CHAPTER 2

Women's Growth and Development Across the Life Span

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Clinical textbooks typically describe what is considered normal growth and development; this description frames the upcoming chapters of this textbook's discussion of variations from what is considered normative. Although this approach may seem comprehensive, the dilemma is that the initial discussion of women's growth and development is often from a biomedical perspective. This representation deconstructs women's bodies into biologic parts and physiologic processes. While such an approach enables quantification of growth, it is known that qualitative aspects of women's lives also influence their growth.

The biomedical model of health is individualist and disease oriented. In Chapter 1, this model is contrasted with a feminist and social model of health. The latter model acknowledges the influence of the culture in which women live, their economic status, the social interactions they experience, and the context in which they access and receive health care. The feminist model acknowledges the many other factors beyond the physiologic functioning of women and the genetic inheritance that affect their growth and development. As a result, even the manner in which we understand and explain what normative growth and development includes changes in the expanded framework of a feminist perspective, thereby allowing for a clearer understanding of the complexity inherent in women's growth and development.

As a first step in considering women's development (cognitive, psychosocial, and functional behaviors), it is important to acknowledge that the traditional models that are used were developed from research about men. For example, psychoanalyst Erick Erikson (1950) expanded developmental theory beyond the years of adolescence to offer a grand theory of human development (**Table 2-1**). He identified eight general stages of development that included several within adulthood. The eight virtues that are the goals of the stages are trust, autonomy, initiative, industry, identity, intimacy, generativity, and integrity.

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TABLE 2-1 Erikson's Eigenetic Model

Age Period for Crisis	Stages							
	1	2	3	4	5	6	7	8
Infancy	Trust vs. Mistrust							
Early childhood		Autonomy vs. Shame and Doubt						
Play age			Initiative vs. Guilt					
School age				Industry vs. Inferiority				
Adolescence					Identity vs. Identity Diffusion			
Young adult						Intimacy vs. Isolation		
Adulthood							Generativity vs. Self-absorption	
Mature age								Integrity vs. Despair

Source: Low, 2001.

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Through a process of resolving eight developmental crises that are sequentially confronted, Erikson's theory offers a comprehensive account of individual development throughout the life span that until recently was applied to both males and females. It is important to understand that Erikson's stages of psychosocial development are based on studies of white, middle-class males (Erikson, 1968) and yet the model is universally applied to women with some gendered assumptions. The underlying gendered assumptions within Erickson's grand theory of development must be recognized because within this theory individuals are treated as a monolith, with minimal attention being paid to gender, socioeconomic, or ethnic variability (Gilligan, 1982; Taylor, 1994). Some of the gender-based assumptions include a normative linear pattern of identity, followed by marriage (intimacy), and then childbearing (generativity) in adulthood. Erikson's theory assumes the need for a female to first develop an intimate relationship with another before she can complete her sense of self as an individual. Interestingly, males (according to this theory) do not have the same requirement. Thus, while the larger context of the theory assumes the desirability of autonomy and distancing oneself from the family of origin, for females autonomy is defined as being dependent on another within the context of a relationship, with a primary focus on caretaking by females.

Other examples of grand theories that are misapplied to women include those developed by Kohlberg (1981) and Perry (1968). Kohlberg's levels of moral development are based on interviews with only men, and Perry actually discarded interviews he had with women, using only data from interviews with men to formulate his model of intellectual development. The difficulty that occurs when these scales are used to assess a woman's developmental level is that they assume universality in development and, again, treat all women as a monolith, not acknowledging the multiple variables that can affect progress through the stages (Belenky, Clinchy, Goldberger, & Tarule, 1986; Low, 2001). Tavris (1992) observes that "because of the (mis)measures we use, women fail to measure up to having the right body and fail to measure up to having the right life" (p. 36). The use of these androcentric models constrains the manner in which women's development is framed, such that women's development is presented as an aberration in comparison to white male development, which is held up as the standard.

This chapter discusses growth and development by contrasting traditional male-biased theoretical constructs with newer feminist theories that challenge some of the basic assumptions about women's growth and development. Alternative theories of female development were offered by feminist psychologists and researchers beginning in the 1970s (Taylor, 1994). Although there is substantial variation in the emphasis of feminist scholars, a primary focus is on the self-in-relation to others or in connection with others (family and peers) as a means of further development. Feminist theories of development emphasize the quality and nature of individual women's experiences. As a consequence, women's development is construed as broader than the traditional process of individualization and includes the value of maintaining connection and continuity within relationships (Gilchrist, 1997).

The definition of relationships within this model contains not just the self-in-relation to others but also inner constructions of relationships that form the sense of self of the female (Kaplan, Gleason, & Klein, 1991). These relationships progressively contain conflict, and it

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is through resolution of this conflict that the relationships become more complex, requiring flexibility that allows connections and relationships to be maintained (Baker Miller, 1991). This view stands in opposition to traditional theories of development that emphasize conflict resolution as entailing greater disconnection and the development of distinct boundaries around identity formation or the process of "becoming one's own man" (Baker Miller, 1991).

Feminist theories are primarily offered in contrast to Erikson's theory of psychosocial development. Gilligan (1982) and other feminist scholars have critiqued his work not only as being descriptive of male development in general, but also as descriptive of primarily white, privileged male development. Black-feminist scholarship has furthered this critique beyond that of the traditional male-based model to include limitations in contrasting models offered by early feminist theorists.

A key limitation of early feminist models is that they were developed by white middle-class Euro-American women who interpret relationships and connection as being similar across all women, regardless of ethnic identity or the influence of racism (Collins, 2000). Owing to this perspective, much of early feminist scholarship was limited by a lack of understanding of the role of ethnic identity and socioeconomic level on development.

The intention of newer feminist models is not to replace male generalist models of development with feminist generalist models of development, but rather to offer alternatives to the constrained models that were previously misapplied to all women. This chapter provides an overview of growth and development within the linear stages of adolescence through older age using a feminist perspective. Emphasis is placed on contrasting models of development outside the traditional biomedical focus.

Subscription to a model that delineates gender differences versus a model that identifies gender similarities and provides an explanation for differences based on gender is a key philosophical dilemma for developmental theorists. The emphasis on difference, rather than similarity, evokes a debate about the risk of essentializing women's development. The difficulty arises because gender differences described by these theories are ascribed as biologic or innate characteristics rather than considering the social and cultural context that can create these differences. Thus the differences described are consistent with social constructs of femininity rather than being biologically determined, but they are wrongly assumed to be biologic in origin (Gilligan, 1982; Martin, 1992). While lauding the work of Gilligan and other early feminist theorists who argue that women have a "different voice" through which they develop and speak, several feminist psychologists and theorists offer the critique that in recent developmental theories, what feminist theorists have described as being uniquely female is instead likely to be based in the social construction of gender roles and has been inadequately explored (Hare-Mustin & Marecek, 1998; Riger, 1998).

This perspective, which results in differing expectations at different times based on gender, is consistent with the model proposed by Erikson (1950). He argues that the particular developmental crisis is not necessarily chronologically driven but rather is driven by social expectations for behavior. Thus expectations for caregiving and consideration by females of themselves in relation to others may have more to do with socially prescribed gender roles of

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femininity than with biologically differing pathways for development. More similarities than differences between males and females may become evident when gender boundaries are broken down and males have a greater level of participation in caretaking for others rather than primarily for themselves. Until that time, however, contrasting developmental models with an emphasis on differences that are primarily socially constructed have prevailed and, therefore, will inform the perspectives presented in this chapter.

Adolescence

The adolescent years are generally described biologically as beginning with the onset of puberty and extending 8 to 10 years beyond this point (Murray & Zentner, 1997). In a chronological sense, these years encompass the ages of 11 to 21 (Condon, 2004). Often this period is described as the "stormy" years, a sobriquet reflecting the stress of puberty and the accompanying bodily changes. For most adolescents, however, the transition is quite smooth in spite of the myriad physical, developmental, emotional, and cognitive changes that occur during this time (Lewis & Bernstein, 1996). Stages of adolescence are commonly categorized into early adolescence (ages 11–13 years), mid-adolescence (ages 14–17 years), and late adolescence (ages 17–21 years) (Lewis & Bernstein; Slap, 1986). Although the changes that occur during this period are discussed here in the contexts of biology and physiology, it is important to remember from a healthcare standpoint that qualitative aspects must be considered. For example, an adolescent woman's sense of body image may be tied to her weight as much as it is to her past experiences (Leight, 2003).

Biology and Physiology

Significant physical changes occur during a young woman's adolescence. Adult height and weight are usually attained during this time, and probably most significant to the adolescent female are changes associated with the development of secondary sex characteristics. The usual sequence of female pubertal events begins with a growth spurt that occurs around the ages of 11–12. This growth spurt is followed by thelarche (breast development), adrenarche (growth of pubic hair due to androgen stimulation), and menarche (Skillman-Hull, 2003; Woods, 1995). Peak height usually occurs about two years after breast budding and about one year prior to menarche (Fritz & Speroff, 2011). On average, the growth spurt in girls begins around age 10, reaches its maximum rate at age 12, and subsides around age 16 (Bassey, Sayer, & Cooper, 2002).

Girls reach puberty earlier than boys. The timing of puberty and onset of menses is controlled primarily by the neuroendocrine system (Lewis & Bernstein, 1996) and genetic inheritance, although it is also believed to be affected by external factors such as general health and nutrition, race, geographic location, amount of exposure to light, and psychological makeup (Skillman-Hull, 2003). Girls who perceive themselves to be "on time" for puberty tend to have a better self-image and are more likely to view themselves as attractive than girls who believe themselves to be either early or late in relation to puberty (Woods, 1995).

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Although the pubertal changes provoke perceptions about puberty, these perceptions are also shaped by the dominant culture (Woods). Lee (1998) observes that women often say their bodies become problematic at menarche—for example, women may state that their breasts are too big or too small, and their hips are an enemy because fat accumulates there.

The onset of puberty depends on a changing body accumulation of adipose tissue. As a consequence, this event marks the beginning of a tension between biologic development and the social context in which it occurs. Our culture today demands perfection, which causes many young women to suffer great anxiety about their bodies. The challenges that present for young women vary based on ethnicity, self-esteem, the social environment, and the contrast between the individual adolescent's sense of herself and society's perceived standard for beauty. In addition, many of the changes of puberty are framed within the social context of sexual development. As the physical sexual characteristics develop, many young women are challenged by a potential mismatch between their socially perceived sexual development and their interpersonal level of maturity and development. Clinicians can serve as an important source of support and information during what is often framed culturally as a tumultuous phase of development.

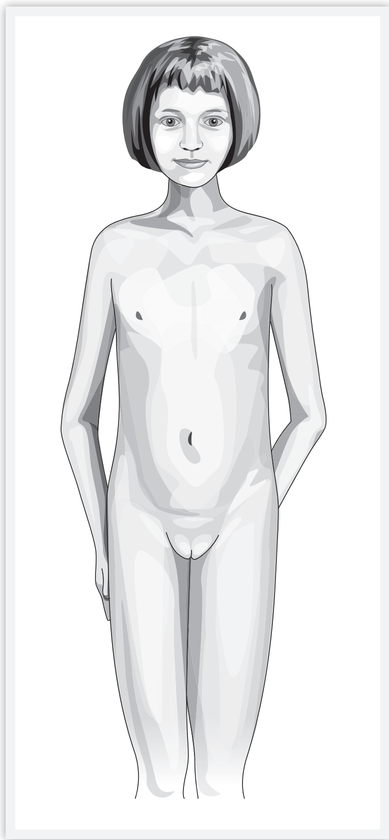

FIGURE 2-1 Tanner Stage I: Preadolescent (ages 10-14): Breasts have elevation of nipple only. There is no pubic hair except for vellus hair, which is fine body hair like that noted on abdomen.

A commonly used scale for staging sexual maturity is the Tanner Scale, which relies on development of the breasts and growth of pubic hair. It divides sexual physical maturity into five stages that extend from preadolescence to the adult (**Figures 2-1, 2-2, and 2-3**). The Tanner model, although widely accepted for staging sexual maturity, is not appropriate to use for determining chronological age (Rosenbloom & Tanner, 1998). Additionally, Rosenbloom and Tanner note that because of the variability in timing of stages and of pubic hair growth, both which are important elements of Tanner staging, the scale should not be used for staging individuals of Asian ethnicity.

Probably the most anticipated, feared, and socially misconstrued aspect of female adolescent development and puberty is menarche, or the onset of menses. Menarche is an important milestone in a young girl's life. The median age for the onset of menstruation for adolescent girls in the United States is 12.8 years, with a range of ages 9–17 (Fritz & Speroff, 2011). The events of puberty trigger the onset of menses when a positive feedback of estrogen on the pituitary and hypothalamus stimulates a surge of luteinizing hormone at midcycle, which is critical to ovula-

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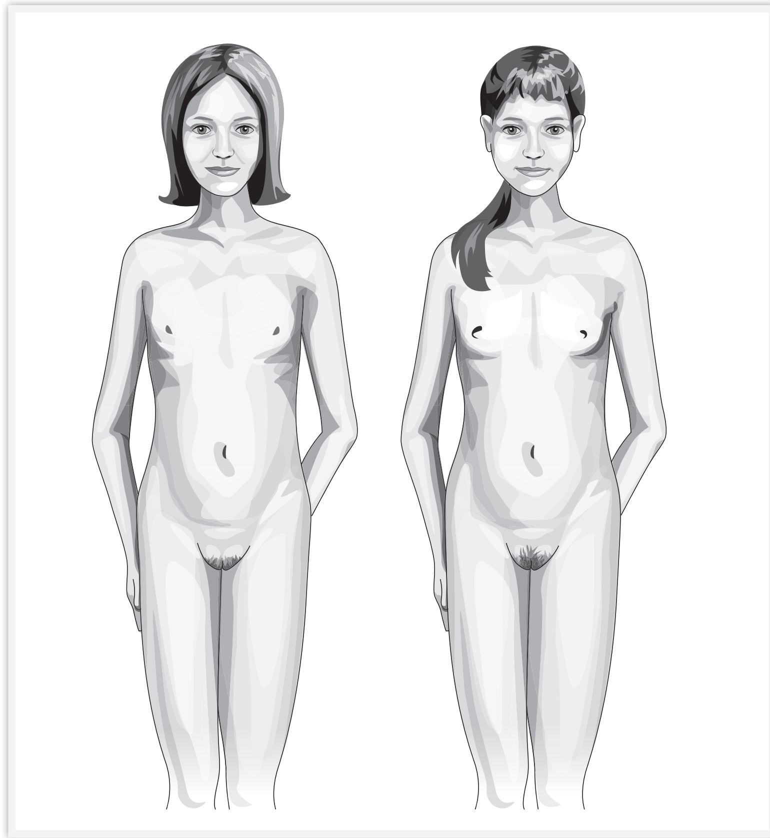

FIGURE 2-2 Tanner Stages 2 & 3: Tanner Stage 2 (left) is referred to as the breast bud stage. There is an elevation of the breast and nipple and the areola widens. Pubic hair growth is sparse, long, and only slightly curly. It is observed mainly on the labia. Tanner Stage 3 (right) (ages 12–14 or middle adolescence): The breast and areola are enlarged further with increased elevation of the breast and nipple; however, there is no separation of their contours. The pubic hair growth begins to occur over the mons pubis, and hair is now darker, coarser, and curlier.

tion (Fritz & Speroff). The first several menstrual cycles usually do not result in ovulation, and often a girl's first-year experience of menstruating is characterized by irregular anovulatory cycles, along with heavy bleeding (Fritz & Speroff).

Menarche is integrally linked to many layers of social meaning for girls and women. It is an event that symbolizes reproduction and sexual potential (Lee, 1998). Thus menarche is important both as a physiologic happening, albeit framed by biomedical metaphors of scientific knowledge, and because it is the social and cultural juncture at which girls become women and gender relations are reproduced (Lee). These relations deal with issues such as power and its absence, women's agency, and the ability to move through the world with credibility and respect (Lee).

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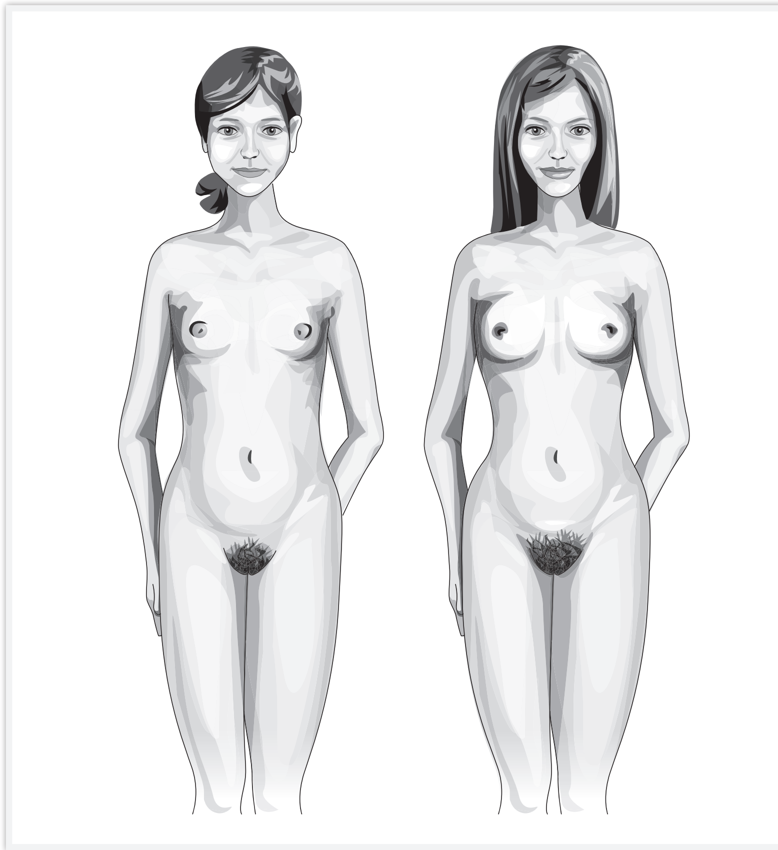

FIGURE 2-3 Tanner Stages 4 and 5: Tanner Stage 4 (left) reveals breasts with areola and nipple forming a secondary mound with projection of the nipple. Pubic hair is adult type but is observed over a smaller area and none is noted on thigh. Tanner Stage 5 (right) (ages 14–16 late adolescence): Breasts are fully mature and only the nipple protrudes as the areola is usually flush with the breast contour. However, a normal variation is for the areola to continue as a secondary mound. The pubic hair is normal adult type: thick, coarse, and curly, and spreads onto the medial surfaces of the thighs. Adult female hair pattern (inverted triangle) is observed.

Psychosocial Development

Adolescence, as previously described, focuses on changes associated with puberty in combination with preparation for the future (Goldharber, 1986). The traditional developmental task of adolescence is to develop a sense of identity and autonomy before progressing toward adulthood. There is a tendency to "try on" various roles as adolescents struggle with who they want to be and how they want to live (Crain, 1980). The role of peers becomes critical in this process, and a distancing from parents and other adults typically occurs (Goldharber). Within almost all cultures there is an acknowledgment that failure to successfully negotiate

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the developmental tasks of adolescence limits an individual's ability to function productively as an adult (Musick, 1993). The interaction between an adolescent's behavior and role performance may either promote or confuse his or her sense of identity depending on the social context in which it occurs. Through a process of trial and experimentation, individuals develop their own set of values and beliefs as well as a sense of themselves as they formalize or commit to their own identity. Initiation of sexual activity, pregnancy, childbearing, and parenting are all gendered roles and experiences that differ in their effects on any one individual adolescent based on the social, cultural, and historical definition that is associated with these behaviors and roles, as well as peers' and family's perceptions of these events.

In contrast, a feminist perspective of female adolescent development emphasizes the young girl's relationship with others instead of distancing from others in the process of individuation as described by Erikson (1950). Current theorists argue that the hallmark of healthy identity development is development of a sense of connection to others, with a primary task being the ability to participate in mutual relationships in which the individual feels active and effective, and is not "lost within" the relationship (Kaplan et al., 1991). The self-in-relation model of adolescent development proposed by Baker Miller (1991) and her colleagues at the Wellesley College Stone Center defines a woman's sense of self as emerging out of experience with a relational process that begins in infancy. From initial interactions with caregivers through the process of becoming a caretaker, the self-in-relation theory argues that women are socialized to care more and more about the development of relationships.

> Beginning with the earliest mother–daughter interactions, this relational sense of self develops out of women's involvement in progressively complex relationships, characterized by mutual identifications, attention to interplay between each other's emotions, and caring about the process and activity of relationship. (Kaplan et al., 1991, p. 123)

Development is delayed if the young girl's relationships are suppressive or oppressive (Woods, 1995). Unfortunately, all too often this is the case for many young women. The predominant culture in the United States discourages a young girl from acting with a sense of self when she is in a relationship; acting as an autonomous agent is discouraged (Woods), and dependence is traditionally encouraged.

Girls usually interact closely with their mothers, a relationship that means girls, as compared to boys, are more apt to learn and appreciate the importance of empathy. Woods (1995) points out that this development may strengthen girls' sense of connection and being emotionally understood, which in turn provides an advantage to girls growing up in Western cultures because they will be carriers of aspects of human experience, including emotionality, vulnerability, and growth fostering.

Reasoning changes as a child grows to adolescence. Instead of just understanding a general rule governing the immediate and concrete, the thinking of the adolescent involves the use of symbols and opening up a world of possibilities (Strauss & Clark, 1996). This type of thinking influences and explains the risk-taking behaviors of adolescents. Strauss and

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Clark point out that the adolescent girl might not be able to appreciate logical sequencing of events, such as pregnancy following an act of intercourse. Maturation in thinking behavior is supported by understanding family members, an emotionally stable environment, parental discipline, and positive life experiences.

Clinical Application

The health of adolescents is critically important to their health in later years (Woods, 1995). Almost from birth, females are socialized to be highly oriented to others, so it is not surprising that risk behaviors and conditions, such as depression or early sexual activity, are more likely to be influenced by the nature of an adolescent female's relational experiences with significant others, family, peers, and others (Baker Miller, 1991). In fact, the major health problems of adolescents relate to their risk-taking behaviors. In contrast to males, these behaviors in females are more often influenced by a desire to maintain important relationships than a desire to "take on" adult behaviors. Female adolescent morbidity is most likely to include pregnancy, sexually transmitted infections, running away, and suicide (Lee, 1998). Risk taking can also be a result of the young girl's environment or may be an expression of symptoms of depression.

The developmental self-in-relation model offered by feminist scholars can be extended into the healthcare visit for adolescents. Trust is a key component of any therapeutic relationship—a fact that cannot be emphasized enough for providers caring for adolescents. Additional time is often needed to establish a trusting relationship with an adolescent.

Sherwin (1998) suggests using a relational approach when providing adolescent females' healthcare services. This approach takes into consideration the full range of human relations that influence how adolescent females define their health (Sherwin). For example, "Tell me about your friends or who you hang out with" and "How would you describe yourself in relation to your friends?" are the types of questions that can be asked of an adolescent during a healthcare visit to assess who influences the adolescent and how she sees herself in relationship to others. The goal is not to isolate the behavior from the relational context in which it occurs, but rather to acknowledge the health implications of behaviors. This enables a more affective approach to risk reduction because the behavior is addressed along with the context in which it occurs. This relational model can be extended as a woman progresses in her healthcare needs across the life span.

Early Adulthood

Young adulthood is generally accepted as spanning the time from late adolescence (age 18) to the beginning of the perimenopausal years (ages 35–50). This period is often referred to as the "reproductive years," reflecting a societal valuing of women primarily for their reproductive capacities (Olshansky, 1996). Health care during the young adulthood years traditionally focuses on health promotion and maintenance, with a primary emphasis on reproductive

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capacity rather than a broader, comprehensive focus on health promotion throughout the life span.

Biology and Physiology

The years between ages 18 and 35 are biomedically considered optimal for reproduction. Generally, most women experience regular menstrual cycles that are ovulatory, providing opportunity for pregnancy if unprotected intercourse occurs. The biologic changes that accompany a pregnancy and that affect motherhood and aging also have a psychological impact in our youth-oriented culture (Blakenship, 2003). Contraception is an important health consideration for heterosexual couples during these years.

Physical health in young adulthood is promoted by consumption of an adequate diet, exercise, and monitoring of overall well-being. These needs for health promotion and maintenance are best met when a woman lives within a social context that is conducive to health (Olshansky, 1996). Optimal health is more readily achievable when a woman does not have to confront racism, sexism, or classism, but instead has access to quality health care, economic stability, and other resources (Olshansky). In reality, however, most women have lives that incorporate multiple and competing demands related to work, economics, childbearing, and childrearing.

Women's changing roles—specifically, the transition from traditional homemaker to working outside the home—have come at a cost to their health, probably because women working outside the home continue to have significant responsibilities within the home. Balancing these competing demands increases the stress level of many women (Condon, 2004). As stress increases, many women have coped by developing unhealthy behaviors such as smoking, lack of exercise, and poor nutrition. As a result, women's health risks for some diseases are now similar to those of men. For example, cardiac disease is now the number one killer of women in the United States, whereas two decades ago the primary cause of illness and health risk for women was related to reproduction. Health problems that frequently occur during this stage of life include cardiac disease, arthritis, occupational injury and related illnesses, cancer, infections (sexually transmitted and otherwise), and reproductive disorders (Olshansky, 1996). Chapters 4 and 8 discuss health promotion and health maintenance in more specific detail.

Psychosocial Development

Erikson's (1968) model identifies two crises that occur during early adulthood. The first is the development of intimacy versus isolation: the process of entering into a life partnership with another individual. It is during this developmental phase that gender assumptions about behavior become more typically defined. As previously noted, women are assumed to require intimacy as a prerequisite for the completion of their identity development, whereas males may progress into this phase without any prior development related to their ability to participate in relationships.

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It is this contrast of what is described as normative for both males and females that challenged Franz and White (1985) to offer an expansion of Erikson's theory of development. Using a feminist lens, Franz and White discourage the use of a single pathway of development that primarily focuses on individuation, and instead encourage the consideration of a two-pathway process that includes both individuation and a process of attachment. They argue that Erikson does not conceptualize being female as somehow inferior or lacking in purpose, nor simply as a vehicle for childbearing and caretaking. Instead, they describe his work as not attending to the process by which attachment occurs through intimacy and relationships with others. Franz and White argue that Erickson does not provide adequate opportunity in his traditional framework for male development of the capacity for intimacy and attachment.

The expanded model that Franz and White (1985) propose includes two processes of development: individuation combined with an attachment pathway in a double-helix model. The double-helix model allows for these two separate strands to be interconnected, depicting the relationship between psychological individuation and attachment as ascending in a spiral that represents the human life span. The strand representing individuation is essentially the same as it is in Erikson's model, but the attachment strand addresses the neglected relational dimension of human development. **Table 2-2** represents the individuation and attachment "strands" as described by Franz and White. The authors argue:

> With changing times and mores, if attachment processes were to undergo fuller development in men and individuation processes were to undergo fuller development in women, sex differences might become more elusive than ever, but individuation and attachment would retain their power as psychological variables associated with psychological value in important nomological nets. (Franz & White, 1985, p.166)

The second crisis of early adulthood is acquiring the ability to become generative versus stagnation. Here "generative" is defined as acting on one's concern for the welfare of the next generation. Reproduction and parenting may accomplish this goal, as can service to others. Stagnation occurs when the person is unable to step outside of herself or himself and be generative. As stated earlier, Erikson's work is based on men and may not be an accurate model for assessing women's development. Newer models of women's development emphasize the relational aspects of women's lives. Understanding women's lives within their individual social context provides a women-oriented perspective for conceptualizing the degree to which a woman reaches a particular level of psychosocial development (Olshansky, 1996).

During the young adulthood years, women's psychosocial development may involve a variety of factors such as accepting responsibilities (parenting, caring for others), creating a career, forming enduring relationships, caring for elderly parents, and deciding whether to become a parent. Although all of these factors influence a woman's psychosocial development, they cannot be understood as generalities that are applied to all women, nor should each be assessed in isolation. Instead, each woman's relation to these factors—to herself and others, to the social context of her life, and to her lived experience—provides insight into her level of psychosocial development.

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TABLE 2-2 Franz & White's Adaptation of Erikson's Theory of Development to a Two-Path Model

	Infancy	Early childhood	Play age	School age	Adolescence	Young adulthood	Adulthood	Old age
Individuation Pathway	Trust vs. mistrust	Autonomy vs. shame and doubt	Initiative vs. guilt	Industry vs. inferiority	Identity vs. identity diffusion	Career, lifestyle exploration vs. drifting	Lifestyle consolidation vs. emptiness	Integrity vs. despair
Attachment Pathway	Trust vs. mistrust	Object & self-constancy vs. loneliness and helplessness	Playfulness vs. passivity or aggression	Empathy & collaboration vs. excessive caution or power	Mutuality interdependence vs. alienation	Intimacy vs. isolation	Generativity vs. self-absorption	Integrity vs. despair

Source: Low, 2001.

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Clinical Application

A woman goes through many transitional periods from age 18 to 35. For women at risk of pregnancy, contraceptive decisions are of paramount importance, and it is critical to have access to and receive information and education about contraceptive options. Decisions related to childbearing (or not) are also prominent and frame much of the healthcare services that women traditionally receive during this phase of their lives. Many lifestyle-related health problems may become apparent during this time. Substance abuse, intimate-partner violence, and stress related to her life or those she cares for can negatively affect a woman's health. Psychiatric illnesses that may become apparent during these years include bipolar disorder, schizophrenia, and psychosis, which may or may not be related to childbearing.

Although young adult women are primarily healthy, it is evident there are many opportunities for life events to negatively affect their health. Health promotion and maintenance during this period are critical to ensure optimal health in the later years of life.

Midlife

Midlife for women encompasses the perimenopausal years (ages 35–50) to menopause (ages 50–65) (Davis & Huber, 2004; Fogel & Woods, 1995). Midlife is actually a transition more than a phase of the human life cycle, and during this time many women experience a recognition that their lives are changing irrevocably. Some women will pursue goals and dreams they may have deferred while dealing with the greater life demands they faced in younger adulthood. If they were parenting during their earlier adulthood, then transitions into other aspects of their lives may be prompted by their children leaving home. Still others may be in the active phases of parenting as more women delay childbearing decisions until later into the early phases of midlife. During this phase of the life span, Erikson (1950) would continue to identify the phases of generativity versus stagnation as a continuing process.

Biology and Physiology

Perimenopause and menopause are biologic markers of the transition from young adult to midlife. Neither is a syndrome or disease, but instead demonstrates a natural maturing of the reproductive system. Social constructions of perimenopause and menopause abound. Martin (1992) encourages us to reframe perimenopause and menopause so that our ideas of a "single purpose" for the menstrual cycle can be reconstructed into images of healthy transitions.

During the perimenopausal years, women may experience physical changes associated with decreasing estrogen levels, such as the vasomotor symptoms of hot flashes and flushes. Other changes associated with aging include a decrease in the size of genitalia, changes in breast structure, and decreased skin elasticity. These changes are more fully described in Chapter 13.

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Although for many years it was believed a preponderance of midlife women suffered mood changes caused by a deficiency of estrogen during this time of life, more recent studies suggest that psychosocial factors have a much greater effect on a midlife woman's mood than do the physiologic transitions of menopause. In fact, mood changes reported by women experiencing menopause may be caused by myriad factors including hormonal changes, normal aging processes, psychological transitions, and cultural beliefs and expectations (Fogel & Woods, 1995).

Psychosocial Development

Midlife is a dynamic period of development during which many complex changes occur (Fogel & Woods, 1995). Women during this time often experience a burst of new energy—termed "menopausal zest" by anthropologist Margaret Mead (Davis & Huber, 2004)—and pursue new interests, acquire new skills, and enjoy more time with friends and family (Boston Women's Health Collective, 1998). Conversely, Gilligan (1982) argues that midlife may be a time of risk for women precisely because of their embeddedness in relationships, orientation to interdependence, ability to subordinate achievement to care, and conflicts over competitive success. Women face midlife by making sense out of their experiences based on their relationships (Fogel & Woods).

Clinical Application

A common myth is that women lose their interest in sex when they reach middle age. Although aging decreases vaginal lubrication, use of vaginal lubricants aid comfortable intercourse. Women who engage in sexual intercourse with men and who are perimenopausal should be provided with information about contraception if they want to avoid pregnancy.

Some women experience changes in memory and cognition as they enter midlife. Research is sparse on this subject. Although some studies implicate decreasing estrogen as a possible cause (Phillips & Sherwin, 1992), others contradict these findings (Buckwalter, Crooks, Robins, & Petitti, 2004; Kang, Weuve, & Grodstein, 2004)

Ageism and bias due to age are common in Western society. As a clinician, it is important to provide supportive care throughout a woman's life span and not assume a woman's health concerns are entirely related to her age.

Older Women

The term "older women" refers to women who have completed menopause. The population of older adults in the United States is primarily female (Davis & Huber, 2004). Many of these women live in poverty and have health problems because they have outlived their support systems (Davis & Huber). Medicare reimbursement is either poor or nonexistent for many of the healthcare services needed by this population. Healthcare issues related to aging are

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primarily women's issues, because older women significantly outnumber older men (Davis & Huber).

Biology and Physiology

Aging changes are due to decrease or loss of functioning at the cellular and/or tissue level, diminished capacity of an organ or system, and a reduction in body capabilities (Pfister & Dougherty, 1996). Theories abound about the cause of aging and the biologic and physiologic impacts of aging, but more research is needed to produce definitive findings. Specifically, gender-related distinctions need more study.

Loss of lean muscle mass, diminished immune functioning, an increase in cardiovascular problems (coronary heart disease and hypertension), and osteoporosis and bone loss are all observed with advanced age (Dimond, 1995; Pfister & Dougherty, 1996).

Psychosocial Development

Research suggests that older women are often caregivers for ailing male spouses or partners, and many end up living alone (because they outlive their male partners), but they continue to maintain a connectedness to other family members. There is no research that looks at the caregiver issue when the partners or spouses are both female. Cognitive abilities involve a range of capacities including motivation, short- and long-term memory, intelligence, learning and retention, and many factors that either facilitate or impede cognitive functioning (Dimond). It is not possible to definitively attribute changes in cognitive functioning to aging because few studies have included repeated measures over time with the same subjects (Dimond). Theories suggest that as we age we begin to disengage from society, and that we make adjustments based on our lifelong patterns, likes, and dislikes. However, there are not enough studies to support these hypotheses.

Clinical Application

Health issues of older women are substantial. The elderly are commonly viewed as frail and vulnerable persons who consume a significant amount of healthcare time, space, and dollars (Pfister & Dougherty, 1996). Ageism—that is, stereotyping and discrimination of a person based on age—is even more common at this stage of life. Elderly women must contend not only with ageism, but also with sexism. Youth and beauty are highly valued in the United States; while older men may be viewed as attractive, the older woman is often pressured to ward off aging (Pfister & Dougherty). Pohl and Boyd (1993) suggest that a key area in which clinicians might begin to link feminist theory with aging women is in health policies and the inequities inherent in them. To promote health and wellness in older women, clinicians must provide them with adequate information about their health status, risks, and ways of improving health through diet and exercise commensurate with their age and capabilities.

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Conclusion

The remainder of the chapters within this textbook present more detailed discussions of the clinical assessment and management of women's gynecologic health. Through the continued use of a feminist framework, an expanded model of gynecologic health is presented that includes great opportunity to both affect change and improve health outcomes for women.

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