

The 8th Annual Conference on Women's Health and the Environment
Caring for Our Mental Health
November 14, 2003

JEFFREY LEWIS

Good morning and welcome to the 8th Annual Conference on Women's Health and the Environment. I'm Jeffrey Lewis, the president of the Heinz Family Philanthropies. It is so gratifying to see so many of you today. Each year we grow in numbers. Each year new faces appear amongst old friends, and that is exactly what this conference is designed to do.

Let me begin this morning by acknowledging the hard work of some very important people. Maggie Carvan, a member of our staff who works here in Boston, and the amazing women of Regina Villa Associates, particularly Nancy Farrell, Carol Matyka, and Regan Checchio. They have helped put this conference together, and they deserve a special round of applause. [applause] Working together with Teresa, they plan the program, line up the speakers, and most important, make sure you get breakfast and lunch. We simply could not do this conference without them.

The topic today is "Caring for Our Mental Health." Your interest led us to select this subject. Every year we ask you to fill out a questionnaire on the conference, to record your likes and dislikes, your thoughts and your wishes. For the past two years, participants at this conference have registered an extremely high interest in mental health issues. Today's conference shows we are paying attention, we are listening to what you say. And again, this year you have an evaluation form in your packets. Please give us your thoughts and ideas for next year's topics, so that we can focus again on what's most important to you.

Since our first conference in 1996, we've explored many aspects of the environment women live in each day, both physical and cultural. Mental health involves both. This conference was designed from the beginning to be the one conference, the one place where people would be placed in an atmosphere and surrounded by others, all with the same simple goal: They want to

hear from the best of the best, without fear of bias about different aspects of women's health and the environment. Today we begin a new page on a very important topic, the nexus between women's health, the environment, and our mental health.

Teresa launched these conferences in an effort to offer women, and a few men like me, a place where they could come once a year to explore, to dissect, to listen, and to share their ideas about women's health and the environment. And we begin today's conference with the woman who is the spirit and the inspiration behind these conferences, someone who embodies the phrase, "When you educate a woman, you educate a family." While there are many superlatives one could use to describe Teresa Heinz, the one I believe best characterizes her is that she's simply the best of the best. Please join me in welcoming my friend and the chairman of the Heinz Family Philanthropies, Teresa Heinz. [applause]

TERESA HEINZ

Good morning. . . It's wonderful to see this room full . . . And it's wonderful to be back here. . . we are here, as Jeff said, because a strong, healthy woman means a strong, healthy family. And you know that as well as I do. And a not well woman means an unraveling of a lot of pieces in our families. This is our eighth annual conference, which means that this is the eighth consecutive year that more than a thousand women gather together and learn from one another and from the remarkable experts we have invited, and who speak with us. It is wonderful to see, as Jeff said, so many old friends and so many new friends. We raised a few eyebrows when we started these conferences in 1996. And at the time, people wondered why we were just focusing on women. After all, the environment affects men's health too, and children's. But I believe there are four compelling reasons for a conversation like this to focus on women.

First, to the extent that the scientific community has paid attention to the relationship between women and health and the environment, it has focused that attention on men. Many of you will remember from the first conference Dr. Bernadine Healy's keynote, when she shared the

wonderful story about a study to prove that estrogen, pure simple estrogen, lowered cholesterol and therefore was beneficial to the heart, which it did. But it also produced unwanted breast growth in the study's subjects. It turned out that the test was conducted on a group of people who, although healthy and young, did not want larger breasts, because every single one of them was a 24-year-old male. Science generally has used men as the norm for human health, either as the epitome of specimens or, I guess, as fair game. But it has often overlooked the distinct physiology of women's bodies.

Second, there's growing evidence that when it comes to environmental threats to human health, women may be the proverbial canaries in the mine shaft. Fifty years ago, women in this country were developing breast cancer at a rate of 1 in 22. Today that rate is 1 out of 7. . . . And growth like that is not the result of better detection alone. Environmental factors must also be playing a part. And as the rates of testicular and prostate cancer also are on the rise, scientists are beginning to connect the dots between women's health problems, men's health problems, and a poisoning of our environment through endocrine disruptors. And there's a great book out on endocrine disruptors, written by Theo Colborn, Pete Myers, and Dianne Dumanoski, who used to be the great science and environmental reporter at the *Globe* until she gave up that position. . . So if you want to read an interesting book on endocrine disruptors, that's one to read.

Third, women continue to play a special role as caregivers in our societies, and our bodies, designed to nurture our children, can also become the pathways for toxins to enter their developing bodies. And just a few months ago, a new study showed that flame-retardant chemicals used in products like furniture and electronics, and also used to be used (although it's forbidden now) in children's pajamas (remember?), are contaminating the breast milk of women. These chemicals have been linked to impaired cognitive development and higher cancer rates in laboratory studies. Women have a special interest in information like that, and a right to know it. The National Academy of Sciences has found that children who are exposed, for instance, to pesticides in their home are four times more likely to develop certain types of cancers. And childhood cancers, which have risen dramatically even if the death rates for those cancers have dropped, are still going up. And pollution exposures in the home and pesticides in daycare are all contributing to increased

respiratory illnesses, cancers, even attention deficit disorder in children. There is no one direct line between exposure and disease, but multiple exposures create a chemical stew for the small lungs, the developing brains, maturing neurological systems, and evolving reproductive systems. This is information that women need to have.

And that brings me to the fourth reason for our annual conference. When women are informed, women act. [applause] From the early years of the industrialization of this country, it was women who led smoke abatement and public health movements concerned about the impact of thickening skies and what it would do to their children. And while more often than not, they had to be represented by men in meetings, in the late 1800's, they were resolute in getting the men to go there demanding the controls. When Rachel Carson's *Silent Spring* was published (by the way, Rachel Carson was from Kensington, Pennsylvania, which is just about four miles up the river from where my farm is in Pennsylvania, on the Allegheny River- and there was, of course, a lot of pollution in those days, and it's getting a little better) . . . it was then in Kensington—and of course, in those days, in Pennsylvania and elsewhere—the women who penned letters to editors around the country, demanding to know the implications of these pesticides for their children's biological systems, and calling the government leaders to respond. Today again it is women who are calling for investigations into the link between the environment and family health, and organizing their communities to research exposure, call for common sense safeguards, and seek out new consumer products to lessen toxins.

We are right to be worried. In the last 50 years, about 80,000 chemicals have been developed and introduced into the environment. And only a fraction of these have been regulated. And even a much smaller percentage (maybe about 6,000) are adequately tested for their impact on human health. Their interaction inside our bodies is still largely a mystery. But they can be found everywhere: in our food, in our cosmetics, in our children's toys, in our carpets, in our plastic containers, in our household products, and so on and so forth. And it's not good enough to be told that it's just a minimal amount in a particular product, because if you just get hit with minimal amounts in all the products we touch, consume, or are impacted by on a daily basis, the stew is rather large. And we don't know what that interaction does.

In 1998, the European Union banned the sale of toys and childcare items made from plastics containing phthalates. Last year we referred to phthalates briefly. They are very common. They are additives that are used in polyvinyl chloride plastic (PVCs), in cosmetics, in wood finishes, and insecticides. They're used in baby teething rings that you put in the refrigerator, for instance. Isn't that nice? And lab experiments have shown that exposure to phthalates can damage the endocrine system, which regulates metabolism and reproduction. In the European Union, fearing that these chemicals would leach from the soft plastic teething rings into the mouths of babies and toddlers, of course, they banned them. But phthalates have not been banned in the United States, where the chemical industry insists they are safe.

A similar dynamic has played out with sunscreens. And I referred to this last year, and I think so did Anna Soto. In 1997, the EU banned five chemicals that are used out of the 25 available in some sunscreens, because of the evidence that they were estrogenic. They could cause cancer. These chemicals are used in this country. The one that is most often (and I mentioned this last year) is octyl-methoxycinnamate. If you put on a base in the morning that has SPF 15, I would say 90% of the ones [available] will have octyl-methoxycinnamate as the number one ingredient. That is the sunblock. It's unnecessary. Clinique has always made, for instance, one with zinc or titanium dioxide (I can't remember). You don't have to have octyl-methoxycinnamate. Why have we not heard from our medical industry or medical people, skin people, FDA, you name it . . . when the European Union, Canada, and Australia banned it in 1997? I don't know. But it's still being used. I think we have to ask these questions.

It may be years before the truth of some claims can be determined. But the point is that as we wait for definitive proof on how chemicals like these affect us, we are all acting like lab rats in a huge, unregulated experiment. And the safety of these chemicals as they interact in the environment is being tested every day on all of us. And we might remember that we all carry about 250 chemicals in our bodies, in our fat, which are not supposed to be there. And interestingly, I was meeting with some scientists the other day on environment and health, doctors—in fact, Dr. Phil Landrigan, who used to be the head of pediatrics at Mt. Sinai, New York, and now is head of environmental medicine at Mt. Sinai, and is one of the really respected

people in the country. And I asked him, "Phil, if this is the case, can we find any bodies, little virgin bodies, little babies, that are clean so we can test, get something from a clean body?" And he said, "No, I don't think so. Maybe one in how many billion people we have, a hundred here and there. But through air, through water, through food, through their mothers, we are passing on a chemical stew to all human beings and all species."

So just as our bodies carry that in our fat, so do our minds. And the brain is part of the body, but we tend not to think of it that way sometimes. But it is important to question, then, whether the environmental factors that affect our physical health can also affect our mental health. And we know for a fact that lead poisoning, lead pollution, does affect cognitive and behavioral health, with attention deficit disorders for sure, hyperactivity for sure. And the reason is because lead, when ingested, will go either to the bones or to the brain. And this is particularly so if you have chronic, slow exposures to lead.

Mental illnesses touch virtually every family in America. Depression is the leading cause of disability in the United States, and nearly twice as many women as men suffer from depression. The World Health Organization says that major depression is the leading cause of disease among women worldwide. And that truly puzzled me. I did not know that. I was stunned by that. I mean, I can see reasons but I just never thought of it being so prevalent.

The study of the relationship between mind and body is still in its infancy. Scientists are only beginning to document the extraordinary connection between the brain and the rest of the body. And we know that the connection flows both ways, and that our physical health affects our mental health and attitudes and our emotions and our mental wellbeing as well. And there is evidence, for example, as I mentioned before, that lead causes, as I mentioned, ADD, etc. But some scientists, although they haven't published this, will go even further and start making links to other problems, such as maybe forms of dementia or Alzheimer's. There are a lot of questions out there, and there are a lot of studies going on, but certainly nothing conclusive on that, that I know of. But we don't want to become lab rats, do we?

Although we still have more questions than answers about the role of environmental factors in affecting mental health, we can make some common sense assumptions. And if chemicals in our

environment can . . . disrupt the endocrine system, it is only reasonable to assume they might impact the hormones that affect our moods. And research has shown that many of the pollutants we are exposed to and the products we consume contain artificial hormones. Again, we dealt with this last year, and the estrogenicity, which is carcinogenic of a lot of these.

And I was particularly, for those who weren't here, rather upset at the PremPro study, which was based on two sets of Premarin and Provera (Provera being a synthetic and the progestin, not a progesterone, and therefore an estrogenic, persistent compound; and Premarin being a combination of so many hormones) and the fact that the people who carried out the study did not do a comparative line of pure estrogen and pure progesterone, just for comparison. And so you have a lot of women in this country who stopped abruptly because they were frightened, and were depressed and crying. One of my friends, 75, she got hot flashes again—unnecessary. And the thing is, you don't do research that way. We have to demand a better quality of research. All I can think, if I become cynical is who paid for the study. I don't know.

So scientists are now beginning to trace the physical impact of the exposure as they interact with our natural hormones. But there is evidence suggesting that these xenoestrogens may be linked to a host of reproductive illnesses and cancers and other deformities which I have seen, and I'm sure doctors here have seen, too (deformities of newborn babies, having to do with reproductive systems, as well as a whole slew of other related problems).

But the issue of chemicals and pollutants in our food, water, and air represents only half of the environment and mental health connection. The other half involves the role of the natural world in promoting mental health. Studies in environmental psychology (I found this very interesting) have found that urban children, particularly girls, perform much better in school if they have regular exposure to greenery. One study by researchers at the University of Illinois found that children who suffer from ADD experience improved concentration and heightened ability to complete tasks and follow directions after playing in green and natural settings. The greener and more natural the setting, the greater the improvement. Isn't that interesting? Makes sense, but it's interesting that there's such a study.

A healthy sense of perspective about one's relationship with the world is key to mental health. And I believe nature gives us a context for developing that perspective. I know that growing up amid the African savanna gave me a deep appreciation of life's complexity, ways of handling that complexity, laws of cause and effect, and a sense of connectedness with the world around me. Those values are my compass still today, and have served me well when events have threatened the stability of my life. Even today, one of the ways I handle stress is to spend some time outdoors or looking at flowers. I always have to have a plant or flowers or something. And in looking at this, I remembered when I was a student in graduate school in Europe, in Geneva. I lived on a very tight budget, \$250 a month, which in those days was enough money but still not a lot of money. And once a week I used to not eat my "protein for the day," which was a little steak, so that I could buy one big red rose which would keep me going. This was during the winter. I had to have something. And I thought I was just being spoiled. But in fact, I think it was going back to that something beautiful of nature that I needed to feel whole. . . Today I just keep orchids, like Phalaenopsis, because they don't give you allergies and they bloom for three months. So I'm always full of these white things around me.

This year, a landmark UCLA study found that women respond to stress differently than men do. The two lead scientists (both of whom we invited, but both of them were giving lectures somewhere else) found that when they were upset at things in the lab, they would start cleaning up things and go out and kibitz and get mad, or just have a cup of coffee. But their male colleagues didn't. The men scientists would go lock themselves up in a room and whatever, figure it out by themselves. So they realized that men have a classic "fight or flight" response, and the assumption has always been that women do as well. So they decided to study this. And actually putting the assumption to test, the researchers discovered that women react to stress by reaching out to friends and by tending to their children and to their families, which they call "tend and mend" or "tend and befriend." And it involves oxytocin, which is a catalyst in getting more estrogen going, etc., which is totally different from a response of testosterone. So this also helps explain why women live longer than men. And numerous studies have shown the connection between strong social ties and health. . . And what's so interesting to me is, when you read that study, you think:

What do we do with our lives today? Women are working so hard in the home. They work outside of the home. Many of them are single. If they're married, their husbands are working hard. And they never have this time for mending, and very little time for tending. And then we should not be surprised that our mental health isn't as good, that our divorce rate is so much higher, because we go to our husbands expecting to do mending with the guys, and the guys don't mend the same way as we do. So there is a disconnect there, and they talk about it in divorce courts. They call it "lack of communication," whatever it's called. But of course there is lack of communication, because there are certain things these guys just don't like to communicate about, and they probably find us very dull. "Don't worry about it." You know. "Put it under the table."

So we are not being terribly smart, but thank goodness science is there now, and maybe it will help us redesign and reshape the hours that we work, how much time during the day we give ourselves for friendship, for being good to ourselves, for being good to our husbands and our children and our parents. And it's all about mending and tending. And that's why we are so strong. And I also think, in a time of such complexity as our world is today, that women are particularly gifted for that reason, to manage complexity, because women do that in their daily lives. You can never count early in the morning when you start, on what it's going to be like at 5 o'clock, how many trips you've had to make somewhere that you didn't plan to do. I think we are really predisposed to be quite important, if we didn't know it. And I think we'd better be very important because the world needs us. [applause]

So in our high pressured, fast paced society, where time is measured in nanoseconds, and being busy 24/7 is considered the height of virtue, our relationship with the world around us is too easily forgotten. We rarely stop to consider how all this activity, this pressure, and all this disconnection from the natural pace of life and one another, might be affecting our mental and spiritual wellbeing. Do we really live to work? . . . To do that, I believe once again we will have to step forward, and we will have to begin to connect the dots. And we have to start demanding honest answers and make smart choices, not just for our own health but for those of our families (our men, our husbands, our parents, and our children, of course).

Today we will be hearing from some women who have already done that, and who have stepped forward and dared to say that our society must take its mental health needs seriously, by moving past stigma and fear, and speaking openly about the challenges that we face. One of the people we'll be hearing from later—or we were supposed to (I apologize)—was Patty Duke. Patty had a coronary bypass and a stent put in, day before yesterday. She called last night. She read me a letter, which I will read a little later. She's very sad not to be here. She's all right. And she's an amazing woman, a very brave woman. And what she must have gone through for 15 or 20 years of being ill without knowing what she had, and yet being so much in the limelight, and being torn apart, she's a great woman and we owe her a debt of gratitude. And I promised her that we would send her the tape of this conference, and she can enjoy it and know that she was part of this, and that she's in our minds and in our prayers. [applause] So as many people (and you will hear some here today) who have been diagnosed with manic depression, like she was, she has used her fame to enlighten and teach the public about this painful disease. Others have parents who were ill, and became apologists and crusaders. And thank goodness for them. And thank goodness that we ourselves are all here, because we all know people or parents who have children with problems, or our own parents. And there shouldn't be any shame. It should be the last frontier of knowledge in the medical family. And we should be part of making it not only acceptable, or non-stigmatic, but forging ahead to make sure that the support systems that are there for people who need it are as valid and as ready and as accessible and as affordable as going to a doctor for a heart checkup or a broken leg or your vaccines. That's what we need. [applause]

Dr. Kay Redfield Jamison is an international renowned authority on manic depression. She will be our first speaker. She's shed a compassionate light on the pain and the anguish of mental illness. She co-authored a standard medical textbook on this disease. As she worked her way up the academic ladder, she was fighting the disease herself. She had her first severe attack at the age of 17, but was not diagnosed until a good ten years later, when she was a young faculty member at UCLA. She wrote a bestselling memoir about her struggle. She has more than any other expert in this field provided comfort and help to people who suffer from mental illness, because she had the courage to show her own suffering, and the guts and love that it took to survive. We are honored

to have her with us today. She's a great gift to people who suffer from mental illness, and I
welcome her. [applause]

KAY REDFIELD JAMISON, Ph.D.

Thank you. I am really delighted to be here. This is a wonderful occasion. It's a wonderful thing that Mrs. Heinz and all the people who work with her do. To educate women is to do the best thing possible, and I just am really very, very honored to be here.

Other people are going to be talking this morning and this afternoon about the specifics of psychiatric illnesses in women and how they affect women, some of the numbers, some of the treatments, and some of the concerns in the field and the research. I've been asked to talk from my personal point of view about the experience of one mental illness, in my case a psychotic form of one of the more common mental illnesses, manic depression or bipolar illness. And I wanted to focus a little bit this morning, as well as having a psychiatric illness and the experience of it, but also within the context of being a woman and having the life of a woman, because I think that we all come from somewhere. We all have environments that have shaped us and informed us from childhood, from being young girls brought up within a family, being brought up within our communities. We're brought up with attitudes, passions, fears, and aspirations. We're brought up with dreams, and we're brought up with notions of what it means to be a girl and a woman. And what I'd like to say is that mental illness doesn't fit into that. It just doesn't. We are educated. We compete. We learn. We rebel. We fall in love. We work at home or in offices. We lose people we love. And at some point we all look back. We reflect on where we've been and where we are going to go.

I was brought up in a world of books, military uniforms, airplanes, science, war, lots and lots of laughter, and I also was brought up in a family that had many people who would go on to suffer as I did from severe manic depressive illness. My childhood and adolescent enthusiasms, from studying sloths to dissecting box turtles on our ping pong table, were encouraged not only by my parents (my father was a scientist) but all of my parents' friends as well. Independence was admired, and it was not discouraged in the least. And in this respect, I was far luckier than I can even now begin to appreciate. I'm actually just finishing up a book about exuberance. And one of

the things that I realized was that I was fortunate enough to be brought up around scientists and mathematicians who loved just life, and loved the natural world, and they loved asking questions of nature. And they took enthusiasm very seriously. They didn't think enthusiasm was something to apologize for. They thought it was part of life. This is not always true, as I found out later in my academic career. Women are not really necessarily expected to be great enthusiasts.

Childhood was a full and a delighting time, but this eventually changed dramatically. Let me turn first to the context of one's upbringing, for no illness exists in a vacuum. And with mania and with depression, one is forced particularly to examine the discrepancies between the values of one's upbringing and the realities of despair, paralysis, and psychosis. One is also forced, fortunately, to look at one's blessings. But always one's values and one's upbringing come back to affect how you deal with an illness, how you accept it, how you accept treatment or you do not accept treatment, how you learn from it, and how you teach others. I had great friends in childhood and adolescence, a full and active life of swimming, riding, softball, parties, boyfriends, summers on the Chesapeake Bay, and all the other wonderful things that go into the beginnings of life. But there was in the midst of all of this a gradual awakening to the reality of what it meant to be an intense, not to say extremely mercurial girl in an extremely traditional and military world.

My mother once told me about a tea she had gone to at the home of my father's commanding officer. The commanding officer's wife was, like the women she had invited to tea, married to a pilot. Part of her role was to talk to the young wives about everything from matters of etiquette (such as how to give a proper dinner party) to participation in base activities. But after discussing these issues for a while, she turned to the real topic at hand. "Pilots," she said, "should never be angry or upset when they fly." Being angry could lead to a lapsed judgment or concentration. Flying accidents might occur. Pilots could be killed. Pilots' wives therefore should never have any kind of argument with their husbands before the men left to fly. Composure and self-restraint were not only desirable characteristics in a woman; they were essential to life itself. As my mother put it later, it was bad enough having to worry yourself sick every time your husband went up in a God-forsaken jet, but now she was being told she was also supposed to feel responsible if his plane crashed. Anger and discontent, lest they kill, were to be kept to oneself.

The military, even more so than the rest of society, clearly put a premium on well behaved, genteel, and even-tempered women.

Had you told me, in those seemingly uncomplicated days of white gloves and broad brimmed hats, that within two years of my early adolescence I would be psychotic and want only to die, I would have laughed, wondered, and moved on. But mostly I would have laughed, because it would have been inconceivable to me. But life doesn't work out as one plans, and it changed precipitously when I was about 16 years old. In my senior year of high school, I was very high for a while, and exhausting everyone around me, but I didn't see anything wrong with that. No one does, when they're high. It's very hard to convince people when they're "hypomanic" that they're ill, because they feel better than they have ever felt in their life. But as Robert Lowell once said, "Mania is an illness for one's friends, and depression is an illness for oneself."

I became suicidally, psychotically depressed when I was a senior in high school. I had no idea where it came from. I had no idea what it meant. Every morning, I would wake up with great enthusiasm, couldn't wait for the day to start. All of a sudden, all I wanted to do was sleep. I was thinking about suicide nonstop. I learned how to load my father's gun. I learned every conceivable way of dying. It was simply dreadful. By the time I'd graduated from high school, however, I had recovered. I went on to college and graduate school, and it was essentially a roller coaster ride: periods of great fun, great activity, and then just terrible, terrible depressions. There were no words for it then. Or the words existed, but I certainly was not familiar with them. I didn't get treatment. I was reluctant to get treatment. Part of military WASP upbringing is that you handle it yourself. And in my father's case (who had the same disease I did, and it is completely rampant in my father's family), he knew that his rating as a pilot would be affected, so he never got treatment.

However, when I joined the faculty at UCLA as a young assistant professor, within three months I was psychotically manic. I was hallucinating, delusional, and I had no choice. And one of the great things about becoming psychotically manic is that actually you haven't any choice but to be brought into the healthcare system because it's a medical emergency. So I was. I was put on lithium. I responded very well to it. And like 50% of the people who have this illness, who are

prescribed medication, I stopped taking it. This was to become an ongoing theme in my life, and an ongoing theme in my research, a reluctance to take medication. As I'm always saying to my colleagues and to the medical students and residents, it doesn't do you any good to have great medications if people don't take them, because not taking a medication is equivalent to having an ineffective medication. It's not a very [important] research field, and medicine has placed far too little priority on figuring out why people don't take medicines.

In one of my many illnesses and recurrences of illnesses, I tried to kill myself. And I'll get into that in a bit. And one of the things I'd like to point out is, these illnesses kill. These are not benign illnesses. These are not illnesses that just cause pain. They kill people. And they kill people young. And they affect people young. The average age of onset for bipolar illness is about 18 years old, 17 years old. So you're given a life sentence of a very bad disease with a possible death sentence attached to that.

I and two of my colleagues started a clinic at UCLA to study and treat mood disorders. And at that time I was anonymous about my illness, for reasons that anybody who has clinical privileges will appreciate. And I used to write anonymous quotes, because it was clear that the residents in the clinic and the psychology interns had some sense of what depression was about, but not a whole lot of sense of what mania was like. So I wrote a couple of passages, and I limited each of the passages to about two paragraphs because I assumed that was the limit of the trainees' attention span, which turned out to be a generous overestimate. [laughter] The first one is a general overview of manic depressive illness, my own perspective, which I labeled "the [modern] patient with manic depressive illness." And the second is a description of some of the less than altogether delightful aspects of taking lithium. So let me just start with a general description of what at least one person's experience of having this illness felt like.

There is a particular kind of pain, elation, loneliness, and terror involved in this kind of madness. When you're high, it's tremendous. The ideas and feelings are fast and frequent like shooting stars, and you follow them until you find better and brighter ones. Shyness goes. The right words and gestures are suddenly there. The power to captivate others, a felt certainty. There are interests found in uninteresting people. Feelings of ease, intensity, power, wellbeing,

financial omnipotence, and euphoria pervade one's marrow. But somewhere this changes. The fast ideas are far too fast, and there are far too many. Overwhelming confusion replaces clarity. Memory goes. Humor and absorption on friends' faces are replaced by fear and concern. Everything previously moving with the grain is now against. You are irritable, angry, frightened, uncontrollable, and enmeshed totally in the blackest caves of the mind. You never knew those caves were there. It will never end, for madness carves its own reality. It goes on and on, and finally there are only others' recollections of your behavior, your bizarre, frenetic, aimless behavior, for mania has at least some grace in partially obliterating memory. What then, after all the medications, the psychiatrists, the despair, the depression, and the nearly lethal overdose? All those incredible feelings to sort through. Who is being too polite to say what? Who knows what? What did I do? Why? And most hauntingly: When will it happen again? Then too are the bitter reminders, medicine to take, resent, forget, take, resent, and forget, but always to take. Credit cards revoked, bounced checks to cover, explanations due at work, apologies to make, friendships gone or drained, a ruined marriage. And always: When will it happen again? Which of my feelings are real? Which of the me's is me? The wild, impulsive, chaotic, energetic and crazy one? Or the shy, withdrawn, desperate, suicidal, doomed, and tired one? Probably a bit of both. Hopefully much that is neither. Virginia Woolf and her dives and climbs said it all. "How far do our feelings take their colour from the dive underground? I mean, what is the reality of any feeling?"

I wrote as well about the difficulties in taking medication, because it is the central clinical problem. The problem is not that we don't have good medications. This is a very treatable illness, as is depression. It's that so many people will not take the medication. Many of the young doctors and clinical psychology interns found it simply incomprehensible and infuriating that patients would stop taking drugs that so clearly worked for them, [under] suffering such devastating illnesses. So I wrote a little blurb called "Rules for the Gracious Acceptance of Lithium into Your Life:"

1. Clear out the medicine cabinet before guests arrive for dinner, or new lovers stay the night.
2. Remember to put the lithium back into the cabinet the next day.

3. Don't be too embarrassed by your lack of coordination or your inability to do well the sports you once did with such ease.
4. Learn to laugh about spilling coffee, having a palsied signature, and being unable to put on your cufflinks in less than ten minutes.
5. Smile when other people joke about how they "need to be on lithium." (This is an occupational hazard of teaching in academic psychiatry departments, is that your colleagues, if they just happen to be a little bit buzzy one day, or a little bit energetic, will say, "Gee, maybe I need to be on lithium." If you're actually taking lithium, it's irritating. [laughter])
6. Nod intelligently and with conviction when your physician explains to you the many advantages of lithium in leveling out the chaos in your life.
7. Be patient when waiting for this leveling out. Very patient. Reread the Book of Job. Continue being patient. Contemplate the similarity between the phrases "being patient" and "being a patient."
8. Try not to let the fact that you can't read without effort annoy you. Be philosophical. Even if you could read, you probably wouldn't remember most of it anyway.
9. Accommodate to a certain lack of enthusiasm and bounce that you once had. Try not to think about all those wild nights you once had. It's probably best not to have had those nights anyway. (That's absolutely not true. I put that in for my husband's sake. [laughter])
10. Always keep in perspective how much better you are. Everyone else certainly points it out often enough. And annoyingly enough, it's probably true.
11. Be appreciative. Don't even consider stopping your lithium.
12. When you do stop, get manic, get depressed, expect to hear two basic themes from your family, friends, and healers. "But you were doing so much better. I just don't understand it." "I told you this would happen."
13. Restock your medicine cabinet.

Manic depression is complicated. It laces together loss with advantage, and it places despair in close proximity to great pleasure. It is difficult to convey how powerful the allure can be. And indeed I am convinced, at a fundamental biological level, it is completely, utterly

addictive. Let me describe the beginning of one manic episode. This is a trip I took to Saturn, unaccompanied by spacecraft.

People go mad in idiosyncratic ways. Perhaps it was not surprising, as a meteorologist's daughter, that I found myself in that glorious illusion of high summer days, gliding, flying, now and again lurching through cloud banks and ethers, past stars and across fields of ice crystals. Even now I can see in my mind's rather peculiar eye an extraordinary shattering and shifting of light, inconstant and ravishing colors laid out across miles of circling rings, and the almost imperceptible, somehow surprisingly pallid moons of this wheel of a planet. I saw and experienced that which had been only dreams, or fitful fragments of aspiration. Was it real? Of course not. Not in any meaningful sense of the word "real." But did it stay with me? Absolutely. Long after my psychosis cleared and the medications took hold, it became part of what one remembers forever, surrounded by an almost Proustian melancholy. Long since that extended voyage of my mind and soul, Saturn and its icy rings took on an extraordinary beauty. And I don't see Saturn's image now without feeling an acute sadness in it's being so far away from me, so unobtainable in so many ways. The intensity, glory, and absolute assuredness of my mind's flight made it very difficult for me to believe, once I was better, that the illness was one I should willingly give up. Even though I was a clinician and a scientist, and even though I could read the research literature, and indeed wrote some of it, and see the inevitable bleak consequences of not taking lithium, I, for many years after my initial diagnosis, was reluctant to take my medications as prescribed. Why was I so unwilling?

(I must say, as I was writing the manuscript for my book, *An Unquiet Mind*, my husband, who was a great supporter of my doing it, an incredible supporter of my doing it, said, "Well, it's very straightforward why you were unwilling to take your medications." He said, "You're not only incredibly stubborn. You're also stupid." [laughter] But I think it was more complicated than that. A lot of it's based on denial. A lot of it is missing the highs. A lot of it is side effects. It's a very complicated sort of thing. It's not straightforward at all.)

I reaped a bitter harvest from my own refusal to take lithium on a consistent basis. A floridly psychotic mania was followed inevitably by a long and lacerating black, suicidal

depression. It lasted more than a year and a half. From the time I woke up in the morning until the time I went to bed at night, I was insufferably miserable and seeming incapable of any kind of joy or enthusiasm. Every thing, every thought, every word, every movement was an effort. Everything that was once sparkling was now flat. I seemed to myself to be dumb, boring, inadequate, thick brained, unlit, unresponsive, chilled skinned, bloodless and sparrow drab. "What is the point in going on like this?" I would ask myself. Over and over and over I would say, "If I can't feel, if I can't move, if I can't think, and if I can't care, then what conceivable point is there in living? The morbidity of my mind was astonishing. My psychiatrist repeatedly tried to persuade me to go into a psychiatric hospital, but I refused. I was horrified at the idea of being locked up and being away from familiar surroundings. I was horrified at the idea of having to attend group therapy meetings, which I found demeaning, and having to put up with all the indignities and invasions of privacy that I knew went into being on a psychiatric ward. I was working on a locked ward at the time, and I didn't relish the idea of not having the key. Mostly, however, I was concerned that if it became public knowledge that I had been hospitalized, my clinical work and privileges would at best be suspended. At worst, and much more likely, they would be revoked on a permanent basis. At the time, nothing seemed to be working, despite excellent medical care, and I simply wanted to die and be done with it. I resolved to kill myself. I was cold-bloodedly determined not to give any indication of my plans or the state of my mind, and I was successful. The only note made by my psychiatrist on the day before I attempted suicide was, "Severely depressed. Very quiet."

I was in a coma for several days, and nearly died. As a result, I no longer fight taking lithium. Repeated psychosis and a nearly lethal attempt have a way of convincing even the slowest of learners. And I am fortunate to have been able to take some of my own experiences into my teaching and writing. I am also enormously fortunate to have had the support of the chairman of my department when I was at UCLA, who was magnificent, and more recently the chairman of psychiatry and the president of the hospital at Johns Hopkins. Each encouraged me to learn, write, and teach from my own experiences. No one suggested for a moment that I give up. No one ever suggested I couldn't go back and compete. I am not so naive as to think this is usual.

I know it's not. I've lectured at most of the major medical schools in the country, and I know that residents and interns and medical students routinely get thrown out of their programs for mental illness. I know that graduate students get thrown out for their illnesses. But it is exemplary, and it is from the exemplary that one learns, instead of always finding problems, because there's no shortage of problems. I think one has to look to the exemplary and standards. And I speak today because of their compassion.

With the very strong encouragement of my late husband, Dr. Richard Wyatt, who was a schizophrenia researcher, and who saw the stigma of mental illness first-hand every day in his research and in his teaching and in his clinical practice, I decided to write a book about my illness, because both of us felt very strongly that the problem was that professionals didn't talk about their treatment, they didn't talk about being on antidepressants, didn't talk about being on mood stabilizers, didn't talk about being on antipsychotics. So what the public sees basically is untreated mental illness. And they don't see all the people that are doing your legal work for you, your teaching, your medical work. And so people have a very skewed view of how treatable these illnesses really are.

I found that far and away the most difficult things to write about were suicide and the violence of mania. Both of these experiences had taken me a very long way from the beliefs of my childhood, and my expectations in particular of being a woman. After my suicide attempt, I had had to reconcile my image of myself as a young girl who'd been filled with enthusiasm, high hopes, great expectations, enormous energy, and dreams and love of life, with that of a dreary, crabbed, pained woman who desperately wished only for death, and took a lethal dose of medication in order to accomplish it.

After each of my violent psychotic episodes, I had to try and reconcile my notion of myself as a reasonably quiet-spoken and highly disciplined person, as someone who's at least generally sensitive to the moods and feelings of other people, I had to reconcile that with an enraged, utterly insane woman who lost all access to all control or reason. These discrepancies between what one is, what one is brought up to believe is the right way of behaving towards others, and what actually happens during these awful black manias, are absolute and disturbing

beyond description, particularly, I think, for women brought up in highly conservative and traditional worlds. They seem to me a very long way from my mother's grace and her gentleness, and farther still from the quiet seasons of cotillions, taffetas, and silks, and elegant gloves that slid up over the elbows and had pearl buttons at the wrist. For the most important and shaping years of my life, I'd been brought up in a straight-laced world, taught to be thoughtful of others, circumspect and restrained in my actions. We went as a family to church every Sunday. And all of my answers to all of the adults in my life ended with a "ma'am" or "sir." (And I have to say, it's only when we moved to California when I was in high school, and I said "ma'am" and "sir" in the classroom situation, and the entire classroom looked at me as if I had just stepped off of Mars or something, that I realized not everybody said "ma'am" and "sir" all their lives.)

The independence encouraged by my parents, which was a real one, had been an intellectual independence. It had not been of a socially disruptive nature. Suddenly I was unpredictably and uncontrollably irrational and destructive. This was not something that could be overcome by protocol or etiquette. God conspicuously was nowhere to be found. Navy cotillion, candy striping, and Tiffany's table manners for teenagers could not, nor were they ever intended to be any preparation or match for madness. Uncontrollable anger and violence are dreadfully, irreconcilably far from a civilized and predictable world. I had, ever since I could remember, inclined in the direction of strong and exuberant feelings, loving and living with what Delmore Schwartz has called the "throat of exultation."

Inflammability, however, always lay just the other side of exhilaration. These fiery moods were at least initially not all bad. In addition to giving a certain romantic tumultuousness to my personal life, they had over the years added a great deal that was positive to my professional life. Surely they had ignited and propelled much of my writing, research, and advocacy work. They had driven me absolutely and completely and utterly to try and make a difference. They had made me impatient with life as it is, and made me restless for far more. But always there was a lingering discomfort when the impatience or ardor or restlessness tipped over into too much anger. It did not seem consistent with being the kind of gentle, well bred woman I had been brought up to admire, and indeed I continued to admire.

Depression somehow is much more in line with society's notions of what women are all about: passive, sensitive, hopeless, helpless, stricken, dependent, confused, rather tiresome, and with limited aspirations. Manic states, on the other hand, seem to me more the provenance of men: restless, fiery, aggressive, volatile, energetic, risk-taking, grandiose, and impatient with the status quo. Anger or irritability in men under such circumstances is more tolerated and understandable. Leaders or takers of voyages are permitted a wider latitude for being temperamental.

Journalists and other writers quite understandably have tended to focus on women and depression, rather than women and mania. This is not surprising. Depression is twice as common in women as in men. But manic depression occurs equally often in women and men. And being a relatively common condition, mania ends up affecting a large number of women. They in turn often are misdiagnosed, receive poor if any psychiatric treatment, have no access to treatment (because of course this country makes no pretense at parity), and they're at a high risk for suicide, alcoholism, drug abuse, and violence. But they, like men who have manic depression, also contribute a great deal of energy, fire, enthusiasm, and imagination to the people and world around them.

Manic depression is a disease that both kills and gives life. Fire, by its nature, both creates and destroys. "The force that through the green fuse drives the flower," wrote Dylan Thomas, "drives my green age; that blasts the roots of trees is my destroyer." Mania is a strange and driving force. It is a destroyer. It is a fire in the blood. Thank you. [applause]

QUESTIONS FOR DR. JAMISON

JL: We can take a few questions before the first panel.

Q: Thank you for your very moving talk that you just gave. It was really, really wonderful. I did have a question that I wanted to ask, which is what you think about the current focus on young children and adolescents having this disorder.

A: Right. It's an interesting issue. I think, like depression, for many, many years it was assumed that children didn't get depression and that children didn't get bipolar illness. Now in fact, if you look back, one of the nice things about bipolar illness or manic depression is that it's actually been studied since the Greeks. It was very clearly laid out more than 2,000 years ago. It's been known for centuries and centuries that it in fact did hit children. Unusually, but did. Emil Kraepelin, who's the premier psychopathologist on bipolar illness in the 19th century, described children and so forth.

Recently, it's kind of gone from not seeing to seeing it perhaps everywhere. And there's been criticism for that. I think you can say that that's due to a lot of things. One is, it does have an early age of onset. Seventeen or 18 is the average. That means that a lot of people are going to get hit younger in order to make that average, obviously from a statistical point of view. There's some question that we might be triggering this illness at a younger age, because there are some overlapping symptoms with ADHD. If you diagnose a child who in fact has bipolar illness and is having ADHD, and you give them stimulants, we'd have to say this is not generally the treatment of choice for people with mania. And so the question is that perhaps this child would have become full-blown manic at the age of 16-17. Now all of a sudden that age has been precipitously lowered.

We also know that there are several environmental things that can trigger an early manic episode, or manic episode of any kind: sleep deprivation, drug and alcohol use. We know that the average age of using alcohol and drugs has gone down. So if you're going to precipitate an episode earlier, that might be part of it. Also sleep deprivation is a very real problem. There's just no question, kids probably aren't getting the kind of sleep that they need. So those might be some of the environmental factors.

And another thing is, certainly the drug companies have had a very large incentive to educate young doctors who are going to be prescribing medications to treat these illnesses earlier. And I think there's some aspect of that, that's been fairly irresponsible. There's a lot of it that's been very good, because a lot of doctors have much more of an idea of bipolar illness now than they did five or ten years ago.

I'm a psychologist. One of my great hopes is that, in fact— Maybe 20 years ago, psychologists weren't studying this illness very much at all. And now it's a very productive field of research and clinical training. And there's a lot of evidence that psychotherapy, for example, is very helpful in this illness. And it may be with young kids. There are just a lot of things that go on.

I think still, if you look at it from a public health point of view, bipolar illness is still under-diagnosed in children, but there's a tendency in some pockets to over-diagnose it. So it's complicated.

Q: I'm sorry, I'm a little tongue-tied here. It's not so much that I have a question. I just want to let you know that you are looking at a success story. Like you, I had bipolar illness. I still have it. I'm on medication now. I have been through two nervous breakdowns. I've been hospitalized twice. I've been in crisis. And I still have memories of that little girl going to school, looking out the bus window, staring blankly into space, so miserable that she didn't know what to do with herself, and she didn't understand what was going on. As I said, I am presently in recovery. I'm doing very well. And when I thought I would not be able to go back into the working world, because I could not keep a job, no one understood me, I am now about to return to the working world. I will be working for an agency who understands what I have been through, and have decided to use that to teach other people to recover as well. I am also a certified peer advocate.

A: Wonderful. Good luck. [applause]

Q: Hi, Kay. I suffer bipolar manic depression, myself. And I have a 16-year-old daughter. Do you have children?

A: No.

Q: My father had it too, and he took his life when he was 30. Do you think my daughter will definitely have it? Or do you think it would skip a generation?

A: Let me give you a general answer, because obviously I don't know the particulars. Bipolar illness is far and away the most genetic illness in psychiatry. It is a very, very genetic illness. However, having said that, the odds are still that an individual child will not inherit the parent's disease. The working statistics used to be—they're very iffy—but if one parent has bipolar illness, that a child would have a 15% chance of getting bipolar illness. If it came from both sides of the family (which is not uncommon because like temperaments often marry), if you had it coming from both sides, it went up to 75%. These are very general statistics, because we know that there are a lot of genes involved in bipolar illness. We know that it's a collection of illnesses. It's not a single illness.

But I want to emphasize one thing in particular. Yes, it's genetic. But yes, it's very treatable. Today's generation is not the same. If I looked around at my father's generation (and his uncle spent his life in an insane asylum; his mother had the illness; his sister and brother had the illness; half of my first cousins have been hospitalized for mania; you know, everywhere you look), it's not the same sort of thing now, because it is treatable. And at an age when a child is going to become ill now, the research is going so rapidly. Neuroscience is an extraordinary field. The good side of drug companies having a big financial incentive because this is a common illness, is that they have a big incentive to come up with really good treatments and really good diagnostic procedures. And so I'm completely boffo. . . I'm very optimistic about this. It's not to take away from how terrifying it can be, and to be concerned about a child, because I know that. On the other hand, people do recover, do get well. And it's very different if you're aware of the possibility the child's going to have it.

My concern actually, and an ongoing major advocacy concern, is that parents who have these illnesses in their families send their kids off to college without ever talking about it with their kids. And they don't talk about the fact that there's suicide in the family, or

alcoholism in the family, or depression or bipolar illness in the family. And they send kids off to college at the age of highest risk for onset, and to the things that we know are likely to trigger mania. Kids, when they go to college, invert like hamsters on their sleep cycles. And when you disrupt the sleep cycle, for somebody with the genetic predisposition for bipolar illness, it is devastating. Sleep biology is very, very important. And likewise they start drinking and using drugs more. As a matter of fact, I was just meeting yesterday with some people from Harvard, and Harvard and Hopkins are hoping to put together some general guidelines for parents before they send their kids off to college, about discussing these things and getting educated themselves, because it's a real chance to do some prevention, or at least warning.

So the odds are, it won't happen to your child. Certainly suicide is much more preventable than it used to be.

Q: [inaudible] . . . so much with this illness. I'm 35 now and I finally accept it. And I take my medication, and I will never stop now, because I've been through so much. It's really a devastating illness. It took my father's life. He was 30.

JEFFREY LEWIS

One of the great things about this conference are the people who actually participate as well as those who come together to lead panels and talk on panels. And we are gifted today to have someone come back for a second time. Dr. Mallika Marshall is a Health Watch reporter for WBZ 4 News. She is the only practicing physician/television medical reporter in New England. In addition to other reporting duties in Boston, she is a regular contributor to CBS Early Morning show and CBS Newspath. There is information in the folder about her, and she is simply an amazing individual. Dr. Marshall. [applause]

MALLIKA MARSHALL, M.D.

Thank you. Thank you so much for having me back again this year. Last year was amazing. There must have been 1,000–1,100 people last year. Now I understand there are more than 2,000 participants this year. [applause] You know, I do a lot of events, I give a lot of speeches, and I have never seen so many faces in an audience before. So that's wonderful. Let me invite the panelists to come on up.

While Kay Jamison was talking, when she was mentioning what it was like to be the wife of a pilot 20, 30, 40 years ago, it reminded me how much in this day and age we are just beginning to realize how important it is that we can't take care of our spouses and our mothers and our children at the expense of ourselves. And it reminds me of a story, and I may have told this story last year, so if you heard it last year, I apologize. But a woman accompanied her husband to the doctor's office, and the doctor said, "Ma'am, can I talk to you privately?" And she said, "What's wrong?" And he said, "Well, your husband is gravely ill." And she said, "Oh my goodness. What's wrong?" And he said, "Well, I'm not sure he's going to make it, but there are some things you can try to do at home to give him the best chance." And she said, "Doctor, anything. What can I do." So he said, "Well, you can't nag him. You can't annoy him. You can't yell and scream at him. Do your best to provide three hot, home-cooked meals a day. You should have sex with him every night. And if you do these things, then your husband may live." She said, "Thank you, doctor." So the husband and wife were driving in the car home. The husband said, "Honey, what did the doctor say?" And she said, "He said you're going to die." [laughter] That is a woman who very quickly learned the lesson that you can't sacrifice yourself for the well-being of others.

Well, I think we have a wonderful panel in store for you this morning. I actually was sitting with two of them at the table before the conference began, and I couldn't get them to stop talking to each other and bantering back and forth, and talking about all these wonderful things that I wanted to come out during the panel. So I'm hoping that they're going to reiterate some of those things, and I might have to ask them about them again. But we're going to take a close look at the relationship between our environment and women's mental health. And joining me up here are four incredibly interesting and accomplished mental health experts. And even though they have a

wide range of backgrounds, each and every one of them is committed to improving the state of mental health among women here in this country.

So this is how this morning's panel is going to work. I'm going to introduce each speaker, and he or she will speak briefly, for about 5 to 10 minutes. And if you go to 11, 12, 13 minutes, I'm going to tap you on the shoulder. And they're going to speak on their particular areas of expertise and interest and how it pertains to this morning's theme. Now, while our speakers are making their presentations, we encourage you to write down any questions that you may have on note cards that are actually available at your table. You should have some pens there as well. If you want to address your question to a particular panelist, please say so on the card. If you want to include your name, I will do my best to pronounce it correctly. And again, make sure it's a brief, concise, and very clearly written question, because I'm the one up here who's going to have to try to read them. Volunteers will be passing through, picking up the note cards. You don't have to get up and take it anywhere. And after we've heard from each of our panelists, I'll begin asking your questions. And I promise we'll get to as many questions as possible, but we are going to end this panel promptly at 12:15. We've been given another half hour. So instead of 11:45, we're going to end at 12:15, because I don't want to eat into the rest of today's program.

Our first speaker is Dr. Margaret Spinelli, who's a trained psychiatrist. She's an Assistant Professor of Clinical Psychiatry at Columbia University, and Director of the Maternal Mental Health Program and Premenstrual Assessment Unit at the New York State Psychiatric Institute. She graduated from Cornell University Medical College, where she also completed her psychiatry residency. She then completed a postgraduate fellowship at Columbia University, focusing on mood disorders in women. Interestingly, prior to her career as a psychiatrist, Dr. Spinelli spent 15 years in nursing, and recognized that health services for women were lacking psychiatric interventions. And so she decided to change that. In addition to managing a private practice in Manhattan, Dr. Spinelli continues to perform research on depression around pregnancy. Dr. Spinelli. [applause]

MARGARET G. SPINELLI, M.D.

Thank you for that introduction. I'd like to thank Mrs. Heinz and the Foundation for inviting me here. It's truly an honor to be before all of you and to be with such a distinguished faculty as well.

A quick history. In the 19th century, the uterus was considered the seat of hysteria. "Involutional melancholia" was the name given to depression after menopause. It signaled the sadness of a dried up uterus. In the 20th century, women reclaimed their bodies. We were equal in all things. We would not be at the mercy of hormones. Empty nest became a thing of the past. In fact, we rejoiced and admitted that life was good, even if the children left home. And we didn't ovulate. And sex was better. Menstruation would no longer be a curse. Premenstrual syndrome was nonsense. We were not frail. But something continued to be wrong. The depressed postpartum mothers continued to suffer. And their physicians would frequently say, "You only have the blues." And those women and their infants would frequently go on to suffer for quite a long time.

But today, I'm here to tell you that we're not equal in all things, and that's good news. And we also have treatments. Here in the 21st century, science and epidemiology have demonstrated that mood disorders are twice as prevalent in women compared to men. So, for example, depression is the same in boys and girls until puberty. And then the ratio becomes again 2 to 1, girls to boys. Women are more vulnerable to mood changes throughout the reproductive life cycles, at particular times of the female cycle, when there are rapid fluctuations in hormones, such as the premenstrum, postpartum in childbearing period, and perimenopause. The fact is, our brains are connected to our reproductive system. Put simply, you might say that our hormones and brain chemicals continue to have a dialogue back and forth. Each regulates the other through a cascade of chemicals that goes from the brain to our pituitary to our ovaries and back again. Science has demonstrated that changes in brain chemicals are the underlying factors in mood disorders. So that serotonin, we understand, and a dysregulation of those chemicals, are the underlying factors in depression, for example. Dopamine, which is another neurochemical, is the

culprit in psychosis. And so our hormones will actually affect how those neurochemicals are synthesized or broken down or regulated in the brain.

The postpartum period, for example, is a time of peak prevalence for psychiatric disorders in women. If a woman is going to have a psychiatric illness in her lifetime, it will be in the immediate postpartum period, within the first three months. The reason, for example, to demonstrate, is that during pregnancy hormones can go up as much as 200-fold. And within 24 hours, a woman is depleted of all those hormones through the placenta and through the childbirth process. And so for women who are particularly vulnerable, or have a vulnerable brain due to perhaps the history of their own psychiatric illness or family, they are more vulnerable to psychiatric illness.

Seventy-five percent of women will complain about premenstrual symptoms, but 3 to 8 percent will have mood symptoms significant enough to interfere with functioning. There's an increase in suicidality in the premenstrum. Women with mood disorders become worse, frequently. There's an increase in admissions to psychiatric hospitals. And these women will go on frequently to have major depression in their lifetime.

A woman who does not receive treatment, who is 26 years of age with premenstrual mood disorder, will have more than 200 symptomatic cycles, or 1,400 to 2,800 symptomatic days, before menopause. The Massachusetts Women's Health Study of more than 25 women found that, in fact, depression is not greater in postmenopausal women. However, it is greater in perimenopausal women (that is, the period around menopause), because again there are rapid shifts in reproductive hormones. Similarly, for surgical menopause. There's a tremendous shift, an abrupt decrease in the hormone as well.

Women are expected still to have a glow and to feel particularly happy during pregnancy. It puts a lot of pressure on a woman to have that kind of happiness. But in fact, 10 to 13 percent of women will have a depression during pregnancy. And it's actually twice as prevalent in impoverished women or women with negative life events or difficulties. The problem is, these women have infants who tend to have lower birth weight. They can't necessarily attend to their prenatal care. They may not eat, might not sleep very well. And also, this is one of the best

predictors of a postpartum depression. Fifty percent of women with an antepartum depression will go on to have a postpartum depression. So think of it. Pregnant women are our most available population in health care. How do we possibly miss the signs of mood disorders in such a great time for prevention? Because you're preventing postpartum depression and preventing illness in parents of children who are then at risk.

Think about postpartum depression. It's a major public health problem. It's probably the most common adverse advent of childbirth, but we don't really put much emphasis on it. Ten to 20 percent of women will have a postpartum depression. Particularly if they've had previous mood disorders or bipolar disorder, that prevalence goes up 5 times. So these women are particularly sensitive. It affects bonding. Think about any mom, anyone who's depressed. They can't really attend to the infant's cues. That infant counts on mom to interact, but mom can't interact. Mom doesn't feel close to the infant. And actually, studies have shown that children of mother's with depression go on to be more irritable, more withdrawn, and tend to have more language or intelligence—lapses in intelligence as well.

Postpartum psychosis is rare. It occurs in only 1 to 2 women per thousand. It is, unless proven otherwise, a first bipolar episode. It's a psychiatric emergency. These women lose contact with reality. They can become delusional. These women must be hospitalized, and unfortunately must be separated from their babies.

The nation was riveted in June 2001, when Andrea Yates killed her five children in the bathtub of her Houston, Texas, home. Thirty-six year old woman, registered nurse, valedictorian, and loving mother. She is now serving a life sentence in jail. But in fact, is she really to blame, or are we to blame? My feeling is that we in society are to blame. Think about what went wrong. Andrea Yates had a history of both personal and family psychiatric illness—red flag. Family denial: She was in bed every day, in a catatonic state, staring and pulling out her hair to show the sign of Satan in her bald spot, which was 666. Partner support: She and her husband belonged to a fundamentalist religion, and they wanted many children. They lived in a Greyhound bus with four of their children. Isolation: She home-schooled her children. She had six pregnancies, five children, in seven years, and was lactating in between. What about education for this couple?

Postpartum psychosis is preventable. If a mom has had a postpartum psychosis or a postpartum depression, simply treating them just prior to that delivery can prevent an onset or a recurrence of that illness. Medical management: Unclear, but it seems that her psychiatrist discontinued her antipsychotic two weeks prior to this tragedy. What about public education? How many really know about postpartum disorders? The pressure is really on at that time for a woman to be happy. The social stigma of psychiatric illness, mental illness, is even greater at that point than any other time in their lives. And what about our judicial system—and psychiatry? We're using 21st century neuroscience in insanity laws that depended on cases going back to 1843.

And so actually a female columnist (which was particularly distressing to me) wrote, "The hands that rocked the cradle must bear the blame." But I would respond differently. I would say that we really have to reach past our rage. We have to stretch the limits of compassion to understand these mothers, to enter the minds of women who kill, because unless we do, other women—and they—will continue to suffer. And it all begins right back there, with the reproductive system. And the Andrea Yates case of course is an unusual case, but they occur. They occur and you don't hear about them.

And I use it particularly to bring this message home: that these illnesses can be identified so early, and they can be prevented early. And education is easy. And I think until we dedicate ourselves as women and men to the education, recognition, treatment, and prevention, vulnerable women will continue to suffer. Thank you very much. [applause]

MALLIKA MARSHALL, M.D.

Thank you, Dr. Spinelli. Our next speaker is Dr. Quentin Regestein. He's also a psychiatrist, at Brigham & Women's Hospital here in Boston. He specializes in treating sleep, fatigue, and attention disorders. He has studied the mind-body connection in a wide range of fields, including cardiology, endocrinology, gynecology, psychiatry, sleep disorders, and psychopharmacology. He's been a study reviewer for the National Institutes of Health and a member of the Advisory Committee on Sleep Disorders. He's currently a member of the medical

advisory board of the Narcolepsy Network, a patients' advisory association, and the editorial board of the journal *Menopause*. He has published 26 textbook chapters and two books on sleep disorders, and has lectured throughout the United States and Europe. Dr. Regestein. [applause]

QUENTIN R. REGESTEIN, M.D.

Thank you. As I take my place on the panel and I look around the room, I now know truly what it's like to be in a minority.

I [could] say a few things about menopause. My colleagues and I are interested in the feelings and actions of women who have already been through the menopause transition. We study their awareness of the world, their decision-making capabilities, their moods, sleep, and hot flashes and night sweats and hormones. But rather than discuss these presently, I thought I'd give a general perspective about menopause to inform the wider discussion that will happen among us all, I guess, in a few minutes, and not just the areas I'm interested in. So I'll just give a few general headlines.

First, menopause is a biological phenomenon. It's a state in which women no longer reproduce, but the original purpose of which was to help human reproduction. It evolved in our earliest ancestors, the original human beings, out on the African savanna, where there are no grocery stores, supermarket, no farms. And for them it was a full-time job just to find enough to eat. Under these circumstances of scarcity and privation, pregnancy and breastfeeding were enormous personal expenses for a woman, because she had to find more of this scarce food. A lot of women, regrettably, and their babies do not make it through the precarious human birth process. And therefore coming out with a live human baby is to come out with a very precious person, but a person who's very immature, totally dependent, completely helpless. And it takes a ton of resources to grow this child up to independent maturity, where they themselves can have their own children and raise a family and propagate the human race. Menopause meant that a mother would not die before her child reached independent maturity. It also meant there would be grandmothers around to add to this vast quantity of resources needed to have a child grow up.

The second headline: Menopause is a cultural fact, and it varies hugely around the globe. In the Far East (China, Thailand), menopausal symptoms are hardly acknowledged. Now zip around to America, where menopause has secured a very firm niche on the cultural radar screen. At present, there is a musical comedy on Broadway, the title of which is "Menopause." Now, the culture doesn't shape attitudes and symptoms. What I want to try and convey is, hard biological endpoints of menopause are determined by the culture, for instance, osteoporosis. About one woman per thousand in this country suffers a fracture from brittle bones. A broken hip can be very serious. Collapsed vertebrae impairs breathing. This prevalence is twice that of men. It's 40 percent higher than English women. English women live in a country whose latitudes are wholly north of the United States. That means they get less sunlight, which means they synthesize less vitamin D, absorb less dietary calcium, and should have weaker bones. No. They have fewer fractures. Why? Well, bones need more than sunlight. Like any biological system, they need stress and strain and challenge. We are the most sedentary people who walk. And this perhaps accounts for it, especially. Now zip down to Africa. Consider the Bantu women. Bantu women have one-ninth the osteoporosis prevalence of American women. Furthermore, Bantu women have less osteoporosis than Bantu men. This shows not only that Bantu women work very hard; it also shows that culture shapes the endpoints of menopause.

Now, these hormone changes that Dr. Spinelli mentioned affect the nervous system as well as the reproductive system, as she said. That means that they affect how women think and feel and act. That is the third headline: Menopause is a psychological fact. My colleagues and I find that those who take estrogen replacement treatments actually perform better on tests of cognition, such things as one needs to define the world and come out with a gratifying response to it. That means vigilance (the readiness to receive new information), attention (the capacity to select the right information out of the complex perceptual continuum around you, and stick to the task without daydreaming, without getting distracted; if you have to be interrupted, getting back on the task and completing it). These are helped by estrogen. Remarkably, unexpectedly, women who are taking estrogens that come from plants, phytoestrogens, do substantially better on these than women who take hormones that come from animal sources, or animal-like. Such plant hormones

also improve the mood of women very much. Now, testosterone does not improve mood. It improves information processing tasks.

Well, these are research averages. These are bald generalizations. These have no meaning outside the specific life of an individual woman. I think that's very important, because women look at the headlines, they read an article, say, "Oh my God, what's wrong with me? I should take this stuff. And when I take it, I feel miserable." We give hormones to some people and they do worse, they feel worse, because there are lots of exceptions. I wish the press would have talked about the exceptions, and the magnitudes of the effects that they recently reported about hormone replacement treatment, because what I'm telling you—I think that's the most basic headline, that any finding is really contingent on the specific life of an individual woman. So that's the most basic headline, that menopause is an individual matter. So there, I think, is the context: that menopause is a biological phenomenon designed to help human reproduction; it's culturally transformed and determined; it's a psychological phenomenon; but in the end, it's an individual matter. [applause]

MALLIKA MARSHALL, M.D.

You're a man, but you know a lot about menopause. [laughter] Thank you, Dr. Regestein. Our next speaker is Dr. Charlotte Brown, who's an Assistant Professor of Psychiatry and the Director of the Health and Behavior Studies Program at the University of Pittsburgh School of Medicine. She received her Master of Science degree from Howard University, and her Ph.D. from American University, both in Washington, D.C. Dr. Brown completed her clinical training at McLean Hospital, Harvard Medical School, and she did her postdoctoral training at the Western Psychiatric Institute and Clinic. Her research and clinical interests include psychosocial factors affecting women's health, and the impact of race and ethnicity on being able to recognize depression and manage it. Dr. Brown is also active in community-initiated activities, especially those in the African American community, that are designed to increase public awareness of depression. Dr. Brown. [applause]

CHARLOTTE BROWN, Ph.D.

Good morning. It's good to be here, although I did undergrad and my training in Boston, and I left the hotel this morning and it just brought back memories of how cold it gets here. It's probably cold in Pittsburgh too, but—

What I'm going to talk about today— We've heard about particular mental illnesses, environmental influences. I'm going to talk about the context of women's lives. And I'm going to talk about an approach that we're using to try to understand why people do or don't seek treatment. We do have good treatments for things like common illnesses like depression. We do have better medications. We have better psychotherapies for them. But half of the people who get depressed don't go into the treatment.

The approach that we're using and beginning to do research on, and I use in some of the work that I do in the community, I think it was first described by Arthur Kleinman. It's called the explanatory models of illness. Howard Leventhal at Rutgers uses a similar approach, and he calls it commonsense models of illness representations. Basically what it focuses on, it says that what you do about something regarding your physical health or your psychological wellbeing has to do with how you understand it, what you think is going on. All of that is influenced by your environmental context. And the environmental context I'm going to talk about has to do with your culture, your home, your family, how you were raised or brought up.

We are all active problem solvers. This season is the flu season. We get the sniffles. What do we do? We don't run to the doctor. We make some evaluation of it: Is this the same thing that I usually experience? If we have a headache with it, a scratchy throat, that changes it. We may say, "Well, I'll see how this goes for a couple of days, and then I'll go to the doctor." What doctor do we choose? Typically our family doctor, an internist. We don't go to the podiatrist. We don't go to the dentist for our cold. We are actively making the decision of what's going on. We experience something, we think, "What's going on? How do I cope with it? Is this something I've had before?" You basically take these steps.

We do the same thing with our psychological wellbeing. We experience sadness, irritability, tiredness. We look to what's going on in our lives to explain it. That makes sense. Mood fluctuations are normal. If you don't have mood changes, you're probably dead. So mood fluctuations are normal. We make some determination as to: Is this something I've experienced before? How do I deal with it? And what we usually do is, we try to cope with it. It's when those coping strategies don't work that we make a determination that "I might need to just suffer through it," which all too often, particularly with depression, people choose to do. Or that's what people think is the appropriate thing to do. Or, "I'm going to get some help."

One of the things that I'm particularly concerned about is, with all of the advances in psychiatry and psychology in terms of treatment for depression, I don't think we've focused enough on the individual and the individual's perspective, and how their own view of their world influences what they do. I'm going to give you some descriptions from some work that we have done with African Americans as well as whites, in terms of how people define what's going on with them. This morning, Kay Jamison gave a very good example of her upbringing. You were taught to deal with it. Self-reliance is an American value. In our studies of African Americans, African Americans say, "This is part of African American culture. We deal with it. We don't put our business in the street. We have struggled through many things. Our grandparents, our great-grandparents have struggled through worse. You don't go in just because you're having a hard life. You deal with it." That's an American value. What's important for us to understand, even though you find commonalities across cultures, for that particular woman, what you have to capture and find out if you're able, if you're going to try to reach her: How does she define that?

In the work that we've done with African Americans, this coping with depression was thought to be, "This is just what happens. This is part of life's stress. If I don't deal with it in this way, I am not functioning according to the values of my culture." When I've talked in more specifics about the work that we've done with African Americans, particularly when it's an all-black audience, people say, "Yes, that's true. Yes, we know that. That's our culture." When it's a mixed audience, you have, as Kay Jamison mentioned this morning, your WASP military people saying, "Well, yes. You deal with it yourself." You have Latinos saying, "That's part of our

culture as well.” You have Italian Americans, Polish Americans saying, “This is how we do it as well.” But what that person focuses on is what they were taught and what they value within their culture. And I don’t think that as clinicians, we are doing a good enough job of starting with the individual. “What does this mean to you? How does this fit within the context of your life?”

You take a mother with young children. I don’t have children, but I am the world’s greatest auntie. I work hard at it. You take a mother with young children. My sister never gets enough sleep. I don’t know how she does it. If she’s stressed (that’s what she calls it), she’s going to attribute it to these kids. I do this, I do that. Now, if things get to the point where she cannot function, she probably is going to initially attribute it to what’s going on in her life, and not necessarily see that as a clinical syndrome. You have young children, you’re running on empty, you’re not going to see this pill as helping you. And if I try to sell you this pill as the help, you’re going to say, “No, I don’t need a pill. I need a nanny. I need a housekeeper.” Now, in fact this woman may be clinically depressed. But what we need to do is, we need to find out where she is. What is her explanation? I think it is the responsibility of mental health professionals to build that bridge and cross it. We are asking people to hand over their psychological well-being to us, and we are not doing enough to reach out.

In our focus group work with African Americans who had depression, basically what became very clear to me were a number of things. People often mistook depression for stress, ongoing stress. In fact, we know that stress can precipitate and maintain depressions. But people often did not recognize it as such, and suffered through multiple episodes before they said, “Wait a minute. I have got to get some help.” And for some of these people, particularly many of these women who were young women, there was help available. But part of their thinking and their understanding of it had to do with how they defined it. Very often, when they went to family and friends—

And when we deal with people who are depressed, very often family and friends are available and very involved. They’re picking up the slack. They’re getting the kids to school. They’re helping with various chores, etc. They know something is wrong. People who are depressed know something is wrong. They are in pain. They may tell you nothing’s wrong.

They may give you an explanation for it. But I have yet to meet a depressed woman or man, if you are able to get them to trust you enough to be truthful, who says, "I didn't know something was wrong." They know something's wrong. One of the difficulties, though, is— And this may be particular to African American culture. I don't know. It probably isn't. When they went to talk with family and friends, very often family and friends were not helpful in terms of how you cope with depression. The message that many of our participants got, men and women, was, "You're not crazy. You don't need to go to Western Psych. You can push through it." That is not helpful for someone who could be helped by treatment. These were well meaning people. These were people who were in fact lending support. So one of the things after learning this that I do is, I not only ask people, "do you have support," but "What do they do? What do they do for you? What are their views about depression?" Because we need to be particular about what we get and how. The person who's going to give you a ride or pick up your kids, may not be the person who is able to hear and help you when you say, "I feel so bad, I want to die." And I don't encourage people to share it with that particular person. Because the worst thing you can do is say, "Oh, you don't mean that." You need to share it with someone who can listen.

One of the things that happened in the discussions in our focus groups had to do with many people stopped talking about how they were feeling. They shut down. Part of that is the isolation associated with depression, but part of that is not needing any more pain. You're already suffering. You're vulnerable. You're pushing yourself beyond your limits. You don't feel like you need to open yourself up, and somebody said, "You can survive one more day." So one of the things that we found was that this view of how people cope with depression and what they think is going on, is very intricately wrapped up with how people define themselves—as women, as men, as part of a cultural milieu, what their culture and values tell them is appropriate to do. If we do not incorporate that in our dialogues with people who are suffering, we're not going to be able to help them to get the care that they need. Very often what we're doing, I think, when we go out and do talks or give information on depression, we try to reach as many people as possible. It's a "one size fits all." It's not working, because people still aren't coming in to treatment. And when they do, they may not be availing themselves of it as much as they need to. I think one of

the answers is to begin starting off with the individual, and letting them shape that dialogue, having them teach us actually how we might be able to use our technology and our skills and our medications more effectively.

The last thing I wanted to comment on is, depression and other psychiatric illnesses are different than diabetes and hypertension. We often draw the analogy to help people engage in treatment. When we have high blood pressure, we don't see the blood pressure increasing. For something like high blood pressure, it's asymptomatic. When we have a physical symptom, we don't see blood cells changing, increasing or decreasing or turning into cancerous cells in our body. We go to the physician and they tell us what's wrong. However, with our psychological experience, we are the experts. We are the one who has had the experience. It is a healthy human instinct to not turn that over. And what we need to understand when we approach people is, don't start off with this "trust me" stuff. You have to dialogue. You have to develop that relationship. People are not going to turn over what's in their head, because this is what drives us. It's not just your heart. It's the brain. That moves us. Everything else can stop functioning except your heart and your brain, and you are still a living, breathing, functioning human being. People are unwilling to turn that over, so some of the tactics, some of the strategies that we use have to be different. They involve acknowledging that the expertise on the experience of the psychological disorder, psychological distress, lies with the individual. And that in trying to reach out, we are really collaborating. What we're attempting to do is say, "I have some skills. I can help you to deal with this. You have the experience. You can teach me what is going on with you, and we work on this together." Too often what is coming across (I don't think often intentionally) is that "I have the answer for you." And rightfully so, the people that we are trying to serve are saying, "I'm not buying that. You haven't heard a word that I've said." Thank you. [applause]

MALLIKA MARSHALL, M.D.

Thank you, Dr. Brown. Excuse me, I think you went over your ten minutes. But it was so fascinating that I couldn't stop you. Our fourth and last speaker, Judy Norsigian, is co-author of

the incredibly popular series of books, *Our Bodies, Ourselves* and *Our Bodies, Ourselves for the New Century*. I was telling her, when I was 15-16 years old, it was like *The Joy of Sex* book. You would sneak into your mother's room and open up and read certain chapters. In addition to her writing, Ms. Norsigian speaks at a wide range of women's health concerns. She's appeared on numerous national television and radio programs, including Oprah, Donahue (I miss Donahue), the Today Show, Good Morning America, and NBC Nightly News with Tom Brokaw. She served on the board of the National Women's Health Network for 14 years, and continues to remain active. Her interests include reproductive health concerns, the media and women's health, genetics, tobacco and women, women and healthcare reform, and advocacy for midwives. She's received numerous awards and serves on numerous boards. But most importantly, she's a cellist, a cross-country skier, and she likes to go board sailing. What the heck is that? She is a board sailor. It is my pleasure to introduce Ms. Norsigian. [applause]

JUDY NORSIGIAN

Thank you so much. And actually there's been no time for board sailing for several years. Like many of you, our lives get packed and we get too busy for all the things that we like to do. I want to join everyone else in thanking Teresa Heinz for bringing us all together in this wonderful way. I think this is a very important meeting. [applause] The theme of this conference is truly all-encompassing, so our various observations will certainly run the gamut.

I prefer to use the term "emotional and psychological well-being" rather than "mental health," though I do use that term sometimes, since "mental health" sometimes has unnecessarily medicalized overtones. Throughout our almost three and a half decades of working on women's health, those of us at *Our Bodies, Ourselves* have come to appreciate the importance of emphasizing prevention, doing all we can to avoid the development of serious problems and illnesses, whether physical or psychological or a combination of both. As we know, our spiritual, psychological and physical selves are all inter-meshed in many, many profound ways. Because the environment can be defined as anything outside our bodies, and because very different factors

can produce the same symptoms or illnesses, and because the kind of research that would conclusively prove cause and effect is usually enormously expensive, we have to make decisions often with inconclusive information.

Whether there are personal choices about our beauty products (some people use them; I never have time to) or cleaning agents that we use in our homes, or regarding public policies and laws that have considerable meta-effects on both physical and emotional wellbeing, I like to use the precautionary principle of public health as my guiding principle here. It's a bit long, but I'm just going to begin with the first sentence: "When an activity raises threats of harm to the environment or human health, precautionary measures should be taken, even if some cause and effect relationships are not fully established." The full text is available at our website and at the SEHN, Science and Environmental Health Network, which Teresa Heinz mentioned earlier.

Causes of much serious mental illness are often unclear. Sometimes there's a hereditary predisposition, as we've discussed. Sometimes biochemical imbalances in the brain play a role, although the sources of these imbalances are often obscure. Sometimes it's because of an environmental toxic exposure. Sometimes it's because of a genetic defect that could not necessarily be inherited but could be something that happens in the course of our living and being exposed to toxins. The stress associated with life crises affects different people in different ways, and we just heard a wonderful discussion of that. But the absence of family and community always makes coping that much harder and less successful. And as you've just heard, sometimes your family and friends are anything but helpful. And that's where having access to therapist—and I don't just mean drugs for depression. I also mean talk therapy, counseling, the kind of support that we can get from the larger community, from professionals, if we can't get it from our immediate friends and family. Creating these systems of support before the need for them arises is one of the challenges that we face as both lay persons and professionals.

I have actually brought a handout. It didn't make it into your packet, and there aren't enough copies for everyone. So if any of you would like the handout which refers to the groups and the resources that I'm going to mention, just give me your card or your e-mail address. I'll

gladly send it to you. It also excerpts from some very important resources that I found helpful when thinking about this issue.

So many factors have an effect on our mental health, or psychological and emotional wellbeing. Violence may be at the top of the list in my book right now, given the research that I've seen. But there are so many other things. The media, which has been the topic of a whole conference or two in the Heinz series. Poverty has a tremendous impact on your health and wellbeing. Racism, isolation, unemployment, overwork. These are just some of the larger issues that can have a profound impact, and I'm going to touch upon a few.

Violence in women's lives is related in many important ways to things like depression, post-traumatic stress disorder, and alcohol and drug use. Many studies show, for example, that women abused by their partners experience more depression or anxiety or phobias than women who have not been abused. The bottom line here is that our public policies and support systems should seek to reduce violence in women's lives. This could go a long way to reducing the depression and other mental health problems we have. Now, that's separate from the physical harm, which is another issue.

Second, I want to mention toxics and the environment. Teresa again gave some great examples of the chemical stew to which we're all exposed. And although there is growing awareness of harm to physical health—we know about air particulates and relationship to asthma in children, for example. And credit goes here to our local group, Alternatives for Community and Environment, to getting the buses and vehicles to stop idling in places like Dorchester and Roxbury. We have very high asthma rates among our children. And the rates will go down because of that. We're not always aware, though, of the effects of these substances on our emotional and psychological well-being, for example, women who develop multiple chemical sensitivities (and they do more often than men do). Over time, living with a constantly debilitating and limiting condition, not surprisingly, leads to depression and other emotional distraught situations for women, in part because our surroundings, our environments, do not accommodate our needs. Cancer, of course. Much of cancer is environmentally induced. We must not forget all the World Health Organization reports on this topic. Anyway, much cancer is chronic in nature,

debilitating for many women. And again, this can have a major impact on psychological and emotional health. I want to cite Health Care without Harm, which promotes environmentally responsible health care, and our local Alliance for a Healthy Tomorrow. They're doing some wonderful work that I think will begin to address some of these larger issues. Do get involved with them, if you have the time or the interest.

Now, a third and enormous topic is of course the subject of the role of the media. Now, here is a potentially harmful environment, especially when we are not media-literate enough to distinguish fact from hype, to recognize for example that many of the consumer ads for prescription drugs (so called direct-to-consumer advertising), this is a phenomenon that took off in 1997, after an FDA directive was issued, and has now burgeoned into a \$3 billion per year industry. Many of these ads are profoundly misleading. They're not true consumer education, as some would argue. And it's interesting that the group of doctors most concerned about the harmful consequences of these types of ads are internists. And they're currently collecting data on this problem in a more systematic fashion. A few of them presented their data at a recent FDA meeting in September on DTC advertising.

One thing that we all need to be concerned about is that drugs be used appropriately. Today our focus has naturally been on drugs like antidepressants, the most commonly used ones being in the class of selective serotonin reuptake inhibitors (or SSRIs). If these drugs are used to address true depression, they can be quite helpful. But my observations, largely drawn from conversations with hundreds of female college students and conversations with clinicians studying in this field, are that many young women in particular are taking these drugs who would be better served by other approaches to their problems. Some students, for example, have reported that they went to a college health service and said they were upset about their poor grades, poor school performance, or they broke up with their boyfriend. They took SSRIs and actually found they felt and did worse. They got off the drugs and they felt markedly better, probably because they weren't appropriate candidates for the drugs to begin with. And this underscores the importance of good counseling, good diagnosis, and good clinical work when you seek out medical professionals.

There is not time today to discuss some of these major issues that address adolescents, but I do want to make sure you know about the huge UK government directive regarding Paxil. Wyeth also recently sent a letter to doctors in the United States about not using Effexor, which is one single SSRI, with adolescents, due to study findings noting increased problems with hostility and suicidal ideation among adolescents who took Effexor. That should be useful to study all the SSRIs in this regard, adolescents in particular.

Drug advertising, of course, is just one arena of the media. If you're interested in the work of the Prevention First Coalition, which is a national group of women's organizations, please go to our website and learn more about this advertising problem.

But I think media portrayals of women to extremely thin body types, ideal body types that are totally unrealistic for most of us, have led to an obsession with dieting in very young girls. And these diets often start quite innocently in girls with no apparent psychological or emotional problems. They just have the natural desire to look good, as the media defines that, and to be liked by their peers. Sometimes this preoccupation with dieting has led to a full blown eating disorder which, as you well know, can be life threatening and does require medical intervention and assistance. So let's think about what we can do to offset these influences and help younger women more effectively resist the harmful effects of some of these media images. I can refer you to AboutFace.org, a group of younger women in San Francisco that have a fabulous website, and our own local Teen Voices, which is producing a national magazine, copies of which should be outside for you to take. And we have them at our offices in the South End, if you like to pick one up. We think they're doing a great job of trying to help young women become media-literate.

The way in which mainstream media addresses another issue, so-called female sexual dysfunction (or FSD), is another example of how we may be doing a disservice and how we deal with sexual difficulties and problems. A Viagra-like drug for women will most certainly be useful for some of us, but the vast majority of us might be better served by other non-medical approaches. The best resource on this is something that is written by Dr. Leonore Tiefer and her colleagues, "A New View of Women's Sexual Problems," and a manual that she's prepared to do

with it. I find this a fabulous resource, and it's also accompanied by a website with lots of good information.

There are other issues I hope we're going to explore today. The issue of lack of sleep, which you've raised earlier, this has a profound impact on all of us, and you can see the effects all around. What about breastfeeding and its influence on psychological and emotional wellbeing? Let's put aside what we know the advantages in terms of breast cancer risk reduction. Research indicates that benefits include improved cognitive and psychological development and a reduced risk of childhood obesity for the babies. Mental health advantages for the mother also needs closer scrutiny, as well as the need for environments supportive of rather than hostile to breastfeeding. We still have that as a major issue in this country. Some research has linked increasing feelings of depression, fatigue, and confusion with increased overtime work and other stressful conditions, like settings where there's no natural light. And although full spectrum lighting is more expensive, it does make a difference. Certain kinds of malaise that have been chronically reported disappear when we produce full spectrum lighting or we get outdoors to see the air, get some fresh air and get some natural lighting in our lives. How community housing arrangements help to avoid isolation and loneliness for women who would otherwise be living alone with limited support, has a tremendous impact on how we feel. And then, how can changes in eating and exercise patterns markedly improve mental health and well-being, even when particular sources of emotional stress cannot be immediately eliminated? I think some of us are experimenting with changes in what we eat and how much exercise and movement we introduce into our lives. But I think this is a crucially important area. And I know when the National Black Women's Health Project (now called the National Black Women's Imperative) conducted the Walking for Wellness project all over the country, in collaboration with the American Heart Association, many of the women who found a walking partner and got walking exercise found that they just felt better. It wasn't just for their heart health that they did this. They felt emotionally and psychologically better for having had more regular exercise.

I'm over my time so I'll stop there, but I'm looking forward to speaking with all of you.
[applause]

QUESTIONS

MM: As you can see, I've been inundated with questions here. You guys have such wonderful questions. Fortunately, there are some common themes, so I'm going to take several questions and try to boil them down into one or two. I'm going to ask the panelists to remain seated when they comment and when they discuss, and so we'll just continue to sit here for the rest of the panel time.

The first question that I've chosen is: Can anyone address the issue of stigma and how the average person can get support for overcoming it? This is something I actually discussed with a couple of the panelists at my table before the morning began. Is there still a stigma about mental illness here in this country? Or—which is what I thought—there's obviously improved awareness over 20-30 years ago, but is there now the problem of over-diagnosing and over-treatment?

CB: Stigma is very, very much a problem in terms of mental illness. It is very real. It keeps people from acknowledging the distress that they may be experiencing. It keeps people from getting help. One of the things that I think is going to be helpful—I don't think it can be combated on an individual level. For the individual who has psychological difficulties or is experiencing distress, what that person will have to do is find a safe place, a safe person with whom they can talk, and seek out— That may be in the form of support groups. It may be in the form of asking a physician or a therapist, "Are there other people that you could recommend that I could talk to, who has experienced this and knows how to deal with this?" Because I simply don't recommend very often that people stand up and tell people, "I have this problem," if they are concerned that these people may be rejecting of them or that it may have negative implications for their employment. Because stigma is real. So we do need to be protective of ourselves while also trying to get support.

On a larger level, I think one of the things we have to do is, we have to begin to break the silence. We have to begin to educate communities, starting off with those community concerns. And what I have found is (and this is just anecdotally), you can go in, and when you talk about depression and other illnesses in a safe environment (say for example, I do a lot of this in churches), people come, they listen, they share. It's a safe environment. Education is key. But it's not this canned approach that one size fits all, because one size does not fit all.

MM: Could I have either Judy or Quentin comment? Because it seems like this morning you were suggesting that there are certain circles in which it isn't necessarily a stigma. Can either of you comment on that?

QR: I saw a cartoon in the *New Yorker*. And these two guys are in a bar. Now, I think men are more confrontational, and women tend to corroborate each other a little bit more. One guy says to the other, "My analyst can see through your analyst." There's sometimes a regrettable and unnatural amplification of a person's mental disturbances, in the name of dignifying his own or her own individuality. We all—I don't know, I can't speak for—I have plenty of problems. And I think that there are systematic trends in the American culture that have made consciousness of one's self more important, but also just simply mechanical ones. Dr. Brown's sister hardly gets any sleep. Chronic partial sleep deprivation is the new epidemic of American culture. But you know, we're ashamed sometimes. You know, you're rough and tough and you can go with no— And the comparisons, the effect of the media: So-and-so is at home, and of course when she, having dealt with her 12 children this morning, and she's going out practice for her Olympic gold medal, and in her spare time she shines up her Nobel Prize medal. And the media convey even images—and you'll have to pardon me because I'm going to get the name wrong—Cheryl Tiegs. She's a famous model. A lot of images appear of her, and she said of these images once, "Gee, I wish I looked like that." They're so retouched. So the point

is that there is an awful lot of idealization going on, transmitted by the media, that provokes shame in us ordinary mortals. And the shame disenfranchises us.

CB: The other aspect of that is when you look at popular television shows, you look at movies, people who have psychiatric disorders are presented in a terrible light. Everybody is violent, doing terrible things. The therapists are incredibly unethical. And for people who are experiencing some difficulty, there is a natural tendency to say, "Well, no. I have this, but I don't do that." We spend a lot of time looking at TV. And for someone who's trying to struggle with "Do I have something that requires help?" they may identify with some of the behaviors, but when it's presented in such a negative light, that forces people to kind of pull in and go underground. And it also forces around us to be afraid, and have negative views of people who have treatable disorders.

MM: Just to play devil's advocate here: What do you say to some people who are concerned that on certain college campuses 15 to 20 percent of undergraduate women are on antidepressant medications? Is that a problem, or is that just that we are uncovering a problem that's long existed and now people are getting adequate treatment?

JN: It varies enormously. Actually, some nurse practitioners have given me figures of 35% and higher. Now, whether they're right or not, I don't know, but that surprised me. I think the issue is in part that we're trying to do a better job of figuring out when young people really need help. And sometimes that includes medications.

The issue you raised earlier, which is what we were discussing about stigmatization, I think there is a change among many young students who freely discuss their medications in audiences of 200 and 300 people, and don't feel the same kind of stigma that, say, members of older generations might have. I think that has changed, partly because of the advertising and the media imagery. Even though people are depicted in sometimes negative ways, the use of these drugs is not an embarrassing thing one shouldn't talk about, the way I think it's felt by many older people. I do see a change there. But the real challenge of

addressing the whole range of life's problems that we all face, not necessarily using drugs when they're not appropriate, is important, because I certainly have seen young women say they felt so much worse on the drugs, when they weren't really appropriate candidates to begin with. And that's why we have to be careful. The drugs are not without their own set of side effects. So we should take them when we need them.

MS: I think 35 to 40 percent is an awful lot of young people who are medicated. On the other hand, as we said, 2 out of 10 women have depression during their lives. And if you think about puberty and these young people going off to college, they're significant stressors. But one of the problems is, medication can become a quick fix. And part of that is, here aren't a lot of mental services available. In New York, we have luxury to practice in a way that says, "I don't have to just give them medication. I do psychotherapy." I have training in analysis. I can do psychotherapy with my patients. Many can't. It depends on going to the right healthcare practitioner. It depends what they're hearing. Are they really eliciting symptoms? I think there are many reasons, and it's complicated. But one of the most important things is to go to the appropriate practitioners, if you can get them. There are a lot of limitations around, as we know, health insurance and such. So my feeling is, you do what you can until you need meds. And once you need meds, don't keep yourself off them.

MM: I'm glad you addressed that, because there were several questions from the audience about over-medication, and what do you do about physicians who only prescribe meds and actually don't do the . . .

QR: I would add that SSRIs are only one class of medication. They can make people very apathetic. It can much change a woman's sexual responses, and men's. But we're all—or at least a lot of us, or at least me—drugged. About 85 percent of Americans use caffeine. Maybe this has something to do with our penchant for quick fixes. We're very impatient. And alcohol. Add the unspeakably devastating tobacco. And you're just to a start.

There's the over-the-counter drugs. So you can't talk about human nature anymore. You have to talk about medicated, drugged human nature. [applause]

MM: Before you comment, Dr. Brown, on the heels of that, I got a card that says, "At 65 years old, I feel the best I have ever felt in my life. I got through menopause with Granny Smith apples." What did those do for you? [laughter] So you must have been eating the peel. "I got through menopause with Granny Smith apples, CocaCola (caffeine for headaches), and chocolate chips. No hormones. My once-a-month nervous breakdown went away after menopause." [laughter]

CB: One of the additional issues, though, in terms of who's getting treated and how they're getting treated, has to do with the fragmentation of care for mental illnesses. So that we don't have a good system— First of all, access to care may be an issue for many women. That may be an issue because of geography. They may be in a more rural—and it doesn't have to be that rural. In some instances, what might be considered suburban is rural, because there aren't appropriate practitioners there. There isn't parity in mental health care, and we don't have user-friendly ways of integrating services. So that while many women are treated in primary care settings, those physicians do not often have an easy method of referring for appropriate counseling. So they do what they can. And I think that that has to be dealt with at a policy level. There are many women who are involved with some type of social service agency. Those could be people who could link women to care. But those people don't have the training to identify some of the problems, and they may have a difficult time helping those women to access care. So our system of how our mental health care system is integrated is really problematic in terms of people having choices, in terms of whether they want to choose therapy or medication. There are a lot of limitations there.

MS: I'm married to a wonderful Italian man. He is the nicest guy I've met in my life. But he would have screaming fits. And I've been therapy-ized, analyzed, so my feeling is: You

must go to a therapist. You must think about medication, think about this and that. And he wasn't harming anyone. He would just do that. He would flare up. And he wouldn't step into a therapist's office. I do psychopharm research. I do psychotherapy research. So the bottom line is, a friend of mine who's a psychopharmacologist in New York is also a kind of guru. He thinks yoga's great. People can get off medication. Meditation. I agree. But I have some questions. Not for everyone. So he was able to talk my husband into yoga breathing, the yoga breathing course where you walked in and you said, "You belong to me." Now, my husband said, "Italian guys don't do this." But you know what? My macho friend, psychopharm, said, "Do it." He said, "If Dick says do it, do it." My husband has been breathing and doing this meditation for a half hour every day for the past year, and I swear, he has never screamed again. It's amazing. [laughter and applause]

JN: Actually, there are many studies that show the benefits of deep breathing for women. And it's worth looking more closely at that, because it's both physical and psychological, just like exercise.

MM: Italian men don't do yoga, but do they eat quiche?

MS: They do! He even cooks it. He loves it.

QR: Additionally, Judy mentioned exercise. I can't tell you how effective that is. When I look in the literature, I blush to tell you, it's like snake oil. It's good for everything. I couldn't believe it. For arthritis? Yes. It increases the metabolic rate of . . . and so on. And the following study was done at Duke, reported about three years ago in the fall. Outpatients who had psychiatric major depression, major disorders, outpatients, were given a trial of Zoloft, which is an antidepressant, given a trial of a supervised exercise program, or given Zoloft plus exercise. Now flash forward nine months. Zoloft, they were better. Exercise, they were just as well as with Zoloft. Exercise plus Zoloft, no better than the other two groups. This is very important stuff. Now, I've noticed that in older women especially,

exercise drops off. Older women don't exercise commensurably with men or with their younger colleagues, just when they need it more. We old people really [need it]. And so I wonder about this. And there haven't been too many systematic studies. But we were told early on, in gym class in grade school, unlike the boys, girls' strength, the athletic qualities of their bodies are not emphasized. In adolescence, they're focusing on their developing physical selves. To them, sometimes it's demeaning, because it completely deflects attention to their feelings and wishes and so on. And many of them become very anti-physical in their orientation. So that women sometimes are not programmed to; are programmed against exercise. And then there's a connection between exercise and cosmetics, rather than exercise and health. And a lot of women bristle at that. So I think in addition to finding treatment, there are things that one can do that improve one's sense of mastery as well as diminish one's symptoms.

JN: Can I just make a footnote that this is a very good example where poverty plays a great role? And if you're in a community where you don't have the options to move or exercise, sports for girls—the list is very long—it makes a difference on your ability to get regular exercise. So it's just one very good example of why we have to think about things more broadly.

MM: Here's another question. None of the speakers have mentioned the impact of what is going on in the world (the war in Iraq, terrorism, etc.), in terms of mental health problems (anxiety, depression, and so forth). Any comments?

QR: After the events of 9/11, there were surveys done of different mental disorders, for instance, the prevalence of panic attacks in the months thereafter. In this case, panic attacks did not change at all. On the other hand, tons of people were afflicted somehow, could not stop thinking about this. It depended on the person.

MS: I'm from New York, and I don't live that far from what was the World Trade Center. And I have to say, I can be very proud to be amongst the mental health professionals who really did an outstanding [job]. Actually, I had been ill initially so I can't count myself there. However, later on. . . What we're doing is, there are many hospitals and institutions that have really continued to help. We at Columbia perform volunteer work with the New York City Police Department. And it's been an incredible learning experience for me. I actually come from a lot of police, so that's been interesting for me. My son is a police officer. And that's been interesting for me, but I've learned about a subculture who says, "You cannot balk. You cannot talk about your psychological problems. And if you do, your gun will be taken away." And they say, "I do this all the time. It's not a big deal." I remember talking to one—you know, that have the dogs that sniff, at the time of 9/11. And I said, "What is this like for you?" "Not a big deal. This is what we always do with bodies." I said, "Well, how many did you identify in one day?" He said, "Up to 100." It is just beyond the imagination. But the worst part is, today they still have their symptoms, many of them. It's very hard, this PTSD that went along with this. I have one woman in particular who's a detective. She was there at the time, and her brother was a fireman who died. And it is so hard, so hard for people in the services (firemen as well) to accept help. I have to say, I'm proud to be with Columbia, which has really opened that up. We have a program where police— And no one can know exactly what we're doing with the police officers. Of course obviously if they're in some danger, we have to bring them into the hospital. For me that's been a wonderful experience. I've learned an awful lot, and also learned to really appreciate them much more. When your son comes home and he says, "You know what they do to me on the job," you go, "Yeah, yeah, yeah." And when I'm hearing it first-hand and hearing what they go through— Because I think we have to realize that many of these people—young people mostly—have chronic PTSD, just from their daily jobs. But this was an overwhelming event. And I think it affected all of us, not just them. All of us, the world round. But I think that the firemen and police are just great.

[applause]

MM: Quentin, I've actually gotten a bunch of cards addressed specifically to you. Obviously there's still confusion over HRT and whether women should be taking it or not. And so this one question sums up a lot of the ones I've received: Are you really encouraging menopausal women to use HRT? I'm especially concerned as a breast cancer survivor, and with the current NIH studies that suggest the opposite, also including increased heart disease and increased strokes in women on HRT.

QR: The questioner refers to the women's health study. The women's health study, the blandishments of the sensationalizing media, the cognitive tendencies of humans to over-generalize, and the limited time we all have to process our soundbite-delivered information, combined to get a lot of people off HRT abruptly. I wish the media had reported that the treated group (the estrogen plus progesterone group) had a lower mortality, if anything; died less. I just wondered about this, and I've talked to people involved. It is true that breast cancer was increased. Breast cancer was increased a bit. There were some 5,129 women who were given estrogen plus progesterone. Twenty-seven of them got breast cancer. There were 4,243 women who had placebo pills, of whom 20 got breast cancer. If you do the arithmetic, it comes out that per 100 women per year, about half a woman got a new breast cancer case. This is regrettable, and breast cancer kills 40,000 more women each year in this country; however, it's not the only way one can die. It is true what the questioner said. There was increased stroke, heart attack, thromboembolic phenomena. There was less osteoporosis, less colorectal cancer. The mortality rate of a broken hip, the 6-month mortality, is larger than the 10-year mortality of breast cancer. Had that study been played out longer, some of these figures might have gone away. As a matter of fact, when the nominal rates—that is to say, if you adjust for all the cofactors (alcohol and so on), the difference went away. The difference is very, very tiny. The mortality statistics are on the side of the treated people. The sudden getting off of hormone replacement treatment has visited sudden and capricious misery in a lot of helpless women. And I think

that it has to be put in perspective. One size does not fit all, as I think some speakers have said, and it's an individual matter. If you have a first degree relative who has breast cancer, or a breast cancer in the family, that is different [than] if there's zero people in your family. Why did a few more people [die]? Really, if you also take in the cofactors, there was no difference in mortality. But let's say, maybe a few people weren't so depressed, so many they didn't drink so much. Or maybe they were just more alert so they could swerve out of the way and avoid an accident. Maybe that's why they, if anything, live more. So I think you have to put this in perspective.

JN: I want to say that this is a vast subject, and this is probably the one place we really have strong disagreements. I would refer you all to the women principal investigators that were involved in the Women's Health Initiative, many of whom have written articles and spoken about this, and they don't represent the data the way you just heard it, for the most part. There is also a wonderful book called *The Truth About Hormones*, which is put out by the National Women's Health Network, that summarizes the data. It's an evidence-based book. And you have to remember that although it's true that these variations were relatively small percentage-wise, we still are thinking about thousands of women, and that there were many women given hormones not because they ever had a hot flash or ever had a problem, because there were purported benefits to heart health and other benefits that were not actually proven, till we did this study, as exactly not being the case. Those women who went off hormones did not suffer the way of those you described. Women with good clinicians were not told to go cold turkey. They were told to wean themselves gradually. Many women had fine clinical advice. And in fact, the PIs did not recommend cold turkey. They recommended you talk about it with your doctor, look at the reasons you took the hormones to begin with, and you make an informed decision. The mass hysteria that I hear described, I do not think reflects what really happened with the majority of women. You're hearing about, yes, some women hurt badly. But I think this is a much more nuanced picture. And we really are intelligent enough to get the good data

and make the decisions. And the media did do some disservice, but much of the media had this information embedded in the last part of the article, and many people didn't read the whole article so they didn't get it. So I'm not going to fault the media 100 percent on this one. And I think the principal investigators did a good job both informing the women in the clinical trials, thousands of them, before it went to the media (which I think is appropriate), and also in speaking to the media. So this is one time where I think the government did a reasonably good job, and I actually don't like a lot of the, I think, misguided and inaccurate criticisms of those who engaged in and conducted this study. I think they did it in one of the best ways we've seen women's health trials done up to now. That's my two cents. [applause]

QR: Well, I am so delighted at this controversy and disagreement, because I know from media people that that's what increases your ratings. [laughter] Just in response: It's difficult to read the original articles because they're not written in English. They're written in jargon. But if you can get through them, I think they paint a different picture. And what you said is true, that the clinicians are different. Subsequent to this mass response, epidemiologists, statisticians, registered their protest. But in the letters of the medical literature, not in the media, I think you can resolve the controversy between myself and Judy simply by, in a graduated way, those people who were on hormone replacement getting off very slowly, seeing how you feel, in a charted, objective, measured way over quite a period of time, and then getting back on, seeing if that's better, worse, or the same, you might be ahead off, but you might be ahead being on.

JN: Actually, many women shouldn't be going off hormone therapy. And you can take estrogen unopposed. Don't have to take Prempro. And there are many women who are keeping on hormone therapy because the alternatives they've tried don't work. And they do have serious disruption of their lives with hot flashes and sweats and things that are not amenable to other interventions. As you pointed out, the risks are relatively low. You

have to weigh what benefit you're getting from a drug or a hormone, against what possible side effects or problems. And for many women, the sensible choice is to stay on estrogen, maybe not with the progestin. And yes, there's an increased risk of uterine cancer, but for some women, actually they put that into the equation, they put in the pretty high success rate with treatment, and they still want to take estrogen. And that's your right to do so.

MM: Okay, we actually have to wrap up. I think you would both agree that every woman out there who's considering hormones or is on hormones needs to discuss it individually with her doctor. I would like to thank all of our panelists here for joining us. It was obviously very stimulating and interesting. [applause] Thank you very much.

JEFFREY LEWIS

Our next speaker is Dr. Carolyn Mazure. She is Professor of Psychiatry and Associate Dean of Faculty Affairs at Yale University. As director of a women's health research program, she heads the largest interdisciplinary women's health research program in the United States. She has a particular interest in determining sex-specific predictors of illness, onset, and outcome. Dr. Mazure participated in the first White House Conference on Mental Health and the bi-national Israel-USA Conference Promoting Women's Health Across Generations. And she has chaired the American Psychological Association's Summit on Women and Depression. As in the previous speakers, she stands on her own, she stands tall, and she is again another amazing individual. Please welcome Dr. Mazure. [applause]

CAROLYN M. MAZURE, Ph.D.

Thank you very much, Jeff, for your kind introduction. And my sincere thanks go to Teresa Heinz and the Heinz Foundation for inviting me to join you today, to speak with you about the importance of research on women's health, including women's mental health.

The focus of my remarks is going to be quite different from what you've heard this morning. They're really going to focus on research and science. We are in a time of enormous development in medicine and in health-related fields. We turn on the radio each day, we open the newspaper, and we see that there are new findings from medical and behavioral health studies. And this wealth of new information can sometimes be troubling. It can often be confusing. But most of all, I find it is truly exciting, because we know that improvement in our health and our health care depends upon new scientific knowledge that can be translated into clinical and personal practice. But what we may not know is, such medical and health knowledge related specifically to women often really is news, because historically women have not been included in clinical research trials. In fact, as pointed out in a National Academy of Sciences report that was published in the mid-1990's, fully two-thirds of all diseases that affect both men and women have been studied exclusively in men. And when women have been included in clinical research trials, studies have not traditionally examined whether there were differences between women and men in study outcomes. This situation has really generated tremendous limits in our understanding of the health of women and in sex-specific aspects of health and disease.

Today I'd like to speak with you briefly about why women were excluded from research investigations, and what has sparked a change in this longstanding convention. Then I'd like to focus on what is happening now, today, in women's health research, including women's mental health research. And I'll end with a view of what needs to be studied, and what can be made possible through research.

So first, what are the reasons that women have been excluded from research studies? Well, there are three major reasons. First, women have been excluded as subjects in research studies in

part due to legitimate concerns about exposing women of childbearing potential to experimental risk. And it is of course true that there's a very serious obligation in this regard. However, excluding all women from studies that are required to prove the safety and the efficacy of new treatments, and from studies that are designed to look at new prevention strategies, has left us with major areas of women's health unexplored. And it has left us without sex-specific data on responses to treatments and prevention strategies that can only be drawn from comparing women and men.

The second major reason that women have been largely excluded as study participants is due to the complexities that we as women bring to research as subjects, as a function of our hormonal changes related to the reproductive cycle. Cyclic changes related to reproductive life, occurring either over the course of a month or over the course of a lifespan, by definition do not allow the constancy often sought by traditional scientific methods. However, despite the underrepresentation of women in clinical research studies, due to the biological factors that set women apart from men, the assumption frequently has been made that the treatments and prevention initiatives which were developed with men would also work for women.

And third, women have not been the target of research efforts based on the misperception that certain conditions do not affect women to the same extent that they affect the health and lives of men, and that when women are affected by these conditions, they will be affected in the same way as men. One of the classic illustrations in this regard is found in the area of cardiovascular disease, long thought to be primarily a man's disease. Critical studies on cardiovascular illness, including response to medical and surgical therapies and preventions, have focused largely on men. Yet despite the focus on studying men, cardiovascular disease is the greatest cause of mortality in women as well as men. And it is also now known that when cardiovascular disease occurs, how it appears and its clinical course can be different for women and men. It is important to emphasize that in no way should our colleagues in cardiology be singled out, however. This tradition of including only male subjects certainly was not specific to one discipline.

As an illustration of how, until very recently, convention did not dictate analysis by sex, I turn to my own field of depression research. This area of work is unusual in including women in

those being studied. And the main reason for that is again, as you've heard today, there's such a high prevalence of women with depression relative to men. And so because so many more women suffer from depression than men, it was likely that women would be included as study participants. As you have heard this morning, these increased rates of depression emerge in young women at puberty, and are maintained in women over decades of life. Yet even though women have been included in studies of depression, it is only in very contemporary research that we're looking for and we are finding sex differences in predictors of depression and in response to treatment.

Well, this brief history now leads us to the second focus of my comments, namely, what is happening now. What are the current developments in this area known as women's health research? The realization of the gravity of this situation generated a reorganization of our thinking about how we conduct research, and led us to initiate change in who we study and why. Importantly, as part of this history, changes in funding requirements for grants from the National Institutes of Health were begun in the 1990's, which required that going forward, women must be considered as subjects in NIH-supported research. That had not been the case prior to 1993. This change was critical symbolically, because many turn to the NIH as a standard for research methodology and excellent science. And this was critical actually, in that the NIH is the largest single source of funding for health research in the country.

Since the mid-1990's, as a function of asking investigators to include women in their research proposals, there has been a steadily growing realization in science that if we want to generate useful new knowledge on human health, we need to study those factors that we once ruled out of the algorithm for understanding health and disease. If we want to advance discovery referable to women's health, it is crucial to reverse our previous patterns of inquiry and realize that the differences presented by studying women are not impediments. They are clues to new knowledge. Now, at this point in our history, we need to galvanize this keen and growing interest through programs of research that focus on the health of women and on sex differences in health and disease, programs of research designed to initiate and support interdisciplinary investigations never before undertaken. And fundamental to this effort, there must be three key concepts.

First, we need to broaden the scope of what is considered women's health. In the past, our conceptualization of women's health concerned mainly reproductive issues, which are critically important. But the reproductive years now constitute less than half of the average woman's life expectancy. We cannot let one aspect of our lives, no matter how important, or for that matter, one or two or three specific diseases or conditions afflicting women, become the sole focus of women's health. All syndromes and conditions that afflict women, and for which scientific information is needed, must be included in our list of priorities.

Second key concept: We need to integrate the study of mental health and behavioral factors into the mainstream of our research efforts. The mental conditions and disorders that affect our psychological lives, affect our relationships, affect the potential for other morbidities, and in fact even affect our very survival, deserve our attention and should be part of any health research agenda.

And third, as we embark on these new programs, we need to inculcate into our research ethic the need to reap practical benefit from our research efforts, findings that can be applied to personal and professional practice, and findings that can be translated into meaningful public policy.

And so I'd like to give you some examples. For example, in our own research program, with regard to my first point about broadening the scope of what is women's health, we study some of the following. We study the molecular mechanisms of breast cancer, and have shown that certain genes (namely BRACA-1, BRACA-2 mutations) are risk factors for breast cancer recurrence in both the ipsilateral and contralateral breasts, which has significant implications for women with these genes when making treatment decisions and considering optimal methods for prevention of new tumors.

We're working to develop gene therapies for fighting ovarian cancer, because we must do better in the genesis of new treatments for this disease. And our investigators are beginning to reveal processes by which ovarian cancer cells spread to other organs.

Our researchers are investigating the mechanisms for maintaining bone, because in fact osteoporotic fractures occur in one of two women over the age of 50 in the United States. And

they're finding that the amount of protein women eat profoundly affects how efficiently calcium is absorbed by the intestinal tract, and that women whose diets are based exclusively on vegetable protein, such as soy, rather than animal protein, may actually reduce calcium absorption—all of this in the face of many women now using vegan strategies, believing them to be beneficial for their health.

Our investigators have also shown sex differences in response to coronary artery bypass surgery, which is, by the way, performed in approximately 80,000 women annually in the United States. There have been many studies on outcome of heart bypass surgery. Some of them have included women. None, prior to this study, actually had as its focus the comparison between women and men in the outcome of this important intervention. In fact, the finding results were that women have more difficult recovery, report more physical problems (such as infection), have lower levels of functioning, report more depressive symptoms, have higher rates of rehospitalization, even after controlling for pre-existing conditions and risk factors. It is not yet known exactly why this is the case, because only recently it has been determined that it is the case.

We're examining the effect of black cohosh, an herb widely sold and advertised as effective and safe for the treatment of menopausal symptoms, in particular, hot flashes. We're examining this in a group of women who have stopped hormone replacement because they have breast cancer. This research actually came about as a function of one of our researchers being present in a waiting room, listening to women talk among themselves about what they're doing to help control their hot flashes, and hearing that women were taking this herb but not reporting it to their physicians. Nor were their physicians asking if they were taking this herb. And yet when the researcher who overheard these conversations looked into the literature at that time, there wasn't a single scientific study on the effect of black cohosh on breasts. And so this particular researcher was someone who studied tumors and became very interested in this concept, and began to study specifically the effect of black cohosh on estrogen-dependent and estrogen-independent breast cancer cells, to determine its safety, and found that when black cohosh was used alongside traditional types of chemotherapy, it can either increase or decrease the effectiveness of the

treatment, depending on the specific type of chemotherapy. Black cohosh also, it was found, can potentially increase the toxicity associated with certain traditional types of chemotherapy.

We're also examining the effects of estrogen on postmenopausal cognitive function, because of increasing recognition that attention and memory disruption occur during menopause, and appear to be related to declining estrogen levels.

We're examining vascular risk in pregnancy, complications of HIV exposure in women, sex-specific effects of undiagnosed diabetes, and the genesis of autoimmune diseases such as systemic lupus, which is nine times more common in women than men, particularly African American women.

And my second point about the importance of including mental health into our research agenda: We are also studying the neurobiology of depression, the role of estrogen in mood disorders, and why women with bipolar disorder are less likely than men to respond to traditional treatments, tend to have a worse prognosis overall, and have a higher risk for suicide.

Our investigators are also finding in animal studies that genetic variability can make some females more susceptible to depressive-like states, and that depending on genetics, it's now thought that hormonal therapies for depression may be useful for some women and not others, with regard to depression.

We're examining new treatments for premenstrual dysphoric disorder, as well as for reasons why depression is so common after heart attack, more common in women than men, with nearly half of all women suffering from significant depression following a heart attack, and for whom the development of depressive symptoms is associated with a higher rate of death. And in other work, we have demonstrated that women do better during cardiac rehabilitation with the addition of stress-reducing interventions added to usual care.

We're studying the role of gender in stress-induced brain changes, and finding that females are more vulnerable to the detrimental effects of stress, and continue to show these effects for a more protracted period of time.

We study women and addictive disorders. Because rates of illicit drug abuse indicate approximately a 2 to 1, male to female ratio, women have been seriously under-studied in this area.

Yet women unfortunately comprise a large and growing subgroup of individuals abusing drugs in the United States. Estimates from the 1994 National Household Survey on Drug Abuse indicate that now a full 37% of the illicit drug-abusing population are women, and that women are more likely than men to be at risk for abusing prescribed substances. Although men are more likely to use and become dependent on drugs, women, when they cross the threshold into drug abuse, are likely to show a greater number of biological, social, and psychological problems than men, with more significant impact on children and families.

We're studying the sex-specific effects of genes on alcoholism, postpartum relapse to smoking, a major problem. In reference to smoking, we know that for the same lifetime exposure to cigarettes, the risk of developing cancer is greater in women than men. The death rate from smoking-related illnesses is rising in women. Yet one in four girls under the age of 18 in the United States now smokes. Importantly, we're discovering that women have increased sensitivity to the behavioral effects of stimulant drugs, such as nicotine, which results in our becoming more rapidly dependent on these substances, and thus informs the need for early prevention of even experimenting with drugs like nicotine.

We're studying the causes of violence and revictimization in the home, because the leading cause of injury-related emergency room visits for women is assault by their partner.

Still others of our investigators are testing the value of community-based mentorship for inner-city young mothers presenting for their first prenatal visit in their third trimester. This program attempts to help young women find a personal direction, allowing them to achieve a life that provides opportunities. These researchers had obtained funding to follow the newborn babies of the young mothers. But until our program was born, they could not find funding to work directly with the mothers.

This is only a glimpse of the many exciting projects underway. It does not mention the whole expanse of work, or the work that has yet to be done. For example, in other disorders more prevalent in women, such as generalized anxiety disorder, panic disorder, post traumatic stress disorder, traumatic grief, eating disorders. It does not include work that has yet to be done in

schizophrenia and manic depression, for which there are known gender differences in age of onset, treatment response, and natural course.

And so looking forward, two questions: What needs to be studied? And what can be made possible through research? When we ask what needs to be studied in women's health research, the real answer, as demonstrated by just this snapshot of studies that I've already listed, is that many content areas need to be studied across many different disciplines, because importantly, there is not a single system or set of topics that define women's health.

I was recently reading about Jeanne Louise Calment, who lived from 1875 to 1997, and at the age of 122, was the oldest fully authenticated human being that has ever lived. She was asked about her longevity. She attributed it to olive oil, port wine, and chocolate. [laughter] Some days I think maybe she's onto something. I would like to think that would do it for all of us. But alas, I suspect not so. We need to know more. And so we turn to research.

What can be made possible through research? The promise of research is discovery and innovation, finding out what we did not know, and using new information to change. Based on research discoveries, we can improve our health, our illness outcomes, and the health and lives of those that come after us. A committee charged by the Institute of Medicine to respond to the question of whether sex matters in our explorations of human health, recently reported: Sex does matter. It matters in ways that we did not expect. Undoubtedly, it matters in ways that we have not begun to imagine.

As Marie Curie (who was never admitted to the all-male French Academy of Sciences, even after winning a second Nobel Prize) is quoted as saying— Well, she probably said a lot of things - but what I could tell you she said is, she said, "I never see what has been done. I only see what remains to be done." We have before us a tremendous opportunity to broaden the scope of knowledge on human health. We have before us the opportunity to form interdisciplinary collaborations in basic science and clinical research which can take us in innovative directions that will truly address the many disorders and conditions, by considering the integration of biological and psychosocial variables. We have the opportunity to build cutting-edge inquiry that can become part of the fabric of this nation's research agenda, inquiry forged for the purpose of

advancing the health and health care of women, of all populations of women in need of care, and based on the belief that we can make a difference in women's lives, and in so doing, we will derive benefit for every member of the society. We in science appreciate your support in maintaining the momentum that can too easily be lost, but is so much needed to affect the future. We welcome the opportunity to talk with you about what we learn and about how we learn it. You ask us to explain our work, and consequently we know it better. You remind us of the need to look for the practical implications of our work because you need to know how to apply our findings. Thank you for your interest in health, in women's health, and in the mental health of women, and for your interest in support of research. Thank you. [applause]

QUESTIONS FOR DR. MAZURE

JL: Dr. Mazure can take a couple of questions before she has to run out to catch a flight.

Q: Dr. Mazure, in light of all of the scientific evidence that's available to both men and women nowadays, can you offer a simple way to evaluate what we're reading and what we're being told, to determine for ourselves what is accurate and appropriate?

A: It's a great question. Basically, I have a two-part answer to that. First is, as you're suggesting by your question, we all have to become better consumers. We have to understand more. And yet the way in which information is provided to us often can be confusing. One part of the answer is that when you see change— So one day you open the paper and it says you should drink a glass of red wine. And the next week you open the paper and it says you shouldn't drink a glass of red wine. Or you should take 1,000 milligrams of calcium, and then you should take 1,500 milligrams of calcium.

One of the things to consider is that at point A, you were being told what was known at that point in time. And at point B, when you're getting new information, it might be that science is actually updating itself and giving you better information. Right now, women are being told that 5% of breast cancer is genetic. That's true today. But as

science advances, that number is going to change. And I think it's important for us to communicate to the public that what you read is what is known today. It's the best information we can give you today. But it will change and it will shift, and you shouldn't feel disenfranchised from the information you get, or from your physician or your provider, because they're trying to provide what's known today.

Part B of the answer is that I think we do have to do a better job of explaining our own work. And I'd like to see more people in venues like this, having the opportunity to talk about their own research and how research works, so that people can be more informed and make their own decisions then, in terms of the credibility of the work. And even the little debate we heard today, I think, is very good for people to hear. There can be disagreements in the scientific community. And you as a consumer need to know that, and to parse out, based on the best information available, what you want to do for yourself.

Q: Hi. You alluded to some scientific knowledge that we have now about onsets of some of the mental health issues (schizophrenia, bipolar). Could you elaborate on that a little bit?

A: Sure. Basically, a lot of what we now take for granted has really been hard fought in terms of getting the research funding necessary to do the kinds of research necessary so that we really do understand the prevalence of these disorders and the natural course of these disorders (how they appear, the symptoms related to it). For example, during the Carter Administration it was Rosalynn Carter largely who was responsible for movement within the NIH (the National Institutes of Health) to find the resources to do the first major nationwide study on the prevalence of mental disorders in this country. People have referred to this work—still refer to it today, because it's very important work—where it began to capture the prevalence of illness in the community, not the prevalence of illness as reported in clinical settings, but what was really going on in the community. And that's so important because we need to understand that we're not alone in these disorders, that they are common, that they exist across socioeconomic classes, they exist across age groups,

they exist across racial boundaries. And we need to be aware of those and make those illnesses and disorders part of our priority. So those are the kinds of studies that have been done that now actually have documented this.

And then in recent years there's been another study that's a major national study called the National Co-Morbidity Study. And that study has basically replicated the earlier work, confirming a lot of the earlier work, and yet expanding on it as well. Because as the name of the study implies, people are now realizing that disorders often don't come alone. They come in conjunction with other disorders. So for example, it's not uncommon for depression and anxiety to occur together. It's not uncommon, as you hear today, for people to have substance use issues in addition to mood problems. And this particular study now has made a huge contribution in helping us to understand that many of these disorders are co-occurring. And you need this work so that clinicians can be prepared, and health services can be prepared, for what has to come in order to provide treatment and prevention strategies.

I do think it's unfortunate that we in this field still are carve-outs, and until we no longer are carved out, it's not clear to me exactly how we're going to really take this on in a serious way. But nonetheless, I think that these kinds of research studies are very important in making the case about the prevalence of these disorders, how pernicious they can be, and the importance of treating them.

JL: Thank you. [applause]

JEFFREY LEWIS

Let me introduce to you Dr. Linda Babcock. Linda Babcock is the James M. Walton Professor of Economics and the former Acting Dean at Carnegie Mellon University at the H. John Heinz III School of Public Policy. Yes! It's so great to have you here. (I'm not biased.) Dr.

Babcock's degrees include a B.A. in Economics from the University of California at Irvine and a Master's and Ph.D. in Economics from the University of Wisconsin at Madison. She has received numerous research grants from the National Science Foundation, and has twice received the school's annual teaching award. She is the co-author of a recently published book - which is outstanding - entitled *Women Don't Ask: Negotiation and the Gender Divide*. I encourage everyone to read it, particularly your husbands. Let me introduce to you Dr. Linda Babcock.
[applause]

LINDA BABCOCK, Ph.D.

Thanks, Jeff, for the book plug. And especially thanks to Teresa Heinz for having the vision to develop this conference and just being a true advocate for women. So thank you very much. [applause]

We have assembled an outstanding panel today. Each member, as in the previous panel, is going to speak for about 5-10 minutes. And I'll introduce each panel member as they begin to speak. Now, remember that you have an important role to play in this panel today. On your tables you have cards that you can write questions on for the panel. When you finish writing your question, you can pass it to a staff member, and I will ask the questions of the panel. Like all professors, I like good penmanship, so please try to write legibly.

I'd like to invite up the panel now to come and sit down. I'll just give some brief descriptions of the panel members. There's a fuller bio in your packets. Because if I were to talk about all the accomplishments of these panel members, I would take the entire hour and a half, just talking about them. And we want to hear what they have to say. So I'll just say something briefly about each one.

Susan Cochran is going to speak first, and she is Professor of Epidemiology at UCLA's School of Public Health, and also a Professor of Statistics in the statistics department at UCLA. She has a Master's degree and a Ph.D. in clinical psychology. She's a fellow of the American Psychological Association, and has received numerous distinguished awards and research grants.

Her research focuses on the mental and physical health consequences of social stigma and discrimination, particularly as it affects racial and ethnic minorities, women, and lesbians. Dr. Cochran. [applause]

SUSAN COCHRAN, Ph.D., M.S.

Good afternoon. I'm delighted to be here today, and I want to thank Teresa Heinz and the Heinz Foundation for letting us spend the day thinking about what is the best way to address mental health issues among women. My task, I think, is to talk for a few minutes about the specific issues that lesbians and bisexual women face when they try to access mental health care. This is a population that is greatly under-studied. It's about 4% of women in the United States, more so in urban areas, less so in rural areas. And I can't help it, I'm a statistics professor, so I say, well, there's 2,000 of us in here, and at 4%, that means there's about 80 lesbians and bisexual women sitting amongst us here in the room. And the reason I say that is to just underscore how isolated many of these women feel.

It's been said that people seek mental health services for any one of three reasons. First, they might be seeking treatment because they have symptoms associated with a disorder. Somewhere around 30% of us will experience a mental health disorder at some point during our lives. And as we've all heard today, these disorders are frequently recurrent or chronic in nature. Recent estimates suggest, however, that only about 40% of people, in the case of major depression, will ever receive even minimal treatment for their disorder. But women in general are more likely to receive services than men.

A second reason why people seek mental health services is that they're having difficulty with stressful life events. Although men and women experience similar rates of traumatic events, unfortunately, women experience more so-called noxious events than men do. Noxious events are described as human-made trauma, those things that are done to us by others, such as, in their most serious rape and abuse, and perhaps in the everyday world, rejection and loss. Noxious events have particularly pernicious effects on our psychological health.

And finally, a third reason why individuals seek mental health services is that they're interested in enhancing the quality of their lives for self-exploration.

Now, lesbians and bisexual women, like other women, seek mental health services for any one of these three reasons. And they do so apparently in far greater numbers than do other women. For example, in a recent survey that my research group did in California, studying the lives of 2,000 lesbians and bisexual women, we observed that about 80% of them reported being in psychotherapy at some time during their lives. This is a very, very high number. And this is not because, as stereotypes go, that homosexuality is a sickness. In fact, counter to stereotypes, most lesbians, like most women, do not suffer at any given time from a mental health disorder. But we do know from recent findings that lesbians, and especially bisexual women, are more likely than heterosexual women to experience stress-sensitive disorders such as depression and alcohol dependence. Generally we think this is a byproduct of the fact that lesbians and bisexual women have more frequent experiences with day-to-day discrimination, and fewer sources of social support, especially from their families.

Lesbians also enter therapy for self-exploration, to deal with what it means to be gay in a world where most are heterosexual and homosexuality is a stigmatized status. We need to remember, in these times of genomics and MRIs and wonderful advances in biological studies, that stress does not simply occur because of genetics or chemical imbalances in the brain; that social exclusion also hurts.

Let me speak for a moment about some of the difficulties lesbians may experience when they seek mental health care. For all women, there are many, many barriers to accessing mental health services. A major one is financial. This affects women no matter what their sexual orientation. A second barrier, as we've heard today, is stigma associated with mental illness. In fact, in several surveys, when people are asked, "What would keep you from seeking mental health services if you needed them?" the number one response by people is that they fear what others would think of them. Lesbian and bisexual women experience both of these barriers, and some others as well. When a lesbian seeks mental health services, she must confront the possibility of anti-gay prejudice. Often mental health services are delivered in the primary care environment, but

providers and their office staff are people too, and like most Americans, vary in their opinions about homosexuality. Lesbians know this, and we estimate that perhaps a third choose not to tell their primary care providers that they are in fact gay. It is difficult to imagine how one could get one mental health care if you don't have the freedom to talk about your life.

For those women who do see a mental health care specialist, finding a specialist who is not biased can sometimes be a trial. Managed care companies may not have provider lists where lesbian-friendly providers are identified. And even asking for a lesbian-friendly provider means a loss of privacy and confidentiality. Many therapists know very little about lesbians' lives, except what they've learned from stereotypes. A therapist might see that a woman's homosexuality is the problem, not what her presenting complaint is, not what she actually comes to therapy to want to work on. And some providers think that it is their job to treat homosexuality, despite resolutions by most major professional organizations that this is inappropriate. How often does this happen? Well, it happens often enough. And when it does happen, it is nearly universally seen by lesbians as an unwelcome intervention and harms the therapy.

I guess the bottom line is that when we think about access to mental health care and treatment issues among lesbian and bisexual women, we need to think broadly. We need to consider the subtle ways in which the life experiences of these women diverge from those of other women. And we need to remember that social disadvantages can carry themselves into the treatment setting. Thank you. [applause]

LINDA BABCOCK, Ph.D.

Thank you very much, Dr. Cochran. Our next speaker is Judith Lewis Herman. She is Clinical Professor of Psychiatry at the Harvard Medical School, and Director of Training at the Victims of Violence Program at the Cambridge Hospital. She received her medical degree from the Harvard Medical School, and her training in psychiatry at the Boston University Medical Center. She is the author of two award-winning books, and the recipient of several distinguished awards.

Her research focuses on the psychology of women, child abuse, domestic violence, and post traumatic disorders. Please welcome Professor Herman. [applause]

JUDITH L. HERMAN, M.D.

Thank you very much for having me here. I want to thank particularly Teresa Heinz for bringing all these . . . people together in this wonderful way.

What I want to talk about is the impact of violence on all of our lives. And what I think is hard for us to recognize is how endemic violence is in our lives and in our society, and how profound the impact is, not only on the direct victims but on all of us; that we all live in a climate of violence that instills fear in all of us, that restricts all of our activities. And you know, when you're frightened, you put your head down. Right? You kind of put your eyes down, you put your shoulders down, you cringe, you get more quiet, you try to make yourself small. And this is something animals do, not just people. And so it's hard to keep talking about it, but it isn't going away, so I'm going to talk about it. I also prepared some handouts in your packets, that give you some data, some statistics.

And if you take a look in your packets, you'll see that the first page says: NIJ-CDC Collaborative Survey. I want to call your attention to this. This is a study that was done five years ago now, collaboratively by the National Institute of Justice and the Communicable Disease Center, to look at the prevalence of violence against women. It's a nationwide survey with 8,000 women, 8,000 men, random sample. It doesn't get better than this in terms of methodology. And the numbers are pretty shocking. If you take a look a look at that first page, 17% of women are rape victims; 3% of men. Physical assault: If anything men are assaulted more frequently than women, over half.

And then they broke down the physical assaults into different kinds of assaults: slapped, kicked, choked, hit with objects, that sort of thing, beat up, threatened with a gun. As you'll see, physical assaults tend to happen more commonly to men than to women, but if you look at the next page, what you'll see is that men's experiences of violence and women's are entirely different

in terms of their relational meaning. For men, the most likely assailant is a stranger. And so once the violence episode is over, it's not likely to be repeated. It's not someone who's part of the person's life. Once he gets away, it's over. For women, the most common assailant is an intimate partner. And what this means is that if violence is part of your life, it's part of your life for a long time, and there's no easy escape. For both men and women, the assailant is usually male. And if you turn to the page where it talks about assault by an intimate partner, there you'll see again that men's experience of physical violence is very unusual; whereas for women, it's about a quarter of us that, over a lifetime, are going to be assaulted by an intimate partner.

I also want to call your attention to that next page, Exhibit 6, women victims' age at the time of first rape. And what you'll see—and this is a true shocker to me. I mean, I know this stuff but I never get over it. Twenty-one percent were under 12 at the age of their first rape. And another 32%, another third, in the 12 to 17 age group. Another 30% in the college years. If you make it to 25 without being raped, your odds go down. But what that means is that developmentally, the fear of violence is part of our growing up. It's part of our childhood, and very much part of our adolescence. And it shapes who we become, our identity and our intimacy.

Given that reality (which has not changed very much, by the way, over the last three decades), where other forms of violent crime have diminished quite dramatically (stranger assaults, robberies, that sort of thing), violence against women and children has not. It's stubborn. It's resistant to the kinds of fluctuations in crime statistics that we generally hear about. Knowing this kind of prevalence, it won't surprise you to find out that women are twice as likely as men to have post traumatic stress disorder, and that in fact the prevalence of post traumatic stress disorder among women is 10%. That's a lifetime prevalence. That's one of the most common of all mental disorders in our population. These figures come from the National Comorbidity Survey, which you heard about earlier. There's been a lot of confusion, I think, in my field, the traumatic stress field, about why women are suffering from traumatic stress so much more commonly than men. Is it some sort of genetic vulnerability? Is it hormones? I don't think so. I think the difference in prevalence can be entirely and adequately explained by the difference in our exposure to violence. In fact, again in the National Comorbidity Survey, if you look for example at male and female rape

victims, men are even more likely to get post traumatic stress after a rape. Sixty-five percent of men suffer from post traumatic stress after rape. About 50% of women. So that I think if you control for the level of violence that we are subjected to, I think it explains the difference.

The other study that I want to call your attention to (again it's in your packet), that I think has enormous policy implications, is a study again conducted by the CDC, this time in collaboration with Kaiser Permanente. The study is still going on, and their latest in is over 17,000 people, because they have access to patients in doctors' offices, and they ask questions about exposures to violence, in particular, exposure to violence early on in childhood. So this is called the Adverse Childhood Experiences Survey. Vincent Felitti, a gynecologist, is the lead author on this, and he's somebody who became interested in this subject because he saw so many women in his GYN practice who had unexplained health problems, that didn't seem to conform to any known medical diagnosis. And it turns out that they were trauma survivors. So he went back and looked at the health impact as well as the mental health impact of adverse childhood experiences. And what he describes is what he calls a dose response curve. The more exposure to these kinds of experiences you have in childhood, the more likely you are to make a suicide attempt as an adult. It's almost an exponential curve. If you see on the chart, I've showed that the more early childhood adverse experience, the more the suicide curve just goes up, and the more health risk behaviors go up: the more likely you are to become a smoker, to use alcohol, to use injection drugs, to have more than 50 sexual partners. There is a way in which early on exposure to violence makes it very difficult for a person to learn to regulate feelings in a safe way. And so in those situations, people use drugs to regulate feelings, they use impulsive behaviors to regular feelings, and tend to end up with major depression and suicidality as well as major health risk behaviors.

So violence prevention as a health intervention is, I think, very much under-appreciated in terms of the health and mental health consequences of violence. We are not putting nearly enough effort into violence prevention. If there's one policy implication that I would draw from these data, I would say, let's put our preventive efforts into preventing violence against women and children. Thank you. [applause]

LINDA BABCOCK, Ph.D.

Thank you very much, Dr. Herman. I'd like to now introduce Barbara Jones Warren. She is a professor at Ohio State University and is the Executive Nurse for the Ohio Department of Public Health. She is a Ph.D. and is an A.P.R.N. She has published in numerous professional journals, and presents her work at a wide variety of conferences. She is the past president of the American Psychiatric Nurses Association. Her research focuses on issues of culture and depression in African Americans as they relate to public mental health and psychiatric mental health nursing education, practice and research. Please join me in welcoming in Professor Warren.
[applause]

BARBARA JONES WARREN, Ph.D., A.P.R.N.

Good afternoon. I am so struck by this wonderful sea of women and the men who are here to support us. And I must say that I give thanks to Teresa Heinz and the Foundation for helping us to tend and mend to ourselves today, as well as present some of these issues that we think are so critical to the issues of women's health.

I would say that one of the most important things—and I believe that the issues of public policy and access to mental health care really rest with the understanding, and are very contingent upon, knowing a lot about multi-layering of cultural issues for women. I think when we looked at the video, it struck me again that we are indeed fascinating, and we're complicated with that fascination that we have with us. So that I'm saying, in my roles— and I am an advanced practice psychiatric mental health nurse - I have been for more years than I will share with you at this time. But as I look at the issues of teaching, as I look at the issues of practice and also research that is being done in the issues of culture, I think it needs to be greatly expanded. And I think we also need to look at expanding our definitions of culture. I think we need to look at it very widely, because the issues of culture that affect women also encompass age, class, sex, gender, sexual

orientation, yes, race and ethnicity and religion, and any other way that a woman chooses to self-define, or that society often self-defines us without even our knowledge or our wish.

I think it's important for us to look at the issues of culture also with mind, body, and spirit. And as a good psychiatric mental health nurse—and you don't have to answer me on this—I would ask you to assess yourself right now, and to think about every day: What do you do to nourish your mind, body, and spirit? That's my PR as a practicing psych nurse, to say that, and to think about that, because everyone in this room is very instrumental in moving forward the issues of women's health, moving forward policy, moving forward the issues of access to care, and for us to all work together.

I think the issues of culture—and when we're looking at this whole idea of women's health—are really grounded in what I call the “isms”: classism, sexism, racism. And so that when we look at public policy and we look at access to care, we have to acknowledge those issues. When we're beginning to do research, we have to look at those issues and how they're influencing things.

So the issues of mental health now add another component, this issue of stigma. We talked about this today. How stigmatized is mental health wellness, body, mind and spirit? Some people refer to it as being balanced when you're well; that I am healthy in all areas. The women I see talk about that. I call it a culturally competent approach to the conduct of education, to practice, and to research. It's a process. It's understanding the world views on an independent one-to-one basis, but also understanding the world views that fuel public policy and fuel access to care.

For example, I must certainly understand where someone comes from, what beliefs, what values they are grounded in. I must also understand, when I'm trying to get research money, where people are coming from, what they think are the value systems. Someone at one point told me, when I said I wanted to really study research in the area of depression for African American women, that it really wasn't sexy enough. Now, if that isn't an “ism” adding to it, I think that's quite interesting. But I think that these things that are important to us as women really are grounded in these whole ideas of: Do I understand where someone is coming from? Do I understand the organizations, the institutions that I am in? Do I understand the public policy

makers and where they are? And how do I flip those things around so that in the lives of us as women, we do all these wonderful things? We're multi-tasking. I tell my husband all the time, "Women multi-task." I said, "You know, men don't quite multi-task." Nothing against them. I love men. But really this issue of multi-tasking is wonderful for us. It's fascinating. But you know, it can kill us if we don't do some parameters on how much we multi-task.

So I think when we're trying to help individuals, when we're trying to access care for people, when we're trying to help them learn more about these things, it's important again to think about it—the issues of adherence. People call it compliance. I don't like the term "compliance." I like "adherence." "Adherence" means to me a much broader context. It means that the person understands; it's culturally competent; it's relevant for them; it meets the needs. The policy is culturally competent; it's understandable for people from different cultural groups and the bases from which they come. So adherence to medication—and this is the touchy thing that we often get into with single individual practitioner-to-client work, that if the person doesn't understand where I'm coming from, and I don't understand where they're coming from, we're not going to get very far. I'd say the issues still exist, again for public policy areas. We have to continue to not try to hide who we are, but to really immerse ourselves in the strengths that we have, and to move those forward. And the issues of culture, I think, are just critical when it comes to public policy and access to care. And I encourage you all again, as I close on this, to make a little assessment. Take care of yourself, and take care of that mind, body, and spirit. And increase and draw that forward as we look at issues of public policy as well, and we force individuals in public policy areas to really examine the issues of culture and the importance that they are to people. We are not the old melting pot, contrary to popular belief of many people. We are a wonderful sea, as we see in here, of a variety of thoughts and issues and minds that create the fascination for the work I think that we all do in mental health. Thank you. [applause]

LINDA BABCOCK, Ph.D.

Thank you very much, Dr. Warren. I'd now like to introduce our final panelist, who is Marylou Sudders. She is the President and CEO of the Massachusetts Society for the Prevention of Cruelty to Children. This nonprofit organization integrates mental health and physical health with social and developmental programs for children and families. She is the previous Commissioner of Mental Health for the Commonwealth of Massachusetts. She holds a Master's Degree in social work, and serves on the boards of numerous organizations, associations and commissions that address health and children's issues. Please welcome Marylou Sudders.
[applause]

MARYLOU SUDDERS, A.C.S.W.

Good afternoon, everyone. Wouldn't you know, they leave the public policy, former public official last? We mend and tend. We are caregivers and caretakers. We are not always so good as women taking care of ourselves. So if nothing else today, we should take today's conference title to heart: Caring for Our Mental Health.

My perspective is probably different and somewhat cloudy and even perhaps myopic, given my life as a public servant and as a former public official. Although trained as a clinical social worker, my career and passion for public policy and advocacy come from personal experience as a teenager struggling to understand what was happening to my once vibrant and loving mother, who, as I now know, suffered from unremitting depressions, probably started postpartum from me, and which she self-medicated with alcohol. After going to many doctors to find out why she had no energy, she turned to the bottle. Her world was reduced to the couch. She didn't even have energy to make it up the stairs to bed. I watched, as a 15-year-old, with shame and anger as her friends, her church, and her family withdrew. So for the last nine months of her life, I took care of her as she died from cirrhosis, four days after her 40th birthday. That nine months also took care of any interest I ever might have had in nursing.

When we think of health, 99 out of 100 times, we think of physical health, not mental health. So I applaud Teresa Heinz for today's conference, for bringing us all together. Mental

disorders are shockingly common, affecting almost every American family. I paraphrase from the recent Presidential New Freedom Commission on Mental Health. I like that quote because so often government reports are pabulum or white bread. Of course to me, the title of this report, "Achieving the Promise," falls short, because it's not clear to me that as a society we have ever made a promise to mental illnesses and people with mental illness. Mental illnesses are an equal opportunity disease. You've heard that throughout today. They strike regardless of age, sex, socioeconomic status, race, ethnicity. And because we're in the great Commonwealth of Massachusetts, as I used to always like to say, it affects Republicans, Democrats, and Independents alike. They affect one in five Americans. They are life-threatening illnesses if not recognized and treated.

The statistics in general, and for women in particular, are numbing. And I'm not going to bore you with all of them, but with a few. Some mental illnesses, such as depression, disproportionately affect women. Depression is the most disabling disorder, and women are at least twice as likely as men to experience a major depressive disorder within a lifetime. That equates to more than 12 million American women. It has been well established that women use mental health services more than men. However, the number of women coming for care still represent only a fraction of those women who are depressed. Mental illnesses rank first among all illnesses that cause disability in the United States, Canada, and Western Europe. And we know mental disorders exact tremendous personal costs, including loss of life and increased morbidity, to name a few. They also incur tremendous significant economic burdens resulting from disability and loss of income. According to the World Health Organization (not some squishy mental health group), four of the ten most disabling health conditions in the world are mental disorders, with depression being number one by the year 2010, for everyone.

We all acknowledge that we have a significant healthcare crisis in our country, and so often forget that mental health is part of that crisis. Health insurance coverage is a consistently strong predictor of mental health service utilization, with better insurance benefits associated with increased level of service utilization. However, as we all know, where is parity insurance for mental disorders? Health insurance coverage does not guarantee the inclusion of mental health

benefits. It is a shame and a scandal, as far as I'm concerned, of course. [applause] Because even for those in the public who don't understand mental illnesses, they understand insurance. When you have an insurance card that says you get so much for physical health care, but then you get this 1-800 number to call for mental health, it sets it apart; it segregates it; it discriminates it. It says it's something else, other than an illness. We don't have parity at the federal level, and we still have 20 states without any form of parity insurance in this country.

Mental health services have also been a particular target for managed care efficiency or cost cutting. Spending on mental health services has declined more than 50% over the past decade by existing insurance programs, and reimbursement for mental health services has increased far more than for any other area of health care. Where is the outrage? Where is the public health campaign? In spite of courageous voices and occasional elected official champions, one surgeon general's report, the latest research breakthroughs, it is still our hidden epidemic. It remains the stepchild of health care. Why? The illnesses continue to be defined by societal attitudes and media's portrayals, the fear of the unknown, violence, uncontrollable behavior. Stigma and discrimination is alive and well and thriving in America. In spite of all of our efforts, stigma exists. It may be covert, and we may be more politically correct in the language we use.

Together, we must stand and say that mental illnesses are illnesses. People with mental illness and their family and loved ones deserve to be treated with dignity and respect. And the historic segregation of physical health and mental health must end. And until such time that that happens, mental illness will always be seen as something else. Then perhaps we will make that promise. We must collectively make that promise before we can achieve it. Thank you.

[applause]

QUESTIONS

LB: And now it's time to answer your questions. We have quite a lot. It's hard to choose. We have an overwhelming amount of questions about the healthcare system and about insurance, so let me start with one of those: We're the only industrialized nation in the world that does not have universal health care. Would you comment on the pros and cons of such a policy, on the availability of mental health treatment? Maybe somebody besides Marylou?

MS: My guess is, you sort of know where I come down on that. We spend a tremendous amount of money in the United States, a trillion dollars actually, on mental health and behavior health care. A lot of it has to do with provision of emergency services, and so in the wrong end, if you would, in my perspective. If we had universal healthcare coverage that included mental health and physical health care, and had acceptable services including alternative services (things like peer support services) in addition to treatment, we'd go a long way to making our society a better place. We are the only civilized country that does not have universal health care, and it's got to change. [applause]

LB: Would other panelists like to add?

: Anybody opposed? [laughter] Okay.

LB: Here's a question from someone who works for the EPA here in Boston: I would like to hear the panel address the issues raised by Teresa Heinz in her opening remarks. What do you see as the most significant correlations between the environment and women's mental health?

BJW: I guess that I start out on that one. I think if you look at the issues of environment, again you look at (and I'll go back again to where women are actually physically living): What kind of state are they in? What kind of cultural base do they come from? And you look at the whole idea of what is culturally responsive treatment. It may be there, but it isn't there for them. It may be accessible, but it isn't there for them. It may be not even affordable,

and it should be affordable. So when you look at those issues, I think we have to begin to examine and to make sure that women, no matter where they are, have the same access to treatment as everyone else. And I think the issues rest obviously with insurance. I think that has to be addressed. And I think people have to have money to be able to pay for the things that they need. The women that I see, the communities that I work in, all want the same things that everyone else wants, but they often don't have access to them. And they are also very fearful sometimes in trying to even get services, because of what it's going to mean to their job situation. So again we get back to jobs; we get back to the environment and insurance. And I think we have to end that.

SC: I think it's important to think about environment in a comprehensive way, not just a physical environment but the social environments that people live in. In fact, there was recently a kind of natural experiment that occurred (and I'm going to miss the state) in South Carolina or North Carolina, where there was money that went to Indian tribes, that was unexpected. So these were people living in poverty who suddenly started getting checks from the gambling money. And it had a profound effect on children's health.

LB: This question is addressed to Dr. Herman: Violence against women and children has not gone down like other crimes. Why does our system keep creating conditions of violence and abuse towards women and children? What is keeping this in place, in your opinion? Until we identify these systemic forces, I don't think we'll be able to change them.

JH: I think the violence is a symptom of women's subordinate status. It's also a means by which women are kept subordinate. So we have a system and social attitudes in which violence against women is normalized, excused, and condoned. Every time we get a high profile rape trial, we get another teachable moment, if you will, in which the attitudes of entitlement to rape, for example, entitlement to take sex by force, are exposed; and the willingness of a large percentage of the population to excuse the perpetrator, to even glorify the perpetrator, becomes manifest. We also have an entertainment industry and a

pornography industry that present violence against women as fun and as sexy. So that we have a situation in which perpetrators are accepted and excused. And as long as those attitudes prevail, the behavior is not going to change. The behavior will change when perpetrators understand that this behavior is no longer socially acceptable.

LB: So what more can be done to change this?

JH: I think it requires a certain kind of militancy, if you will, a certain kind of fighting spirit on the part of women. It's not going to be being nice and being friendly about it. Trying to charm people out of this isn't going to work. If that was going to work, it would have worked by now. I think it requires a certain amount of organizing, not only to provide services to the victims once the violence has happened, but to let it be known in high schools, for example, on college campuses, that this behavior is simply unacceptable. When there's a rape in a high school, we don't want anymore the situation where the word gets around and it's the girl's reputation that gets destroyed, and the girl . . . It's the boy's reputation that needs to be destroyed. And all the parents of all the kids need to get together and [ostracize] the . . . Criminal prosecution isn't going to work, as long as there is social acceptance of the behavior. [applause]

LB: Other panel members, would you like to add to that?

MS: The one thing I would say is, right now Massachusetts has started, all with private dollars, a *Stop It Now* campaign, a mass media campaign. It was created by teenagers for teenagers . . . for women to say no to partners when partners are being aggressive with them. It's an incredible campaign. You'll start seeing the billboards (there's actually some up now) and TV spots. All the major TV channels have come together on this. It's a huge public education campaign really targeted to teenagers, called *Stop It Now*. And it's that kind of very public "It's not acceptable," that will start to change behavior.

Let me just give you one, to me, incredibly frightening statistic: 70,000 children in Massachusetts are reported abused or neglected every year. Just to give you a sense of what that is, the Fleet Center holds 20,000 people. So that's filling the Fleet Center 3+ times. That's the number of kids who are abused and neglected, primarily by caretakers, and a lot of it is sexual, and a lot of it is physical violence. And it's that kind of campaign that you have to start and be very public about, if you really want to start changing behaviors in the long run.

LB: What kind of women's mental health support groups are available, especially for people without insurance?

BJW: I think there are some (what I call) self-help groups that exist. The National Black Women's Imperative has some groups that exist. I think wherever people's communities are, one of the best places to locate a lot of services is through the public mental health systems. And often there are groups through there. There are women's advocacy groups that go on within communities. So I think those are places that you can begin to look for those support groups. And there are some therapists that are often listed in areas that do run groups and do pro bono work. And often your mental health associations will have those individuals listed as well.

: I think contacting mental health associations. Contacting the National Alliance for the Mentally Ill, the state chapter where you live. And also groups such as - Massachusetts is proud to have a group called Empower, which is a consumer self-help movement of very strong peer support. Hopefully, your public mental health authority, like the state department . . . call the Commissioner's office, they should be able to give you some of those resources. They are hard [to find], but they do exist.

SC: There's also the Web. A lot of people use the Web. And the other thing to remember is

that the person who's most likely to be diagnosed by their physician with a mental health disorder is the person who comes in and complains directly about symptoms, where the provider goes, "Oh, that person has depression." So another way to get treatment is to actually make that part of your presenting complaint when you go in for a visit.

JH: I'd just like to add, though, that there's nothing like taking your own initiative. If there isn't a support group around, there's no reason why you can't start one. And a lot of the organizations that exist today started sometimes with one woman at her kitchen table, basically putting up a notice in a supermarket or on a community bulletin board, saying, "Does anybody else have this problem? I want to start a group to talk about this." That kind of grassroots initiative can be done.

LB: I have a number of questions concerning the cutbacks in services due to tax cuts. So let me read a couple of them: In Massachusetts, many of our state mental health facilities are in the process of downsizing and closing. How can we continue to provide services when programs are being eliminated? Also: Unprecedented tax breaks for the wealthiest 2% of the country [have] resulted in massive cutbacks in vital human services, including mental health services across the nation. How do you propose we address this problem?

MS: Well, you didn't hear what she said. She's from Ohio. She can't answer this one.

MS: Let me go back to remind my friends from Massachusetts of something that happened a couple years ago. Something positive came out of a horrible thing. Several years ago when the legislature, in their wisdom, decided to not pass the state budget till November, when it's usually in July, we took devastating cuts in three state agencies. The Department of Mental Health was one of those three. (My friends from Massachusetts, I can see a few people nodding their heads.) And if you remember, we collectively came out strong together, all our voices together, got the governor to stand with us to say, "This is wrong. This cannot happen. These are devastating cuts." And the lesson that year was, the legislature actually came back in session and restored the funds to the Department of

Mental Health first. And one of the lessons we took from that was: We will never be last again. We might not always be first, but we will never be last again. And that is the message that I keep saying, even though I'm no longer a public official, to my friends in the mental health community, which is: We don't know what's going to happen in this year's budget, but that we need to stay strong. We need to stay together. It's got to be the voices of professionals, the voices of consumers, the voices of public officials, appointed officials, elected officials, the entire voice of the mental health community standing strong, so when the budgets come out, it is collective voice and not singular voice. And that is what starts to change. When the devastating impact of these kinds of cuts— I used to feel like I was the commissioner with a chip on my shoulder, saying, "Mental health! Mental health!" But not really, because we actually did some very good things. We need to remember to take the strength and build upon it. And that's one of the things. But one of the devastating things about some of the cuts in mental health is that because we're never terribly well funded, because we've always been the stepchild, whether it's insurance-driven or public mental health dollar-driven, that the cuts are even more insidious because you never started off at the same bar. So you need to stay strong. This is not the time to be quiet. And you know I will always stand with you. But it's your voices that need to be heard. [applause]

BJW: Seriously, I would say that I'm not from here, but in the state of Ohio a very similar circumstance occurred, and we did the same thing. The other thing that we did is that we have an Office of Research, a program evaluation for the state of Ohio in mental health. And we collected all of the research that had been done over a number of years, and the various programs and the various policies that came out of that research. A lot of that research then went on to be funded through National Institutes. But the issue was that we wanted to show a firm grounding, that there were very important issues that needed to be covered when you looked at the issues of mental health and wellness. So I would say that

you need to do that as well. You need the advocacy, you need the support of everyone, but you also need to have the data to back up what you're talking about as well.

LB: I have a few questions about the role of religion and faith - differences in access to treatment for some groups, but [we] haven't talked much about issues of religion and faith. Could the panel members address that?

BJW: I'm not sure what the individual may mean. I think that is a cultural...in my mind it is another cultural influence. And I think you have to provide care for people in the areas that they need it. And people must have access to individuals that can provide that for them. I can only speak on a personal basis from the standpoint of practicing. And that is a component of what I will include in care for someone, when they ask for that. Those issues are important to people. There are those individual cultural issues, but they also may be influenced within the community. So often you have to get the people that are important to the individuals that are coming in to you, and it's also a good access source in order to do some continuing advocacy and some work in those areas. So I think it's important. I think religion and spirituality are very important to a lot of people, and you have to include those when you're looking at issues.

SC: Religiosity is a protective factor. When you think about things that keep people healthy, religion and faith really is protective for mental health.

LB: What hope is there to reduce or eliminate violence in our lives, when we live in a country where violence is the first solution to world problems? [applause]

JH: I'd say, nonviolent regime change would probably be the way to go. [laughter, applause]

LB: Do you have some other things to add? [laughter] Is there any research on mental disorder rates among homosexual men and women who have not come out or discussed their sexuality, compared to those who have come out about their sexuality?

SC: There's only hints and pieces. That work has not actually— It would be very difficult to do it. There are some hints and pieces from some of the major HIV cohort studies, that suggest that it's good for your mental health to disclose. But I don't think we really know the answer to it yet. In another five years, six years, I think we'll know.

LB: Okay, so we'll have to reconvene in another five years. You can tell us the answer to that. This person wants to know about the long-term effects of violence in video games and other TV and programming on children.

JH: I don't know that literature well enough to really speak about it with confidence, but my impression is that there is considerable data to suggest a correlation at least, between, for example, the number of hours of violent programming that children watch and some of the behavioral manifestations of violence in children's lives. But what I think the data are even stronger about (and this is both in terms of violent TV programming and also exposure to pornography) is the desensitization that occurs across the board, the greater the exposure to images of violence. It's only a small subgroup of the children or the adolescents exposed that are actually going to act out violently, where you can demonstrate a correlation between seeing violence depicted, for example, in a movie or on TV, and copycat crimes or an immediate kind of cause and effect. But what you see (and this is well documented in the literature) is a general increase in callous attitudes, a decrease in empathy, a trivialization of violence, and failure to appreciate the consequences or to empathize with victims. And I think that desensitization is seen across the board, and not just in high-risk or vulnerable populations.

BJW: That's critical. We have some researchers in the state of Ohio that did a multi-site study, not just in Ohio but also included outside of the state, and looked at various socioeconomic classes of kids, and examined this whole idea of violence (watching violent TV programs, exposure to violence in schools). And there really was no difference based upon the class

kind of issues; that it was the exposure to violence that really affected these kids' mental health outcomes. And so I think that's critical for us to think about.

I have a film that I show to kids in schools, and it's on gang violence. And it's this whole idea of this desensitization. I still watch that film, because some of these bodies of these kids are riddled with bullet wounds, and I still go like this when I see them. And I've used it for years. These kids, as third graders, look at this film like "No big deal." And it doesn't make any difference what class of kids that I'm taking to. And so it is that whole issue that we've got to deal with K through 12. I mean, we have to do that. [applause]

LB: We have a lot of questions about this issue of violence. Someone wants to know what kind of violence prevention programs you think could be most successful. And how should we implement them?

JH: I think there are two places that are key in terms of violence prevention. One is a pretty obvious one, and that's in the schools. It's already been mentioned. Start early on. It's a message that needs to be age-appropriate. You could do different concepts as the kids mature. But you can start early on. And some of the most successful ones that I know about are ones, for example, where you invite a lot of participation. You don't simply present this in the classroom, but you invite parent participation, you invite participation from the kids. One program I like particularly, called the Child Assault Prevention Program, involves three little skits: one of a kid-on-kid attack over lunch money; one of a stranger attack; and one of a relative. And each time, the actors show a problem, and the kid not being able to escape. And then the kids problem-solve. Well, what could kid do? There's a discussion in class. How could the kid get away? What do you say to your uncle when he says, "Do you want to play that little game with me?" How would the kid be able to seek support, resources? What would prevent the kid from telling? How would a kid reach out for protection? And so that you involve the kids not just as audience but as problem solvers. And the other lesson that we seem to have learned about prevention is,

you can't just do it as a one-time thing. It has to be done repeatedly in each grade, with as much community involvement as possible.

The other thing I want to mention, besides the school-based prevention work, is the preventive work with pregnant women and newborns; that early intervention in that first year of life, there are so many studies now that show that it pays off magnificently in terms of preventing future problems, both for the kid and for the mom. It's a wonderful way to invest money. The problem politically for legislatures is that the payoff is down the road. And the further down the road you get, the bigger the payoff is. By the time these kids are 18, it's a fabulous payoff. But they want to see it [in the] budget cycle. So funding that kind of preventive intervention, even though it's wise public policy, really needs a much more organized constituency. [applause]

LB: I have a question that says: What can one person do to effect change in public policy and help research on issues relating to mental health?

MS: Believe it or not, governors, senators, your public officials actually do read those letters. They do listen to those phone calls. My first job as a social work student was actually in the office of the governor, in his Office of Constituent Services. And phone calls would come in where people were saying they wanted the governor to veto something, or not veto something, sign something into law. We tallied them up, took them up to the governor's office, and they absolutely— It really does matter. There have been times in my life when I think it really doesn't matter. It really does matter to elected officials to know how you feel. It does not take much to make a phone call, send e-mail. They all have e-mail now. The easiest thing to do is that, on an issue you care about.

A little bit more effort is, you join a group of advocates on an issue that you care about. If it's mental illness, if you're a consumer of mental health with other consumer groups, if you're a family member and you want to join groups such as NAMI or PAL, which represents families with little kids. It doesn't take a lot to join a group, to get their

newsletters, just to see what the current events are that are going on for people. That's the easiest way to really affect, and it does matter.

Your voice really does matter. I know we all get cynical. We read the paper and think it just doesn't matter. People really do count those phone calls, letters, and e-mails. It's really the quickest way to get to a legislator. I really have to tell you, it does make a difference, even when you think it doesn't. It really does make a difference.

LB: Depressed people have antidepressant medications prescribed by their primary M.D. without referral for psychiatric evaluation by a qualified therapist. Is this doing a disservice to patients or not?

MS: Absolutely.

BJW: Yes. I can't tell you the number of people I see in my practice that have been placed on some type of antidepressant, the antipsychotic medication, whatever it maybe, the anxiolytics, and it's the wrong dose; they really have not been adequately assessed, including those cultural nuances and those issues that you have to get to, the issues of the environment and all those things. And there's really a growing body of research out there also that looks at the genetic changes and the influence in regard to racial and ethnic groups, and the enzymes and the metabolic changes. And those things often, some of the primary healthcare providers may not have access to. So I think it does do a disservice. And I think it's important always for people to get referred in to a mental healthcare provider and to let that person then monitor what's going on with them. Otherwise you're just shooting in the dark all the time, I think, and it's unfair to the person.

MS: The number one prescribers of psychiatric medications for children are pediatricians. Pediatricians, on average, receive one hour of psychopharmacology training in their medical school training. And pediatricians are wonderful people. This is not a knock on pediatricians. But psychiatric medication and how it affects hormones, how it affects the

lives of people, the side effects, really need to be prescribed by specialists. And it's frightening, who prescribes medications, in terms of what they have for understanding of those medications. It really behooves all of us to ensure the connection between primary care and mental health practitioner, so that individuals get absolutely the best care they can.

We did a study a couple years ago in Massachusetts that looked at prescribing practices among the Medicaid population. There were a whole lot of things that were scary about that data, which is still in the process of being analyzed. But the number of individuals with MassHealth (Medicaid) who had more than one prescriber for psychiatric medications, without the prescribers knowing what the other individual was prescribing, is just frightening for individuals. So it is absolutely essentially, once again, to really bridge mental health and physical health care. Because the reality is, when people first are symptomatic, they probably don't pick up the phone and call a mental health practitioner. We'd like you to, but you don't. So you go to a primary care doctor, you go to your pediatrician, and that's your access point. So for me, it's always about bridging mental health and physical health care in order to get the best care for individuals that need it.

LB: How can we get that message out to people?

BJW: Keep talking about it. I'm sure, like most of us here or many of us here, we spend a lot of our lives talking about that and stressing the importance of it, and also spending time with other mental health providers, and also other healthcare providers. I mean, we have to really go in there and educate them, just as much as we get educated on the cardiovascular issues, the endocrinology issues, those kinds of things that go on. So I think a lot of that is really up to the mental healthcare providers, to also make sure that we're just out there, keep talking, keep bridging, keep working with individuals so that they're hearing our voices all the time. I tell people I work with that I wouldn't prescribe cardiovascular drugs. That's not my area of specialty. I would never do that. So why would they think that they could prescribe something that's my area of specialty as well? And they kind of go, "Well..."

MS: The more educated the consumer, the more you should demand the kind of health care you want. And so if you went to your family healthcare practitioner, your pediatrician if you're going for your child, or if you're going for yourself, and someone suggests some dosage of whatever (Zoloft, Paxil, Prozac), I suggest you go for a walk, being a big believer in exercise. However, I would say, "I want a referral to a mental health practitioner." Lots of reasons you aren't referred is because of, if you belong to a managed care plan, the managed care barriers, if you would. You should just demand it. Like when I go to my primary care doctor, she would never think of treating me for something that's really a specialty. And that's what it is. And the more educated you are, and the more you're comfortable demanding what you believe you're entitled to, we will start to see the changes.

JH: I think we need more meetings like this one. Really. [applause] Look at the amount of interest that's out here. People can overcome stigma by themselves, but you see other people who are out in force, who are interested in this issue, who aren't afraid to acknowledge their own experiences with depression or violence or whatever, it normalizes it, people no longer feel alone, and they feel more entitled then to say, "I want a referral to a psychiatrist or a mental health practitioner, just the way I would want a referral to a gynecologist or an orthopedic surgeon."

LB: I think that's a terrific note to end our panel discussion on. I'd very much like to thank our speakers for joining us here today. And again, thank you to Teresa Heinz for having this event for us all. Thank you. [applause]

TERESA HEINZ

Thank you so much. I haven't won any Oscars, but I'll try and do justice to Patty Duke. And she wrote last night . . . "I am so disappointed to be missing this year's Heinz Foundation

Annual Conference on Women's Health and the Environment, specifically with the topic being 'Caring for Our Mental Health.' I am honored to have been invited, honored to be associated with such esteemed panelists and presenters as have been assembled, and honored to share some of my story with you. Unfortunately, I'm not destined to be a speaker on the topic of women's health this week, but rather an untimely and unexpected real life patient. Some coronary artery work rearranged my plans. I'm home now, resting and getting my energy back, and encourage you to never take for granted those little aches and pains that are a sign of our maturity (or our misspent youth). And I send my deepest regret at not being able to be with you in person. You can be sure that I'm with you in spirit.

"I began my career as an actress more than 40 years ago, and I have been blessed beyond words with many interesting roles and many treasured friends. But only since my diagnosis and treatment of bipolar disorder more than 20 years ago, have I begun to understand the real importance in my life of being a so-called celebrity. And that is the ability to draw attention to the fact that mental illness is a disease, fundamentally no different than heart trouble or diabetes, neither of which carries a social stigma. In writing and speaking over the years about bipolar disorder (manic depression), I've learned that the stigmas our culture associates with mental illness are serious and real. But we have the power to counter them with information, with education, with patience, and with love. I have been an advocate for many things in my life, and I have been blessed with many wonderful professional experiences. But nothing is quite as satisfying as when a person approaches me in the supermarket in my Idaho home, and tells me that a sister, brother, aunt, uncle, friend, mother, daughter was inspired to get help for their depression or mental illness because someone like me spoke out about it in an honest and non-judgmental way. Somehow, all of us think we're the only ones.

"I appreciate that you are all gathered here today with Teresa Heinz, doing the compassionate and diligent work of understanding, training, educating, and teaching about how to improve women's health. You are all heroes because you are each in your own way helping speak out in an honest and non-judgmental way. Slowly but surely, one person at a time, you are helping to serve mental health. And we are together making sure that people who need help will

get help. We still have a long road to travel. But together, as women, mothers, daughters, sisters, aunts, grandmothers, and friends, the support we give those in need makes that road smoother.

Thank you, and I hope to meet you all one day in celebration. God bless each one of you. In love, Patty Duke.” [applause] . . .

Thank you for coming. And if you have ideas for next year, we'll do it again. God bless.
[applause]

[End]

THE TEXT WAS EDITED TO REMOVE CONFERENCE DIRECTIONS AND CONFORM TO A PRINTED VERSUS SPOKEN FORMAT.