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Lifetime risk factors for women's psychological distress in midlife

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Abstract

Research on the causes of psychological distress in women in midlife has focused on current adversity and hormonal changes associated with menopause and paid less attention to possible risk factors across the life course. We examined the factors in childhood, adolescence and earlier adult life that show persisting effects on psychological symptoms reported annually over a 6 year period (47–52 years) using prospective data on a cohort of 1500 British women who have been followed since their birth in 1946. Even after taking into account the powerful effect of recent life stress, this study found that women with a high level of psychological distress had different life course trajectories than those with less distress. They were more likely to have scored highly on the neuroticism scale or exhibited antisocial behaviour when they were teenagers, and to have had prior experience of mental and physical health problems in adult life. Those whose parents had divorced reported more distress in midlife, particularly if they too had experienced marital breakdown. These factors accounted for the associations between some of the adult sources of risk, particularly those to do with interpersonal difficulties or poor adult socioeconomic circumstances, and psychological distress in midlife. There was no evidence that concurrent menopausal status had any effect on the level of psychological symptoms except for those women on hormone replacement therapy who had a small and independent additional risk. More attention to a long term temporal perspective is warranted in research on the causes of psychological distress in women at midlife.
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Introduction

Women suffer more than men from depression and anxiety disorders throughout the reproductive years (Kessler, McGonagle, Swartz, Blazer, & Nelson 1993, Bebbington et al., 1998; Kohn, Dohrenwend, & Mirotznik, 1998). This has generated enormous debate about the causes of these specific disorders, and psychological distress and wellbeing more generally, in women at different life stages. Much of the research on middle aged women has focused on the possible role of hormonal changes associated with the menopause but evidence is inconsistent (Nicol-Smith, 1996; Bromberger, 1998; Klein, Versi, & Herzog, 1999; Dennerstein, Lehert, Burger, & Dudley, 1999). While relationships between psychological distress and current adversity, such as life stress or low socioeconomic status, are commonly found (Greene & Cooke, 1980; McKinlay, McKinlay, & Brambilla, 1985; Bromberger & Matthews, 1996; Kohn et al., 1998), the evidence for certain social roles or changing social roles common at this life stage are mixed. Generally role quality (Bromberger, 1998) and stability (Costello, 1991) rather than role occupancy seem to have more impact on mental health. Studies

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suggest that loss of a partner through bereavement or separation has acute and longer term effects on psychological distress (Hope, Rodgers, & Power, 1999; Richards, Hardy, & Wadsworth, 1997). Parenting of adolescent children may be a time of great stress (Silverberg, 1996) and, despite some discussion of an empty nest syndrome, an improvement in wellbeing may occur when children leave home (Aquilino, 1996; Sawyer Radloff, 1980).

Less attention has been given to whether women's experiences over the life course affect the risk of affective disorders or psychological distress in middle age. In contrast, the studies by Brown and his colleagues of depression in younger women emphasised the role of early loss of mother as a key vulnerability factor that raised the risk of depression in the presence of a provoking agent (Brown & Harris, 1978, Bifulco & Moran, 1998). Research by the same authors demonstrated the importance of childhood adversity (parental indifference, physical and sexual abuse) in the aetiology of depression and anxiety disorders (Brown & Harris, 1993). Other studies have found a link between adult depression and maternal lack of care, family violence, parental marital problems and divorce, family drinking problems and mental illness; studies are generally retrospective or have not focused on midlife women (Kessler & Magee, 1993; Kessler, Davis, & Kendler, 1997; Mullen, Martin, Anderson, Romans-Clarkson, & Herbison, 1994, 1993; Mullen, Romans-Clarkson, Walton, & Herbison, 1988; Widom, 1998). Two prospective studies from childhood that have followed their subjects into the thirties provide even stronger evidence of a link between adult affective disorders and the early environment (Rodgers, 1990a; Sadowski, Ugarte, Kolvin, Kaplan, & Barnes, 1999).

Thus the factors in childhood, adolescence and early adult life that influence the levels of psychological distress among middle-aged women and the pathways through which they operate remain to be elucidated. The Medical Research Council National Survey of Health and Development (MRCNSHD), is a prospective cohort study of a representative sample of the British population born in 1946. The cohort has been followed up to age 53 years, and the women have provided information about their symptoms every year since they were 47 years old as part of a study of midlife health and the menopause (Kuh, Wadsworth, & Hardy, 1997). The purpose of this paper is to examine the social, economic and health experiences in childhood, adolescence and earlier adult life that have persisting effects on women's psychological distress in midlife over and above any impact of current life stress and menopausal status. To identify some of the possible pathways across the life course, we investigate to what extent (1) childhood and adolescent behaviour and temperament mediate or moderate the effect of family background, (2) prior adult health mediates the influence of early experience and (3) adult social and behavioural factors mediate or moderate the influence of early experience and earlier adult health on midlife psychological distress.

Earlier research on this cohort demonstrated a link between adult affective disorder (as measured by the Present State Examination) at 36 years and measures of the early environment (Rodgers, 1990a) and childhood behaviour and temperament (Rodgers, 1990b). Measures of early behaviour were more strongly associated with adult symptoms than the environmental measures and suggested that childhood and adolescent behaviour and personality mediated the long term effects of the early environment. Two possible processes were hypothesised: that individual temperament led to different adult circumstances and lifestyles (such as family formation, prosperity and social support) with implications for mental health, or that some females had a susceptibility (genetic or otherwise) to disorder which persisted into adulthood and made them vulnerable to adversity. These two explanations are examined in this study which builds on the earlier work by investigating the level of emotional symptoms reported over a 6 year period, rather than just the previous month. By taking account of whether prior mental and physical health mediates the effects of childhood adversity on midlife distress (a question consistently neglected in this area of research (Kessler & Magee, 1993)), we are able to better assess the role of other potential adult mediators such as social support.

Method

The population

The MRCNSHD is a socially stratified cohort of 2547 women and 2815 men born in England, Scotland and Wales and followed up 19 times between their birth and age 43 years (Wadsworth & Kuh, 1997). The original sample comprised all the births to non-manual and agricultural workers and one in four of the births to manual workers in the second week of March 1946. At 43 years the cohort were generally representative of the population born in Britain at that time (Wadsworth et al., 1992). Since 1993 when cohort members were age 47, a postal questionnaire has been sent annually to 1778 (70%) women with whom there was still contact to collect information on health symptoms, the menopause and life circumstances (Kuh, Wadsworth, & Hardy, 1997). Of the original cohort 6% had died, 12% had refused to take part at earlier follow-ups and 13% could not be traced. Between 1993 and 1998, 1569 out of 1788 women (88%) completed at least one questionnaire, including a checklist of health symptoms. Of these women, 1023 (65.2%) completed all six questionnaires,

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