Women and Midlife Transitions: A Call to Action for Nursing and Primary Care

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To the faculty of Washington State University:

The members of the committee appointed to examine the clinical project of PAMELA MCGILL find it satisfactory and recommend that it be accepted.

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Abstract

Women born in the post WWII years are entering midlife in large numbers. These women in the 40 to 65 age group will have a significant impact on primary care settings with their transitional and developmental issues. The sociocultural, historical, relational, and environmental contexts of these women’s lives will be important for nurses and care providers to understand in order to support well-being. The framework for this work was feminist developmental theory, and Parse’s nursing theory of human becoming. Gaps were found in the existing literature regarding the psychological care of midlife women in the primary care setting. Integrating the psychological with the physical aspects of care within the unique context of each woman’s life is vital to fostering well-being and facilitating empowerment for growth and change. Recommendations are made for a Midlife Women in Transition: A Clinician’s Toolkit for use in assessment, intervention, and evaluation of a strength-based and empowering approach in primary care.
Women and Midlife Transitions: A Call to Action for Nursing and Primary Care

According to the US Census Bureau of Statistics, there are 78.2 million people who were born in the post war years 1946 to 1964. This is the largest generational cohort in history. Of the men and women who comprise this group, approximately 50% are women (US Census, 2008). These women are living longer, healthier lives than past generations, and expect more of the health services they choose (Hankinson, Colditz, Manson, & Speizer, 2001). Women are more likely to seek treatment of illness, and to ask for preventative services than men (Addis & Mahalik, 2003). But are midlife women getting what they need from primary care, or are there important areas such as psychological health and well-being, that are not being adequately addressed? The literature lends validation to the hypothesis that there is a significant lack of attention to the midlife stage of women with regard to psychological wellness (Outram, Murphy, & Cockburn, 2004). Primary care providers (PCP’s) and nurses have a unique opportunity and important role in assisting women in their pursuit of higher levels of psychological health, well-being, and empowerment.

In this paper, women’s’ developmental and midlife transitional considerations are addressed, using Parse’ theory of human becoming (Parse, 1992) as the guiding framework. The feminist developmental perspectives of Carol Gilligan also provide a context for the exploration of midlife women’s challenges. The ultimate goal of this work is the empowerment of midlife women, facilitated through the implementation of a positive, purposeful, and consistent primary care process.
Midlife Women’s Experience

The Salience of Context to Midlife Evaluation

The middle years, those between 40 and 65 (Etaugh & Bridges, 2004), present challenges and change that can be overwhelming to midlife women (Banister, 2000). Transitions encompassing social, economic, cultural, physiological, psychological and spiritual aspects of a woman’s life occur at this stage (Banister, 1999; Bannister, 2000). Primary care providers and nurses typically have not addressed the transitional needs of midlife women, other than global issues such as menopause, roles, empty nest, (Lippert, 1997) and general health (Bannister, 1999; McQuaide, 1998). They also have not given credence to the context of culture, history, or environment that is part of each woman’s experience (Bannister 1999). Thus, the provider’s understanding of the midlife woman’s developmental and transitional issues within a larger picture of her unique context will be pivotal to affecting health improvement, and encouraging empowerment.

The Midlife Experience of Women

A theoretical understanding of midlife women’s’ lifespan and developmental considerations is found in the work of female developmental pioneer, Carol Gilligan (1982). Gilligan explores and delineates what is most central to the experience and development of being female: that of connection to others and caring affiliations.

“....the events of midlife—the menopause and changes in family and work—can alter a woman’s activities of care in ways that affect her sense of herself. If midlife brings an end to relationships, to the sense of connection on which she judges her worth, then the mourning that accompanies all life transitions can give way to the melancholia of self-deprecation and despair. The meaning of midlife events for a woman thus reflects the interaction between the structures of her thought and the realities of her life”. (Gilligan, 1982, p. 171)
Women experience various midlife transitions at different chronological points in the middle years. Some transitions are very predictable, for example menopause, children leaving home, retirement, and caring for aging parents. However, other transitions are not as predictable such as divorce, death of a family member, chronic illness, or financial difficulties (Etaugh & Bridges, 2006). There are still other transitions that are not linked to events so much, as to the inner climate of change, an inner stirring or unrest, and the sense that life will not last forever (Bannister, 1999; Brehony, 2002; Leggett, 2007). Any of these events or stirrings may be the impetus for new ideas, career changes, acquisition of new skills, or renewed enthusiasm for life. “Midlife experiences may result in a woman discovering the direction to a new and unexpected personal potential” (Bannister, 2000). Etaugh and Bridges (2006) found that midlife role transitions can be positive experiences, while at the same time less fortunate women with fewer financial resources and social support may be at risk for psychological distress. Midlife transitions may contribute to feelings of anxiety, stress, depression, or encourage substance abuse (Samuels, 1997). As noted by Johnson et al (2005) in testing the reliability and validity of the Personal Progress Scale Revised, women who were empowered were more likely to use coping skills, and to be less apt to suffer distress, either physical or psychological. Thus, as will become evident through this paper, all women can benefit from a strength-based approach to primary care.

Purpose

The purpose of this article is to focus attention on the developmental and transitional challenges of midlife women, and to analyze the current literature with respect to how the
needs of this population are currently being met. The outcome of the analysis is a recommendation that will assist primary care providers and nurses in a more empowering, holistic assessment and intervention process. The proposed assessment process can be used therapeutically to open discussion and facilitate appropriate PCP/nurse to client respect, relationship development, and mutual problem-solving. It can also lead to referrals, and resource suggestions. It is acknowledged that the primary care visit is not a social encounter, but a professional opportunity for intervention (Meadows, Thurston, Quantz & Bobey, 2006). Nurses and doctors will be involved in the care of these women, whether in primary care, mental health care, or in other settings. It is established that nursing and medicine have an ethical and moral duty for assessment and intervention during midlife years (AMA, 2001; ANA, 2008), and thus more directed assessment and interventions are warranted. The new process is premised on the link with human becoming theory that stresses growth and development, belief in the woman’s abilities, and her freedom to choose what has meaning for her. Thus, this new model is strength-based and positive versus the traditional medical model, which is pathology-based (Johnson et al, 2005). The literature supports the idea that empowerment is connected to well-being, and control over one’s life (Nyatanga & Dann, 2002). The new primary care process proposed is designed to identify the individual’s midlife transitions and strengths, as well as address dysfunction that may be occurring. Both positive signs of readiness for growth and development, and distress symptoms may otherwise go unnoticed without direct attention to assessment, and sensitivity to the context in which they occur.
Concept of Empowerment

The concept of empowerment had its origins in the 1950's when social activism against imbalances of power began to surface. It continued with ever increasing momentum into the 1960's and 70's when issues such as women's rights, civil rights, disability inequities, and other social causes were championed (Shearer & Reed, 2004; Ryles, 1999). In the 1980's psychology writings began to portray empowerment as a way individuals could participate in taking control of their lives. During the 1990's, when personal health promotion began to emerge as important, the notion of empowerment also began to be seen in the literature, and in health education (Shearer & Reed, 2004). Empowerment, as it applies here, is considered to be a psychological concept (Menon, 2002). It is a process that can be facilitated by healthcare providers who interact with clients within a therapeutic relationship. Nurses and primary care providers are positioned to attend to clients with an attitude of understanding, and respect for their ability to manage their own lives (Nyatanga & Dann, 2002). To what degree the midlife women feel empowered can be assessed using a health empowerment instrument (Nyatanga & Dann, 2002). What this implicates is that empowerment is not something given to another person, but can be made possible by way of relationship, connectedness, and belief in the client's abilities or strengths (Shearer & Reed, 2004). Brown, McWilliam, & Ward-Griffin (2005) call this approach to empowerment “client-centered empowering partnering”. Definitions of empowerment (Merriam-Webster's Collegiate Dictionary, 1993) are: “1) to give official authority or legal power to; 2) to enable; or 3) to promote
self-actualization or influence of”. It is this last suggestion of meaning that lends energy to the concept of healthcare providers facilitating clients to higher levels of well-being.

Conceptual and Theoretical Framework

The literature review conducted for this analysis was multidisciplinary in order to fully explore and integrate present knowledge about women’s midlife developmental and transitional issues. The literature reviewed represents professional disciplines such as psychology, social work, occupational health, medicine, and nursing. The review focused attention on the female midlife transition stage. As a result of the review, gaps in the knowledge or practice base were discovered, as well as the role primary care and nurses are assuming in midlife assessment and intervention for the aforementioned population.

The Problem

Women in the middle years, those between 40 and 65 (Etaugh & Bridges, 2004), are often not given the primary care attention they deserve (Rosenfeld, 2004; Outram et al, 2004). This period of time for women, beyond the reproductive years and preceding the elder stage, is a unique and complicated experience (Bannister, 1999). One reason postulated for this lack of attention, or misunderstanding of midlife transitions and experiences is western cultural bias (Bannister, 1999, 2000; McQuaide, 1998). The western culture has portrayed midlife women in the menopause period in a negative perspective; less attractive (Etaugh & Bridges, 2006), prone to depression or anxiety, or simply invisible (Bannister, 1999, 2000; McQuaide, 1998). However, conflicting evidence has been demonstrated that points to the midlife stage as one of freedom,
renewed energy, and enthusiasm (Etaugh & Bridges, 2006; Lippert, 1997). McQuaide (1998) found that factors that predicted well-being in midlife included adequate income, satisfying social outlets and roles, and stimulation of her talents or abilities. The woman’s view of herself as positive is also important. Viewing women in the midlife stage in relation to their environmental situation and relationships provides a basis for understanding the transition experience from a female developmental perspective (Shearer & Reed, 2004; Gilligan, 1982). Other recent theories of women’s development point to considering each woman’s midlife period from many different perspectives. This inclusive way of thinking will assist clinicians in fully understanding each unique experience (Lippert, 1997). Traditionally, theories and research on life span development have focused on men, and subsequently applied to women. Not until fairly recently have feminist theories brought credibility to the idea that women are different, developmentally speaking, than men (Gilligan, 1982).

The recommendations in this paper are grounded in feminist developmental theory and guided by Rosemarie Parse’ nursing theory of human becoming. Parse’ theory of human becoming supports this feminist developmental perspective by her view of humans as self-directed beings who are involved in the world, have an innate knowing, and are free to make their own choices. The meaning of the person’s reality is affected by values held, and the woman’s interpretation of this reality in context of her environment and present moment (McEwen & Wills, 2002; Parse, 1999). Nurses can best support the patient by believing in her freedom to choose, and working together with the patient to assist in the creation of well-being (McEwen & Wills, 2002). Parse’s
concept of transforming also fits well with the concept of facilitating empowerment, to the end that patients can create new behaviors and ways of being, with the help of nurses and primary care providers. Cultural sensitivity and competence is important to incorporate into this framework (AOA, 2008), in order to serve all women in the best way possible. This conceptual and theoretical framework calls for professional thought and action that incorporates the client’s interpretation of her world, given the values, meaning, and unique ways of being she embraces in that particular moment. Proposed

The Midlife Assessment Process

The proposed process is not designed to diagnose mental problems, nor will its implementation require extensive training for primary care clinicians and nurses. What it is poised to do is provide tools identifying common midlife transitions, and facilitating empowerment. Although the emphasis of this process is not pathology-based, it includes basic screening for depression, anxiety, and alcohol abuse. The primary goal for providers is to create a mutual, caring relationship that opens the door to intervention and assisting the empowerment of patients. The busy healthcare reality of today eschews spending too much time on each patient (Outram et al, 2004). Many female midlife patients will not feel comfortable speaking of transitional or difficult issues due to time constraints, or feeling like the issues they are dealing with are not important enough to be aired at the primary care visit (Outram, et al, 2004). The midlife transitions assessment process involves having the client complete the forms during the check-in period at the primary care appointment, at which time she can begin to reflect on her own midlife experiences and strengths. This process paves the way for the clinician to quickly assess
a woman’s climate of well-being and her strengths, as well as any areas of stress or difficulty. It provides the clinician with information for intervention or empowerment prior to seeing her. Additionally, time is used efficiently for clinician and patient, and there is opportunity for enhancement of the clinician/patient relationship, as well as important mutual discussion, intervention and planning. There may need to be another appointment scheduled if issues are of a significant or lengthy nature. This may also be the appropriate point that a referral is made to a psychiatric nurse practitioner, psychiatrist, mental health provider, or other community resource. Evaluation of progress toward empowerment can be accomplished through regular visits. During regular visits providers can encourage continued growth and development during midlife, and assist with new issues or changes. This data can also be utilized to increase awareness and effectiveness of care providers.

The Proposed Process

Midlife Women in Transition: A Clinician’s Toolkit

The proposed process materials packet is termed Midlife Women in Transition: A Clinician’s Toolkit (see Appendix A). The toolkit contains; 1) an introductory sheet that explains the midlife stage of life, why it is important to participate in the assessment process, and what the possible benefits may be; 2) an empowerment measurement tool; 3) a midlife transitions checklist; 4) a self-report depression scale; 5) a self-report anxiety scale; and 6) an alcohol abuse screening item. The toolkit is designed to be customized for the inclusion of cultural or community specific resources for midlife women.
The first page in the kit is an introductory letter aimed at educating women about midlife development, and the middle years. Research has supported the idea that many women have preconceived ideas about midlife, or have been influenced by societal myths about the aging process (Bannister, 2000; McQuaide, 1998).

The next item, located under the introductory page, is The Personal Progress Scale Revised, a 28-item psychological health and empowerment instrument that has been shown to predict resilience and well-being (Johnson et al, 2005). It is based on "The Empowerment Model" which addresses ten outcome areas of psychological intervention; positive self-esteem and self-worth, decreased distress, gender and cultural identity awareness, perception of control over one’s life, positive self-care, problem-solving ability, assertiveness, access to resources, gender and cultural flexibility, and active participation in positive social pursuits (Johnson et al, 2005). The client rates each answer on a scale from 1 to 7, with 1-almost never, through 4-sometimes true, to 7-almost always. This instrument has been shown to assess overall empowerment over time, which will be invaluable for continuity of care (Johnson et al, 2005).

The third item in the kit is the Midlife Transitions Checklist. This questionnaire has instructions and seven categories with individual item check boxes. Categories include; Role Changes, Social Changes, Physical Changes, Occupational Changes, Losses, Mental/Emotional Changes, and Spiritual/Cultural Changes. The rationale for this tool rests in the literature to date that identifies issues common to the midlife period (Leggett, 2007; Lippert, 1997; Samuels, 1997; Sheehy, 1995). These may be considered by the client as positive or negative perceptions of midlife transitions. The woman checks the
items that have impacted her in the last year, or that are still significant for her. At the end of the checklist are blank lines where she is to note her best strengths, and write down questions, or elaborate about her midlife experiences. The developmental literature speaks of the importance of the midlife woman’s identity, and how it is shaped by her experiences (Gilligan, 1982; Lippert, 1997). The opportunity to document some of the midlife experience may add significantly to the woman’s understanding of herself and identity, as well as offer the clinician additional information or insight into the patient’s world, and its context.

The next tool in the kit is the Center for Epidemiologic Studies Depression Scale (CES-D). The US Preventive Task Force (2002) recommends screening for depression in the primary care setting. The CES-D is a self-report depression scale for use in the general population. This tool has been shown to be time-effective and easy to take (Radloff, 1977). There are 20 items, which are scored by a likert-type scoring system of numbers 0-3. It has been shown to have high internal consistency, reliability and validity in different types of epidemiological studies. It emphasizes mood, and symptoms, rather than diagnosis (Radloff, 1977). The middle years of life can lead to depressive feelings for some women; the symptoms can be hormonally related (Bannister, 2000), linked to stress (Leggett, 2007), connected with loss (Samuels, 1997; Etaugh & Bridges, 2006), role changes (Bannister, 2000), or other factors. This screening tool is, therefore, an important piece of the midlife women’s assessment.

Bannister (1999) examines midlife women’s experience of midlife “confusion”, as related to the many emotional fears, uncertainties, and feelings of anxiety about the many
changes happening at this stage. The Beck Anxiety Inventory (BAI) is the next item in
the kit. Although a study using it on midlife women was not found in the literature, it has
been shown to be useful for identifying anxiety symptoms in a variety of populations
(Loebach Wetherell & Arean, 1996). Routine screening is not yet an evidence-based
recommendation for primary care, however given the losses and complications of midlife
(Bannister, 1999), this is recommended for inclusion. This short, simple screen has 21
symptoms of anxiety scored from 0/not at all, 1/mildly, 2/moderately, or 3/severely. The
client rates as to how much they were bothered by the symptoms in the past month. The
sum of the numbers rated equals the score, which is easily calculated and interpreted.
This screening instrument, although fairly new, shows high internal consistency and no
significant differences by race or sex (Loebach Wetherell & Arean, 1996). Screening for
a variety of anxiety symptoms will augment the information gathered during the
assessment, as well as opening the discussion to expression of uncomfortable feelings.

The last screening tool is aimed at detecting alcohol abuse or dependence. The short
form CAGE consists of 4 questions; C: Have you ever tried to Cut down on your
drinking; A: Has anyone ever been Annoyed by your drinking; G: Have you ever felt
Guilty about your drinking; and E: Have you ever taken an Eye opener drink in the
morning? A score of 1-2 yes answers may indicate an alcohol problem (Fiellin,
Carrington, & O’Conner, 2000). (Samuels (1997) found that substance abuse is common
at midlife, but often not detected in primary care settings. Additionally, the literature
supports the practice standard of using a formal process to screen for alcohol use, as well
as abuse or dependence. Primary care physicians are encouraged by the National

Evaluation

The clinician’s toolkit is proposed as a best practice to address midlife women’s developmental and transitional needs in a way that will assist in empowering her to higher levels of psychological health and well-being. To evaluate the effectiveness of this toolkit intervention, it is suggested that nurses and primary care providers institute a progress-tracking process. The tracking and evaluation process may include a computerized system of tracking progress, initiating reminders for clinical updates on toolkit forms, and running quality assurance studies, such as patient satisfaction questionnaires. Statistics regarding client progress could be used to further more research on midlife women’s psychological care.

Summary and Conclusions

The post WWII years spawned the largest generational cohort in US history, 50% of which are women. These women are now entering the midlife years between 40 and 65 and will impact primary care with their numbers, as well as their midlife developmental and transitional issues. It is recommended that care providers and nurses approach midlife women with an understanding of the sociocultural, historical, relational, and environmental context of women’s lives. The feminist theories of female development, and Parse’ theoretical perspective of women provided the framework for this work. The literature supports the hypothesis that midlife women are not receiving the attention they
need from primary care and nurses. With a consistent, positive assessment and intervention process, it is postulated that nurses and primary care providers can assist with empowering clients to higher levels of psychological health and well-being. It is not suggested that primary care assume responsibility for mental health services. It is hoped that primary care can become a source of first-line assessment, intervention, and ultimately, empowerment for midlife women. Integrating the psychological with the physical aspects of care within a context of each woman’s unique experience is vital to midlife women’s well-being, and enhancement of her potential. The *Midlife Women in Transition: A Toolkit for Clinicians* is the result of the gaps found in the literature concerning midlife women’s psychological care in the primary care setting. As part of the process, a mutual, caring relationship can result to the benefit of both care provider and client. It is recommended that a systematic evaluation process be instituted to include measurement of psychological progress and empowerment at yearly visits. This is a call to primary care for empowerment action; this action can make a difference in the quality of life and psychological well-being for every midlife woman served.

**Further Research**

More research is needed to examine midlife women’s lives in regard to developmental perspectives and midlife psychological well-being. The Clinician’s Toolkit needs further research to validate and test its effectiveness. The PPS-R empowerment instrument was tested on diverse women, however, most of the research on midlife women has been on white, educated, married subjects. This calls for more research on diverse midlife women, including vulnerable groups. Research projects that integrate the sociology and
psychology fields with nursing and medicine will enhance knowledge of midlife growth and development.
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Appendix

Midlife Transitions Checklist

Instructions: Please take a moment to look over the categories of transitions or changes that may occur during the midlife period between the ages of 40 and 65. Mark the box of any transitions that you have experienced, either previously or currently. If you wish to speak to the clinician about any of the transitions that are particularly notable to you, please use the comment section at the end, or discuss during your appointment time. Also write in what you feel are your 4 best strengths.

Name ___________________________ Date ________________

### Role Change
- [ ] Married
- [ ] Divorced
- [ ] Widowed
- [ ] Remarried
- [ ] Dating, or new relationship
- [ ] Empty nest (children left home)
- [ ] Adult children returned home
- [ ] Care giving for a parent or relative
- [ ] Late parenting or adoption of child
- [ ] Newly a grandparent
- [ ] Parenting grandchildren
- [ ] Other __________________

### Social Change
- [ ] Move to new home, community, city or country
- [ ] New social responsibilities
- [ ] Change in friends or social contacts
- [ ] Volunteering or new learning activities
- [ ] Change in family relationships
- [ ] Change in community contacts or relationships
- [ ] Other __________________

### Physical Change
- [ ] Skin changes, wrinkles, dry skin
- [ ] Change in sex drive, either more or less
- [ ] Vaginal dryness, or pain
- [ ] Fatigue/tiredness
- [ ] Decreased ability to sustain activity
- [ ] Unable to do the activities you used to
- [ ] Joint pain or other problems
Weight concerns
Menopausal symptoms:
Hot flashes
Irritability
Night sweats
Emotional swings
Periods have stopped or erratic
Other

Occupational
New job
Job burnout
Job satisfaction good
Retirement date set
Retired
Difficulty coping at job
Other

Loss
Loss of health or vitality
Chronic illness diagnosis
Accident, injury, or surgery
Loss of youth or appearance
Loss of a loved one or friend
Loss of financial security
Other

Mental Health and Emotional Changes
Emotional ups/downs
Mental illness diagnosis
Self esteem poor
Self esteem good
Depression
Anxiety
Excessive substance use
Enthusiasm for life
Renewed energy
Other

Spiritual/Cultural
Feelings of unrest or spiritual distress
Cultural change
Spiritual emptiness
Women and Midlife

- Spiritual well-being
- New dreams to accomplish
- Religion or cultural practice changes
- Other

Comments about my life or issues that I feel are important to discuss:

My four best strengths are: