Midlife Crisis Perceptions, Experiences, Help-Seeking, and Needs Among Multi-Ethnic Malaysian Women

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In the present study, researchers explored attitudes toward midlife crises, experience with midlife crises, help-seeking, and needs among multi-ethnic Malaysian women. A total of 14 focus group discussions were conducted with 89 Malaysian women of different ages and socioeconomic backgrounds. Women expressed concern over physical aging and decline in their physical functional health. Having a midlife crisis was frequently reported. Issues that were frequently reported to trigger a midlife crisis, such as empty nest syndrome, impact of aging on sexual and reproductive function, extended parenthood, caring for aging or ill parents, and career challenges were noted by the study participants (listed here in order of most to least frequently reporting of these themes across the group discussions). Overall, these issues were associated with attitudes about aging. A comparatively less open attitude toward sexual attitudes and help-seeking for sexual problems were found
among the Malay and Indian women. This may imply that intervention to increase positive attitudes concerning both sexuality and help-seeking intentions should be culturally specific. The use of religious coping for comfort and consolation was frequently reported; therefore, those providing midlife crisis prevention and intervention programs should consider involving faith-based interventions in the Malaysian setting.

**KEYWORDS** midlife crisis, menopause, awareness, experiences, help-seeking, multietnic

**INTRODUCTION**

The term “midlife crisis” is described as personal turmoil and sudden changes in personal goals and lifestyles, resulting from the realization of aging, physical declination, or entrapment in certain roles (Wethington, 2000). Midlife crises represent a complex interplay of different biological, psychological, and social factors. Midlife crises have been associated with physical aging and menopause (Lachman, 2001), empty nest syndrome or sense of loneliness once all children leave home (Mitchell, 2009), a time of frantic overload from juggling the multiple roles of parent and caretaker for elderly relatives (Riley & Bowen, 2005), and career challenge or change (Lachman, 2001).

Most of the studies on midlife women’s attitudes and experiences have been based on women from Western countries. To date, little research has been conducted on emotional and psychological well-being among midlife Asian women. Additionally, little work has been published on midlife crisis in ethnic groups within the Southeast Asian societies. Studies from Western countries have revealed that reactions to menopause are largely a cultural phenomenon (Lock, 2002; Kaulagekar, 2010). In general, in cultures in which women view menopause more positively, menopause tends to be relatively less problematic (Melby & Lampl, 2011). It is likely that women’s experiences in midlife differ in relation to their background, cultural, and ethnic affiliations; therefore, health prevention and implementation should be tailored to women of specific regional, socioeconomic, and cultural populations (Wray, 2007; Ward, Scheid, & Tuffrey, 2010; Mahadeen, Halabi, & Callister, 2008). Friendship networks and social support and having positive attitudes toward life and aging were among factors associated with well-being at midlife (McQuaide, 1998). Additionally, midlife women with low family incomes have been reported to have lower levels of overall well-being and satisfaction than their high-income counterparts (Waldegrave & Cameron, 2010).

Studies have also indicated that many menopausal women have unmet needs in coping with their bodily changes so that identifying midlife women’s
needs and delivering appropriate health services is important (Wu et al., 2011). Fostering positive and continuous social relations within the family was identified as one of the most important factors in coping ability at midlife (Lange, 2003). High spirituality has been positively correlated with midlife crisis coping for some women (McQuaide, 1998; Cigrang, Hryshko-Mullen, & Peterson, 2003).

To date, the cultural implications of perceptions and experiences of midlife crisis have not been previously investigated in Malaysia. Malaysia, a country in Southeast Asia, is located partly on a peninsula of the Asian mainland and partly on the northern part of the island of Borneo. Peninsular Malaysia is a multiethnic society where Malays, Chinese, and Indians are the predominant ethnic groups. The Malays are the original inhabitants, whereas the Malaysian Chinese were mainly from the Southeastern China provinces of Zhejiang, Fujian, Guangdong, Hainan, and Guanxi, and the Malaysian Indians are a group largely descended from immigrants from Southern India. Such ethnic diversity provided research opportunities for the cultural implications of midlife crisis.

Relatively little primary research has been conducted to date on midlife crisis in this society, and midlife women’s psychosocial well-being within this sociocultural context has not been previously investigated. Therefore, using qualitative inquiry, researchers in the present study addressed the following issues: (a) women’s understanding about midlife crisis, experiences, help-seeking, coping strategies, and needs, and (b) the correlates of midlife crisis and sociocultural influences. This study differed from previous studies by exploring the unique multicultural population of Malay, Indian, and Chinese origins (the three largest ethnic groups in Southeast Asia), thereby filling a gap in the existing literature on cultural implications of the midlife crisis.

METHODS

Study Sample

A convenience sample of multiethnic women over 45 years of age with diverse educational and socioeconomic backgrounds was recruited in the Klang Valley area of Malaysia. The first step in recruitment of focus group participants began with word-of-mouth referral and through personal contacts by research assistants, which provided 45% of the participants. Once recruited, women were screened for eligibility using the following inclusion criteria: (1) age 45 years or over, (2) willing and able to provide written informed consent, (3) lived in Klang Valley, and (4) was a Malaysian citizen. Subsequently, the focus group participants were asked to refer us to other women they knew who also met the criteria, such as their friends, family, or acquaintances via snowball sampling method, which provided the remaining 55% of participants.
Data Collection

A semi-structured focus group moderator’s guide corresponding to the research questions was developed. This semi-structured guide allowed the moderator to pose questions that flowed from one issue to the next. Focus groups discussions (FGDs) were conducted in community settings and at places that were convenient for the participants, such as their home or workplace. Groups were separated into the three main ethnic groups of Malays, Chinese, and Indians to allow comparison across the groups with different cultural and religious backgrounds and to ensure group homogeneity so that participants would feel at ease in expressing themselves. Besides ethnic diversity, participants representing a broad array of socioeconomic backgrounds within each ethnic group were recruited to allow exploration of differences in experiences in groups from different socioeconomic backgrounds. Group discussions were conducted in English, Bahasa Malaysia (Malaysian national language), or the respondents’ native language (Cantonese and Mandarin). After group discussion, a brief questionnaire was administered to participants to gather information regarding their demographic backgrounds, frequency of experience of a midlife crisis, and menopause status. The women were asked if they have experienced a midlife crisis, with response options being “frequently,” “occasionally,” “seldom,” and “never.” Women were asked to classify their menopausal status as “premenopause,” “perimenopause,” or “postmenopause,” but no standard definitions were provided to respondents. A signed written informed consent was obtained from all the participants prior to the FGDs. The study protocol was submitted for ethical review by the Medical Ethics Committee of University Malaya Medical Center and was granted approval.

All FGDs were conducted for approximately one hour and were audio-taped and transcribed verbatim. FGDs conducted in languages other than English were forward translated into English. Notes taken by the moderator and note taker supplemented the audiotape transcripts to glean details from the discussion.

Data Analyses

The sampling process, data collection, and analysis were continuous and iterative. All group discussions were immediately analyzed and compared with the analysis of the previous discussions, which, in turn, further shaped the subsequent sampling, data collection, and analysis. The FGDs were continued until data saturation was reached or no new information was uncovered. Coding and categorizing were carried out using the QSR NVivo qualitative computer software program.

The data were analyzed using open coding to identify major themes representing the information that emerged from the discussions. Subsequently more specific axial codes were developed from the initial open codes (Strauss & Corbin, 1998). The codes were analyzed using an interpretive
descriptive method. Coding was performed by a single coder, and the consistency of coding was assessed by intra-observer reliability. The calculated intra-rater agreement was in the 90th percentile range.

RESULTS

Participants’ Background
A total of 14 FGDs were conducted between April and October 2010. Each focus group consisted of five to eight participants, with a total of 89 participants in this study (Table 1). The participants’ ages ranged from 45 to 75 years, with a mean of 55.94 (SD ± 7.85 years). The ethnic distribution of participants was similar to the broader community, where the majority were Malays, followed by Chinese and Indians. Most participants were married (89.9%), were housewives (61.8%), had secondary school or higher education (64.0%), and had an average monthly household family income less than RM 2,000 (50.0%). In total, 64 participants were postmenopausal, and 36 participants reported frequently or occasionally experiencing midlife crisis.

Bodily Changes and Physical Health
Across all three ethnic groups, a number of participants expressed concern and frustration over their own bodily changes. Some negative emotional responses due to aging observed across the focus groups were sadness, worry, anxiety, depression, and fear. Although those who were highly educated and currently employed expressed relatively few concerns, a minority of less educated housewives who had high household incomes also appeared to consider aging in a more positive light and experienced relatively little distress. On the whole, participants who had low household incomes were more likely to express concerns over their physical appearance.

Women showing positive attitudes toward aging reported that having good social interaction and support from friends helped them cope better with the negative side effects of aging. When faced with a crisis, more Indian and Malay participants turned toward religion for support and solution than did Chinese.

Sometimes it is beneficial to talk to more people. (40-year-old Chinese, housewife)

Sometimes I do yoga or something, so you can overcome all the problems. (45-year-old Indian, administration staff)

When I am sad, I did not do anything, just keep quiet. Very sad . . . I just sleep, or I pray. I don’t want to talk to anyone, I just pray. (65-year-old Indian, housewife; quote forward translated from Bahasa Malaysia)
Participants with more positive self-perceptions of aging reported better physical health, regardless of ethnic group, socioeconomic status, or educational levels. Age-related morbidity was reported more by women with lower household incomes. Compared with those with higher household incomes, more women in low-income households felt resigned to their situations,
viewed deterioration of their physical health as inevitable, and did not appear to take any preventive measures.

Mental Health and Emotional Well-Being

A considerable number reported that they experienced depression at some point during their midlife years, especially during menopause. More participants in low-income households reported experiencing personal turmoil or stressful life events than those in high-income households. Among the most frequently reported stressful life events were death of spouse, family conflict, and financial problems.

   I don’t feel depressed over sickness, but other things. Like . . . I have been so active all this while, working and all that . . . now suddenly I am no longer working, sitting in the house, I feel very depressed. And sometimes when my children have problems, I also tend to feel depressed. Sometimes I feel anxious, but often very mild, I will then read some books . . . usually religious books. I also watch TV, discuss with my friends, laugh it away, then it goes off. (62-year-old Indian, retiree)

Many participants, regardless of ethnic group, reported that socializing with friends would help to ease an emotional crisis. A considerable number, of whom the majority were Malays and Indians, who suffered depression or stressful events turned to religion as a form of coping.

   Ah . . . my family is very close. So it’s not like you are alone or anything you know . . . I know some people will feel very lonely and all that but for me, my family is very close. So there’s always people around and the friends around. You know, the Christian network is very good. Yes . . . I don’t really feel anything. (56-year-old Chinese, secretary)

Career Challenges

On the whole, the majority of working women in this study did not find their midlife years to pose a challenge to their career.

   Definitely in the office you would feel it because you are an old staff. When new staff come they will give more attention, because you are going to go off another few years. I felt bad. That all come to depression part. (67-year-old Indian, administrative assistant)

   It’s alright for me, because I think we are not heading for retirement, we have achieved whatever we wanted. And there is no threat, nothing can happen to us. They can’t throw us out, like we also pass our time, at
the same time we are also working. (45-year-old Indian, administrative assistant)

Further data collection and analyses revealed that women with more positive self-perception were also less likely to have career problems.

Empty Nest Syndrome
Half of the participants with children who had left home for studies, marriage, or work reported feeling sadness, emptiness, depression, and extreme loneliness, whereas the remaining half felt relief when their children left home for studies, jobs, or marriage, as they finally had free time to pursue their own interests. Some reported that interaction with friends and socializing may help to get over the empty nest syndrome.

When my daughter left us for work in KL, I cried every day. My daughter called me every day to console me. (59-year-old Chinese, housewife)

Actually, I am staying alone in the house. My husband works every day. I don’t, because of my activities . . . so I don’t really feel this . . . empty nest syndrome. (65-year-old Chinese, housewife)

Extended Parenthood
Of those that reported giving care for their grandchildren, only approximately one-fifth reported experiencing stress related to extended parenthood or providing care for their grandchildren. Most of the participants, regardless of ethnic group, expressed a favorable view toward providing care for their grandchildren. When probed whether they regarded providing care for their grandchildren as an extended period of stress after years of caring for their own children, most of them viewed extended parenthood as not bothersome.

These days, a lot of problem if want to send to nursery employ maid. If we are capable of helping, we try to help, it is happiness to be able to look after our own grandchildren. (49-year-old Malay, administrative support staff; quote forward translated from Bahasa Malaysia)

If we love our children, we will do anything for our grandchild. I don’t feel it is a pressure. (57-year-old Chinese, technical assistant)

Caring for the Elderly
Only one-fifth reported ever caring for their disabled and frail parents. Many of them agreed that providing geriatric care can be very exhausting and cause
fatigue, stress, and even depression. More participants in the low-income than in the high-income households and who cared for frail elderly parents without help from other siblings or a caregiver faced additional challenges. Regardless of ethnic group or educational level, most of the study participants, including those who had never cared for the elderly, held the view that managing or providing care for elderly parents was a way of expressing filial responsibility.

Even now I already remind my children . . . I have only one child . . . when I am old, you have to take care of me. (47-year-old Indian, housewife)

I don’t mind, because she is our own mother. I took care of my mother, and she lived in the village and I travelled to and fro and when she passed away, I felt I have had done my part, no regret . . . I have done my responsibility. But if I did not take care of her, I would regret it. (46-year-old Malay, technician; quote forward translated from Bahasa Malaysia)

Reproductive Health and Sexuality

Perimenopausal or postmenopausal women reported experiencing a greater number of symptoms than premenopausal women. Additionally, more women who were currently experiencing a life crisis, financial difficulty, or marital disharmony reported greater frequency and severity of symptoms. Regardless of ethnic group, many participants viewed the menopausal transition symptoms as part of a natural process in a woman’s reproductive life; women in the higher-income households sought treatment more frequently than women in lower-income households. The study participants prefer to use traditional or nonmedical forms of relief, and these include vitamins, healthy foods, traditional herbs, and exercise. Further, interactions between participants in group discussions revealed that menopause was not perceived as a disease, and therefore it could not be cured using modern medicine.

The majority of the women in this study experienced age-related changes in sexuality and reproductive function. Nevertheless, many viewed woman’s lack of desire for sex after menopause as normal. Only a minority of the women in this study responded to changes in their sexual interest in a negative manner. Negative responses were particularly reported when sexual needs differed between participants and their husbands, as reported in the following excerpt.

I am already old, and so is my husband, we are not concerned. (51-year-old Malay, administrative staff; quote forward translated from Bahasa Malaysia)
At that time . . . near menopause, I don’t like sexual intercourse. Firstly, a lot of blood when we had sex and further, our body feel tired. I don’t like husband to come near me. I went to see doctor but cannot find reason, a lot of blood when we had sex. I told him to look for other women. Now he is not staying with me . . . (72-year-old Indian, housewife; quote forward translated from Bahasa Malaysia)

Most women in this study did nothing when confronted with sexual problems. Nevertheless, Malay and Indian women in this study were more likely than the Chinese to view it as inappropriate to seek help for sexual problems and described their sexual desire as at the bottom of their priority list.

Needs

Participants indicated that women need information about factors that can contribute to midlife crises and how to address them. When probed, they believed that midlife crises were more likely triggered by psychological crises due to marital or financial problems rather than emptiness when children leave home, grief at losing elderly family members, or midlife career challenges.

Most participants had no knowledge of medical treatment for midlife crises. Some even viewed that midlife women need emotional comfort rather than medical treatment. Women affected by midlife crises in this study viewed keeping oneself occupied and talking to friends and family members as key steps in dealing with the crisis.

Having friends is very useful, mingle with people, it will help. It will be problematic if one keeps hiding at home. (48-year-old Chinese, housewife)

For this reason, many participants suggested that women’s midlife support groups should be formed at community level.

DISCUSSION

Having a midlife crisis was a frequently reported experience among participants in this study. Across the ethnic groups, the most frequently reported midlife-related issues faced by these women were changes in physical condition, health, and mental functioning, similarly reported in other studies on Asian women (Shea, 2006; Ho et al., 1999, 2003). Also the less-educated women were more likely to anticipate negative attitudes toward menopausal symptoms, physical health, and physical aging than the more highly educated. These results parallel those of numerous earlier studies on
the association between social class, education gradient, and health status in the elderly (Cagney & Lauderdale, 2002; Ho et al., 2003).

The current results also indicate that physical aging, changes in body shape with age, and attitudes toward treatment seeking or prevention did not vary by ethnic group or educational level. Instead, women of high-income households had a stronger desire for prevention and treatment-seeking to avoid all aspects of aging than those from low-income households; this is congruent with findings from a systematic review (Pollack et al., 2007), which reasoned that wealth or affordability facilitated the access to preventive health-care measures or health-care services (Pollack et al., 2007). The findings in the present study that women of higher income appeared to be able to manage and cope better with the negative health aspects of aging has also been reported in the past literature (Lange, 2003). In light of the above findings, midlife-related health interventions or educational interventions should target women from low-income households.

Current findings also show that negative attitudes about menopausal symptoms, physical health, and physical aging were more frequently reported by women who had experienced personal turmoil or stressful life events (consistent with findings observed in other studies), suggesting that physical health, psychological, and socioeconomic factors may sensitize women to symptomatic responses (Ho et al., 2003). A recent systematic review reported that most studies showed a significant positive association between negative attitudes toward menopause and general symptom reporting and depression (Ayers, Forshaw, & Hunter, 2010), implying that behavioral health or educational interventions to increase positive attitudes toward aging should target women with social-emotional problems.

Religion and spiritual coping has been linked to greater social support and psychological adaptation, and fewer depressive symptoms and less psychological distress among the elderly (Lowry, 2002; Koenig, George, & Titus, 2004). Likewise, especially among the Indians and Malays in this study, using religion as a means of coping influenced participants' attitudes, helped to promote a sense of transcendence particularly as health declined, and also served an important avenue for coping with emotional stress. Health-care providers should consider including spirituality in assessments and interventions for the elderly population (Lowry, 2002).

In the order of most frequently repeated theme across the groups, the issues that may trigger midlife crisis noted by the study participants were (1) empty nest or children leaving home, (2) impact of aging on sexual and reproductive function, (3) extended parenthood, (4) caring for aging or ill parents, and (5) career challenges. Overall, women's midlife-related issues were associated with attitudes about aging in the women themselves. Negative attitudes toward aging were negatively related to midlife-related issues. The extent to which a woman's life is affected by aging depends on how a woman views herself (Mackin, 1995). Again, this implies the
importance of behavioral health or educational interventions to increase positive attitudes toward aging among women. Women should be guided to accept the inevitability of the aging process and encouraged to view midlife as not a crisis but as a time for re-evaluation of goals and their ability to meet their goals (Mackin, 1995).

Extended parenthood and caring for aging or ill parents were rarely regarded by the study participants as stressful midlife events. This could be due to strong beliefs held by Malaysians regarding filial responsibility. Women who were caregivers have reported experiencing a variety of physical health problems and emotions, including anger, guilt, or anxiety (Donelan, Falik, & DesRoches, 2001; Ngan & Cheng, 1992). Hence, public education and local outreach campaigns may enhance awareness among women about the associated health risks, ways to reduce anxiety or depression, and the availability of supportive resources for caregivers (Donelan et al., 2001). Efforts to reduce guilt associated with relying on alternative caregivers should be also highlighted (Donelan et al., 2001). Further, women experiencing job instability may be most affected by inability to cope with midlife career crises (Lachman, 2004). In this study, the women who were employed did not face job instability or financial strain, so that career challenges was the theme least reported.

Women in this study were generally conservative in their sexual attitudes. Their personal sexual satisfaction was connected to their husbands’ sexual functioning and needs. A comparatively less open or receptive attitude toward sexual function and help-seeking for sexual problems among the Malay and Indian women in this study may be associated with the cultural and social expression of sexual behavior, a finding in accordance with previous research (Wray, 2007). This may imply that intervention for increasing both positive attitudes concerning sexuality and aging and help-seeking intentions should be tailored to the social, ethnic, and cultural beliefs of the target population.

On the whole, the current findings revealed that help-seeking for physical health conditions was more frequently reported than for emotional or behavioral problems. The low frequency of help-seeking for emotional or psychological problems was associated with social and cultural influences. Within the Asian community, emotional problems were viewed as shameful and unreported, and many tended to rely on family to handle them (Sue & Sue, 1999). This suggests that intervention to promote help-seeking for emotional problems should emphasize cultural appropriateness and use a family system approach, rather than individually-based intervention.

Cost appeared to be a prohibitive factor for help-seeking, as socioeconomically disadvantaged women in the study were less likely to seek help or take preventive measures. Other factors for not seeking help that emerged from the discussions were being resigned to the situation and believing that health problems are inevitable due to the natural degenerative effects of
aging. Reluctance toward seeking help for sexually-related matters rather concerned shame or embarrassment around sexual problems and perceiving sexual problems as unimportant or not serious. Others have reported similar findings (Lindau et al., 2007; Gott & Hinchliff, 2003), and such barriers to help-seeking were likely to be due to cultural and societal perceptions that sex is not important in midlife (Gott & Hinchliff, 2003). Physicians may need to adopt a more proactive investigatory role with elderly patients in raising sexual health issues during health visits (Lindau et al., 2007; Gott & Hinchliff, 2003).

Several important themes related to midlife women’s needs emerged from the focus groups. Focus group participants expressed a strong interest in obtaining information regarding factors which contribute to midlife crises and how to alleviate symptoms. Another important theme that emerged in all the discussions was the need to educate women in general about midlife crises so that they can identify family members and close friends with midlife crises and be able to provide support. This finding is in accordance with the observation that having a greater social network and engagement in activities promotes positive healthy behavior (Peterson, Yates, & Hertzog, 2008). The participants’ responses also indicated a lack of programs designed to address the psychosocial needs of midlife women at the community level, which warrants attention to establish such prevention and intervention programs. This could take the form of local counseling or support groups that provide women going through midlife crises with the opportunity to learn more about it. Additionally, community-based facilities in which older and midlife women have the opportunity to interact are needed, and steps can be taken to assist them to recognize problematic beliefs and behaviors associated with midlife.

In interpreting these results, certain limitations with the study design must be considered. Firstly, the total number of women approached, proportion found eligible, and proportion of those eligible who agreed to participate were not recorded, therefore may indicate the presence of selection and participation biases. Secondly, qualitative methodology has acknowledged limitations (Greenhalgh & Taylor, 1997), including the use of a non-representative convenience sample which may be subject to selection and participation biases, reducing the generalizability of the results. Furthermore, the focus groups format may have made the information participants provided subject to social acceptability bias. Also, the small sample size, particularly in specific ethnic groups, did not permit meaningful statistical comparisons to be made with adequate statistical power. However, the qualitative paradigm in this research aimed at tapping into women’s experiential life and not making statistical generalizations (Sandelowski, 1995). Another study limitation was that for some women, discussions of midlife crisis problems were hypothetical as they had not been in these situations. Further, midlife crisis and menopause status were self-reported and
not assessed by standard instruments or definitions, and thus may be subject to misclassification of these states. Additionally, forward translation of FGDs conducted in languages other than English may have also resulted in biased and inaccurate transcription. Lastly, the reliability and validity of coding were limited because transcripts were only coded by a single coder.

CONCLUSION

The results of the present study suggested that women’s midlife perception and experiences were the product of a complex interrelationship between biological, psychological, social, cultural, and economic factors. Ethnic or cultural distinctions were observed in coping with midlife; for instance, the Malay and Indian women who participated in this study were more likely to rely on religious or spiritual coping than the Chinese participants. However, the factors identified in this study must be further explored through large, prospective cohort studies. The findings of the sample under study have implications for health care professionals and family members in supporting women at midlife and for developing interventions to promote the psychosocial well-being of midlife women of diverse backgrounds.

Finally, the implications of this study include the need to design culturally-sensitive informational interventions and programs (intended for all family members, not only women), to educate women about the key issues underlying midlife crisis as an aspect of aging and to promote help-seeking. Interventions and programs for coping with midlife should also incorporate the spiritual and religious-oriented context and encourage participation of faith-based organizations.

REFERENCES


