



# News for Women in Psychiatry

Newsletter of the Association of Women Psychiatrists

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## PRESIDENT'S MESSAGE



*Altha Stewart, MD*

The end of the year is, in many cultures, a time of reflection and giving thanks. I've spent some time recently, reflecting on the many things I've seen and done this year, especially the not so subtle reminders of the ways that gender bias has become acceptable and institutionalized, and continues to crop up in our day-to-day existence. This lesson is brought home again and again, as I go about my business, even when running personal errands. The places where people gather for those personal services—barber shops, doctors' waiting rooms, grocery lines, even the fish market, are perfect for hearing what the general public knows and feels about illness, health, relationships, and not surprisingly, gender differences. A trip for a haircut brought this fact home to me a couple of months ago.

Knowing of my work in the area of sports, a 26-year-old (male) barber greeted me in the following way: "Why couldn't the men play like the women over there?" referring to the US men's basketball team's performance at the 2004 Olympic Games.

He had seen me a week or so before the finals and we had talked about the need for the men to "step up to the plate" like the women. (As you know, it turned out that the women claimed the gold, while the men only brought home a bronze medal). When I asked him what he thought made the difference in outcome for the two highly skilled and motivated teams, he replied, "They just didn't play well together; everybody wanted to be Iverson." He agreed with the news report that alleged one of the team players had even said it was "...no big...It wasn't like (i.e., as important as) an NBA championship ring..." My immediate thought at the time was: how selfish and self-centered if that's true. As he turned to service his next client, I said to him, "Well, that's just selfish," and he shrugged his shoulders and said, "What do you expect, they usually make a lot of money to play, to win." That explanation was enough for him and the men moved on to another topic. That's when I realized that there was more than just a bit of truth in his statement. Women professional athletes, as a rule, compete for smaller purses (interesting that a feminine term is used to describe the compensation to the winner) than men, and in fact, in some sports, play a slightly modified game from the men. As the commentators for the Olympic Games pointed out, there are other differences between members of the women's and men's basketball teams. Many of the women, although currently professional basketball players, for years had played overseas and until seven years ago, had little hope of playing professionally in the U.S. Even now they play a shorter season which requires off-season jobs, (again, often overseas playing the sport they love, to win) and earn substantially less than their male counterparts.

*President's Message continues on page 2*

*President's Message continued from cover*

In an earlier issue I introduced a theory put forth by our founder, Alexandra Symonds, on the "psychodynamics of expansiveness in the success-oriented woman." You will recall that Allie spoke of women going "beyond traditional sexual stereotypes," including being flexible and changing when necessary, taking risks to expand one's horizons. The women who represented the U.S. in Olympic basketball clearly understood this dynamic. I think this may be a part of the answer to the young man's question to me about why the men didn't play like the women. Whether we believe it's genetic, societal/environmental, or cultural, or all of the above, women do seem to "get it" when it comes to working together to achieve a common goal, even when that means setting aside individual fame and attention in the service of the group.

Which brings me to this issue's attempt to relate the message to the aims and purposes of the organization: "influence the policy and procedures of the APA and work collaboratively to achieve the same ends."

Our membership includes many who are members of APA as well as AWP. At times it has seemed that as an international voice in psychiatry, the AWP often stands alone on issues of major importance to women psychiatrists and patients. For example, the APA has not aggressively advocated in re-

cent years its pro-choice position, despite hard-fought, longstanding, member approved positions on the issue. APA members on the BOT and in the Assembly need our continued support as they work to persuade the APA to risk taking the right step even when it might not seem the politically correct one.

Additionally, while the literature on disparities in healthcare based on culture, race and ethnicity continues to expand, we must still remind those in the field to pursue work to eliminate those disparities based on gender differences and those that occur where race and gender intersect. Discussion of issues of access, quality of care and quality improvement tools that promote positive treatment outcomes must include gender variables if overall improvement of services to women is to be achieved. The culture of gender must not remain an afterthought as the field of psychiatry is transformed.

It is not my intention here to diminish the progress achieved by APA in many areas relevant to our (AWP's) aims and purposes. There has been an increasingly consistent presence of women in key APA leadership positions (at the governance, component, and staff levels) over the last decade. In fact, next year in Atlanta, Dr. Olarte will chair our annual meeting symposium with a panel comprised of the women who've been elected to lead the APA as

president, true women leaders in psychiatry, who will share their experiences and wisdom with us in what I'm sure will be a historic occasion. Allie must be smiling! Whether we agree with our APA colleagues on every position, I think we are obliged to take advantage of all opportunities to lay the foundation for institutionalizing the practice of including gender factors when considering each issue of importance in psychiatry today. We owe it to all women psychiatrists and patients. Being at the table where the decisions are made and taking the risk to engage in the dialogue, despite the politics, is an important part of the change process.

For those of you who are not up on your Greek gods, I want to share a *history* told to me by an analyst friend during a trip to her native Greece a few years ago. It is the story of Hygieia, known as the giver of health, her name the origin of the word *hygiene*. In the past, physicians who pledged the traditional Hippocratic Oath spoke her name in the opening sentence. A common image shows her as a fine young woman feeding a huge sacred snake which is wrapped around her body. The image of that snake together with the rod of Asklepios (her father, said to be "linked with a constellation of idealistic medical ideas"), is the true symbol for medicine. However, it is not the first symbol that comes to mind when I think

*President's Message continues on back cover*

## *News for Women in Psychiatry*

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# News from the APA and Elsewhere

## Mentoring and the Committee on Women

The APA Committee on Women met on September 11<sup>th</sup>. As Chair, I looked forward to being in Washington, D.C. and meeting with the committee of extraordinary women who had accomplished so much. I was especially pleased to learn that the Committee on Women had four new APA resident fellows who would be working with and mentored by our committee members. Why do I believe this is so important? I attribute many opportunities I have had to the mentoring I received as an APA Mead Johnson Fellow (now called the APA Bristol-Myers Fellow). I was first involved with the APA as a resident APA fellow, where I had experiences on several APA components. It was while attending those gatherings, both inside and outside the meeting rooms, that I learned about networking and leadership by women.

This year our resident fellows are Sarah Barrios, APA/Bristol-Myers Squibb Fellow; Carrie Ernst, APA/GlaxoSmithKline Fellow; Luisa Gonzalez, APA/AstraZeneca Fellow; and Nakia Scott, APA/AstraZeneca Fellow. These women came to our meeting with an energy that was contagious to other committee members. Their optimism about medicine and psychiatry was refreshing, and their interest in the stories and successes of women in psychiatry helped us establish an important focus for this upcoming year. I believe their participation in our meeting kept us all more honest.

Our committee is composed of a diverse group of women psychiatrists who take their responsibility to the APA organization and membership earnestly. We reviewed the charge of the Committee, which is to: (1) define and advocate preventative therapeutic actions to meet the mental health needs of women; (2) promote the recruitment, involvement, and retention of women psychiatrists in academic, research, administrative and professional organizations, and develop methods for increasing their participation and leadership; (3) review and stimulate research in women's mental health and address misconceptions that exist in the general population and the profession

about women's mental health issues; and (4) provide information, networking, and collaborative opportunities for women colleagues at all stages of career development.

The resident fellows met with current committee members including Leslie Gise, immediate past Chair; Ann Ruth Turkel; Caroline Fisher; Melva Green, Vice Chair; and Asha Mishra, corresponding member. Two of our members, Barbara Schindler and Deborah Spitz, corresponding member, were unable to attend. Three of the current committee members have also had experiences as APA resident fellows. Also present was Judith Carrier, PhD who is the APA Director of Career Development and Women's Programs and staff person responsible to help the committee navigate through the APA organizational structure and accomplish our goals.

In addition, numerous key leaders of the APA came to our Committee meeting, giving the residents an opportunity to understand the APA as an organization and the committee's relationship with the APA Women's Caucus, the Assembly, and the Association of Women Psychiatrists. Our guests included Nada Stotland, Annette Primm, Pedro Ruiz, Rosalyn Seligman, Donna Stewart, and Deborah Hales.

This year our committee will continue to monitor the efforts of our group to attract more attention to gender differences in the *DSM-V*. As Chairperson of the Gender Workgroup, Katherine Phillips provided an update on her committee's ongoing work, which includes writing of a white paper.

Melva Green, Vice Chair of our Committee, has recruited the assistance of our resident fellows in developing a workshop for the annual meeting on novel career paths taken by women psychiatrists. The experience of submitting a proposal for a national meeting in a short time frame can be a new one for residents-in-training.

Due in part to the interest of our resident fellows, the committee will work to promote the recognition of women psychiatrists who have contributed much to improve the mental health care of others. We must help our new women and men

colleagues learn from those women who have shaped the APA organization and the field of psychiatry both in the past and in the present. The future of psychiatry will be shaped by those we mentor today.

*Kathy Vincent, MD, Chairperson, APA Committee on Women*

## Plan B Rejection Triggers Calls for Investigation

In early May, the Food and Drug Administration (FDA) announced that it would not approve Barr Pharmaceuticals' application for over-the-counter sales of Plan B, the company's emergency contraceptive product. With this decision, FDA rejected the recommendation of its own advisory committee, which voted overwhelmingly in December to approve non-prescription distribution of Plan B. The decision also ran counter to the advice of FDA's professional medical staff who reviewed the application and recommended its approval.

FDA is hiding behind the excuse that there is not enough data on the use of Plan B by young women. In fact, the overwhelming weight of the scientific evidence shows that women of all ages can use Plan B safely and effectively without physician supervision. The application included data from studies on the use of Plan B by many thousands of adult women and teenagers in the U.S. and around the world. The data show that:

- Young women who are given emergency contraception (EC) in advance are not more likely to have unprotected intercourse or to use condoms less often than those who are given only information about EC.
- Young women with easier access to EC are not more inclined to use EC frequently
- Young women are equally capable of using EC safely and correctly after reading information on the product label.

Moreover, by imposing this requirement, FDA is setting a far more stringent standard for EC than for other products seeking approval for over-the-counter distribution. As *The New England Journal of Medicine* succinctly argued in an editorial published weeks before the de-

cision: "A treatment for any other condition, from hangnail to headache to heart disease, with a similar record of safety and efficacy, would be approved quickly."

The denial of the Plan B application has real-world consequences for U.S. women. The Bush administration is blocking women's access to a safe and effective method of preventing unintended pregnancies by insisting on maintaining an unnecessary prescription requirement.

Dr. Steven Galson, acting director of FDA's Center for Drug Evaluation and Research told reporters that he made the decision to overrule his staff and reject the advice of FDA's scientific experts. But NWHN has challenged the credibility of this claim, asserting that Galson's decision was influenced by political interference and pressure.

A number of medical and drug safety experts, including several who served on the advisory committee that recommended approval of the application last year, have said that the decision to reject the Plan B application, despite expert consensus, calls into question FDA's scientific integrity. Women's health advocates are urging Congress to launch a congressional investigation to determine what led to this outcome. An investigation is essential to determine how this could have happened, to ensure that it won't happen in the future and to restore faith in the scientific basis of policy decision-making at FDA.

Please contact your congressional representatives and urge them to support a public investigation of FDA's Plan B decision. For contact information, visit [www.nwhn/action/congress.php](http://www.nwhn/action/congress.php).

*Amy Allina, National Women's Health Network, Reprinted from The Women's Health Activist, July/August 2004.*

### **SWHR Answers CMS Call for Comment on MMA Implementation**

The Society for Women's Health Research has called upon the Centers for Medicare and Medicaid Services (CMS) to ensure that implementation of the 2003 Medicare Modernization Act (MMA) does not "serve as a disincentive to research and development of new drugs for conditions that affect women disproportionately, predominantly, or differently than men."

"Because women live longer than men,

often suffer from co-occurring medical conditions, and can require multiple and diverse drug combinations for disease management, they can be negatively affected by prescription drug coverage and formulary plans that do not account for these complexities," said Martha Nolan, the Society's vice-president for public policy. "If formulary plans are not flexible," Nolan added, "and prescribed treatments for conditions that affect women disproportionately, predominantly, or differently than men are not sufficiently covered, then research and development of new treatments for the conditions may be stifled."

The Society outlined areas where CMS can work to ensure that subpopulations, including women and minorities, receive appropriate medical care and research is not discouraged:

- Ensure sufficient flexibility in offerings of existing drugs and biologics, including off-label usage;
- Allow flexibility in incorporation of newly approved drugs and biologics, making sure that decisions are based solely on clinical effectiveness and take into consideration the unique needs of subpopulations, such as women and minorities;
- Be sensitive to the complexities of treating co-occurring medical conditions, which often require multiple and varying drug combinations for disease management.

*Amy Hoskins, Society for Women's Health Research*

### **Healthy Women Today**

Where do you go to access the most up-to-date women's health statistics today? The Office on Women's Health and the National Women's Health Information Center (NWHIC) are proud to announce the launch of our new and comprehensive National Women's Health Indicators Database (NWHID). This is a free online tool, which can be accessed at [www.4women.gov/statedata](http://www.4women.gov/statedata) or through the NWHIC site at [www.4women.gov](http://www.4women.gov).

NWHID contains extensive national health data, which compiles valuable health statistics information from the present and back-dated to the year 2000. This database will be updated on an annual basis in order to keep up with current trends and health facts, and has been

developed as a free tool for your use. This new outline tool can benefit health professionals, researchers, members of the press, consumers, and more—anyone looking for current and reliable health statistics.

Through this data base you have immediate access to the following breakdown of statistics on a national, regional, state, and county level: demographics; mortality; access to care; infections and chronic disease; reproductive health; maternal health; mental health; prevention; violence and abuse.

Access is free, and users can make their own tables and graphs out of any data in the database. Age-adjusted data and three-year averages are included for many of the health indicators.

Questions about the new database? For general comments and more information about the project, contact: Suzanne Haynes, PhD, [shaynes@osophs.dhhs.gov](mailto:shaynes@osophs.dhhs.gov) or Laurie Konsella, MPA, [lkonsella@osophs.dhhs.gov](mailto:lkonsella@osophs.dhhs.gov)

### **FDA Recommends Against Approval of the Testosterone Patch**

The FDA's Reproductive Health Drugs Advisory Committee met in December 2004 to advise the agency on the safety and efficacy of a testosterone patch for treating low sex drive in women. Procter & Gamble, the company asking FDA to consider this new product (with the proposed name Intrinsic), had conducted research in women who have had their ovaries removed, are taking estrogen, and are experiencing lack of desire for sex. The committee voted unanimously against approval, citing concerns about the safety of long-term use and use by groups of women not yet adequately studied.

While recognizing that this problem is real and needs attention, the National Women's Health Network had urged the committee not to recommend approval as long as there are still so many unanswered questions. The NWHN was very pleased with both the final vote and the discussion. The full NWHN statement on Intrinsic is available on their website at <http://www.nwhn.org/content/index.php?pid=66>; a quick summary of key points is below.

*Evaluating the Research:* The research indicates that Intrinsic could offer some benefit to the narrow group of women in whom it has been studied. The drug is



### Choosing Tenure First, Babies Later

The November/December issue of *Academe* wrote up the unequal consequences of choosing tenure first, babies later. A “baby gap” separates men and women in academe, say two researchers who examined how having an academic career affects when and whether male and female professors have children.

Two years ago in the journal, Mary Ann Mason, dean of the graduate division at the University of California at Berkeley, and Marc Goulden, the division’s principal research analyst, looked at the effect of having children on women’s and men’s career paths in academe.

The researchers’ new analysis examines the issue from the other side, asking

what happens to male and female academics whose secure a tenure-track job first and then decide whether to become parents. Mason and Goulden conclude that a successful career in academe has significant costs for women in terms of marriage and children. “Women, it seems, cannot have it all—tenure and a family—while men can,” they write.

Women with tenure are more likely to be single, more likely to divorce or separate from their spouses, and less likely to have as many children as they want, compared with their male peers. In fact, “only one in three women who takes a fast-track university job before having a child ever becomes a mother.”

The analysis shows that gender equity in academe is even more out of balance than it seems. “In focusing on professional

outcomes as the measure of gender equality, we have failed to notice the widening gap between men and women in forming the families they want....A true measure of gender equity in the academy would look at both career and family outcomes.”

The article, “Do Babies Matter (Part II)?: Closing the Baby Gap,” is online at <http://www.aaup.org/publications/Academe/2004/04nd/04ndmaso.htm>.

The 2002 article, “Do Babies Matter?,” is also online, at <http://www.aaup.org/publications/Academe/2002/02nd/02ndmas.htm>

*Judith H. Carrier, PhD, Director of Career Development and Women’s Programs*

## Feature Articles

# The Trimesters

BY SHAILI JAIN, MD

The first day of November, I woke up feeling queasy, the room seemed to spin and I felt suddenly nauseous. I ran to the bathroom to vomit. It had to be I thought to myself; I had never felt this way before...there was no other explanation. One hour later I stared at the positive pregnancy test that lay in front of me.

Residency and pregnancy, a common occurrence. My twenties almost over, consumed with school, exams and internship, now seemed as good a time as any to have a baby. I was approaching the end of residency, was married and well settled. Why not? This simple reasoning which had seemed so straightforward in the months prior to conception would in no way prepare me for the months that lay ahead.

The morning ritual of nausea and vomiting started from that day. Staggering out of bed to vomit in the toilet was the only stimulus strong enough to haul me out of bed where I would otherwise have gladly lain all day. I was overwhelmed with tre-

mendous fatigue, every muscle in my body seemed affected, the energy sapped from me. Gingerly I would get ready for work; whilst at work I would walk around avoiding strong odors and the embarrassment of vomiting in front of my colleagues or patients. This was awful! “It’s all normal,” my mother reassured me, “the sign of a healthy pregnancy.” Well, this was not normal for me. I could not tolerate being anything but energetic and focused at work. Instead I watched the clock all day, waiting for the hour I could go home and sleep, my mind constantly preoccupied with the symptoms I was experiencing. The weeks rolled by and the nausea did not let up. My care over my appearance slackened. Comfort replaced vanity.

I was not myself. I abruptly left a pe-

diatric mortality conference as I was unable to face another slide of a dead baby. Working on a child in the in-patient unit, I watched as a five-year-old girl was put into seclusion. The child kicked and screamed for what seemed like a decade. Her wailing pierced me to the core. I suppressed an overwhelming urge to push the guarding staff member out of the way and free the child. Irrationality was setting in. I had never dreamed that pregnancy would mean I would lose my sense of professional mastery.

Over the dreary weeks of the first trimester, I mulled over my fate. I was about to embark on my professional career—the culmination of a decade of hard work and dedication. At the same time, it was a perfect time to start a family. Work and personal life had progressed well side by side before. But now I was overcome with this eerie feeling that these two paths had crossed and I was not sure what the consequences were going to be. Panic set in; was this what life was going to be from now on? I feared I had entered a no man’s

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**This simple reasoning which had seemed so straightforward in the months prior to conception would in no way prepare**

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## I had never dreamed that pregnancy would mean I would lose my sense of professional mastery.

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land of perpetual dissatisfaction.

Four decades ago my parents had left the land of their birth to come and live in the West. They both endured much personal sacrifice so their children could live a life free from overt corruption, nepotism and sexism. They dreamed that we could all grow to be free to fulfill our potentials. I was living that dream, I loved being a doctor and I had an ambition to be the best doctor I could possibly be. But now I wondered if I had imposed a glass ceiling on my own dreams the minute I saw the positive pregnancy test. Living in a society with a myriad of opportunities for the individual, had I sealed my own fate when I had signed up for motherhood?

I frantically searched the literature for guidance with my dilemma. Sure enough much had been written about the pregnant resident but very little in the last two decades. I wondered what had happened in this time; had women found a way to perfectly balance motherhood and professionalism? Was there some secret I did not know or had political correctness

mutated the debate? I read with inner discomfort the stories of pioneering professionals who had been fired for getting pregnant, alienated or subjected to great hostility. This was not my case. I had incredibly supportive family and supervisors who were nothing but empathic and positive about the situation. So why this nagging feeling that pregnancy was sapping away from my professional focus?

The weeks rolled on to the second trimester the nausea lifted, the fatigue lessened. I felt my mental acuity return, my motivation and my drive. The baby growing inside me was making its presence known in a more pleasant way; quickening led to actual kicks; I got bigger; I became more protective over my growing child's safety, slowing down when driving and eating healthier. My previous resentment of how the pregnancy was affecting my professionalism gave way to fears of how being a doctor was going to affect my being a mother.

I begrudgingly began to discuss my pregnancy with my longstanding therapy patients. We began to process how my upcoming leave and gravid state would affect them. My previous efforts not to self-disclose in therapy, to maintain a neutral stance was now altered. The core elements of my life were on display for everyone to see. Intellectually I could grasp why it had to be discussed, as a pregnancy cuts

to the heart of sex, rivalry, and attachment. But that did not mean I liked doing it.

Winnicott's primary maternal preoccupation came to mind. I was preoccupied with my growing child, doctor visits, test results, labor, nursery furniture, family visits. For the first time ever, I "no showed" on a patient, found myself in the wrong class for academic lectures, vegetarian for 15 years I mindlessly ate a pep-

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## The core elements of my life were on display for everyone to see.

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peroni pizza....The chaos went on.

Once during a therapy session, my baby kicked so vigorously that my whole abdomen visibly shook. I wanted to laugh out loud at this surreal experience but I maintained my professional composure as my narcissistic patient continued to talk about why she felt ignored at work oblivious to what had just occurred right in front of her eyes.

The months passed and I entered the final trimester. During this phase something happened which seemed to help me resolve this growing conflict. A patient who I had been treating for many years for a psychotic illness suffered a serious setback which I believe was, in part, due

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## ASSOCIATION OF WOMEN PSYCHIATRISTS

*The Association of Women Psychiatrists (AWP), was founded in 1983 by Alexandra Symonds, MD, to facilitate mentoring and leadership development among women psychiatrists, as well as to promote the health and mental health of all persons, particularly women.*

### AIMS AND PURPOSES:

- Form a national and international network of women psychiatrists
- Improve communications and provide support to women psychiatrists
- Promote women psychiatrists into leadership positions in all aspects of health care
- Collect and disseminate information on women's mental health issues
- Encourage and support activities and research in women's mental health issues
- Advocate for just legislation for women
- Encourage women psychiatrists to actively participate in the American Psychiatric Association, both locally and nationally
- Influence the policy and procedures of the American Psychiatric Association and to work collaboratively to achieve the same ends.

to my pending absence. I had previously put much effort into the case and was making some headway when the patient relapsed. My own professional ambition clashed with my personal life. But as the dust settled I seemed to be more accepting of the situation. I still had a patient

who needed care; it was still my duty to alleviate her distress. I was still very pregnant. Mothering and doctoring would have to find a way of co-existing comfortably. Being a mother would make me a better doctor. Being a psychiatrist, an observer of the human condition, would

make me a better mother....in time.

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*Shaili Jain, MD was Chief Resident, Department of Psychiatry, Medical College of Wisconsin, at the time this article was written.*

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## Why Run?

BY NINA CERFOLIO, MD

**T**he cannon thunders, slashing through the thick anxiety of the morning, marking the start of my first New York City Marathon. An emotional hug from my running friend brought both goosebumps and tears. Despite rumors of threats to destroy the Verrazano Narrows Bridge, the courage of over 20,000 runners who refused to allow the terror of 9/11 from participating in the race was uplifting. My legs begin to move, and soon my breathing becomes heavy and labored. The questions that plagued me throughout the many months of training course through my mind with each step. How difficult would it be to complete 26 miles when my longest effort was only 18? Could I make it past the 20-mile mark, the so-called "wall" ?

As a psychiatrist, running has become an antidote for a profession that is primarily sedentary and cerebral. Running allows me to release the day's stress. Preparation for the marathon required training five days a week during the spring and summer. It was a new sport full of challenge and excitement. Despite the anxiety in not knowing if my body could go the distance, my "long" runs eventually extended to 18 miles. I grew more confident.

Finally it was marathon morning. The first 12 miles of the race were difficult and my fear of not finishing was constant. I felt a lack of confidence and an anxiety of failing, because I had never completed a marathon. However, when we approached hills, particularly the Queensboro Bridge, my stride became comfortable. There was this fantastic feeling of being able to run without any effort whatsoever. It was the runner's high.

After descending from the bridge onto First Avenue, the crowds roared. Tens of

thousands of people were screaming and cheering at the top of their lungs. "That a way to go!" "Looking good!" It was fantastic. My body was totally warmed up and my pace increased. I understood why people go out and run long distances. The feeling cemented my passion for running.

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**...the courage of over 20,000 runners who refused to allow the terror of 9/11 from participating in the race was uplifting.**

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Approaching the 23-mile mark, I still worried about "the wall." But when I entered Central Park, a quick look around re-energized me. It was familiar ground because this was my training route. The American elms, more than a century old, were comforting friends. The unique aroma of fall in New York permeated the park. Much to my surprise and amusement, I felt relaxed and my pace began to increase. No matter what happened, I knew I could finish the race; I would become a marathoner. I passed runner after runner. Some would ignore me while others would attempt to hold me off. The physiques and talent of these runners impressed me. Then, all of a sudden, at the top of a hill, the finish line appeared. The crowds in the grandstands on both sides of the road were screaming.

Crossing that finish line was exhilara-

tion unlike anything else in my life. The clock read 3 hours and 44 minutes. My first attempt to run a marathon qualified me for the Boston Marathon. Boston is the only marathon that runners must qualify for based upon time. It is a smaller, more prestigious race that admits only runners who are typically in the top 10%, based on age and sex. It was a dream come true.

After much reflection, it seems that the joy I derive from running is associated with four distinct benefits: achievement, socialization, play, and an opportunity to help others. The first—the thrill of achievement—is about setting and reaching a goal. Part of the long-distance training is a process of developing a base of six to eight miles per workout. It was a fantastic experience to see my best efforts of a week or two ago steadily improve. Hills, which most runners dread, become opportunities to pass others. Another component of distance running is speed. Again, with training, my speed continued to improve. What a joy to dash along at a six-minute pace. It was unbelievable to me that a 40-ish female could compete with college athletes, male and female.

With a couple of marathons under my belt, I started looking for a new challenge, and found it in the Kurt Steiner 50-Kilometer Event. That's a distance of over 31 miles. The day of the race, which happened to be my 43rd birthday, the weather was awful. The temperature stayed in the low 20s and the wind chill factor reached six degrees. Despite fatigue and cramping, I crossed the finish line and came in second among females. It was my favorite birthday ever. The accomplishment was beyond anything I ever imagined.

A second benefit of running is that it pro-

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**...running has become an antidote for a profession that is**

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**...this fantastic feeling of being able to run without any effort whatsoever. It was the runner's high.**

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vides a fantastic way of interacting socially with people who share similar values. Most runners enjoy a healthy lifestyle. There is no nicer way to spend a Sunday afternoon than running with a friend in Central Park. As one jogs, conversation flows and mediocre jokes are funny. You meet and greet acquaintances running in both directions and the time passes as you celebrate life. I have developed many friendships while jogging away the miles.

My inspiration to begin running came when I volunteered to run a half-marathon as an Achilles Track Club guide. Achilles is an international organization of disabled distance runners and my task was to accompany a 20-year-old Jamaican man, who uses a wheelchair, for the last 13 miles of the race. Upon finishing, I immediately got hooked on road racing and wanted to experience for myself the emotion and exhilaration of runners completing the marathon.

A third benefit of the sport is the opportunity to "play." It is a powerful tool for personal development. While running, I regress to an earlier time in childhood when life seemed fair. It was a time when hard work resulted in success. When one practices medicine, there is only some correlation between effort and success. Efforts put forth in a therapeutic relationship are not always related to the patient's emotional growth. Sometimes, routine treatment re-

sults in dramatic success. On other occasions, great insight and effort result in no improvement. With running, however, additional mileage and speed work improve my endurance and race times. It's reassuring for life to be fair.

The fourth benefit of running is an opportunity to help others. Both psychiatry and running permit me to improve my self-esteem and quality of life by helping others. I am legally blind in one eye. Running al-

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**...the joy I derive from running is associated with four distinct benefits: achievement, socialization, play, and an opportunity to help others.**

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lows me to feel good about myself and to help others with disabilities feel similarly. It's also given me opportunities to do further good.

As an Achilles volunteer, I became involved in a research project to test the effect of running on increasing the T-Cell count of children with AIDS in South Africa. It required traveling to the city of Durban. Now thoroughly hooked, I decided to combine the research effort with running the Comrades Marathon. It is a 56-mile race

between Pietermaritzburg and Durban in South Africa, which attracts over 10,000 runners and is considered one of the greatest ultra-marathon in the world.

On race day, despite not training sufficiently as a result of a medical issue, I found myself feeling strangely confident. Five hours into the race, we passed the Ethanbeni School for physically disabled, blind, and HIV-positive children. It was near the middle of the course and it was the site of our AIDS research. The entire school came out and rooted me on like crazy. They were my cheering squad and friends. They were my inspiration to finish the next 30 miles.

Along the route, marked by amazing twisting inclines and downhill, I met many passionate international runners who had completed Comrades numerous times. Their positive, upbeat outlook supported me in my effort to finish the 56 miles. I completed the event in ten hours and 38 minutes, winning a bronze medal for my efforts. I had a fantastic feeling of good, a "high" that lasted for hours.

Running allows me to be more expansive and make a positive contribution to society, while at the same time enriching my life. For that I am thankful. Can't wait to get out there again!

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*Nina Cerfolio, MD, is Clinical Assistant Professor of Psychiatry at NYU Medical School and Clinical Assistant Professor in OB/GYN at NYU Downtown Hospital in New York City.*

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## **Changing the Face of Medicine: Celebrating America's Women Physicians**

BY DIANE K. SHRIER, MD

I was recently invited to review the exhibit at the National Library of Medicine, *Changing the Face of Medicine: Celebrating America's Women Physicians*. In preparation, I spent two hours with the associate curator, Manon Parry, and an additional two hours going through the exhibit on my own. It was a remarkable experience which should be of great

interest to our members. I have, therefore, prepared for our readers an expanded version of the article published in *The Lancet*.

While 50% of medical students and 25% of physicians in the United States are now women, the struggle for equality is not over in medicine. Despite prominent exceptions, women physicians continue to lag behind their male colleagues

in attaining positions of authority and leadership in academic medicine, professional organizations, and medical institutions. They are less likely to be adequately mentored (by men or women) and to have same gender role models to demonstrate a range of effective ways to balance professional and personal responsibilities and to deal with continuing subtle or overt gender bias and discrimination. As noted by Janet Bickel in a recent report from the American Association of Medical Colleges, "the potential of most women [in medicine] is being wasted."

A multi-year non-hierarchical collaborative effort of the National Library of Medicine, the Office of Research on Women's Health at the National Institutes

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**And when, even after qualifying as physicians, they [women] were denied employment, they established women's medical colleges and hospitals and clinics, especially for women and children.**

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of Health, the American Medical Women's Association, and a large number of consultants and volunteers produced this remarkable and evolving multimedia exhibit celebrating the diversity of achievements and experiences of women in medicine over the past 150 years. An Ad Hoc Advisory Board nominated 339 women physicians whose personal lives and professional achievements would be researched and presented as exemplars in the 20 minute introductory video, website, digital portrait gallery, and/or artifact portions of the exhibit. The women physicians ranged from pioneers to those in the early stages of their careers.

As noted at the entry to the exhibit, "women have always been healers," but "when medicine became established as a formal profession in Europe and America, women were shut out....Women waged a long battle to gain access to medical education and hospital training; had to overcome prejudices and discrimination...." Now a diversity of women from all races, ethnic and socioeconomic backgrounds and gender orientations, married or not, with children or not, are successful in every aspect of medicine.

The exhibit was divided into eight sections. In *Setting Their Sights* and *Opening Doors*, seven pioneer women physicians were identified. In the mid 1800s, the first movement for women's rights included campaigns for women to be admitted to medical schools. And when, even after qualifying as physicians, they were denied employment, they established women's medical colleges and hospitals and clinics, especially for women and children.

In both the women's movements of the mid-1800s and of the mid-1900s, women only gained access to greater rights to careers in medicine through a joke that backfired. Elizabeth Blackwell (1821-1920), the first woman to graduate from an American medical school, was rejected by every medical school in New York City and in Philadelphia. When she applied to Geneva Medical College in upstate New

York in 1847, the faculty asked the all-male student body to vote on her admission, being certain they would reject her because medicine was regarded as unsuitable for women. As a practical joke, the students voted "yes" unanimously and Elizabeth Blackwell graduated two years later. Similarly (not in the exhibit), in the mid 1960s, when the Civil Rights Act of 1964 making it illegal to discriminate in employment situations on the basis of race, color, religion, or national origin was being debated in the United States Senate, a Southern senator amended it to in-

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**From the very beginnings of women in medicine, there was controversy among women physicians about whether they were the same or different from men physicians.**

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clude sex, hoping that the ludicrousness of such an addition would lead to the act's defeat.

From the very beginnings of women in medicine, there was controversy among women physicians about whether they were the same or different from men physicians. Both points of view are valid. Elizabeth Blackwell thought that women were particularly suited to the role of physician because of their caregiving skills. She focused on establishing clinical services for women and children, while advocating for women's rights and reforms in medical education. Her compatriot, Mary Putnam Jacobi (1842-1906) on the other hand, saw women and men as equal in their abilities and pressed for access to the highest levels of training in scientific research. Jacobi became a medical scien-

tist and the first woman to be elected to the New York Academy of Medicine. She married a prominent pediatrician and combined a distinguished medical career and a family.

While the first women physicians faced daunting professional and social obstacles and challenged the then prevailing assumptions of women's biologic frailty, lesser intellectual abilities, and core responsibilities as mothers and wives, subsequent women physicians still have had to deal with the challenges noted in the next two sections of the exhibit, *Confronting Glass Ceilings* (or sticky floors) and *Challenging Racial Barriers*.

Johns Hopkins Medical School opened its doors for women in 1893 only through the generous donations of Mary Elizabeth Garrett and others who required their admission. Florence Sabin (1871-1953) was one of 14 women in that first class of 45. The harassment she endured from her fellow interns after graduation led her to focus instead on building a career as a research scientist. She was the first woman to become a full professor at Hopkins, but in 1925 she was passed over for the Chair of the Department of Anatomy, leading her to leave Hopkins to become the first woman to join the Rockefeller Institute. Her work in cellular immunology led to her election as the first woman physician to be elected to the National Academy of Sciences, in 1936.

Gerty Cori and her husband Carl, both graduates of the German University in Prague, emigrated to the United States in 1922. "They formed a dynamic research partnership in biochemistry" and discovered what has been named the Cori Cycle on glucose metabolism. As has often been the case, Carl received far more professional recognition and positions of leadership in academic medicine than did his wife. In fact, he was actively encouraged to continue his research without his wife, which he wisely refused to do. In 1947, they became the first American couple to win the Nobel Prize in medicine.

The exhibit deliberately did not focus only on those exceptional women physi-

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**Johns Hopkins Medical School opened its doors for women in 1893 only through the generous donations of Mary**

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cians who, despite all the odds, achieved at the highest levels and broke through the barriers. Other women physicians also were exemplified as role models. Women of color and minorities who faced not only gender discrimination but financial hardships and racism were highlighted for their clinical work and advocacy. In *Making Their Mark, Enriching Medical Education*, and *Caring for Communities*, a sampling of women physicians served as exemplars of the diversity of choices for professional careers and personal lives. Women physicians often brought new perspectives and focused on areas that had received less attention from the medical profession—public and occupational

health, innovative teaching and clinical programs, and improved access to medical care for those most at risk because of poverty, minority status, gender, and age.

The exhibit, shown at the National Library of Medicine on the campus of the National Institutes of Mental Health in Bethesda is free and open to the public from October 14, 2003 through April 2, 2005, and will then become a traveling exhibition to other sites around the United States and possibly abroad. The exhibit and additional material gathered is available on the National Library of Medicine's web site ([www.nlm.nih.gov/changingthefaceofmedicine](http://www.nlm.nih.gov/changingthefaceofmedicine)) and will remain a permanent part of the computer-

ized archives of the National Library of Medicine.

As my physician daughter and I have learned from our own personal experiences and from our research study, *Generation to Generation: Mother-Daughter Physicians*, it makes a great deal of difference to have a supportive role model, an effective mentor, and the active encouragement of teachers, family, and friends.

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## AROUND THE WORLD

### Torture and Rape In Zimbabwean Militia

The prevalence of rape and other sexual atrocities in the Zimbabwe military is increasing. A growing number of human rights groups have charged in recent months that forced sex and sexual torture are routine elements of life for men and women alike in the Youth Service, used as both reward and punishment. The resulting pregnancies and infections with sexually transmitted diseases, including HIV, devastates lives and creates a terrible heritage, a report by the Solidarity Peace Trust stated. Amnesty International documented cases of rape within the Youth Service. The Amani Trust has estimated that as many as 1,000 women are being held in Youth Service camps as sexual servants.

Anthony P. Reeler, a former director of the trust who has been barred from entering Zimbabwe by the government, said: "What's happening in the camps I would call forced concubinage....It's much more in line with the 'comfort women' of the Japanese and Philippine armed forces [of World War II]."

—Michael Wines, *The New York Times*, December 28, 2003

### Bordello Business

A high court in Seville has ruled that the owner of a so-called alternative club must make social security payments for 12 women who worked there as prostitutes. The decision is part of a nationwide struggle to define the status of prostitution, which is neither prohibited nor regulated under Spanish law. Catalonia's regional government has already begun to regulate brothels and clubs. In Madrid, prostitutes marched through the streets with picket signs last summer, demanding labor rights.

In the majority opinion, the justices said that the women observed a regular timetable and rented space for their belongings and that they received a share of drink sales, which constituted an employment relationship, and were therefore entitled to a contract with employer-paid social security benefits. But the national association representing 300 such roadside clubs objects to such a concept, said the association's lawyer, José Luis Roberto, declaring that clubs operate as hotels featuring shows or other entertainment, renting rooms to the women to entertain clients.

Women's groups who defend prostitutes' rights have welcomed the verdict, but with reservations. They complain that it grants the women the right to social security payments as alternative waitresses, not sex workers, a category that does not exist under Spanish law. They advocate open regulation of the sex trade. Some 300,000 women are engaged in prostitution in Spain, generating annual business worth more than \$22 billion.

The legal status of prostitutes has been unclear in Spain since the restoration of democracy 25 years ago. The recent wave of immigration to Spain has brought the issue to the fore. Most prostitutes in Spain are immigrants from South America, Africa and Eastern Europe.

—Dale Fuchs, *The New York Times*, January 18, 2004

### Immolation In Afghanistan

Doctors and human rights workers are discovering more and more young women who have set themselves on fire, desperate to escape the cruelties of family life and tribal traditions that have not changed with the end of Taliban rule and the dawn of democracy. Doctors and nurses in Kabul and Jalalabad have seen more cases recently, partly because the population expanded with the return of two million refugees and partly because cases are being tracked for the first time by rights groups, hospitals and the government. And the trauma and social upheaval of years of war, poverty, and illiteracy in Afghanistan have also increased the traditional pressures on young women, they say.

Dr. Soraya Rahim, deputy minister of women's affairs, on

her return from a government investigative trip to Heart, said, "It takes different forms in different provinces. Some take tablets. Some cut their wrists. Some hang themselves. Some burn themselves. But the reason is very important. The first reason is our very bad tradition of forced marriage. Girls think this is the only way, that there is no other way in life."

Educated urban women who were repressed by the old Taliban government have benefited from the changes in Afghanistan. Many are now working and studying. But the new order has not improved women's longstanding low status in villages and remote tribal areas. Daughters are often exchanged between families, are given in marriage as compensation for crimes, or are married to men two or three times their age. Brides leave home to live with their husband's extended family, where the mother-in-law rules the household. Often they are seen as little more than a new source of labor.

While the authorities have little idea of the full extent of the burnings, because families hide them out of shame and often claim they are accidents, the desperate attempts of young women to escape their lives are undeniable. They often resort to burning, since kerosene and cooking fuels are easily accessible to women.

—Carlotta Gall, *The New York Times*, March 8, 2004

## HEALTH ON THE HOMEFRONT

### Fractured Forearms

According to a Mayo Clinic study published in *The Journal of the American Medical Association*, broken forearms have become significantly more common among children and adolescents, especially girls, over the last 30 years. From 1969 to 2001, the rate of forearm fractures rose 52% for girls and 32% for boys, with the largest increases among children in early puberty. Pediatric specialists were concerned not so much about the pain of the broken bones as about what might lie ahead. Some experts say American children consume far less calcium than they should to build healthy adult bones. Dr. Craig B. Langman, a kidney specialist affiliated with Northwestern University, estimated that no more than 20% were receiving their recommended daily requirement. If that shortfall is causing the increase in broken bones, the cast wearers of today may be the wheelchair users of the future, their failure to build bone density now placing them at greater risk for hip fractures later.

To Dr. Sundeep Khosla, the Mayo Clinic researcher who led the study, it makes sense that early adolescence is the time for such a warning signal. The most vulnerable period for both sexes has never varied: age 12 for girls and 14 for boys, the time of the growth spurt that accompanies the onset of puberty. As a child grows, some of the calcium that normally goes to replenish bone mass is diverted to create new bone, creating a risk of temporary brittleness. At that adventurous age, boys and girls are apt to be in situations that test their bones. The question for doctors who examine the Mayo study is: Which factor has been tipping the balance, lower calcium intake or greater physical activity and risk? The study was intended to track frequency, not delve deeply into causes, although it indicated that activities like snowboarding and skateboarding had small roles in the increased fractures. Khosla blames inadequate nutrition. American youth is more sedentary overall. The decline of calcium in children's diets is well established. Khosla cited a study showing that teenage girls drank 50% more soft drinks in 1996 than they did in 1977 and about one-third less milk.

Dr. Jordan D. Metzl, medical director of the Sports Medicine Institute for Young Athletes at the Hospital for Special Surgery in Manhattan, sees a clear link between the increase in broken bones and the growth of competitive sports, especially for girls: "In 1971, there were 30,000 girls in competitive sports in high school, and in 2002 there were just over three million. Now, we have year-round sports activities for kids starting as young as seven or eight." The risk of injury is shown to be twice as high in organized sports events as in casual play. Those dangers are exacerbated by the fact that children are more sedentary when it is not game time.

Some doctors tell parents to consider preventive measures usually associated with older people, like calcium supplements and weight training. When children are growing most rapidly, Khosla said, they need 1,300 mg of calcium a day, the equivalent of four eight-ounce glasses of milk in addition to a balanced diet: "Ideally, you should get that through your diet. But I think many of us are starting to make the recommendation that if you can't, you should consider supplements." Metzl's institute started a gym program for children last year, offering weight training in the hope of avoiding injuries. "The answer," he said, "is not going to be making sports less competitive. That would be nice, but it's not where society is right now.... Parents and coaches have to think in terms of preparing kids' bodies."

—John O'Neil, *The New York Times*, September 23, 2003

### To Squeeze into the Glass Slipper

With shoes reaching iconic cultural status, women are having parts of their toes lopped off to fit into the latest Manolo Blahniks or Jimmy Choos. Cheerful stories about these operations have appeared in women's magazines, major newspapers, and on television news programs. But the stories rarely tell the dangers. For better "toe cleavage," women are risking permanent disability, according to many orthopedists and podiatrists.

Over half of the 175 members of the American Orthopaedic Foot & Ankle Society who answered a recent survey said that they had treated patients with problems due to cosmetic foot surgery. The society will soon issue a statement condemning the procedures. The American Podiatric Medical Association is also likely to formally discourage medically unnecessary foot operations.

But advocates for the procedures say that critics simply do not understand the importance of high heels. Foot fashion and function have long been in conflict. Chinese girls' feet were bound to shorten them by bending the toes backward. High heels have been fashionable in the United States for decades, even though they can cause not only serious foot problems but knee, pelvic, back, shoulder and even jaw pain. It is not just the height of shoes that can lead to damage: a 1991 study found that almost 9% of women routinely wear shoes that are one to two sizes too narrow. A 1993 study found that women have more than 80% of all foot surgeries, primarily because their shoes are too tight.

Narrow shoes can cause the big toe to bend outward, permanently changing the shape of the bone and causing a bunion, or swollen big-toe joint. Women have more than 94% of bunion surgeries. By scrunching up the smaller toes, fashionable shoes can also cause or worsen claw or hammer toes, a condition in which the smaller toes are permanently bent downward. Painful and unsightly corns or calluses often form on the tops of such toes. Foot doctors disagree sharply on treatment of such problems. Most

# **Wyeth Full Page Black and White Ad**

advise patients to stop wearing the offending shoes.

An increasing number of doctors are performing delicate and expensive operations to allow women to continue to wear their favorite shoes. Dr. Suzanne M. Levine, a Manhattan podiatrist, said that this year she will undertake 40% more cosmetic foot surgeries than she did three years ago. Among the most common are operations to shorten toes, at a cost of \$2,500 per toe, and collagen injections into the balls of the feet—to restore padding lost from years of wearing high heels—about \$500 per injection. Her business is taking off because shoes are an increasingly necessary fashion accessory.

The foot is a complex network of 26 bones, 33 joints, 107 ligaments and 19 muscles that must support more than 100,000 pounds of pressure for every mile walked. Even small changes can unexpectedly undermine the foot's structural integrity and cause crippling pain. Collagen injections have risks.

These risks explain why many foot doctors advise patients to try everything—including never wearing high heels again—before risking surgery. There are no solid figures for cosmetic foot procedures, so the American Orthopaedic Foot & Ankle Society is beginning a study to measure how common the operations have become. Critics say that one factor compelling the increase they are seeing in such procedures is a push by doctors to expand their practices in areas not covered by managed care.

—Gardiner Harris, *The New York Times*, December 7, 2003

### Weird Science

It has often been noted that drug companies have favorite letters; they range from X to Z. Think of Nexium, Clarinex, Celebrex, Xanax, Zyban, and Zithromax. Why are these letters so popular? “Some letters look better in print, make sounds people like saying and are associated with innovation,” said Steve Manning, the managing director of Igor, a San Francisco branding company. “X is associated with science fiction, high tech, automobiles, computers, and drugs,” as in “The X Files” and “The Matrix,” Xerox, Lexus and the Microsoft X-box. James L. Dettore, president of the Brand Institute, a branding company in Miami (its successes include Lipitor, Clarinex, Allegra, and Sarafem), said the letters X, Z, C, and D, according to what he called “phonologics,” subliminally indicate a drug is powerful. “The harder the tonality of the name, the more efficacious the product in the mind of the physician and the user,” he said.

A drug is probably the hardest thing to name. Executives want a name that will enhance sales. Patients want a hint of what it does. The FDA doesn't want implied medical claims. And if it sounds too much like another drug, a pharmacist might accidentally harm consumers. Dettore says he tests up to 15 names for each client's drug. First he checks data banks in about 40 countries to see if the names are already copyrighted and to make sure they don't mean anything misleading or vulgar in other languages. He has focus groups talk about their feelings. For example, Sarafem—a form of Prozac aimed at women with severe premenstrual irritability—comes from angelic seraphim, “but with -fem from feminine and a very soothing prefix.... Lipitor is ‘lipid regulator’ with the -tor of atorvastatin, the generic name [and] is grounded as a cardiovascular-sounding suffix.” Levitra, a Viagra competitor, comes from “elevate,” he said, but “we tested and it sounds European, elegant, with premium connotations.” “Le” indicates masculinity in French,

he noted, and ‘vitra’ can allude to vitality. Viagra is said to make men feel vital and like mighty Niagara Falls. Dettore then recruits a test panel of doctors to scribble and phone prescriptions to a panel of pharmacists to see if confusion ensues. Finally, he submits the two best names to the FDA.

The agency rejects about a third of all applications, weeding out dangerous sound-alikes. It frowns on syllables like “ultra,” “max” or “new,” or names that sound like generic drugs. Prozac and Paxil, for example, are fluoxetine and paroxetine, and so “-oxetine” endings are taboo because they will eventually compete with the generics. The agency also turns down faddish suffixes: does “SR” mean “sustained release” or “senior”? Does “XL” imply “extra long” or “excellent”? “The original name proposed for Rogaine was Regain, as in you regain your hair,” said Bill Trombetta, a professor of pharmaceutical marketing at St. Joseph's University in Philadelphia. “The FDA said ‘You can't use that name—it promises too much.’”

The companies even register names before they have a drug to fit them. Dr. Yusuf K. Hamied, chairman of Cipla, an Indian generic drug company, operates more freely, letting his imagination roam. In India, his version of Viagra is called Silagra, from its generic name, sildenafil citrate. Indians were already so familiar with Viagra that it made sense to echo Pfizer's name. But in Latin America, he sells it as Eviva. It sounds like “revive” but also has an echo of the female Eve. He said he nearly named it Tarzia “because it makes you feel like Tarzan.” In the Middle East, he was blunt. There, it's Erecto.

—Donald G. McNeil Jr., *The New York Times*, December 28, 2003.

### Teenagers Say No to Sex

A record number of teenagers have received warnings about pregnancy. The Centers for Disease Control and Prevention, in its annual tally of birth statistics, announced that the teenage birthrate declined 30% over 10 years to a historic low of 43 births per 1,000. African-American teenagers showed the sharpest declines, down more than 40% since 1991. The decline, combined with a decrease in abortions among teenagers, points to a promising trend: fewer teenagers are becoming pregnant. According to the Alan Guttmacher Institute, in women 15 to 19, the pregnancy rate dropped from 11.5 per 1,000 in 1991 to 8.5 in 1999, the latest year with available statistics. It estimates that in this age group, the abortion rate declined from 40 per 1,000 in 1990 to 24 in 1999.

Educational efforts have been crucial to reducing the numbers. A tremendous amount of attention has been focused on preventing teen pregnancy. This involves initiatives at the state and local levels, including school-based programs, church-run, private and community programs. Campaigns to raise AIDS awareness have also helped reduce teenage pregnancy, especially among blacks, who have the highest rates of HIV and AIDS.

The debate over what type of sex education can take credit continues. In 2003, the federal government devoted \$117 million to abstinence education. Comprehensive sex education, on the other hand, teaches that while abstinence is preferable, young people need information about sex and contraception. The Guttmacher Institute says that two-thirds of public school districts have policies to teach sex education, and that 35% of those

require that abstinence be promoted as the sole option for unmarried people. Birth control and condoms can be mentioned just in terms of failure rates.

Leslee Unruh, president and founder of the Abstinence Clearinghouse in Sioux Falls, S.D., said, "I look at these declines as evidence that teenagers across the country are embracing the idea of abstinence until marriage." The Guttmacher Institute disagreed about the major influences over the decrease. The decline began in the early 90's, long before the abstinence movement came into political force. The Guttmacher Institute points to statistics that show that teenagers are having less sex and they use contraception more effectively when they do. According to the CDC Youth Risk Behavior Survey, the percentage of high school students who have ever had sexual intercourse dropped. Among girls, it fell to 43% in 2001 from 51% in 1991. For boys, it fell to 48% from 57% in the same period. The survey found that use of condoms among high school students rose to 57% from 4% in those 10 years.

Some experts credit an entirely different factor for helping drive down the pregnancy rates: the strong economy of the 1990's. Debra Hauser, vice president of Advocates for Youth, an organization that works on adolescent sexual health, said, "When young people have a sense of their own future, they delay sexual initiation and postpone pregnancy."

—Linda Villarosa, *The New York Times*, December 23, 2003

### **AIDS Fears Grow for Black Women**

In the past, concern about black women and AIDS was mainly focused on those who had used drugs or had had sex with users. In government studies of 29 states, a black woman was 23 times more likely to be infected with AIDS than a white woman, and black women accounted for 71.8% of new HIV cases in women from 1999 to 2002. Though new cases of HIV among black women have been stable in the past few years, the number of those who have been infected through heterosexual sex has risen. In 2001, according to the Kaiser Family Foundation, an estimated 67% of black women with AIDS contracted the virus through heterosexual sex, compared with 58% four years earlier. Black women accounted for half of all HIV infections acquired through heterosexual sex in men or women from 1999 to 2002, the Centers for Disease Control and Prevention said.

Though heterosexual transmission has risen for all women, researchers say a black woman has a greater chance of coming into contact with the virus when she has sex with another black person because, compared with the general population, there is a higher rate of HIV among black Americans. Recent studies suggest that 30% of all black bisexual men may be infected with HIV, and up to 90% of those men do not know they are infected. Researchers for the CDC have referred to these men as a "bridge" to infection from gay men to heterosexual women.

Multiple factors heighten the risk for black women. Nobody knows for sure how much the spread of the AIDS virus among blacks can be attributed to the behavior of bisexual men. Some reports have suggested that black men are more likely to keep their bisexuality a secret, but that, too, is hard to quantify. Researchers say it comes down to a numbers game: blacks make up roughly 12% of the nation's population but in 2002 accounted for 42% of people living with AIDS and more than half of all

new infections. Blacks tend to have sexual relations with other blacks, experts say, which works to confine the virus within the African-American "sexual network."

The shortage of black men as potential partners may be an important factor. This gender gap, experts say, may lead black women to make unsafe sexual decisions and raise their risk of infection. Although women outnumber men in the general population, the gap is wider among blacks. According to 2002 census data, there are 12.6 million black women 21 or older, compared with 9.9 million black men. On college campuses, the numbers are more uneven: in 2000, according to the National Center for Education Statistics, more than one million black women were enrolled in degree-granting institutions, compared with 635,000 black men.

The shortage of available black men can contribute to the spread of HIV in other ways. In 2002, according to the census, 37.7% of black men 15 or older were married and living with their spouses, compared with 58.5% of white men. Among women 15 or older, 29.2% of blacks were married and living with their spouses, compared with 54.3% of whites. Fragile relationships can facilitate the spread of sexually-transmitted diseases. The lower number of economically viable black men destabilizes marriage and long-term partnering. A man will have sex with one girlfriend, return to a previous girlfriend and then go back to the new one, increasing the danger.

—Linda Villarosa, *The New York Times*, April 5, 2004

### **MIXED MEDIA**

#### **Pulp Fiction Written by Women**

Pulp fiction usually evokes images of male authors like Dashiell Hammett or Raymond Chandler. But in its prime women were there, too. *In a Lonely Place* is one of three examples of the pulp genre written by women and reissued in November by the Feminist Press in a series called "Femmes Fatales." The others were *The Girls in 3-B* (1959), a lesbian romance by Valerie Taylor, and *Skyscraper* (1931) by Faith Baldwin (a very popular writer in her day), about young women going to the city to find work and love. All have their original cover art — a girl fleeing a serial killer, girls in semitransparent slips, a girl posing against a skyscraper suggestive of a phallus.

Pulp fiction was named for the cheap paper it was printed on. From the 1930's to the 50's, pulp was sold in vending machines and drugstores everywhere. It was usually written in spare language, even without character development or narrative coherence. The tales moved fast, and they were a guilty pleasure, easy to conceal under the mattress. Now they cause a laugh of recognition of those sometimes painful prefeminist days when women were either virgins or dames, compelled to choose between love and marriage, and frequently punished for being sexual.

Livia Tenzer, the series editor, and Jean Casella, the publisher, write in a forward to the books that although the Hays code restricted the depiction of sex in movies, pulp fiction largely eluded censors. Pulps were relatively small books, read secretly, and discarded. What distinguishes pulp written by women, Tenzer said, "are images that counter the standard, conventional myths about American womanhood." *Skyscraper*, for example, published during the Depression, taps into male anxieties about

women taking away jobs. The Feminist Press is planning to publish more pulp fiction for its “Femmes Fatales” series.

—Dinitia Smith, *The New York Times*, January 1, 2004

### Aging Gracefully in Hollywood Movies

Hollywood is governed by conventional wisdom. Teenage boys are the major target. The most marketable actresses are both pretty and young. Some nominations for the Golden Globe Awards defied convention: Four of the five actresses up for best actress in a comedy are near 40 or older, including Diane Keaton, 58, who starred in *Something's Gotta Give*; Jamie Lee Curtis, 45, in *Freaky Friday*; Helen Mirren, 58, in *Calendar Girls*; and Diane Lane, 38, in *Under the Tuscan Sun*. And unlike many star-driven epic movies produced last year, these films will actually make money.

Actresses considered past their prime do not command the \$20 million salaries of younger stars like Julia Roberts. Films featuring older actresses do not require expensive special effects, so budgets are more reasonable, often less than \$40 million. And it is older female moviegoers, a group largely ignored in recent years, who are popularizing these movies. Ticket sales among men and women in the over-40 age group increased sharply in the past 15 years. Some analysts think baby boomers are interested in seeing stars they grew up with; others suggest that the woman in a couple is increasingly choosing the movie.

From the 1930's and into the 1950's, women's movies were common, often portraying a woman in peril who is forced to overcome hardship and who learns she needs a man to be fulfilled. After the 1960's, women were portrayed as more free-spirited and independent. By the 1990's, strong female characters willing to avenge any slight—particularly from a man—showed up more frequently. In 1991, *Thelma and Louise* became a cultural event and a box office hit. In 1996, *The First Wives Club* in which three women (one played by Keaton) punish their husbands who desert them for younger women, was also a hit.

In 1995, the percentage of women 18 or older who went to the movies at least once a month peaked at 27%. But in the late 1990's, that percentage dropped as Hollywood delivered a string of female-oriented box-office disasters with predictable plots. Studios began making more action films for teenage boys, who see them in groups over and over. Teenagers are still the largest segment of the audience, mainly because they are repeat customers. But in the past 15 years, the older audience has changed the scene. Tickets bought by men and women older than 40 grew to 32% of overall ticket purchases in 2002, from 20% in 1987, according to the National Association of Theater Owners. By contrast, the percentage of tickets purchased by filmgoers from 12 to 39 years old dropped from 80% in 1987 to 67% in 2002. Much of the decline, studio executives say, is a result of new distractions, such as video games and the Internet. The latest crop of movies for older women is a new attempt to attract that audience. There is still a dearth of parts for older actresses, even though the number of older actresses nominated for Golden Globe awards has increased in recent years. Until three years ago, only two or three older actresses were acknowledged in all of the categories.

—Laura M. Holson, *The New York Times*, January 18, 2004

### Feminist Awareness

The Julia Roberts film, *Mona Lisa Smile*, invites moviegoers to look back at the pre-feminist 1950's from the vantage point of our presumed enlightenment. Set at a fictionalized Wellesley College, the movie offers a blend of wintry campus scenes, pretty girls and relief at how far we've come. The protagonist, a progressive art historian, tries to inspire critical thinking in young women who see their elite education as a passport to upper-class wifedom, not to intellectual independence. The movie recalls the period's political witch hunts, and of how much sexism ultimately had in common with McCarthyism. Both depended on dividing the world into absolutes: chaste vs. fallen woman, good citizen vs. suspected Communist. Even though Roberts's character leaves Wellesley in frustration over its academic constraints, she is seen off by an adoring group of bicycle-riding students. The scene evokes the 19th-century “Bloomers,” pioneering feminists in trousers who defiantly rode bicycles (considered dangerous to sexual virtue). The film's conclusion weaves these girls symbolically into the history of the women's movement, leading us to imagine that, like their feminist foremothers, these students ride toward the freedoms of decades to come.

But do female students today continue to ride their bicycles steadily, considering themselves inheritors of the hard-won freedoms of the 1960's and 70's? This is not the case. Feminist awareness and political questioning are just as hard to inspire in reality as in the movie. Although nearly all women students expect to pursue careers, this is where enlightenment ends. The ability of a college degree to unlock professional doors seems to make “feminism” obsolete. But mere access to a work world still constructed by and for men cannot relieve underlying obstacles to genuine equality. And, in the classroom, the promise of career opportunities for women cannot alone counterbalance certain disturbing beliefs and behaviors, which go unnoticed by most. The supposedly equalizing force of college does not necessarily enable women to stake equal claim for their opinions in class. It is still common for even the very brightest female students to hold their hands over their mouths when they speak, or to cut off their own remarks, mumbling, “Forget it, it was stupid.”

But literacy in sexual politics means literacy in all politics. Despite some reawakening of student activism via Howard Dean's Internet-based campaign, in the author's experience, attempts to introduce contemporary politics into classroom discussions meet with blank stares. Even this past year, as our country began a war, there was mostly silence when the topic of Iraq was brought up—a mix of anxiety and paralysis, plus some grumbling over my deviating from the syllabus.

Each year the writer feels increasingly compelled to look less to syllabuses and more to teaching “wakeful” political literacy: the skills needed to interpret all cultural messages. Students need to understand the implications, for example, of a “Family Time Flexibility Act” which, while claiming to help women balance home and family, may have decreased overtime pay. A film like *Mona Lisa Smile* merits more than our own complacent smiles; the troubling 1950's may not be quite the ancient relic we think they are.

—Rhonda Garelick, *The New York Times*, January 24, 2004

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## For Your Bookshelf



**Sexual Revolution in Early America**, Richard Godbeer, Johns Hopkins University Press, Baltimore, MD, 2002, 430 pp, cloth, \$35.95.

In the news, just behind the Iraq war, is the boiling discussion of how to define marriage and civil unions. You can enlarge your thinking with this really fun but thoughtful history of sex in America. The author, a history professor at UC Riverside, smiles coyly from his picture on the back cover and confronts us with how sex, now and through history, has frustrated efforts to contain it.

In early America, he writes, "alleged savages posed a threat to English virtue and civility, (but) so too did the mundane challenges of the North American 'wilderness' itself...proponents of a conventional moral order worried about the ease which colonists became debased of their own accord if left unsupervised, wallowing in 'loose embraces,'...Some of the unions that these would-be reformers condemned were in fact committed, though informal...According to English law, a man and a woman could become married without a public ceremony, without the exchange of specific vows, and even without witnesses: couples could declare themselves husband and wife in private and henceforth consider their unions legally valid....By the late 16th century, church marriage had become the norm in England. But across the Atlantic, informal marriage underwent a major revival; especially in those regions of British America where ministers and magistrates were in short supply...The distinction between godly and ungodly families became hazier with each passing decade as the children of New England's settlers reached sexual maturity. Whereas many of the northern colonists had crossed the Atlantic specifically to become part of a

covenanted community, their children were not self-selecting....Almost half of the convictions for fornication in Middlesex County during the second half of the 17th century involved at least one church member or child of a church member."

The author is a good storyteller: "Sexual relationships had an important role to play in Anglo-Indian relations along and beyond the margins of British America. The colonists had every incentive to cultivate amicable relations with strong and populous Indian nations in the interior: at least for the time-being, the English wanted their trade more than their land; they also feared the possibility that native warriors might ally with the French or the Spanish against them. Considerations such as these doubtless played a part in the...conciliatory attitudes of many traders and officials. Anglo-Indian relations were often shaped by personal and

physical interactions. As travelers, traders, soldiers, and diplomats dealt with Native Americans on territory and under circumstances that nobody fully controlled, their interactions, accommodations, cultural misunderstandings, and conflicts were as much sexual as they were economic, diplomatic, and military" as were those of their kings and queens.

In a brief afterword, Godbeer evokes our current conflict about marriage vs. civil unions: "That ongoing struggle over sexual morality did not simply pit two opposing camps, one espousing and the other rejecting moral order, against each other. Instead, it took the form of a tripartite engagement between those who championed official values, those who adhered to alternative sexual codes, and those who disregarded issues of morality altogether...."

I wonder if the current vicious, sometimes silly conflict could have been avoided if the authorities then had fully respected the separation between church and state; had endorsed civil unions as the norm, leaving to the church any additional sacraments a family might seek for religious endorsement. Could the respectful adherence to the separation of church and state have saved us from this unseemly controversy?

M.S.

**Intuition: Its Powers and Perils**, David G. Myers, Yale University Press, New Haven, CT, 2002, 322 pp, cloth, \$24.95.

The author, a psychology professor, is anecdotal in his evidence for and against intuition. "Nobody can dictate my behavior," said Diana, Princess of Wales, in her last interview before that fateful ride....I work through in-

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stinct, and instinct is my best counselor.”

Myers does not dismiss the importance of data. “When objective information is available...by all means attend to it” but he puts intuition on an intellectual footing with cognition. “Not everything important is measurable...In such cases, our judgment must be guided by seasoned experience, by informed intuition, by the whispers of our accumulated, ineffable knowledge. Physicians and mechanics...can often make spot diagnoses...Even quicker and more astoundingly accurate are professional chicken sexers. Poultry owners once had to wait five to six weeks before the appearance of adult feathers enabled them to separate coverels (males) from pullets (hens). Egg producers wanted to buy and feed only pullets, so they were intrigued to hear that some Japanese had developed an uncanny ability to sex day-old chicks...The sex difference, as any chicken sexer can tell you, is too subtle to explain.”

At the same time the author acknowledges that intuition, like cognition, requires analytic examination. He explains the process of cost-benefit analysis in decision-making, sounding like a corporate executive with a vision. In the section entitled “Thinking smarter about risk,” he explains why “people’s probabilistic intuitions of any given risk are likely to be wrong,” saying that our biological predisposition is to be risk averse, and encourages us to focus on a single vivid scary event and not factor in the ordinariness of safety. It encourages us to take greater risks when skiing because we think it’s under our control—when it isn’t—and fear only what’s immediate.” For example, it’s difficult to get people interested in global warming. This is a fun read with good advice, an excellent index, interesting references, and nice graphics.  
*M.S.*

**Evil: An Investigation**, Lance Morrow, Basic Books, NYC, 2003, 276 pp, cloth, \$24.00.

Inspired by 9/11 and the invasion of Iraq, *Time* magazine essayist and author, Lance Morrow has written a comprehensive book titled *Evil: An Investigation*. It weaves moral catastrophes from world history into discussions of current issues, nearly anticipating the revelation of atrocities committed by American soldiers at Abu Ghraib prison.

Morrow examines the nature of evil and how it functions in daily situations, from office politics to remote villages across the world where anguished families comb through mass graves for clues of murdered loved ones. Although at times difficult to define, globalized by electronic media from every corner of the universe, evil permeates human consciousness effortlessly and Morrow believes humans usually recognize it. He views it like a gas or vapor that thrives on indifference and opportunity but is almost always an exercise of power. He suggests it is an element in human nature and, in an interesting section of the book, explores how the rest of the world practiced discretionary passivity in light of events in Serbia and discusses the role of collective memory and revenge in dealing with it.

Although a convert to the Roman Catholic Church, he devotes minimal attention to Satan as a force and examines evil from multiple philosophical perspectives. He thinks that attitudes toward evil are strongly influenced by cultural narratives and generational views and questions if the struggle between Islamist terrorism and Western secular democracy is a confrontation between incompatible ideas about justice, good and evil.

Morrow’s personal disclosures about failures of compassion or insufficient will to act in the face of unconscionable events inspire self-reflection. His crisp style occasionally drags because he feels compelled to consider every grade of evil from monstrous to mundane. The book is timely as America clings precariously to its position as arbiter of human rights worldwide.

*Harriett Koskoff*

**Couples Therapy: A Nontraditional Approach**, Daniel B. Wile, John Wiley & Sons, NYC, 1993, 229 pp, paper.

This is a second edition of a book first published in 1981. It was first brought to my attention over a year ago by Steven Wolin, MD, Director of Family Therapy Training at George Washington University Medical Center. I was able to pick up a good used copy through Amazon.com. In recent years I have begun to do more couples therapy and reading more books and articles on the subject and have cobbled together my own pragmatic, pre-

dominantly present and future oriented, and collaborative, nonadversarial framework, drawn from several different practitioners and my own clinical experiences. Wile’s theoretical and clinical approach seemed to fit in very well and was particularly helpful when I would feel stuck as to what to do next.

This small, highly readable and well-organized book has 18 short chapters. Wile contrasts his orientation to couples therapy with a series of traditional approaches, namely psychoanalytic, systems, and behavior therapy. He concludes that, for different reasons, traditional couples therapists view troubled couples as “acting out primitive wishes, manipulating and double-binding their partners,” and choosing not to relate in more healthy ways. Practitioners of marital therapy often end up adopting adversarial, manipulative, judgmental approaches while sometimes claiming otherwise or urging couples to be more realistic about the nature of human relationships, to give up their fantasies about an ideal relationship and to instead negotiate and compromise as though they were drawing up a legal or business contract. Wile makes a paradigm shift in which the therapist is able to take the side of each of the partners and legitimize their feelings and fantasies, to see each of the partners as “deprived, trapped, and isolated,” and finds a way to incorporate their problems, disagreements and fantasies into their relationship and to achieve a shared perspective. Wile gives many examples of his approach in contrast to more traditional approaches.

I recommend this book very highly not only to all psychiatrists doing couples therapy, but also to those of us who do primarily individual work. Wile’s perspective on couples is helpful in getting our patients (and us) to take a different perspective on their partners.

*Diane K. Shrier, MD*

**Women’s Mental Health: A Comprehensive Textbook**, edited by Susan G. Kornstein and Anita H. Clayton, Guilford Press, NYC, 2002, 638pp, cloth.

Three years ago I was asked by Dr. Kornstein to contribute a chapter on Career and Workplace Issues for this textbook, the first such comprehensive review of the research and clinical literature on women’s mental health since 1981

(*Women and Mental Health* edited by Howell and Bayes, Basic Books). In the past two decades, there has been a major expansion of the knowledge base on the effects of gender on psychiatric disorders and their treatment, the links between reproductive life events in women and mood and anxiety disorders, and about other psychiatric, medical and psychosocial concerns affected by being female. Thus this textbook is long overdue. In addition to the editors (who also have contributed chapters), there are 70 authors, both men and women, the majority from departments of psychiatry and each with expertise in their specific subject matter. Kornstein is Professor of Psychiatry and Obstetrics and Gynecology, Chair of the Division of Ambulatory Care Psychiatry at the Medical College of Virginia, Virginia Commonwealth University (VCU) and Executive Director of the Mood Disorders Institute and of the VCU Institute for Women's Health. Dr. Clayton is Professor and Vice Chair of the Department of Psychiatric Medicine at the University of Virginia (UVA) Health System and Medical Director of the UVA Center for Psychiatric Clinical Research. Both did a masterful job of organizing and editing this textbook.

The book is divided into five parts and each chapter includes a substantial bibliography. Unfortunately, case vignettes had to be omitted from the final text due to its size. Part I consists of seven chapters on Women's Psychobiology and Reproductive Life Cycle of particular relevance to psychiatry. Part II, the largest part of the book, focuses on the Assessment and Treatment of Psychiatric Disorders in Women and consists of 12 chapters on a wide range of important disorders and their treatment with an emphasis on differences to be considered for women patients. The nine chapters in Part III deal with Psychiatric Consultation in Women who have other medical issues of particular interest to psychiatrists. Part IV includes seven chapters on Sociocultural Issues for Women in which my chapter appears. This section includes developmental perspective, marriage and family, career and workplace issues, trauma and violence and three chapters on special populations such as lesbians, women of color, and elderly women. Finally, Part V consists of two chapters on Research and Health Policy Issues.

I would recommend this book as a reference that ought to be on the bookshelf of every psychiatrist and other mental health professionals. It is well-organized, well-edited, comprehensive and up-to-date.

*Diane K. Shrier, MD*

**Finding Their Own Voices: Maine Women at the Millennium**, James Andrew Mitchell, Down East Books, Camden, ME, 2002.

Thirty-two women from all over and in 12 fields now working and living in Maine are profiled in 144 pages by a "Man of Good Conscience" who recognized the importance of identifying strong, courageous, independent and competent women with histories/her stories of success, lack of self-confidence and perennial put downs. They overcame difficulties, made choices, balanced all parts of their lives and pursued non-traditional careers. They help both women and men, are in 70 different careers, and, best of all, demonstrate resilience of the heart and heaven spirit.

Mitchell began his project because he recognized his two granddaughters ongoing maturation and their need for good role models.

One woman quoted Martin Luther King II's August 22, 1963 speech in which he advised others to "see, make, take opportunities to recognize your prime, whatever time in your life it may occur; to challenge and tune into yourself."

Rarely does one have the opportunity to read and reflect about one's personal life experiences and values and simultaneously gain new insights and courage for the days to follow from reading a 142-page book of two page biographies of 34 women.

The only physician profiled, Diane Schetky, MD—a forensic and child psychiatrist and one of the courageous subjects—offered me this book as a gift.

Mitchell, a husband who observed his wife's sexist professional experiences, and grandfather of two then young granddaughters, realized, with Gloria Steinem's brilliant words, that all young women and men, wherever they attend school and/or work, could benefit from "hearing directly" the words of honest, gifted, good risk-taking women in all fields, courageous enough to reveal their personal histories and later steps and moves to establish healthy, worthwhile, dedicated personal and professional

*Books continue on back cover*

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*President's Message continued from page 2*

of the symbol of medicine. Look closely the next time there's a news story on TV about a health issue and you'll probably see a caduceus on the background graphic. The caduceus, which is symbolized by a shorter rod, entwined by two snakes and topped by a pair of wings, is derived from the ancient symbol of the Greek god Hermes (male), also said to be an inventor of magical incantations and protector of merchants and thieves. Like many of my peers, I had always assumed (or was I taught?) that the two images were interchangeable. In a world where men made the rules, this version of 'herstory' may be one of the earliest recorded lessons in institutionalized gender bias – the original symbol of the profession of the healing arts (associated with feminine origins), replaced by the masculine symbol for commerce and protector of merchants and thieves, and initially called the "magic wand" or "golden wand" of medicine. (Forgive all the obvious symbolism, but I told you up front my friend was an analyst!)

I'd like to think that AWP includes

some of the descendents of Hygieia and represents the values and principles for which she stood – *giver of health*. As we enter a new year, be assured that we will continue to resist the practice of redefining gender differences to suggest different is deviant or abnormal. We will continue to work on access and privacy issues, clinical practices that integrate and improve health and mental health services (including evidence-informed guidelines and pharmacotherapy), administration and leadership issues, research (academic and community based), training and education, advocacy, and self-determination on behalf of our patients and ourselves. Sometimes we'll be the lone voice, but whenever the opportunity presents, we'll collaborate with our colleagues in APA to promote the health and mental health of all persons.

Just remember, you can't get the fruit if you don't go out on the limb. Happy New Year and see you in Atlanta!

*Books continued from page 19*

lives in Maine.

Who should read this book? Everyone at every age and in every life circumstances will gain not only personal inspiration, but can then encourage others around them, whether within or beyond medicine, and from pre-teens to seniors to benefit and be encouraged to look within themselves for positive role models and at painful put-downs and closed doors they may have believed happened only to them and were their own fault.

Young men reading these biographies with open minds, willing to understand and learn about women's life experiences and invisible (too often) strengths, can redirect their attitudes and behaviors to the current and future women in their personal and work lives.

As physicians, we may well recommend some of our patients to read the book too. Many subjects admitted being told "no, you can't; no, there's no money for you; no, you have to care for the home and everyone in it; no, you deserve being treated this way (abused)."

*Leah Dickstein, MD*

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