



WOMEN AT THE CROSSROADS:

**A literature review of the mental health risks
facing women in mid-life**

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The Pennell Initiative for Women's Health exists to champion the cause of women's health by researching and addressing the physical, emotional, mental and spiritual needs of women over the age of 45. They seek to improve every women's prospect of living well into healthy old age by promoting understanding of health issues and taking action to benefit women from middle age to very old age.

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The Pennell Initiative for Women's health will be publishing a summary of this report. This can be obtained at their website address or by contacting:

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The Mental Health Foundation is the UK's leading charity working to promote mental well-being and the rights and needs of people with mental health problems and people with learning disabilities. They aim to improve people's lives, reduce stigma and discrimination and to encourage improvements to local services.

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The Mental Health Foundation will be publishing an Update on this report. For details on how to obtain this please contact the Foundation on the above details.

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INTRODUCTION

This review focuses upon women aged 45-60: an under-researched subgroup of the adult female population. Women in mid-life occupy a unique position in the lifespan at the intersection of a number of age-related and lifelong pathways. The lives of these women can be distinguished from those of both older and younger women along a number of important dimensions including their family and working lives, economic situation, general health, and the complexity of their roles both inside and outside the home. Personal and economic changes are common at mid-life as are physical changes; all have particular and distinct implications for women's emotional and psychological health.

The aim of this review is to address a knowledge deficit. Though some evidence exists about the extent of psychological distress in women aged 45-60, far less has been gathered about the causes of such difficulties or the challenges to mental health associated with mid-life experience. The lifespan is routinely conceived as containing a number of discrete stages: women's lives are characterised by experiences that have overlapping threads and meanings and these combine with age-related issues in ways that warrant focused attention. This review draws evidence from a range of sources to identify the key parameters of mid-life women's lives. These include: the areas and types of risk to their mental health from a range of sources, the extent of psychological distress, and the ways in which research and policy could reduce the challenges that commonly face women in mid-life and alleviate or prevent mental ill health.

It should be noted at the outset that the age group 45-60 years does not map perfectly on to the existing field of research: researchers and national statisticians punctuate the life span in whatever ways they see fit. So, although we have tried to locate research which matches the age span of interest, inevitably we also draw upon the findings of research which only offers a close approximation.

A SOCIAL INEQUALITY FRAMEWORK

There is now a wealth of evidence that points to the inappropriateness of discussing women's mental health problems in terms of individual pathology. It is both more accurate and useful to conceptualise women's mental health problems as responses to – and sometimes as creative ways of coping with – damaging experiences that are rooted in their lived experiences of inequality and abuses of power. Accordingly this review will be carried out from a social inequality perspective, which means that we will be particularly attentive to the mental health implications of gender, class, and race. This framework will be used to identify the ways that social inequalities can impair the mental health of women in this age group, and to focus attention on the ways that women survive and thrive.

Social inequality exists when an attribute such as gender, race or class affects access to socially valued resources including money, status and power. Dimensions of social inequality are hierarchies of domination – power relationships that limit and restrict some people while privileging others. They do not merely represent different lifestyle preferences or cultural beliefs, values and practices: there is a fundamental conflict of interests at their core. This perspective alerts us to the fact that many of the taken for granted institutional, social and domestic arrangements in our society are structured to meet men's needs at women's expense. Thirty years ago there was very little research evidence, or published work, making connections between inequalities in society and the psychological well-being of individuals. Now there is extensive literature, and there can be no doubt those social inequalities are major determinants of women's mental health (Busfield, 1996; Ussher, 1991; Williams, 1999).

We shall begin with a reminder of the main ways in which social inequality can impact on the mental health of women.

- First, through inequitable access to resources known to affect mental health, which include money status and power.
- Second, through processes of subordination that sustain and hide social inequality, including discrimination, exploitation and oppression.
- Finally, through serious abuse of power including sexual and physical violence and abuse.

Each of these overlapping topics will now be considered, and what is known or can be inferred about the psychological well-being of women in mid-life, reviewed.

INEQUALITY, RESOURCES AND MENTAL HEALTH

In the first instance we shall consider the effect of inequality on mid-life women's access to a range of resources known to affect mental health, most notably money, status and power.

Money and poverty

One of the most significant influences on physical and psychological well-being is the availability of, and access to, money. The positive association between poverty and mental health problems is one of the most well established in all of psychiatric epidemiology (Buck, 1997). Furthermore, research has consistently documented that low income is associated with high rates of mental disorder amongst women (Belle, 1990; Bruce et al., 1991; Platt et al., 1990), though few studies (e.g. Butler and Weatherley, 1992) have directly examined the mental health implications of poverty for mid-life women.

The existence of inequalities in our society means that as a consequence of their gender, race, class, and age, many women in mid-life have restricted access to money. 'Gender, rather than an individual's skills and abilities, continues to be a major determinant of individual economic prosperity'. (Equal Opportunities Commission, 2000a. page 7).

Education

In a society which values education, a woman's educational attainment is likely to be directly linked to her identity and self-esteem. Additionally, having low or no qualifications is strongly related to low-skilled and low-paid work or unemployment, lack of money and poor housing. All of which are predictors of poor physical and mental health. It is noteworthy, therefore, that a higher proportion of women than men aged between 45 and retirement age has no qualifications: 30 % of women compared with 20 % of men (Figure 1).

Other data indicates that the ages at which women and men have children are strongly related to qualification levels: those who are most highly qualified being more likely to delay having children. In the age group 25 to 34, 84 % of women without qualifications had dependent children compared with only 29 % of those with degrees or equivalent. The situation had reversed by the age of 45 to 54, so that 22 % of women with no qualifications had dependent children, compared with 42 % of women with degrees (Equal Opportunities Commission, 2001d).

We also draw attention here to the findings of an American study (Elman and O'Rand, 1998) designed to determine who is most likely to seek re-training at mid-life (45-61 years). This study found that individuals already in occupations requiring high skill levels were most likely to re-enter training, while those with the fewest resources and rewards were least likely to do so. The authors argue that this is one of the ways that education operates to preserve occupational advantage, and to impede women and people from ethnic minority groups from accessing opportunities and increasing their income.

Income and pay

As a result of the combined disadvantages of lower income and reduced levels of full-time employment, many mid-life women have significantly lower incomes – and as a consequence have less choice and power than their male peers and partners (Figure 2).

Overall, women’s gross income is 49% of men’s (Office for National Statistics, 2002) and the differential earnings of the sexes explains some of this discrepancy. Although both women and men aged 55+ have lower levels of economic activity than their younger counterparts, there is a clear gender differential in terms of earning capacity within the 55-59 year old age group. In this cohort, women’s incomes are nearly two fifths lower than those of men (Equal Opportunities Commission, 2000a). It is also the case that in all ethnic groups men have higher average hourly earnings than women in this, and indeed all other, age groups (Equal Opportunities Commission, 2000a).

Two and a half million employees have weekly earnings below the Lower Earnings Limit (LEL); the majority of this group are women (Equal Opportunities Commission, 2001b). This is both age and gender related. Whereas 15 % of female employees in the 40-54 age group earn below the LEL, only 1 % of males in this group is in the same position. Amongst the group of employees aged 55 who are below the LEL, 28% are female and 6% are male (Figure 3).

Figure 1: Highest qualification by sex and age

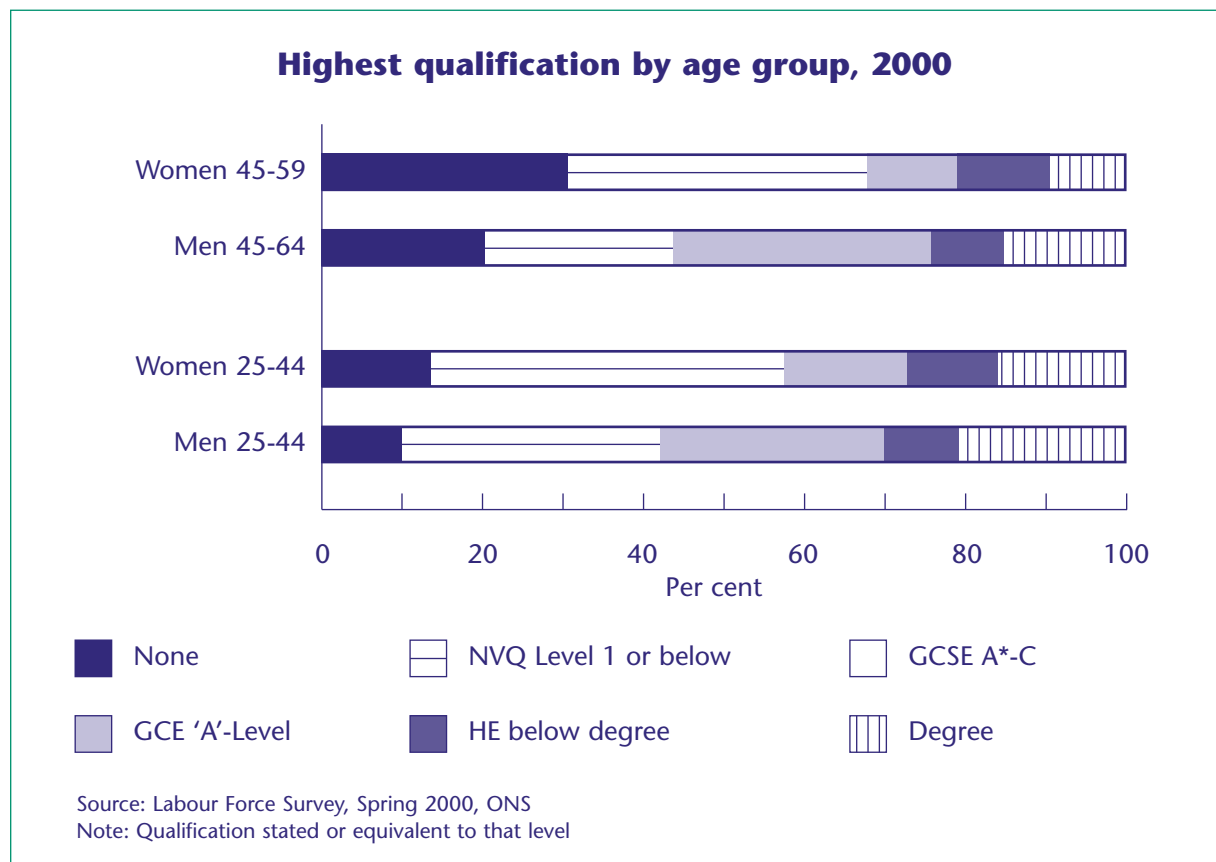
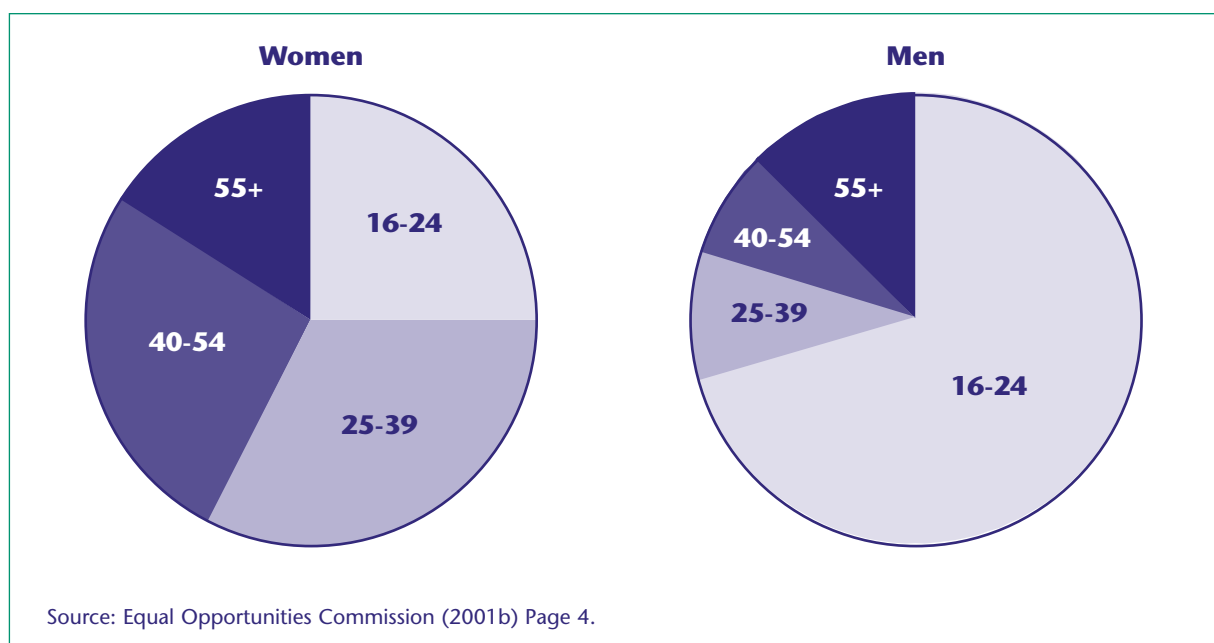


Figure 2: Median individual gross income by sex and age



Figure 3: Employee earning below the Lower Earnings Limit by sex and age



Changes in marital status and household composition after the age of 50 can also affect a woman's standard of living. The period between the ages of 50 and 74 years is one when many married women will become widows. The financial consequences of widowhood are an important aspect of the income dimension of transitions after 50. Given the greater mortality among the poor than the rich, widowhood at a relatively young age may be particularly likely to result in poverty.

Patterns of employment

Over the last two decades the employment participation of women of all ages has steadily increased (Table 1). These days just under a quarter of women aged 55-59 are in full-time work, with a slightly higher proportion working part-time.

In terms of both the types and patterns of work there are some distinct gender-based patterns and differences between men and women. In 2001 44% of women in employment in the UK worked part-time compared with only 9% of men (Dench et al, 2002). As they get older more women tend to work part-time: two fifths of female employees aged 16 to 44 work part-time compared with around half of those aged 45 to 64. The most common reason for working part-time are family commitments. The relationship between part-time working and having dependent children for women is very clearly demonstrated in Figure 4.

Working part-time has a huge impact on women's earning potential both in the present and future. Age and number of children compound the situation with older workers and those with higher number of children being the worst off. An additional factor is the status of much part-time work. Part-time workers are more likely to be found in low paid, low status jobs with fewer prospects for career advancement or higher incomes, they also have less opportunity than younger women to benefit from the equality strategies of recent years. Further, women tend to remain in these jobs in the long term and often for the majority of their working lives.

The ways in which education, the family, and access to the labour market interact are complex, but women have different opportunities and experience different types of discrimination throughout their lives. The resulting inequalities can clearly be seen in employment and income (Equal Opportunities Commission, 2001d). Overall, women remain disadvantaged compared to men, as occupational segregation means they are concentrated in lower skilled and lower paid jobs with less access to vocational training and education (Equal Opportunities Commission, 2000a). Bearing in mind these structural difficulties, it is interesting to draw attention to a large US survey (Carr, 1997) which found that women have higher levels of positive mental health and lower levels of depression when they have achieved the goals that they set for themselves earlier in life.

Unemployment

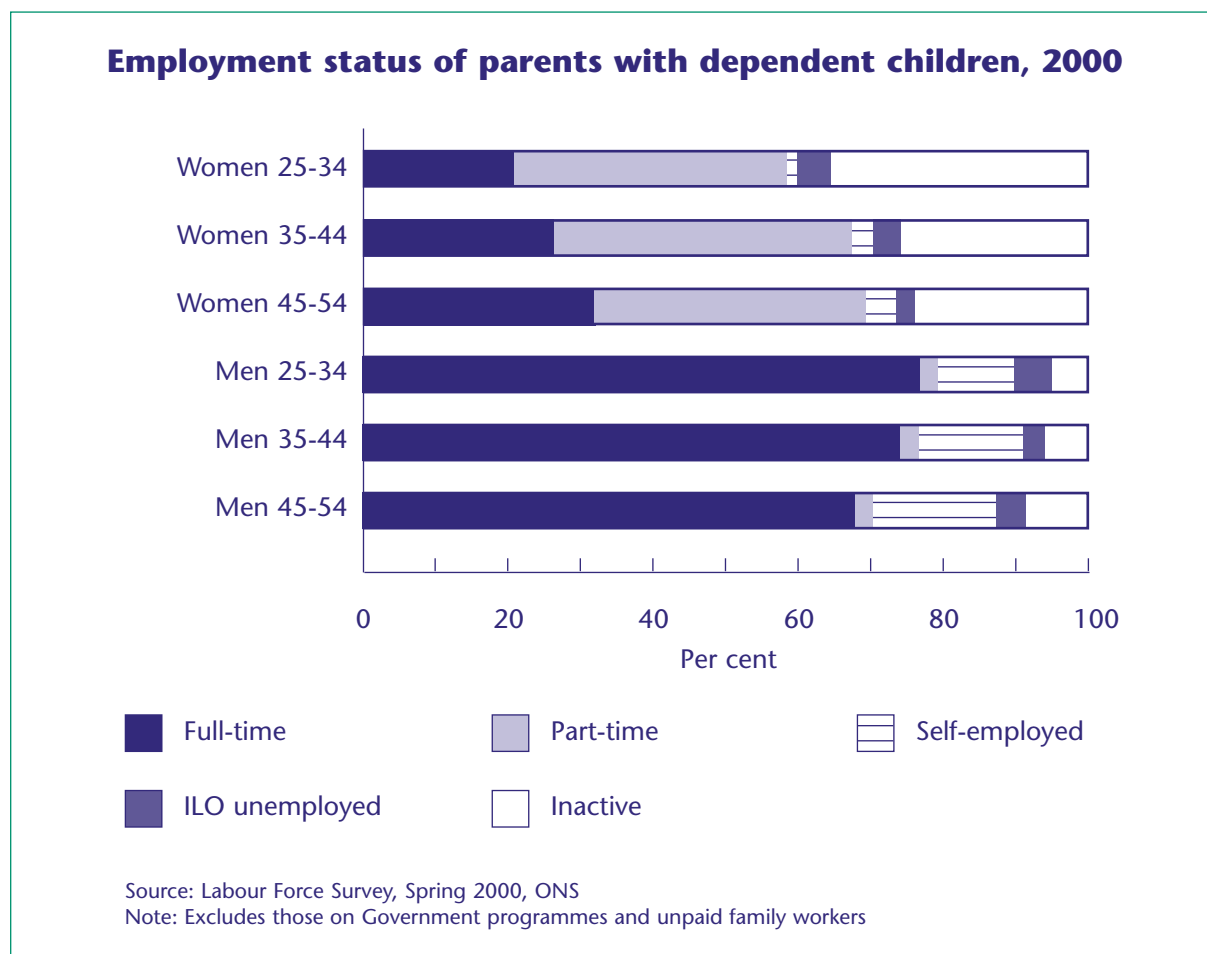
There are few women in mid-life who define themselves as unemployed: who are without a job and seeking work. The unemployment rates in 2001 for women 45-54 and 55-59 were 2.4% and 2% respectively (Office of National Statistics, 2002). These are amongst the lowest unemployment rates for any age/sex group. It is, however, the case that many mid-life women are housewives and carers for dependent relatives: they are not unemployed in any sense but tend not to be actively earning an income.

Table 1: Economic activity of working women by age

Economic inactivity rates of working age women by age: UK 1984-2001					
	Working age %	16-24 %	25-34 %	35-49 %	50-59 %
1984	33.0	30.3	38.8	28.9	41.2
1985	33.0	29.1	37.2	27.9	41.6
1986	32.0	27.9	35.5	27.4	41.2
1987	31.1	27.0	34.2	26.7	40.3
1988	30.1	26.8	32.0	25.3	40.6
1989	29.1	25.9	30.9	24.9	39.0
1990	28.7	27.2	29.8	23.5	38.6
1991	29.0	28.2	30.1	23.6	38.6
1992	29.4	32.1	30.0	22.7	37.9
1993	29.4	33.6	29.0	22.9	37.5
1994	29.4	34.8	28.8	22.9	36.6
1995	29.4	35.2	28.4	23.3	36.5
1996	28.9	34.3	27.8	22.7	36.9
1997	28.6	34.0	26.6	23.0	36.6
1998	28.5	34.6	26.3	22.8	35.7
1999	27.9	35.0	24.9	22.4	35.1
2000	27.5	34.4	24.7	22.2	34.0
2001	27.6	35.8	24.9	21.7	33.7

Source: UK Labour Force Survey Spring Quarters Historical Supplement, 001
Data for figures 3.2 and 3.5

Figure 4: Employment status of parents with dependent children by sex and age



Gendered work to gendered retirement

Increasing numbers of people, both men and women, are leaving work before state retirement age. Existing evidence suggests that while the minority of individuals who retire ‘early’ make a choice and are happy with their decision, a larger proportion is forced into early retirement through health problems, redundancy and family demands (Bone et al, 1992) (Table 2).

Caring responsibilities are a key reason for many mid-life women to leave work (Table 6). This group is more likely to experience problems in adjusting to and coping in retirement (Barnes et al, 2002). Recent research suggests that a significant number of women find retirement challenging; many miss their work which provided social and personal support as well as an income (Milne and Williams, 2000). Women with a strong social attachment to the workplace tend to be less willing to retire than those without, and are less likely than men to be positively oriented to retirement (Mooney et al, 2002). Despite the fact that most mid-life women will never ‘retire’ from domestic and family responsibilities, the role of paid work as a source of independence and identity should not be underestimated. This is a consistent finding regardless of the nature or status of the work (Phillips et al, 2002). Many older women still expect their ‘retired’ years to be predominantly organised according to traditional gender roles, supporting the contention that both women’s working lives and retirement are structured by gender considerations (Barnes and Lakey, 2002; Milne and Hatzidimitriadou, 2002).

A particularly powerful feature of gender relations relates to the societal expectation that men should marry women younger than themselves, a tradition associated with the maintenance of a power differential within marriage. Due to different retirement ages, women tend to retire before or at the same time as their husbands. There is some evidence that older husbands are uncomfortable with their wives continuing to work and also that wives themselves prefer to retire at the same time as their husbands in order to be able to 'look after' them (Arber and Ginn, 1995). Where the household depends on the income of the wife she will continue to work beyond her husband's retirement: this is almost exclusively the case for poorer households, households where children under 21 still live and/or families where the husband has long-term health problems (O'Rand, 1992). The fact that over a quarter of women workers aged 50+ retire to take care of a dependent family member further reinforces the influence of patriarchy on retirement. As noted by Arber and Ginn (1995) these 'decisions' reflect constraints on women rather than choices. The gender culture embedded in many organisations also has implications for retirement; there is evidence that many women leave work before their state pension age due to ageist employer policies.

Gendered pension patterns

Table 3 shows current pension membership among women and men, by type of pension and age. The total figures show that men are more likely than women to have personal pensions, a factor clearly linked to women's work patterns and the recent changes in employer pension provision. While 23% of men working full-time have personal pensions, 14% of women working full-time and 9% of women working part-time have such pension schemes. For those groups in mid-life it is clear that about the same numbers of women as men belong to a pension scheme; slightly more men belong to personal pension schemes and slightly more women in the 55+ age group contribute to an occupational pension scheme. It is interesting to note that between two fifths (45%) and under a tenth (8%) of women working part-time also contribute to a pension scheme. What needs to be borne in mind in interpreting these figures is the fact that the total number of women working full-time is far lower than the total number of men. Furthermore, fewer women will have worked full-time for the duration of their working lives and thus will have accrued lower pension contributions.

Table 2: Reasons for retirement by sex

	All (%)	Men (%)	Women (%)
Own ill-health	26.6	26.0	27.7
Ill-health of others	5.2	4.1	7.5
Involuntary redundancy	14.5	15.0	13.7
Voluntary redundancy – reasonable financial terms	17.8	23.6	7.1
Spend more time with family	5.4	2.5	10.7
Enjoy life while young and fit	5.7	5.8	5.4
Fed up with work or wanted a change	5.3	4.4	6.9
Other	12.7	8.5	20.5
Fixed retirement age	6.9	10.3	0.7

Source: Disney et al (1997)

Access to money and resources in mid and later life is pre-eminently a life course issue. The impact of lifelong employment patterns and reduced income in youth and early adulthood has a long-term impact on pension status for women. Research has shown that the financial inequalities inherent in work structures are reproduced in retirement for many women; it is also likely that they influence wider issues concerning the marginalisation of women in mid and later life and their ability to act independently and make choices (Bardasi and Jenkins, 2002) – all key determinants of mental health.

In terms of access to the state retirement pension, at present only 28% of older women receive a full state pension in their own right. Because of low pay and part-time employment, two million women currently earn too little to pay national insurance contributions and therefore will not qualify for a State pension in their own right. As this is a gendered pattern which is likely to continue in the future, the potential for many women in mid and later life to find themselves ineligible for the state pension, is considerable (Pension Provision Group, 1998; DSS, 1999).

37% of women receive a pension of less than £40 per week and 75% of pensioners claiming income support are women. Women who are single, divorced or widowed are particularly at risk in this respect (Pension Provision Group, 1998; DSS, 1999), as are women from ethnic minority groups and the lowest socio-economic groups (Vincent, 1995). A recent review of take up of the MIG (minimum income guarantee) by the National Audit Office reveals that of the 2 million eligible pensioners only 200,000 claim this benefit (ONS, 2002). This powerfully indicates not only that there are considerable levels of poverty amongst older people but that means testing in retirement are not effective ways to alleviate poverty; this will have a particular and acute impact on older and upcoming retired women (Table 3).

Pensions policy and women

Recent changes to pension policy are having a particularly negative impact on women's incomes: of particular note is the emphasis on private or occupational pensions, and the raising of the state pension age to 65 years. We have already reviewed the numbers of women in receipt of private or occupational pensions. The current emphasis placing increasing responsibility for pension status on employers and individual workers particularly disadvantages mid-life women who for a range of gender-based structural reasons, have little opportunity to benefit from work-based pensions or build up a private pension fund (Bardasi and Jenkins, 2002).

The raising of the state retirement age to 65 for women is being phased in from the year 2010 (HMSO, 1994). Women will need an extra five years National Insurance contributions or credits in order to be eligible for a full state basic pension than is the case at present. This expectation places additional pressure on mid-life working women:

'To the extent that there are pressures to avoid contravening the norm of male economic dominance, in addition to lack of employment opportunities, wives will continue to retire well before the new pension age of 65, thus reducing their chance of fulfilling eligibility requirements for a full state pension as well as the value of any other pensions' (Page 85).

If women continue to leave the labour market mainly in their late 50s – as we have identified – the gap between their retirement and pension age will be widened, making the majority of wives wholly financially dependent on their husbands until aged 65 (Arber and Ginn, 1995). This status has clear implications for women's well-being: financial dependence is a known risk factor for compromising mental health.

Table 3: Current pension scheme membership by sex and age

Pension scheme members	Age						Total %
	16-17 %	18-24 %	25-34 %	35-44 %	45-54 %	55 and over %	
Women full-time							
Occupational pensions	(0)	32	60	66	65	61	58
Personal pensions	(6)	4	17	20	13	11	14
Any pension	(6)	35	70	78	71	68	66
Men full-time							
Occupational pensions	(0)	24	52	64	63	55	54
Personal pensions	(0)	4	26	29	26	19	23
Any pension	(0)	27	68	79	77	65	67
Women part-time							
Occupational pensions	1	4	35	40	41	23	31
Personal pensions	0	1	13	13	9	8	9
Any pension	1	4	44	48	45	29	37

Note: Figures in brackets denote small numbers of cases
Source: *Living in Britain: Results from the 2000/01 General Household Survey*

There are two other changes which are likely to have an impact on mid-life women. In April 2001, stakeholder pensions were introduced that are designed to provide a second tier pension for those on moderate incomes who are unable to join an occupational scheme or for whom personal pensions are not suitable (DSS, 1998). This applies to many women and may be of considerable benefit to those who have compromised their earnings through breaks of service and part-time working: once they have 'bedded in' the impact of stakeholder pensions on women in mid-life will need to be reviewed to evaluate how far this is the case.

The government also plans to replace the State Earnings Related Pension Scheme (SERPS) with a State Second Pension from 2002, aiming to target additional resources at carers and those on incomes of up to 10K. This is likely to assist the many mid-life women on low incomes or who give up work to care for dependent relatives; time will tell how far they counteract the cumulative disadvantages that we have identified in this review.

Overall, present policy emphasis on individual responsibility for pension status and the raising of state retirement age condemns increasing numbers of current and future women pensioners to an impoverished later life. Unless there is a change of policy direction, the pension penalties of motherhood, caring for dependent relatives and retiring early to support a disabled or sexist husband, will persist for the foreseeable future. These disadvantages are further accentuated for lone mothers, and divorced and widowed women (Milne and Williams, 2000).

Savings

Wealth is much less evenly distributed than income in mid-life. In 1997-98 half of all households in Britain had less than £1,500 of savings and 30% had none (Women and Equality Unit, 2000). Women are far less likely to have stocks and shares. Older women living alone are generally much poorer and have fewer savings than older men, because they are far more likely to solely rely on state pensions for their income rather than both state and occupational pensions (Milne et al, 1999).

Property ownership

Housing and living arrangements are well-documented determinants of health and psychological well-being (Sixsmith 1990). Research consistently shows that home ownership is commonly associated with a wide range of physical (Gurney and Means 1993) and psychological benefits (Clark et al 1998). An individual's capacity to retain their social networks and adjust to mental or physical ill health is greater if they live in a permanent housing situation under their 'control' (Matheson, 2002).

At all ages women are less likely to be home owners than men (Arber and Ginn, 1995) and despite the fact that increased age tends to be associated with increased numbers of people owning their homes outright, this trend is biased towards men (Matheson, 2002). Analysis of the 1995-6 Family Resources Survey suggested that women aged 55-59 years who are early retired or have been sick long term are less likely to be owner occupiers (Baker and Harris, 2000). Even when women are homeowners the quality of housing is likely to be inferior to that of men. Forrest and Leather (1998) conclude on the basis of their review of homeownership that:

'Just as some of the worst housing conditions are experienced by female-headed households in the early stages of the lifecycle, it is also likely to be women who make up a disproportionate number of disadvantaged home owners in old age' (p.35).

It is also women who disproportionately occupy substandard public and privately rented housing (Leather and Morrison, 1997; Matheson, 2002.)

Status and power

Gender inequalities mean that women are systematically accorded less status and power than men, and the consequences of this are ameliorated or accentuated by the interactive effects of other aspects of a woman's life such as her class, race and age. Whilst many women in mid-life will not experience the full range of disadvantages associated with later life, age as a dimension of inequality cannot be ignored (Milne and Williams, 2000). The tentacles of late life disadvantage have powerful roots in mid-life and the social process of ageism is experienced by many women in their 50s. Many writers have drawn attention to the fact that ageing is a gendered social process which men and women experience differentially (Walker 1993; Arber and Ginn 1998). As long as women are primarily charged with the task of reproduction, nurturing and the transmission of values to the next generation, they risk being perceived as socially redundant and of limited social value when that work ends. As de Beauvoir (1972) notes, older women are often seen as 'past it' and useless, whereas older men are often perceived as mature, distinguished and desirable. A 'double standard of ageing' operates which combines ageism with sexism and accords older women a doubly oppressed status in mid and later life. The significance placed on youth, appearance and reproductive capacity

undermine the contributions of women in mid-life, fuel a negative image of their roles and marginalise their views and position in a range of economic and social contexts.

'Because a lot of women do manage to look younger now, if you look your age when you're 50, it feels like a failure. I keep thinking when will I be allowed to give up and stop trying so hard – when I'm 60? 70?' (SIRC, 2001)

That older and mid-life women often experience themselves as socially 'invisible' has been widely reported (Greer, 1991; Apter, 1996). Other writers make the point that class and race also determine the nature and experience of ageing, and Arber and Ginn (1991) have identified black older women as being particularly disadvantaged by the triple jeopardy of ageism, sexism and racism. The differential impact of social inequalities on women's lives means that there is huge diversity in experience of oppression and privilege. What we need is research that will substantiate and offer understanding of the particular implications for women at mid-life.

Relationships with other women

The effects of social inequalities on women's access to material, social and psychological resources, is typically detrimental. However, an exception to this is their potential access to valued relationships with other women. Like members of any disadvantaged group, women are well placed to seek support and value from each other. That these relationships are a source of therapeutic support for women both within and outside of mental health services is well documented (Bernardez, 1996; Harris, 1998a; Watson et al., 1996). In contradistinction this type of resource is less readily available to men (Miller and Bell, 1996). Indeed women between the ages of 45-60 may be particularly sensitised to the value of relationships with other women having been young during the re-emergence of the feminist movement in the 1960s and 1970s. There is also good evidence (e.g. Williams and Windebank 2000) of the benefits of community development work with women, especially those living in deprived communities (Holland, 1995).

Summary and priorities for change

In this section we have traced ways in which women's psychological well-being can be affected by their access to material and social resources and have linked 'being female' with a range of gender and age-related disadvantages that impact on opportunity, income, status and power. We suggest the following priorities for action:

Research

- *The challenges facing mid-life women:* Qualitative studies to explore the relevance and meaning for women of the issues that to date have been mainly identified through surveys. Mapping the cumulative ways in which women are disadvantaged socio-economically and how they manage the consequences of disadvantage would extend knowledge and illuminate ways to develop coherent and effective responses. Adopting a life course approach would reveal the threads of disadvantage in women's lives and the links between the separate strands.

- *The emotional well-being of mid-life women:* Research that explores the emotional well-being of women in mid and later life, including poor women and those from disadvantaged social groups. Hearing the voices of mid-life women – a time of life largely unexplored in research – would be very valuable.

Policy

- *Retention:* Policy initiatives aimed at facilitating the development of organisations cultures that are sensitive to the needs of mature women workers and that challenge discriminatory practices and pay differentials.
- *Retirement:* Policy initiatives that increase the possibility that women will be supported and enabled to make a positive choice to stay in work. Guaranteeing the continued provision of a universal state pension would offer some protection for women.
- *Poverty:* Measures to prevent the widespread income poverty which currently exists amongst women in mid and later life. The benefits system is widely regarded as an area requiring reform. Women who are retiring should be able to access an income that allows them to live comfortably; it is regarded as demeaning to claim means tested benefits particularly when women have contributed significantly to child rearing, family and community life.

Mental health

- *Support from other women:* Ensure that mental health services provide mid-life women with opportunities for group work with other women with whom they share important life experiences. This should include ensuring that mature women workers are able to contribute to supporting their counterparts with mental health problems.
- *Mental health promotion:* Work preventatively through community development initiatives in areas of social deprivation including identifying the roles played by mid-life women in supporting others and opportunities for them to be supported.

INEQUALITY, OPPRESSION AND MENTAL HEALTH

In addition to socio-economic disadvantages, mid-life women also encounter challenges and potential disempowerment rooted in processes of discrimination and oppression. It should be noted that while discrimination and oppression exist in all areas of life, and are imbedded in many practices and systems and take on many forms, they are often invisible and hence are viewed as irrelevant by perpetrators.

Unpaid work

Housework

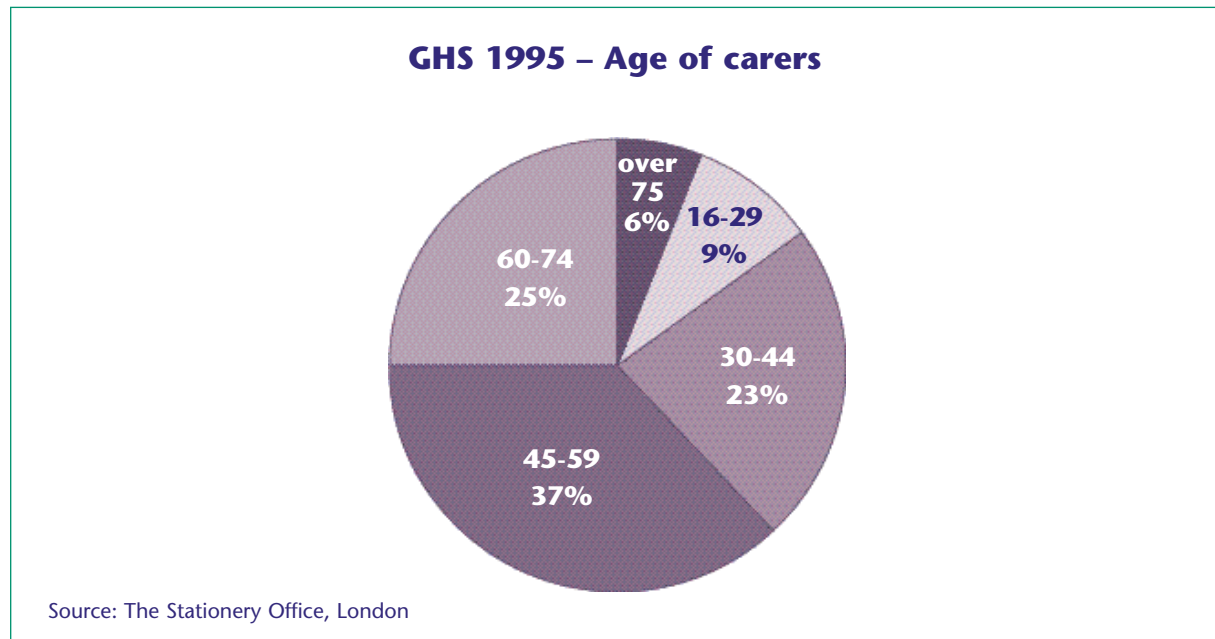
Women as the chief carers in families also hold most responsibility for household tasks, and this is particularly likely to be the case for older women. Research shows that married men report doing about 9 hours of 'housework' per week while their wives report an average of 24 hours (Seymour, 1992; Pilcher, 2000). Over recent decades there has only been a very gradual shift towards equality in this sphere. Additionally, there is evidence that women's personal or spare time is conflated with household tasks (Seymour, 1992), and that as a result many women feel that they have 'no time to call my own'.

Women's home roles are often characterised by considerable responsibility, a lack of power, and blame: there is now ample evidence that these exact a mental health cost from women (Brown and Harris, 1978; Williams and Watson 1996; Williams 1999). In mid and later life women who have primarily worked within the home appear more likely to experience depression than women who have also been employed, an outcome which is suggested to be mediated by low self-esteem, helplessness and poverty (Rodeheaver and Datan, 1988).

Gender and caring in mid-life

Overview

The likelihood of becoming a carer increases with age (Figure 5). Whilst only 9% of those aged 16-29 are carers, 37% of those aged 45-64 are carers, 25% are aged 60-74 and 6% are aged 75+ (OPCS, 1998). Approximately half of all carers are aged between 50 and 64 years old; most people take on the caring role between their mid-30s and mid-50s and many continue to care for the rest of their lives (Carers UK, 2002). By their late 60s almost one woman in three will have cared for a dependent adult at some point in her life. The mid-life group predominantly care for elderly parents (52%), although they also provide care to older spouses/partners (20%) and grown up children (18%). It has also recently become recognised that grandparents make a significant contribution to meeting childcare needs: surveys show that care by grandparents is the most common form of care used by women who work (Phillips et al, 2002).

Figure 5: Age of Carers in the 1995 General Household Survey (GHS)

The responsibility for caring in mid-life falls predominantly on women (Maher and Green, 2002; Milne and Hatzidimitriadou, in press). Two thirds of carers are women and one third male. Women are also particularly likely to become a co-resident carer – caring for someone in the same household and women also predominate in those groups with the heaviest commitments (Parker, 1992). About double the number of women carers provide intensive care than men – care that involves bathing and personal care; a third (30%) spend 20+ hours caring per week including an eighth (12.5%) caring for 50+ hours (Maher and Green, 2002). In fact under the age of 65 women provide an average of twice as much care as men (Mooney et al, 2002). Women also appear more likely to be the sole or primary carer for a dependent relative rather than being a member of a network. There are indications that these patterns can be accentuated amongst some ethnic minority groups (Adamson, 1999; 1996; Atkin, 1992; Katbanna, et al, 1998).

Married people not in paid work, part-time employees and those in low status, poorly paid jobs are more likely to become carers than more advantaged groups; most of these are women. While being employed does not affect whether or not women start caregiving, women who do start are more likely to reduce employment hours or stop work altogether (Pavalko and Artis, 1997). As Pavalko and Artis 1997 conclude:

'Thus, the causal relationship between employment and caregiving in late mid-life is largely unidirectional, with women reducing hours to meet caregiving demands.' (Page 170).

The pivot generation

What makes the needs of the mid-life carer unique is that many are combining paid work, home commitments – which may include supporting children – and care for an elderly relative. By the age of 50, three fifths of people still have a living parent and just over a third are grandparents (Grundy et al, 1999). At the same time 69% of men aged 50-64 and 63% of women aged 50-59 are in paid employment. This ‘sandwich’ or ‘pivot’ generation typically has a multiplicity of roles in both their work and family lives.

The consequences and impact of caring

Most of the evidence relating to the consequences and impact of caring relates to carers providing intensive support and has been gathered from small-scale research projects. Many of this group are women carers aged 45-60. This literature indicates that the consequences of caring are far-reaching and long term, these include:

- Psychological and emotional consequences
- Effects on employment
- Financial consequences
- Physical and social consequences.

Whilst the main focus of this section is the psychological and emotional consequences of caring, it is important to recognise the interlinked and cumulative nature of the range of effects caring has on a carers’ health and well-being.

Psychological and emotional consequences

There are no grounds for suggesting the process of caring for others in itself damages psychological well-being. However, the work of women carers is typically undervalued, associated with powerlessness, isolation, and financial hardship: all known determinants of mental health difficulties.

Evidence linking caring and emotional well-being is well established (Parker, 1990; Draper et al, 1996). Co-residency, intensive caring, and length of caring are all positively correlated with poor mental health as is being the sole or primary carer (Evandrou, 1996; Hirst 1998). Evidence from the General Household Survey (Office for National Statistics, 2002) suggests that compared to women in general, women carers are 23% more likely to have symptoms of psychological stress (Singleton et al, 2002). Recent work using the British Household Panel Survey has suggested that caring has a significant negative impact on the emotional health of carers (Hirst, 1998; Henwood, 1998). Stress among carers is widely reported and is particularly associated with depression; the GHS 2000 evidenced that a third of mid-life carers report feelings of stress (ONS, 2002).

Around one-third of those caring for a disabled spouse experience clinical level depression (Levin et al, 1994; Ballard et al, 1994). In Liston et al’s study (1995), one third of the 93 carers interviewed felt their health was affected by caring, with nearly two thirds reporting stress and half reporting depression. In a recent survey undertaken by Carers UK (formerly Carers National Association), 65% of carers said their emotional health had been significantly affected by caring (CNA, 1992) with 52% being treated for stress related illnesses (Henwood, 1998). The combined negative effects of carers’

having less time for themselves, suffering from poor concentration and tiredness, and being unable to pursue career advancement cause mid-life carers great stress (Hutton and Hirst, 2001). The psychological consequences of caring are most prevalent among people caring for a spouse or parent with a serious disability, dementia or with a chronic mental health condition like schizophrenia (Mooney et al, 2002).

Effects on employment

The relationship between employment and care is not straightforward (Glendinning, 1992; Parker and Lawson, 1994; Caring Costs Alliance, 1996). Caring responsibilities can impact on employment in a variety of ways with reduced levels of participation through fewer hours of work, movement from full-time to part-time employment or withdrawal from the labour market altogether (Department of Social Security, 1999). This is a particular feature of caring amongst mid-life women carers (Phillips et al, 2002). Unlike childcare, the onset of eldercare, its course and duration is more uncertain and unpredictable (Martin-Matthews and Campbell, 1995). Care may be intermittent and demanding, and therefore, both difficult and stressful for an employed person to provide.

Analysis of the Family and Working Lives Survey (1994-5) found that the onset of caring did not affect work for two thirds of respondents, but 16% had stopped work altogether and 10% had reduced their hours (Evandrou and Glaser, 2001). However, as time spent caring increases, there is a greater likelihood that those in work at the onset of caring will stop working (Hutton and Hirst, 2001). In 1995, Joshi et al (1995) found that one in seven of the workforce were involved in caregiving and that the majority of caregivers (80% of men and 60% of women) were in paid employment.

Significant changes in the UK population have led to there being fewer younger people, and a larger number of older people requiring support and care. Future predictions suggest that this situation will continue. The number of people aged over 75 is projected to increase by over 70% over the next 35 years or so (Carers UK, 2001). Over the same period, the number of people most likely to provide care – those aged between 45 and 65 – is projected to rise by only 11% (Mooney et al, 2002). The implications of this for employment are that employers try and retain older workers, particularly women. This results in a situation whereby women in their forties and fifties are being targeted by employers to enter and/or remain in the labour market, while at the same time there are more care demands being made on them.

The nature of work is also changing. As well as employers wanting to retain and attract women, both women and men are working longer hours. One in six employees now works in excess of 48 hours per week and 11% work over 60 hours (Ashdown, 2000). Between 1979 and 1999, there has been a threefold increase in the numbers of women aged 50-54 who are working 40 or more hours per week and increasing numbers of couples both work. Decreasing numbers of permanent jobs and increasing levels of job insecurity are also factors, which make the nature of the labour market different.

Financial consequences of caring

Research indicates that carers providing substantial amounts of care face much financial hardship (Carers National Association, 1997). Half of these carers' incomes are within the lowest two fifths of income distribution (CNA, 1998) and one in five intensive carers have difficulty paying for essentials such as fuel bills (CNA, 2000). Housing is strongly correlated with income. Parker's research (Parker,

1998) suggests that those who care intensively are less likely than their counterparts to be in owner occupied accommodation. Some of this undoubtedly reflects the prolonged lowered income status of both the disabled person and their carer (Glendinning, 1992).

Caring can also involve extra costs (Glendinning, 1992). To meet these extra costs, carers often draw on their savings and those of the person they care for. Financial stress is also incurred by local authority charges for services such as home care, day care, meals on wheels, and respite care, which have greatly increased over the last decade (Hancock and Jarvis, 1994).

As has been noted many women lose the opportunity to make proper pension provision; one of the key reasons for this is interruptions to employment by periods of caring. This may be a second interruption following an earlier break for child rearing. Those carers who begin caring when they are employed, compromise their earning capacity for the remainder of their working lives as well as for retirement. As Evandrou points out, 'Lower pension rights may extend the employment impact of caring well beyond statutory retirement age' (Evandrou, 1995).

From a review of the literature on the reconciliation of work and family life, Devon et al (1998) conclude that many carers do not have an either/or choice between employment and providing care, but rather must adopt compromise solutions involving a number of strategies. Most mid-life carers aim to achieve a balance between work, family responsibilities and caring for an older relative, rather than giving up work completely.

Recent research funded by the Joseph Rowntree Foundation (Barnes et al, 2002) reveals that factors encouraging people to stay in paid work include: financial necessity, satisfaction with and commitment to work, and the potential of work to offer a respite from caring responsibilities. Factors leading people to leave work include: the increasingly demanding and stressful nature of many jobs, the negative impact of work on their health, the ability to take early retirement with a full pension, and life events which lead them to prioritise their personal and family lives over paid work (Phillips et al, 2002; Mooney et al, 2002). In addition, as we argue above there is a strong rationale for women employees in mid-life to remain in paid work. They need to build up their pensions and pursue work-based aspirations.

Physical and social consequences of caring

Carers who care intensively are at increased risk of experiencing health problems or disabilities themselves (Arber and Ginn, 1991). The 2000 GHS found that of those mid-life carers caring for 20+ hours per week, a third report having a longstanding illness or disability and three quarters (72%) had consulted their GP about their physical health over the last year (Singleton et al, 2002). Despite this, many carers cannot afford to either be ill or be admitted to hospital due to the intensity of their caring role – particularly if they are not properly supported by services. Early discharge from hospital is of no value to a carer who is told to 'rest' but who must care for her disabled parent or husband. This is particularly the case for sole or primary carers who tend to have limited support from other relatives (Hirst, 1998).

Caring can also have social and personal costs. Leading a life constrained by caring is described by Twigg as 'restrictedness' (1994). This refers to facing a timetable of caring tasks, worrying about leaving the cared-for person alone as well as broader constraints such as a limited social life. Working carers often experience a 'time bind' resulting in less time for themselves and their family (Mooney et al, 2002).

Summary and commentary

There is likely to be an increasing demand for both care of older people and grandchildren because of population trends and the current government emphasis on encouraging as many people as possible to enter and stay in paid employment. Yet, the same trends mean that there will be fewer people available to provide informal care. Women are increasingly moving into the labour market and working longer hours than in the past. Furthermore, one of the effects of the much discussed 'pension crisis' is to make early retirement, whether to provide care or for other reasons, an increasingly unrealistic option for many people.

A second concern is that the costs of caring are carried largely by individuals – primarily women – despite the value to society of the informal care they provide. As noted above, it is individual women who bear the financial consequences if they retire early without a full occupational pension, take a career break, forgo career advancement or reduce their hours of work in order to provide care. The financial consequences in terms of impact on pensions can be long-term, especially for women, who have often been less able to build up their pension entitlement over the years.

The workplace

There is good evidence that women's physical and mental health can be enhanced by employment outside the home (Doyal, 1999; 2000). Paid work is a potential source of important determinants of mental health including, self-esteem, financial and emotional independence, and social support. However, as Doyal (2000) also observes, work can also be a source of stress when it is poorly paid, of low status, a source of high demands, and offers the person little opportunity for control. It is evident from the work reviewed below, that it is those women whose lives are already most disadvantaged by social inequalities that are most likely to experience the psychological disadvantages and least likely to experience the psychological advantages of paid work.

Occupational stereotyping and segregation

Men and women do different jobs in different settings with women concentrated in certain areas. Around 31% of all employed women work in the public sector and four out of five public sector workers are female (Equal Opportunities Commission, 1999). In education and health care 69% of all employees are female, and women also predominate in clerical and secretarial work, personal and protective services and sales. Commenting on this segregation, Doyal (2000) points out that the most stressful occupations are those which require a worker to be responsible for the well-being of others: occupations which are predominately filled by women.

As well as vertical segregation between 'male' and 'female' jobs, there is also horizontal segregation between men and women in the workforce. Women are much more likely than men to be in the lowest positions in each occupational setting. They occupy only about one third of managerial and administrative jobs and within this category are likely to be in the lowest grades (Dench et al, 2002). This gender difference in occupational status is reflected in earnings. Despite the Equal Pay Act women still earn around 70% of the average male wage (Equal Opportunities Commission, 2002).

Discrimination

The evidence that has been reviewed in the sections on income, and employment suggest that women's employment patterns are powerfully determined by gendered structural and situational factors which are not of their own making (Bardasi and Jenkins, 2002). Disadvantage is deepened by discrimination within the workplace.

Women of all ages are affected by sex discrimination in employment and older workers, both male and female, are affected by age discrimination. These combine to result in 'gendered ageism' which is viewed as operating widely within the workplace and is linked to the development of a 'gender culture' (Bernard and Phillips 1998; Tyler and Abbott, 1994). The 'gender culture' has a number of distinct implications for mid-life women.

First, sex discrimination is deeply embedded within organisational cultures, structures and practices; for example women are routinely viewed as ageing earlier and as being 'older' at a younger age than men (Itzin and Phillipson, 1993, 1995; Itzin and Newman, 1995). There is clear evidence of age barriers limiting job opportunities for women aged 55+; which do not apply to men with equivalent qualifications and experience (Bone et al, 1992). Due to this discrimination women's careers are blocked with negative consequences for their income, status and prospects. This trend has implications for retirement; there is evidence that many women leave work before their state pension age due to ageist employer policies (Mooney et al, 2002). There is further evidence from the US (Auster, 2001) that mid-career professional women experience more stress in dual career households than their male counterparts. This study also found that the majority of women are not leaving professional jobs to spend time at home but because of the effects of gender inequality on their working lives

Second, the occupational profiles of women do not fit neatly with the expectations of the man made workplace; no account is made of their roles outside of the workplace or caring commitments. Attempts to improve the position of women employees through equal opportunities policies routinely meet resistance from men and cause conflict between, predominantly male managers and, predominantly female subordinates (Arber and Ginn, 1991; 1995). This pattern of individual and organisational discrimination is likely to be decisive in shaping a range of experiences affecting women in work and retirement; gendered work results in gendered retirement, an issue that we have already explored here.

The cost of age discrimination to the economy is estimated as £31 billion in lost production; being without work can have a dramatic effect on physical and mental health: depression being a particular risk of unemployment. Leaving work early has profound implications for pension status and poverty as well as physical and mental health in late mid-life and post retirement (Help the Aged, 2002).

Summary and priorities for action

In this section we have traced ways in which women's psychological well-being can be affected by processes of oppression and subordination, with a focus on women's lives at work and at home. On the basis of this review we suggest the following priorities for action:

Research

- *Older women workers:* Research to address the deficit of studies concerned with the psychological well-being of older women workers, including studies that explore the psychological survival of women who have worked for decades in jobs that are poorly paid and undervalued.
- *Part-time work:* Research to explore and compare the retirement experiences of women working full-time and part-time, and which aims to identify the determinants of successful transition.
- *The impact of gendered patterns of work:* Research to systematically investigate the ways in which gendered work affects other areas of the lives of mid-life women, including their friendships, housing, accommodation, leisure and education – and the consequent implications for their mental health.

Policy

- *Caring:* Much greater development of support for carers, including changes to benefits and pension entitlements, greater flexibility in the way work is organised and specific provisions within the work environment such as access to telephones and work-based counselling services.
- *Family friendly policies:* To date these have mainly focused on working parents with young children. Greater attention now needs to be given to those caring for dependent relatives or grandchildren. These could include, for example, phased retirement or career break without incurring pension penalties, extended lunch breaks, home working and opportunities for working in the evenings.
- *Value and status:* Greater public acknowledgement of the contribution made by those who care for vulnerable others. A change of culture within the workplace and wider society to recognise and value the contribution of mid-life carers and develop an 'ethic of care', so that the psychological and emotional consequences of caring are not to continue to fall inequitably on the pivot generation of women.
- *Retirement:* Protecting the universal state retirement pension as this ensures a minimum income for many women entering retirement with little occupational or private pension.
- *Organisational policies and practices:* Studies which increase understanding and appreciation of the ways in which age and gender interact in constructing present organisational policies and practices, which affect both work and retirement.

Mental health

- *Carers:* Preventative interventions – including primary care support and enhanced support for the cared for person – that are accessible to a wide range of carers. There is evidence of what is effective in supporting carers: more needs to be done to ensure women gain access to support at an early stage in the care trajectory and in a flexible and coherent way.
- *Recognition:* Service providers need to develop greater sensitivity to the psychological implications of the work and home roles of mid-life women; they need to provide interventions that are appropriate to juggling a range of responsibilities but do not pathologise women or medicalise their needs.

INEQUALITY, SERIOUS ABUSES OF POWER AND MENTAL HEALTH

Physical and sexual abuse

The existence of structural inequalities creates opportunities for very serious abuses of power. Physical and sexual violence and abuse, perpetrated overwhelmingly by men is a common and sometimes covertly sanctioned means of expressing and maintaining dominance in family and community settings. Research shows that between one in ten and one in three girls experience sexual abuse in childhood – depending on the definition of abuse and at what age childhood is deemed to end. Violence can and does occur over the lifespan, from childhood to old age, with elder abuse being the most recent aspect of domestic violence to receive sustained research attention. The lifetime prevalence rates for women experiencing domestic violence is one in four, and the peak incidence of physical and sexual violence occurs in young women (Domestic Violence Data Source, 2002). The mental health implications of these power abuses are now well substantiated (Goodman et al., 1999; Harris and Landis, 1997; Ristock, 1995; WHO 2000). Indeed, physical and sexual assault are normative experiences in the lives of women who have serious mental health problems, who are homeless or living in secure psychiatric services.

By mid-life substantial numbers of women will have experienced these kinds of trauma often in conjunction with other forms of exploitation and oppression. Those that have had the resources and opportunity to work through their psychological impact will be well placed to make the best of their futures. However, many will not be so fortunate: unfortunately as yet most statutory mental health services are ill equipped to support women and find some resolution to these profound experiences of disempowerment (Williams and Scott, 2001).

Summary and priorities for action

While women at mid-life do not appear to be at high risk of physical and sexual abuse when compared with younger women and children, many women arrive at mid-life with histories of trauma. There is still much we need to know about how mid-life women survive and cope with these experiences, and the effects on many areas of their life including their education, work and relationships.

On the basis of this review we suggest the following priorities for action:

Research

- *The impact of trauma:* Studies to explore the ways that a history of trauma can affect the psychological well-being of mid-life women, including through the impact on education, work and relationships.

Policy

- *Tackling abuses of power:* Public bodies and services need to continue to name the abuse of power as a serious problem for individuals and our society, and to work together to prevent and redress the problem.

Mental health

- *Recognising abuses of power:* Mental health services need to heed the research findings and name abuse of power as one of the key determinants of mental distress and the difficulties that are called madness.
- *Competence in dealing with abuse:* Mental health services need to develop competence to deal with the mental health implications of sexual, physical and emotional abuse. The understanding and skills needed to work with mid-life women will both be different from those needed to work with younger women although they will share a skill and knowledge base.

INEQUALITY, MID-LIFE CHALLENGES AND MENTAL HEALTH

In 1996, Apter offered this observation:

'There is, for the generation of women now in mid-life, no typical family type or employment pattern. Different women report entirely different senses of constraint and opportunity'. (Page 558).

She queries whether it is reasonable to speak of general changes in mid-life. The data reviewed here would support the considerable diversity amongst women in their experience of mid-life, but suggest that there are also important patterns that are related to the existence of social inequalities in our society, and also to some shared challenges that characterise this particular phase of life.

Relationships

Marriage

At the ages of 50-54, the Family Resources Survey (Baker and Harris, 2000) found that 82% of men are married and 79% of women. Whereas 74% of men and only 48% of women are married amongst those aged 70-74.

Research consistently shows that the mental health benefits of marriage are greater for men than for women and that men who are married are less likely to report symptoms of depression than their unmarried counterparts (Earle et al., 1998; Williams, 1984). This is perhaps unsurprising when we take into account the fact that marriage is an institution like other social institutions, and as such tends to meet men's needs better than women's. Whilst generally speaking, marriage functions as a buffer against depression, evidence suggests that the quality of marital relationship in mid-life is the important mediating variable, rather than marriage per se. Unhappily married women are much more likely to be depressed than those who report higher levels of marital satisfaction (Earle et al, 1998). Such findings indicate that marital status itself may be a less powerful indicator of emotional well-being at mid-life than marital satisfaction, self-rated health, and employment status. This has some common sense validity and is reflected in evidence relating to late-life marriage (Milne and Hatzidimiriadou, in press).

Children

When children leave home it is likely to have different emotional resonance for today's mothers than for their own mothers, largely because of shifts in women's roles and sources of identity. In the 1960s and 1970s there was much discussion about the 'empty nest syndrome' (e.g. Harkins, 1978), a syndrome for which there seems to be little evidence (Dennerstein et al, 2002). More recently there are indications that for a growing number of families, their children leaving home is a transitory rather than permanent phase due to the rising cost of housing and education. Interestingly, a large Australian study (Dennerstein et al, 2002) found that for the majority of women in their sample, their last child leaving home had a positive impact on their mood and their level of stress. Characteristically there were women who were not worried about their children leaving home.

Childless women

In 1998 16% of women aged 45 were childless – it is anticipated that this trend towards increased childlessness will increase. So that nearly a quarter of women born in 1973 will be childless when they reach the age of 45 (Women and Equality Unit, 2000). It should be noted that employment rates and hours of work are closely related to parental and caring responsibilities. For childless women these are likely to be higher than those for mothers. For fathers the opposite applies – men with children are more likely to be working and working longer hours than men without children (Equal Opportunities Commission, 2000b).

Divorced women

The significance of marital dissolution for mental health is well documented. For example, in their large US survey Earle et al, 1998 found that separated people are three to four times as likely to be depressed as the married. Divorced people now account for 8% of the adult population, compared with only 1% in 1971 (Equal Opportunities Commission, 2000c). In 1998 separated and divorced women together formed nearly three fifths of lone mothers, with single women comprising two fifths.

The divorce rates for women and men 45+ are much lower than for younger age groups (Dench et al, 2002) (Table 5). However, divorce at mid-life is likely to have different material and psychological implications than when it occurs at an earlier time of life. A longitudinal study carried out in the US in the 1980s (Wallerstein, 1986) found that most women in the sample who had divorced in their 20s and 30s had re-established themselves emotionally, socially, and vocationally 10 years post divorce. In contrast, many of the women who were aged between 40 and 55 when they had divorced had not. These women continued to suffer from losses of self-esteem and income and many were depressed and lonely. Although there were some women in this group who welcomed divorce, these women were in a minority. While this study was carried out in the US some time ago, many of the contextual challenges faced by women are likely to be generalisable to this country in the 21st century. This includes the loss of income and the decreasing social value and loss of self esteem which often accompanies divorce; this acts as a barrier to establishing new relationships and picking up the threads of a new life (Coone, 1991). Particularly at risk will be women whose employment history has been intermittent (Bogolub, 1991).

Widowhood and bereavement

The 2000-2001 General Household Survey indicates that significantly more women live alone in later life than men. A key cause of this is widowhood; as women tend to marry older men, they are more likely to be left widowed in their mid or later lives. In the age group 65-74 yrs, 37% of women live alone and in the 75+ age group this applies to 60% of women; corresponding percentages for men are 19% and 33%. In mid-life – 45-64 yrs – very similar numbers of women and men live alone; 15% and 16% respectively (OPCS, 2002; Dench et al., 2002) (Table 6).

The impact of grief caused by the loss of a long term partner can be serious and long term. Many studies indicate significant increases in mortality and morbidity follow the death of a loved one. Particular risks are associated with the first six months. Common feelings include: shock, numbness, disbelief, anxiety, sadness, a sense of meaninglessness, loneliness, confusion, anger, guilt and relief; the latter is usually associated with release after a long illness or very stressful long term caring for a person with dementia (Nolan et al, 1996; Briggs and Askham, 1999). Sometimes sufferers also

experience sleep and appetite disturbance and a preoccupation with thoughts of the deceased. Many newly bereaved people withdraw from social contact; some may do so permanently (Littlewood, 1992). The consumption of alcohol and tobacco may also increase.

Table 5: Divorce rates by sex and age

Age	Rates per thousand of married population	
	Women	Men
16-24	30.3	29.0
25-29	32.3	31.5
30-34	27.3	28.4
35-44	19.4	21.7
45 and over	5.1	6.3

Source: Office for National Statistics
Data for figure 2.11

Table 6: People living alone by sex and age

Age	Women	Men
	%	%
16-24	4	6
25-44	7	17
45-64	15	16
65-74	37	19
75 and over	60	33
All ages	18	16

Base: All persons aged 16 or over
Source: General Household Survey, 2000-2001
Data for figure 2.9

The impact of widowhood on a woman's emotional and psychological well-being is significant. It represents a multiple loss; loss of a confidante, sexual partner and social role are all involved to a greater or lesser extent. These personal losses may be accompanied by economic deprivation associated with the loss of the partner's income or pension. A number of authors have suggested that the impact of bereavement may be particularly severe upon women who have occupied the traditional role of wife; when widows say their life has no meaning it is a literal truth, for it is through the relationship she defined herself and her identity (Littlewood, 1992).

Isolation and loneliness

As already noted a number of significant life changes occur in mid-life – retirement, relocation, widowhood, and bereavement; these tend to reduce the size and quality of an individual's social network (Victor et al, 2000; 2002). Of particular note is the consequence of living alone. Isolation and loneliness appear to be more common among those living alone (Andersson, 1998); higher numbers of widowed or divorced women report loneliness as a concern (Milne et al, 1999). Further, there is an increase in the number of people reporting loneliness with advancing age (Audit Commission, 2000). This suggests a causal link between living alone, isolation and loneliness as the proportion of people living alone increases with age (Wenger, 1996).

Health and the menopause

The General Household Survey (GHS) collects a range of information about self-perceived health. There is little difference between males and females on these measures, but as people get older they tend to be more likely to report both longstanding illness and restricted activity. Around 45% of women aged between 45 and 64 years, and 61% of those aged 65 to 74 reported a longstanding illness (Table 7). 19 percent of those aged 45-54 report that they have a disability (Table 8).

There is widespread cultural approval for supporting the physical well-being of mid-life women through exercise and diet. As an approach to the menopause, it is widely favoured by those who are opposed to the medicalisation of the menopause and its 'treatment' through hormone replacement therapy (HRT). Cousins and Edwards (2002), for example, conclude:

'we show that active living is a worthy alternative – potent for health promotion, broader than hormones in its benefits, and is the more empowering and ethical route for women's long term health' (Page 325)

However, these authors rightly note that this strategy is not equally attractive and accessible to all women. The general trend in the recent SIRC study (2001) was one of improvement in women's lives post menopause, particularly for those taking HRT. The positive effects are particularly experienced by middle class well educated women. Research in this country (McCarthy, 2002) and Canada (Morrow, 2000) notes that women with disabilities encounter systemic barriers to information and help around managing menopausal symptoms. There are indications, therefore, that social inequalities also impact on the management of the menopause – advantaging some women whilst disadvantaging others. In the face of growing evidence that the health risks of HRT are greater than first anticipated, it would seem wise to increase our understanding of the menopause and its management through exploring it within its social context and from the perspective of non-medical intervention. Women are often only offered HRT as treatment for menopausal symptoms. More information about alternatives to HRT, which is evidence-based, should also be available to enable women to make an informed choice.

Table 7: Self-reported sickness by sex and age

Self-reported sickness¹: by type of complaint, gender and age, 2000-01				
Great Britain				Percentages
	Poor general health	Longstanding illness	Limiting longstanding illness	Restricted activity²
Males				
0-4	4	14	4	11
5-15	3	23	9	10
16-44	6	23	11	10
45-64	18	45	27	17
65-74	22	61	38	20
75 and over	29	63	44	23
All	11	33	18	13
Females				
0-4	3	13	4	7
5-15	3	18	8	11
16-44	8	22	11	12
45-64	16	42	27	19
65-74	21	54	35	21
75 and over	26	64	48	27
All	12	32	19	15

Source: *General Household Survey*, Office for National Statistics
 1 See Appendix, Part 7: Self-reported sickness
 2 In the 14 days before interview

Table 8: Disability by sex and age

Prevalence of disability by age – women: UK, 2001					
Women	16-24	25-34	35-44	45-54	55-59
	%	%	%	%	%
Any disability	9	11	16	23	39
DDA disabled	6	8	12	19	34
Work-limiting disabled	7	9	13	19	33
Base: All people of working age					
Source: <i>Labour Force Survey</i> , Spring 2001					
Prevalence of disability by age – men: UK, 2001					
Men	16-24	25-34	35-44	45-54	55-64
	%	%	%	%	%
Any disability	8	13	17	26	36
DDA disabled	6	11	14	22	31
Work-limiting disabled	6	10	13	21	30
Base: All people of working age					
Source: <i>Labour Force Survey</i> , Spring 2001					

Summary and priorities for action

In this section we have considered some of the specific challenges that characterise the lives of many mid-life women.

Research

- *Naming the risks:* A longitudinal panel study that started with an inclusive sample of women aged 50 would provide an invaluable source of data for teasing out the causal pathways, interactions and effects of social inequalities on psychological well-being.
- *Roles and relationships:* The role of private 'choices' such as getting married, having children, getting divorced on women's well-being and the consequences of early life 'choices' on later-life issues such as widowhood would be valuable.
- *Menopause research:* Research on the effectiveness of alternative treatments to HRT is needed. Additionally, information about the menopause and treatment choices need to be offered to marginalised groups of women, e.g. ethnic minority groups, and those who have physical, psychiatric or learning disabilities.

Policy

- *Employment policy:* Employment policies and practices that facilitate the inclusion of mid-life women with ill health or disabilities.

Mental Health

- *Information about the menopause:* Women find balanced and coherent information about the menopause empowering; thus it should be made accessible to all women in all situations. The long term benefits of HRT as the treatment for menopausal symptoms is not yet proven conclusively and alternative, evidence-based treatments should also be promoted.

INEQUALITY AND VULNERABLE GROUPS

The data reviewed above suggests there are substantive grounds for identifying the groups of women who are especially at risk of mental health problems in mid-life. Included here would be women whose access to valued material and psychological resources have been seriously affected by inequalities such as race, class and disability. Also included are women who have not been able to protect themselves from experiences of oppression and discrimination, which leave them, feeling diminished, constrained and blamed. Finally, at risk are women whose childhood and adult lives have been marked by sexual and physical violence, abuse and trauma.

It is important to note at this point, that some women enter mid-life with the benefit of the accumulated privileges of class and race. They include women who are well educated, middle class and white and those who are materially and psychologically secure due to valued domestic and work roles. Women who feel able to rightfully exercise power and control in their lives are psychologically advantaged. They may face similar challenges to their less advantaged peers around the menopause; sexism and ageism, and continuing and emergent demands for family care. However, they are less likely to experience these demands as overwhelming, and more likely to have choices about how they respond to these challenges e.g. buying in childcare or support for ill parents (SIRC, 2001). Indeed, a number of women in this group are reported as finding a number of their mid-life challenges to be new, or additional, sources of satisfaction (e.g. Reid and Hardy, 1999). Retirement for example, may offer a middle class professional woman with financial resources and good health, a new set of social and educational opportunities.

There is insufficient space within this review to explore the mid-life challenges facing women from black and ethnic minorities in any depth but it is helpful to acknowledge that evidence from existing research suggests that racism extracts a mental health cost for women (Milne and Williams, 2000).

Summary and priorities for action

Focusing specifically on the psychological needs of mid-life women from disadvantaged social groups, we suggest the following priorities for action:

Research

- *Marginalised women*: Comparative research that explores the experience of mid-life for different groups of women, including those who are socially marginalised
- *Differences between women in mid-life*: Differences in histories, life styles and futures amongst mid-life women need to be made more evident, rather than submerged, by research in this field. mid-life women are not a homogeneous group.
- *Hearing the voices*: The voices of women from these marginalised groups need to be amplified through research.

Policy

- *Challenging disadvantage*: Policy interventions that increase mid-life women's access to money, work, choice and value, and which support them to find workable solutions to the challenges of mid-life.
- *Policy informed by women*: Policymakers need to ensure that policy is informed by the needs, views and experiences of women from marginalised social groups.

Mental Health

- *Divergent groups of women*: Mental health workers need to be aware of the consequence of further de-valuing mid-life women, and be responsive to the mental health needs of women across the social, racial and cultural spectrum.

MENTAL HEALTH OUTCOMES

This sub-section will outline the prevalence of mental ill health amongst mid-life women and service responses.

Patterning of distress in this group

Women aged 45-64 on average visit a general practitioner (GP) 6 times a year (Table 9). Women of all ages are more likely than men to contact a GP about a mental health difficulty. More specifically, 16% of women aged 55+ were estimated to visit their GP in 1999 for this reason, compared to 13 percent of men (Table 10). Interestingly the rates for these women are lower than those for younger women. Whether this reflects actual differences in psychological well-being, or GP insensitivity to distress in older women is hard to determine from these data. The model of ageing which dominates medicine assumes an inevitable decline in physical and mental well-being from middle age, may play a role in this context.

Anxiety and depression

In terms of self-reported distress, 24 % of women in this age group report anxiety or depression (Women and Equality Unit, 2000). More specifically, a consistent finding in community studies of depression is that rates for women are approximately double those for men (Beekman et al, 1999; Copeland et al, 1999).

The key risks for developing depression lie in a range of social and economic vulnerabilities, many of which have been identified in this review. Bereavement; retirement; recent divorce; isolation and loneliness; and poverty, are all powerful determinants of depression. As they are regularly and cumulatively experienced by women in mid-life they are clearly at enhanced risk of experiencing depression (Bowling et al, 1997; Bowling and Browne, 1991). The lack of a confiding relationship appears particularly significant (Brown and Harris, 1978).

Reliance on drugs and alcohol

Self reported average weekly alcohol consumption of women aged 45-64 in 2000 was 6.2 units a week; half that consumed by younger women (Table 11). However, there is evidence that alcohol abuse amongst women is largely hidden, and amongst mid-life women is rarely identified as a social or personal problem. There is some evidence that particular groups of women are vulnerable to both alcohol and drug abuse. These are isolated and depressed women who live alone (Corrigan and Butler, 1991; Davidson and Marshall, 1996), non-English speaking women who are culturally isolated (Russo, 1990), and those who are homeless (Kutza and Keigher, 1991). The extent to which mid-life women are dependent on prescribed drugs is unclear although it is likely – given older women are the largest sex-age group prescribed psychotropic medication – that this is a pattern established during mid-life. Finally, 27% of women smoke in the 50-59 age group, and while these are lower rates than for younger women they still represent a significant health cost.

Service provision

As yet, mid-life women are not a defined group that demands – or appears to ‘need’ – a separate or distinctive response from mental health services, nor have they been identified as such within the recent mental health strategy for women’s mental health services (Department of Health, 2002). However, the existence of this strategy, as well as other evidence (e.g. Williams et al, 2002), indicates that the majority of women are very dissatisfied with statutory mental health services. A primary concern is the lack of demonstrable interest shown in a woman’s past life, those needs who’s roots lie in social and economic disadvantage, or her current social and emotional context:

‘Our needs are ignored, we are treated as illnesses’. (Williams et al, 2000, page 5).

‘The responsibility that many women have, beyond themselves, is not really acknowledged, Most of the time it is not just the women in front of them they have to “treat” but the whole system that she cares for, supports emotionally and is needed by. Some women may need to get away from the “system” they are in but they will do this with enormous anxiety so that has to be addressed’ (Williams et al, 2000, page 10).

Table 9: GP consultation by sex, age and year

NHS GP consultations per year, by age, Great Britain: 1998 and 2000				
	Average number of consultations per year			
	Women 1998	2000	Men 1998	2000
All ages	5	5	4	4
0-4	6	4	6	6
5-15	3	3	2	2
16-44	5	5	3	3
45-64	6	5	4	5
65-74	6	7	5	6
75 and over	6	7	7	6

Base: All persons
Source: *Living in Britain: Results from the 2000/02 General Household Survey*

Data for Great Britain shows that women make greater use of GP services than men. When expressed in terms of the number of GP consultations per year, women average five such consultations, and men four.

Table 10: Help-seeking for a mental health difficulty by sex and age

Proportion contacting a GP about being anxious or depressed for a mental, nervous or emotional problem, by age, in the past year: England, 1999

Women				Men			
16-34	35-54	55+	All ages	16-34	35-54	55+	All ages
18	24	16	20	11	18	13	14

Base: All persons aged 16 and over
Source: *Health Survey for England, 1999*

Table 11: Weekly alcohol consumption by sex and age

Mean weekly alcohol consumption, by age: Great Britain, 1992-2000

	Number of units				
	1992	1994	1996	1998	2000
Women					
16-24	7.3	7.7	9.5	10.6	12.6
25-44	6.3	6.2	7.2	7.1	8.1
45-64	5.3	5.3	5.9	6.4	6.2
65+	2.7	3.2	3.5	3.3	3.5
All ages	5.4	5.4	6.3	6.4	7.1
Men					
16-24	19.1	17.4	20.3	23.6	25.9
25-44	18.2	17.5	17.6	16.5	17.7
45-64	15.6	15.5	15.6	17.3	16.8
65+	9.7	10.0	11.0	10.7	11.0
All ages	15.9	15.4	16.0	16.4	17.4

Base: All persons aged 16 and over
Source: *Living in Britain: Results from the 2000/01 General Household Survey*

Care management and the Care Programme Approach (CPA) were intended to be a key organisational mechanism for delivering the aims of community care policy. However, these systems for allocating and distributing welfare resources were not intended to address issues of structural inequality. The individualisation of need, which is at the heart of CPA, dislocates the woman from her social and historical 'world' and fails to define, and therefore, to meet, those needs with social, economic or historical causes. The status and value accorded mid-life women also makes it difficult for them to voice their needs and many lack the income, and social resources, to deploy creative choice.

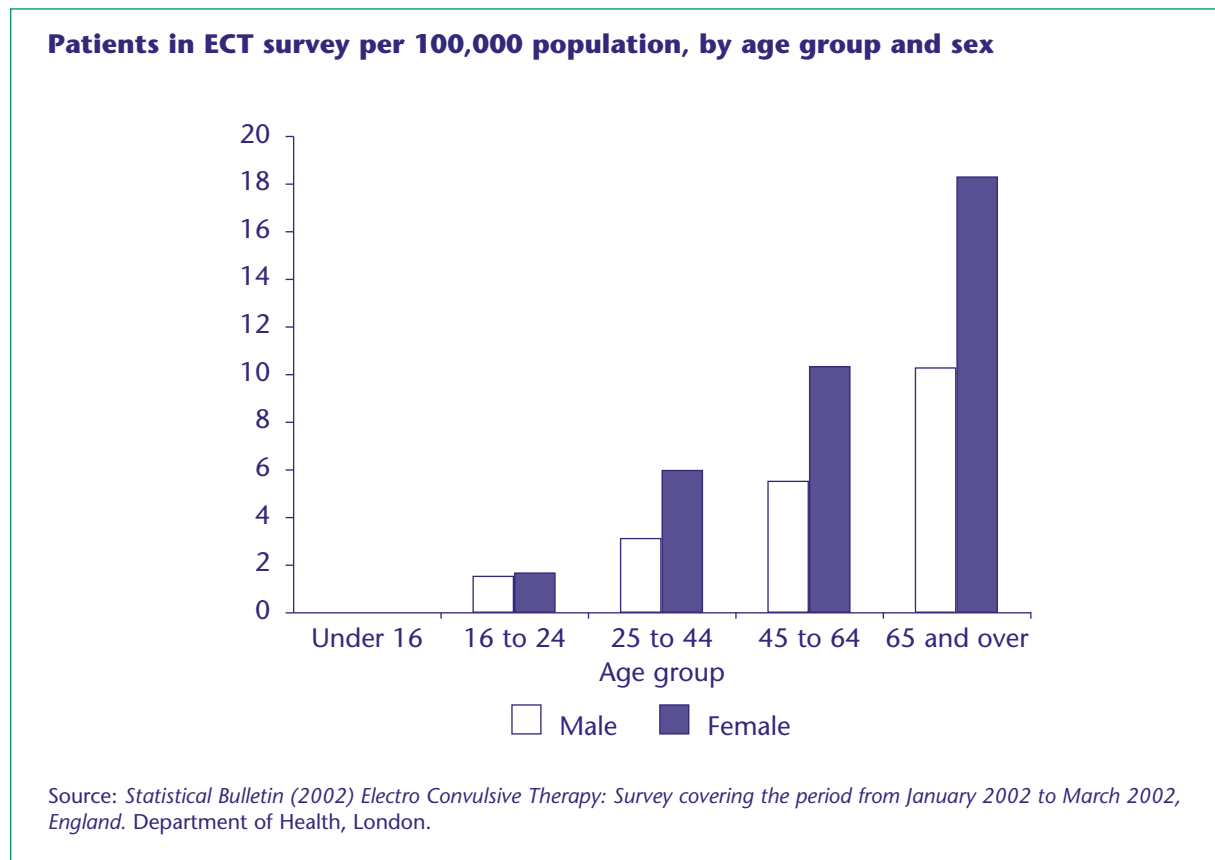
This is a particularly powerful issue for those mid-life women whose histories are characterised by a high level of involvement with psychiatric services. Such women are highly likely to have survived traumatic childhoods, and an adult life of deprivation and disruption (Williams and Scott, 2000). The quality of mental health services means that most will have received little help to change the trajectory of their lives. Instead, they are likely to have been further re-victimised within services and over medicated (Warner and Ford, 1998; Williams and Keating, 2000). It is axiomatic that women who have already experienced abuse or trauma do not receive mistreatment or abuse within services.

'I feel threatened by men, they get more angry and I've been sexually assaulted by a man on the ward. When I need to use the bathroom at night there are often men wandering in the corridor' (Williams et al, 2000 page 6).

In addition to the very real possibility that they will be sexually victimised or re-victimised within mental health services, most women have to endure inequalities within services which render them, as service users, dependent and powerless.

'Treatment and care generally involved women being powerless in the process. Not being listened to, or consulted, forced to take medication or sectioned. Women need to be allowed to control their own lives'. (Williams et al, 2000, page 9).

We also note that the risk of ECT increases with age – almost twice as many women receive ECT as men (Figure 6). The difference between the rates for females and males is apparent in all age groups recorded in the survey, with a more pronounced difference in the oldest age groups.

Figure 6: ECT by sex and age

Clinical interventions

Whilst there is growing acknowledgement that women with mental health problems require individualised care, little attention has been paid to the existence and meaning of gender, class and race by professionals. They often fail to analyse the experiences of women and men separately, which presents as 'neutral' the gendered challenges of mid-life and ageing.

Whilst efficacy of treatment for depression suggest that mid-life women may be as responsive as younger people to talking therapies, recent evidence suggests that age is negatively correlated with the likelihood of patients receiving psychotherapy and family therapy; this suggests a persistence of a belief that older people are either not worthy of, or do not benefit from, therapy. Whilst some attention has been given to developing appropriate models of psychotherapy for work with people in mid-life, little work has been done to either develop gender appropriate models, or to evaluate the effectiveness of current therapy models for women (Milne and Williams, 2000).

Summary and priorities for action

In this section we have summarised research relating to mental health outcomes for mid-life women and service responses to their needs. We suggest the following priorities for action:

Research

- *Mental ill health amongst mid-life women:* More work is needed both from an epidemiological perspective and an experiential one, to map the extent and nature of mental ill health amongst mid-life women. What women consider would ameliorate their mental ill health would also be valuable.
- *Women with enduring mental health problems:* Studies that help to determine the factors that differentiate women who first seek help from mental health services at mid-life, from those who have been long term users of these services.
- *Treatment regimes:* Gather more precise data about the use of physical treatments to manage the distress of mid-life women and in which contexts these treatments are delivered.
- *Safety in services:* Women-only facilities go only part way to ensuring safety for mid-life women receiving in patient care. More work is needed – in partnership with women service users – to identify how to make services safe for women.

Policy

- *Mid-life women:* Ensure that women in mid-life who are experiencing mental distress are differentiated and identified explicitly in mental health policy
- *Safety in services:* It is likely that research into safety in services will result in a need to develop and implement safety policies for mental health services.

Mental health

- *What women want:* Find out directly from mid-life women using services what they want from services, professionals and others in their context e.g. family members.
- *Extend talking therapies:* Women find talking therapies helpful. It is vital to offer wider and easier access to a range of talking therapies in mental health service settings and in primary care.

CONCLUDING COMMENTS

Women in mid-life are a complex, heterogeneous and diverse cohort. Their lives and health related challenges are unexplored and they are rarely conceptualised as a 'group' by services, researchers or policy makers. They remain largely invisible. Yet, much like women's relationships with their family, community and jobs, it is only when the focus turns to what is actually managed and achieved on a daily basis, that the sheer breadth and depth of the mid-life woman's 'lot' becomes apparent. This most often occurs when the woman 'fails' or is exposed as not 'coping' with her multiple roles.

This review has highlighted the key dimensions of the lives of mid-life women which do – or might be expected to – have an impact on their emotional and psychological well-being. The literature reviewed exists in a number of different domains and emanates from a number of sources. To date this group of women have received very little specific attention, and the literature reviewed here has been somewhat uneven; much evidence is 'hidden' in broader texts.

The authors have focussed on what is distinct or unique about mid-life women's lives and the mental health challenges they face, rather than what is shared with other groups. Some dominant themes emerge. There is a powerful sense that mid-life women are at a crossroads or in transition from one stage of life to another; some decisions have already been made e.g. whether to have children or not, and there are certain facets of life which are unlikely to substantially alter, such as career choices. She is often juggling several roles: wife/partner, mother, worker and is often asked – in addition to these demands – to support her ailing parent/parent in law. Mid-life carers are predominantly women. A core component of her life is providing care for others, often at immense personal and psychological cost. Divorce and widowhood are also significant life changing events which many mid-life women face; both exact a considerable mental health cost on women. She is also much less likely to remarry than a younger woman and must accept living in a single person household, most probably for the rest of her life. Her income status may be relatively established and it is at this stage of life that women are obliged to come to terms with decisions made earlier in life. For example, as a consequence of working part-time to look after children, a woman's pension will be significantly lower.

This is not to present a negative picture of mid-life, merely to be honest about the nature of this stage of life, the mid-life – between past and future, and between youth and old age. For some women the changes are beneficial. It is also useful to note that even the dominant themes need to be interpreted with care as there is much variety both within and across the mid-life period (45-60 years). Particular groups of women – black women, women with enduring mental health problems – will be facing additional and different challenges.

Another key theme relates to the role and impact of social inequalities. The literature does show that both lifelong and age-related social inequalities create and perpetuate psychological distress in mid-life women. This period of life is a point when the cumulative effects of lifelong privilege or disadvantage find expression in great diversity amongst women; these are revealed in their experiences, contexts, physical and emotional well-being, and future life opportunities. Whilst mid-life women will be facing common challenges such as discrimination and oppression in the workplace, and ageism, they will be more or less able to deal with these on the basis of their socio-economic status, work opportunities, personal histories and health. Those mid-life women with least resources face the greatest challenges to their mental health; they are the least powerful and the most marginalised.

There is a widespread societal assumption that this group of women will continue to absorb the impact of changes related to ageing, family life, the community and the workplace; that they will simply carry on shouldering the burden of an increasing and often complex range of demands, demands which may compromise their well-being and mental health. It is testament to their strength that so few appear to develop mental illness although we need to be cautious before making this assumption as we know little about the genuine prevalence and incidence of mental illness in this group. We know even less about the effects of juggling multiple roles on women's more general psychological health and quality of life and on ways that they avert or survive mental health crisis.

Opportunities to alleviate distress and disadvantage and reduce the mental health costs on mid-life women lie in the arenas of research, policy, and services. Having identified some of the key parameters of the debate it is important that investment is made in: building up a more robust evidence base around the mental health of women in mid-life; developing policy that focuses on the needs of this group, and developing services that explore ways to support and meet their needs. These changes need to be underpinned by the voices of women. If we are to meet the needs of future generations of mid-life women it is imperative that we gain a much clearer understanding of their experiences and views, and their management of the mental health challenges that mid-life presents.

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