How can Therapists and Other Healthcare Practitioners Best Support and Validate their Queer Menopausal Clients?

A thematic analysis of 12 LGBTQ+-identified and menopausal participants' experiences in therapy and in the healthcare system

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Abstract

How do queer people experience menopause? And what is the queer menopausal experience of therapy and the wider healthcare system? The existing literature examines lesbian lives, but there are no studies of the wider LGBTQ+ population, particularly as clients in therapy. For this study, semi-structured interviews were conducted with 12 LGBTQ+ identified participants. While some participants had positive experiences, practitioners overall were frequently unable to meet their needs, both in terms of menopause knowledge and understanding queer identities. In summary, participants felt that therapists should: listen to queer menopausal clients and not make assumptions; understand that this client group is likely to have had previous negative experiences with healthcare practitioners; realise that both they and their clients are likely holding inadequate information about menopause; understand that menopause can also be a positive experience; and undertake further training around GSRD (Gender, Sex and Relationship Diverse) identities, menopause and hormones. Queer menopausal clients frequently face multiple discrimination when accessing therapy and healthcare services: acephobia (prejudice against asexuals), ageism, biphobia, homophobia, misogyny (where applicable), and transphobia. Practitioners of all kinds, and by extension training organisations, have a long way to go in creating sufficiently safe and appropriate services for this client group.

Keywords

menopause, queer, LGBTQ+, GSRD, therapy, healthcare

Definitions

Perimenopause

Perimenopause starts in bodies with ovaries as early as the 30s when oestrogen begins to fluctuate and reduce (Santoro, 2016). This may affect both menstruation and mental health (Wharton, Gleason, Olson, Carlsson & Asthana, 2012). Common symptoms include hot flushes, insomnia, and anxiety. Those experiencing perimenopause are also more susceptible to depression during this phase of life (Gyllstrom, Schreiner & Harlow, 2007).

Menopause

Menopause is said to have occurred one year after the final menstrual period, supposedly around 50 but the age range is actually very wide. It can start much younger after surgical removal of the ovaries. Symptoms of lowered oestrogen include anxiety, depression, hot flushes, insomnia, memory loss, weight gain, thinning bones, and drying and thinning of tissues around the vagina and urethra, causing pain and stress incontinence (Monteleone, Mascagni, Giannini, Genazzani, & Simoncini, 2018; Santoro, Epperson & Mathews, 2016).

Queer

I have used a broad definition that includes anyone who identifies as LGBTQ+ – encompassing same-sex relationships, disruption of gender norms, and/or rejection of binaries (Sullivan, 2003). (Thus also *queering.*)

Therapists

‘Therapists’ stands for counsellors and psychotherapists.

Introduction

Context and Rationale

As a bisexual AFAB (Assumed Female At Birth) person, I had very mixed experiences getting support during menopause, as did a number of people close to me. Even aside from the tide of ageism and misogyny in public life, such as a senior bank official describing the economy as “menopausal” (Monaghan, 2018), I was struck by the sheer invisibility of queer narratives around this aspect of ageing. While being aware of the wide variety of experience within LGBTQ+ identities, I felt that these voices, united by the experience of menopause, needed to be heard, and that the subject as a whole deserved further exploration.

In tandem, I have long been aware of the inadequacy of counsellor training around GSRD (Gender, Sexual and Relationship Diverse) identified clients (Davies & Barker, 2015), of whom LGBTQ+ clients form a part.

In exploring how these issues might interact, I intended this research to form a guide for counsellors and psychotherapists and their training organisations. Working from a social justice standpoint (Lyons et al, 2013), I

wanted this project to have “catalytic validity” through igniting cultural and political consciousness (Tracy, 2010, p. 846).

I undertook this research as part of a Masters in Counselling and Psychotherapy at the University of East London.

Before putting a call out for participants, I searched for precedents in the literature. This proved somewhat challenging.

Literature Review

Introduction and background

Looking at the media, most menopause-related material is heteronormative, (e.g. Currie), and at times somewhat pantomimic (“#flushfest2019” (Menopause Festival, 2019); *Menopause the Musical* (2001)). It is not always edifying to cisgender (living in the gender assigned at birth) heterosexual women, let alone anyone LGBTQ+ identified. We might well conclude that society is sexist and ageist as well as homophobic, biphobic, and transphobic (Kelly, 2008). We might also infer from this that to be both LGBTQ+ and menopausal confers on the individual a very specific form of structural stigma (Hatzenbuhler, 2016).

Aside from some studies which include lesbian experience, (e.g. Kelly (2008), and Winterich (2003), there is almost no peer reviewed literature

about queer experience of menopause, and barely more grey literature (i.e. non-peer-reviewed or non-published work) or creative output. The literature focuses almost completely on heterosexual experience and assumes that only women experience menopause. Structurally the literature is analogous to the popular image of a galaxy: a multi-armed spiral leading to a central black hole.

On reviewing the existing literature I found that journals devoted to older LGBTQ+ lives barely mentioned menopause, and journals focusing on menopause barely mentioned LGBTQ+ experience. Similarly, turning to the therapeutic literature, I found only one study, from mid-2019, about the experience of the menopausal therapist (Bodza, Morrey & Hogan, 2019), and only one member journal article by a therapist about the experience of menopausal women in therapy (Brayne, 2011). This seems to mirror wider societal taboos and reflects the overall invisibility of menopausal experience.

Menopausal experience may not always be negative – it may be neutral or positive (Hyde, Nee, Howlett, Butler & Drennan, 2011). But the self-deprecation and sense of brokenness in many mainstream accounts – e.g. “I ... feel so numb I can’t even be bothered to loathe myself” (George, 2018, para. 41) – may be particularly alienating to queers because, in an already prejudiced society, self-deprecation is a form of self-harm (Gadsby, 2018).

Sexuality and ageing

Marshall (2011, p. 391) points out that studies of sexuality and ageing are generally “underpinned by a biomedical model of heterosexuality,

deflecting attention from gender [and] sexual diversity," in other words, not taking account of psychological and social contexts. Too often, as noted by McGlotten and Moore: "...what counts as sexual function is constrained by heteronormative and patriarchal ideologies that frame sexual activity as penetrative sexual encounters loosely based on a model of sexual reproduction" (2013, p. 262). Ultimately, "Older people's sexuality can represent 'a dark continent', which most people, including physicians, prefer not to think about." (Dominguez & Barbagallo, 2016, p. 513).

Among the general population, menopause may be seen as a significant mechanism for queering – or disrupting – gender (Cooper, 2008), and also, potentially, sex. "As among many queers, sex between older persons often happens outside of the reproductive 'imperative'." (McGlotten & Moore, 2013, p. 262). "It seems to us that all old sex becomes queer sex" (2013, p. 267).

In fact, if a cisgender heterosexual woman loses her capacity for childbearing and PIV (penis-in-vagina) sex, has she stopped being a woman? Such potential for transformation may direct those experiencing menopause to an "alternative economy of pleasures" (Butler, 2006, p. 36) – in other words, a whole new world of experience previously only lived by queers.

Older LGBTQ+ health experiences

Older LGBTQ+ adults experience specific issues, including social stigma, isolation, financial issues and concerns about disclosure, as well as major health disparities when compared with heterosexuals (Fredriksen-

Goldsen et al, 2011, cited in McGlotten & Moore, 2013). Population-wide, chronic health conditions begin to manifest around the age of 50 (Hoy-Ellis, 2016). Although psychological distress appears to decline around this time, the rates among LGB adults of this age (and older) remain significantly higher. (Hoy-Ellis, 2016).

The word “menopause” has only a passing mention in the World Professional Association for Transgender Health (WPATH) *Standards of Care* (WPATH, 2012). Johnson et al (2018) do not mention it at all in their extensive *Interdisciplinary Approach to Transgender Ageing*.

LGBTQ+ clients in therapy

Non-heterosexual people are more likely to have worse mental health than heterosexuals (Chakraborty, McManus, Brugha, Bebbington & King, 2011), and their mental health is likely to be negatively affected by institutional discrimination (Everett, Hatzenbuhler & Hughes (2016); Hatzenbuhler, McLaughlin, Keyes, and Hasin, 2010). This group is also more likely to experience prejudice and harassment (Government Equalities Office, 2019). The latter survey, however, was inadequate (from personal experience of completing it) due to the emphasis on legally actionable incidents – much queerphobic prejudice occurs below the legal radar, in the form of “*microaggressive trauma*, or the excessive and continuous exposure to subtle discrimination (both interpersonal and systemic) and the subsequent symptoms that develop or persist as a result.” (Nadal, 2018, p. 13). Many

LGBTQ+ clients think twice about returning to therapy because they have experienced pathologisation or erasure (Delgado-Romero & Shelton, 2011).

Trans people are particularly vulnerable to depression and suicide attempts due to minority stress (Tebbe & Moradi (2016), and this is especially the case for non-binary people (Lefevor, Boyd-Rogers, Sprague & Janis, 2019). And many trans clients have very low expectations of the treatment they will receive (Anzani, Morris & Galupo, 2019), highlighting a great need for practitioners to examine their own biases and assumptions around gender, to achieve cultural competence beyond simple acceptance (Hendricks & Testa, 2012).

King, Semlyen, Killaspy, Nazareth and Osborn's 2007 systematic review of LGBTQ+ client experiences in therapy is comprehensive but does not mention issues of ageing, and neither does Moon et al's otherwise very nuanced 2009 report on counselling bisexual clients. I have not yet found a study of the significance of age differences between therapists and their LGBTQ+ clients, and Rosen, Miller, Nakash, Halpern and Alegria (2012) note that this is a neglected area of research.

Lesbian experience of menopause

It is 30 years since Cole and Rothblum (1990) highlighted the heterosexist focus and language in menopause research, but little appears to have changed. Lesbians have been studied, at least to some extent. (Bisexual women appear rarely, for example in Degges-White and Myers (2008).) In

non-peer-reviewed literature, there are several books about lesbian experiences of menopause, e.g. Kelly (2005).

It's frequently stated that lesbians are freer from the male gaze, so grieve less about the loss of youthful appearance and have "a broader definition of 'sex' which isn't tied to penetration" (Ussher, Pertz & Parton (2015), p. 461). This is more explicitly explored by Kelly (2008), who notes that several participants in her lesbian-only study commented on how Hormone Replacement Therapy [oestrogen and progesterone, taken in menopause] may promote "compulsory heterosexuality" (Kelly, 2008), i.e. enforcing a cultural norm that benefits men over women, and encouraging women to maintain this status quo by staying young-looking and remaining available for penis-in-vagina sex.

This theme is reinforced by Winterich (2003) who compares heterosexual and lesbian experience of menopause, stating: "Heterosexual women may be more constrained by cultural ideas about menopause, gender, and heterosexuality." (Winterich, 2003, p. 640). By contrast, "none of the lesbians describe partners who complain about menopause, and many accounts illustrate female sexual agency because women openly discuss sex and act on their desires." (Winterich, 2003, p. 640).

LGBTQ+ Menopause Overall

"The Geriatric Clinic: Dry and Limp: Aging Queers, Zombies, and Sexual Reanimation" (McGlotten & Moore, 2013) is the closest paper I have found to

the spirit of queer menopause, with its focus on queer ageing and the "dangerous lure" of normalising medical treatments (McGlotten & Moore, 2013, p. 261). It has a sharp, sardonic edge to it that is often lacking. Similarly, Cooper's (2008) paper "Prime Time. TV Menopause, Queerly a Case for Review", explores how older women on television are portrayed as "sexless beings who fall outside regulatory norms of gender identification" and are thereby queered (Cooper, 2008, p. 35).

Wingo's (2018) study of AFAB healthcare is wide-ranging, although menopause is not central to it. For example, a young trans man expressed discomfort at a clinic's gendered signage, experiencing feelings of self-consciousness from being the only unaccompanied man in the waiting room. "This created an additional obstacle to obtaining care for masculine-presenting individuals in our sample." (Wingo, 2018, p. 353). Two other participants noted a lack of post-hysterectomy information for AFAB people who take testosterone, and that menopause information was insufficiently inclusive of lesbians (Wingo, 2018).

Among LGBTQ+ therapy books, Garnets and Kimmel (2003) devote three pages out of 795 to menopause. Kort (2018) does not mention it at all. It does not appear in the index of Kleinplatz (2012), a general sex therapy book, though there is brief in-text mention.

Regarding people Assigned Male At Birth (AMAB), Hunter and Mohamed (2018) researched transgender women's feelings about hormone

therapy and reaching menopausal age. A number of the participants did not see menopause as relevant to them, perhaps due to being at the younger end of the participant group. However, the study concluded that there was “a need for improved communication and clarity around service provision of transgender healthcare”, particularly “about what might happen when they reach ‘menopausal age’” (Hunter & Mohamed, 2018, p. 8).

There is little more in grey literature. Peggy Shaw’s monologue *A Menopausal Gentleman* is about a butch lesbian’s experience of “trying to pass as a person when there’s a beast inside me” (Shaw, 1998, 01:04; Ormiston, 2012). Henry’s (2015) study “A Wrinkle in Time” explores a parallel world: “growing old is an unbecoming process that wrinkles temporalities of desirable heterosexual growth to the point of unrecognizability. In short, growing old is a queer time.” This relates well to McGlotten and Moore and to Cooper: when exploring queerness, the ordinary laws of expression begin to warp.

The lack of research on queer menopausal experience is concerning and highlights the significance of this study. It also feels symbolic of the erasure of queer menopausal lives.

Methods and Materials

Introduction

While I might have used a solely social constructionist viewpoint, in an attempt to avoid making assumptions about the subject I am researching (Burr, 2015), it would seem somewhat privileged to state that objective reality cannot ever be trusted. For people who are experiencing ongoing prejudice it plainly does, or we would not need social justice. While I see that the stories available to us shape the meanings we make and thereby our experiences, I also come from a place of critical realism, believing that "...we need to claim some 'authentic' reality exists" in order to create change in that reality. (Braun & Clarke, 2013).

My research partly aligns with Critical Sexology because menopause impacts both sexual expression and identity, and particularly because one aspect of Critical Sexology is the location of sexual identities and practices within wider power structures (Barker, 2016; Barker & Scheele, 2016).

Participants

After obtaining ethical clearance for this unfunded preliminary study (on 29th March 2019 from the School of Psychology Research Ethics Committee at the University of East London), I put out a call on my blog and posted it on Facebook. A number of the initial responders were from my own networks. Here I note a parallel with my private practice. GSRD-identified clinicians often work in correspondingly small communities and we often reflect on any dual relationships we may have. A colleague referred to us as 'village doctors'.

It was suggested that someone I was already acquainted with might be less likely to reveal personal details in an interview. However, as I know from working and living within queer, kinky, and CNM (Consensual Non-Monogamy) communities, self-disclosure, (whether about gender, sexual/kink preferences, or trauma), seems to be much more normalised.

Out of the approximately 40 people who responded, 12 took part in interviews. Nine participants were in the UK, one in the US, one in Australia and one in Belgium. Ages ranged from 46 to 62. 11 were AFAB, and one AMAB. Regarding the AMAB participant, although my focus was mainly on people born with ovaries, the biopsychosocial nature of menopause (Ayers, Forshaw & Hunter, 2011; Hunter & Rendall, 2007) indicates that the queer experience of it is not confined to AFAB people and this participant provided a very necessary voice.

Three participants were cis, three non-binary, two transmasculine, one agender, one genderfluid, one genderqueer, and one transfeminine. Six identified as queer, three as pansexual, one as asexual, one as bisexual, and one as lesbian.

A number of participants were in the helping professions, reflecting my social and professional circles. Perhaps given the majority whiteness of these professions, the majority of the participants were white. In future studies I would seek to investigate the experiences of a more diverse sample.

Design

The purpose of my study was to seek testimony about individual experience in a “context marked by injustices” (Peñaranda, Vélez-Zapata & Bloom, 2013, p. 44). In the absence of a truly objective and universal way of calculating emotions like depression or distress (Braun, Clarke & Rance, cited in Vossler & Moller, 2015), the richness of this qualitative study comes from participants’ interpretations of their own experiences, via experiential Thematic Analysis (Braun & Clarke, 2013) rather than statistics. I wanted to give participants a platform rather than enlist them to prove something. Queers are already used to having to prove their validity, both within the mainstream and their own communities.

To be both queer and menopausal has multiple intersecting resonances (McNair, 2017). Perhaps because my therapist training was integrative (Zarbo, Tasca, Cattafi, & Compare, 2015), I feel comfortable holding the complexity of diverse experience.

I did 10 interviews on Zoom and two in person. The interviews were around an hour each. Zoom allowed me to connect with people unable to come in person. I am used to long Zoom sessions from my client work: convenience and accessibility outweighed any potential loss of nuance (Iacono, Symonds & Brown, 2016). I transcribed the interviews myself.

Procedures

My interviews took place over a three-month period. My interview questions followed this structure: (1) Menopause history, (2) Menopause knowledge, (3) Life experience of menopause, (4) Interactions with the medical/healthcare system, (5) Menopause in the therapy room, (6) General impact and thoughts about therapy. (A list of all questions can be found in TABLE ONE.) Perhaps because this is the first study of its kind, as far as I know, I felt it was important to ask about experiences beyond therapy, particularly as menopause symptoms are likely to be a driver for interactions with the wider healthcare system. I also reflected on the National Counselling Society's code of ethics, which state that care and respect for the participant should always be prioritised over the research being undertaken (National Counselling Society).

Data Analysis

Participants were all keen to tell their stories. I used Thematic Analysis (TA) because its robust structure does not impose theoretically on the material (Braun & Clarke, 2013). I felt participants' experiences stood alone without needing the levels of interpretation that, say, Interpretive Phenomenological Analysis or Discourse Analysis might demand. I was also intending to code in response to a specific pre-existing research question (Braun & Clarke, 2006). My TA therefore, as described in Braun and Clarke (2006) was theoretical rather than inductive. It was also reflexive (Braun & Clarke, 2013) – due to my age and identity, I could not separate myself from the subject matter. I was aware that this might cause me to be less objective with participants, but it also enabled me to empathise more fully.

I printed up the transcripts, highlighted relevant text, and hand-wrote the codes on Post-it notes stuck on each page. For clarity, I input the codes and page/line references into a spreadsheet. I then used a pivot table to show the most popular codes and therefore the dominating patterns within the data as a whole. As this was not a quantitative study, I treated the numbers as a guide, to help me gather my thoughts, rather than anything more mathematically specific or directive. As I repeatedly went over the texts, I was reminded that qualitative research is a "*recursive rather than linear* process" (Braun & Clarke, 2013, p. 16). From the codes, I gradually formed five themes, which I reflected on until I was satisfied that there was sufficient variety between them, and that the subthemes I created from them drew a picture of the relevant data that was sufficiently meaningful. I then organised them in the form of a mind map (Braun, Clarke & Rance, cited in Vossler & Moller, 2015), to facilitate my reflections on the best order to arrange them in.

Positionality Statement

My research was significantly influenced by a major life event: I applied to UEL when I was in the middle of treatment for breast cancer. I was therefore negotiating issues of physical and mental recovery throughout, as well as my own menopause, my own evolving gender and sexuality, and my changing relationship with endogenous and exogenous hormones.

Regarding power dynamics, I share some identities with my participants but not others, so I kept in mind Alcoff's words about "speaking with and to rather than speaking for others" (1991-2, p. 23).

I am aware of the implications of being a white middle class researcher operating in a white-middle-class-constructed system, and specifically within white-privileged queer culture (Logie & Rwigema, 2014). And there is always an imbalance when requesting personal material for the benefit of one's own studies, however worthy the subject matter – particularly when the power balance between researcher and participant is already unequal. Many people with non-normative identities experience minority stress (Meyer, 2003; Richards & Barker, 2013), and members of marginalised communities get tired of people studying them without offering support in return (Mertens, 2015).

Results

Themes

The key themes which emerged from the data were:

1. Therapists need to acknowledge their Queer Menopausal Clients' experiences rather than make assumptions about them.
2. Queer Menopausal Clients are likely to have had previous negative experiences in the healthcare system, in therapy and in life in general.
3. Available information about menopause is inadequate, and therapists need to realise that both they and their clients may hold inaccurate knowledge about it.

4. Therapists should not assume the Queer Menopausal experience is exclusively negative.
5. Therapists need more training in Gender, Sex and Relationship Diversity, menopause, and hormones.

Note

All names have been changed. Please see TABLE TWO for participant details.

Theme One

Therapists need to acknowledge their Queer Menopausal Clients' experiences rather than make assumptions about them.

Therapists should enquire and not assume. Several participants felt that therapists should listen rather than tell their queer menopausal clients about themselves. In other words, "…being respectful around not dismissing things, and taking it seriously. … And be aware of how intense and difficult it can be for people, and to not dismiss that in any way, or minimise it." ("Robin", 45, genderqueer, lesbian, communications specialist). This could apply to all therapy – however, deficits in empathy with queer clients seemed particularly unhelpful.

There was at times a disjunct between what participants felt they should expect from therapy and what therapists were willing to offer them. Participants reported having to educate their therapists, which could be seen

as activism, but also created stressful encounters. “Alex”, (47, genderfluid, pansexual, somatic sex educator) emailed their therapist, saying: “’I am getting very tired of spending my time and my money teaching you about non-monogamy and teaching you about gender.’”

This situation pushed participants into seeking more appropriate support. One even set up their own LGBT counselling service, the first in their area. But it is notable that an already marginalised client group had to do this extra labour in order to obtain the services they needed.

Therapists should be proactive about mentioning menopause. The majority of participants felt it would have been helpful if their therapists had proactively mentioned menopause. For “Katie”, (56, cis woman, asexual, psychotherapist), “It’s hard enough to talk about sex unless your therapist brings it up. … How are we going to talk about Menopause in therapy, and its effects, unless we are given permission to do so?” Some therapists might see this as spoon-feeding, though their own discomfort with the topic may come into play here also. The issue seems to be about what clients have the right to expect. Conversely, “Bret” (46, non-binary, pansexual, project manager) suggested that some therapists might feel awkward mentioning menopause, for fear of being accused of ageism.

Therapists need to acknowledge the fluidity and complexity of queer lives. Several participants felt that non-normative identities and life paths were simply not understood by most therapists. “Look beyond the

medical model," ("Sarah", 48, transfeminine, queer, therapist), "What age are you and how is that changing things? … How is it affecting your sex life? … Your partner is grieving because you have not had children, and now you are taking hormones. … It's, just in the space of a few sentences, really complex."

This is doubly challenging for clients who are contemplating transition during perimenopause. Several participants agreed that this could be confusing and disorientating.

Theme Two

Queer Menopausal Clients are likely to have had previous negative experiences in the healthcare system, in therapy, and life in general.

Social isolation of older queers. For some participants, perimenopausal symptoms exacerbated already difficult feelings. Katie felt very isolated due to meeting very few other asexuals. "Eve" (58, cis, queer, chaplain), based in the US, experienced years of biphobia from lesbians: "I am really tired of dealing with peoples' shit. So I find that it's easier to say I am queer [than bisexual]." "Louise" (49, agender, queer, social worker) was working in a small community in Australia and feared being outed.

For Sarah, transition was at times an isolating experience, although she had a long-term partner. Previously read as a cis man, she did not have a long history in queer community behind her. "Lucas" (52, transmasculine,

queer, planner), based in Belgium, remembered his pre-transition years of drinking and trying to be as feminine as possible to push his feelings away.

Experiencing challenging symptoms. Participants' symptoms included insomnia, brain fog, vaginal dryness, forgetfulness, mood swings, anxiety, irritability and depression (sometimes without realising initially what was going on, which caused extra distress). In addition, some had existing serious gynaecological issues which affected their relationships and working lives. One participant had to stop work altogether. Concomitant effects on mental health were notable, and there was a sense that being queer exacerbated this: "The queer community is ... already carrying so much. ... They are more likely to have mental health issues." (Alex)

Negative interactions with doctors and the healthcare system. The majority of participants had negative experiences with GPs, ranging from inadequate to distressing. There seemed to be both a lack of knowledge and lack of curiosity on the part of doctors, leading to a sense of frustration and failure from participants.

When they went to their GP to talk about menopause Bret was told they should be on antidepressants. Bret disagreed, saying they did not want to lose their libido, (for them a vital part of their queer identity). The GP wrote the prescription anyway. The non-consensual writing of prescriptions was echoed in several interviews. When menopause comes into the frame, it feels like a licence to infantilise patients.

"Erin" (48, non-binary, queer, counsellor) spoke about: "Strapping on my armour" before educating their GP about their gender and sexuality. Katie's GP threatened to "make" her go to the gynaecologist if her periods had not stopped within six months. Katie is a survivor of sexual abuse, as well as being asexual, so the idea of going to a sexual health clinic caused huge anxiety for her. This was not helped by healthcare staff sometimes not believing she had never had sex.

"Clare", (62, cis, bisexual, writer), asked her GP if she had gone through menopause: "They just said, 'Why do you want to know? You don't need to know.'" Louise's GP was "Very insensitive. Very arrogant." "They never once asked me about my sexuality. … They just assumed I was heterosexual."

Robin began to have frightening symptoms that were doubly confusing on top of their existing diagnoses of ADHD and Bipolar Disorder. "I had to go through five doctors before I got one that was even remotely helpful." When they mentioned they had had top surgery (removal of breasts), the discussion swerved abruptly away from perimenopause:

> "[One GP] started asking what genitalia I was born with, and whether I was born with normal genitalia. … I had [another GP] say 'I don't understand what genderqueer is,' and get quite aggressive with me, and just not seem to understand whether I was taking hormones or not, and when I said no, they were like, 'Why are you not? You are not transitioning

then? Are you a man or a woman?' … The medical facts seemed almost impossible for them to grasp without me being humiliated and interrogated."

"Ben" (51, transmasculine, pansexual, counsellor), asked his GP for testosterone for perimenopause symptoms and was met with "absolute negativity and suspicion." Allocated to a men's ward for minor surgery, a nurse asked Ben if he could be pregnant, in full earshot of the other patients.

Participants had many stories of friends (queer and not) being ignored or bullied when asking for help. This created generalised anxiety. "Why can't people just believe patients?" said "Ellis" (47, AFAB non-binary, queer, unemployed). Ellis had a hysterectomy for medical reasons but had no idea that menopause symptoms would start almost immediately.

It seems clear that, despite the drive to attain "Person-Centred Care" in the NHS, (Person-Centred Care, 2019), the message has not got through where queer, trans and menopausal patients are concerned.

Negative experiences with therapists. Sarah saw a therapist who "Laughed in my face when I mentioned there was such a thing as Pink Therapy." The quiet streets near the therapist's practice did not feel safe and Sarah mentioned this to her therapist, who replied "'So - you were exploring vulnerability? – Well, you had better get used to that'", implying that Sarah had claimed an identity that she, a cis woman, already knew well.

Alex attempted to educate their monogamy-promoting therapist until the day they walked out for good, with the therapist shouting at them.

There were a number of situations where a participant's experience with a therapist had been generally positive, but the therapist's apparent lack of understanding of sexuality and gender caused clients to conceal aspects of themselves.

Having to perform for different gatekeepers. Menopause support groups online are often very normative. Bret did not come out as non-binary in a Facebook group because they feared being asked to leave. They felt as if they were "doing stealth". Seeking help meant tolerating "lots of gendered assumptions."

Participants who were both considering transition and entering menopause had to perform for two sets of gatekeepers: GPs (by taking care not to mention gender in case they were denied testosterone), and gender clinics (by taking care not to mention menopause in case they were told they weren't trans enough). This is a complex balancing act to perform while in a state of evolving identity and also confusion due to menopause symptoms.

Theme Three

Available information about menopause is inadequate, and therapists need to realise that both they and their clients may hold inaccurate knowledge about it.

Participants may have received inadequate information about menopause when younger. Bret: “Menopause pretty much wasn't discussed, so all I knew was that your periods stopped and you apparently lose interest in sex and your middle gets thicker ... [and] you move into old lady phase.” Several participants’ mothers had struggled a lot, changed rapidly, and two had to take two years off work with mental health issues. It felt like a shameful mystery.

Current menopause information is inadequate. Relevant information is hard to access and is not queer-friendly. Alex said: ‘How we can have more than half the population where their bodies are still an absolute fucking mystery!’ Erin wanted a five-year timeline of what happens during menopause, like education around periods at school. They also felt that society needs to stop assuming that all women want babies, and that some women need to be reassured that they are still women when they go into menopause. Clare felt that healthcare providers “should not assume that PIV sex is sex.” If Bret hadn’t heard about menopause from a queer friend, “I may well be … thinking that I am developing mental health problems or my body is falling apart.”

Mainstream menopause support groups often upheld patriarchal views. Bret felt this was a very common narrative, “…about women feeling able to deliver what is expected of them by their boyfriends or husbands, and that inevitably involving intercourse.”

Katie felt that mainstream advice was for rich people. “It all felt a bit self-indulgent; … those of us what are working, you can’t just kind of go to your yoga class today and do XYZ and have a massage.” She also noted how little advice was relevant to asexuals. Assumptions are often made that a person in menopause is either mourning the loss of sex or wanting to have more.

Eve sensed that gynaecologists talked more about sex with straight women patients than queer ones. Her doctors never mentioned oral sex, and the impact that, for example, vaginal odour might have on this. Ellis experienced body-wide dryness: “Nothing really prepared me for the symptoms.” They ended up researching vaginal moisturisers for their GP: “I have been like my own doctor.”

Robin summed up the labour that seemed to be expected from them: ’I am not there to educate GPs about transness.’

Perimenopause hardly known about. Louise knew nothing about perimenopause, and thought her hot flushes were symptoms of anxiety which meant she might not be cut out for her job. Others reported similar experiences of GPs not knowing enough.

Lucas had a positive experience: the gender clinic staff took care not to use the word “menopause” as its feminine implications could be alienating to

transmasculine clients. However, the effects of low oestrogen were not fully explained to him.

No participants had known until recently that perimenopause can start in your 30s. It feels symptomatic of systemic societal denial about an unavoidable aspect of life, and an entire chunk of the population being gaslighted about their own experiences.

Hormones not understood properly. Several participants had thought that hormones were gendered and did not realise that all bodies need both oestrogen and testosterone. Some therefore did not ask for potentially helpful treatment for fear of being feminised. Eve went to her trans women friends for hormone advice: “They know this stuff way better than general practitioners do.”

Robin had done A level biology at school and noted that the teaching went into far more detail around genetics than hormones, potentially implying an agenda to reinforce gender binaries and essentialism.

Theme Four

Therapists should not assume the Queer Menopausal experience is exclusively negative.

Joy at symptoms changing or ending. Most were very happy at the end of menstruation, or the prospect of it, and the cessation of mood swings,

anxiety, depression and insomnia. Despite experiencing menopause-like symptoms at times, particularly hot flushes, while taking a testosterone blocker, Sarah was very happy with the effects: “Within weeks of having taken the Decapeptyl, it was like my face feminised, and I remember having a Skype consult with [someone] and they just said ‘Wow, you look different’”

Benefits of queerness. Several participants agreed that being queer inoculated you against some of the more patriarchal aspects of menopause and ageing. Erin was doing research to “get out of the Western-centric mindset [of] menopause as the end of the world.” Louise felt that queers talk about these issues more, and that queer women “don’t have to perform in the same sort of sexually stereotypical way that maybe heterosexual women or women in straight relationships have to.” They added: “I am becoming more sexually exploring and adventurous and open the older I get.”

Ellis said that “queers are aware of the patriarchy and misogyny and how that affects how menopause is seen.” For them, menopause is a “time when there is quite a lot of energy as well, if it can be harnessed.” Several participants also noted positively that menopause had altered or evolved their sense of their own gender and sexuality. For Robin, at first it was “a bit weird and disorientating”, but ultimately they found the change welcome. “I think it has shifted although I am not totally sure how, but it does feel gender-wise [as if it] has put a bit more of the feminine woman’s experience into it.”

Sense of a new life stage beginning. Clare finally ended a long relationship post-menopause: “I don’t feel the propelling need that I had for 30 or 40 years to go out and [have sexual relationships] and that is such a relief!”

Bret felt coming through menopause could “prove really, really transformative.” Robin found their experiences encouraged them to slow down and find a sense of gratitude for small things. Ben was prompted to be more mindful and self-caring, and “[take] responsibility for my body.”

Theme Five

Therapists need more training in gender, sex, and relationship diversity, menopause, and hormones.

The participants were unanimous that therapists needed more training. This also applied to doctors and other healthcare staff.

Gender, sex, and relationship diversity. There were multiple concerns about therapists inaccurately representing themselves as queer friendly. Eve: “Good liberal therapists will […] pretend that they know what I am talking about, when their knowledge is based on *The L Word* or seeing the movie *Carol*.” Others felt defeated by the lack of knowledgeable therapists. Louise: “My expectations are so low.’ […] ‘Their definition of queer is so vanilla and narrow.” Personally, I note the disturbing number of counsellors who claim in online discussion that they can work with anyone, simply by asserting that they don’t judge. (Hope, 2017).

Katie wanted more understanding of asexuality, and clarification that post-menopausal women are not suddenly asexual. Eve wanted therapists to be mindful of their own internalised homophobia. For Louise Australia needs to evolve and embrace GSRD therapists.

Robin had a good experience with a much younger therapist because she did her own reading and was “respectful around not dismissing things.” Lucas had one bad experience with a therapist, adding: ‘I don’t think any training would have helped her.’

Sarah felt therapists need to understand that trans women “are not trying to replicate cis experience.” Ellis felt therapists should not assume a client’s trans identity was the reason for them seeking therapy.

Two participants realised with hindsight that their transition had been delayed by having long-term therapists who were affirmative towards them but did not know enough about trans issues. In several cases, participants stayed with their therapists for a very long time, perhaps due to fearing having to explain themselves to a new practitioner.

Menopause. Eve said that cis female therapists should “deal with [their] own fears about [menopause].” Alex wanted therapists to make recommendations about menopause resources. Lucas felt practitioners should be sensitive about language to avoid invoking dysphoria. “I used to call

my clitoris Mr C," he laughed, and for menopause he jokingly offered (translated from Dutch): "The end of the brothel in my pants."

Several participants said that gender clinics needed to know more about menopause. Ellis found their clinic insufficiently knowledgeable about taking HRT and testosterone together.

Hormones. Until our interview, Bret had thought oestrogen was exclusively a feminising hormone. Louise wanted therapists to assure queer clients that they won't "dob [them] in" for taking illegally acquired hormones. Sarah wanted therapists to know that "Hormones are mind-altering substances." Notably, there was no sense of exogenous hormones being equated negatively with medicalisation, e.g. Kelly (2008), and Steinke (2019).

Discussion

Summary

"It is unacceptable for professionals not to have a basic level of knowledge about the gender, sexuality and relationship structures of their clients." (Barker & Richards, 2013, p. 8). It seems that most therapist training organisations still treat GSRD clients as liminal, identity-wise and developmentally.

Queer menopausal clients are currently being poorly served by therapists and other healthcare practitioners. This client group is likely to have

already experienced minority stress which is compounded by the sometimes stressful and confusing symptoms of perimenopause.

Being LGBTQ+ adds the experience of queerphobic prejudice on top of the ageism, ableism and misogyny experienced by those in menopause. In addition, many LGBTQ+ people may not seek help because of a well-founded fear of ignorance or prejudice and having to explain themselves repeatedly. One of my concerns when starting this project was that queer people in menopause may be missing out on support, advice, and treatments, and this has been largely confirmed.

Implications for clinical therapeutic practice

Society struggles to recognise the seriousness of menopause as a life stage and a potential health condition. This lack of recognition will of course also affect therapists themselves.

Some therapeutic practitioners, depending on modality, may feel that to “support” or “validate” their queer menopausal clients would be to collude with them, and therefore be undesirable. This relates to the contrast between medical and social models, and whether a therapist feels they are the “cognitive authority” in the room (Haegele & Hodge, 2016, p. 203). However, my research makes clear that these are much needed aspects of therapy. Therapist disclosure, of queer identity and/or menopause status, may be helpful here (Butler & Byrne, cited in Moon, 2008). I also conclude that the

current attempt to create a more medical-model-driven hierarchy in counselling – (BACP, 2020) – may be potentially unhelpful.

My findings suggest that mainstream counselling and other healthcare trainings need to build in GSRD and menopause/age awareness systemically, from the very start, and not leave them to be taken care of by optional bolt-on CPD modules post-qualification. (This of course also applies to education around race, class and disability.) The therapy world needs strong leadership on this, but overall it needs far greater awareness of power dynamics (British Psychological Society, 2018).

While in the UK a counsellor or psychotherapist is not expected to have previous training in medicine, an understanding of hormone function (and bodies in general) would be helpful. It's worth noting, however, that many therapists may avoid mentioning hormones, particularly to a cis woman client, as this could be received negatively. See, for example, the negative media response (Estes, 2012) to a study by Durante, Rae and Griskevicius (2012) that found that women's ovulatory cycle influenced their voting preferences.

Overall, more thorough training would give therapists more confidence, and having a better understanding of gender and sexuality would contribute both to client work and therapist wellbeing. It would also help with the fear of getting things wrong that may hamper some practitioners.

Implications for society

It is perhaps unsurprising that there is no cultural template for the non-heterosexual, non-cis menopause. While mainstream media appears superficially to promote Pride, for example, it remains extremely transphobic and causes measurable stress (Ellis, Bailey & McNeil, 2016). It is also ageist in its promotion of consumption-driven unattainable youthfulness.

The white western cultural construction of menopause overall promotes a particular negativity and mourning for youth. Much of the focus is on loss: of fertility, the vagina's capacity for PIV sex, and attractiveness to men. Promoting queer interpretations and better sex education may provide a much-needed counterbalance. And clarity around other menopause narratives feels essential. It is very necessary to research populations beyond Caucasian women living in the west, and there is a lot of work to be done around measuring menopausal experience against other aspects of ethnic and geographical identity (Yisma, Eshetu, Ly & Dessalegn, 2017).

Potential future projects

To repeat this study on a larger scale I would do a survey, as the project had a lot of interest. I would also like to focus on sex and how it is impacted by queer menopause (Glyde, 2020), and the creative adaptations people make (also across the wider population) to increase pleasure in the ageing body.

I would like to explore the systemic failure of mainstream sex education, particularly in terms of the relentless focus on PIV sex, which does older

people (and many others) no favours. As menopause is a hormonal transition, its impact on identity is worth further examination.

Research on how therapist modality influences attitudes to GSRD identified and/or menopausal clients feels long overdue, as does an examination of how clinicians can be more effectively trained around GSRD. A survey of organisational barriers to this also feels timely.

Conclusion

I hope my work has contributed to greater understanding of the needs of queer menopausal clients. The message to therapists is very clear – this industry needs to do better. I hope this unequivocal feedback will encourage others to do further work on this previously neglected subject and catalyse long overdue systemic change.

7,425 words

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BIOGRAPHICAL NOTE

Tania Glyde (they/she) is a psychotherapist and counsellor in private practice in central London (https://londoncentralcounselling.com/). Qualifying in 2013, they specialise in working with clients who are GSRD (Gender, Sexual and Relationship Diversity) identified, which includes people who are LGBTQ+, kinky, non-monogamous, and sex workers. They founded the London Gender, Sexual and Relationship Diversity Practice (https://www.londonsexrelationshiptherapy.com/), a group of seven practitioners, in 2014. They are a member of the National Counselling Society, and a Pink Therapy Advanced Accredited GSRD Therapist.

In their previous career they were an author and broadcaster, publishing two novels and a memoir. More recently they have written for the *Lancet* and *Lancet Psychiatry,* including 'BDSM – Psychotherapy's Grey Area' (https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366%2815%2900058-9/fulltext)

Table One – Interview questions (three pages)
(referred to on page 14)

(1) PERSONAL DETAILS
a) What is your age? b) What is your occupation? c) What is your relationship situation? d) Do you have children? e) How would you describe your sexuality? f) How would you describe your gender? g) What is your pronoun?
(2) MENOPAUSE HISTORY
a. Have you experienced perimenopause? b. Have you experienced menopause? c. What symptoms did you experience? d. Can you tell me how you knew (if you knew) perimenopause or menopause were starting? e. If not, how long did it take to figure this out? f. Can you give a timescale for your symptoms (i.e. what age these phases started and ended) g. Have your menopause symptoms affected your daily life?
(3) MENOPAUSE KNOWLEDGE
a. What did you know about menopause when you were younger? b. How did you find out about it? c. Did you know anything about perimenopause specifically, ie how early it might start? d. Among your partner(s) *(where applicable)*, friends, or social circles, do people discuss perimenopause and/or menopause much? e. If so, do you notice a difference between how queer and non-queer friends/peers talk about it?

(4) LIFE EXPERIENCE OF MENOPAUSE
a. If you have any existing mental or physical health issues, do you feel these were exacerbated or initiated by perimenopause and/or menopause? *b.* Have menopause symptoms affected your working life? *c.* Have menopause symptoms affected your relationships? *(And your sex life, if relevant)* *d.* What are your coping strategies (if any)? *e.* Do you think you have adapted to this new set of symptoms? *f.* Have you experienced a grieving process around menopause? *g.* Do you think your sense of your gender or sexuality has evolved as a result of menopause?
(5) INTERACTIONS WITH THE MEDICAL/HEALTHCARE SYSTEM
a. Have you spoken to a doctor or nurse about your menopause symptoms? b. Have you had good experiences interacting with medical practitioners when it became clear that perimenopause and/or menopause were affecting you? c. What happened when you asked about it? d. *(Where applicable)* If you are taking hormones for gender affirmative reasons, have any of your healthcare practitioners previously mentioned perimenopause or menopause? e. Do you find the information given out about perimenopause and/or menopause to be sufficient? And appropriate? f. What do you think should be done better around this? For everyone in general? For queer people in particular?
(6) MENOPAUSE IN THE THERAPY ROOM
a. Have you been to counselling or psychotherapy? b. Did you have existing confidence in your therapist that they were GSRD (Gender, Sexual and Relationship Diversity) affirmative? c. Did you find the process helpful? d. Did issues of perimenopause and/or menopause come into the room? Implicitly or explicitly? e. Would you have welcomed your therapist proactively mentioning perimenopause and/or menopause? f. Would you have welcomed your therapist seeming to know more

about hormones? (Whether taken for gender affirmation purposes, or for menopause purposes)
(7) GENERAL IMPACT AND THOUGHTS ABOUT THERAPY
a. What has been the worst aspect of perimenopause and/or menopause for you? b. Has there been anything positive about perimenopause and/or menopause for you? c. What would you want therapists to understand about their queer menopausal clients? d. How might your therapist (or other practitioner) have helped you better?

Table Two - Table of participants (referred to on page 17)

Name (changed)	**Age**	**Pronoun**	**Gender**	**Sexuality**	**Occupation**
Bret	46	They	AFAB Non-binary	Pansexual	Project Manager
Erin	48	They	AFAB Non-binary	Queer	Therapist
Katie	56	She	Cis Female	Asexual	Therapist
Eve	58	She	Cis Female	Queer	Chaplain
Louise	49	She	AFAB Agender	Queer	Social Worker
Clare	62	She	Cis Female	Bisexual	Writer
Robin	45	They	AFAB Genderqueer	Lesbian	Communications Specialist
Sarah	48	She	AMAB Transfeminine	Queer	Therapist
Lucas	52	He	AFAB Transmasculine	Queer	Planner
Ben	51	He	AFAB Transmasculine	Pansexual	Therapist
Ellis	47	They	AFAB Non-binary	Queer	Unemployed
Alex	47	They	AFAB Genderfluid	Pansexual	Somatic sex educator