Manuscript Number: IJOSM-D-22-00104R1

Title: “It’s all about the story”. Osteopaths’ experiences of exploring menopausal symptoms: a qualitative interview study

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ABSTRACT

Background: The prevalence of natural menopause means that middle aged women seeking osteopathic treatment are likely to have symptoms, but it is unknown how osteopaths explore and give advice about it.

Aim: To explore osteopaths’ experiences of screening for symptoms of menopause and providing advice to climacteric patients.

Methods: Elements of interpretative Grounded Theory, via semi-structured interviews with a purposive sample of six experienced osteopaths and constant comparative analysis to identify themes.

Results: Three themes emerged: *Breaking the ice*: describing the menopause as a sensitive topic with social, personal, and professional barriers to explore it; *Personal - not so personal,* revealing the influence of practitioners’ personal experiences of the menopause; and *Storytelling*, illustrating osteopaths’ narratives about patient interactions.

Conclusions: The three themes combined flexibly to form partially overlapping therapeutic approaches, underpinned by participants’ personal experience of the menopause and conception of osteopathy: *Sharing Stories,* where personal disclosure is leveraged to enhance the rapport, with links to the Communicator therapeutic

approach (Thomson 2013b); *Telling Stories,* where the absence of personal experience led to a de-personalised narrative and elements of the Treater approach; and *Changing the Story*, where personal experience plays no role and the focus is on patients' empowerment, (Educator approach).

Further research is needed to explore findings on osteopaths without personal experience of menopause and to evaluate osteopaths' training to address sensitive topics.

Implications for education/practice

- Some osteopaths reported feeling unprepared for discussing complex menopausal symptoms, which osteopaths with personal experience of menopause overcome by leveraging a shared narrative. This is unavailable to male or younger practitioners without specialisation in female health, suggesting that further education may be helpful prior to starting practice.
- Findings suggest that further training about the evidence for managing menopausal symptoms, and cognitive communication approaches to patient education could promote sustainable behaviour changes.
- New educational curricula and clinical training could incorporate a broader biopsychosocial perspective of the menopause and communication skills training to support sensitive and effective patient care, irrespective of an osteopath's personal experience, specialisation, age, gender.

Keywords: Menopause, Narrative Medicine, Osteopathy, Therapeutic Relationship

INTRODUCTION

Menopause is considered a natural part of the aging process in women and is defined as occurring after twelve months of amenorrhea, usually between 46-52 years of age (Schoenaker et al, 2014) and at a mean age of 51 in the UK (NHS, 2022). Ovarian aging and the consequent decline in oestrogen and progesterone production induces menopause, sometimes accompanied by somatic, vasomotor, metabolic, sexual, urogenital, psychological, and musculoskeletal symptoms (Monteleone et al, 2018). These are variably experienced by about 75% of the 13 million women of menopausal age in the UK (Constantine et al, 2016; ONS, 2022), making it likely for women of that age bracket in the care of an osteopath to experience symptoms.

The lived experience of the menopause

The transition to menopause can be a normal occurrence and a physical non-event, (de Salis et al, 2018) or be transformative and liberating, accompanied by a sense of freedom and rebirth (McBride, 2019). Conversely, for some women the transition to menopause can be emotionally challenging. Women may question their relevance, attractiveness, and vigour (Sergeant & Rizq, 2017), feel invisible and vulnerable and in need of personalised healthcare (Hoga et al. 2015). Different narratives often intertwine and are experienced simultaneously or successively (de Salis et al, 2018).

Unmet medical expectations

A review of qualitative evidence (24 studies) showed that “healthcare providers pay little attention to a woman´s perceptions of her experience of the menopause” (Hoga

et al, 2015, p. 252), leading to unsatisfactory medical encounters. This seems to be due to traditional biomedical discourses around the menopause which position it as a discrete biological event but fail to consider women's needs and experiences of feeling unwell in the context of their individual circumstances (Sergeant & Rizq, 2017).

Literature also highlights women's expectations that their healthcare providers (HCPs) initiate conversations around sexual health during the menopause, although less than one-fifth were asked about it (REVIVE survey, Kingsberg et al, 2013; EMPOWER survey, Kingsberg et al, 2017). This reflects a generalised lack of questioning of older adults about matters concerning sexual health (Wyman et al, 2018; Schaller et al, 2020).

Barriers to discussing the menopause

There is little research into HCPs' barriers to initiating conversations about the menopause. Barriers have been investigated in discussing female sexual health which are exacerbated during the menopause: biases and discomfort ("fear of opening a floodgate", Gott, 2004, p. 529), lack of training and skills, time constraints and administrative factors (e.g., how to code for menopause in insurance claims) (Kingsberg et al, 2019). Moreover, it has been reported that HCPs seem to adopt a more biomedical perspective with older patients than younger adults (Gewirtz-Meydan et al, 2020), confirming women's perceptions of HCPs paying little attention to their experience of the menopause (Hoga et al, 2015) and the possible influence of ageism (Wyman et al, 2018).

Even less literature addresses HCPs' experiences in relation to the psychological and social implications of menopausal symptoms and their potential impact on sexual

health and activity. Since no studies specifically looked at osteopaths' experiences of working with this patient group, it is unclear what conversations about the menopause take place in osteopathic practice. This study aims to fill a gap in research and explore how osteopaths screen for symptoms of a potentially sensitive topic and how they provide advice to climacteric women.

METHODS

The COnsolidated criteria for REporting Qualitative research (COREQ) (Tong et al, 2007) were used to enhance the reporting of this study, as demonstrated by de Jong et al (2021).

Design

The study design was qualitative, with elements of constructivist Grounded Theory (GT) (Charmaz, 2014) via semi-structured interviews. The interpretative method of this epistemological approach was deemed appropriate for this project as it aims to understand and portray the experiences and meaning from the participants' perspectives (Charmaz, 2006) and has an inductive approach to generating theories. Like all qualitative research with interpretative approach the purpose is in depth-explanation and meaning and not generalisability (Carminati, 2018).

Participants and recruitment:

The aim was to recruit a purposive sample of eight to twelve osteopaths, male and female, with more than five years of practice expertise (Benner, 1984) and who had treated at least two patients with menopausal symptoms in the past six months. Eight osteopaths expressed interest and six participated in this research project.

Recruitment was via non-coercive emails and Participant Information Sheet (PIS) sent to addresses from the General Osteopathic Council (GOsC) database of registered osteopaths.

Data Collection and Analysis:

All interviews were video- or audio-recorded and lasted approximately one hour. They followed an interview guide (Table 1) with open-ended questions. Four repeat interviews were carried out at later stage to clarify statements.

Table 1 Interview Guide

Please could you start by telling me about your current osteopathic practice.
How do you typically explore the gynaecological history and menopausal symptoms during case history taking with a new patient?
What kind of factors might prompt you to ask more about the menopause during follow-up sessions?
Please can you tell me about a patient where menopausal symptoms were an important part of the patient's presentation or your treatment or management advice
What about a patient where you felt that menopausal symptoms may have been important, but it was more difficult to talk about or to manage or to give advice?
In your clinical experience, what patient-related factors make it easier or more difficult to explore the relevance and impact of the menopause?
Do you think there is anything about you personally and as an osteopath that makes it easier or harder to work with menopausal patients?
Is there anything else you would like to say about your experience of working with menopausal patients?

The interviewer and participants were alone during the interviews, which were subsequently transcribed verbatim. Analysis focused on the audio-recording of the transcripts as analysing audio- and video-taped data was considered too complex for undergraduate research. Transcripts were then analysed using elements of GT to

generate codes in a two-stage approach of initial coding ("to define actions or events in a given situation": Thomson et al, 2013b p. 2) – and focused coding (Charmaz, 2014), to achieve higher levels of conceptualisation (Table 2).

Table 2 Examples of coding and themes

Verbatim quote	Initial coding	Focused coding	Theme/subtheme
05: I make this joke that my husband couldn't believe it and his argument … "I'll pay for you to go. When is your next acupuncture session, you know, I'm going to pay for it!" that kind of thing…"	Sharing own experience, with humour	Reassuring the patient (affective reassurance)	Storytelling/ Sharing Stories
06: "Yeah, well I always say: 'well, this is a change that every woman that reaches this age is going to pass through – some of us have way more symptoms, some of those have got all of them – but it's something that is going to happen, and we need to just learn how to adapt to that'".	Positioning menopause as a process of change and adaptation	Cognitive Reassurance (Aiming to change the patient's negative beliefs)	Storytelling/ Changing the Story

Constant Comparative Analysis (Charmaz, 2014) was applied to transcriptions and codes and between interviews in an iterative process to allow the constant comparison of data and participants, noting differences, similarities, and relationships, and leading to progressive levels of abstraction (Bryant & Charmaz, 2007) and to the interpretations about the meaning of participants' experiences.

Memo writing:

To encourage analysis and reflexivity, monitor assumptions, keep an audit trail, and strengthen credibility (Lincoln & Guba, 1985), the researcher kept a critically reflective

stance from the early stages of the project, writing informal notes and a journal, slowly merged in one single document (understandably, according to Birks et al, 2008) with increasing levels of analysis (Table 3).

Table 3 Journal entries: Reflective and analytical memos examples

28/10/2021: I found this interview particularly challenging. This participant struggled to really open and kept giving what felt like "matter-of-fact", pragmatic statements with limited introspection. They replied they did not have any cases [examples] of two of the main questions, basically cutting short the interview. I went in circles for a bit but then managed to go deeper with a few questions and get some meaningful answers (to be seen upon transcription). Have realised that the direct approach of the participant ….was a bit frustrating. I kept asking questions from different angles – and maybe sometimes not so different – because I felt I was not going anywhere.	*11/01/2022: Interesting. Participant X swings from Empowering to Explanatory (top-down) positions with their patients. Consider if it's driven by the patient's beliefs and suggestions (what they say and what they think they have) or if it's driven by the osteopath's beliefs, training, experiences*
31/12/2021: Have started to colour-code the Line-by-Line. This is immersing me once again with the data. I can see it's giving me a deeper or different insight into their statements. I am looking at the examples they have given to me more than the abstract statements, and I have re-worked some of the initial coding I had previously written. I am starting "to find" more meaning and to become more analytical in my approach to the participants' statements.	*24/01/2022: Opportunity to ask for clarifications about critical but grey areas. Barriers: what do they mean for Britishness? Impact of social norms? Why is it more difficult to talk about the menopause vs. bowel and bladder? Conversations getting easier with age: why? Experience? Comm skills?*

Trustworthiness:

This undergraduate study was limited by the author's limited research experience, the time constraints for persistent observation with the data, and an insider position (Merton, 1972 as cited by Darwin-Holmes, 2020) as a middle-aged female osteopath with personal experience of menopause, which influenced the researcher's positionality (Darwin-Holmes, 2020).

To enhance trustworthiness (Lincoln & Guba, 1985) and transparency, the following actions were undertaken (Table 4):

Table 4 Actions taken to enhance trustworthiness

Credibility	• Well-established research method • Reflective journal and memos • Debriefing sessions with supervisor • Triangulation: literature search in adjacent settings
Transferability	• Purposive sample to provide meaningful data • Sample with and without personal experience of menopause • Rich description of the research setting
Dependability	• Process reported in detail in research design • Discussion with a peer about researcher positionality
Confirmability	• Reflective approach and admission of researcher's beliefs • Triangulation: any theme resonating/emerging in other settings (physiotherapy; allopathic medicine)

Ethical Considerations

Ethical approval for this study was granted by the University College of Osteopathy Research Ethics Committee. Osteopaths who read the invitation and PIS, and agreed to take part, were asked to sign a Consent Form. They received the interview guide in advance to enable them to reflect on particular patients' examples. Participants were invited to check the copy of their verbatim to transcript to ensure that their views were accurately represented, and their anonymity had been maintained.

RESULTS:

Six osteopaths participated in this research – five female and one male, four with and two without personal experience of menopause, with a variety of osteopathic interests. One was specialising in female health. Eighteen individuals declined, explaining they did not meet the 5+ years of experience criterion (11) or did not have the time (7). No

one dropped out. Participants expressed a range of views about their experiences of exploring women's menopausal symptoms. Several iterative stages of data analysis led to the development of three inter-connected themes:

1. How osteopaths initiate conversations about the menopause: *Breaking the Ice*
2. How personal experience influences those conversations: *Personal – not so personal*
3. How osteopaths establish rapport and give advice to women with menopausal symptoms: *Storytelling*

1. Breaking the Ice

The osteopaths reported that the menopause can be a sensitive topic to discuss during the medical encounter. They described various reasons related to patients (e.g., possible associations with aging, and sexual and psychological health issues), to themselves (e.g., lack of confidence or training), and social norms (a taboo in conversations).

04: *"Because they are very intimate questions, and I am not qualified as a gynaecologist"*

01*: "It's always harder to get patients to open up about things that… you know, we're very British, we don't talk about [it] …"*

Most of these practitioners described asking gentle, gradual questions about the menopause, with one introductory general question and time to let the topic surface:

05: *"'Where are you now?' …and you just opened a general conversation"*

They acknowledged that information and insights into patients' experiences might emerge over several sessions and depended on how much patients chose to share:

01: *"…sometimes you don't get this information at visit one because they're not comfortable to really talk to you at that point"*

04: *"I want to leave the space for each woman to decide what they want to share…"*

Other osteopaths described more straightforward approaches to questioning, justified by their status as HCPs.

03: *"…as you get their date of birth, I will ask "are they going through menopause at the moment?" "…it's partly for a prognostic value…" "I will always try and address it in the initial consultation …"*

Participants reported no hesitation in asking more questions if there were signs and symptoms which did not fit a musculoskeletal picture or suggested a systemic health condition:

02: *"…if you were suspecting polycystic ovaries, … it would definitely make me ask more questions".*

01*: "if they are complaining of pain everywhere or symptoms everywhere"*

2. Personal - not so personal

Personal experience was described by some participants as helping them to understand a patient's "whole experience" of the menopause:

02: *"… if it's happened to me, then surely it could happen to other people, so it just made me more aware"*

For osteopaths with personal experience, being of a similar age was also thought to help them bond with menopausal patients.

02: "*you could read about menopause in a book... The actual reality of that, as we now know, … I've learned over the years: textbook and real life – puff! – miles apart"*

These osteopaths explained that when younger, they would have had the knowledge about relevant signs and symptoms and appropriate advice but would have lacked appreciation of the nuances of patients' lived experiences.

05: *"I would have had the clinical understanding, of course, … I would have respected and listened to it but yes, it's the stories, I wouldn't have had the stories to share".*

Being of the same gender was described as a factor which helped osteopaths to open conversations about intimate matters.

01: *"I think being female and being of that age means that you have some empathy with the patient …"*

The male osteopath also recognised the benefit of same gender conversations about specific health issues:

04**:** *"I have a male patient who has prostate issues. There are less difficulties to discuss sexual issues … with a male as a male."*

'These osteopaths all reported offering evidence-based advice about symptom management, covering a range of medical and lifestyle approaches (Table 5). Some participants explained how they aimed to educate patients about life-hygiene interventions to improve their quality of life and achieve broader well-being.

03: *"…looking at diet, nutrition, looking at sleep, looking at exercise…"*

Table 5: Advice and Recommendations Provided

Allopathic Medicine	
NHS sources	*02: "I've been tending to use the NHS website [www.nhs.uk/conditions/menopause/] because you're obviously going through your GP, …, and to quote the NHS back at the NHS is quite helpful"*
Referral to GP; suggest blood tests	*03: "I would I always say "right, you need to get in touch with your GP to find out now if you are […] in that menopausal or peri-menopausal phase"*
Referral to gynaecologists	*04: "We have a very strong network of referrals to specialists. One of the clinics where I work […] has gynaecologists. I've got contact with the Obstetricians".*
Lifestyle Advice	
Diet/nutrition	03: *"you may then want to give advice about diet potentially, anti-inflammatory diet" "I'm not a nutrition specialist but there are practitioners in [town] that I will sometimes recommend the patient to go to"*
Exercise	*03: "…with all patients I'll try and get them to exercise, look at their sleep, look at their nutrition, and try and talk about stress levels…"*
Sleep hygiene	*06: "Try to do some more exercises, it is going to make your body more tired so it's easier to fall asleep. Try to avoid screens two-three hours before going to bed; …".*
Complementary & Natural Medicine	
Osteopathy specialised in female health	*01: "…a friend of mine is a women's health osteopath […], and obviously I refer patients to her"*
Acupuncture	*05: "if they're hot sweats or feeling depressed, finding it hard to cope, then I will refer them to the acupuncturist"*
Bioidentical hormones	*01: "Talked to them about bioidentical hormones and they did it. And then you could make a bit of a more informed choice".*
Meditation	*03: "Another thing I recommend is meditation. So, I'll refer them to the University of Bangor's website because they've got some very good, guided meditations. Same for Headspace, that app…"*
General Education	
Reference to public discourse	*02: "if someone is a type of patient who does like social media, I will say 'just have a look at Davina's [McCall] page this month'"*

Osteopaths with no personal experience considered that specialising in female health helped them initiate deeper conversations and provide advice.

04**:** *"Again, if I were specialised and working in an Ob/Gyn clinic, I'd have no problem with that, because each question I ask has a medication or a treatment on top of it."*

3.Storytelling

Storytelling emerged as a strong theme as most participants with personal experience *shared stories* with their patients to personalise their interactions.

02: *"…I will share my experience, my personal journey through this …. Back it up with science and back it up with facts..."*

A second perspective to storytelling was presented by a male osteopath who *told* (archetypal) *stories* about the Circle of Life which aimed to de-personalise his interactions with female patients, reduce patient-practitioner power imbalances, minimise sexual inferences and reduce potential communication barriers.

04: *"…when I put myself in the position of 'Let me tell you a story'. It's not about them anymore so … the sixty-year-old doesn't have to think 'I'm not a woman anymore because I've been frozen'"*

Most of the osteopaths reported using humour with the aim of lessening potentially negative emotions associated with the menopause.

05: *"I turn into that monster too!... We just laughed about this…"*

A third perspective was a narrative shift towards a *story of change* and adaptation, once again depersonalising the conversation. Empathy was expressed, when necessary, but without sharing personal stories.

03: *"…you never say to a patient 'I know exactly how you feel' but it's almost like, 'I can understand that. It must be really tough that you're feeling like'"*

The three interconnected themes presented above of: 1. *Breaking the Ice; 2. Personal – not so personal;* 3. *Storytelling* evolved into three concepts which identified how osteopaths formed three partially overlapping therapeutic alliances, all influenced by their own personal experiences of the menopause, approach to questioning and advising, emotional or cognitive intent, and conception of osteopathy:

a. Sharing Stories – where osteopaths "break the ice" cautiously and gently, and where personal disclosure is leveraged to enhance the rapport, linking it to osteopaths' therapeutic approach as Communicators;

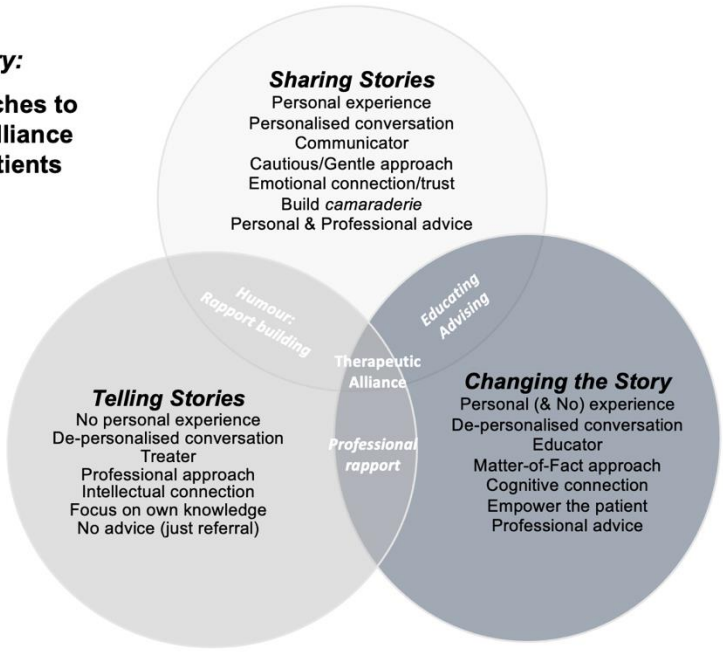
b. Telling Stories – where the absence of personal experience or specific female health training leads to a de-personalised conversation, letting the topic surface. The conception of osteopathy shares characteristics of the practitioner-centred (Treater), with emphasis placed on technical rationality and their own (lack of female health) knowledge (Thomson et al, 2013b).

c. Changing the Story – where there is no role for the osteopath's personal experience. The clinical interaction is focused on changing the narrative by empowering the patient to reframe past experiences and negative cognitions into more helpful beliefs, linking the therapeutic approach as Educator.

Fig. 1

It's all about the story:

Osteopaths' approaches to form a therapeutic alliance with menopausal patients



DISCUSSION

The purpose of this study was to explore osteopaths' experiences when screening for symptoms of menopause and giving advice to climacteric patients.

The three interconnected themes suggest three approaches to the therapeutic alliance: *Sharing Stories, Telling Stories* and *Changing the Story*, all influenced by the presence (or not) of personal experience of menopause and the osteopaths' conception of osteopathy.

a. Sharing Stories – Practitioners with personal experience of menopause

The osteopaths in this study with personal experience of menopause appeared to be highly aware of the sensitivity surrounding the exploration of climacteric symptoms. Their approach was cautious and gentle, aiming to understand the patients' experience, and they slowly tended to personalise the interaction by *sharing stories* of their own experience of the menopause to enhance the credibility of their professional

advice. Their therapeutic approach was the one of a “Communicator” (Thompson et al., 2013b) and their advice was evidence-based, consisting of a mix of personal experience and professional knowledge (Fig 1, top circle).

Sensitive questioning about the menopause was connected to its intimate nature and associations with sexual and psychological health, as no concerns emerged about discussing other potentially uncomfortable topics, such as urinary and intestinal issues, which were seen as more gender neutral.

Kingsberg et al (2019) reported that barriers to clinicians' approaches to screening for menopausal symptoms were due to its association to female sexual health, and identified in discomfort, biases, lack of sensitivity, lack of training, time constraints and concerns about cost and (insurance) reimbursement. Patient-related barriers were social stigma, misperception (about the inevitable aspects of aging), discomfort, lack of awareness and lack of knowledge (Kingsberg et al, 2019).

This echoes the findings of this study - except concerns about time and costs – as these osteopaths described the impact of social norms, patients’ lack of awareness and knowledge about the menopause, and their own sense of unpreparedness as barriers to starting conversations. Maciel and Laganà (2014) also identified limited training in assessing female sexual dysfunction and limited availability of female physicians interested in this area. Enablers to starting discussions were professional demeanour, comfort with the topic, and understanding and empathic disposition (Nusbaum et al, 2004). Filler et al (2020) also identified clinicians’ barriers in lack of knowledge and skill in patient-centred care for women or women’s health.

Conclusions from published evidence report an inconsistent/avoidant approach to discussing the sexual health of middle-aged women: Kingsberg et al’s (2017)

EMPOWER survey (n=1858), revealed that only 19% of menopausal women were asked about sexual health by their HCPs; half of the respondents of the VIVA international survey (n=3520) - Vaginal Health, Insights, Views, and Attitudes - said their HCPs had not raised the topic of vaginal health during the menopause (Nappi & Kokot-Kierepa, 2012). More broadly, Palaiodimos et al's study (2020) (n=1017; 55.26% female) revealed that 59.25% of female across all age groups had their sexual history never taken, which became 84% of over 50s (n= 166) and 88% of over 60s (n=140) across both genders. These findings suggest that further research would be of benefit to explore osteopaths' attitudes and capabilities in exploring old female patients' health issues. Adjustments in curricula and practical experiences during training have been recommended by the literature (such as the use of ad hoc questionnaires, a biopsychosocial approach to menopause education, (Maciel and Laganà, 2014) to overcome these barriers which seem to develop during the years of medical school education, with limited hours dedicated to human sexuality and limited training in interviewing skills (Feldhaus-Dahir, 2009).

In contrast with the findings above, this study suggested that, despite feeling "*unrehearsed*" (02), osteopaths with personal experience of menopause discussed symptoms using cautious, gentle questioning over several sessions to get insights into patients' experiences.

This sensitive, slow, and broad-minded approach, preferably with open-ended questions, was also recommended by Kingsberg et al, 2019, as it helps to create a safe space and addresses the HCP's potential discomfort in asking questions and responding to issues that may arise. This gradual, mild, non-judgemental approach allows patients narratives to unfold, evoking Charon's narrative-based medicine

(2001) to establish a deep and effective therapeutic relationship. She advocated creating a “partnership of telling and listening” (p.1899), facilitated by time and continuity, two factors participants described as benefits they provide versus the economic constraints of allopathic medicine.

More recently, Launer (2022), commenting on Michiels-Corsten et al’s *Inductive Foraging* (2021), explained that doctors perform a facilitatory act during anamnesis, (from the Greek ‘recalling to mind’) which “suggests an act of recovery and re-creation by the patient” (p.236) and sees the practitioner gather information by allowing the patient narrative flow as much as possible. Using open invitations is what was recommended to make patients active participants and not objects of case-history taking. More broadly, Tyreman (2018) advocated the role of “narrative at the centre of healthcare” (p.2) for patients to give meaning to measurements, counts and graphs, - the contemporary descriptors of illness and health -, and make a positive sense of them.

Participants felt that their personal experiences helped them to be empathic and understand the psychosocial impact of the menopause. Maroshita et al (2019) reported similar opinions from doctors who had experienced illnesses which changed their perspectives and deepened their wisdom. This led to more active, practical involvement with patients’ issues (Fox et al 2009).

Osteopaths with personal experience reported sharing their own stories, including humour about their own experiences. This strategy aimed to increase rapport and create links to support affective and cognitive reassurance, which has been found to help in conditions with an uncertain aetiology and prognosis (Pincus et al 2013), such as the menopausal transition could be. Their findings suggested that affective

reassurance triggers an immediate but transient response in patients, in terms of perceived support, satisfaction, reduced anxiety, and building trust in the practitioner. It is cognitive reassurance (Coia & Morley, 1998), that impacts behavioural changes via increased knowledge, changes in beliefs and understanding, enhancing patients' control and efficacy. In the medium term, this leads to better patient compliance, symptoms management, acceptance, and coping (Pincus et al, 2013). Osteopaths in this study initially used personal experiences to strengthen the credibility and then delivered cognitive reassurance, patient education and evidence-based advice.

This sharing of personal experience may be interpreted as crossing professional boundaries. These are defined as "dynamic lines intended to set the limits, and clearly define a safe, therapeutic connection between therapists and their patients" by the College of Physical Therapists of British Colombia (CPTBC, 2015, p.6). Sharing excessive personal information or problems with a patient can be categorized as a "Boundary Blurring, a warning sign for boundary-crossing" (CPTBC, 2015, p. 19). According to Pugh (2011), personal factors, such as physical and psychological issues or social isolation, and professional factors, such as working in isolation, lack of knowledge or respect for professional standards of practice, lack of clinical knowledge or experience and workload may increase the risk of practitioners blurring boundaries. Interestingly, the Osteopathic Practice Standards acknowledge that disclosing personal information may, in certain situations, "support empathy and trust with a patient" (GOsC, D2, 2022). This is a controversial point: in Fox et al's phenomenological study (2009) of 17 doctors' personal experience of illness, some reported that sharing information about their own experiences can, sometimes, be a

helpful consultation tool; others felt it would alter the rules of engagement and might constitute a misuse of professional standing.

These osteopaths' biopsychosocial perspective and emphasis on interpersonal and communication skills show a collaborative conception of osteopathy (Thomson et al, 2014) emphasizing the "partnership with the patient, respecting them as an equal" (p.154).

b. Telling the Story – Practitioner without personal experience of menopause

The male osteopath in this sample obviously lacked personal experience of the menopause and had not had additional training in female health. His approach to questioning was to ask one open question and then allow information to surface at the patient's own pace (Charon, 2001; Launer 2022). He then used a deliberately depersonalised communication approach of telling stories, including archetypal narratives, to reframe the role of the middle-aged woman in society, from uninteresting, infertile being to an independent, self-reliant individual, aiming to deconstruct the menopause and reduce fear. *Telling stories* – often with the help of humour – was described as a tool to break the barrier to this conversation, stripping it of the patient-practitioner power dynamic (Nimmon & Stenfors-Hayes, 2016) and any gender component. There is limited research available on the experience of gender concordance on physicians when discussing the menopause, or other intimate topics. Research has indicated patients' same-gender preferences in some healthcare consultations (Gott et al, 2004, Palaiodimos et al, 2020), and the need to strengthen knowledge and skills about sensitive topics, especially for practitioners who do not have personal experiences to use. In our findings the male osteopath described having simpler, unproblematic interactions when discussing intimate matters (e.g., prostate)

with patients of the same sex, as was reported by female participants about the menopause.

In his approach, lack of specialisation and personal experience led to referrals to gynaecologists. His conception of osteopathy shared some of the characteristics of the practitioner-centred, with emphasis placed on technical rationality, and their own knowledge and responsibility. (Thomson et al, 2014).

c. Changing the Story – practitioners with and without personal experience of menopause

Two practitioners – with and without personal experience - adopted a matter-of-fact stance to asking questions, normalising the discussion via their assumed biomedical legitimacy as HCPs, and explaining early in the process the rationale for this line of enquiry. Their aim was diagnostic and prognostic, and to inform treatment (Fig. 1, bottom right circle). A pragmatic attitude (using questionnaires; explaining beforehand why such questions are being asked) were also endorsed by literature (Kingsberg, 2019), as it helps "the patient relax and become matter-of-fact" too (Andrews, 2000, p. s-22).

These osteopaths' interaction with the patient was not focused on sharing personal experiences, even if they showed empathy when necessary. They wanted to support the patient to *change their story* about the menopause, focusing on a "life-enhancing narrative" (Tyreman, 2018, p.3) of opportunity and adaptation. They strived for cognitive reassurance (Pincus et al, 2013) to influence a change in attitudes and behaviours, via life-hygiene interventions and education aimed at improving the patients' quality of life.

This group seemed to conceive osteopathy as empowerment (Thompson et al, 2014), based on a high level of patient involvement in decision-making, with emphasis on education and self-management.

Implications for education

The three approaches partially overlap, in a flexible combination of personal experience, approach to questioning and advising, emotional and cognitive intent, and conception of osteopathy.

Conversations with the climacteric patient are enabled by a tactful, gentle narrative flow together with personal experience and specialisation. The absence of these, especially to younger or male osteopaths, contributes to that sense of "unpreparedness" osteopaths feel when addressing the topic. Adjustments both in curricula and practical experiences, with a focus on developing narrative communication skills, a better understanding of the biopsychosocial dimension of female health in the middle age, and on a broader familiarity of evidence-based management options, would provide the knowledge to students, less experienced practitioners, or osteopaths without personal experience to overcome that sense of feeling "unrehearsed", regardless of their specialisation, age, gender, or inclination to share personal experiences.

Limitations and future research

The study used elements of GT, but data saturation and theoretical sufficiency (Charmaz, 2006; Glaser & Straus, 1972) were not achieved as further insights to the core categories and/or the discovery of additional properties for those categories may have emerged with more interviews with osteopaths without personal experience of

menopause and more male participants. Their reduced number has also limited transferability.

The researcher's gender (female) and age (peri-menopausal) are likely to have influenced her positionality in relation to the subject, participants and research context and process (Darwin-Holmes, 2020). Personal experience of the menopause may have increased rapport with interviewees with similar characteristics and enabled the exploration of their experiences in more depth. The interpretations and conclusions should therefore be considered from a combined 'emic' and 'etic' perspective (Fetterman, 2008) and require further exploration.

Further research is needed to assess the validity of the themes identified for osteopaths without personal experience of menopause. Qualitative research could be conducted to assess perceived communication barriers and the impact of osteopaths' age and gender in managing patients with menopausal symptoms. Also, new insights may be gained from ethnographic observations, being the data based on self-report.

The benefits and limitations of using humour, which frequently emerged as a tool osteopaths used to neutralise potentially uncomfortable conversations, could be further evaluated.

Studies appraising the communication competencies about sensitive topics in undergraduate curricula could provide useful insights about practitioners' preparation to deal with them, informing future education and practical experiences.

Conclusions

The osteopaths who took part in this project described the menopause as a sensitive topic, with social, personal, and professional barriers which influenced the way they explored patients' health experiences and offered advice.

Different communication approaches were influenced by whether osteopaths had personal experience of the menopause or extra training in female health, or not. Approaches were also influenced by their conception of osteopathy, which impacted the way the therapeutic relationships were established to elicit patients' narratives. Storytelling emerged as a key communication strategy, ranging from a. sharing osteopaths' personal stories about coping with the menopause, b. telling a story, de-personalising the narrative, or c. changing the story, to help patients focus on the life-enhancing narrative of their experience of the menopause. Storytelling was used both as a narrative tool to (a.) personalise the conversation establishing *camaraderie*, aiming to understand the person's experience and to build an empathetic bond before giving advice, with a Communicator therapeutic approach (Thomson at al, 2013b) or to de-personalise the interaction, either (b.) creating an intellectual bond stripped of the power/gender imbalance but guided by the osteopath's technical rationality or (c.) establishing a more matter-of-fact platform empowering the patient with an Educator therapeutic approach, aiming at an encounter between equals.

Despite the limitations of qualitative research, this study provides valuable insights into the narrative communication strategies used in osteopathic practice to explore patients' experiences of the menopause and the barriers practitioners without personal experience in this condition may face. The findings may assist the development of additional osteopathic education about sensitive, effective ways to communicate about the menopause, which may eventually contribute to enhanced patient care.

WORD COUNT: 4995

<u>Statement of competing interests</u>

None

Funding:

This research did not receive any specific grant from funding agencies in the public, commercial or not-for-profit sectors.

Acknowledgements

The authors are grateful for the contributions of the study participants: it has been a privilege to hear your stories.

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