty, women experienced an associated deprivation of affirming reflections (Spira & Berger, 1999). They often felt, or feared becoming, invisible or even worse; devalued. For woman whose sense of self-worth was based on their youth, body image or feminine attractiveness (Pines, 2010), an identification with the social perceptions resulted in a devaluation of self and/or the activation of defences to refute the loss of youth, and accompanying fears and feelings (Holmes, 2008; Wilk & Kirk, 1995).

The loss of a youthful appearance was not the only concern. In the second descriptor "fear of decline and helplessness against aging", women feared that menopause marked the beginning of physical and mental deterioration (Bemesderfer, 1996b; Holmes, 2008; Kogan, 2010; Pines, 2010; Spira & Berger, 1999; Wilk & Kirk, 1995; Zachary, 2002). Increased limitations, as opposed to the physical freedoms of youth, were feared. A sense of helplessness to prevent any forthcoming decline prevailed and women dreaded a future of passivity, deficiency and dependency. These fears indicate a belief about menopause and life thereafter that is further explained in the following descriptor.

It appears from the descriptions that contributed to the third descriptor, "proximity to death and fear of death", that until this point in a women's life, menopause had been internalised as a distant and abstract physical and psychological phenomenon, felt at some semi-conscious level to be the precipice between living life and dying. Upon arrival at this stage of life, women now consciously experienced menopause as foreshadowing death and were faced with relinquishing the omnipotent fantasies of immortality that accompanied youth (Kogan, 2010; Wilk & Kirk, 1995). Meanings and fears associated with death and dying surfaced (Holmes, 2008; Kogan, 2010) manifesting for some in an unbearable existential death anxiety.

The findings of this subtheme are summarised in the following vignette:

R: I can't be menopausal—I can't. I am not ready. I don't want to be old!
T. What is old like—what does it mean to you?
R. Fat, ugly, mean, bitter—the end—not wanted by anyone, not able to do anything. (Spira and Berger, 1999, p. 264)

The anxiety evident in this extract is further explored in the following subtheme.

Loss of feminine power

The subtheme, loss of power, reflects the menopausal women who experienced anxiety from a perceived or real loss of the ability or capacity to act or perform effectively. Descriptors in this subtheme include; (1) sexual insecurities; and (2) loss of certainty and uncertainty.

The first descriptor "sexual insecurities" captures experiences of those women who felt insignificant and desexualised as a result of changes at menopause. This descriptor further reinforces how the internalisation and identification with cultural influences shapes a woman's experience of menopause. Findings suggested that the perceived loss of attractiveness and desirability, along with changes in libido contributed to the loss of women's sexual confidence. Sexual insecurities also stemmed from male reaction to the menopause. In some incidences male partners struggled with their spouse's natural aging process, fleeing the relationship in search of younger reproductive women to maintain their own sense of youthful potency (Pines, 2010).

For some women fearing the loss of herself as sexually attractive is more significant than the loss of her childbearing capacity (Wilk & Kirk, 1995). Anxieties and fears associated with a sense of sexual inadequacy often generated an envy of youthful, sexual, reproductive women who confronted the menopausal women with what she wants but can no longer have or be.

The second descriptor of "loss of certainty and uncertainty" concerned accounts of women's fears, anxieties and vulnerabilities associated with containing overwhelming emotions and physical symptoms. This descriptor captured experiences where internal change instigated a loss of the known self and faced menopausal women with unpredictable feelings and challenges, summoning her to reorganise her self-view as she moved into an unknown future (Pines, 2010). Writers described clients who experienced feelings that were not congruent with their previously known or portrayed sense of self (Zachary, 2002) and those who feared knowing: "But I'm afraid of what I will find if I give myself time to look inside" (Holmes, 2008, p. 53).

A sense of uncertainty was often accompanied by feeling, or fears of, not being in control. Sometimes this was experienced consciously, for example by knowingly

having behaved in ways disproportionate or inappropriate to a circumstance (Spira & Berger, 1999), experiencing life as frantic and fragmented (Holmes, 2008), or in attempts to manage unpredictable physical symptoms associated with a body in hormonal turmoil (Bemesderfer, 1996b; Holmes, 2008). At other times, issues of self-control were more passively presented, for example, through continued indecisiveness (Zachary, 2002) or via dreams. The following dream, amongst other things, indicates the client's sense of being out of control and entering into unknown and unfamiliar territory.

> A recurring dream theme during this period involved Agnes being a passenger in a vehicle that loses it brakes and runs about of control. In a typical version of that dream, she is on a tour bus travelling through an exotic country she has never seen before. The driver abandons the bus and it begins to career down the road (Bemesderfer, 1996b, p. 362).

An underlying pattern of anxiety has threaded its way through this theme as women's expressions of their menopause experiences were voiced.

Of striking contrast to experiences of menopausal clients described in this literature, the loss of certainty and uncertainty for menopausal therapists almost unanimously focused on encountering unpredictable and uncontrollable physical symptoms in the practice of psychotherapy as discussed more fully in the next theme.

Theme Three: Challenges of Relational Interplay

The theme of challenges of relational interplay comprises two subthemes and six descriptors and represents an exploration of the therapeutic relationship within the wider discussion on menopause in psychotherapy. The thematic map (Figure 7) illustrates the subthemes "disruptions to practice" and "intersubjectivity" from which this theme was abstracted. Through the vehicle of transference and countertransference "challenges of relational interplay" conveys some of the interpsychic fears and conflicts of women in menopause. It explores the clinical challenges faced by menopausal therapists and the relationship dynamics that evolved in the therapy as issues related to menopause were addressed. This theme is shaped by parallel processes and mutually unresolved conflicts.
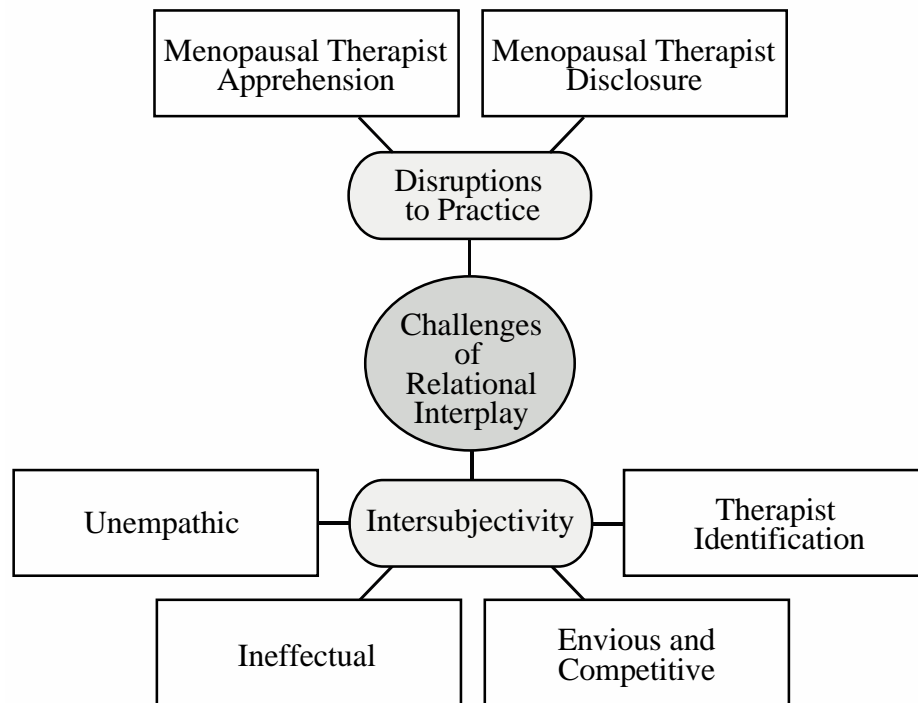
Figure 7. Thematic network for "Challenges of Relational Interplay"

Disruptions to practice

This subtheme evolved from the writings of menopausal therapists who shared thoughts and feelings of how their own physical menopausal symptoms impacted on their sense of self and their therapeutic practice. Experiences were grouped into two descriptors; (1) menopausal therapist apprehension; and (2) menopausal therapist disclosure.

The descriptor of "menopausal therapist apprehension" refers to experiences where therapists felt self-conscious coping with unpredictable hot flushes in the therapeutic setting. There was discomfort at clients unexpectedly knowing something private about them. Frost (2006) wrote of her experience: "Suddenly, my body was showing my clients very personal things about me." (para 4). She felt uncertain about how her physical menopausal symptoms were experienced and interpreted by clients, commenting: "I imagine my glowing, red face says 'Look! I'm menopausal! Or does it?" (para 4). Other therapists having similar experiences expressed a range of responses including a loss of confidence, depression and anxiety or fears that their career was at risk (Frost, 2006). Some experienced a loss of certainty for the practitioner they had known themselves to be and felt conflicted by their predicament. They felt the quality of their practice was tested by these unpredictable intrusions (Bridges, 2011; Frost, 2006). During intense physical sensations, therapists often felt challenged to remain emotionally present to their client (Bridges, 2011; Frost, 2006).

Therapists reportedly searched for ways to manage their physical symptoms in order to reduce anxieties and maintain their desired standard of practice. They particularly wished to minimise the potential imposition of these hot flush experiences on the client (Frost, 2006).

Concerns for the client and the therapy are evident in the descriptor, "therapist disclosure". This descriptor refers to the therapist's dilemma of whether or not to acknowledge their hot flushes with the client in the therapy. This issue was considered a theoretical concern, related to matters of transference and therapeutic holding. For example, Frost (2006) was worried that in disclosing her menopausal status the client might not experience her as "strong or available enough to hold them [the client] and their problems" (para. 9).

In deciding to disclose, Frost (2006) discovered that all client responses to her menopausal status were "grist to the mill" (para. 11) of the therapy, which, helped her to gain further insight into her clients. She reported that: "In spite of my reservations, I have found that disclosure can be a way of role modelling congruency. It can also offer clients the opportunity to separate out what belongs to them and what belongs to the therapist" (para.11). Not all therapists she spoke with, agreed with or used this approach, some preferring instead to say nothing or to manage their disclosure on a case by case basis.

This subtheme described the mind-body tensions of menopausal therapists and indicates the sense of impotency sometimes felt by women therapists in the flux of change. The following descriptor captures further experiences of the challenges of relational interplay that exists when menopause is presents in the therapy.

Intersubjectivity

The four following descriptors; (1) unempathic; (2) ineffectual; (3) envious and competitive; and (4) therapist identification support the notion that the topic of menopause has a particular impact on the interplay of the therapeutic relationship.

The first descriptor concerned experiences and descriptions of transference and countertransference explored by therapists who frequently struggled with getting it right for their menopausal client/s. These therapists felt at times in the therapy that they were perceived by the client to be unempathic, mis-attuned, unsupportive, neglectful or aggressive, often reflecting the client's past and unresolved issues with their own menopausal mother (Holmes, 2008; Kogan, 2010). In the following example the client experiences the therapist as unsupportive and as a threat to her fertility and childbearing

fantasies: "If this baby is going to be born, it will happen in spite of you and not because of you. I feel that to give up trying to become pregnant is to give up life; for you it is probably a beginning, for me it's the end" (Kogan, 2010, p. 89). In this example it is as if the therapist has become symbolic of menopause, which itself is perceived as a threat to life.

The second descriptor "ineffectual" describes therapist's experiences of feeling flawed and inadequate when clients projected their own insufficiencies, fears and anxieties: "These hysterical spells allowed Bess to show me how it felt to be her mother's victim. In the transference, I felt obliterated, wiped out, defective, and useless when she surrendered to despair" (Holmes, 2008, p. 67). The mother/daughter issues mentioned here link with the "intergenerational relationships" subtheme that will be explored in more detail in the following theme.

Therapists experienced further feelings of incompetence as clients associated them with "medical practitioners" who had failed to ease their suffering by affirming or reinstating their youthful reproductive capacity. The following extract illustrates:

> During this period, Dina first cast me in the role of the ineffective gynaecologist who had performed an unsuccessful "plumbing job." Like him, I was obviously impotent, since I could not impregnate her through analysis and thus fulfil her wishes. (Kogan, 2010, p. 88)

Several therapists (Holmes, 2008; Kogan, 2010; Pines, 2010; Zachary, 2002) reported a shared sense of impotency and pain with the client "in the face of irreversible physiological reality" (Pines, 2010, p. 137).

Other shared feelings were "envy and competition"; this third descriptor describes instances where both client and therapist compare themselves to each other around issues such as youth, fertility and success. Representing all these things, one young therapist commented: "I felt that there was envy of the position of the younger woman, with a firm putting me in my place as the inexperienced one with a lot to learn" (Zachary, 2002, p. 31). For the childless menopausal client, the therapist became the target of envious attacks as, in the transference, she was perceived to be the fertile reproductive women the client longed to be (Pines, 2010). Issues of envy and competitiveness were evident for one therapist who "found herself experiencing competitive feelings toward the client, specifically including the wish to handle her own menopause better than the client was handling hers" (Bemesderfer, 1996a, p. 637).

The fourth descriptor, concerns the menopausal "therapist's identification" with the menopausal client. Descriptions included therapist's reflections on how

unconscious associations to their own menopause impacted on their feelings and work with menopausal clients (Bemesderfer, 1996a, 1996b; Kogan, 2010; Spira & Berger, 1999). They often overlooked signs or client references to menopause. This omission was understood by some, as an unconscious denial of the psychological responses they had to their own menopause (Kogan, 2010). Therapists' feelings of anger in response to a client's non-acceptance of their aging process were understood by Spira and Berger (1999) as a possible unconscious defence against identification with the client's resistance. Kogan (2010) reflected on her unconscious fears which almost had her colluding with the client's manic defence to conceive in order to stave off aging and death.

Therapists who became conscious of their identifications and reflected on their own menopausal experience reported an increasing ability to respond empathically and work more effectively with their menopausal client (Bemesderfer, 1996a, 1996b; Spira & Berger, 1999). In this way the process allowed for a mutually reparative experience.

Theme Four: Disentangling of Tensions

This theme comprises two subthemes and four descriptors and represents the key foci important to menopause that were processed in the therapy. The thematic map (Figure 8) illustrates succinctly the key subthemes of "relinquishment" and "intergenerational relationships" to which "disentangling of tensions" was anchored. As the loss of reproductivity and youth came into consciousness, losses and fears were mourned, conflicting internal objects and current object relations were understood, incapacitating feelings worked through, and defences relinquished giving most clients described in this literature set a pathway to growth and maturity.
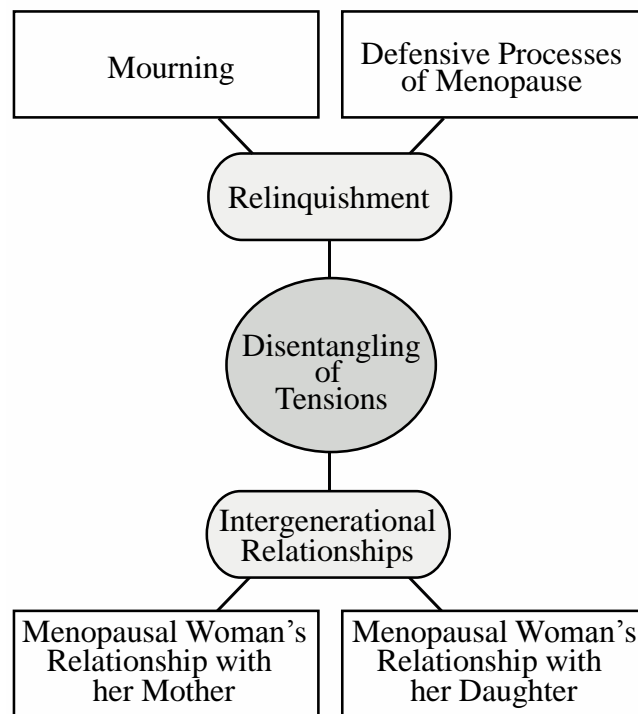
Figure 8. Thematic network for "Disentangling of Tensions"

Relinquishment

This subtheme refers to the process of working through what was, what was not and what will never be. The first descriptor of this subtheme: (1) mourning, captures the range of losses evoked at menopause which were processed and grieved for in therapy. The second descriptor gives examples of; (2) defensive processes of menopause to be worked through and surrendered.

Dreams of pregnancy and/or miscarriage/death of a baby were prevalent in the experiences of women as they mourned the loss of reproductive functioning as the end of a significant life phase. Menopause signified the loss of identity and belonging to a developmental stage that was known and familiar. For some clients described in the literature, the therapy process involved: coming to terms with their reality, processing difficult feelings, relinquishing longings for a last baby, increasing the ability to self soothe and recognising that their emotional mothering and motherliness continues and is unaffected by physical change (Pines, 2010).

Pines (2010) writes about the childless women whose need to relinquish hope for a child and mourn an unfulfilled potential can create a painful sense of loss and an anxiety of how to fill the emptiness that is particular to their situation. For example, coming to terms with and mourning the lost dream of having children to accompany them in life enabled one client "to feel that she was still a woman despite her

childlessness" (p. 137), in this way claiming herself beyond cultural expectations that link femininity with reproduction.

The loss of childbearing capacity results for some women in mourning or re-visiting and grieving unborn babies:

> Also at this time, a foetus that was aborted from the mother's body- though not from her mind - in her youth may be brought to life as the child who was never born, whom the mother must now mourn deeply, since she can no longer have children (Pines, 2010, p. 128).

Past traumas (Bemesderfer, 1996b; Pines, 2010), identity issues (Pines, 2010) and other significant losses including relationships and the death of parents were also called to mind at this time of change and constituted the mourning experiences captured in this subtheme

The second descriptor of this subtheme is "defensive processes of menopause". The range of defences relating to menopause and the psychotherapeutic journey were varied and included; regression, dissociation, idealisation, repression, reaction formation, displacement and humour. Also prominent in the findings and indicated in some other themes were the defences of projection, projective identification, identification, denial, and manic defense. Projection was used unconsciously by patients' to lessen tension by limiting the patient or therapist's affective experience of issues related to menopause (Holmes, 2008; Zachary, 2002). Projective identification was clearly illustrated in the case material presented by Holmes (2008) and Kogan, (2010) who described patients using this defence when working through relationships particularly those involving mother and daughter issues. The defence of 'identification' concerned experiences where menopausal women were identifying with their adolescent children (Pines, 2010; Zachary, 2002), a dead parent (Holmes, 2008), the internalized object representation of mother (Bemesderfer, 1996b; Spira & Berger, 1999; Wilk & Kirk, 1995; Zachary, 2002; Holmes, 2008; Pines, 2010) or other menopausal women (Kogan, 2010; Spira & Berger, 1999). The defence of denial was evident when women in the menopausal transition denied their inner reality as a defence against the loss, vulnerability and challenge of aging (Wilk & Kirk, 1995). The use of 'manic defence' was noted by therapists who felt it served to avoid the pain inherent in growth and its accompanying loss. Manic behaviours facilitated avoidance of knowing oneself, aging, death, sexual problems, feeling the emptiness and loss of youthfulness and reproductivity (Kogan, 2010).

It was evident that defences were not always clearly defined. They were often interlinked, for example; in identifying with her mother a client may project aggression toward another (Spira & Berger, 1999), or in denial of aging, a woman may act out a manic defence by dieting and exercising to achieve the waif-like look of youth (Wilk & Kirk, 1995). In focusing on the defence strategies within each case study, it became evident that the experiences at menopause and defences employed are unique to each woman's past and current life circumstances. In this study defences related to fears of loss and aging or to mother/daughter relationships.

However, not all defences were worked through or relinquished. Some authors wrote about the positive defence of sublimation as being the desired outcome of working through the menopause transition (Kogan, 2010; Pines, 2010, Spira & Berger, 1999). This is further elaborated on in the final theme "renewed sense of self".

Intergenerational relationships

The "intergenerational relationships" subtheme concerned descriptors of; the (1) menopausal woman's relationship with her mother; and the (2) menopausal woman's relationship with her daughter. Inherent in these descriptors is the client's relationship with her own menopausal self.

Firstly, case illustrations indicated that clients who, as adolescents had difficult relationships with their own, then, menopausal mothers, had a negative construction of menopause and therefore themselves later as a menopausal woman. In disentangling the tensions and processing the meanings of menopause in relation to mother/daughter relationships, therapy involved creating an awareness in the client of their mother's experience of menopause. In line with the theme of silence, typically clients could not recall their mother's menopause ever being discussed (Spira & Berger, 1999; Wilk & Kirk, 1995).

It was through material brought into therapy, that the client and/or therapist became conscious that the mothers appeared to experience difficulties accepting their life stage at a time when their adolescent daughters (the clients) were becoming young women. These now menopausal woman recalled feeling unimportant, easily abandoned (Spira & Berger, 1999), uncelebrated (Holmes, 2008) and not affirmed for their femininity: "I wanted my mom to like who I was and what I was becoming" (Spira & Berger, 1999, p. 268). Some clients did not feel "good enough" growing up feeling unable to ever please their mother (Spira & Berger, 1999). Others believed that to be accepted they needed to be useful (Kogan, 2012). These clients described their mothers

either as depressed, withdrawn (Holmes, 2008; Wilk & Kirk, 1995), unavailable, disinterested (Bemesderfer, 1996b; Kogan, 2010: Wilk & Kirk, 1995) or unpredictable, exhibiting self-critical or abusive storms of rage for which the daughter felt somehow responsible (Spira & Berger, 1999).

In one example, Spira and Berger (1999) posited that the mother of an adolescent might suffer from envy associated with a loss in narcissistic supplies. The adolescent, "no longer filling mother's self-object needs, experienced her mother's "self-berating" periods as frightening. She could not influence or avoid them. She was no longer mother's pleasure." Mother's fear of her age related shifts "resulted in a regressive reaction, expending desexualized energy in storms of hostility toward her blossoming daughter" (p. 266).

It seemed that the clients' expectations and beliefs about menopause were shaped by their adolescent experience. Some fully expected to replicate their mother's experience: "Betty said menopause meant 'getting old and unattractive and senile' (Wilk and Kirk, 1995, p. 239); "[Rose] believed menopause meant withdrawal, decline, and death" (Wilk & Kirk, 1995, p. 239); "Raini imagined that menopause meant erratic and rageful behavior" (Spira & Berger, 1999, p. 265).

The clients were encouraged to rework beliefs and separate out their mothers' issues from their own: "You mean it might have been her own physical stuff? Not me, I grew up thinking I wasn't good enough, pretty enough, popular enough!" (Spira & Berger, 1999, p. 264). The process of separation involved exploring the clients' similarities to and differences from their mothers (Holmes, 2008). This enabled them to expand their perspectives, see their mothers more objectively (Bemesderfer, 1996b) and become more empathic towards their mothers' experience:

> The long and painful working through of Dina's relationship with her mother eventually led to a greater understanding of her mother's plight and to forgiveness, her hate for her mother mitigated to a certain extent by her love for her (Kogan, 2010, p. 91).

The literature also described explorations of separation difficulties experienced by either the mother of the adolescent or the adolescent herself (Pines, 2010; Bemesderfer, 1996b); the separation of the internalised mother from the real, actual mother (Bemesderfer, 1996b); and separating out from the internalised mother: "Bess often regressed to identification with the toxic introject and self-attacked, assaulting "the old lady in the mirror" [her mother]. Part of the work [involved] extricating the maternal imago from her psyche" (Holmes, 2008, p. 68).

The therapy was characterised by first developing an awareness of, then relinquishing life patterns and defensive behaviours related to the clients' early relationship with their mothers. As the separation from the maternal introject took place in the therapy so too did the working through of negative transference.

Secondly, the literature relating to "menopausal women and their relationship with their daughters", described the issues discussed above as well as challenges with rivalry, self-control and the acting out of the maternal imago.

The issue of rivalry pertained to experiences in which clients struggled to remain youthful as their daughters were blossoming into womanhood: "Betty's attempt to "stay young" found her in an unconscious competition with her daughter" (Wilk & Kirk, 1995, p. 238). The loss of reproductive capacity and youthfulness appears to create in some menopausal women a sense of being surpassed or pushed out, by their fertile and increasingly independent daughters.

Menopausal women were fearful of replicating their own mothers' menopausal behaviours, for example, losing control and having their behaviour impact negatively on their daughters (Spira & Berger, 1999): "At her daughter's recent graduation, Betty said, 'I spoiled my daughter's graduation. I behaved just like my mother and it scared me'" (Wilk & Kirk, 1995, p. 239).

Menopausal women in therapy showed an increased capacity to separate out from their daughters and/or have an increasing understanding and tolerance of their daughters needs for autonomy (Spira & Berger, 1999; Bemesderfer, 1996b). Some menopausal clients became more accepting of their own life stage and exhibited an increased ability to both acknowledge their envy of, and take pleasure in, their daughter's growth. One therapist recounts:

> She [the menopausal client] recalls the wicked queen's envy of Snow White for being young and beautiful. She dislikes the picture of herself as an envious older woman and realizes that she is pleased by her daughter's vibrant youthfulness as well as envious of it (Bemesderfer, 1996b, p. 365).

Theme Five: Renewed Sense of self

The final theme "renewed sense of self" is defined by three subthemes: "acceptance", "freedom" and" self-determination", which were thought to support a woman in reframing her self-concept and valuing herself beyond being a youthful, reproductive woman. Findings indicated that through the psychotherapeutic process most women integrated previously unprocessed hurts and current realities associated with the menopause. With the end of pain and mourning, they were able to develop an

acceptance of self and life, enabling them to recognise the freedoms associated with menopause and to develop an increased ability to self-determine.
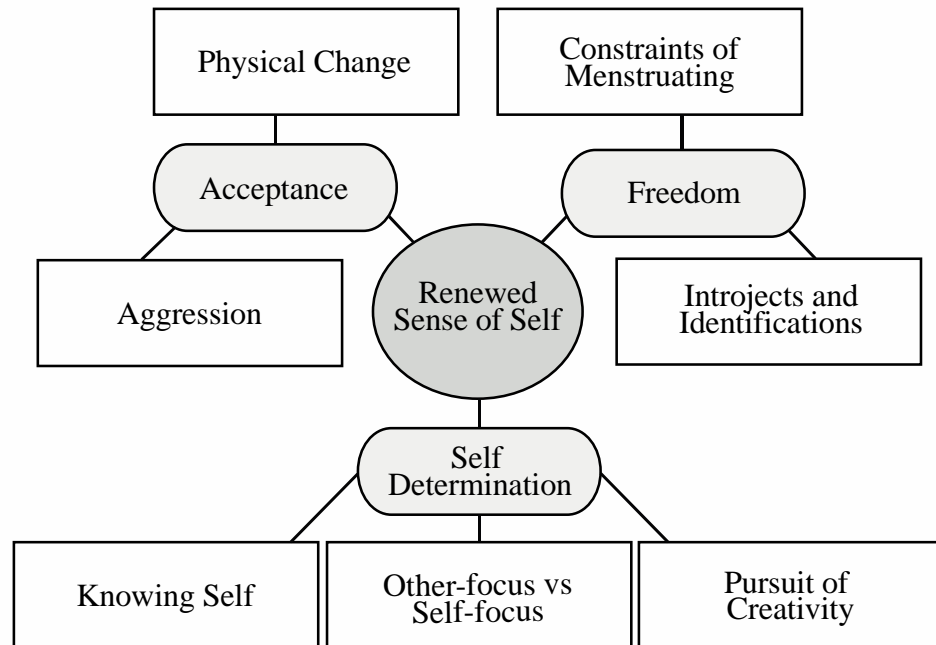

Figure 9. Thematic network for "Renewed Sense of Self"

Acceptance

The subtheme of acceptance was defined by two descriptors; (1) physical change; and (2) aggression. The first descriptor illustrated those clients who came to accept the physical changes of menopause and expand their focus beyond the body: "As she internalized self-esteem, she became freer to accept her physical changes and mobilized her aspirations to find her way through this life stage" (Spira & Berger, 1999, p. 265). For some clients, acceptance involved becoming comfortable with the aggressive feelings they had previously defended against (Holmes, 2008). These women discarded some previously accepted cultural messages of femininity and developed equanimity with their renewed self. Holmes (2008) described this as expelling "the phallic paternal introject into the world, simultaneously identifying with his power and separating herself from his oppression" (p. 121).

Freedom

This subtheme depicts experiences that are about freedom from, rather than freedom to. It includes two descriptors; (1) constraints of menstruating; and (2) introjects and identifications. Pines (2010) commented that: "for many women who have not enjoyed their sexuality, childbirth or childrearing, the menopause may be a

relief" (p. 128). The first descriptor captured accounts of clients who felt "freedom" from the cycle of monthly periods (Spira & Berger, 1999). Others felt sexually freer, with no possibility of pregnancy (Pines, 2010).

The second descriptor "introjects and identifications", described how the freedom from parental relationships and growing children can help menopausal women gain autonomy, allowing more space for them to be themselves. A few articles mentioned the process of separating from the internalised paternal representation (Bemesderder, 1996b; Holmes, 2008). Others elaborated on issues of identification with and separation from maturing children, particularly daughters (Holmes, 2008; Spira & Berger, 1999). However, the major emphasis in these case studies was the client being freed from internal representations of mother.

Self-determination

This subtheme captured the experiences of both clients and therapists who had made meaning of their menopausal experiences and were open to 'self-determination'. The descriptors of this subtheme are: (1) knowing self, (2) other-focus versus self-focus and (3) pursuit of creativity. For the descriptor 'knowing self' therapists' comments included an increased capacity of clients to "'give birth' to some good parts of her own self" (Kogan, 2010, p. 91); to value herself and "explore the power of her own intelligence" (Spira & Berger, 1999, p. 265): to feel optimistic about the future and to feel "renewed strength" (Pines, 2010, p. 134). A therapist reflected on her own menopause transition and commented on feeling: "as if a deepening had taken place, a sinking into who I really was" (Brayne, 2011, para. 26). For another therapist, reflecting on her menopausal status "encompassed a comprehension of herself as a woman, not only with her own psychodynamic issues, but also as part of the current cultural and medical context" (Spira & Berger, 1999, p. 268).

The literature suggests that a woman's attention at this time of her life progressively shifts from 'other' back to the self. Examples in the descriptor, 'self-focus versus other-focus', described how some menopausal women came to enjoy time alone (Zachary, 2002) and the space to take care of their own needs and/or interests (Holmes, 2008; Pines, 2010). A growing sense of self resulted in freedom from the need to be defined by others and gave some clients the courage to take up new pursuits or reignite old interests (Bemesderfer, 1996b; Holmes, 2008; Pines, 2010; Spira & Berger, 1999; Zachary, 2002).

"Pursuit of creativity", the third descriptor of this subtheme, refers to renewed productivity: in the work place (Bemesderfer, 1996b), in family roles i.e. grandmothering (Pines, 2010; Zachary, 2002), and in recreational endeavours (Bemesderfer, 1996b; Holmes, 2008; Pines, 2010; Spira and Berger, 1999; Zachary, 2002). The creativity resulting from an increased internal locus of control is illustrated by the following client comment:

> I am thinking of going back to school and taking a few art courses. I used to enjoy drawing and sitting outside to sketch. I was too embarrassed to do it when I was young—like everyone would look at me. Maybe now I am old enough to look at what I am doing, rather than worry about what people are seeing or thinking! (Spira & Berger, 1999, p. 266)

Therapists in this study considered the pursuit of creativity a successful outcome of the menopause transition. Bemesderfer (1996b) considered the therapeutic focus for her client was to work through feelings of loss and liberate intellectual creativity from the anxieties of menopause. Similarly, Pines (2010) considered that the gradual appearance of new possibilities eventuated as the client's mourning subsided. Spira and Berger (1999) described this as a shift from sexual to other subliminatory creative channels; a transformational process Kogan (2010) states; "is an affirmation of life" (p. 93). In this way, menopause is a positive developmental opportunity where a woman can rework female identifications, redefine herself and rediscover her creative capacities in new ways.

Core Theme

The consecutive reduction of themes produced the conceptual core theme of impotency/potency, which describes the menopausal woman's initial sense of impotency, as she enters the menopause transition, to one of potency as she processes and come to terms with this significant phase of development and redefines herself beyond being a young reproductive woman.

The Merriam-Webster's Collegiate Dictionary (2001) defined "potency" as the "quality or state of being potent", as well as "the ability or capacity to achieve or bring about particular results" (p. 909). There are few psychotherapeutic studies that discuss female impotency and/or potency; most of the literature discusses these concepts in relation to masculinity and male erectile function. Van Buren (1996) pursued the idea that female potency has been feared over centuries, and that gender constructions have hindered the realisation of women's potency impeding the development of female subjectivity. Blasdel (2003) explored the concept of female potency, defining it as the

influence a woman accrues from her sexual and reproductive capacities (p. 34). Relating this understanding to the study findings; a woman's inability to conceive and the concomitant reduction or absence of power evident at the menopause creates changes that for some women, threatens their sense of self, creating a physical and psychic impotency. These losses are experienced in a variety of ways, for example; feeling sexually inhibited, unattractive, ineffective, powerless, uninteresting, shameful, and/or unattractive; a loss of self as an object of sexual desire; exposed as having nothing to offer. The findings suggest that working through and making sense of these feelings of impotence creates the opportunity for sublimation, further growth and the development of female potency in the absence of the influence accrued from fertility. By taking on the power of the paternal imago, a woman is able to recreate and develop a sense of agency, take charge of her own subjectivity, feel confident in her new sexual identity, act independently and shift from the internal creativity of childbearing to further creative expression in the external world.

For the purpose of analysis in this study, each thematic network has so far been regarded individually. When looking at the themes as a whole, their interrelatedness becomes evident and so does the core theme. Particular threads, such as; cultural influence, existential conflicts, dreams and mind-body tensions are seen to weave their way through all themes, signifying their relevance to the menopausal process, shaping the responses of both menopausal clients and therapists and their sense of potency.

Summary

The purpose of this chapter was to fully explore each of the thematic networks, expounding on the significance of each theme, illustrating it with the descriptors and supporting the interpretation where appropriate with extracts from the original texts. A description of the overarching core theme has been given, indicating its relevance to therapeutic process and outcomes. The next chapter contains a discussion of these findings in relation to the research question and to relevant literature.

Chapter Four: Discussion

Introduction

In this chapter I discuss my findings in relation to the original research question: *"From the perspective of the therapist, what happens when client, therapist and menopause meet?"* The following three sections summarise and discuss the themes that emerged from the study; (1) how menopause manifests in psychotherapy and what factors influence its presence; (2) matters most likely to be explored and worked through in therapy with women experiencing the transition of menopause; and (3) how menopause influences the therapeutic relationship. I compare and contrast the findings with the wider literature on menopause and discuss possible clinical implications. The limitations of this research and suggestions for further research are considered. Final thoughts conclude this dissertation.

1. How menopause manifests in psychotherapy and what factors influence its presence

The findings of this study indicate that the presentation of menopause in psychotherapy can be often indirect, hindered or unintentionally overt. This section discusses the significance of dreams at menopause and how bio-socio cultural discourses influence menopause in psychotherapy.

Dreams at menopause

Clients entering therapy seldom directly indicate their menopausal status. A significant finding was that menopause often presented itself in the therapy through more covert means such as dreams. Freud (1900/1958) referred to dreams as "the royal road to knowledge of the unconscious activities of the mind" (p. 608). The essence of dreams, reported in this study, varied as the client proceeded through the therapeutic process. Rossi (2009) described dreams as creative processes that engage the mind-body-brain in adaptive processes during periods of transition. Different types of dreams were found to be connected to the different themes that developed from this study. Dreams associated with the theme of "silence", signified hormonal changes in the body. In the theme of "loss and fear of loss", dreams involved longings for a last baby, a loss of control, or insecurities arising from a felt loss of sexual power. Within the theme of "disentangling of tensions", dreams often concerned pregnancy, miscarriage or the death of a baby as women mourned the loss of their reproductive capacity and unborn children. Finally dreams of development, expansion, or optimism were evident during

the theme of "renewed sense of self". These findings are consistent with Mankowitz's (1984), suggestion that as the unconscious comes to life in dreams, it reveals both representations of struggles and "hidden sources of healing" and this is particularly evident during life transitions such as menopause. Mendell (1988) concurs, noting that dreams of babies and pregnancy were found to occur more often during menopause than in other life phases. These findings reveal that dreams provide a portal or "road" for menopause to enter therapy, allowing exploration of feelings and conflicts associated with this developmental phase.

Therapist and client unawareness of, and inattention to, menopause in psychotherapy was captured in the theme of "silence" (described in Chapter Three). This is understood to stem from two dominant discourses: the anti-aging and the biomedical, both of which shape meanings, expectations and beliefs about menopause and menopausal women.

Anti-aging discourse

The finding that there is a general silence surrounding menopause and that women do not often bring this into therapy, is consistent with the findings of earlier studies which discuss women keeping their menopausal status hidden (Bowles, 1990; Engebretson & Wind Wardell, 1997; Kolod, 2009; Lax, 1982, 1997; Mackie, 1997; Mankowitz, 1984). Studies across a range of ethnic populations reveal differences in physiological, psychological and social attitudes towards and experiences of menopause, indicating that menopause is a socially and culturally constructed phenomenon (Chornesky, 1998; Im, Lee, Chee, Brown, & Dormire, 2010; Shore, 1999).

The silence surrounding menopause is thought to reflect the Western world's obsession with youth and beauty (A. Bernstein & Lenhart, 1993) resulting in a culture which historically shuns aging women and shows little recognition for menopause as a rite of passage (Mankowitz, 1984). The stigma associated with aging potentially denied women any positive self-expression (Herzig, 2006) or the ability to articulate their experiences of or ascribe meaning to this significant life change (Engebretson & Wind Wardell, 1997). As I reflected on this, I was struck by the parallel with Fanon's work on race and discrimination (as cited in Dalal, 2002). Fanon's theory discussed the subjugation of coloured people and their identification with white attitudes. Dalal wrote; "as the white subjugates the black externally, so the 'white; part of the native subjugates the 'black' part within" (p. 99). Similarly, as Western society subjugates aging menopausal women externally, so too, does that part of the woman that identifies

with societal norms, suppress the aging, menopausal woman within, attacking and devaluing the seemingly failed self.

Biomedical discourse

Michaud (2010) speculated that silence may, in part, be attributed to the "authoritative voice of the biomedical perspective" (p. 37) where attention is focused on the management of menopause as a deficiency disease. Implicit in the biomedical discourse is the need to control menopause by managing any symptoms or conditions related to hormonal changes. Michaud's views are shared by others (e.g. Stephens, 2001) and were evidenced in the findings of this study, where menopausal women feeling physically at odds with themselves, sought medical support to recover their "normal self" (Stephens, 2001, p. 657). Michaud is concerned that this automatic default to the medical profession in relation to the symptoms of menopause impacts on a woman's inherent knowing of her experience and her willingness to share or pass on these experiences. Wilk and Kirk (1995) are similarly concerned that therapists, by neglecting to explore fully the developmental intricacies of the menopause transition with either clients or colleagues, appear to have also internalised and accepted the cultural assumption that menopause is a medical problem thus inadvertently colluding with and contributing to this "silent realm" (Bridges, 2011, para. 2).

Mind-body tensions

Mind-body tensions were an underlying thread that wove through the findings of this study. Rothfield (1997) and Stephens (2001) focused on menopause from a corporeal perspective, pointing out evidence of mind/body dualism where hormonal activity is split into either an objective physical realm governed by biomedical science, or the psychological realm of women's subjective experience of menopause. Rothfield however, informed by Merleau-Ponty's (1968, as cited in Rothfield, 1997) philosophical phenomenology, proposed resisting the mind/body split by integrating psych and soma as "embodied subjectivity" (Rothfield, 1997, p. 33), i.e. living our bodies with both objectivity (that one has a body) and subjectivity (that one is a body). This reminds therapists to offer women the opportunity to enter the subjective field of the menopause experience "as one who is very much part of [this transition] rather than merely its object" (Rothfield, 1997, p. 48). Stephens (2001) posits the need to incorporate social life into the "lived body" experience, acknowledging that the self is understood in the context of social life. This integration of bodily (object/subject) and

social experience shifts the focus from the client/woman as injured, diseased or deficient to someone experiencing a challenging developmental transition.

The overt appearance of menopause in psychotherapy refers to findings related to therapists whose own menopausal transitions entered the therapy e.g. via hot flushes. A discussion about how these events evoked tension and challenged the therapists to clarify perspectives on congruency and self-disclosure will be further explored in the third section of this discussion.

Clinical implications

In order to provide an opportunity for menopause to enter therapy, and as therapists drawn on in this study have demonstrated (Bemesderfer, 1996b; Brayne, 2011; Bridges, 2011; Kogan, 2010; Spira & Berger, 1999), therapists need to examine their own attitudes towards menopause; re-evaluate their own internalised cultural assumptions around aging and femininity; promote menopause as a natural stage of female development; pay attention to client dreams; and generally support women to embrace, give voice to and explore the potential of their menopause experience. This will often be demonstrated through an attitude of openness, honesty and straightforwardness. Additionally, therapists who employ holistic ways of approaching this transition and women's experiences of it can support their clients to integrate an "embodied and culturally embedded experience of menopause" (Stephens, 2001, p. 651).

2. Matters most likely to be explored and worked through in therapy with women experiencing the transition of menopause

This section focuses on two major findings of this thematic analysis: firstly, the theme of loss and fear of loss; and secondly, the subtheme of intergenerational relationships.

Loss and fear of loss

…the image of the bereft, menopausal woman is with us still; she is either … [a] colourless dream-figure hovering at the periphery, hoping for a useful role, or she is flushed and neurotic, moody as an adolescent but without the freshness or the promise (Mankowitz, 1984, p. 103).

This quote depicts the menopausal woman as insignificant, ignored and conflicted. Despite a growing body of literature from feminist and sociological fields that challenge the prevalent biomedical view and the cultural stereotypes of menopausal women, Mankowitz, (1984) indicates, as do the findings of this study, that this image,

an outcome of the dominant discourses, continues to exist in the minds of many women, thereby creating dread and fear of this life stage.

The psychotherapy literature examined in this study described the physical, psychological and social changes, along with conflicts related to menopause in terms of loss, or fear of impending loss. The loss of youthfulness brought fear of aging and/or death. The loss of fertility brought a sense of emptiness, a lacking, and a diminished sense of self-determination, with fears of meaninglessness. The loss of power created sexual insecurities, uncertainty and fears of disconnection and isolation. This upheaval and disruption to physical and psychic equilibrium often manifested itself in defensive behaviours, anxieties or depressive feelings.

My analysis of the findings from the theme loss and fear of loss suggest that related issues can be addressed in therapy by considering the concepts of impotency, depression versus mourning, individual experience and existential concerns.

A sense of impotency

Concerns about loss of youth, fertility and power are expected to emerge in clinical encounters with women transitioning through menopause (Benedek, 1950; Huffman & Myers, 1999; Katz-Bearnot, 2010; Kolod, 2006, 2009; Lax, 1982; Mankowitz, 1984; Mendell, 1988; Patterson & Lynch, 1988). Psychoanalytic theory posits that transitions from one life stage to another, such as the menopause, involve change and disruptions to psychological and physiological balance which may involve regressive responses (Lax, 1982).

A women's body at the menopause undergoes changes that signify an ending rather than a beginning (compared to the other life stages of puberty and pregnancy). The loss of reproductive capacity is often experienced as a fading of beauty, function and usefulness, in short, aging (Mendell, 1988; Shore, 1999) and the foreshadowing of death. Deutsch (1925/1984) described the menopause as "[w]omen's last traumatic experience as a sexual being" (p. 56), and "a narcissistic mortification that is difficult to overcome" (Deutsch, 1945, as cited in Notman, 1990, p. 244). Other writers were more optimistic for women's future opportunities (Bemesderfer, 1996b; Benedek, 1950; Lax, 1982; Pines, 2010; Spira & Berger, 1999).

For many menopausal clients, and some menopausal therapists, described in this study, the change in physicality and associated loss of 'what was known' was difficult to bear. Menopause presented as an experience over which women had no control, leaving them with a sense of impotency. Studying the works of Deutsch, Benedek and

Lax, Harris (1990) found that self-esteem was a central issue for women at menopause. Lax (1982) highlighted how difficult it is for women to avoid feelings of shame and maintain a positive sense of self when under pressure to look good, be reproductive and prove themselves valuable (i.e. potent) members of society.

Depression versus mourning

In the findings of this study, some patients presented with depressive symptoms associated with the change, loss and grief of this transitional period. Deutsch (1925/1984) thought depression was an inevitable response to a narcissistic blow induced by "the remobilized castration complex" (p. 60). Benedek (1950) linked external issues and cultural values with psychophysiologic issues and thought that a depressive response depended on a woman's psychosexual history and personality. Lax (1982) asserted that there was an "expectable depressive climacteric reaction", "regarded as a phase-specific affect" (p. 165) indicating the necessity of mourning losses associated with the menopause.

However, the research indicates that therapists had difficulty in separating out depression at menopause from depression associated with other significant life events that can occur at this time e.g. decline or loss of parents, children leaving home, readjustment of the couple relationship (Bemesderfer, 1996a, 1996b; A. Bernstein & Lenhart, 1993; Notman, 1990; Pines, 2010). Bernstein and Lenhart (1993) warned of exaggerating menopause as a causal factor for the range of issues facing female clients at midlife. Bemesderfer (1996b) disputed depression as an outcome of menopause, asserting instead that it was common for most "perimenopausal women" to experience a "transient depressive mood" (p. 352). Others conclude that links between menopause and depression occur particularly for women with a history of issues associated with menstrual hormonal fluctuation (Pearson, 2010), affective disorders (Avis, 2003) or previously identified narcissistic vulnerabilities (Mendell, 1988).

Mourning is expected at every phase of the life cycle until the new phase opens up new possibilities (Mendell, 1988; Pines, 2010). Mourning at menopause involved understanding the symbolic meanings assigned to menopause and their origins as well as reflection on actual felt experiences of loss associated with hormonal change (Notman, 1990). Grieving loss is considered important for further adaptability and psychic maturity (Lax 1982; Mendell, 1988). In this context, regressions at the menopause are not considered pathological; experiences of loss are expected, as is mourning the loss. This study showed that the mourning that occurred and was

processed in therapy, focused on the loss of; reproductive capacity; unborn babies; loss of youth; fear of death; as well as grieving earlier unprocessed trauma or loss. Case illustrations suggested that therapy supported women to adjust to the concurrent body and identity changes experienced during this life stage.

Acknowledging the individual

Most therapists in this study posited that each woman's physiological and psychological experience is unique and stems from a range of internal and external influences (Bemesderfer, 1996b; Holmes, 2008; Kolod, 2009; Spira & Berger, 1999; Zachary; 2002). This notion is supported by the wider psychotherapeutic literature (Benedek, 1950; A. Bernstein & Lenhart, 1993; Derry, 2004; Formanek, 1990; Harris, 1990; Katz-Bearnot, 2010; Lax, 1997; Mendell, 1988; Neugarten, 1967; Walter, 2000)

Lax (1997) succinctly summarised many influences that can shape a woman's experience of menopause:

> The manner and extent to which a woman responds to the climacteric will depend on the severity of her physiological symptoms, the nature of past experience, her internalized object relations, her psychic structure, the strength of her libidinal investments, the width of her conflict-free ego sphere, the nature and strength of her ego interests, the extent of her healthy narcissism, the nature of her current object relations, and the nature of her familial and social setting (p. 157).

I argue that whilst not all women in psychotherapy will have conflicting menopausal experiences, an awareness of menopause and attention to individual responses will prevent any feelings or fears of loss associated with this life phase from being inadvertently diminished or overlooked. These findings remind us that, as with other developmental stages or presenting issues, the therapy is enhanced when menopausal women are encouraged, through their stories, to construct meaning of their menopausal transitions (Lippert, 1997).

An existential view

I also consider that in this context, a useful way to think about the theme of "loss and fear of loss" is in terms of Yalom's (1980) four existential concerns: death, meaning, isolation and freedom. Menopause has been perceived as the demarcation between youth and old age. Woman in the menopause transition no longer feel protected from death. The physiological changes of this life stage have women searching for a new sense of purpose or meaning beyond being attractive and/or reproductive. This change confronts the menopausal women with the finding of

freedom within her newly acquired limitations and to face in a "felt" way, as distinct from a "knowing" way, that she must take ultimate responsibility for the way she lives out her life. Implied in this interpretation is the need for therapists, and in particular menopausal therapists, to reflect on personal meaning and existential concerns. However, the specific mention of menopause as an existential journey had only the briefest of mentions in the literature of this study and similarly in the wider literature on menopause. Although referring to midlife rather than menopause specifically, Becker (2006) argues the benefits of incorporating an existential emphasis into therapy as a way of addressing the pain and avoidance associated with the "ultimate concerns" (Yalom, 1980, p. 8).

Intergenerational relationships

The exploration of mother/daughter relationships as a focus for therapy was a significant finding in this research. Most of the menopausal clients studied, described a revival of conflicted identifications and issues with their own mother; daughter; and maternal introjects, yet there is little written in the wider psychotherapy literature on this intergenerational relationship relative to the menopause.

The two aspects of the mother/daughter relationship that emerged from the findings were identification and separation. These will be explored in the following discussion.

Menopausal woman and her mother

Another factor that contributed to women's feelings of impotence at menopause was the inevitability of becoming "like" their mothers. Findings in this study indicated that identifications with mother were more complicated, if the earlier mother and daughter (client) relationship had been difficult and remained unresolved when the client entered the menopausal transition. These clients expressed negative constructions of menopause and of themselves as menopausal woman.

Wilk and Kirk, (1995) found that some women equate menopause with getting old and leap a number of years to identify with their now elderly mothers, activating a dread of frailty, illness and loss of control over their bodies and lives. Notman (2006) observed that some women recall their mother's experience of, and response to, her menopause and project this onto their own experience of this life stage.

Theoretical viewpoints

Harris (1990), drawing on self-psychology theory, proposes that a woman's self-object relationship determines her ability to cope with disruptions to her physical and psychical equilibrium throughout the menopause. In self-psychology, early relationships are fundamental in establishing self-esteem, self-soothing and idealising capacities. Mothers therefore, are instrumental to the development of a daughter's positive self-object functioning, and this mitigates any threat to self-image that changes associated with menopause can pose. Harris (1990), like Lax, (1997) indicated that the ability to mourn and work through self-image issues at the menopause supports a woman to adapt and create an identification with an idealised matriarchal role model to further her feminine self.

Holmes's (2008) psychoanalytical perspective considered that a woman's behaviour at menopause is reflective of a tendency at this phase to expel internalised objects from her psyche. She posits that during menopause, as in adolescence, there is an increase in libido and aggression which is either (1) turned against the self, resulting in a passive hopelessness, whereby the loss of fertility is thought to be experienced as a symbolic castration; or (2) directed away from the self, expelling the maternal introject with whom she formerly identified and partially expelling the paternal introject, casting off his oppression and identifying instead with his power thus inaugurating a new period of creativity and autonomy.

Traditional theories of infant development describe a linear model of separation wherein the infant emerges from a symbiotic fusion with mother to an intrapsychic separate sense of self (Mahler, Pine, & Bergman, 1975) so any continuing attachment to mother is considered a developmental arrest. In contrast, contemporary theories depict an infant moving in a nonlinear manner from an initial undifferentiated state to become a separate self with other (Stern, 2000). This identity development is thought to be "interactive and relational throughout the life cycle – leading not to separation but to autonomy with connectedness" (P. Bernstein, 2004, p. 601). As such, a woman's continued attachment to her mother is seen not as a regression or failure to separate but as an expected on-going reorganising process (P. Bernstein, 2004). Paula Bernstein (2004) posits that woman should be expected to revisit, re-examine and de-synthesize "representations of self-versus-mother and self-with-mother over her lifetime" (p. 601) particularly during developmental milestones such as the menopause (Mendell, 1988).

Reworking the relationship of the menopausal woman with her mother

The reworking of difficult mother/daughter relationships described in the literature of this study involved a range of foci including;

- the patient's experience as her mother's daughter;
- the influence of mother's menopausal experience on the client's understandings and beliefs;
- an unravelling of mother's issues from own;
- the identification of similarities and differences between themselves and their mother;
- the separating of the internalised mother from the real mother;
- separating out from the internalised mother;
- developing an awareness of life patterns and current defensive behaviours.

As the therapy progressed and these internal conflicts were worked through, clients gained a sense of their own and their mothers' individuality. At times a new found empathy for mother and for the self, followed. This finding is supported by Paula Bernstein (2004) who suggests that a focus on self-with-other, rather than on "separating" from the mother, supports those with conflicted mother relations to deepen their connections. Once all the representations of self and the internalised mother have been explored, a greater sense of autonomy with connectedness can be created resulting in greater objectivity and compassion. Paula Bernstein concludes that "the woman's endless struggles with her mother can be viewed as an avenue of exploration leading to an even richer understanding of herself, of her mother, and of her internal conflicts" (p. 623).

Menopausal woman and her daughter

When considering the menopausal client's relationship with her daughter the study results indicated challenges with rivalry, self-control and the acting out of the maternal imago. The impact of envy and hostility on the mother-daughter relationship is reported in the wider literature (Lax, 1997; Notman, 2006). A Western culture that values youth and beauty contributes to strains in mother-daughter relationships at menopause, yet other factors are also at play. Paula Bernstein (2004) describes the shared bodily experience of mothers and daughters. While delighting in her daughter's blossoming into adulthood, the menopausal mother can also experience envy and become competitive with her daughter's youthfulness and fertility. The menopausal

woman can see both her future in her older mother's body and her past in the body of her daughter. This process of dual identification during the menopausal changes can induce hopelessness, anger and rebellion: youth, fertility, beauty and desirability are departing; I am becoming an old crone (like my mother) and will be supplanted by my own daughter.

Reworking the relationship of the menopausal woman with her daughter

The wider literature acknowledges difficulties experienced by the menopausal woman with her daughter at this life stage (Hershberg, 2006; Notman, 2006). However, it was difficult to find any literature that described specifically how the psychotherapeutic process helps to resolve or diffuse these mother-daughter conflicts. The findings of this thematic analysis indicated that the therapeutic process reworked the menopausal woman's relationship with her daughter by exploring the representations of the menopausal self and the internalised mother. More specifically, issues of loss and separation were explored leading to an increased capacity for menopausal women to differentiate from their daughter/s'. This allowed them to become more accepting of their own life stage and increased their ability to both acknowledge their envy of, and take pleasure in, their daughters' growth.

Renewed sense of self

The findings of this study indicate that the psychotherapeutic process supports the menopausal woman to reframe her self-concept. Having processed loss; fear of loss; and intergenerational relationship conflicts, the menopausal woman moves towards a "renewed sense of self" (see Chapter 3, p. 63), adjusting her perceptions of femininity, individuality and self-worth (Benitez-Bloch, 2004). Lax (1997) cautions that a "renewed sense of self" is not to be confused with reinventing oneself, which can be a defensive response to the psychic significance of the menopause transition involving a determination to conduct oneself as if what is happening within is of no importance. Menopause then, "is a psychologically fertile time for women, as they master the tensions between expectations, realities and possibilities" (Stotland, 2002, p. 8).

Clinical implications

This study has revealed a need for further dialogue about menopause and how therapists work with menopausal clients. Specific to experiences of "loss and fear of loss" and "intergenerational relationships" of which the psychotherapeutic process can lead to a renewed sense of self, I suggest therapists:

- Have an awareness of the tendency for some women to self-subjugate as a result of internalising negative cultural stereotypes.

- Have an understanding that a transitional depressive mood can be expected to accompany a women's menopausal transition as she manages change and loss.

- Recognise the range of potential internal and external influences that determine a woman's experience and meanings of menopause.

- Give thought to the existential concerns which are evident during the menopause transition.

- Consider mother-daughter relationships through the lens of menopause when working with women at midlife.

- Consider their own views of how female development and, therefore, menopause is conceptualised, as it has implications for how they will respond to clients who discuss their menopause experiences (Silverman, 2003).

- Remain alert to menopausal women who reinvent themselves as a defensive response to changes and challenges at menopause.

3. How menopause influences the therapeutic relationship

In the findings of this study, the influences of menopause on the therapeutic relationship were defined through descriptions of therapist countertransference and therapist's thoughts on the transference relationship. The findings discussed in this section are limited to mother/daughter transferences; therapist identification, envy and competition; and issues of therapist disclosure.

Mother-daughter issues

Firstly, many transference and countertransference responses related to mother/daughter relationships found in this study, might be described as "common" to many therapeutic encounters, for example; the good/bad mother transference, or the therapist's identification with the powerless child. So, what relates specifically to menopause? Findings showed that, as clients enter the menopause transition, they often recall their own mother at this life stage. Those clients, who as adolescents experienced difficulties with their then, menopausal mother, unconsciously re-enacted aspects of the mother-daughter relationship with the therapist as they worked through past conflicts, and identifications. Therapists reported clients in therapy playing alternating roles of either, their adapted selves or their unstable internalised menopausal mother. The therapist in the transference was cast in complementary roles (Kogan, 2010). In either

the ineffectual or unempathic role, therapists experienced feelings of impotency and inability to help and support the patient (Kogan, 2010; Spira & Berger, 1999; Holmes, 2008). I noted that there was an absence of any mention of the therapist's relationship with her own menopausal mother in the case illustrations. In what ways, if any, might the therapist's relationship with her own mother, have impacted on how she felt about or responded to her client? Were any parallel processes evident?

However, therapist countertransference responses of helplessness and impotence may also indicate an attempt by the patient to get rid of unwanted feelings of rage and impotency felt as they faced loss and the uncertainty associated with their menopausal status. In this case the therapist acts as a container for the clients impotent feelings related to the perceived loss of sexual capabilities and the real loss of reproductive capacity. In time, Benitez-Bloch (2004) suggests, the client becomes stronger and the therapist becomes a new object who, unlike the client's mother can attend to the patient without the patient feeling the therapist will be destroyed either by her anger or separation.

Therapist identification

Secondly, countertransference responses identified in the data were often linked to anxieties the therapist had about client struggles that were comparable to their own. Identifications included; the loss of fertility, aging and death. From a phenomenological perspective, intersubjectivity is inherent in experience, that is; subjectively is shaped by interactions with others and the world. Menopausal therapists belong to a larger group of menopausal women. Menopausal therapists/writers in this study were both commentators and cultural members, they are part of what they are commenting on and cannot be separated from it (Braun & Clarke, 2006). The menopausal therapist may share the menopausal client's conflict of intellectually agreeing with more contemporary views of menopausal women, whilst struggling with internalised beliefs which impact on self-worth and self-acceptance (Ruderman, 1986). It could be concluded that a possible reason for the difficulty some therapists have in empathically attuning to their menopausal client is that the therapist herself may consciously or unconsciously be struggling with her own menopausal stresses. Ellman (1996), when discussing midlife patients, suggested that, if therapists identifications are not acknowledged and worked through, the countertransference responses will remain unconscious and the therapy process is likely to be hindered.

Envy and competition

Thirdly, transference/countertransference responses of envy and competition refer to envy of the other's situation and the potential for competitiveness between therapist and client. In a society that values youth and beauty, it is unsurprising that the study and analysis found competitiveness between menopausal clients and younger female therapists. Spira and Berger (1999) suggest that a loss of self-esteem and the associated shame may be defended against by a hostility or envy towards threatening younger women (Lax, 1982). What was not evident in this data set, but may be a consideration for further research, is the potential for the menopausal therapist to experience envy when working with younger female clients. However, Ruderman (1986) in her study of midlife therapists working with younger clients, assumed that envy arose from the therapist's mourning past life gratifications.

Envy and competition could also arise in the therapy when therapist and patient are both transitioning through menopause. Bemesderfer (1996a) provides an example when describing a therapist who wanted to handle her own menopause more successfully than the client was handling her own. In understanding these feelings the therapist self-reflected and concluded that the feelings arose from a therapist transference (sister rivalry). Interestingly, the therapist did not link these feelings to her own menopausal experience. Perhaps the latter may have required reflection on what meanings the therapist was making of her own menopause and within that an understanding of the socio-cultural and contextual pressures that influenced these meanings and her competitive desires. It may have been that old wounds from early sibling experiences were being revived, but what would it mean if she was not "handling" her menopause better than the patient? How might acknowledgement of this have impacted on her self-esteem and influenced the therapeutic relationship? Further research with an explicit focus on transference/countertransference specifically related to menopause is required to understand the commonalities of the menopause when therapist and client are concurrently transitioning through this developmental stage.

Therapist disclosure

Fourth and finally, concerns about self-disclosure and congruency were raised by menopausal therapists who experienced hot flushes intruding into the therapeutic relationship

Menopausal therapists wrote of the distress they experienced when physical hot flushes occurred unpredictably in the therapy leaving them feeling vulnerable in their

perceived transparency. These unpredictable intrusions (Frost, 2006) raised concerns for the therapist about "best practice", and challenged therapists' notions around congruency and disclosure. Beyond the articles utilised in this thematic analysis, I was unable to find any further literature that specifically discussed therapists' disclosure of menopausal symptoms, so instead I relate the findings of this study to the general psychotherapy literature about therapists' self-disclosure in treatment. Goldstein (1997) noted that, therapists' life events intrude on the therapy affecting the therapist's vulnerability, restricting emotional availability and raising issues of disclosure. Goldstein also highlighted that self-disclosure by the therapist can become problematic when there is "stigma attached" (p. 56), as there may be around menopause.

Stolorow and Atwood (1992) described an intersubjective viewpoint which values the shared experience of patient and therapist. Goldstein (1997) believes that patients are, consciously or unconsciously, nearly always aware of occurrences taking place in the therapist's life. With this in mind, Goldstein suggested that when decisions are to be made about self-disclosure, therapists need to consider "not only the possible effects of self-disclosure on the patient but the impact of remaining silent" (p. 49). Menopausal therapists faced with this dilemma (Bridges, 2011; Frost, 2006), struggled with concerns for the patient, the therapeutic relationship and therapist congruence.

In reviewing Rogers' concept of congruence (authenticity and genuineness), Tudor and Worrall (1994) explored communication as a requirement for congruence. Whilst not downplaying the relevance of the concepts of therapist congruence, self-disclosure and transparency (i.e. the therapist explicitly sharing their own experience with the client) they preferred the idea and practice of "apparency", which they defined as "the appropriate communication of self-awareness", whereby the therapist practices "the quality of being actively apparent" (p. 200), by having a dynamic and relational appearance in the relationship. Although they are referring to the therapists' experiences/responses in relation to something clients disclose, as distinct from the seemingly unintentional revealing of something personal to the therapist such as a hot flush, the concept of "apparency" may offer menopausal therapists an alternative lens through which to integrate their physical experience into the therapy. Might this approach lessen the anxiety felt by those menopausal therapists who not only struggle with the 'intrusion' of hot flushes in therapy but contend with concerns for both the client's experience and the quality and effectiveness of their practice?

Clinical implications

The findings of this study of menopause in psychotherapy and the available wider literature highlight a need for therapists to pay particular attention to how their own mothers coped with menopause (Patterson & Lynch, 1988). This would be relevant for male therapists also. Therapists who are transitioning through menopause alongside their client are encouraged to be alert to how their own responses to menopause may echo those of the client's, and influence countertransference and interactions. Further to this, therapists may wish to clarify their theoretical stance relating to self-disclosure.

Limitations of the study

The first limitation – and, literally, a limit - is the small number of articles analysed. The scarcity of literature related to the research question does not allow for broader generalizations to the wider population. However, in line with understandings about qualitative research generalisability, this is not considered to be the greatest concern (Denzin & Lincoln, 2000). It is consistent with Myers (2000) who asserts that small qualitative studies involving an in-depth examination of a situation "can gain more personal understandings of a phenomenon and the results can potentially contribute valuable knowledge to the community" (Myers, 2000, para. 9).

Secondly, in this study I was unable to explore the ways menopause in psychotherapy might intersect with other aspects of identity such as; race, class, sexual orientation, or the range of different circumstances in which women enter the menopause transition e.g. early menopause, surgically or medically induced menopause. In terms of the location of this study and the significance of and my interest in biculturalism there were no available studies. It is also difficult in this study to decipher whether women coping with on-going complex mental health issues share the same experiences as other menopausal women. It is unknown how these variables may have influenced findings, although with such a small data set, diversity may have had little consequence.

Thirdly, there was no literature found to include male therapists' working with menopausal woman, or a therapist (either gender) working with the husband or partner or children of menopausal women. The findings of this study may not apply equally to these therapeutic dyads.

Further research

In the psychotherapeutic literature, I found only one study involving a number of therapists working with peri-menopausal women that determined menopausal themes (Mendell, 1988). There were only a few single case illustrations where the therapeutic relationship was the focus of the study or was indicated in the study discussion (Kogan, 2010; Spira & Berger, 1999; Wilk and Kirk, 1995). My study indicates that further research focusing on menopause and the therapeutic relationship is required. Although similarities between the transference and countertransference responses found in the data set of this study and those depicted in the midlife literature exist (Ellman, 1996; Goldstein, 2007; King, 1980; Ruderman, 1986), there is a lack of literature that specifically illuminates; (1), mother/daughter relationships, transference/countertransference and menopause in psychotherapy; (2) menopausal therapist and menopausal client countertransference/transference responses, (3) envy and menopause in the therapeutic relationship and (4) therapist self-disclosure in the context of menopause. Further research in these areas would provide for enhanced clinical understandings and practice.

In addition, studies involving a range of therapeutic dyads including; male therapists and menopausal women; male patients with menopausal partners or mothers; menopausal therapists with younger female patients or daughters of menopausal women would contribute to a greater understanding of the study question.

Furthermore, studies of menopause in psychotherapy that included different population groups as indicated in the study limitations would deepen therapist knowledge and understanding.

Conclusion

This dissertation topic arose from my own desire to understand menopause better from both a personal and professional perspective. The main objective of this research was to examine relevant literature and provide a comprehensive understanding of menopause in the context of psychotherapy. A thematic analysis of the literature revealed five patterns of experience; silence, loss and fear of loss, challenges of relational interplay, disentangling of tensions and renewed sense of self. The development of the themes showed a general pattern of "progressive forward movement" (Meier & Boivin, 2000, p; 60) in therapy from silence to creative adaption and self-determination. Subthemes and descriptors were identified and these provided

detailed insight into how issues related to menopause may be presented, thought about and worked through in the every-day practice of psychotherapy.

The overarching conceptual theme of "impotency/potency" captured the dialectical tension present within each of the themes. The study findings also indicate that therapy and the therapeutic relationship allows menopausal women to; express thoughts and feelings; engage in meaning making; dispel a sense of impotency and to communicate a sense of self - thereby embodying her experience and embracing her potential and potency. Although based on a limited sample, these findings are consistent with developmental theories which recognise that transitioning from one life stage to another involves changes in physical and psychological equilibriums which can induce distress during the period of adjustment (Erikson, 1963; Lax, 1982, 1997).

Following discussion of the five themes, conclusions were drawn from an exploration of the findings in conjunction with the wider literature. In the first theme, "silence", I elaborated on the significance of dreams at this life stage and the mind/body dualism that underlies dominant anti-aging and medical discourses. I posited a forward focus for therapists to reflect on their own attitudes towards menopause and consider the notion of embodied subjectivity (Rothfield, 1997) to allow menopausal women to explore their lived body experience. The second theme examined was "loss and fear of loss". I described the loss of fertility, youth, beauty and feminine power faced by many women entering the menopause transition and suggested existential concerns as an alternative lens for conceptualizing loss at menopause. In the third theme, "challenges of relational interplay", I explored the findings of mother/daughter transferences; therapist identification, envy, competitiveness and issues of therapist self-disclosure and encouraged therapists to reflect on how the experiences of menopausal women in their own lives may influence their work with menopausal clients. Menopausal therapists working with menopausal clients may need to be attentive to the possibility of identifying with their clients and may need to clarify their self-disclosure stance. With regard to the fourth theme, "disentangling of tensions", I described how the process of mourning at this life transition can facilitate further growth and creativity and discussed the influence of female development theory on clinical practice. Issues of identification and separation related to mother/daughter relationships were also considered and the uniqueness of individual responses to menopause reiterated. The fifth theme, "renewed sense of self", revealed that acceptance, freedom and self-determination are important to a woman's ability to reframe her self-concept and value herself beyond being a youthful, reproductive woman. I reiterated a caution to therapists to be alert to the

possibility that a woman who is unable to accept changes at this life phase, may defensively reinvent herself (Lax, 1997).

Mendell (1988) highlighted the difficulty of knowing whether the outcomes shown in studies like this are indicative of a successful therapy or a successful negotiation through a challenging life event. Bemesderfer (1996b) stipulated that it is women experiencing significant difficulties associated with menopause who are more likely to that find their way into therapist caseloads than the menopausal population at large. I believe that psychotherapy offers the opportunity for women whether experiencing difficulties or not, to talk about what society does not. The findings of this study indicate that women traversing this developmental passage whilst in (or practicing) therapy have an opportunity to "reflect on their experiences and the meanings they attribute to menopause" (Spira & Berger, 1999, p. 272). An attentive, reflective therapist with awareness and understanding of the multifaceted nature of menopause is more likely to effectively support this process. The findings of this study offer therapists' further understanding of menopause as it relates to clinical practice and in particular provides insight into how menopause when present in the therapy may influence the therapeutic relationship.

This study has focused on a particular population of menopausal women, i.e. those in psychotherapy. It provides an understanding of menopause as it relates to psychotherapy, highlighting the clinical significance of this developmental event when working with women in midlife. Menopause is both a real physical process and a socially constructed phenomenon, as such; the "lived body" is open to creative intellectual exploration and meaning making. This is the work of psychotherapy.

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Appendix A

A list of the 11 articles selected for thematic analysis

Bemesderfer, S. (1996a). Psychoanalytic aspects of menopause. *Journal of the American Psychoanalytic Association, 44*, 631-638.

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