RESPONSE

TO THE HOUSE OF COMMONS SELECT COMMITTEE

ON WOMEN AND EQUALITIES

ENQUIRY ON MENOPAUSE

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londoncentralcounselling.com

queermenopause.com

ABOUT TANIA GLYDE

Tania Glyde (they/them) is a psychotherapist/counsellor and author, working with Gender, Sex and Relationship Diverse (GSRD) identified clients.

In 2019 they researched the experiences of LGBTQIA+ menopausal people in therapy and the wider healthcare system.

1. ***Could you tell us about your experience of menopause?***

I am in my mid-50s and I have been post-menopausal for over five years. With hindsight, I realise my perimenopause started at least 15 years ago, sometime in my late 30s. My menstruation became irregular when I was 39 but, along with other things I was experiencing, I didn't realise this had any significance at the time.

My experience of getting help from GPs was initially highly inadequate, but I didn't know what I didn't know.

Aged 42 I was told by GP#1: 'We don't test people for hormones just because they're feeling a bit down.'

Age 44 I managed to get a hormone test, but GP#2 said that the 'normal range' was so wide that it couldn't really tell them anything. I started feeling worse and worse around this time, which started to impact my emotions and behaviour. I had no idea why.

Age 48 I was having more obvious hot flushes and I asked again for a hormone test. GP#3 tested me, said ‘Within the normal range’ and dismissed me. When I pushed back, and asked what these temperature spikes could be, she replied crossly, ‘Well I don’t know!’ Once again, I did not know enough to argue with her.

Aged 49 I saw GP#4, who said that because I had been having hot flushes and other side effects for six months already, I should be ‘done by the end of the year’. Six years later they are still occurring.

Throughout all this I had been told that I could not have HRT because I’d had a stroke in 2008. Unfortunately it turned out that no one had read my records properly.

Aged 50, GP#5 finally had a proper look at me records and realised the stroke I had had was not due to a blood clot and therefore it was relatively safe for me to try taking combined HRT.

Aged 52, I was diagnosed with oestrogen receptor positive breast cancer, so I had to stop the HRT. During and after the treatment period, outside the oncology team I had a number of interactions (directly or less directly related to breast cancer) with a variety of health practitioners. I made a point of mentioning menopause in every single appointment as a possible influence on my situation and wellbeing. I got many blank stares, and the only person who engaged with me was a dental hygienist, a woman in her 50s.

I noted, for example, the radiotherapy operators’ lack of understanding or recognition of menopause, (radiotherapy exacerbated the side effects), and I finally took it to the department head. This was three years ago. As menopause awareness grows, I am hoping that others won’t have similar experiences.

a) What prompted you to start campaigning and raising awareness around menopause?

In 2019 I did a Masters in Counselling and Psychotherapy at the University of East London. It was clear, from the increasing number of conversations I was having with queer/non-binary friends about menopause at the time, that LGBTQIA+ people were needing more support and information with menopause but had no idea where and how to ask for it.

There was no research in existence that examined the experiences of LGBTQIA+ menopausal people in therapy and the healthcare system overall. My research identified a wide range of inadequacies in how this group had been treated, by both therapists and GPs. These experiences ranged from frustrating to traumatic.

My research is entitled 'How can therapists and other healthcare practitioners best support and validate their queer menopausal clients?' It is published in the Taylor & Francis peer-reviewed journal *Sexual and Relationships Therapy*.[i]

We know that things are bad enough for cisgender heterosexual women in menopause. They still cannot be assured of decent standardised treatment from the healthcare system, and still risk experiencing ageist and infantilising attitudes when seeking information and support.

However, for LGBTQIA+ people the situation can be even more challenging. When I started my research in early 2019, there were almost no relevant public discussions happening online, no specific websites, and no resources. Not even much naming of the issues at all other than in the occasional blog. I started a

website (queermenopause.com) and an Instagram account (@queermenopause) to create a starting point for a more public conversation.

My research was published in February 2021. In the last two years I have spoken at conferences about queer approaches to menopause[ii], and have written a chapter for the *Pink Therapy* psychotherapy series to be published in 2023. With other menopause activists, including the Menopause Inclusion Collective[iii], I am now working towards helping organisations use more inclusive language around menopause.

It's important to say that being LGBTQIA+ is just one aspect of a person's identity. If someone is LGBTQIA+ and is also a person of colour, disabled, with low financial resources, experiencing stress, neurodivergent, HIV positive, or is a trauma survivor, menopause may further exacerbate their situation. Unfortunately, there are still almost no inclusive books on menopause that talk about this.

The publication of Heather Corinna's *What Fresh Hell is This? Perimenopause, Menopause, Other Indignities, and You* (2021) is therefore a very welcome development[iv].

2. ***Some evidence to the Committee expressed concern that LGBT+ people have traditionally been excluded from the conversation on menopause.***

a) ***Why do you think this is?***

1) **General prejudice**

LGBTQIA+ people, despite the many differences between us, are othered in many similar ways. We may be seen as dangerous, decadent, perverse, disruptive, hypersexual, a threat to children, dissimulative, childlike, deserving of mockery, deserving of abuse, and even that we don't really exist. We are seen as such a tiny minority that we are not worth bothering about, or so incredibly powerful that we are a threat to the very fabric of society – sometimes simultaneously.

2) **The gender binary**

Trans men and non-binary people are left out of the menopause conversation due to both a pervasive unwillingness to (a) see beyond the experiences of cisgender women, and (b) to adapt social systems to trans and non-binary peoples' needs. This causes harm. (The general impact of this exclusion is vividly described in the blog post 'Humility and humiliation' where the author, a trans man, expresses frustration and rage at an inadequate and prejudiced healthcare system[v].)

Along with this, the binary gendered language around menopause can be alienating and excluding, and potentially cause dysphoria[vi].

For example, enforcing the gender binary impacts one group very heavily: people who are Intersex[vii]. Despite campaigns, clinicians are still operating on those born with variations in their sexual or reproductive anatomy, and without informed consent (either theirs or that of their parents). This may be done through subterfuge,

in order to normalise and binarise, sometimes condemning someone to years of surgeries, confusion, and consequent trauma. Surgeries may be performed without honest explanation as to why. ‘‘Many intersex women never experience periods, yet as part of the powerful medical institution, doctors wrongly tell intersex people that they are in post surgical menopause.’ (Davis and Khan, 2021).

3) **Avoiding irrelevant and potentially harmful resources**

The mainstream framing of menopause means many LGBTQIA+ people may avoid educational and support resources because they feel excluded by them. This could include ‘feminine’ or heterosexual-focused material, or the assumption that everyone is married to a cisgender man and is having PIV (penis-in-vagina) sex (or mourning the ending of it). Mainstream media encourages binary thinking, where the image of the wealthy white cisgender woman with a private doctor is still prominent. On top of gender, race and class are just two other aspects of a person that will impact how they interact with menopause information in the media and elsewhere. The overall impact is that people avoid interacting with resources, and so do not have a say in them.

4) **Unsafe healthcare environments**

If someone is queer, trans or non-binary they may experience mockery or hostility when trying to access care. Another reason an LGBTQIA+ person may avoid attending health clinics is that they may find being touched, being seen naked, or having certain words used about body parts or genitals, very challenging, and they may not feel confident that a practitioner will be aware of this and ask for consent, or discuss anything with them first. There is a strong need for gender-affirming healthcare across the board.

b) ***What can be done to remedy this?***

1) **Training and education**

Training of practitioners from the ground up, and everyone from the youngest age at school, about gender and sexuality beyond the binary. This sounds like a straightforward goal, but it is clear that it is anything but.

2) **Inclusive resources and language**

Publicity campaigns need to present menopause more accurately, and acknowledge, whether in posters, leaflets, and all media output, the experiences of everyone who may experience menopause. People need to use more inclusive language, (including avoiding gendered greetings[viii]), whether additive (including more identities), or using the most neutral language where appropriate. 'People with ovarian systems' can be a good starting point (as opposed to 'people with testicular systems'.)

3) **Listening to a wider range of people**

It is relevant to observe contemporary queer and trans menstruation movements[ix]. Members of those groups will age and go into perimenopause and will welcome your far-sighted policy making. Understand that there is an increasing number of young people identifying as non-binary or genderfluid.

3. ***Menopause is now part of the secondary school Relationship and Sex Education (RSE) curriculum.***

a) What do you think would be helpful for young people to know about menopause?

1) Young people should be taught that menopause is a phase of life that happens to a lot of people. That it doesn't just happen to middle-aged people, and it can occur for a number of reasons.

2) It is also important to teach about bodily autonomy, in terms of fertility for example. As attitudes to menopause across the board show, it's clear that loss of fertility makes someone a second class citizen. This is part of a general infantilisation of people who have ovaries.

3) Teaching about menopause is an opportunity to teach about intersectionality. Elsewhere I have written: 'Menopause isn't a 'taboo' – it's an aspect of life that is stigmatised by structural ageism and misogyny.'

4) However, it's also important to teach about the positive aspects of it, that it is a hormonal transition that is likely to be transformative.

4. ***What are the challenges you think that LGBT+ people experiencing menopause face in terms of diagnosis and treatment?***

To quote my research: '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.'

1) **Lack of information, especially about perimenopause**

Some of this is also what the mainstream population faces – systemic ageism, minimisation of health impacts, and a lack of information from a young enough age to understand when perimenopause may be happening. Some may be holding inaccurate information, particularly something they may have been told in their family when young, and not realise it is inaccurate.

2) **Existing trauma and health issues**

The LGBTQ+ population tends to have a higher level of addiction and of mental illness than average. Also a higher level of trauma. This may be exacerbated by perimenopause without the person realising.

3) **Practitioner assumptions**

Practitioners may make assumptions about the habits, lifestyles and even the genitals of their clients and patients. A common assumption is that all patients are heterosexual and cisgender. Asexual people may be told that they will 'find someone' and thereby find their presumed sexual self. (This is also a form of conversion therapy.) This is stressful and an experience like this may cause someone to stay away from getting help.[x]

4) **Poor trans and non-binary awareness**

As I have said above, trans and non-binary patients may face ridicule or stonewalling by clinic staff, ie mocking pronouns and ignoring name changes. Practitioners may dismiss anything they do not immediately understand, including dysphoria. (This is even more serious when someone transitions and the gender marker on their records is changed, but then they are left out of cervix, prostate or breast screenings.) The lack of joined up thinking here causes escalating stress and is damaging to mental health. Having to deal with this level of prejudice in our healthcare system, that is supposed to be for all, is enough to turn a person away, and someone may not access the healthcare they need.

5) **Anticipatory stress**

Poor experiences in healthcare mean that many LGBTQ+ people may experience a lot of stress before seeking help. None of this is beneficial to health. This also applies in terms of a sense of needing to perform for gatekeepers, such as if someone is starting transition when also coming into menopause. From my research: '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).'

6) **Practitioners needing greater understanding of GSRD identities**

LGBTQIA+ people are not a homogeneous group. As well as LGBTQIA+ identities, the GSRD (Gender, Sex and Relationship Diversity) umbrella includes consensual non-monogamy, BDSM/kink lifestyle and practices, and being a current

or ex-sex worker. If healthcare practitioners do not understand this, the person may feel stigmatised and not mention these further aspects of their life.

7) **Inadequate explanation of hormones**

Sex hormones are treated in a very binary way. Few people realise that the ovaries produce testosterone, and the testes produce oestrogen.

Of course, ‘It’s your hormones dear’ has been used to stigmatise and gaslight cisgender heterosexual women, so there may be an assumption that all patients feel the same. In fact supplemental hormones, for those who wish to, (or are able to), take them, are also seen as part of life and a way to feel, and appear, more congruent. Non-binary people, for example, may microdose testosterone rather than take a full dose. There needs to be far more joined up thinking about how oestrogen, progesterone and testosterone, exogenous and endogenous, interact with the body and with each other, and the best use of them for each individual patient across the board.

Education is poor to the point that a transmasculine or non-binary person may be experiencing, for example, Genitourinary Symptoms of Menopause (GSM; previously known as ‘vaginal atrophy’), but fear using topical oestrogen in case it feminises them. People are suffering in silence and education is needed.

Someone AFAB (Assigned female at birth) transitioning by taking oestrogen blockers and testosterone will be in the position of going into puberty and menopause at the same time. Again, this needs to be named and understood.

5. ***What do you think are the three most important things that employers can do to support their LGBT+ employees going through menopause?***

1) **Listen to the needs of LGBTQIA+ menopausal employees.**

Believe them when they ask for what they need. As with all menopausal people, someone may need to use the toilet more often, (whether due to heavy bleeding or Genitourinary Symptoms of Menopause) or open a window or have a fan. They may need more time to respond to things due to brain fog. Menopause may be bringing many contradictory feelings, both relief at the end of menstruation, whether it has already occurred or not – but also grief for many reasons.

Menopause, and the discussion of it, may bring a reminder of a 'feminine' aspect of a person that is hard to experience. Make sure that if someone needs to take regular breaks, or time off, due to menopause side effects, (and exogenous hormone increase/reduction side effects as part of transition or because of preparing for surgery[xi]) that this is not used against them. Ditto ageism, and people in middle age and older having menopause used as an excuse to start edging them out of the company, whether in a white or blue collar position.

2) **Accept that it is not just women who experience menopause.**

Ensure that the workplace understands the full range of gender identities and expressions. Also names and pronouns. And not make assumptions about anyone based on how they look, or their name, or anything else. Employers can make it clear that discrimination around this (or anything else) will not be tolerated. This means that the education needs to start at the top, with the employers themselves.

Make sure any menopause information you provide is gender inclusive or gender neutral.

3) **Look at this group through an intersectional lens**

Reflect on what other difficulties may they be experiencing, such as minority stress and trauma, that will be exacerbated by menopause.

CONCLUSION

I want to say that LGBTQIA+ menopausal people also have positive experiences when accessing healthcare. There is anecdotal evidence that parts of the medical world are starting to listen. However, until we have a level playing field on this, which we are very far from, it is necessary to point out where work needs to be done.

For anyone who feels there is a risk of erasing women's experiences by including everyone else, it's worth noting the parallels elsewhere. Age is a good example. Although the mainstream narrative around menopause is about middle age and ageing, in fact people as young as teenagers can go into menopause for health or surgical reasons. For them the 'tragic ageing' narrative may not feel relevant.

Ultimately, everyone's experiences should be named in order that they receive equal care. It is about making sure everyone is included who needs to be.

I welcome the Committee's interest in LGBTQIA+ experiences of menopause and I am very grateful for this opportunity to present my evidence.

Tania Glyde

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FURTHER READING

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