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‘Difficult to Divulge’: The Impact of Organisational Silence around the Menopause

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Grace*

Abstract

This article presents an account of one woman’s experience of the menopause. Affecting 51% of the global population, menopause has the potential to negatively impact home and work life. Yet, the arrival of menopause can often be a surprise due to a lack of education and awareness. Over 63% of UK working women claim menopause has negatively affected their careers, yet only 30% of employers support women to work through the menopause, and the cost to business and to women’s health is significant. Shrouded in silence, the menopause is often misunderstood, and taboo exists. Therefore, women do not divulge, and many leave their jobs unsupported. Through Grace’s story, this article explores how women’s hormone health can affect work and by opening up conversations and raising awareness, as we have with mental health, it is possible to eradicate the silence behind the taboo.

Keywords

menopause, silence, symptoms, taboo, voice, workplace

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Introduction

Menopause is trending on political, legal, health and workplace agendas. Affecting 51% of the global population, menopause has the potential to impact the individual's working life. A bio-psych-socio-cultural process (Ilankoon et al., 2021), menopause is often a negative experience (BMA, 2020), but can be experienced more positively if women are provided with the tools to manage it (Chartered Institute of Personnel and Development [CIPD], 2021). Almost two-thirds of FTSE 100 companies fail to publish menopause support (Brand, 2022), and only 30% of businesses actively support menopausal employees (CIPD, 2022). Termed the last workplace taboo (Jack et al., 2021), 63% of UK working women claim menopause has negatively affected their careers (CIPD, 2021), with one in 10 leaving their jobs (Women and Equalities Committee, 2022).

Many women do not divulge their menopause status, fearing repercussions in the workplace, perpetuating their silence and gendered ageism. Grace's story draws attention to the impact of the 'silent' menopause at work and explores the bidirectionality of women's menopausal health impacting work and workplaces and, in turn, affecting menopause health. We answer calls by Riach and Rees (2022: 4) for more research on 'confounding factors' around menopause; Hardy et al. (2018) about the impact of work on the menopause; Atkinson et al. (2021a: 3) on menopause experiences stemming from surgeries such as oophorectomy or cancer treatment; and Jack et al. (2014) on coping strategies.

The realities of menopause have been shared by media and celebrity storytellers, led by presenters such as Mariella Frostrup, and documentaries such as 'Sex, Myths and the Menopause', Davina McCall's exploration of how menopause affects the workplace (Morris, 2021). High profile presenters have amplified awareness of oft-unspoken realities such as midlife confusion, shame, hysteria, workplace discrimination, ridicule and taboo (Atkinson et al., 2021b). In parallel, the impact of World Menopause Day and social media have generated greater openness about menopause, evidenced through a growing range of websites, blogs and podcasts – engaging ways of communicating that can be replicated organisationally (Morris, 2021). Viewed as a cultural zeitgeist (Beyene, 1986), according to Muir (2021) we are about to witness a tipping point.

A study by Hardy et al. (2018) concludes menopausal women want empathy, support for symptom management, supportive policies and menopause awareness training for line managers. The Institute of Government and Public Policy (IGPP, 2023) suggests tackling menopause at work involves addressing inadequate workplace practices and raising menopause visibility, while others cite potential backlash from heightened menopause awareness (Atkinson et al., 2021a), such as menopause health concerns interpreted as women complaining (Butler, 2020). In contrast, Tunley and Kapilashrami (2021) argue that silence translates into a lack of support while talking contributes to normalising menopause at work. The workplace can be a site of tension where women mould their bodies and hide menopause symptoms to maintain acceptable norms (Beck et al., 2022), a huge burden for one-third of women who experience long-term symptoms (Hamod and Moger, 2022).

The menopause

A biopsychosocial phenomenon (Ilankoon et al., 2021), caused by hormone deficiency, menopause occurs in all menstruating females. A transition that women will experience differently, menopause is not an illness or disease (National Institute of Aging, 2021). Diagnosis is clinical, based on the absence of menstrual periods for 12 months (Peacock et al., 2022), and for most women it is a natural process signifying the end of reproductive life (NHS, 2022). A three-stage transition termed perimenopause, menopause and post-menopause (Hillard et al., 2017), it typically occurs between ages 45 and 55, although 1% of women in the UK experience menopause before the age of 40 and one in 1000 before age 30 (NHS, 2022). Premature menopause triggered by cancer treatments and surgical procedures presents different challenges that can influence the onset of conditions such as dementia and osteoporosis (Faubion et al., 2015).

Symptoms of menopause

Menopause symptoms are physical and psychological (Atkinson et al., 2021b) and typically last seven years (Hillard et al., 2017) but can continue beyond 10 years. Up to 70% of UK women will experience physical symptoms such as hot flushes, night sweats, vaginal dryness, hair loss, aching joints, nocturia and itching skin (Hamoda and Moger, 2022). Psychological symptoms include anxiety, mood swings and sleep deprivation (Beck et al., 2021). Cross-cultural research highlights differing experiences of menopause symptoms based on geographical location and ethnicity (Hickey et al., 2022). For instance, women in western countries suffer more from vasomotor symptoms like night sweats and hot flushes, in contrast to only 5% of Asian women who found joint pains during menopause to be most problematic, affecting over 70% of women. Cultures where menopause is a social stigma (Asad et al., 2021) can influence the severity of symptoms (Beck et al., 2021) and prevent disclosure (Brown, 2022).

Stress is a significant contributor to menopause mental health, with fluctuating hormones and increased cortisol affecting cognitive function, manifesting as brain fog and difficulty concentrating (Ali et al., 2020). Symptoms are heightened by work environments where women cannot control temperature, ventilation and noise (Women and Equalities Committee, 2022), with symptom management proving easier if working from home (Brewis, 2020).

Menopause symptoms precipitate sleep disruption, impacting work and relationships (Schaedel et al., 2021). Lifestyle changes, diet, exercise, stress management and self-care can reduce symptoms, but many lack awareness of this (Beck et al., 2022). Hormone replacement therapy (HRT) can alleviate some symptoms (The Lancet Diabetes & Endocrinology, 2022), yet shortages coupled with long delays to reduce controversial HRT charges in England, rectified in April 2023 by introducing a prescription prepayment certificate (GOV.UK, 2023), have added to the daily challenges of working through menopause. Indeed, HRT may not be prescribed by general practitioners, who are insufficiently trained to recognise menopause symptoms, such that many women can meander down a myriad of clinical pathways looking for a diagnosis at a cost to the NHS, the economy and women's health. Consequently, many seek private menopause health support, with some placing the cost on credit cards and contributing to personal debt (Bache, 2021).

Menopause and the workplace

UK women are living longer, working more and retiring later (Kopenhager and Guidozzi, 2015), with many working through their entire menopause cycle. Of the 15.5 million UK working women (Office for National Statistics [ONS], 2021), 4.5 million are aged 50+ (Women and Equalities Committee, 2022) and crucial to the economy (Muir, 2021). Yet, three in five women compromised by ‘hormonal chaos’ (Kopenhager and Guidozzi, 2015: 372) find it difficult to cope at work, with employers often ignorant of how to create a healthy working environment, hindered by neutral work cultures and blanket policies (Verdonk et al., 2022).

Menopause is gaining political traction. In 2022, the Women and Equalities Committee, a UK Parliament Commons Select Committee, published its findings into menopause in the workplace. The report encourages employers to support employees through menopause training and policies. Supported by trade unions (Williams, 2022), the report recommended enforcement of Section 14 of the Equality Act 2010 to distinguish menopause as a protected characteristic (Women and Equalities Committee, 2022). However, it was rejected by government who were concerned with burdening employers further following Brexit and the COVID-19 pandemic (Reeves, 2023). The All-Party Parliamentary Group on Menopause (APPG, 2023) concluded current support is inadequate and made 13 recommendations to break the menopause taboo via employer-led campaigns, policies and supportive interventions and the appointment by government of a menopause employment champion.

Workplace environments affect menopause and impact engagement, motivation, performance and employee relations, ultimately leading to 900,000 women leaving work prematurely (Women and Equalities Committee, 2022). While their exit contributes to skills shortages and pension inequality (Brown, 2022), many women fear speaking out for fear of ridicule (Kopenhager and Guidozzi, 2015). Negative attitudes towards age, coupled with the challenge of working while experiencing debilitating menopausal symptoms, impact many women (Rees et al., 2021).

A joint study by King’s College London and The University of Nottingham asked, ‘What do working menopausal women want?’ (Hardy et al., 2017: 37). Three themes emerged: employer/manager awareness, employer–manager communication and employer actions. Requests for empathic language, supportive policies and menopause training for line managers highlight the need for workplace adjustments for women to remain safe and age well at work (Equality and Human Rights Commission, 2019).

The UK charity Wellbeing of Women has garnered commitment from some organisations to the Menopause Workplace Pledge to support and retain menopausal employees (Wellbeing of Women, 2022). To date, 2000 employers have become signatories, recognising that menopause support mitigates against legal claims, reduces absenteeism and increases productivity (Rees et al., 2021). Reaffirming its menopause commitment, the Labour Party’s manifesto includes mandating menopause plans for organisations with 250+ employees (Adu, 2023). Trailblazing the way, London’s mayor, Sadiq Khan, launched a ‘world-leading’ menopause policy to shift perceptions and provide support and menopause leave (UNISON, 2022). Many organisations too are creating menopause-friendly workplaces, such as the Bank of Ireland that offers staff who suffer menopause symptoms 10 days of annual paid leave (Slattery, 2022); the same offer was rejected by the UK government as counterproductive and discriminative against men (BBC, 2023).

Coping strategies

Despite the growth of workplace menopause policies, an implementation gap exists (Hardy et al., 2019). Women's lived experiences highlight how work can exacerbate poor health, particularly in gender-biased workplace cultures (Atkinson et al., 2020). Steffan (2021) argues blanket human resource policies are inadequate, while Verdonk et al. (2022) refer to small tokens of acknowledgement such as ventilated spaces that support women's symptoms. Butler (2020: 697) draws upon the notion of menopause being managed at work, asking 'are bodies manageable?'. Further questioning whether we are managing menopause or embarrassment, Jack et al. (2014) concur recommending workplace resources to facilitate and support, as opposed to manage.

Coping strategies can involve women moulding their bodies to belong in a given space (Beck et al., 2022), such as Steffan's (2021) description of women concealing their bodies in baggy clothes to conceal weight gain. Jack et al. (2019) alludes to women hiding themselves, intensifying workplace invisibility. Verdonk et al. (2022) refer to strategies to counter forgetfulness, such as double-checking work and making lists. Putnam and Bochantin (2009) highlight the concealment of kit women bring to work to provide relief: cold packs, heaters, blankets, fans, spare uniforms and black cushions for light seats (to conceal unpredictable menstrual flow), while Jack et al. (2014) share how women reschedule meetings around symptoms. Education around strategies to manage menopause symptoms is advocated (Asad et al., 2021), with a greater focus on health and wellbeing to improve quality of life. The ideal is to enable women to control their symptoms in a supportive climate – not always possible as behavioural changes and an inability to control symptoms lead to symptomatic reactions (Butler, 2020). For women to share their experiences, an organisational culture of allyship and supportive safe spaces are required (Women and Equalities Committee, 2022), with an increase in menopause cafes providing such support (Beck et al., 2021).

Menopause: Silence and voice

Historically shrouded in silence, only now are women challenging decades of silence around menopause, yet barriers that prevent disclosure remain (Hardy et al., 2019). Barriers include myths and taboo about menopause (Morris, 2021), as well as fear of ridicule (Grandey et al., 2020), such that little over 30% of women disclose their menopause status at work (Beck et al., 2021). Unsurprisingly, concerns about stigma are a deterrent to disclosure (Tunley and Kapilashrami, 2021). Working while transitioning through menopause is multifaceted and for many women menopause remains taboo, particularly in male-dominated environments (Grandey et al., 2020) where 41% of women have witnessed menopause treated as a joke (Fawcett Society, 2022). Research by Health and Her (2019) identified that the majority of women keep their transition through menopause private and instead work extra hours to compensate for menopausal symptoms. This equates to 'two million women giving up their own time for something which is out of their control' (Bache, 2021: 2).

Confronting the silence about menopause means changing workplace cultures to normalise menopause conversations so women can disclose without fear (CIPD, 2019). To

achieve this, lessons can be learned from the evolution of mental health in the workplace, which effectively went from 'don't ask, don't tell' to 'do ask, do tell and let's talk' (Pfeffer and Williams, 2020: 2). The model already exists, providing hope for a future where menopausal women can thrive and remain at work (Tunley and Kapilashrami, 2021).

What follows is the voice of an individual experiencing the whole range of menopause symptoms with little access to understanding from HR, line management or policy. Grace's situation was more challenging by working in a predominantly male environment with little empathy for menopause concerns. While debates about menopause are increasing, they have yet to permeate organisational cultures to ensure that menopause is no longer perceived as a 'professional liability' (Trethewey, 1999: 445) as experienced in Grace's story.

Grace's story

Plagued by hormonal afflictions since a young adult, I balanced the challenges of endometriosis and premenstrual dysphoric disorder (PMDD) in secret until catapulted into a surgically induced menopause age 50 when I underwent a private, bilateral oophorectomy (full hysterectomy with removal of ovaries). Armed with an A4 menopause fact sheet, I read about the potential symptoms and proceeded, not understanding the full impact. Unlike the majority of women who experience menopause naturally, mine was surgically induced due to the abrupt cessation of hormones, putting my body into a sudden and premature menopause. The impact of a sudden drop in the sex hormones progesterone, oestrogen and testosterone, and an increase in the stress hormone cortisol, immediately impacted my psychological, physical and genitourinary health.

I worked in the male-dominated Financial Services sector for 16 years and turned up for work daily regardless of my emotional or physical state of being. Sometimes, when fatigued, I would book out a darkened meeting room, lock the door, put chairs together, set an alarm and sleep. Holding a leadership position I took advantage of my privilege, justified to myself by my propensity to work late. A secret, I didn't share for fear of judgement or repercussion. Upon reflection, I had become deviant through circumstance.

A few weeks after the operation I experienced the top five menopause symptoms: daily hot flushes, night sweats, broken sleep, brain fog and irritability. Paranoia was my enemy, made worse when I lost my hair, my skin was crawling and my mood was low. Despite diminished confidence and constant anxiety, I returned to work within six weeks, as it was expected. A void of support from HR meant a return-to-work interview did not take place, so adjustments for a gradual return were not captured. Unlike women going through pregnancy, a risk assessment for menopause was not undertaken. Had I returned to work having broken a bone I would not have let these points pass; however, because my absence was gender related, I accepted it as the norm and 'soldiered on'. Shortly after, I reacted adversely to hormone replacement patches, so I stopped usage, not realising alternative HRT preps were available. At that time, I didn't seek further help from my GP to manage the menopause – looking back I can't explain why. Upon reflection, it was vanity and fear of additional weight gain. Subsequently, I struggled at work. I used a LadyCare – a magnet attached to underwear below the naval to regulate body temperature and reduce hot flushes. It worked, partially, yet I remained fatigued and made errors, over spoke, lost words mid-sentence, double-booked

my diary and turned up to meetings late. I became unrecognisable to myself, and relationships at work and home fractured. Still, I didn't divulge my menopause status, which required courage and trust that I simply could not muster.

Within my cohort of mainly male senior managers, workplace banter discouraged the sharing of personal information. Inapt comments regarding female health were 'women's issues'. For me, I feared ridicule and insensitive negative labelling. The work culture was rarely challenged and 'women's issues' were something to 'be suppressed for home', as my new male manager announced when I cried at work for the second time, labelling my behaviour 'unprofessional' and 'ugly'. In my private life I was supporting a mother with dementia, a daughter leaving home for university and a husband recovering from cancer, all while working full time and managing my menopause symptoms that my heightened stress levels compounded. At the time I didn't make the connection between cause and effect. Looking back, I was merely surviving and it is only in retrospect the severity of those moments is realised.

Experiencing menopause symptoms daily, I failed to function well at work and performed only by overcompensating. My prior confident and competent behaviours inadvertently changed through menopause, and without discussion I was sidelined, with the caveat my unprofessional behaviours needed to be addressed. A replacement role was suggested, but there was an alternative, leave with a non-disclosure agreement. Distraught, I accepted the first option but received no training to perform the new role, so my husband would spend time at weekends attempting to bring me up to date with work I couldn't focus on during the week, creating work–family conflict. Following 24 years of managing call centres, the new role exacerbated low self-confidence, anxiety and menopause mental ill-health. An empty being, I still attended work daily, believing it was the right thing to do.

During irregular 1-2-1s, a new female line manager would mock my nervous demeanour. I shared my background of menopause and received flippant advice to build more resilience. I wore black clothing, never colour, fading further into the background. A former extrovert, I sat among introverts in IT where, despite attempts to make conversation, people didn't speak. I felt invisible, ignored and experienced frequent panic attacks – symptoms synonymous with menopause. I struggled psychologically, but I still attended work daily.

Over the following six months, 1-2-1 meetings were cancelled often. I would present at the door and be dismissed with a swift hand movement and no eye contact. I eventually gave up and presented to my GP with anxiety, who urged me to speak with my employer. I approached my line manager who, without a trace of empathy, advised if I was unhappy I should leave, reinforcing my belief that I no longer belonged. I left the meeting and felt compelled to join a trade union.

Joining a trade union provided an unexpected outcome. I now belonged to something bigger than myself, albeit an invisible cohort, yet psychologically I was no longer managing menopause alone. With a newfound confidence, I took control and moved to a different workspace that was positive and inclusive. I adopted a strategy to 'manage' my manager, stay low maintenance, smile always – kill with kindness and avoid contact when possible. Having changed the dynamics of my workspace and my relationship with an elusive manager, I started to function and manage my menopause symptoms, helped by a low dosage of antidepressant that levelled my thinking.

I developed strategies to support my wellbeing, such as taking a heater into work, wearing warmer clothing, improving my stamina and fitness by taking the stairs, modifying my diet by reducing refined sugars and adding protein to avoid energy dips, taking breaks, talking – under muttered breath – with colleagues experiencing similar menopause challenges. Having an outlet to mock and laugh at the beings we had become provided relief and a sense of belonging.

Upon reflection and pondering my experience as a senior leader, little attention was paid to the health and wellbeing of the workforce, and silence about the menopause was the norm. I now question my behaviour in those moments. Why was I silent, not only about my own struggles with menopause but about other women within my cohort? Why was I reluctant to poke and prod, generate understanding and show interest? Why did I not actively support women's health initiatives at work? Why the silence? These questions have kept me awake at night but, at that moment, I would not have done anything differently because my behaviours were influenced by organisational culture. In candour, I simply didn't want to raise my head above the parapet and associate myself with an 'unsolvable' gender-related problem. Neither did I relish being labelled 'menopausal, hormonal, old'. My menopause health was private and I was paid to do a job that came first – my health and that of my family were secondary. I was foolish.

Unsurprisingly, I was served with redundancy and had seen it coming. The reality is that with a 21% pension and a salary package topped up with a car allowance, private health care, life insurance, mobile phone and internet, I was too costly to the business, as were several others aged 50+. Homing in on menopause behaviours to remove me from a pivotal role seriously affected my health, such that I was later diagnosed with post-traumatic stress disorder and short-term mental ill-health. I took my case to a solicitor who confirmed the wrongdoing. As the three-month employment tribunal window had elapsed, I was powerless to proceed. Disappointed and traumatised, I did not have the energy or foresight to challenge. To heal, I turned my attention to becoming educated, supporting other women, becoming a menopause advocate and workplace menopause consultant, and have since been awarded a PhD scholarship. To conclude, I refer to Professor Brown: 'When we deny our stories, they define us. When we own our stories, we get to write a brave new one' (Brown, 2015: 6).

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