DOCUMENT RESUME

ED 192 200 CG 014 656

TITLE	Women's Dependency on Prescription Drugs: Hearing Before the Select Committee on Narcotics Abuse and Control, House of Representatives, Ninety-Sixth Congress, First Session.
INSTITUTION	Congress of the U.S., Washington, D.C. House.
REPORT NO	SCNAC-96-1-8
PUB DATE	13 Sep 79
NOTE	108p.: Parts of this document may be marginally legible due to small print.
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	*Advertising: Alcoholism: Blacks: *Drug Abuse: Drug Addiction: *Drug Use: *Females: *Hearings: *Physicians: *Rehabilitation Programs: Sedatives: Sex Bias: Stimulants
IDENTIFIERS	*Congress 96th

ABSTRACT

This record of the Select Committee on Narcotics Abuse and Control contains testimonies addressing the problems facing drug abusing women. The extensive prescribing of legal drugs such as tranquilizers, sedatives, pain killers, and stimulants is examined. The problems of polydrug abuse and alcohol abuse in combination with other drugs are also explored. A member of Women-Together, Inc., a self-help counseling and peer therapy group, describes her problems with prescription drug abuse and how she worked to overcome addiction. A psychiatrist/psychoanalyst presents testimony on the miseducation of doctors about mind-drugs and on the various advertising policies and gimmicks used by drug companies to attract physician use of their products. Sexism in drug advertising is also discussed. The treatment procedures for drug-dependent women used by various programs are described in testimonies by women associated with those programs. A final testimony concentrates on prescription drug abuse by middle-aged black women. A section on Women and Pills reports on women's vulnerability to prescription drug abuse, lists eight danger signals of addiction, and presents a complete chart of the 12 most abused drugs. (NRB)

WOMEN'S DEPENDENCY ON PRESCRIPTION DRUGS

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

FIRST SESSION

SEPTEMBER 13, 1979

Printed for the use of the
Select Committee on Narcotics Abuse and Control

SCNAC-96-1-8

U.S. GOVERNMENT PRINTING OFFICE
52-028 O WASHINGTON : 1979

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

LESTER L. WOLFF, New York, *Chairman*

PETER W. RODINO, Jr., New Jersey
E (KIKA) DE LA GARZA, Texas
MORGAN F. MURPHY, Illinois
CHARLES B. RANGEL, New York
FORTNEY H. (PETE) STARK, California
GLENN ENGLISH, Oklahoma
BILLY L. EVANS, Georgia
LEO C. ZEFERETTI, New York
STEPHEN L. NEAL, North Carolina
JAMES H. SCHEUER, New York
TOM RAILSBACK, Illinois
ROBIN L. BEARD, Tennessee
BENJAMIN A. GILMAN, New York
TENNYSON GUYER, Ohio
LAWRENCE COUGHLIN, Pennsylvania
ROBERT K. DORNAN, California

Ex Officio

MARIO BIAGGI, New York
CARDISS COLLINS, Illinois
DANTE B. FASCELL, Florida
LINDY BOGGS, Louisiana
BARBARA A. MIKULSKI, Maryland
EARL HUTTO, Florida
ROBERT T. MATSUI, California
GEORGE DANIELSON, California
DANIEL K. AKAKA, Hawaii
MATTHEW J. RINALDO, New Jersey
ROBERT L. (BOB) LIVINGSTON, Louisiana
CHARLES F. DOUGHERTY, Pennsylvania
HENRY HYDE, Illinois
JOHN W. JENRETTE, Jr., South Carolina

COMMITTEE STAFF

PATRICK L. CARPENTIER, *Chief Counsel*
ALMA BACHRACH, *Chief of Staff—Supply*
ROBERT M. HENDLEY, *Chief of Staff—Demand*
ROSCOE STAREK, *Minority Counsel*

TASK FORCE ON WOMEN AND DRUGS

CARDISS COLLINS, Illinois, *Task Force Cochairman*
ROBERT K. DORNAN, California, *Task Force Cochairman*

BARBARA A. MIKULSKI, Maryland
LINDY BOGGS, Louisiana
BENJAMIN A. GILMAN, New York

TASK FORCE STAFF

ALMA BACHRACH, *Chief of Staff—Supply*
TONI BIAGGI, *Professional Staff Member*
PATRICIA REED, *Professional Staff Member*

CONTENTS

WOMEN'S DEPENDENCY ON PRESCRIPTION DRUGS

THURSDAY, SEPTEMBER 13, 1979

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, D.C.

The Select Committee met, pursuant to notice, at 1:14 p.m., in room 2118 Rayburn House Office Building, Hon. Cardiss Collins (acting chairwoman of the Select Committee) presiding.

Present: Representatives Stephen L. Neal, Benjamin A. Gilman, Lawrence Coughlin, Robert K. Dornan, Lindy Boggs, and Barbara A. Mikulski.

Staff present: Patrick L. Carpentier, chief counsel; Alma Bachrach, chief of staff—supply; Toni Biaggi and Elliott Brown, professional staff members; Roscoe Starek, minority counsel; and Diane Striar, press officer.

Mrs. COLLINS. This task force hearing of the Select Committee on Narcotics Abuse and Control will now come to order.

Recently, the Select Committee on Narcotics Abuse and Control formed a task force which is charged with the responsibility of addressing the problems facing women who misuse or abuse drugs. This is a critical problem requiring our immediate attention.

I am especially gratified to share the assignment with Congressman Dornan, to chair this task force on women and drug abuse. As one of the few women in Congress, I feel a particular sense of duty in dealing with this particular subject.

We are all prone to thinking of drug abuse in terms of the male population and in terms of illicit drugs such as heroin, cocaine, and marihuana. It might surprise you to learn a greater problem with this is some 2 million women who are dependent on legal prescription drugs and, in addition, an estimated 5 million women who are abusing alcohol, often in combination with other drugs.

Doctors write more than 200 million prescriptions each year for tranquilizers, sedatives, painkillers, and stimulants; alarming statistics show that women account for two thirds of these prescriptions.

Moreover, because of the double standard that exists between men and women, it is not uncommon for a doctor to advise a male patient to work out his problems in the gym or on the golf course, while a female with the same symptoms is likely to be given a prescription for Valium. What happens next is borne out by emergency room statistics. Six out of seven persons reporting a drug crisis of any kind are women.

Particularly susceptible to abuse of legal drugs are women between the ages of 18 and 25. Complicating the problem for most of these women is the added responsibility of caring for small children and the

stigma of drug abuse which has kept many women from seeking problem treatment.

Researchers cite a number of reasons why more women than men abuse mood-altering drugs. These range from the boredom of housewives to the increased amount of stress women are encountering while changing their roles in our society.

No question, it would be a simple matter to blame the medical profession or the pharmaceutical industry for the lack of control in prescribing or monitoring the distribution of these drugs, but the problem goes much deeper than that.

One of the primary functions of this task force will be to create a public awareness to encourage preventive measures and adequate treatment.

Today, the committee will hear from Mrs. Cynthia Maginniss who is consultant to Together, Inc.

We will also hear from Dr. Robert Seidenberg, who is a clinical professor of psychiatry at Upstate Medical Center, State University of New York, in Syracuse; Ms. Phyllis Halpern who is coordinator of women's programs for the New Jersey State Department of Health, Alcohol, Narcotic and Drug Abuse Control; Dr. Doris DeHuff, executive director of a national demonstration program, Stamford, Conn.; and Ms. Barbara Gibson who is a senior administrative associate of Addiction Research and Treatment Corporation in New York City.

Before going forth with the hearing, we will at this time have a statement from the cochairman of the task force on women and drug abuse, Mr. Dornan.

Mr. DORNAN. I thank my distinguished colleague. It is, indeed, an honor to chair this important committee with so distinguished a colleague.

I would just like to say very briefly that I concur wholeheartedly that this series of committee hearings is critically important because I believe that if they are given the proper equipment, treatment, and service, it will save lives. It is with a great amount of satisfaction to be a Congressman or Congresswoman.

Today, we are voting on a nuclear aircraft carrier. We will be handling the defense budget. All this week, we will be voting on export controls to Communist countries, discussing massive computers. All of these issues have, in the long run, the import because they deal in the saving of human lives.

But when you discuss medical problems in the Congress, especially when it involves drugs, you literally have the ability as a Member of Congress to save lives in the short run—next week, the week after, next month, to make a dent in the yearly death toll of those who overdose and die by abusing drugs, particularly those who have a polydrug problem and mix them with alcohol.

We only read about the movie stars and rock performers, people who have attained some fame or notoriety when the overdose to death, but the other statistics are cold loss on the charts, automobile-death statistics.

Well, the reason I as a male volunteered to serve on this committee with Mrs. Collins over some that you might think would receive more attention like the cocaine task force we have or the PCP task force, marihuana task force, is because as a male, there are women in my

family—my mother deceased in 1967. I believed her life was shortened by poorly prescribed medical attention. I have three daughters. They are all very healthy, thank God. Not one of the three has been to a doctor where on occasion they haven't been offered tranquilizers of some form. Ridiculous, given their health and energy levels.

My wife of 25 years next April has come as close to death as any humanbeing possibly can at the hands of doctors who would otherwise be considered honorable in their profession.

Growing up as a healthy young man, I held doctors on a high plateau of esteem, literally on a pedestal. It was a profession that I considered similar to a calling to serve in the clergy or rabbi or minister or priest. I try not to denigrate doctors unnecessarily; they have served me well over my lifetime. But I can assure you they are no longer as a profession on a pedestal.

I think the worst chauvinist trip I have ever seen in my life is what Mrs. Collins alluded to in her opening statement—this treating men like men and telling them to get their act together and get to the gym, and treating women in our country as though they are some sort of stupid puppy dog and addicting them on drugs that our society is still not fully aware of the unbelievable danger, particularly the psychotropic drugs.

I think if we are going to do anything on this committee—and I look forward to every hearing we have—it is going to be to bring feens on a subject that the heavy manufacturers of prescription drugs in this country like Hoffman-LaRoche refuse to concede. And that is that they are dealing with dynamite.

I will just close by saying that I personally believe that there are more tears shed, more heart-felt anguish, and more families broken up, more divorces caused, more reconciliations caused to fail, by the improper prescribing of drugs than any of the myriad sociological problems we have in this Nation, tearing apart our family unit.

So I repeat; it is an honor to sit here with you, Mrs. Collins. Thank you.

Mrs. COLLINS. Mr. Gilman?

Mr. GILMAN. Thank you, Madam Chairman. I want to commend the gentlelady from Illinois and the gentleman from California for the task force holding these hearings and for doing the research necessary to prepare for the hearings. I am particularly concerned with the psychological effects of mood-altering drugs and the effects of these drugs on our female population, indeed, all of our citizenry.

We need to examine why physicians are so poorly informed regarding the effects of all of our drugs and why they are causing such extensive use of drugs such as Valium, a drug that we are finding is more addictive than we initially believed it to be and which has become so pervasive in its use throughout our Nation.

I look forward to the testimony by our witnesses. I know it is going to be beneficial to all of us on the Select Committee on Narcotics. We have spent a great deal of time and attention and funds in reaching out to all parts of the world to see what we can do about reducing the supply of narcotics at its source. I certainly think it is time that we examine some of our problems right here at home where we have an even more serious problem with regard to polydrug abuse and alcohol mixed with that polydrug abuse.

I am sure these hearings are going to be beneficial to the work of this committee. Thank you, Madam Chairman.

Mrs. COLLINS. Thank you very much.

Those two bells which just rang mean we have a vote in the House of Representatives so it is a timely place to recess just for about 10 minutes. And then we will come back and receive testimony from our witnesses.

[Whereupon, a recess was taken.]

Mrs. COLLINS. This hearing will reconvene at this time.

Our first witness is Mrs. Cynthia Maginniss. Mrs. Maginniss, you may begin your testimony now, please.

TESTIMONY OF CYNTHIA MAGINNISS, WOMEN-TOGETHER, INC., GLASSBORO, N.J.

Mrs. MAGINNISS. When I was an adolescent, my great grandmother died. The women in my family—my mother, my grandmother, my aunt, and I—were given tranquilizers in spite of the fact that my great grandmother was my father's relative, not my mother's. My mother and father were divorced when I was 12, and I was sent to a boarding school. I took an overdose of aspirin, and the school failed to report this to my family.

My mother was given both tranquilizers and amphetamines for nerves and her weight by her doctor. She was about 10 to 15 pounds overweight. She was also an alcoholic, although she hid it well like many other housewives. When my mother died, I was 16 and was given tranquilizers for 1 week. The general mood in my family and society seems to be that women should not cry a lot, and we should be drugged instead of crying.

When I was in college, I weighed 105 pounds. I want to point out to you I weigh 105 pounds now. I went to a diet doctor for my weight problem. I was weighed and had my blood pressure taken every week by a "helper." I never met a doctor. I lost 20 pounds.

Another doctor gave me tranquilizers for my nerves and because I was having trouble sleeping. I got a kidney infection and vitamin deficiency and dropped out of school to be hospitalized.

When I was 18, I had a nervous breakdown. I was hospitalized in a prestigious private hospital and given various medications including Thorazine in doses large enough to put me to sleep during the day and additional, but ineffective, therapy. The only reason I know I was taking Thorazine is because the patients identified it for me. I was never told by a doctor or nurse what I was taking. I believe that the other patients and aides helped me much more than the psychiatrists did.

After being hospitalized, I married. And when we decided to have a child, I stopped taking Thorazine which I had been taking for about 4 months after being released from the hospital. I was not receiving any therapy or followup during this time. When my son was 18 months old, we moved so that my husband could get his master's degree. I was depressed and bored. I mentioned this to my gynecologist, and he prescribed Valium, 5 milligrams to be taken as needed. He told me I could take more than one at a time if I needed to.

The next several years of my life are very blurry, but I'll try to give you the facts and impressions as I remember them. I went to another doctor who gave me diet pills out of his closet. He had great big bottles of pills in his closet and would give me envelopes full.

My gynecologist gave me more Valium and Darvon for cramps; 2½ years later, we decided to have another child. I only took Valium during my pregnancy—up to 15 milligrams at a time as needed. After the birth of my second child, I was more depressed and anxious and developed colitis. My family doctor gave me a relaxant and another pain killer. My doctors never asked me what else I was taking and didn't tell me what I was being given.

I didn't tell them how often I was upset or how much I was upset because I was afraid of being labeled a hypochrondriac or complainer. And the doctors seemed to know best what to do for me. During this time, I went to a local mental health center and saw a fairly competent doctor. When he moved, I stopped going because my new doctor started telling me his problems.

When I was 25 years old, we moved again, and I was depressed. And my gynecologist increased my Valium to 10 milligrams to be taken as needed. I want to state now that I wasn't as physically hooked as some people because I took such large doses at times that I would get sick and not take my pills, "my friends," for a day or two.

I also only took diet pills on weekdays and not on weekends. So on weekends, I didn't really need the tranquilizers to get me to sleep or down from being high. I can also see now that I was happier on weekends when I had more to do and my husband was home, things like that.

I went to a new doctor in Glassboro and became more jittery and depressed. I stopped the amphetamines, but my unhappiness continued. When my children misbehaved, I took two 10-milligram tablets of Valium. I want to clear this up. I took 5 to 10 milligrams of Valium—it wasn't milligrams, but 5- to 10-milligram tablets.

I slept late. I had insomnia and overdosed a few times. I told my doctor, and he gave me a 6-month prescription for Valium and Darvon, 100 of each, refillable 4 to 6 times. I got colitis again and started taking Triavil along with the Valium.

I went to a women's club meeting and saw two women from Together, Inc., who were talking about hotlines and drug overdose and abortions. They did draft counseling and things like that. At the time, I didn't think it pertained to me. I took their card, and when I took my next drug overdose, I called them. They got me to describe my house and neighborhood and came and found me. We talked, and they seemed to care very much. And they asked me to come to a women's group meeting and I went.

I found a place where I felt safe and cared for—a place where I could be me and not who I thought I should be. Shortly after attending my first group, I went to work on the hotline. I attempted to kill myself one more time, taking 480 milligrams of Valium and a few Darvon. After this episode, another doctor who knew about my suicide attempt offered me tranquilizers for colitis, but I learned self-hypnosis instead, and I don't get colitis any more.

The women in my group and I noticed that we were not coping by using pills and alcohol any more. Some of us were getting outside therapy, but we knew that our real growth was happening in our women's group. We applied for funding as a pilot program. We have been in existence for 5 years.

I worked for a counselor for 2½ years and am now a consultant to Together, Inc., and to another women's program, Alternatives for Women Now. I have taught women's courses at several colleges, and I speak anywhere I can about women's alternatives to drugs.

I gave you an attached form to find out more about Together, Inc.

[The information referred to appears on pp. 51–61.]

Mrs. MAGINNISS. I just want to pay attention briefly to my family. My father, grandmother, and most of my relatives thought that I was being helped by my doctors. They also did not realize the depths of my despair and self-hate. My husband was a fairly traditional male in that he wanted a sweet, dependent wife like Donna Reed or somebody. He didn't realize that for me, that role was depressing. He supported me when I took the doctor's prescription for happiness and became fearful when I tried less traditional forms of treatment such as gestalt, bioenergetics, transactional analysis, assertiveness training, consciousness raising, primal therapy, and goal setting, to name a few.

He was also threatened by my involvement in all-female groups, but has come to see that they are more conducive to growth than mixed groups. My children are fine, beautiful people. I have three, ages 13, 10, and 3 years.

Partly because of the training that I have obtained in communicating with them and partly because I now have room in my life for them, now that I'm fulfilling myself, they seem to cope well in the world.

Together has had a profound effect on me because of the atmosphere of acceptance and the very special treatment offered to clients. I would never have entered a traditional drug program where I would have expected, and often found, a male-dominated, confrontive atmosphere designed to deal with people very different from me.

The modeling done at Together by drug-free women staff who are coping with life in alternative ways is certainly more useful to a woman than being told how to be a woman by a man. The majority of counselors are ex-prescription drug abusers, and as such are able to understand the problem and show the client that change is possible.

Mrs. COLLINS. I am sorry, I am going to have to interrupt again to go back on the floor for a vote.

[Whereupon, a recess was taken.]

Mr. DORNAN. In the interest of time, we will begin, and Mrs. Maginniss, please continue with your statement, and I am sure Cardiss Collins will be here in a second. Please proceed.

Mrs. MAGINNISS. I am going to go back a paragraph, continuing the thought.

Together has had a profound effect on me because of the atmosphere of acceptance and the very special treatment offered to clients. I would never have entered a traditional drug program where I would have expected, and often found, a male-dominated confrontive atmosphere designed to deal with people very different from me.

The modeling done at Together by drug-free women staff who are coping with life in alternative ways is certainly more useful to a woman than being told how to be a women by a man. The majority of counselors are ex-prescription drug abusers, and as such are able to understand the problem and show the client that change is possible.

In many other drug programs, the medical model is used, which comes from the perspective of attempting to cure a drug-abuse problem and make the patient whole again. This model is ineffective, as clients often substitute other destructive coping mechanisms, such as smoking and alcohol, and believe that he or she is not whole and OK.

At Together, the approach is to support the already whole individual while helping her to discard outmoded destructive behaviors. This is done in a caring, but nonrescuing atmosphere by strong centered feminists. It is done, in my mind, miraculously in spite of the humiliating and time-consuming medical exams of women already under a doctor's care, endless paperwork required by the funding agency, and the threat of urine-monitoring by the State.

I know that all drug programs suffer some of these same problems, but women who are abusing prescription drugs are not the same as people using illicit drugs, who are often court referral cases.

By teaching new life skills, helping the woman see herself in perspective to our often sexist society, aiding her in setting her goals, and in getting on with her life, Together performs an effective service to the client. I think that this program works also because clients can become involved in helping others as hotline volunteers, typing, or doing something in the office, being a group leader, counselors, and staff trainers and administrators.

Another plus is that there are no fees involved at all, unlike many mental health centers that women can go to. Confidentiality is highly prized, as many clients start out without their family's knowledge.

To me, the areas of need for improvement nationwide are for more treatment facilities like Together and more prevention through education and information. I would like to see TV ads about prescription drug awareness such as, "Do you know what you are being given? Why? For how long? Are you aware of the side effects? If not, ask. It's your body."

I would also like to see people become more wary of doctors and start to think of doctors as their employees rather than gods. I believe that I am wary of governmental restraints, either of doctors or pharmaceutical companies. I believe that women, and consumers in general, have both the ability and the right to make informed choices.

I would also like to see school children trained in coping skills which can replace drugs, some coping skills like stress-reducing techniques, self-hypnosis, and assertive communications.

These hearings are certainly a step in the right direction, and I feel very hopeful. Thank you for giving me the space to share with you.

Mr. DONNAN. Does that complete your statement?

Mrs. MAGUIRE. Oh, I have something else I want to share just quickly.

As I was coming down here, I was reading Good Housekeeping magazine, September 1979. In it, there is a letter to the editor. I would like to read it because it expresses what I feel:

I would like to express my thanks to you for this article, "Women and Pills." I have spent six months of nightmares taking prescription tranquilizers prescribed by my doctor. When I read your article, I threw out the medication. In a very short time, I have completely recovered and am once again able to function normally.

My medication was named among the twelve most abused medication drugs you listed. Actually, I had been given three of the drugs on your list during this period. I will be forever grateful to you, Good Housekeeping, for publishing that article.

I am not going to give the woman's name, but I think there are a whole lot of women out there, a whole lot.

Thanks for having me here.

Mr. DONNAN. There certainly are. Thanks for an excellent statement.

In the course of the period when you were using the psychotropic drugs, did you run into other friends or acquaintances, family members, who weren't so lucky as yourself to find some group support, who just continued on the path of pain-killing at a certain level where it is affecting their lives immediately?

Mrs. MAGINNISS. Yes; I have one very close relative, who is an older woman in her seventies, who is taking Valium and painkillers which are not effective, really, for her. She has a back problem, and I have tried on several occasions to get her to try self-hypnosis or acupuncture or something like that, because she is very tired. I think if she wasn't taking the drug, she would have more energy and could function better.

I have seen a lot of relatives doing something. My aunt was given diet pills when she was pregnant, and I know a lot of women who have been given them. Often, the women do stop taking them on their own, but for that period of time, they are not functioning as well as they could be.

Mr. DONNAN. When someone does stop taking them on their own, has it been your experience it is because of some outside stimuli, like a good magazine or newspaper article, or just commonsense?

Mrs. MAGINNISS. Usually, it is because the situation they are coping with stops. For instance, their children grow up, and they are not crazy housewives any more. They maybe get a job, something like that. Or maybe they go for marriage counseling or they end the marriage, something like that.

So often the situation changes. It is not that they have been given information; they just don't need the pills any more.

Mr. DONNAN. I notice in the early part of your testimony, at the funerals of some family members, you were given tranquilizers. It has only been my recent experience at funerals of friends which I have noticed a composure, almost a stoned effect, on family members that I had never noticed at funerals before—very little crying, very little emotion. I wondered if it has been your experience that this situation grows rather than has reached any plateau, or anyone has decided maybe if letting the pain out of losing a loved one is better than boxing it all up and running the danger of it beginning a period of use of tranquilizers.

Mrs. MAGINNISS. That has been my experience. My father died a few years ago, and I wasn't taking any medication. Whenever I felt like it, I cried. I don't know that I will ever get over it completely, but I got over the depression and feeling of loss, and I was able to remember him positively a lot quicker than I could my mother.

With my mother, my grief went on for years because I kept suppressing it with pills and things. I think it is better to get it out and cry. It is normal and natural to feel sad.

Mr. DORNAN. One other question before I turn to my colleagues. In all of your interacting with doctors and medical persons, did you ever run into a doctor, particularly a male doctor, that really seemed to have a grip on this problem and leveled with you, or ever brought it up himself that maybe there was some other health course to take than running out of pills?

Mrs. MAGINNISS. I don't think I ever really did. I thought I had. My last doctor seemed to be pretty good and aware. In fact, he had recommended someone to our agency. Then, I was seeing him one time, and he said—he seemed pretty calm—"Oh, yeah, I'm taking Valium."

No, no, I don't think I have really.

Mrs. DORNAN. I only have in a forum like Senator Kennedy chaired on the other side the other day, ex-addict doctors who themselves are on tranquilizers. Years and years of going in and out of hospitals all around Los Angeles and 10 years of hosting the broadcast shows—I did talk shows—I don't ever recall a doctor speaking out vigorously about trying to get a real handle on this problem.

Mrs. MAGINNISS. I would say Dr. Seidenberg does.

Mr. DORNAN. Well, I have seen him testify before, and I would agree with that.

Let me turn to my distinguished colleague from Louisiana, Mrs. Boggs.

Mrs. BOGGS. Thank you, Mr. Chairman; and thank you, Mrs. Maginniss, for your testimony. I am very sorry I haven't been here for the entire proceeding. I was grateful to be admitted to this committee as an ex officio member because, unfortunately, I don't have the time to sit on it in a sustained manner.

Of course, we are grateful to you, Mr. Dornan, for chairing this and to Mrs. Collins and to the other members of the committee.

I might just say, in passing, that the story in Good Housekeeping really emanated from Margaret Adams, one of their editors, who was present at the hearings held last year by this committee on women and drug abuse. It is gratifying to realize that the committees have had very positive results.

I am interested in the fact that you were prescribed Valium throughout pregnancy. Was it ever mentioned to you that Valium may have some effect on the fetus?

Mrs. MAGINNISS. No.

Mrs. BOGGS. Congresswoman Mikulski and Congressman Miller and I, along with many other Members of Congress, are very interested in the ramifications that ensue in cases of domestic violence. We have been told that some physicians, particularly with affluent patients, sometimes don't know what else to do with pregnant women when they are victims of some kind of family battering. Tragically, the incidence of this abuse seems to increase sometimes when they are pregnant. Some physicians provide tranquilizers so the women can sleep and cope with the situation.

Of course, there is the potential for very adverse impact upon the babies when they are born: Infant drug dependence, genetic problems, and so forth.

I really am very grateful to you for your courage and frankness. I know others have many questions to ask you, but let me add, we are so glad to have the various witnesses come here because only through this kind of exchange from people who have experiences across the spectrum of the problem and who have worked to develop applications of solutions can we really come forth with some positive and productive hearings which will lead to meaningful Government responses.

Thank you very much.

Mr. DORNAN. Our distinguished chairwoman has joined us, Mrs. Collins.

Mrs. COLLINS. Thank you very much, Mr. Doran. I have just two or three questions.

I notice from your testimony that you mentioned that you took Valium during your pregnancy, and up to 15 milligrams at a time as needed. How often did you feel you had to take those?

Mrs. MAGINNISS. Every night to get to sleep, and often around dinnertime. Sometimes in the morning, if my son was running around a lot, or something like that. But usually around dinnertime, when things got a little heetie, and every night to get to sleep. Also, if I had any interaction with my father or older relatives, and I would feel insecure, I would take the Valium.

Mrs. COLLINS. I felt it interesting also on page 1 of your testimony, you said that your doctors never asked you what else you were taking. Not at any time, ever?

Mrs. MAGINNISS. No.

Mrs. COLLINS. When talking to various friends and people you met in Together, do they have the same situation that many doctors just don't ask their patients if they are taking other medication?

Mrs. MAGINNISS. They don't ask; and sometimes, if you tell them, they forget it or they don't care. I have had that. I am allergic to penicillin. It is written on my chart, and the doctors don't see it. Often, they are just very, very busy. Sometimes, they don't care.

Mrs. COLLINS. You mentioned on page 2, I think, of your testimony, in the first paragraph, that, "I took their card, and when I took my next drug overdose," you called the people at Together, Inc. When did you first realize that you were overdosing?

Mrs. MAGINNISS. That day, or in my lifetime?

Mrs. COLLINS. Just generally, when did you say to yourself, "Hey, I am taking too much of this stuff. Why am I doing it," those sorts of things?

Mrs. MAGINNISS. I knew I was doing it to escape. I knew I was taking too many at times. Somehow, I didn't think it was a problem.

Mrs. COLLINS. Did you ever realize for yourself that it was a problem?

Mrs. MAGINNISS. Not until after I stopped doing it. I guess my last suicide attempt I can remember being in the hospital with the sheet over my head, I was so embarrassed. Someone came in and I said, "I don't like this; I don't want to do this any more," and the person looked at me and said, "Then why don't you stop?" That's when I realized it was within my power to stop doing it.

So until then, really, maybe I wanted to die; maybe it was a bit for attention. It is a little confusing in my mind why I did it. A lot of

times, it was just to escape for a little while. I knew it took 10 Valiums. I would sleep longer than if a took 1 or 2.

It is difficult to say why.

Mrs. COLLINS. The program, Alternatives for Women Now, what does that do?

Mrs. MAGINNISS. That is an organization that does job counseling and returning to school. They also work with battered wives, and they have a component for child care.

Mrs. COLLINS. When your doctors prescribe these drugs for you, do they ever tell you anything about the danger of mixing medication with alcohol or other drugs, anything like that?

Mrs. MAGINNISS. No. In fact, when I mentioned I used to take them around dinnertime, often, I would take my Valium with a glass of wine. And I had no idea that was wrong. I get angry sometimes, when I realize that I was not informed.

Mrs. COLLINS. Thank you very much.

Mr. Chairman?

Mr. DORNAN. Ms. Mikulski?

Ms. MIKULSKI. Thank you very much, Mr. Chairman.

Mrs. Maginniss, I would like to thank you for stepping forward and sharing with us your own personal story. I think it is a compliment to you and other women like you who are willing to come forward and provide what I consider is an exposure of what is a major problem. It takes a great deal of courage to come into a public forum with this architecture and high ceilings and share with us your own story.

I have just a few questions. And not to be repetitive, as you consulted physicians at these various times, benchmarks in your life, either the points of enormous grief or pregnancy or acute physical illness, did they take those problems and handle them as natural processes that most adults need to cope with, for example, grief. Did they approach childbirth as a natural life process to be facilitated and enhanced and nurtured or were your various symptoms viewed as diseases to be attacked and cured and, therefore, place you under attack? How did they approach that?

Mrs. MAGINNISS. I was given the impression that there was something wrong with me.

Ms. MIKULSKI. Even when you were pregnant?

Mrs. MAGINNISS. Yes; and with the postpartum depression, sometimes I was given kind of a pat on the back, oh, don't worry about it, that happens to everybody, but generally, I had the feeling I was given a pill to cure what was happening to me.

And I now believe that the pills that I was taking made me more depressed and more anxious than if I hadn't been taking them.

Ms. MIKULSKI. One other question. Were any other treatment modalities suggested to you, whether counseling, biofedback for pain, any other approaches other than a pharmaceutical one?

Mrs. MAGINNISS. No. No. Sometimes, they would say "Sit down and put your feet up and get somebody to watch the children," which could have been useful at times. But I was never referred to anyplace else which would have been very helpful and turned out to be helpful in the long run.

Ms. MIKULSKI. I see. Now, you are part of a group called Women Together which I gather is a self-help counseling and peer therapy

program. How do you feel that has benefited either yourself or the members of that group?

Mrs. MAGINNISS. Are you talking about the people who work there or the clients?

Ms. MIKULSKI. Well, I am a social worker myself. And I find that in helping people, I most often help myself.

Mrs. MAGINNISS. It is incredibly helpful.

Ms. MIKULSKI. Whatever way you can describe it.

Mrs. MAGINNISS. I feel like I am doing something worthwhile, something challenging, something that uses my mind. I am not a good full-time mother. I find it tasking, boring. I like my children a lot; I enjoy being with them on a part-time basis. And I think that there are a lot of women like me who would rather be out doing something else than staying home taking care of 2-, 3-, and 4-year-olds all day.

Yet, I think that there is something about our society that says we should do that and that we are not OK if we don't do that. I don't want to see it swing the other way: it is not OK to do that. But there are some women who really enjoy that. But for me, it was not rewarding. So it gave me a chance to get out and do something good.

Every time I teach assertiveness training, it reinforces the assertiveness within me. So I feel every time I help other women, I help myself a little more.

Ms. MIKULSKI. Thank you very much.

Mr. Chairman and Madam Chairwoman, I just wanted to comment. As you know, I am a member of the Subcommittee on Health in the Interstate and Foreign Commerce Committee, and I thought the members of this committee would be interested to know the approach that we have taken on the authorization for the programs related to drug abuse and alcoholism. In pursuing our own work on that subcommittee, we found that there was a severe problem of women being addicted to illicit drugs but we found that the Federal dollar was being targeted to the hard core heroin addict, persons who would be more likely to commit violent crime to get funds to maintain the habit. There was no orientation to the problems of women in drug abuse for what some of us call medically prescribed junkies. And, of particular interest to Mrs. Collins and Mr. Dornan is there is no family orientation to the treatment of drug abuse so that you can take a look at the person within his or her family and then see what type of approaches and treatment modalities would be.

We tried to do some conscious raising with HEW and had them place on a short-term lease with a 1-year authorization and mandated they take a look at this particular area. The work of this committee will certainly reinforce this. And I thank you very much for your effort.

Mrs. BOGGS. Would the gentlewoman yield? I would like to say that one of my subcommittees is responsible for appropriations for the Veterans' Administration. This year, the Veterans' Administration is taking a very positive step toward family orientation in the treatment of drug abuse. This is one area of the government that is working properly in that regard. Unfortunately, it took a great number of Vietnam-era veterans to make the Veterans' Administration see the necessity for this type of innovative program. But I do think that we are moving in the right direction.

Mr. DORNAN. Excellent point. It is amazing with all of the years of experience with alcoholism that we knew the whole family had to be approached on that that it took so long to come around to involving the whole family process and approach with drug addiction. It is an excellent point.

Mrs. MAGINNISS. May I say something in this area? The Federal or the State guidelines that we are under make it very difficult at times to get clients in. And I just want to mention that we had one woman who we were required to have medical examinations. And she got bruises on both her arms from having blood taken.

Her husband did not know she was coming to us. He probably would have physically abused her had he known. And we were required for funding to have this done to her. And she had to dress in the bathroom for 10 nights and things like that until the bruises disappeared. And that is very unfair to the housewife. It is almost impossible to give treatment under circumstances like that at times because of the guidelines and the restrictions that have been under——

Mr. DORNAN. In your own experience, did your husband ever go to any of your doctors and question them?

Mrs. MAGINNISS. No. No. My husband is fairly shy and quiet that way. And he really is very proud of me now, but he still is not involved in what I am doing very much. He has his own life. And I guess he always felt that the doctors knew best.

Mr. DORNAN. Mr. Gilman?

Mr. GILMAN. Thank you. Mr. Chairman. And Mrs. Maginniss, we are very interested in your testimony. How many years were you an abuser of Valium?

Mrs. MAGINNISS. Valium? Maybe 8.

Mr. GILMAN. Is that the main drug of abuse?

Mrs. MAGINNISS. For the last 5 years, I would say definitely.

Mr. GILMAN. How old were you when you first started taking Valium?

Mrs. MAGINNISS. I think I was about 16 the first time. I mentioned my mother died. That was the first time I took Valium.

Mr. GILMAN. And then, there was a period of time you were off it?

Mrs. MAGINNISS. A couple of years, a few years.

Mr. GILMAN. And after your youngest was, I guess, a few months old, you started taking it again?

Mrs. MAGINNISS. Yes.

Mr. GILMAN. And the doctor prescribed it?

Mrs. MAGINNISS. Always.

Mr. GILMAN. Did he in addition to the prescription of Valium warn you of any of the dangers of abuse?

Mrs. MAGINNISS. No.

Mr. GILMAN. Was there any information printed that was given to you or on the bottle that you were given?

Mrs. MAGINNISS. Usually, it didn't even have the name of the drug. In fact, for years, I didn't know what I was taking because they didn't put the names on. And if I asked him, I never received——

Mr. GILMAN. Did the doctor provide the medication or did you buy it at a pharmacy?

Mrs. MAGINNISS. Sometimes the doctor; sometimes the pharmacy. But for years, no name.

Mr. GILMAN. And you didn't know actually what drug you were taking?

Mrs. MAGINNISS. No; I didn't know.

Mr. GILMAN. When did you first learn it was Valium?

Mrs. MAGINNISS. I think I heard some people talking about it, and I mentioned—in fact, it was a rap group. And I took out one of my pills, and we looked it up in a PDR book or somebody said they had taken it, that was what it was.

Mr. GILMAN. How long had you been taking it before you identified——

Mrs. MAGINNISS. Years. I don't know exactly, but for a long time.

Mr. GILMAN. More than a year or two?

Mrs. MAGINNISS. Yes.

Mr. GILMAN. And you eventually asked your physician what medication you were taking?

Mrs. MAGINNISS. No, I found out myself.

Mr. GILMAN. And after you found out, did you make any inquiries about the medication?

Mrs. MAGINNISS. No.

Mr. GILMAN. At any time, did your physician give you any warning about abuse of this drug?

Mrs. MAGINNISS. No.

Mr. GILMAN. Did you finally begin to take more and more of it as time went on?

Mrs. MAGINNISS. Yes. Yes.

Mr. GILMAN. What dosage were you initially taking?

Mrs. MAGINNISS. Five milligrams as needed.

Mr. GILMAN. And how often did you take that?

Mrs. MAGINNISS. Sometimes two times a day. Sometimes I would take 10 of them a day.

Mr. GILMAN. That is 10 pills?

Mrs. MAGINNISS. Yes.

Mr. GILMAN. And then, what did they eventually increase to as you begin to take more and more?

Mrs. MAGINNISS. Sometimes around dinnertime, if things got really hectic, I would take 10, 13, 15.

Mr. GILMAN. All at one time?

Mrs. MAGINNISS. Yes.

Mr. GILMAN. How many in 1 day?

Mrs. MAGINNISS. The most I have taken was 48 Valium with a couple of Darvon.

Mr. GILMAN. Do you know how many milligrams of Valium was in each one?

Mrs. MAGINNISS. Ten.

Mr. GILMAN. Ten milligrams to a tablet?

Mrs. MAGINNISS. Yes.

Mr. GILMAN. And you took as many as 40 in 1 day?

Mrs. MAGINNISS. Yes.

Mr. GILMAN. When you did that, did they have any bad effect?

Mrs. MAGINNISS. That was my last suicide attempt. I was taken to the hospital and was in intensive care for 24 hours.

Mr. GILMAN. Did you notice any psychological effects? Did you get any psychological effects from this overdose?

Mrs. MAGINNISS. Psychological, no. Physical, I walked into walls and things like that. Most of that time, I just hated myself. I really hated myself. I felt like a weak, unimportant person. And I had hallucinations. I had bad dreams. I would have trouble getting up in the morning, trouble going to sleep at night. I took naps every day.

I have found out since that some of my symptoms were withdrawal symptoms because also during that time, I was getting away from them a little bit. You know, it is kind of an up and down thing when you try to take care of yourself and grow. And I would have the hallucinations. And I think that was because I was withdrawing.

Mr. GILMAN. At any time, did you discuss any of those symptoms with your physician?

Mrs. MAGINNISS. I think I talked mostly about the depression and feeling like I didn't like myself and having trouble sleeping. But he always seemed so busy, and he would usually just write me a prescription.

Mr. DORNAN. Would the gentleman yield?

Mr. GILMAN. I would be pleased to yield.

Mr. DORNAN. You said 48, but that was a deliberate overdose attempt.

Mrs. MAGINNISS. Right.

Mr. DORNAN. What was the highest number of 10 milligrams you ever took in 1 day just to feel better, knowing you would have to take care of the children and maintain——

Mrs. MAGINNISS. Maybe 12.

Mr. DORNAN. Twelve? And your group associations, have you ever heard of anyone taking as many as 30 10-milligram tablets a day to maintain, having built up that high a tolerance?

Mrs. MAGINNISS. No, No. I very rarely took them in the morning. I very, very rarely did so that I would go all day, and then just take mine at night, in the evening. So I didn't—my taking it was different from a lot of people who take it throughout the day.

Mr. DORNAN. Have you heard doctors scoff at even someone who could take 12 a day and function and maintain and stay up all day and accomplish?

Mrs. MAGINNISS. No. I haven't. I haven't heard them make fun——

Mr. DORNAN. I didn't mean make fun, but say, "That is impossible."

Mrs. MAGINNISS. No, No. I haven't.

Mr. DORNAN. I have read of cases where people would take 20 or 30 10-milligram tablets a day after, say, 7 or 8 years of use they had built up that tolerance. And I have heard doctors say it was absolutely impossible, someone would sleep all day. And I found these people to be telling the truth.

Mrs. MAGINNISS. I think a lot of times, doctors really don't know what they are dealing with.

Mr. DORNAN. Thank you.

Mr. GILMAN. Thank you, Mr. Chairman.

There came a time when you finally withdrew from the use of Valium; is that correct?

Mrs. MAGINNISS. Yes.

Mr. GILMAN. What age was that?

Mrs. MAGINNISS. I was about 26 or 27. I am 33 now.

Mr. GILMAN. You had used Valium for some 10 years?

Mrs. MAGINNISS. Well, yes, about 10.

Mr. GILMAN. At the time that you decided to withdraw from Valium, was that under a doctor's direction?

Mrs. MACINNISS. No.

Mr. GILMAN. That was a voluntary act on your part? Had you been advised at all by any physician prior to that to try to withdraw?

Mrs. MACINNISS. No.

Mr. GILMAN. In other words, in that 10-year period or whatever it was, you had been using and abusing Valium, you never received any advice from any physician with regard to the dangers of the overusage of Valium nor did you receive it from any pharmacy or from any drug company?

Mrs. MACINNISS. Only I have an uncle who is a pharmacist, and he told me a couple of times I shouldn't take them. But the pharmacy that I went to never said anything to me.

Mr. GILMAN. How many times in that period of time did your doctor prescribe Valium?

Mrs. MACINNISS. I really can't tell you.

Mr. GILMAN. Approximately? Would it be more than——

Mrs. MACINNISS. About every 6 months, when I went for my regular Pap test. About every 6 months.

Mr. GILMAN. And you would have had at least more than five or six prescriptions?

Mrs. MACINNISS. Oh, yes. I moved recently, and I found bottles of Valium in drawers that I hadn't been in for years. I was really shocked that I had that many just lying around and hidden in things.

Mr. GILMAN. And on each occasion you went back for a prescription, was there any discussion with the physician about the number you were utilizing?

Mrs. MACINNISS. No.

Mr. GILMAN. What other drugs of abuse were you using?

Mrs. MACINNISS. Well, I took Darvon and again, that was something that if I had a lot of cramps, I would take three or four. I took as I said Thorazine. I had other things—Triavil, a lot of pills that——

Mr. GILMAN. Were they all prescription drugs?

Mrs. MACINNISS. Oh, yes.

Mr. GILMAN. And had the physician recommending, warned you of any abuse of those?

Mrs. MACINNISS. No.

Mr. GILMAN. Or the problem of the multiple use of all of those drugs?

Mrs. MACINNISS. No. No. I must say that a lot of the doctors I went to didn't know I was taking more than one as needed. But the one particular doctor did and never did anything about it. But I was given a lot of other things that I just never identified.

Mr. GILMAN. Had you ever inquired of any physician about the danger of utilizing more than one drug at a time?

Mrs. MACINNISS. No.

Mr. GILMAN. You mentioned that Together has been a great deal of help to you. What unique feature about Together is so worthwhile as compared to some of the other drug rehabilitation groups?

Mrs. MACINNISS. I think the main thing for me is that it is a women's organization. I don't think that women, housewives, are going to be helped by going into traditional drug therapy places where they

are going to be in encounter groups and going to be among a lot of men sitting around who are heroin addicts, something like that, maybe teenagers there. I think women who are middle-class housewives or just housewives need to be with other women like themselves.

Another thing we do is we do not gear ourselves toward the drug abuse. We have groups that are all women, all kinds of women, growth groups. And the drug abuser fits in there. She doesn't stand out, and she is not in a group that is geared toward drugs. So she just grows and stops using her drugs, which is what happened to me. As I felt better about myself, I didn't need the drugs.

Mr. GILMAN. And the most important aspect is feeling comfortable being with other women and not having a——

Mrs. MACINNISS. That's right. If you were getting medication from your doctor, would you go to a drug organization, having your urine monitored, and all sorts of papers written about you, you know? These women generally trust their doctors; they don't come into us as drug abusers. They come in because they want to take assertiveness training or they are having problems with their husband or something. Then, they admit that they are using drugs, and we work on that. But it is not a focus.

Mr. GILMAN. How long have you been drug-free?

Mrs. MACINNISS. About 6 years.

Mr. GILMAN. Thank you very much for being so frank with us. And we appreciate the willingness to testify.

Thank you, Mr. Chairman.

Mr. DORNAN. Yes, Mrs. Collins.

Mrs. COLLINS. I have one minor question for our witness, please. You mentioned in response to one of Mr. Gilman's questions that you had physical problems such as walking into walls and what have you. Did you mention that to your doctor as a possibility? Did you say, "I am walking into walls: could it be the medication I am taking," something like that?

Mrs. MACINNISS. That was after my last suicide attempt. I did at times tell him I was very sleepy all day long, and I didn't feel like making dinner some nights, and things like that. I didn't really ask if that was because of the medication: no.

Mrs. COLLINS. Thank you.

Mr. DORNAN. To this date, have you ever seen a side-effects chart on Valium?

Mrs. MACINNISS. I have read about it in the PDR book, but I have never been given one by a doctor or with pills, anything like that: no.

Mr. DORNAN. Some of the medical journals where they publish full-page ads very expensively and beautifully produced, or in some of the pamphlets that come with Valium in bulk, they will list a series of side effects. And among those are things like dizziness, slurred speech, anxiety, anger. Do you recall ever seeing those?

Mrs. MACINNISS. No. I would like to say, too, if those pamphlets look like any that come with the birth control pills, I probably wouldn't have read them.

Mr. DORNAN. Very small print?

Mrs. MACINNISS. And very wordy, confusing. And at that point, I was worried about taking care of little children. I would not have read the pamphlets.

Mr. DORNAN. Were your own conditions on the side-effects chart—say, disorientation, confusion, anxiety, anger, since they will give them to people who are having marital problems? They give them to people who are having marital problems. So it is nice to be given an anxiety-producing pill for financial problems.

When I confront doctors with a side-effect chart, they give a flippant answer like, "That is a standard side-effect chart. That comes with every drug. That covers the landscape so you wouldn't get sued." But then, upon further investigation, I find out that by looking at other people's and looking at other bulk purchases to see what their side-effect charts were, the side-effect charts were very different. And they wouldn't put in spacial disorientation, dizziness, anxiety, sleepiness, drowsiness, for some other pills. They would have some other things just the opposite—hypertension, insomnia.

I think the disregard of discussing side effects with a patient when they give them a serious prescription drug like Valium is really the beginning or core of the problem, and the fact that most people's experience is they never meet a doctor who is opposing the pellmell prescribing of these. You never reached a point where prescriptions were so easy to get, where you ever considered taking your doctor's prescription pad out of the office or double prescription?

Mrs. MACKINNISS. No. I knew I could go anywhere and get them. All I had to do was walk in and say I was having trouble sleeping and nervous, and I could get them from anybody.

Mr. DORNAN. In your group associations, have you ever heard of people calling in their own prescriptions, pretending to be a nurse?

Mrs. MACKINNISS. No. All the people I know had a very easy time getting the prescriptions. I want to say that I think the doctors don't tell women about the side effects because they think that we are so whifty we would develop these side effects out of our own minds, something like that.

I think they have a very sexist attitude about women. I think they would tell me because a man has to go into an important job every day, but women just stay home. And so what if they get a little dizzy, you know, things like that. I really think they are very sexist in their attitudes toward women.

Mr. DORNAN. I have no further questions. And I will see if any of my colleagues do. But first, I would like to emphasize also the courage I think it takes to come before a congressional committee on this subject. I have spoken to some very courageous women who tried to do what they could behind the scenes, but they said the scars are still so hurtful that they would cry in public.

We have had some very famous people we have approached through our committee staff and asked them if they would expand on a book or their public testimony to try to help this problem, help other people. And they have expressed exhaustion. They just have to turn to other things or again this fear that it is just too hurtful and too soon.

So, I appreciate your coming forward. And I repeat what I said in my opening statement, if we can get the word out through the media, our own committee, and congressional processes, you are really helping people and maybe even saving lives. We have only become aware very recently of Valium deaths, and I think it is an irrefutable fact not any of my colleagues——

Mrs. COLLINS. Mr. Chairman, just let me associate myself 100 percent with all of your remarks. It is certainly the sentiment of Cardiss Collins as well as all the other people here, you are to be saluted. And we do thank you for coming before us.

Mr. DORNAN. Thank you very much.

Dr. Seidenberg; is he in the room?

Please come forward.

Dr. Robert Seidenberg, psychoanalyst and clinical professor of psychiatry at the Upstate Medical Center, State University of New York at Syracuse. Doctor, we welcome you to our committee.

We did not swear in the first witness, so I will forgo that formality with you. You have testified before, and you are so respected in your field. I have no reason to believe that anything you would tell us would not be the whole truth and nothing but the truth. Welcome before our committee.

And if you would like to submit your written statement for the record or read all or parts of it, as you will, sir.

[Dr. Seidenberg's prepared statement appears on p. 62.]

TESTIMONY OF ROBERT SEIDENBERG, M.D., PSYCHOANALYST AND PSYCHIATRIST, UPSTATE MEDICAL CENTER, STATE UNIVERSITY OF NEW YORK AT SYRACUSE

Dr. SEIDENBERG. Thank you, Mr. Dornan. I am certainly very happy to be here today. And following the very poignant and important testimony that you have just heard, I can only reaffirm from, so to speak, my side of the desk, the atrocities that have gone on in this area, and try to pinpoint some remedies.

I am particularly happy for hearings of this nature because I am a "first-amendment junkie." I am against censorship. But I feel that the people who have access to massive advertising and public media must be confronted and must not be protected by the immunity of so-called professional brotherhood or other silencing devices.

I think that members of the medical profession have been orbiting in the sky on this issue because of a grave intellectual deficiency in themselves; physicians do not seem to understand the meaning of conflict of interest. They simply don't understand this concept as attorneys generally do; that you don't get educated by your suppliers and that you don't chronically accept gratuities and gifts from your suppliers. This is what has happened massively in the medical profession.

It starts off in medical school and is really the No. 1 chronic drug abuse problem. The No. 1 drug abuse problem is the miseducation of doctors about mind-drugs.

With that introduction, I will go onto the more formal part of my report. I must also say that my interest in this field parallels remarks of Mr. Dornan. I, too, was of "woman born," and have three daughters. And I do have a selfish interest as a parent and person in trying to leave this world perhaps a tiny bit better than what I found.

And, I have felt that the feminist movement is a very worthwhile place to spend one's energies. I was and am a member of NOW. And as one of the founding members in our local chapter, I am very proud of my work on behalf of that organization. Women have always joined in civil rights movements where it pertained to the general population

and men. But we men have not responded in kind; men in the feminist civil rights movement are all too rare.

The year 1979: Does misogyny still sell mind-drugs? This author reported 10 year ago, the blatant sexism and prejudice against women depicted in medical and psychiatric drug advertisements. Since these "messages" were obviously designed both to attract the attention and approval of the physician, I asked, "Does Misogyny Sell Mind-Drugs?"

Since then, many experts and observers have confirmed that: (1) the chief target for psychotropic usage indeed is women; and (2) their representation in the advertisements are on the whole entirely reprehensible, qualitatively, and quantitatively.

For some of us, sadly, there is little wonder or mystery why twice as many women are "receiving" tranquilizers as men.

The present abbreviated presentation is a lack-of progress report. Many in the pharmaceutical industry claim that the advertisements have vastly improved in the last decade. I have found scant improvement and taking into account the runaway proliferation of "throw-away" periodicals in the last few years and the continuation of bald sexist content, one can see only an intensification of the drive to tranquilize.

In my very amateurish and unartistic way, I have tried to put together a collage of the throw-away slick magazines that every doctor receives free each month. This is called "Controlled Circulation." All doctors don't get the same magazines. It depends on the specialty. But they have one thing in common: They are all free. They are financed by the drug ads that are presented in them. These are throw-away apart from the journals that we get as members of professional organizations to which we subscribe. These all come gratuitously and, I might add, in triphammer succession. And these are just the magazines; there is a variety of other gifts.

We get perks of all kinds. There is now a radio station. We get a free radio with a wave length that zeros in on educating us, interspersed with drug ads. This is the latest gimmick that has been put forward—a whole host or barrage of so-called educational activities, all underwritten by the drug companies.

Now, for lack of time I don't want to linger too much on any one of these items. But here again, the seeming indifference to this state of affairs by the medical profession to me is just appalling. I really think that here doctors are not just greedy, but are ingenuous. Doctors as a group just don't understand what conflict of interest is all about.

I feel perhaps instead of learning about tranquilizers, they ought to go to law school briefly or have a law professor in medical school to really teach the meaning, the manifestations, the implications, and the consequences of conflict of interest. They should be taught what gratuities do both to donors and recipients and their effects on integrity. There might be a few lectures on "collusion." Finally, physicians might be reminded of Milton Friedman's warning: "There are no free lunches."

One of the saddest events in this regard has taken place in the last 6 months to that very prestigious Cornell Medical College. There is what is called a continuing medical education—CME—program in which doctors are supposed to continue in their education in order to

keep up their skills, in order to keep their membership in national organizations, and to continue in their licensing in certain States.

Well, Cornell Medical College became involved in this continuing medical education program. And it was a vast program, is a vast program, that is videotapes sent to groups all over the country—26 cities. Free educational literature is sent to doctors around the idea of stress—I will later discuss the invention of new symptom-complexes in order to promote tranquilizers.

In this whole program sponsored by Cornell Medical College, the letter signed by Theodore Cooper, the dean of the medical school, there was one item that struck home, which really disillusioned me—financially underwritten by Roche Laboratories, the company that manufactures Valium. In the course of the continuing roundtable clinical series, the question of how one treats "stress" and related conditions, frequently arises. Predictably, Valium is always right up there as the recommended remedy. Of course, stress vastly expands the market for Valium. You no longer have to be neurotic or anxious to be tranquilized. That Cornell should lend itself to this new promotional gimmick truly saddens the heart.

More on conflict of interest: There is a throwaway we get called Modern Medicine. This is the magazine that is privately owned, published by Harcourt, Brace and Jovanovich at the present time, which is worldwide and goes to practically all the English-speaking countries. It provides information that doctors use about their profession, about disease entities, again filled up and obviously financed by the drug and pharmaceutical companies through advertisements.

Well, there is a story behind this. First of all, the editor in chief of this magazine is Dr. Michael J. Halberstam who testified before Senator Kennedy a few days ago. He is a well-known physician, novelist, and also happens to be as just stated, the editor in chief of Modern Medicine. He testified, as I understand, in favor of Valium, saying that it is a very good drug, and among other effects it has kept many families together.

May I add parenthetically that Valium and others in 1976 broke up the family of New York Times throwaways. Does Dr. Halberstam, as the recently appointed editor in chief of Modern Medicine, worry that the drug and money might suddenly be withdrawn from him if Harcourt, Brace and Jovanovich innocently publishes a book critical of the medical profession or drug industry? Dr. Halberstam knows however that the drug industry does not take kindly to criticism. One wonders what effect that knowledge has on editorial policy, et cetera.

Now, there is a story here that wasn't well publicized. This happened in 1976. The New York Times Co. owned Modern Medicine along with seven other throwaways. At that time, however, the New York Times newspaper ran a series of five articles critical of the medical profession and pharmaceutical companies.

Now, the pharmaceutical companies at this time did not take their own medicine. They did not take Valium for their stress. Instead, they heavy-handedly cancelled $500,000 worth of advertisements in Modern Medicine, causing that journal a severe financial crisis. That was in February 1976.

In June 1976, the New York Times Co. sold all eight of their throwaway magazines. Here is an example of the type of pressure

that the pharmaceutical companies can exert on the education that doctors receive and the ruthless power that they can display when they want to, the power in reserve that they have at their disposal. What a chilling effect such collusive action has on all publications can only be surmised.

OK, moving right along as they say, there is only one area in the ads that has improved: The appearance of females as physicians is now occasionally seen [fig. III]. I repeatedly brought this discrepancy—absence of female physicians—to the attention of the pharmaceutical industry in the early seventies.

Before that, we never saw a woman represented as a physician. Of course, she is here represented alone. They apparently still don't trust her with a patient. I think they have a little fright showing a woman physician and a patient together, but that may come soon.

There is a very distressing part of this ad that I don't think many people have picked up. Smith Kline and French who make Stelazine use this ad chronically, again and again, talking about the patient's excessive neurotic anxiety.

Now, in small print, if you will observe, on the right, it states that this drug is effective for the management of the manifestations of psychotic disorders as classified by the Food and Drug Administration. Then, it says, "Possibly effective: To control excessive anxiety, tension and agitation as seen in neuroses or associated with somatic conditions."

Now, what does "possibly effective" means? It means that not only has it never been proved effective, it is not even probably effective. It is just possibly effective. But their major advertising campaign is directed to the general physician who sees a greater numbers of people who have chronic excessive anxiety than psychosis. So obviously, the market for the chronic anxiety is made larger for Stelazine, a very potent major tranquilizer which has caused tardive dyskinesia in more instances than they will say. Despite the often terrible side effects of major tranquilizers, this type of deception has gone on, apparently unchallenged. Obviously, thousands of doctors have seen this ad without questioning its propriety. And I doubt whether there have been any questions directed toward the manufacturer or the journals in which these ads appear, clearly snake-oil-type promotion.

Figure IV represents another continuing and unchallenged abomination promoted by the pharmaceutical companies.

Mr. DORNAN. Excuse me, Doctor. May I interrupt you for just a second?

On the figure No. III, one with the female physician——

Dr. SEIDENBERG. Yes.

Mr. DORNAN [continuing]. You pointed out under possibly effective. There are the words "excessive anxiety." and the word "neurosis" below. The main thrust of the ad has to be a lady doctor, excessive neurotic anxiety. But there is a little asterisk next to the "y" in anxiety as though they could cover themselves if there were another asterik down below warning you that this is only under possibly effective.

Did you lose that other little asterisk somewhere in reproducing it? In other words, the major thrust of the ad.

Dr. SEIDENBERG. I have the ad in full. I didn't really see that.

Mr. DORNAN. The major thrust of the ad which is covered under possibly, as you put out, not even probably effective. So there is very much a ripoff.

Dr. SEIDENBERG. Yes; the asterisk refers to the bottom: Stelazine has been evaluated as possibly effective for this indication.

Mr. DORNAN. So that reinforces what you said of selling this ad on something that it will possibly do. It is in the probable category.

Dr. SEIDENBERG. Not even in the probable class.

Mr. DORNAN. Thank you.

Dr. SEIDENBERG. And as I indicated before, the reasons for this questionably ethical representation are quite apparent, to me anyway. The market for excessive neurotic anxiety is far greater than for psychosis. The patient with the former conditions is more likely to be under the care of the general practitioner or internist than psychiatrist. Now, over 70 percent of psychotropic drugs are prescribed by physicians other than psychiatrists.

Figure IV represents another continuing and unchallenged abomination wrought by the pharmaceutical companies—that of gratuitously manufacturing new metaphorical diseases and syndromes for which their drugs are to be used—I have already mentioned the stress hype. In the past, they have created "empty-nest syndrome," "sleep-cripple," "office-fixture," and the neologism, "copelessness"—interestingly and sadly, all pejoratives.

Here in figure IV, we see their new stigma for the elderly woman, "sundown syndrome." There are many experts in the field of geriatrics who feel that the use of the tranquilizers here is a form of social control, diminishing the ability of the elderly to make their legitimate needs known.

The virtues of surrealistic art aside, the one-dimensional draping of a woman's body with her walker, over the letters of "P A I N" does little to enhance the image of that sex, as seen in figure V. Again, the portrayal of women passively and recumbently "dissolved" in pain is an all too familiar false stereotype. Men are never depicted in this pejorative manner.

Figure VI carries on an apparently fruitful advertising tradition of identifying women with pills—up to their ears in them. Here, "their" pill is supposedly the better one—to replace the others. Unwittingly, Sandoz herein projects graphically their industry's success with women.

This advertisement fosters and promotes the image of women as pill-popper as well as of that sex with the ubiquitous headache.

The woman as child is an all too familiar theme in drug advertisement. Here, in figure VII, she is shown on a merry-go-round. The phrase, "going around in circles" does little to enhance her value as a responsible and employable person.

Now, these are all ads from 1978 and 1979. I have them all the way back to the beginning of the tranquilizing era, back to the late sixties. But I wanted to just take those that I clipped out of very recent throwaways and other magazines that have come to me to show what is going on here and now.

The methodology of "changing" people with the use of drugs by the medical profession is one of the cruel hoaxes of our times. How

ridiculous it sounded in the sixties when the "kids on the street" gave this as the rationale for doing their drugs.

Figure VIII shows the distraught, disheveled female mental patient seeing everything and everyone, including the approaching male, in a negative way—"everything I saw was negative." The advertisement tells us that the antidepressant, Norpramin, "helps change her world from negative to positive."

One might add parenthetically that many men today would dearly welcome being seen more positively. It is hoped that this could be accomplished without having to drug the other.

Last: We see in figure IX an inglorious theme that surfaces too frequently in these drug advertisements. This is the ironic dehumanization of psychiatry's own client, the mental patient, here again, the woman. She is depicted in this figure diminutively as the captive or caged bird, here in an ungilded cage.

Whether descriptive or prescriptive, this illustration sets people, patients, apart as a deranged, animal-like class, a pejoration which we generally deplore when expressed by the unsophisticated. Is it accidental that the caged bird is a woman?

The horrors of prescription, mind-drug promotion have barely been exposed in this brief discussion. Obviously, affecting all patients, there is little doubt that women have been and are unabatedly the prime targets for this exploitation.

To resist and counter this massive onslaught is noble work, indeed.

Thank you.

Mr. Donnan. Doctor, thank you for your excellent testimony. I just open with a brief question here. Is there any doubt in your mind that, if these advertisements were run in general circulation, news magazines or other general interest magazines, Time, Newsweek, People Magazine, one, there would be an immediate and forceful reaction from women around the world, around the country, that they were being ridiculed and, two, that if they were not attacked and were allowed to persist, that they would be effective in the selling place,

Dr. Seidenberg. No question about it. I have observed in previous testimony that Good Housekeeping does far better ethically because there are many drugs that the Journal of the American Medical Association and its other periodicals take ads for drugs which they have not recommended in their own pharmacopeias. They will take the ads of drugs which are highly questionable in their effectiveness, and continue to advertise them time and time again. Good Housekeeping doesn't do that and won't do that—will not permit ads of products that they cannot recommend.

Mr. Donnan. I should ask you two questions. You agree they would be effective?

Dr. Seidenberg. Yes. This is principally why the value of committees such as this, and hearings such as this, is invaluable. As I indicated before, I am against censorship.

I feel they should advertise, but they should feel the full force of criticism from people who recognize what they are doing and confront them head on. There should not be this mock ethical coverup and consortium in which doctors and people in the pharmaceutical industry must protect one another as if there is some lofty purpose in which

they are engaged, loftier than what is generally tolerated in society as a whole.

Mr. DORNAN. The reason I had asked you the first question, if Federal advertisements were in more general circulation magazines, do you believe there would be a reaction outcry?

Dr. SIDENBERG. Yes, I really do. Ordinary people as well as activists and civil rights organizations would make their disgust known in no uncertain terms, and the practice would soon be stopped. It is, indeed, very peculiar that physicians seem to tolerate these abominations without much protest—and what is worse, with probable acceptance and approval.

Is there something basically wrong with physicians? I think there is a certain ingenuousness, a certain feeling of somehow, the drug companies can pay for all this, but it isn't going to affect us any; that we are not going to be brainwashed—we just aren't going to be influenced. Somehow we can be chronically bribed without feeling its effects.

For example, the board of trustees of the American Medical Association several years ago, October 1974, voted to drop the drug ads completely. Even in taking that action, they said, "We'll discontinue it. Of course, it never has influenced us, it never influences our editorials or policy or what goes in the journals." The board of trustees voted to eliminate all ads from AMA periodicals, but unfortunately, when it was put to vote before the house of delegates, they didn't go along with it.

Mr. DORNAN. Have you ever been aware of a female doctor that has taken exception to the ugly way women are treated in this?

Dr. SIDENBERG. Oh, yes. Unfortunately, this is more complex than what I can say, but I think that, because the drug industry controls so much of the literature in the journals, what people have to say adversely just gets buried and not known. But there is a strong female caucus in the American Psychiatric Association. Here is a position paper, "Sex Bias in Medical Advertising, 1976, Committee of Women of the American Psychiatric Association," prepared by a colleague of mine, Dr. Virginia Davidson of Houston, Tex., in which she outlines this whole horror story of how women are depicted in the official journals of the American Psychiatric Association.

Two years ago, there was a task force organized in the American Psychiatric Association asking the question, could we divest ourselves of drug advertising? This supplies half a million dollars to the American Psychiatric Association, including $15,000 toward their major lectureships, which are held every year at our conventions. And it is embarrassing—every time you get a cup of coffee, you have the name of the pharmaceutical company on the cup; every time there is any handout or they have a symphony playing, sponsored by this corporation, without any feeling that there is something bad or wrong about it.

Now, this task force that investigated recommended we should have more vigilance, but no divestiture. We should be more cautious. What they wanted was a cosmetic job from now on. We would continue to take the money for these lectureships, but we wouldn't have the name of the drug company associated with them. We would have these listed in the back of the brochure or the back of the magazine. We would continue to take drug ads. The task force admitted that money from

the pharmaceutical companies is the lifeblood of many educational programs of the APA.

Mr. DORNAN. Incredible.

Madam Chairman?

Dr. SEIDENBERG. These are all psychiatrists: ironically it is our pride to have some understanding of human nature. But that is why I really believe doctors and psychiatrists ought to have courses in civil liberties law. I think this is our only salvation. I don't hold them to be malicious; I don't hold them to be particularly devious or greedy in their practices. I think it is just lack of knowledge about worldly affairs.

Mr. DORNAN. Madam Chairman?

Mrs. COLLINS. Thank you. Dr. Seidenberg, I am very interested, and I think you have done an excellent job of choosing illustrations in making your collages because it certainly brings home the point you were trying to make.

In looking through these, I was very interested in seeing one magazine or publication you questioned, the name of which is "Diversion." It says, "For Physicians at Leisure." That was most appropriate.

Dr. SEIDENBERG. Yes, we are educated in everything. We get financial advice how to invest in the stock market, real estate, and so forth, all with the ubiquitous drug ads inserted.

Mrs. COLLINS. The other one here, it says, "Psychiatric Capsule & Comment," very, very catchy. Here is another one that caught my eye, "Human Sexuality." Up here, it talks about discovered affairs, crises, and sex. It seems to me that this kind of advertising would not even be of interest to physicians, let alone anybody who is prescribing drugs and other medications for human beings.

Lindy Boggs, my colleague from Louisiana, just pointed out on this one that right in here, it says what this particular drug does not do or does do. It says there is less dry mouth, blurred vision, and less urinary retention. The implication, as Lindy has said, is that the drugs indeed do these things to the human body.

Dr. SEIDENBERG. These drugs are not innocent.

Mrs. COLLINS. Which had previously been advertised as Lindy said.

Another one that struck me immediately was this one for which it is Lithium.

Dr. SEIDENBERG. Yes.

Mrs. COLLINS. It says, "Do Lithium dosage schedules keep your patients going around in circles?" Obviously, they are aware patients are going around in circles, but aren't willing to do anything about it. This one, I thought, was particularly appropriate, especially in light of Mrs. Maginniss' suggestion at the end of her testimony that perhaps there should be some advertising making people aware of some of the problems of drugs, perhaps some public service television, something like that.

I think rather than being used in this context, if it were used on a TV ad where women could really see how really mired down in drugs they really are being, and to see this woman here, as you said, with drugs up to her ears, I think would have a profound effect on making many women begin to think about, indeed, what is happening to their lives.

Finally, and without going into any further details on this, I just plain thought this was sick. Just plain sick. That is the one on the sundown syndrome.

I do have a couple of questions. First of all, can you tell me how and why you became involved in the issue of drug use and misuse among women?

Dr. SEIDENBERG. Of course, our ultimate motives go very deep and are obscure, but I can try.

Mrs. MIKULSKI. Mrs. Collins, never ask a psychiatrist about his motives. We will be here forever. We will hear you about your mother. I say that as a social worker who has been through those kinds of things.

Dr. SEIDENBERG. Well, when you have a Jewish mother, you know you have been born of woman.

OK, first of all, in the general area of tranquilizers, because of my own philosophical approach, I realized when the tranquilizers were presented as miracle drugs, a hoax was at hand. I mean, there was no Valium deficiency in the blood that had to be made up. These were simply drugs like street drugs, cousins of the poppy and grape, things that clouded people's minds temporarily, gave them euphoria, as drugs have done traditionally for thousands of years. But now, they are being packaged as a biochemical cure for troubles. This is a hoax. This is a terrible hoax.

You hear, for example, when someone gets depressed, instead of asking: Why are you depressed, what are the circumstances, maybe you can solve this with some type of social action or help, the first recommendation is a chemical antidepressant.

Now, I think people need antidepressants, but I think the best antidepressant, for example, is doing something worthwhile with your life, achieving something, developing your talents.

Another wonderful antidepressant is obvious, relationships with people. When these things fail, maybe you have to resort to a chemical antidepressant, but that is a defeat. When you have to resort to chemicals, you are, in effect, throwing in the towel.

Now, physicians should not be in the business of dispensing drugs of this nature, because it gives a medical and therapeutic aura to the drug. I feel it is much better for a person, if they want to forget things, if they want to cloud their sensorium, to go out and buy a drink at a bar. Then, they know they are intoxicating themselves, and they know it may be wrong; they cannot rationalize their behavior as a medically sanctioned treatment.

This is a horribly radical statement, but I think it is preferable if you want to drug yourself, to take the responsibility for it, know what you are doing, know it is no medical treatment. But when the drug comes from a physician, it has the sanctification and authority of the medical profession behind it and promotes the myth of really curing your troubles. That is the big hoax of our age.

I think in the future we will understand this, but in the meantime, this illusion has gotten so entrenched, it has become so profitable for some that you just can't budge it from its illogical ubiquity.

Mrs. COLLINS. Doctor, I have probably utilized all my time, but I do have one final question; and before that question, I just want to

comment that I found your remarks on page 2, that over 70 percent of the psychotropic drugs have been tried by physicians other than psychiatrists, absolutely appalling.

Dr. SEIDENBERG. That is modest. I think the testimony will show it is much greater than that. This is what they have zeroed in on. They put these ads in journals, these throwaways, that go to the general physician and then instruct him to treat anxiety, depression, et cetera, as biochemical conditions that a doctor should be treating, a physician should be treating, as if there are some deficiency of these chemicals in the body of the distressed person.

Mrs. COLLINS. Your point is very well made.

My final question is: Do you believe women rather than men are more inclined to become abusers of licit substances, and if so, why—briefly?

Dr. SEIDENBERG. One should be careful here lest we attribute this to feminine weakness. Women are exposed to the medical profession much more than men are. Statistically, a woman sees a physician twice as often as a man does, not because she is neurotic or hypochondriacal, but for legitimate needs of medical attention, for gynecological problems, obstetrical problems, pediatric problems with her children, both physical and emotional. So she gets exposed to the medical profession twice as much as the male does.

On this exposure basis, she is apt to complain perhaps, about being tired or being nervous, or unable to sleep. As the previous witness said, that is all a doctor has to hear these days, because it resonates with the conditioning he has already received through these journals time and again. So then, he is very happy to write a prescription. It saves him time and promotes the appearance of doing something. Sadly, many people don't feel they have been adequately treated unless they go away with a prescription.

Mrs. COLLINS. What about a placebo?

Dr. SEIDENBERG. Well, that has been recommended and, incidentally, in many of these cases, placebos work just as well as these potent tranquilizers.

Mrs. COLLINS. That is the point I was trying to get to.

Dr. SEIDENBERG. Many studies have shown they work just as well, but to me, prescribing placebos is repugnant. That is deception. That is fooling people and, ultimately, when you fool people, something happens to you, too, you see. It is morally self-destructive when you use your authority to fool others.

I think a doctor has to take a risk with the truth, even though he may be unpopular and lose business. Ultimately, honesty does work better.

Mrs. COLLINS. Thank you, Mr. Chairman.

Mr. DORNAN. Doctor, before I turn to one of the regular members of our Select Committee on Narcotics Abuse and Control, Mr. Lawrence Coughlin from Pennsylvania, I am going to thank you, because I have to leave. I have some amendments pending on the Department of Defense bill. I will tell you that I am going to quote you extensively in Los Angeles, where I have scheduled a couple of television shows on another subject. I am going to change it to this subject because it is of more immediate impact of helping people who are suffering because of abuse.

And I want to thank you for coming forward as a male because I thing males are either subconsciously or consciously ashamed of what is taking place here in or out of the medical profession and the nutrition and advice for exercise seems to be only for the boys. And yours is the voice maybe crying in the wilderness now, but I think we are just on the verge of recognition of this problem.

And I am certainly proud to have made your acquaintance and see you in the vanguard. So I can return to what I said in my opening remarks, I restrained myself from deprecating the profession. And I had them on a pedestal for most of my life because I do find this zeal buried in some doctors, but motivated to go to medical school, but because of the pressures in the profession, they disregard it over the years. And I expect doctors to come through for us en mass here soon and reverse what they have done wrong.

So I will ask the chairwoman to please regain this position; I am off to DOD. Thank you, Doctor.

Dr. SEIDENBERG. Thank you, Mr. Dornan.

Mrs. COLLINS. Mr. Coughlin from Pennsylvania?

Mr. COUGHLIN. Thank you very much, Madam Chairman. I just have two very brief questions. One, Doctor, have you had any occassion to raise the advertising issue with either the AMA or FDA?

Dr. SEIDENBERG. Yes. This is an ongoing effort and I have been doing this for over 10 years. It is wearisome work, and in my first encounter on this issue with the American Psychiatric Association. I pointed out the ads with their horrors of deprecation of psychiatric patients in general. And as a result, they did set up a committee of psychiatrists to try to monitor these ads. But I have seen no progress. I have shown you some very recent examples.

They somehow either don't see the issue very clearly or prefer to look away for reasons best known to themselves.

Now, in the American Medical Association. I am also a member there; as you see I am a pretty straight fellow. I am establishment all the way. There appeared an editorial in the Journal of the American Medical Association written by Dr. Nathan Kline who is very closely associated with the biochemical theory of mental illness, exhorting doctors, general physicians, to go out there and treat some 12 to 20 million people who are depressed and are allegedly in dire need of drug treatment. The doctor asserts that this is an obligation of the general physician.

This appeared in the September 17, 1978, Journal of the American Medical Association. "Treatment of Depression." There are an estimated 12 to 20 million patients with depression in need of treatment. This is sort of a case of finding exhortation which ends us by saying: "Not to treat depression is to deprive oneself of an important and gratifying experience and to subject one's patients to pain or even risk of life."

And then the good doctor predicts that we will get even greater tranquilizers in the future which will give relief of depression in days or even minutes. Won't it be wonderful to be rendered insensitive to all personal and worldly troubles.

Well, I wrote the editor of the American Medical Association on November 15, 1978. I will paraphrase the letter here:

The appearance of Dr. Kline's chemical polemic on your editorial page leaves little doubt that the pharmaceutical companies have attained their goals of controlling your Journals and prescription pads. Yes, indeed, it certainly pays to advertise.

This editorial, pleading as it does with the physician not to deprive oneself of the important and gratifying experience of pushing tranquilizing drugs onto the American people achieves an all-time low in ethical conduct at a time when prescription drugs now constitute the major problem of drug abuse in America. The JAMA through Dr. Kline asks that even more should be dispensed. How unconscionable.

The contents of the editorial stating 20 million depressed patients out there in need of a cure for depression sounds like a sales pitch given to detail men before they embark on their appointed rounds. The idea apparently is that none of us is ever to suffer from the scourge of depression for even minutes, and for patients who apparently not knowing what is good for them or perversely perhaps wanting to be depressed, but not take their medicine, Dr. Kline hopes that the future may bring "an antidepressant that is long-acting to insure patient compliance."

These patients, former people, we presume, apparently cannot be trusted to know what is good for themselves and are to be drugged by the benefficient physician. So how many full members of the AMA among us have argued that the massive advertising of psychotropic drugs in our journals with its enormous financial rewards would not influence editorial judgment, they were wrong, weren't they?"

Then, I got a reply from Dr. William R. Barclay, the editor of the journal. He takes strong exception to the implication in my letter that the article entitled, "Tricyclic antidepressants," and the editorial calling attention to the article were in any way motivated by pharmaceutical interests.

Pharmaceutical products Dr. Barclay wrote are the main tools that doctors employ for the management of illness.

And I see nothing wrong with publishing the views and experience of physicians on the use of drugs, whether they are to be used to treat infections, heart failure, psychological states, or any other conditions.

By suggesting that psychological states should be treated like infections, heart diseases, or any other condition, Dr. Barclay displays a dangerous naievete that should be a source of embarassment to physicians.

Mr. COUGHLIN. My question was directed specifically toward the advertising. Have you ever raised a question concerning this advertising with the FDA?

Dr. SEMENSHAW. They have contacted me at times. I have published, and they know my work in this area.

Mr. COUGHLIN. To the best of your knowledge, has either the AMA or the FDA ever challenged the pharmaceutical industry with regard to certain ads in certain papers?

Dr. SEMENSHAW. Yes. They have challenged. I know that, on many occasions. A lot goes unpublicized. There is one ad. I remember, advising that their drug could be mixed in the patient's food or drink, without the patient knowing it. It was tasteless, odorless, and colorless. I pointed out this flagrant violation of patient human right to the American Psychiatric Association, in whose periodicals these ads appeared.

They changed that particular ad, apparently feeling that there might be something wrong with deceiving mental patients. So that there are changes that are being made.

And also when I pointed out there were no women shown as physicians, this as we have seen has been changed. And there are a few improvements occasionally. But substantially the violation of good taste goes on. I think the FDA would like to do more, but they have guidelines, obviously, which they have to obey.

The ad for stelazine, to me, is one that somebody should definitely look into because it is patently deceptive.

Mr. COUGHLIN. Do you think that the FDA should have some additional powers in policing this kind of advertising?

Dr. SEIDENBERG. Well, the following is a difficult statement to make, but I think the FDA like others was really taken in by the idea that you could cure medical illness with drugs. I really think they believe that. And once you believe that, a lot of other stuff flows very freely. And they couldn't very well back away once they had gone along with the idea that these drugs were actually antipsychotics or antidepressants or cures for neurosis. They weren't. They were just drugs that would give a euphoria, would put people to sleep, would dope them up like the drugs that have been known for centuries. You just can't cure problems of living with drugs: these things may get cured in Congress, in our legislative halls and our social environment, but not by drugs. Drugs only add to the problem as we have heard in the testimony today.

Mr. COUGHLIN. So you think that the solution to this kind of advertising is not in regulation, but in education?

Dr. SEIDENBERG. Yes; as I said, I am a first amendment junkie. I feel when you suppress expression, you create other problems which may be far worse. I want them to advertise, but I want them to feel the full brunt of public opinion, of congressional investigations, and everything else, and to suffer condemnation for their contemptible action with Modern Medicine to put that magazine out of business because the New York Times dared to say something critical about them.

Mr. COUGHLIN. Thank you, Madam Chairman.

Mrs. COLLINS. Thank you.

We are going to go out of order in just a minute. Mr. Gilman has to leave, Mr. Gilman.

Mr. GILMAN. Thank you, Madam Chairman.

Doctor, in criticizing the deceptive type of advertising, my colleague Mr. Coughlin has been trying to elicit from you the mode of attack on this problem.

Dr. SEIDENBERG. That's right.

Mr. GILMAN. We are trying to find what you recommend: how best should we police this in your mind? Should it go the profession in your opinion? Who should do the policing?

Dr. SEIDENBERG. The first line of defense should be the profession themselves with the psychiatrists and physicians who don't have to accept these ads in their professional journals.

Mr. GILMAN. Is the profession doing anything in that direction?

Dr. SEIDENBERG. To me, they are doing a poor job, a horribly poor job, because they have been bribed, simply put. It is a sellout.

Mr. GILMAN. What else do you recommend besides the professional self-policing?

Dr. SEIDENBERG. As things generally go, unfortunately, people rarely police themselves—and I know the record of self-policing is not too

good—I suppose there have to be outside people bringing pressure to bear. Even before we have the FDA come in, I would look to others, perhaps the formation of strong consumer groups.

The feminist movement is taking an active role. The witness we heard before, these people are in the forefront of exposing and of telling it how it is. They are the important critics. The FDA, as I have said, is not. They are fuzzy minded about this issue. They actually feel these drugs are effective for mental illnesses. Because many there are also physicians, they too have been educated by the pharmaceutical industry. And, the revolving door phenomenon with the drug companies applies here as in other branches of Government.

So I am not that hopeful or confident about their possible effectiveness even though I do respect a lot of people in the FDA. The remedy ultimately has to be through education. It has to start at the beginning level. Just yesterday I received a phone call from the president of the American Medical Student Association who is trying to negotiate with the pharmaceutical companies to desist from giving medical students free gifts and gratuitous educational items.

They start in the freshman year apparently to get them used to the idea of taking; to overlook conflict of interest. These perks should be eliminated. I don't know how successful he will be because it is very seductive to receive free stethoscopes, free ophthalmoscopes, free medical books, and medicine for yourself and your family.

Mr. GILMAN. You feel there should be some Government restriction on that sort of thing by the company?

Dr. SEIDENBERG. You are again going over my head. The political, economic, and civil liberties issues here are quite complex. I really am not here to say that is going to be an unmitigated, good solution. But I would say that the more hearings you have of this nature and the more that it is covered by the media and the more it gets out to the people, this will be of inestimable help.

Mr. GILMAN. We heard a great deal of testimony today and prior days about the lack of adequate advice by physicians to the patients with regard to the side effects, with regard to abuse of various narcotics and drugs. What can be done to make the physician more responsible in prescribing narcotics to his patients?

Dr. SEIDENBERG. Again, there is no easy solution because he has already been miseducated. He has been educated by his suppliers who have told him these things are not only effective, but safe.

Mr. GILMAN. Let me ask you this, Dr. Seidenberg: You are a professor at the Upstate Medical Center. Do you feel that the type of education we are giving to our physicians today is sufficient pharmacologically to make them fully aware of all of the problems with regard to drug abuse?

Dr. SEIDENBERG. No. I think there are terrible gaps at this level, but again, at the risk of being boring on the subject, I think that the pharmacology is being taught and maybe taught too well. But the ethical considerations and how perks affect the donors and the receivers. These moral considerations are really epistemologically outside of medicine and aren't being taught. And I really am seriously repeating, physicians and medical students, ought to be taught about ethical behavior, civil liberties and conflict of interest by judges and lawyers.

Mr. GILMAN. You made a recommendation of that nature to your own university, have you?

Dr. SEIDENBERG. No, I haven't. You know about the prophet in his own province. I am not, incidentally, a full-time staff member. I am a clinical professor. I am mainly in the private practice of psychoanalysis in my community.

Mr. GILMAN. Thank you, Doctor.

Thank you, Madam Chairman.

Mrs. COLLINS. Thank you very much. Every time I sit in this chair the bells start ringing. We will go on for 5 minutes before we have to leave.

Mrs. Boggs?

Mrs. BOGGS. Doctor, I have a very bad cold. I haven't taken any medicine for it so that's why I can't speak up.

Dr. SEIDENBERG. I believe in medication. I am a great believer in it for valid medical conditions.

Mrs. BOGGS. Do you feel the physician education, particularly along ethical education is, as you say, outside really of the purview of the medical field per se, and more properly belongs there, with direction so it is able to be helpful in these regards? In the education of physicians in the use of the drugs, in the kinds of effects that these drugs have, not only the medical but social and economic upon their patients, do you feel that improved physician educating will really help to impact on the development of a civil system for women?

Dr. SEIDENBERG. So it is really both to educate doctors and have educated people as doctors. And the problem of sexism is one for society in general. Hopefully, doctors will eventually get the message, although they are very slow in receiving it because of their isolation and aloofness from general social movements. Doctors are probably the last people who find out what is going on in the world and they are not going to be told by drug-financed periodicals.

As you know, politically, we are very naive. There is so much to digest, so much material to learn in the technical areas. We are not well-read; they are not generally literate people. We don't know the political and social movements going on. They don't know the need and mechanisms for social change. We do marvelous jobs in technical areas. We know little about delivery systems, things that are now being discussed in the halls of Congress, delivery systems in health care.

The salutory changes in the structure of medical care come from outside the medical profession, which is carried along kicking and screaming at every point. Medicaid and medicare, which we now take for granted as valuable and necessary, the medical profession was against them every step of the way. It is just that we are not broadly educated people.

Mrs. BOGGS. I would like to say two things, one, present company excepted. Also, you are speaking of some of the people I love.

Dr. SEIDENBERG. I don't claim exception. I have been very lucky in certain ways.

Mrs. BOGGS. Education is a two-way street, and certainly, I agree, the humanistic aspects of education should be enhanced in the medical area. I recognize that and I think a great many doctors recognize this as well. I have observed that many medical schools are now going back to the teaching of family medicine and are placing real emphasis upon

the inner relationships that exist in the social spectrum as well as in the medical areas.

There have been more direct courses in ethics added to the medical curriculum which is a very healthy sign. But do you feel that your education or your work with women in regard to the effects of drugs upon people will be helpful to the medical profession and will allow them to see themselves in these regards?

Dr. SEMENSENG. Yes. I have some optimism here, much coming through social organizations, civil rights groups—the women who are for the first time organizing in their own behalf, women's health committees, who are demanding certain services to be taken care of the way they never have been before, these are all positive and wonderful things that are happening. And I think women, as they think more of themselves, and as they are beginning to think of themselves as first-class citizens, they are going to demand first-class treatment. They are going to demand to be instructed, not to be thrown a piece of paper and say, "You take this."

I was appalled by an event several years ago in this regard. There was a representative of the American Psychiatric Association who came before a congressional committee, actually recommending that no inserts detailing side effects be placed in containers containing tranquilizers; that women would get these symptoms—side effects—because they had been reading about them.

Here is a psychiatrist who came before a committee and representing the American Psychiatric Association, saying inserts should not be put in the containers of tranquilizers because it would make women neurotic. They would get the symptoms that the side effects would illustrate.

As you know, these women should be enraged. They should march in front of the buildings, in front of the conventions, and say, "You can't treat us like this any more." And you see the ads; they are still here. I could reproduce these 100-fold. Women are depicted as shrews, bothering their doctors, filling up doctors' waiting rooms, seen on merry-go-rounds, et cetera.

These images are used sadly to resonate with the prejudice physicians may have toward women.

Mrs. BOGGS. Doctor, do you think the entrance of more women into the field of medicine will contribute to developing better services for women and also bringing a more humanistic approach to medicine?

Dr. SEMENSENG. Yes, I think this is a great step even though you must understand that many women who go into medicine have to follow the party line and very often have to conform to a male-educator system. Otherwise, they pay terrible penalties. Very often, you hear women physicians mouthing perfectly horrible things: "Well, I have made it; I don't see why other women can't do it. They treat me well." this sort of singular anecdotal experience; it saddens you to hear this lack of perspective.

But you have got to understand that women are frightened; they are going into an area that they are not wanted. I have quotations of the deans of medical schools saying, "We don't want women students." And it was only with a Federal gun at their heads that they had to accept them. Now, they accept them. You can't feel completely wel-

come or accepted when you know you are there because the dean has a Federal affirmative action gun at his head.

Mrs. Boggs. Excuse me, Doctor. We are going to have to recess for about 10 minutes because we have a record vote on the floor, and we only have a few minutes remaining.

Thank you very much.

Dr. Seidenberg. You are very welcome.

[Whereupon, a recess was taken.]

Ms. Mikulski. While Congresswoman Collins is voting on whether we should have the MX missile or not, she encouraged the meeting to go on. So if I could have your attention and ask a few questions, I would appreciate it.

First of all, I would like you to know I am extremely supportive of your remarks and made similar ones myself to this committee about a year ago. And it precipitated an enormous criticism of me. I was considered excessive and a whole host of other things.

But let me give you what some of your colleagues, both in institutional or private practice, said in response to the work such as yours and as a practicing physician in Congress what you could say. Most of the response that I receive was from private practice groups who were not psychiatrists, who would be or will be delivering primary care, both in urban and rural areas. They were either family practitioners or internists.

They said that it is all well and good for you to talk about alternative modalities, et cetera, et cetera, et cetera, but for us, we have very few options in the way of arming for mental health care to the patients that we see.

Traditional psychiatric treatment is not readily available to the poor, to the working class, to people in rural areas. The treatment is long, expensive, perhaps even excessively analytical. So when you are talking to a women who has just been deserted, who has four children, and is suffering from varicose veins from working at various bars, dressed in a miniskirt and trying to survive by yelling yahoo while she sells cheeseburgers. She is depressed and extremely anxious, but when she turns to some other mental health facilities, there are either non or just those that really don't want to take the time, what would you say to that?

And they say, in order to keep people functioning, in order to keep people out of the hospitals, we are giving them prescriptions.

Dr. Seidenberg. Well, of course, that is the justification, and they would say rationale. I would say it is a rationalization. Just because you may not be able to do the right thing doesn't justify doing the wrong thing. One can indicate to a person very frankly that if you have very severe social and psychological problems that they are very real. And it isn't going to be of help to them to have one more problem—that of drug dependency and often serious side effects.

Ms. Mikulski. Well, I think the other question, then, is what efforts are being made within the profession itself to alter the way mental health services are given, to make them more easily available, to make them more accessible, and to deal with the issue of cost.

Dr. Seidenberg. Well, I think, of course, there was this tremendous surge, as you know, of community mental health in the late sixties. And apparently, for various reasons, some people feel because it was

underfunded or other people feel because it wasn't based on proper concepts, that it didn't do what it was supposed to do.

We get into the bind of concentrating on something conceived of as mental health as apart from the rest of living. There are certain realities that no one can instantly do anything about. There are certain problems in this area that have been thrust on to the medical profession which belong elsewhere.

For people who are economically and socially deprived, mental health remedies are silly. People are thereby misguided by seeking or being encouraged to seek medical solutions. This person, as you indicate, is bereft of support, bereft of means, and then it is said: "Well, this is a mental health problem because she is depressed or upset," that really is going in the wrong direction. It is a cop-out. The result is that she is drugged so that she will forget or be distracted from the real problem that she should, or maybe the world or her environment should, be responsible for.

So there is such a thing as doing nothing as an alternative to doing the wrong thing. And I think drugging people because of social problems is the wrong thing to do. As we have heard today tragically, it just doesn't work.

Ms. MIKULSKI. From what I gather, you are advocating a more holistic approach to the delivery of health services.

Dr. SEIDENBERG. Holistic, not just in the medical profession. It is holistic in the community sense that there are political issues, social issues, there are economic issues, that are tough indeed.

Ms. MIKULSKI. Well, I will deal with some issues that are not related to the private question, but Mrs. Collins is here, and I was only supposed to have 5 minutes—that is for both your comments and mine.

Dr. SEIDENBERG. I think this is a very vital issue, that of receiving so-called mental health in a sense much broader than is generally perceived.

Mrs. COLLINS. May we have some order please?

First of all, we are running into a time problem. I would appreciate it, the committee would appreciate it, if you would very directly answer the questions because we do have a panel of three others who have been here since 1 o'clock, who also wish to be heard. And, unfortunately, our hearing time concludes at 5 o'clock today. So if you could be direct in answering the questions, we would be most appreciative.

Dr. SEIDENBERG. I am trying.

Ms. MIKULSKI. Let me rephrase the question. What provable, positive steps have been taken by members of the medical profession to change the curriculum within medical schools, to bring out the whole issue of the family, which I think is not an esoteric subject of women?

A curriculum that is oriented to women's problems viewed as natural functions rather than diseases. Not by bringing in more judges, but teaching values?

You did talk about bringing in a judge to teach somebody about the conflict of interest. That, of course, is based on the assumption that lawyers and judges are ethical, which in the Judiciary Committee, they might debate that.

What we are coming down to is the basic values in our society, what do we consider important. What are our values, but in terms of ourselves and our beliefs and our profession?

Now, Congress is somewhat limited unless we get into capitation grants and so on. I am interested in knowing what our leaders and spokesmen such as yourself are doing to take the steps in curriculum change.

Dr. SEMENBERG. Well, not enough is being done. There is activity in the American Psychintric Association to revise their programs in teaching students and residents in the problem of sexism and racism and the changing social family values. This is an ongoing process. It is very difficult, but it is ongoing, but not enough. Our world is changing so fast, we are just not changing quickly enough to keep up with it.

Ms. MIKULSKI. Time is running out. I yield back the balance of my time.

Mrs. COLLINS. Thank you very much. Thank you very much, Doctor, for your very enlightened testimony.

Our next witnesses will come before the table as a panel. They are Ms. Phyllis Halpern who is the coordinator for women's programs, New Jersey State Department of Health, Alcohol, Narcotic and Drug Abuse Control.

Also Ms. Doris DeHuff who is executive director of the drug liberation program for Stamford, Conn.

And Ms. Barbara Gibson who is the senior administrative associate, Addiction Research Treatment Corp., New York City.

Because we are so severely limited in time, I am going to ask you to please just give us a brief summary of your remarks so we can get to the questioning. And your remarks in full will be placed in the record.

And why don't you begin, Ms. DeHuff?

TESTIMONY OF DORIS DeHUFF, EXECUTIVE DIRECTOR, DRUG LIBERATION PROGRAM, STAMFORD, CONN.

Ms. DEHUFF. I did want to tell you how very grateful I am, and I know my colleagues are, to be allowed to speak here. I will make my remarks brief. I am particularly grateful because, as you know, drug addiction and its treatment as social issues go is not a dinner jacket affair which people clamor to attend. Except for those courageous few who admit their addiction to drug alcohol, addicts recovered from dependency on other drugs do not tend to surface in the halls of Congress, or in corporate executive suites, attesting to their personal addiction and, hopefully, their recovery experience, leading the way for others.

As one who has worked in the yet infant field of addiction for the past 10 years, battling the constant frustration of pounding on impregnable doors and ears, begging for attention and funds to treat this human crippler, I am doubly grateful. I need not dwell on the overwhelming statistics of which we have heard so much this afternoon as with regard to women and prescription medications and alcohol and their abuse of it.

To help you understand why and how we in the drug liberation program in Connecticut have since 1972 accumulated considerable experience in treating women, let me briefly describe the agency. We are in Fairfield County. And our close proximity to New York City has its proven effects on the extent of drug abuse in our area.

In 1978, region 1 had 32 percent of Connecticut's first and readmissions to drug treatment, although we account for only 21 percent of the

State's population. This also is an area that has the highest per capita effective buying power in the State.

Well before the issue of women and drug abuse began to receive the special focus it demands, this became a major concern in our agency. We started a multimodality program funded by the National Institute on Drug Abuse to treat 305 clients. We currently have eight treatment units. All are coeducational except for the women's center which is our newest program.

And the purpose of this program specifically is to treat and deal with women who are addicted to legal substances such as prescription medication, often in combination with alcohol. These women have been out there for a long time now unnoticed, untreated, with the scope and intensity of the problem growing at an alarming rate as certainly the testimony here has verified.

From our experience in treating other women, we could anticipate the more obvious difficulties in attempting to treat this particular group. They are not likely to accept treatment at a place identified as a drug abuse agency. They would certainly resist the notion of identifying themselves as addicts, let alone commingling with those addicted to street drugs and the lifestyle that must often involve. They would be older than other types of drug-dependent women, we thought often middle-aged, often with children, for whose care they could not arrange during the mother's involvement in treatment.

We believe these women would have many more medical and possibly psychiatric problems than many of the people using common street drugs. They might well be women who would be encouraged to be dependent on others through the course of their lives.

We designed our concept of an appropriate treatment program for them accommodating the notion that they should bring their children into treatment with them. And we were fortunate enough to be funded for this program by the National Institute on Drug Abuse. We opened the doors to the residential component of the women's center on June 1 of this year.

In late August, we had seen and evaluated 32 women, 20 of whom had been to treatment, and a total of 7 young children in residence with these mothers. Before I tell you what we learned about these women, let me just briefly describe how the program is structured.

It is a freestanding facility in downtown Stamford, but in a residential neighborhood whose purpose was to present a nonthreatening atmosphere for women to come to. It is specifically designed to meet the treatment needs for women who are polysubstance abusers. 18 years and older. And its unique program structure allows women to keep their children with them during their treatment stay.

We serve the entire State of Connecticut and are open to out-of-State residents as well.

The purpose of this center is to offer care in three modalities to drug-dependent women who have been abusing a variety of drugs, particularly sedatives, minor tranquilizers, other prescription medications, often in combination with alcohol.

This type of total treatment experience in a drug-free milieu is intended to provide maximum opportunity for women to reconstruct their lives.

Evaluation is done on an outpatient basis and includes an intake interview, urine testing for drugs and alcohol, a psychiatric assessment, and review of any medical/psychiatric/substance abuse information from the referral source.

I would like to explain that the reason we feel that medical coverage is necessary there is because, as you may know, very precipitous withdrawal from some substances such as barbiturates can lead to a life-threatening situation. People can go into convulsions and die and have been known to do that. So we feel medical attention at the intake process is extremely important.

Routine detoxification can be accomplished within the residential unit, but currently addicted clients with a history of medical problems or complicated withdrawal from substances will be referred to a hospital detox unit.

An appropriate candidate is started in treatment in one of three drug-free modalities—residential, daycare, or outpatient. And during the course of treatment, the client can move from one modality to another; staying free of drugs, of course, is the essential requirement. So there is a residential treatment component, daycare component, and outpatient component.

And just briefly described, they deal with the woman as a whole. We know that we have to become involved in family counseling. You have to treat the whole family. And where this has been done, we know how much more successful that is than treating the isolated and so-called identified patient.

Let me just paint a few representative portraits for you.

Mrs. COLLINS. All right. May I make a suggestion please. I certainly would like to hear. I am sure the entire task force would like to hear, a summary of the testimony from your fellow women on the panel. So I wonder if I might go to them now, and we will still have time for a few questions.

[Ms. Duff's prepared statement appears on p. 73.]

Mrs. COLLINS. Ms. Halpern?

TESTIMONY OF PHYLLIS HALPERN, COORDINATOR OF WOMEN'S PROGRAMS, NEW JERSEY STATE DEPARTMENT OF HEALTH, ALCOHOL, NARCOTIC, AND DRUG ABUSE CONTROL

Ms. HALPERN. Thank you. I am going to try to summarize my data. I am not going to read it directly.

Mrs. COLLINS. Thank you. The testimony in full that you have submitted to the committee will be included in the record.

Ms. HALPERN. I would like to mention that the DAWN figure, the drug area warning network figure, for emergency episodes for women in the year from May 1977 to April 1978, was over 69,000, and that that number based on the DAWN collecting system does not represent all of the emergency rooms in the country. There are many that are not included in that count. I think that is significant. We don't really know the total number of overdoses for that year or any other year for that reason.

I would like to talk about our women's centers. We have two. Together, Inc. that you have already heard about, is one. And the other

is, the Women's Resource and Survival Center, in Keyport which is located in an economically depressed area. Forty-two percent of their WRSC population have income levels of below $5,000, and 53 percent of the sample were using psychoactive drugs when admitted.

One of the most significant findings from that women's center is that over 16 percent of women who were using drugs did not know the name of the drugs they were using. The average age of the women is about 35 years; 54 percent were married; 45 percent were separated or divorced; 55 percent were homemakers; and 37 percent were employed outside of the home.

Together, Inc., which you heard about from Cynthia is located in south Jersey in a less economically depressed area where incomes range from under $6,000 to $18,000, but drug abuse of this kind is primarily found in women whose income is not above $11,000. These figures are significant, and we will get to the reason why they are. Of the women, 49.9 percent who enter are using drugs or medication. They are predominantly within the income range from under $6,000 to $12,000.

Valium and tranquilizers predominate. Over 100 women admitted using cocaine received from a friend, although they were not regular users. The primary source of drugs was, 3 percent from psychiatrists, 97 percent from general practitioners or other medical doctors.

In a random telephone survey, Together, Inc., found that over 22 percent of women over 18 responded to the question, do you use drugs and alcohol to cope with stress, affirmatively. Projecting that number in Gloucester County would mean 11,400 women in that one county were using drugs to cope with stress. From our experience in New Jersey, some recommendations come to mind as ways of reducing the dangers of prescription drug abuse, dependence and overdose among women.

One: All prescriptions for drugs in the high overdose categories should have the name of the drug clearly stated on the label along with instructions for use.

Two: Enclosures similar to those that accompany birth control pills should be in the package stating the dangers of use in combination with alcohol or other drugs, the risk of habituation when used for long periods of time and the risk of death from overdose.

Three: The enclosures should include appropriate warnings about the use during pregnancy and when breast feeding an infant.

Four: In the case of psychotropic drugs, the enclosure should recommend their use be accompanied by psychotherapy or counseling on a regular basis.

These recommendations would provide women users with basic information needed to foster responsible use of drugs. They would know the name of the prescribed medication they are taking, the danger of synergism with alcohol or other drugs, the possibility of habituation and death from overdose, and the possible effects on the unborn or newborn of drugs in their blood that pass through the placenta or into breast milk.

The recommendations for psychotherapy are of particular importance in view of the fact that most medications are prescribed by therapists. There is a profile here based on information that comes out of epidemiological studies of depression. In those studies, it has been

shown that twice as many women as men are diagnosed as suffering from depression. It is the young, 25 to 40, married, separated, or divorced, working, blue collar mother who is most likely to be depressed. This women has less access to social support systems than do other groups even though her life situation is more stressful.

The women described in these studies matches in her characteristics—ties, the women clients of the two New Jersey Women's Centers. Without a support system of social services, counseling or therapy, medication by itself does not help her solve her problems or reduce her life stresses. This is the woman who needs to be alerted to the value of counseling when taking psychotropic medication for prevention of deepening dependence.

The studies also show that this woman is coping with, quite often, demands of a job, family responsibilities, husband, children, and household management. She has little hope of rising in a career as the white collar woman. Further, she is caught in a traditional family role situation that means she must fulfill all the family role responsibilities ascribed to women and at the same time cope with the stresses of a dead end job.

The authors observe that feelings of helplessness and hopelessness are primary factors in her depression, and we may add to her drug use. Counseling for this woman should deal with her drug use as a temporary measure and instill respect and understanding of the long-term dangers of drug use. With the support of counseling or therapy, she would be aided in looking at her problems and in devising ways of dealing with them in order to decrease the stress in her life.

Family therapy should be available, hopefully to attain greater cooperation and caring between family members. Group therapy should help her perceive that she is not alone—new friendships with other women may be helpful.

Further opportunities for training or education may open her life to new opportunities. With increased self-respect and hopefulness, this woman could give up her drug use. She will have gained greater control over her life—a real reward.

In answer to the question, are current treatment services available to women with this specific problem, based on my experience adequate services do not exist. How can we provide these services through existing agencies at a minimum cost? New Jersey State clinics for treatment of illicit drug abuse can treat people with these problems, but women using prescription drugs are fearful of methadone clinics and unwilling to use them.

A real possibility for treatment development should be possible through a small expansion under title XX of the Social Security Act. Title XX moneys are now available for alcohol treatment. Categorical funding is available for counseling of eligible persons with alcohol problems as well, under the category of counseling in New Jersey.

By the simple inclusion of counseling services for dependency on prescription drugs, services could be developed through staff training and program development for the women discussed here today. We respectfully urge this committee to consider this recommendation and the necessary steps for its implementation.

Thank you.

[Ms. Halpern's prepared statement appears on p. 89.]

Mrs. COLLINS. Ms. Gibson?

TESTIMONY OF BARBARA GIBSON, SENIOR ADMINISTRATIVE ASSOCIATE, ADDICTION RESEARCH & TREATMENT CORP., NEW YORK, N.Y.

Ms. GIBSON. Thank you. I shall concentrate my remarks today on prescription drug use, misuse, and abuse by middle-aged black women, basically because I was under the impression that was the specific group we were going to be dealing with today.

I choose to so limit myself not only because this segment of the total population presents unique and distinct implications for policy directions and intervention strategies, but because it further illustrates a pressing need to broaden the scope of congressional action in attacking what is considered a medical/social problem.

The use, misuse, and abuse of prescription drugs by middle-aged black women is a function of the interaction of the agent—the drug—the host—the middle-aged black woman—and the environment. Before the clinical horizon is met and symptoms appear, there is a prepathogenic period during which the characteristics of the agent, host and environment—the causal variables or determinants—converge to set the stage.

The agent in this case is a wide range of prescription drugs whose nature and classification, in terms of psychotropic effect, tolerance tendencies, and abuse potential, is well-documented and presented here by others in this and also in other settings. Its presence and availability is of concern and is crucial as a point of intervention because it is a factor that is within the scope of human control and susceptible to the direct actions of Congress.

The mechanisms by which these drugs are made available and distributed provide opportunities for specific and direct action that would have immediate impact on the problem under discussion. The availability and distribution process, as relates to the host under consideration, middle-aged black women, has special circumstances that speak to the economic, social, and psychological constraints of black women in general, but poor black women most specifically.

It also brings into consideration these women's access to health care and the quality of that care when available. Also, these considerations, especially economic condition, health care access and quality of health care, are within the *domain of congressional concern and influence.*

Although the literature suggests that abuse of prescription drugs is found in middle class, suburban, middle-aged women, as well as in the lower socioeconomic setting of the black urban arena, there are significant differences in how access, availability and delivery of health care, and subsequently prescription drugs, is effected.

Within the urban black arena—the environmental determinant—there is a significantly decreased availability of health care services. The State of New York has approximately 1 physician for each 1,000 population; for predominantly black and Hispanic areas of the State, that is, Bedford-Stuyvesant, the south Bronx, central Harlem, the rate is 1 physician for each 16,000 persons.

Much of the health care is delivered in crowded outpatient departments of understaffed and overworked municipal hospitals or in medicaid mills. This has a sharp contrast to the family physician setting in surburbia or rural America.

The central Harlem resident receives her treatment in a supermarket atmosphere where she is a chart number or a medicaid number. Harlem Hospital receives over 1 million outpatient visits annually. Due to the paucity of general practitioners in the community and the economic status of its constituents, it is used as a doctor's office.

As other hospitals in areas of the medically indigent, its emergency room receives patients who would more suitably be treated in a private physician's office. Instead, emergency personnel make cursory exams, referrals to specialty clinics, and hand out prescriptions. Most clinic referrals are not met and when the presenting problem reappears, the patient returns to the emergency room, gets another referral and another prescription.

In the medicaid mill, the physician caters to the patients' expectations. The patient does not feel treated unless a prescription is recorded. Perhaps the patient is ping-ponged or cross-referred within the specialty areas of the clinic to produce multiple medicaid or medicare reimbursements. Thus, the female who is experiencing problems related to menopause and complains of general fatigue, aches and pains, hot and cold flashes, cardiovascular problems, et cetera, will see a gynecologist, a cardiologist, perhaps a dentist and podiatrist. All will bill medicaid separately and each feels obliged to prescribe something.

The habits and customs of the host—the black woman—especially as they relate to her response to illness, are also important. Often, due to economics, she has become accustomed to self-mediate. When a minor problem appears, she goes to the medicine cabinet and gets one of those pills prescribed long ago for a complaint long forgotten. Maybe she hasn't medicaid coverage, or the wait is too long, or she can't take off from work. At any rate, she avoids the complicated, protracted and dehumanizing interface with her available health system.

The psychological characteristics of our host play an even greater role in differentiating her from her suburban, middle-class white counterpart. These include the widely discussed pressures and stress of being poor, black, and female. I will not delve into all of the ramifications of inadequate housing, poor education, lack of job opportunities, burdensome financial and familiar responsibilities, discrimination, alienation, and hopelessness that converge to exacerbate the normal anxiety and stress of menopause—with its own set of psychological sequelae.

Mrs. COLLINS. Ms. Gibson, may I interrupt you at this time? We roughly allowed about 10 minutes to each of you, and your 10 minutes have just expired. And I will ask at this time if I may get on with the questioning.

[Ms. Gibson's prepared statement appears on p. 102.]

Mrs. COLLINS. And since I am the only questioner, we can possibly finish at the time that has been allotted to us. May I start, please, with Ms. DeHuff.

In your statement, you speak of the difficulties of getting funding, not only for drug rehabilitation programs, but for the newly opened

women's center. Would you tell us briefly what your experiences are and what social funding is available?

Ms. DeHuff. Yes. The total program for 60 clients of whom 20 or more would be women plus their children of undetermined number at this point would run around a total of $200,000 of which we would receive 60 percent from the National Institute on Drug Abuse.

Of course, you cannot use these funds for support of children so that those funds would have to be raised in addition.

Mrs. Collins. Thank you.

Ms. Halpern, what type of grassroots organization could be used to draw more women into drug treatment? And what ways could they best achieve this?

Ms. Halpern. The kind of organization that works best are women's centers such as Together, Inc., and the Women's Resource and Survival Center. Women go there because they have problems in their lives. What happens is that in the course of group work, the fact that they are coping by using medication comes out. They are in an environment where they have support and share with other women. They are best able to stop their drug use in women's centers just as Cindy reported. That kind of mutual help experience really works.

Mrs. Collins. Ms. Gibson, do you know or have you studied to see if there is a correlation between the use of drugs by black women at early ages, follow through to the older person?

Ms. Gibson. That was one of the things I began to do in preparation for this. There are no studies that indicate this kind of thing. Such studies have not been done, just as no studies have really been done in terms of an ethnic breakdown with regard to women who abuse substances. I am a firm believer, from indications of studies that have been done with regard to substance abuse in general, that a person's habit with regard to using drugs does not begin at 35 or at 50 or 60, but it is something that, I think, has its roots in a person's orientation from early childhood.

Mrs. Collins. Do you find any special problems with the older person who is relying on drugs?

Ms. Gibson. Yes. In the studies that I have done with regard to prescription-drug misuse among the elderly and, of course, in our society, the largest portion of our elderly persons are women, there is a frightening percentage of women who are misusing prescription drugs, tranquilizers as well as medications for hypertension.

I think that a lot of it has to do with the strong desire to maintain youth, which equals to a lot of us, mythically, of course, that to be young is to feel good. But there is a large percentage of women who use drugs, and I think studying drug use among the elderly certainly can give us indicators about the type of work that we usually do with regard to drug use among females in general, from high school or junior schools through.

Mrs. Collins. Thank you.

Ms. DeHuff, in your view, why is it that psychiatrists have not been able to treat the woman polysubstance abuser?

Ms. DeHuff. Because I think they essentially are nonpsychiatric problems. They are problems that deal with living and society today and the complex pressures that a woman is facing. Women, unless there is a late news flash, have to bear the children of the society. They

are being pulled apart, I think, in terms of providing proper care as mothers and assuming the kind of role the romance literature is saying they should assume.

I think they are feeling many pressures, and certainly, in treatment from the medical profession, there is sexism; there is no doubt about that.

I might say that the main issue is that I think women are constantly being told either to bear up or bear down, and that is about as far as it goes.

Mrs. COLLINS. You have done, I think, work on this for quite a while. Do you see any great difference between the treatment of a 20-year-old as opposed to a 50-year-old woman? And do you know or think that their problems are similar or dissimilar?

Ms. DEHUFF. I think, essentially, they are similar. Certainly, the feeling of low self-esteem runs through all ages. I think the support systems are what differ essentially for the younger as opposed to the older woman.

Mrs. COLLINS. Ms. Halpern, what do you think is your greatest frustration as a professional who is trying to alleviate this very critical problem?

Ms. HALPERN. Working in a State system, the difficulty seems to be the limitations of each department and division and the inability to cross over. The fact that we fund two women's centers is sort of remarkable, in a sense. That was kind of a creative thing for the division to do. I would like to feel that I could reach the Division of Youth and Family Services in the Department of Human Services. I have had some conversations with them, in which they were not at all welcoming about the idea of sharing any of the problems that we have talked about today.

Mrs. COLLINS. I thought your suggestion on page 8 of your testimony, that title XX moneys might be available since they are available for alcohol—more money could be put in there for counseling, if nothing else, on drug abuse. That is something that this task force will pursue, a mandatory watch to see if there is something we can do. If so, we will certainly do that.

You mentioned that you deal primarily with narcotics. I am wondering if the older woman is a part of your option. Do you deal with her using narcotics: do you have cases like that, or are there cases like that?

Ms. HALPERN. Our CODAP data, which you know is Federal data that we fill out on all of our clients in the State, has an astonishing curve on that. It is in the needs assessment that I gave you. For reasons that we don't fully understand, many people terminate their illicit drug use or their dependency on methadone between 30 and 35.

Mrs. COLLINS. And you don't know the reasons for that?

Ms. HALPERN. No.

Mrs. COLLINS. That's interesting.

Ms. HALPERN. We could do something in research on that, possibly, by checking with some of our social work supervisors to see what kind of factors enter into it.

Mrs. COLLINS. Ms. Gibson, in your experience, would your curve go similarly?

52-928 O - 80 - 4

Ms. GIBSON. In most cases, yes. We have some women who are beyond the age of 35 who are still being treated who are maintained on methadone. I have asked women why they have stopped at a certain age, and in most cases, the response is that they are tired. It is very interesting that most of the addicts, hard-core addicts, are able to control themselves when they get to the point that they are willing to do so and they just get tired; then they can stop, and things just change.

Mrs. COLLINS. That is basically the same, too, for men; isn't it?

Ms. GIBSON. Oh, yes; and it is a very interesting thing to watch when they get tired and start changing their whole lifestyle.

Ms. HALPERN. You might raise the question about whether they do shift in some cases to alcohol and licit drugs. We don't know the answer to that.

Ms. GIBSON. It is high.

Mrs. COLLINS. Just a few more questions, please. You, in your statement, Ms. Gibson, expressed concern about the medicaid mill contributing to the problem. What changes would you make in that system?

Ms. GIBSON. Well, my first response would be encouraging something of a watchdog nature. I think that one of the things that happened to medicaid mills is, there is not any real attention given to the presenting problem other than just giving them prescriptions. I think what might be helpful is some watchdog agency that can literally do a random examination of medical records that would indicate that there is, indeed, some real medical examining done, there are some very pertinent questions asked with regard to the present problem.

I think also there is probably—and I think there is now—an agency or some mechanism that does examine the amount of prescriptions that are issued by a given physician in a medicaid mill. The problem is that there is not the time or, in a lot of cases, the caring for the kind of patient who has to go to a medicaid mill for medical services. That would be the only thing, because you can't legislate a person's concern, but you can legislate the structure under which he operates, which might change some things.

Mrs. COLLINS. Is it your experience that a drug dependency, or do you know of any cases where a drug dependency, has begun at midlife rather than in a followthrough?

Ms. GIBSON. No; I don't, because I have not interviewed any women at middle age who have a presenting problem, and there are no studies whatsoever, that I was able to come across, that indicate anything around this area.

Mrs. COLLINS. Ms. Halpern, do you feel the Federal Government is sensitive to, and active enough in, working to decrease this problem?

Ms. HALPERN. Not yet. I think they could certainly improve a great deal. There is room for much improvement.

Mrs. COLLINS. Ms. DeHuff, let me ask you one final question, and that is, you mentioned just briefly in your overall remarks how you operate within the center. Can you tell me what you do, that is different from other centers, that gets results?

Ms. DEHUFF. I should think the residential component and attention to children, whether they are on an in-patient basis or out-patient basis, providing family counseling, and the fact that you do provide women with a total investigation of their medication patterns, what

their physical health status is, and a mental status, so that you can really take a look at where she is now and what kind of attention she needs before she can even get down to reconstructing her life with other means, such as therapy, within the area.

Mrs. COLLINS. Ms. Gibson, I was impressed with the question you raised in your statement. You said, "Need we study how much the patient suffers when we can already exercise some control over the source of suffering?" And then you ask, "Need we look all around the problem to find a solution, when immediate relief is at hand?"

Why do you raise those questions?

Ms. GIBSON. I raised that question when I began to think of the value of this hearing and of the value of a lot of other hearings. That is not to say that I questioned the concern of the persons who are present. I am not as political as I intend to be, but have become more political than I was, and I am aware that congressional committees throughout Congress are able to get into bed with each other when they need to in order to get some things done or something passed.

I am wondering if it is perceived as of yet that, when we talk about the problems of a given group in society with regard to stress and strain for living, are we recognizing that we are able to legislate almost everything in this country? It seems to me that all of these people can get together at some point and begin to share the concerns that they have within each of their committees and somehow see the connection.

I think a case in point is the ERA. I don't mean to be pushing the ERA, but we are talking about women.

Mrs. COLLINS. Push it.

Ms. GIBSON. Women who are under stress. I shudder to think of the kind of stress that is created by women who get up and out every day, go to a job, and know that there might be one gentleman or two or three who were doing the same kind of work that they are doing, and who are getting twice the money. That is just one case in point.

Just that discriminatory process that exists has to cause stress. It is no wonder that women have to take something to survive. What is it that is preventing congressional persons from looking at the ERA, not in terms of a threat, but in terms of a minute facilitator for some easier processes for going from day to day for women in the society, and for men, too? I just cannot believe—we are all here today, giving you information. We are talking about pill use, pill prescription misuse, but what we really are talking about is the thrust to try to cope, and that coping mechanism has to do with the Committee on Commerce, with the Banking Committee, with the Committee on Welfare, with the Committee—you name it. It all is somehow connected.

I just don't think that we can afford to be so tubular in terms of our concerns, and not somehow understand that we all share the banquet table of life. So that is the thing that I am trying to say, and I am glad to be here today.

I also think that, if we don't start talking, if congressional people don't start talking, we are not going to get anywhere. It is just that we keep going on. I think we have got to really examine why some things are allowed to exist in our society, and be honest about the fact that there are some people who are benefiting, but there are also a lot of people who are not.

I have got to begin to weigh because sometimes you have got to get away from the benefiting and get to dealing with those people who are not, because that is where the future of the country lies. To me, it seems simple, but I know that it is not.

Mrs. COLLINS. Well, we will try to make it more simple.

I think that all of us will read, particularly on this particular task force, the remarks that all of you have made. And all of our witnesses today, I can't thank you enough for coming. You have made this first hearing really a premiere hearing, when it comes down to women and drug abuse.

Our committee chairman who, unfortunately, could not be here at this time—he was testifying over in the Senate this time, this morning—Mr. Wolff sends his very personal thanks.

With that, we must adjourn this hearing.

Thank you very much.

[Whereupon, at 4:57 p.m., the hearing was adjourned.]

PREPARED STATEMENT OF CYNTHIA MACINNISS, TOGETHER INC., GLASSBORO, N.J.

When I was an adolescent my great grandmother died. The women in my family—my mother, my grandmother, my aunt, and myself—were given tranquilizers in spite of the fact that my great grandmother was my father's relative, not my mother's. My mother and father were divorced when I was 12 and I was sent to a boarding school. I took an overdose of aspirin and the school failed to report this to my family.

My mother was given both tranquilizers and amphetamines for nerves and weight by her doctor. She was also an alcoholic although she hid it well like many other housewives. When my mother died I was 16 and was given tranquilizers for a week.

When I was in college I weighed 105 pounds and went to a diet doctor for my weight problem. I was weighed and had by blood pressure taken every week by a "helper." I never met a doctor. I lost 20 pounds. Another doctor gave me tranquilizers for my nerves and because I was having trouble sleeping. I got a kidney infection and vitamin deficiency and dropped out of school to be hospitalized.

When I was 18 I had a nervous breakdown. I was hospitalized in a prestigious private hospital and given various medications including Thorazine in doses large enough to put me to sleep during the day and additional, but ineffective, therapy. I believe that the other patients and aides helped me much more than the psychiatrists did.

After being hospitalized, I married and when we decided to have a child, I stopped taking Thorazine, which I had been taking for about four months. I was not receiving any therapy or follow-up during this time. When my son was 18 months old we moved so that my husband could get his master's degree. I was depressed and bored. I mentioned this to my gynecologist and he prescribed Valium, 5 milligrams to be taken as needed.

The next several years of my life are very blurry, but I'll try to give you the facts and impressions as I remember them. I went to another doctor who gave me diet pills out of his closet. My gynecologist gave me more Valium and Darvon for cramps. Two and one half years later we decided to have another child. I only took Valium during my pregnancy—up to 15 milligrams at a time (as needed). After the birth of my second child, I was more depressed and anxious and developed colitis. My family doctor gave me a relaxant and another pain killer. My doctors never asked me what else I was taking and didn't tell me what I was being given. When I mentioned my problems I tended to minimize how much or how often because I was afraid of being labeled a hypochrondriac or a complainer and doctors are so busy and God-like and I thought they knew best. During this time I went to a local mental health center and saw a fairly competent doctor. When he moved I stopped going because my new doctor started telling me his own problems.

When I was 25 years old we moved again and I was depresed and my gynecologist increased my Valium to 10 milligrams to be taken as needed. I want to state now that I wasn't as physically hooked as some people because I took such large

doses at times that I would get sick and not take my pills, "my friends," for a day or two. I also only took diet pills on weekdays and not on weekends. So on weekends I often didn't take my other pills. I can also see now that I was happier on weekends when I wasn't alone with two children and I had more to do.

I went to a new doctor in Glassboro and became more jittery and depressed. I stopped the amphetamines but my unhappiness continued. When my children misbehaved, I took three to ten milligrams of Valium. I slept late. I had insomnia and overdosed a few times. I told my doctor and he gave me a six month prescription for Valium and Darvon, 100 of each, refillable 4 to 6 times. I got colitis again and started taking Trinvil. I went to a women's club meeting and saw two women from Together, Inc. who were talking about hot lines and drug overdose and abortions. At the time I did not think that it pertained to me. I took their card and when I took my next drug overdose I called them. They got me to describe my house and neighborhood and found me. We talked. They cared. They asked me to come to a women's group meeting and I went.

I found a place where I felt safe and cared for—a place where I could be me and not who I thought I should be. Shortly after attending my first group, I went to work on the hot line. I attempted to kill myself one more time, taking 480 milligrams of Valium and a few Darvon. After this episode another doctor offered me tranquillizers for colitis but I learned self-hypnosis instead.

The women in my group and I noticed that we were not coping by using pills and alcohol anymore. Some of us were getting outside therapy but we knew that our real growth was happening in our women's group. We applied for funding as a pilot program. We have now been in existence for 5 years. I worked for a counselor for 2½ years and am now a consultant to Together Inc. and to another women's program, Alternatives for Women Now. I have taught women's courses at several colleges and I speak anywhere I can about women's alternatives to drugs. Please see attached forms for more information about the program, Together Inc.

I want to briefly pay attention to my family. My father, grandmother and most of my relatives thought that I was being helped by my doctors. They also did not realize the depths of my despair and self hate. My husband was a fairly traditional male in that he wanted a sweet, dependent wife. He didn't realize that for me that role was depressing. He supported me when I took the doctors prescription for happiness and became fearful when I tried less traditional forms of treatment such as Gestalt, bioenergetics, transactional analysis, assertiveness training, consciousness raising, primal therapy and goal setting to name a few. He was also threatened by my involvement in all female groups but has come to see that they are more conducive to growth than mixed groups. My children are fine beautiful people. I have three, ages 13, 10, and 5 years. Partly because of the training that I've obtained in communicating with them and partly because I now have room in my life for them now that I'm fulfilling myself that they seem to cope well in the world.

Together has had a profound effect on me because of the atmosphere of acceptance and the very special treatment offered to clients. I would never have entered a traditional drug program where I would have expected, and often found, a male-dominated, confrontive atmosphere designed to deal with people very differently. The modelling done at Together by drug-free women staff who are coping with life in alternative ways is certainly more useful to a woman than being told how to be a woman by a man. The majority of counselors are ex-prescription drug abusers and as such are able to understand the problem and show the client that change is possible.

In many other drug programs the medical model is used which comes from the perspective of attempting to cure a drug abuse problem and make the patient whole again. This model is ineffective, as clients often substitute other destructive coping mechanisms such as smoking and alcohol and believe that he/she is not whole and okay. At Together the approach is to support the already whole individual while helping her to discard outmoded destructive behaviors. This is done in a caring but non-rescuing atmosphere by strong centered feminists. It is done, in my mind, miraculously, in spite of the humiliating and time consuming medical exams of women already under a doctor's care, endless paper work required by the funding agency and the threat of urine-monitoring by the state. I know that all drug programs suffer some of these same problems but women who are abusing prescription drugs are not the same as people using illicit drugs who are often court referral cases.

By teaching new life skills, helping the woman see herself in perspective to our often sexist society, aiding her in setting her goals, and in getting on with her life; Together performs an effective service to the client. I think that this program works also because clients can become involved in helping others as hotline volunteers, typists, group leaders, counselors, and staff trainers and administrators. Another plus is that there are no fees involved at all, unlike many mental health centers. Confidentiality is highly prized as many clients start out without their family's knowledge.

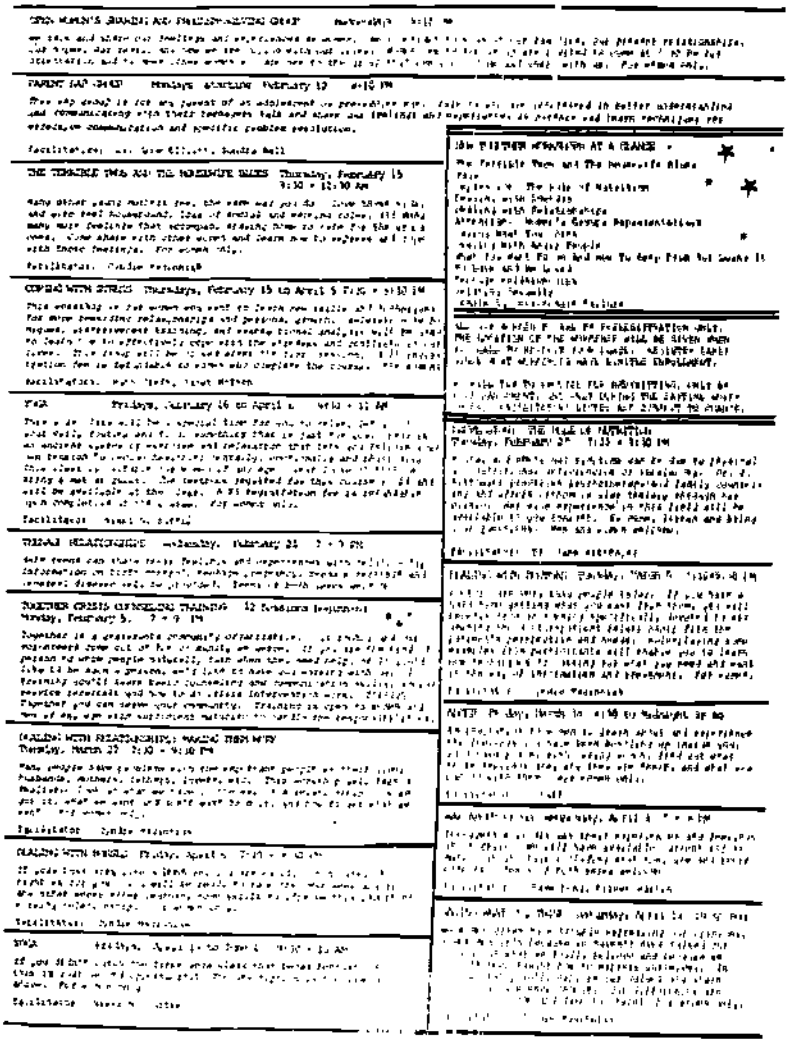
To me the areas of need for improvement nationwide are for more treatment facilities like Together and more prevention through education and information. I would like to see T.V. ads about prescription drug awareness such as, "Do you know what you are being given? Why? For how long? Are you aware of the side effects? If not, ask. It's your body." I am wary of governmental restraints either of doctors or pharmaceutical companies. I believe that women and consumers in general have both the ability and the right to make informed choices. I would also like to see school children trained in coping skills which can replace drugs. Some coping skills like stress reducing techniques, self-hypnosis and assertiveness communications.

These hearings are certainly a step in the right direction and I feel hopeful. Thank you for giving me the space to share with you.

Spring Calendar 1979

Together Inc.
7 State Street
Glassboro, N.J.
08028

(609)881-4040



Spring Calendar 1979 (cont.)   609-881-4040

DEALING WITH ANGRY PEOPLE
Tuesday, April 24 7:30 - 9:30 PM

Are you afraid of angry people? [illegible] For women only.

Facilitator: [illegible]

WOMEN AND [illegible]
Thursday, April 26 [illegible] PM

[illegible] For women only.

Facilitators: [illegible]

GETTING A JOB
Saturday, April 28 1 - 4 PM

[illegible]

Facilitators: [illegible]

[illegible]
Saturday, May 5 10 to Noon

[illegible] For women only.

Facilitator: [illegible]

[illegible]
Thursday, May 17 9:30 - 11:30 AM

[illegible] For women only.

Facilitator: [illegible]

[illegible]
[illegible], May [illegible] to June [illegible] [illegible] - 10:30 PM

[illegible]

Facilitator: [illegible]

ASSERTIVENESS TRAINING [illegible]
Thursdays, May [illegible] to June [illegible] 7:30 to 9:30 PM

[illegible] For women only.

Facilitators: [illegible]

[illegible]
Tuesday, June [illegible] [illegible] - 9:30 PM

[illegible] For women only.

Facilitator: [illegible]

[illegible] / [illegible] FAILURE
Tuesday, June [illegible] 7:30 - [illegible] PM

[illegible]

Facilitator: [illegible]

[illegible]

[illegible]

Together Inc.   7 State St. Glassboro, N.J.

[illegible] SERVICES

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

A Brief Synopsis of Together Inc.

EVALUATION GOALS

Together's system of evaluation was designed this year. The goals of this evaluation were to provide data on the population served, to evaluate outreach effectiveness and to evaluate treatment. Specifically the goals were as follows:

To divide the women attracted to Together into three groups (drug users, drug users who enrolled as clients, and women who state that they do not use drugs);

To discover the differences and similarities among the three groups of women attracted to Together's programs;

To discover any correlations between demographics and drug use;

To analyze data from discharged clients to discover how successful treatment had been in eliminating drug misuse;

To analyze data from discharged clients to discover how successful clients had been in achieving completion of their overall therapy contracts;

To determine numbers of women served in each of the three groups.

EVALUATION METHODS

The backbone of the evaluation is a blue form which serves as an initial demographic and drug use screening device. This form is completed on the occasion of her first appearance at Together by each woman who has in-person contact with Together's Women's Services program. These forms are then grouped chronologically into the three groups and coded into Fortran computer language. The data is then run by computer and analyzed for correlations, similarities and differences among the three groups; for target populations not being adequately served; and for the publicity mode best utilized.

In evaluating treatment success, a process has been established for not only tabulating success statistics from the question: Did the client eliminate drug misuse during treatment, but also for determining what small degrees of success were achieved during treatment. To do this the evaluation introduces "success modules," components of treatment success. A discharge form has been designed which asks questions such as what counselor-client contracts were established during treatment and which of these were completed; did the client obtain a desired job, or participate in job training; did a client participate in educational testing, take courses, matriculate or complete a degree; and, what groups and behavior change courses did the client attend/complete during treatment at Together.

Another means of evaluation are workshop and group evaluation forms which are filled out by the women participating in the group sessions. On this form the women briefly state what worked for them in the group or workshop, what did not work, and what they got for themselves by attending. This informal evaluation serves the triple purpose of (1) providing information to the primary counselor on her client's progress, (2) providing client feedback on the content and facilitation of groups and workshops, and (3) providing a vehicle for the client through which she can make concrete her own impressions and accomplishments.

EVALUATION RESULTS

At this writing all the evaluation data is available with the exception of the treatment success module information. The program is currently being written to computerize this information. For the purposes of this proposal a minimal amount of analysis was done by hand on the folders of the discharged clients to show the percentage of counseling contracts completed by successful clients, by clients who left without completing treatment and by the overall client population for 1978.

Statistics have been compiled on basic treatment and service at Together during the period from November 1, 1977 to October 31, 1978. During that period Together had 316 different women attracted to its Women's Services program. Of the 316, 119 (or 38 percent) stated use of drugs on their initial screening forms. This is an increase in the drug-using percentage of 37 percent this year over 1977. From this 119, 38 women fulfilled the admission criteria and were willing to undertake the responsibilities of client status. This is an increase in admissions of 67 percent over last year. This increase in outreach to the target population seems to parallel the increased efforts of Together in the area of outreach.

The staff presented 147 sessions of groups and workshops during this period. There were 1,586 participants in these sessions (including repeaters).

Staff counseled clients in 655 individual appointments, an increase of 18 percent last year. This increase was in spite of the fact that the client slot allocation remained the same. Staff counseled women who were not eligible to become clients in 218 individual appointments. There was an increase of 102 percent in counseling women who were not using drugs to cope with their problems. There seems to be some indication that, as we provide services to more women, more drug-using women are attracted to our services, perhaps because of the decrease in identification as a drug misuser.

During this period we discharged 30 clients. This year we had been hastier in admitting clients to the program, sometimes admitting them when they had only been seen once. Therefore we had more clients who left without completing treatment. Nine of the 15 who split without completing treatment left the program *before they had* 10 weeks of treatment. The percentage of successful completion of treatment for those clients who remained in the program at least 10 weeks was 53 percent.

The files of the 30 clients discharged in this period were analyzed to determine what percentage of counselor-client therapy contracts had been successfully completed. Clients who had been successfully discharged had completed 92 percent of their therapy contracts. Clients who had moved or had been referred to others treatment had successfully completed 72 percent of their therapy contracts. Clients who were by standard evaluation unsuccessful in eliminating drug misuse had in fact completed 24 percent of their counseling contracts.

It was no surprise to find that successful clients attended more group sessions than unsuccessful clients. The average number of group sessions attended by a successful client was 13 group sessions. The average number of sessions attended by a client who left without completing treatment was five.

This year, in the first year of computerized evaluation, Together has compiled 4 years of statistics based on the initial screening questionnaire which has been completed by 711 over the 4-year period. The analysis of the three groups of women seen in this program is based upon these 4-year figures. The first group of drug using women is represented by 355 women, the client group is represented by 125 women, and the remainder, 231 women, represent women who were attracted to the program by workshops and groups, but who were not using drugs to cope with their problems. The information from these 711 respondents was collected from July 1974, through October 31, 1978. At times the total will exceed the 711 total because certain questions permitted the respondents to check more than one category.

The following analysis of Together's data has been written by Dr. Pearl Bartell, a member of the Sociology Department of Glassboro State College:

Women come to Together for a variety of reasons. The largest stated reason is personal growth and development 279 (31.65 percent). The other reasons in descending order are: problems in a relationship 239 (30.69 percent); problems related to alcohol or drugs 51 (6.34 percent); and personal problems 49 (6.9 percent). The category of "other" was selected by 187 (23.23 percent) respondents. At this time there is no breakdown of this category.

The respondents are predominately 25–34 years of age, married and Euro-American. Interestingly, these findings also occur in the random telephone survey recently conducted by Together.

The respondents are divided rather equally between those who have attended or completed high school 288 (40.7 percent) and those who have attended or completed college 323 (45.7 percent).

Household income approximates provide interesting data on the range of participants that come to Together. The data is as follows: Under $5,000, 175 (24.8 percent); $6,000–$11,999, 172 (24.3 percent); $12,000–$17,999, 155 (21.9 percent); and over $18,000, 138 (19.5 percent). The remaining 67 individuals (9.5 percent) chose not to answer this item. This does indicate a good heterogeneous mix of women from a variety of socio-economic levels using Together.

Looking at the employment status of the respondents, more women tend to be employed full-time outside the home 221 (30.82 percent). Although Together is affiliated with Glassboro State College, only 8 percent of the respondents are full-time or part-time students. This indicates that they are definitely reaching the community as their primary target population.

The next broad area of information collected on the questionnaire is on drug usage. Drugs or medications have been used for physical or mental ailments by

205 (28.8 percent) respondents and socially or for recreation by 107 (15 percent) of the respondents. Three hundred and fifty-five women (49.9 percent) list that they are currently using drugs or medication. This seems to be a very high admission rate for an item that is probably often underreported. It may represent either greater drug usage than reported or great comfort with the confidentiality practiced by Together.

Eighty-five respondents (23.94 percent) of 355, define their use of medications or drugs as problematic. Sixty-one respondents would like to eliminate drug usage and 25 would like to control the usage.

Those currently taking drugs are interested in other services Together has to offer:

Individual counseling	110
Family counseling	9
Self-growth workshops and groups	38
Career information and general counseling	15
Other	6

The three main drugs/medications taken daily are tranquilizers/sedatives, Valium and Over-the-Counter drugs.

It is also interesting to see the primary source for the drugs women are taking. The primary source is doctors. This is quite significant when one considers that alcohol and Marijuana/Hashish are included in the listing.

The final material involved asking women if they were interested in participating in counseling. One hundred thirty-five women (19 percent) of 711, stated that they were interested.

When the data was run by dividing the population into three categories (non-drug users; pre-treatment drug users; and clients enrolled in the program), some interesting differences emerge from the data.

Another aspect of our study illustrates drug usage by reason of drug intake (physical/mental illness—recreation) and, type of drug by the three categories. What is immediately apparent is the increase in drug usage as one moves to the client status. The total incidence of drug usage under drugs for physical or mental illness show an increase from 27 (10.38 percent) for non-drugs users to 35 (12.15 percent) for the pretreatment group to 220 (78.47 percent) for the clients. The same pattern, although not quite so dramatic, occurs when drugs are used for recreation. Non-users have 21 (12.93 percent) instances, pre-treatment users have 58 (32.95 percent) and clients 97 (55.11 percent). Together is successful in recruiting the group with the greatest drug usage for either physical/mental illness or recreation for client status.

Although the correlations (Lambda) for self-confidence and desired amount of change by self-designated group were low (.20), there are certain items of interest. The most dramatic indicator is the no answer rate. These rates take a sudden jump for the client group to 51.3 percent and 50 percent respectively. It seems plausible that one has to have a certain level of self-confidence to deal with these questions at all. One also sees a decrease in self-confidence and a decrease in those desiring to change nothing about themselves from non-drug user to pre-treatment user to client. There is also an increase percent of those with very low self-confidence and those desiring to change completely through the same categories.

In conclusion, the program at Together seems to be serving a broad base of the community with approximately one-half of the women attendees currently taking some form of drugs or medication. Less than a quarter of these women define their drug usage as problematic. This may be explained by society sanctions and that the largest primary source for drugs and medications are physicians. Together has been successful in enrolling as clients those with the greatest drug intake and those who respond with less frequency to questions about self-confidence and desire for change.

A. GENERAL PLAN FOR THIRD PARTY RECOUPMENT WITH GOALS, OBJECTIVES AND TIME FRAMES

Together will contact the New Jersey Division of Narcotics and Drug Abuse Control by September 30, 1979 for technical assistance in developing a plan for third party recoupment for Together's outpatient, drug-free program.

B. OUTREACH PROGRAM

Together's program is designed so that much of the program provides outreach and treatment simultaneously. The Open Women's Sharing Group, the workshops and the hotline attract potential clients to the program.

The workshop calendar is mailed to over 2,000 addresses of persons who have requested to be on the mailing list and, as the budget permits, to all the homes in Glassboro or a nearby town through the postal local. All workshops are advertised in newspapers and feature articles are done whenever such coverage is warranted. Radio and TV interviews are given whenever requested or when arranged by Together's publicist.

In addition to the calendar and regular publicity, Together answers (and solicits, when staff time permits) local speaking engagements which have topics such as Assertiveness Training, Women and Tranquilizers, Self-Nurturing for Women, or a general overview of Together's programs.

Together has submitted a concept paper to the Division of Narcotics and Drug Abuse Control which, if funded, would provide staff for outreach and prevention work with health professionals and with the target population.

C. ANNUAL PROGRESS REPORT

1. Treatment

Together successfully met its matrix during the 12-month period from November 1, 1977 to October 31, 1978. The average number of clients enrolled in treatment per month was 25.4.

The other treatment goal of fiscal year 1979 was to successfully eliminate drug misuse in clients within a 6- to 18-month period. This year Together enrolled clients more quickly (after one session rather than two or three interviews) and thus had a higher splitee rate than in 1977. However, of those who stayed in the program 10 weeks or more, 55 percent successfully completed treatment.

The program has had some problems with meeting the requirements for the New Jersey Department of Licensing and Standards. Most of the problems were easily corrected, but on two points the program experienced some difficulty. One was on the requirement that drug programs do urine monitoring.

Together held strongly that not only was it contrary to Together's treatment philosophy to do urine monitoring, but also that it was impossible to serve our particular population with such a requirement. A poll of clients confirmed staff intuition on this point and verified that most clients would drop out of the program if required to submit to the urine testing. They saw the urine testing as a suspicion of their dishonesty and as humiliating.

A rationale was written up along with an alternative plan for monitoring the progress of clients in Together's program. It was presented in August, 1978, to Dr. Solomon Goldberg, Director of Licensing. We are still awaiting action by Dr. Goldberg on the alternative plan. The other licensing regulation with which Together had difficulty was the requirement that a client receive three hours of counseling per week. That is also a problem given Together's client population. The women in the program were used to the mental health model of seeing a counselor once per week for an hour. Although some clients can and do come to group sessions weekly, the majority cannot or will not arrange for that frequency of counseling. However, the staff is now making a strong attempt to encourage clients to attend a special group (the closed client work group) or to attend other short term workshops or series workshops to meet the required 3 hours of therapy per week. At this time roughly one-third of the clients meet the requirement and staff counselors include group treatment on every treatment plan.

The treatment staff increased this year. Together continued to have the same number of counseling hours paid by the Statewide Services Contract, and acquired new counselors from the Glassboro State College Work Study force and from volunteers. A system was designed whereby hotline counselors who wanted to get training in and to do individual, group and family counseling could join an apprenticeship program which involved them with counseling and counseling training simultaneously. The Women's Services program had two paid work study students and seven volunteers involved in this program in recent months. The participants began by taking notes in group sessions and contributing as co-counselors as they began to feel comfortable doing so. The note taking during group sessions increased their awareness of counseling techniques and group process. At the same time participants came to a weekly 2-hour counselor training

group which taught advanced Active Listening, problem solving, gestalt therapy and Transactional Analysis.

The training process used didactic methods, practice group with counselors taking turns using their own real problems while their peers counseled them, and videotape feedback and discussion. For the last month of each course, counselors-in-training were assigned clients and given close supervision.

At the close of the progress report period Together received an extra allocation of five treatment slots. For several months prior to that allocation, Together had had a matrix at 8 percent above its funding which exerted a strain on such a small program. The Single-State Agency responded with additional slots that will enable Together to increase its paid counseling hours by nearly 50 percent.

Both paid and volunteer counselors were provided with additional training at the Training and Education Center (TEC) in Trenton. Courses they have taken include Behavior Modification and Effective Communication in Relationships. Counselors also received training at several conferences they attended such as the Displaced Homemaker, New Jersey Women and Alcohol, the New Jersey Private Drug Treatment Conference, and the Garden State Crisis Intervention Association Conference.

One of the program goals of the Women's Services Program at Together was to organize volunteers to take over some of the non-counseling work of the agency on a trial basis. One of the work study students and a volunteer organized a program for persons who wanted to do office work, babysitting and other projects. Much typing and filing was accomplished through this project and the project is expected to continue under the direct and consistent supervision of a volunteer.

During the period of the progress report, Together staff ran the following number of sessions of the following workshops:

Open women sharing group	52
Assertiveness training	19
Coping with stress	17
Client therapy group	13
Client contract group	8
Getting a job	5
Do-it-yourself car repair	4
Women in transition	4
Men's and women's communication	4
Self-nurturing	3
Surviving a loss	3
Finding time	2
Parent sharing group	4
Rape workshop	2
Meditation	2
Anger	2
Sexuality	1
Communication	1
Macrame	1

A Woman's Resource Library was organized and completed this year. It is housed in the attic of the building and contains books and materials of interest to clients and staff.

Together is audited by the Region V Office of the New Jersey Division of Narcotic and Drug Abuse Control. There have been recent changes in the audit procedures and Together has received two written site visit reports in this progress report period, one from a review of case management and treatment process in July, 1978 and one on organization factors in October, 1978. These audits are included in Appendix F-5.

2. Outreach and publicity

Together's outreach effort was aided this year by Betty Ford who announced in early April that she had a problem with misuse of prescription drugs.

Much publicity for the program was generated from the media's interest subsequent to her announcement. A former recipient of services at Together appeared on the Joel Spivak Show and Eye On, two Philadelphia based shows and a short sequence was shown of her on the NBC-TV News, New York.

Prior to Ms. Ford's announcement the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) had approached Together to do a feature article on the prescription drug treatment for women at its program. Their staff wrote

a fine article and published it in the national circulated ADAMHA News. It was published at approximately the same time as Betty Ford made her

While attention was focused on the issue of women and prescription drugs, Together was invited to be represented on a panel at the New Jersey conference, Women and Prescription Drugs, held in Princeton in May, 1978. Staff also presented a workshop at the Glassboro State College conference for women, Guideposts, entitled: Women and Tranquilizers. This workshop was partly the research of Dr. Robert Seidenberg, a Syracuse, New York psychiatrist. Dr. Seidenberg had done much published research on the topic of women and prescription drug advertising in medical journals. It was also the work of Susan Rovello, a counselor and work study student at Together. Dr. Seidenberg was kind

enough to let Together duplicate his slides of actual drug ads in 10 years of medical journals. Together developed a slide show presentation from these, from slides taken by Ms. Rovello and Dr. Seidenberg's research and Together's supportive data.

As a result of the increased awareness of the problem of misuse of drugs by women, Together decided to attempt more blatant outreach to the female drug misuser. A workshop was advertised entitled, Women and Medication. Staff were surprised when only a few persons attended. Most were agency personnel. It was decided to try again. A local township Board of Health decided to gauge the interest of the community in such a workshop. The Board ran ads in the local papers soliciting inquires about such a workshop. Again, there was very little response. The Board decided not to sponsor the workshop. Together put it on the calendar once more. This time only one person (a nurse) attended despite wide local publicity. The staff has concluded that women do not identify drug misuse as their presenting problem and/or if they do see it as a problem, they are not willing to publicly identify themselves as ones who have this problem. As a result of these experiences and conclusions, the program will not offer this workshop again except to agency personnel or as part of other workshops such as Dealing with Doctors or Depression.

One result of these experiments with the drug workshop was that the program decided to hire a consultant who once had the problem of misuse of drugs to devise and pres nt new workshops which might appeal to women from their own perspective of their problems.

The staff continued to interface with other agencies and groups both as members and as program speakers.

Together staff belong to the local Women's Support Services: the Gloucester County Human Services Coalition; the Mental Health: Alcohol and Drug Abuse Task Force of the Southern New Jersey Health Systems Agency; the Region V Advisory Group on the Drug Abuse Treatment of Women, the New Jersey Task Force on the Drug Abuse Treatment of Women, and the Garden State Crisis Intervention Association.

Together staff have spoken this year at local libraries' mothers' groups, local JayCeettes, at organizations of University Women, the Contemporary Club, N.O.W. chapters and have spoken on various local radio shows.

Together staff has provided training to other human services personnel such as those at women's centers, at a law enforcement seminar; at hotline counselor training; at the Garden State Crisis Intervention Association Conference; at training for rape crisis counselors and at the New Jersey Training and Education Center's Women in Treatment course.

3. Evaluation

Together designed a new system of evaluation of outreach and treatment during this year. Faculty from Glassboro State College were involved in the design and in this year's analysis. Volunteers were utilized in the data collection and coding.

Together as a whole (including Youth Services and Crisis Services components) developed and ran a random telephone survey in the local area to assess the need for services, the recognition of Together as an agency, and Together's various services by the community at large. There were also questions specific to Together's various target populations. The survey was conducted by speaking to one woman from each household called in a random selection of phone numbers from two adjacent local exchanges. The surveyors completed 293 questionnaires, giving staff much data on our local population. A more in depth account of the survey is to be found in Together's Application for Health Service Contract under the section entitled Existing Problem or Need.

5. Other funding

Attempts at seeking funding additional to the Statewide Services Contract treatment slots have been only moderately successful. Together received a grant from Gloucester County CETA to provide the Women's Services component with a Grant Developer position. The program had much difficulty finding a suitable applicant for this position. The program has now hired a qualified, competent grant developer who supervised the final stages of the program's 4-year evaluation. She will be working on obtaining monies for outreach, prevention and community paraprofessional training.

During this past year we completed work on a de facto Certificate of Need for the programs move to treatment quarters across the street. The staff also submitted a concept paper to the Division of Narcotics and Drug Abuse Control for an outreach and prevention project.

CLIENT INFORMATION SHEET

Welcome to the Women's Program at Together. Since you have expressed an interest in becoming a client, here is some important information for your consideration.

The staff is comprised of reputable feminist counselors whose main interest and concern is their clients' individual growth and development. Health, educational goals, employment/vocational goals, legal, and psychosocial development are the areas we work with.

In addition to individual counseling, we offer couple counseling, open groups such as the Wednesday night rap group, closed client groups, and workshops of special interest. Participation in the groups and workshops that are appropriate to your individual needs is an integral art of being a client in our program.

You will be asked by your counselor if you have had a physical and PAP smear taken in the last six months. If so, then you will be asked to sign a records release form for that medical information to be forwarded to your counselor. If you have not had the physical examinations, as a client you are eligible to receive them free of charge. You or your counselor will call the Gloucester County Family Planning Clinic to arrange an appointment for you. The physical will consist of taking your weight, height, temperature, pulse, respiration, blood pressure, work, routine urinalysis, PPD skin test for T.B., a PAP smear, and a pelvic examination. It is, of course, your option if you wish to obtain these required services from your own physician, at your own expense. If anything shows up that needs to be taken care of, you will be referred for further free tests and/or told what treatment seems to be indicated.

Your intake counselor will fill out a data base form with you, which consists of family and personal information. This form is designed to gather and organize a complete and comprehensive assessment of your needs. Any and all information is kept strictly confidential. Your name is deleted from all records and replaced with an identification number. The files are kept in a locked, fireproof file cabinet to which only counselors have keys.

In order to remain active in the program, you are required to receive services at our facilities a minimum of twice a month. Generally, you will meet with your primary counselor for an individual session once every 2 weeks, in addition to group work.

Should you decide to become a client in the Women's program at Together, we ask that you agree to be involved with us for a minimum of three months.

Feel free to map out concerns and areas of interest with your counselor.

OTHER GROUPS, WORKSHOPS, AND SERVICES AT TOGETHER

1. We have two women's bulletin boards, one in each building. We try to keep it current with things of interest to women. Feel free to post anything you want to share with other women.

2. We publish a schedule of events which list the groups and workshops available here. We welcome you to offer suggestions for future workshops and events. When you fill out a 3 by 5 card with your name, address, and zip code, you will be put on the mailing list. This will be attached to a statistical form that serves two purposes; it gathers data for funding purposes, and it provides information that helps us to determine who is eligible for additional services.

3. A reminder that our local number is 881–1010, for contacting staff, general information, rap, counseling, crisis intervention, and pre-registration. We have

a toll-free (within N.J.) number for women's referrals and information: 800–322-8002. Both numbers are answered 24 hours a day, 365 days a year.

4. We have a lot of miscellaneous resources (both people and paper) to share if we know what you need and want. See a staff member.

5. The Women's Program offers the following:

Open Groups.—Anyone welcome anytime.

Closed Groups.—Enrollment is closed after the first meeting.

Workshops.—Groups on specific topics: self-growth, social, health, career, or relationships. Workshops offer practical information and exercises that deal with specific issues.

Counseling.—We are funded to provide individual counseling for women who are using prescription, over-the-counter, or street drugs as a means to cope with stress and surviving. Other individual counseling is available on a limited basis.

Couple Counseling.—On a limited basis.

INTAKE PROCEDURE

1. Give potential client the information sheet.

2. Explain being a client:

(a) Individual session bimonthly;

(b) Group involvement required;

(c) Medical work—reassure them that the women at Family Planning are caring, efficient, professional. We need the info for making sure everything's OK, and as a requirement for our files;

(d) First preference for all groups and workshops, access to closed client groups;

(e) Give her a calendar and a Wednesday night rap group orientation sheet.

3. Ask her what she wants to get from counseling and write it down.

4. Explain that she will need to make a 3-month committment to the program in order to be accepted.

5. If she is still uncertain, give her time to think about it, with the responsibility for calling back being hers.

6. If she makes the committment, do data base starred items. Write client's name, address, and phone number on an index card and attach it to the data base rather than writing it on the form itself. Assign her to a counselor.

7. Have client fill out a demographic form.

8. For homework, have her write down her goals in counseling and an approximate time period to work on these. This is to be shared with her regular counselor.

9. Have her call family planning at the end of the appointment and record the time of her appointment with them.

10. Give her a filled out medical release form to take to Family Planning. Tell client that counselor will call her in a few days.

11. Put a note in the counselor's box with the client's name and number.

12. Put client's folder in intake file under Assigned Clients.

13. Write the counselor next to the client's name in the staff minutes book.

For those potential clients whose phone numbers are unavailable, send the form letter, an orientation to the Women's Rap Group, and a calendar to them through the mail.

PHYSICAL EXAMINATION INFORMATION

1. Weight _____
2. Height _____
3. Temperature _____
4. Pulse _____
5. Respiration _____
6. Blood pressure _____
7. Eyes _____
8. Ears _____
9. Nose _____
10. Throat _____
11. Abdomen _____
12. Chest Sounds _____

Physician's Signature _____

Please attach xeroxed copies of the laboratory results of the following tests: Health Screen I (SMAC): AIG ratio; albumen; alkaline Phosphatase; bel-

rubin; total calcium; cholesterol total; creatinine; globulin; lactic acid; phosphorus; protein total; transaminase SGO; urea nitrogen (BUN); uric acid; routine urinalys's; skin test for TB; PAP smear; GC.

Thank you.

ORIENTATION TO WOMEN'S RAP GROUP

Welcome to the Wednesday Night Open Rap Group sponsored by the Women's Services Program at Together.

The Women's Group is a listening and sharing workshop, a warm, secure, safe place in which individual problem-solving and general issues pertaining to women are the agenda. We also enjoy hearing women "brag" to each other about our changes as individuals.

We ask that each person in the group observe the following group norms which help make the group a source of support and help to all:

1. Every group member is asked to *keep confidential what happens in the group.* You are free to share what happens with you personally in the group with other people, but what happens with other women in the group *must* be kept confidential.

2. When problem-solving is in progress, *try not to do or say anything that will distract* or confuse the person working on the issue.

3. We ask that each group member *share feelings honestly* and to help others in the group to do so. This works better than telling stories or hearsay, for example.

4. It helps others to share by *refraining from advice-giving.* It works better to share what your experience was or is, and how you worked it out. It is important to remember that what worked for you may not work for someone else. One example of owning what you say is by prefacing your comment with "This is what works for *me*," or "What works for *me* is . . ."

5. We have a system of what we call "*check-ins*" and "*check-outs*," which simply means that we introduce ourselves to the group with our first names, and *share how we are feeling at that moment* (for example, happy, sad, energetic, angry, peaceful, etc.). This is a good time to announce if you plan to leave the group early, or if you need to take time to deal with an issue in that session. At the end of the session, we *check-out* the same way.

6. There is *no smoking* in the room the rap group is held in. However, smoking is permitted in the hallway (at 7 State St.) and in the rec room (10 Delsea Dr.).

COPING WITH STRESS

Course goals

1. Provide supportive environment for experiencing stress for the individual and for group awareness.

2. Provide tools for understanding and handling stress and to increase the knowledge of forces that shape our inner and outer selves. (relaxation, assertiveness, T.A.)

3. Create context in life to include stress.

Group contract

1. No smoking during session.
2. Time commitment.
3. Participants will notify together if a session will be missed.

Facilitator's contract

1. Facilitator present at all meetings.
2. Hot line and facilitators available during weeks for crisis, 881-4040.

Course outline

1. Relaxation techniques.
2. Awareness techniques.

Topics concerning the following:

Tension, positive self image, burn out, assertiveness, time structuring/goal setting, nurturing, rational thinking.

Definition

Life—A game with rules, goals, risks and umpires.

Stress—Pressure, strain. A force that tends to distress the body Nervous tension.

Cope—To struggle to overcome problems or difficulties. To put up with.

Handle—To deal with.

PREPARED STATEMENT OF DR. ROBERT SEIDENBERG, PSYCHOANALYST AND PSYCHIATRIST, CLINICAL PROFESSOR OF PSYCHIATRY, UPSTATE MEDICAL CENTER, STATE UNIVERSITY OF NEW YORK AT SYRACUSE

1979: DOES MISOGYNY STILL SELL MIND-DRUGS?

Ten years ago, this author reported the blatant sexism and prejudice against women depicted in medical and psychiatric drug advertisements. Since these "messages" were obviously designed both to attract the attention and approval of the physician, I asked, "Does Misogyny Sell Mind-Drugs?" Since then many experts and observers have confirmed that (1) the chief target for psychotropic usage indeed is women: and (2) their representation in the advertisements are on the whole entirely reprehensible, qualitatively, and quantitatively.

For some of us, sadly, there is little wonder or mystery why twice as many women are "receiving" tranquillizers as men.

The present abbreviated presentation is a (lack of) progress report. (Many in the pharmaceutical industry claim that the advertisements have vastly improved in the last decade.) I have found scant improvement, and taking into account the run-away proliferation of "throw-away" periodicals in the last few years and the continuation of bald sexist content, one can see only an intensification of the drive to tranquillize. (Figures I, II)

There is only one area that has improved: the appearance of females as physicians is now occasionally seen. (Figure III) I repeatedly brought this "discrepancy" to the attention of the pharmaceutical industry in the early '70's. On the same figure (III), however, there appears a bit of ongoing deception in the promotion of Stelazine that should be stopped. On the left, the caption reads: "Your patient's "excessive anxiety" (quotes mine) is enough to worry about." However, in the fine print (on the right) the FDA has classified the indications for this major tranquillizer as effective in the management of "psychotic disorders" (quotes mine). Again, in small print, we read that it has been determined that this drug is only "possibly" (quotes mine) effective in controlling "excessive neurotic anxiety."

The reasons for this questionably ethical representation are quite apparent: the market for "excessive neurotic anxiety" is far greater than for psychosis, and the patient with the former condition is more likely to be under the care of the general practitioner or internist than psychiatrist. Now over 70 percent of the psychotropic drugs are prescribed by physicians other than psychiatrists.

Figure IV represents another continuing and unchallenged abomination wrought by the pharmaceutical companies, that of gratuitously manufacturing new metabhorical "diseases" and "syndromes" for which their drugs are to be used. In the past, they have created "empty-nest syndrome," sleep-cripple," "office-fixture," and neologism, "copelessness." Here (Figure IV) we see their new "stigma" for the elderly woman, "sundown syndrome." There are many experts in the field of geriatrics who feel that the use of tranquillizers here is a form of social control, diminishing the ability of the elderly to make their needs known.

The virtues of surrealistic art aside, the one-dimensional draping of a woman's body with her walker, over the letters of "PAIN" does little to enhance the image of that sex, as seen in Figure V. Again, the portrayal of women passively and recumbiently "dissolved" in pain is an all too familiar false stereotype. Men are never depicted in this pejorative manner.

Figure VI carries on an apparently fruitful advertising tradition of identifying women with pills—up to her ears in them. Here, "their" pill is supposedly the better one—to replace the others. Unwittingly, Sandoz herein projects graphically their industry's "success" with women.

This advertisement fosters and promotes the image of women as "pill-popper" as well as of that sex with the ubiquitous "headache."

The woman as child is an all too familiar theme in drug advertisement. Here, in Figure VII, she is shown on a merry-go-round. The phrase, "going around in circles" does little to enhance her value as a responsible and employable person.

The mythology of "changing" people with the use of drugs by the medical profession is one of the cruel hoaxes of our times. How ridiculous it sounded in the 60's when the "kids on the street" gave this as the rationale for doing their drugs. Figure VIII shows the distraught, disheveled female mental patient seeing everything and everyone, including the approaching male, in a negative way—"everything I saw was negative." The advertisement tells us that the anti-

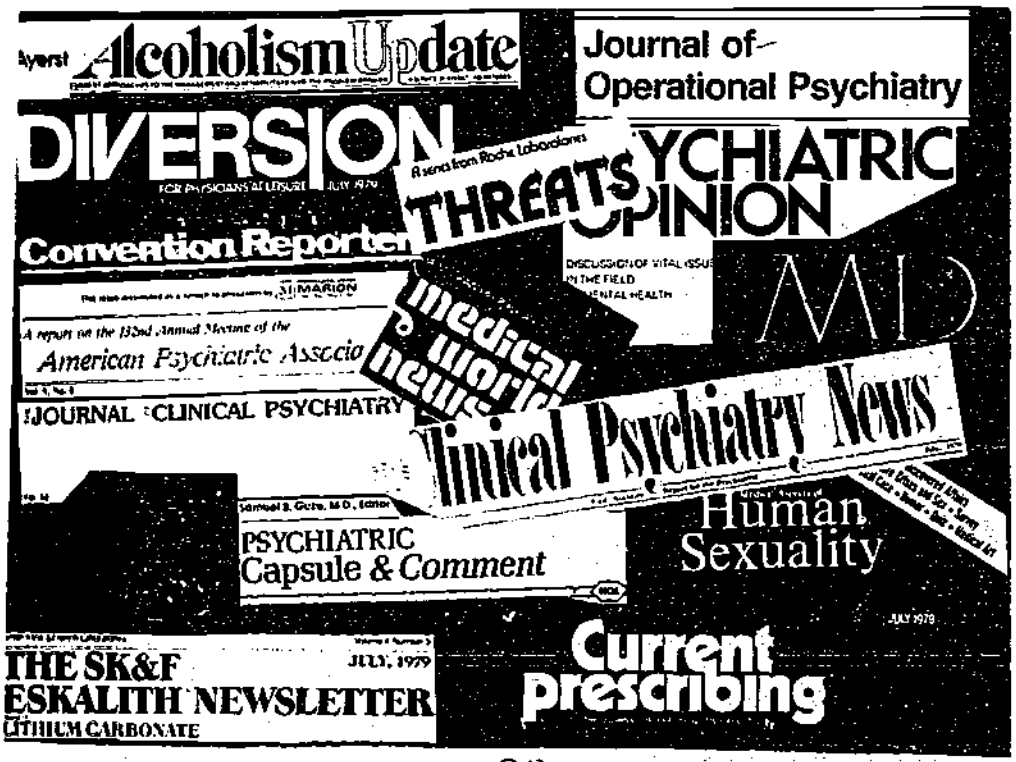
depressant, Norpramin, "helps change her world from negative to positive." One might add parenthetically that many men today would dearly welcome being seen more positively. It is hoped that this could be accomplished without having to drug "the other."

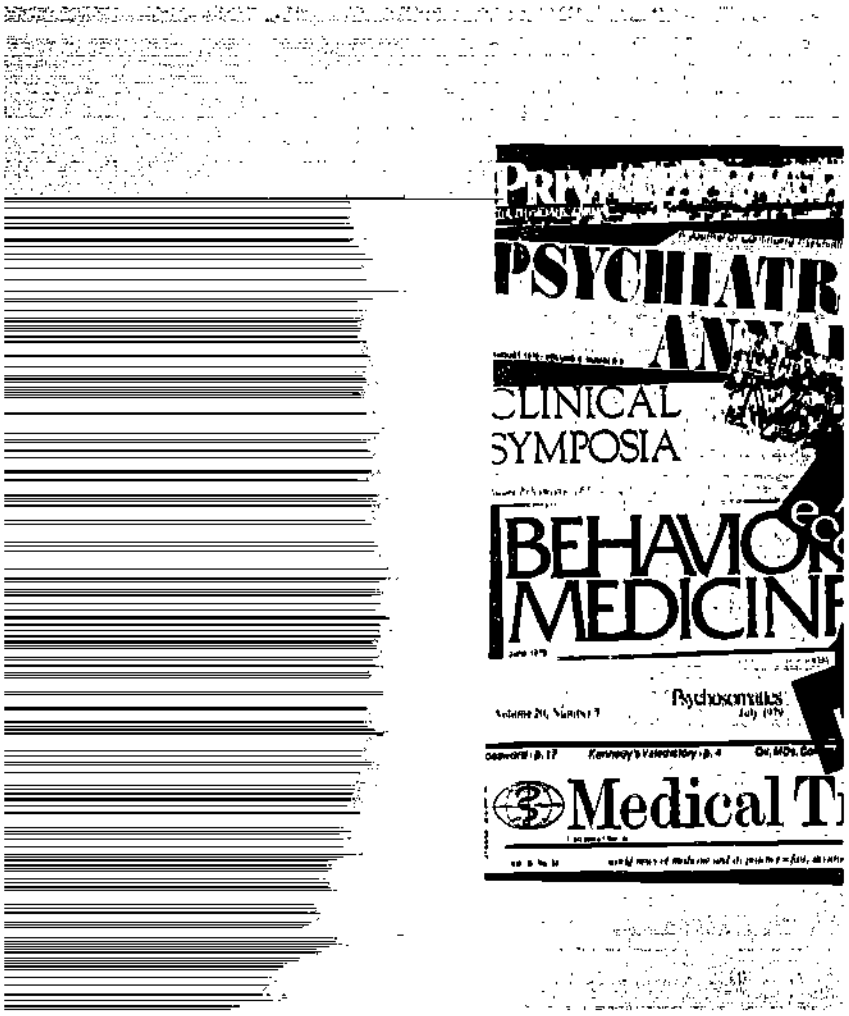
Lastly, we see in Figure IX, an inglorious theme that surfaces too frequently in these drug advertisements. This is the ironic dehumanization of psychiatry's own client, the mental patient, here again, the woman. She is depicted in this figure diminutively as the captive or caged bird (here in an ungilded cage). Whether descriptive or prescriptive, this illustration sets people (patients) apart as a deranged, animal-like class, a pejoration which we generally deplore when expressed by the unsophisticated. Is it accidental that the "caged bird" is a woman?

The horrors of prescription, mind-drug promotion have barely been exposed in this brief discussion. Obviously affecting all patients, there is little doubt that women have been and are maliciously the prime targets for this exploitation.

To resist and counter this massive onslaught is noble work indeed!

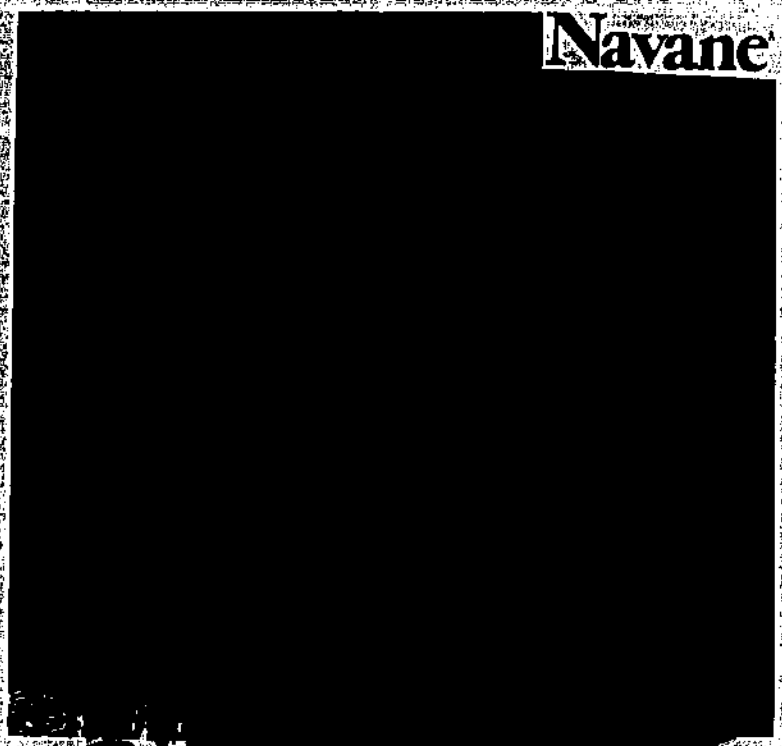
Figure 1


Alcoholism Update
Journal of Operational Psychiatry
DIVERSION
FOR PHYSICIANS AT LEISURE
A series from Roche Laboratories
THREATS
YCHIATRIC
OPINION
Convention Reporter
DISCUSSION OF VITAL ISSU
IN THE FIELD
MENTAL HEALTH
MD
A report on the 132nd Annual Meeting of the
American Psychiatric Associa
JOURNAL CLINICAL PSYCHIATRY
Medical World
Clinical Psychiatry News
Samuel B. Guze, M.D., Editor
PSYCHIATRIC
Capsule & Comment
Human
Sexuality
JULY 1979
THE SK&F
ESKALITH NEWSLETTER
LITHIUM CARBONATE
JULY, 1979
Current
prescribing


PSYCHIATR
ANNA
CLINICAL
SYMPOSIA
BEHAVIOR
MEDICINE
Psychosomatics
Medical T

A SERVICE FROM SANDOZ PHARMACEUTICALS
HYSICIAN
PEAKS
rnal of Continuing Education in

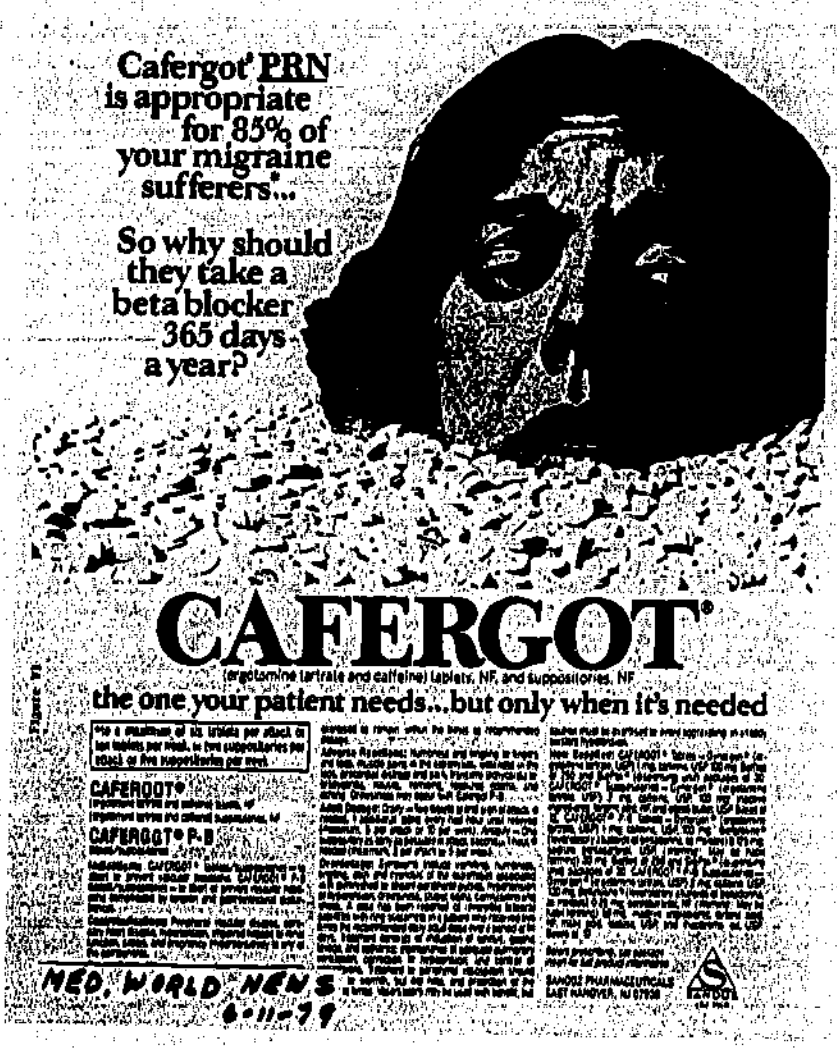

DRUG THERAPY 10/19
Tab
SK&F CO.
a SmithKline company

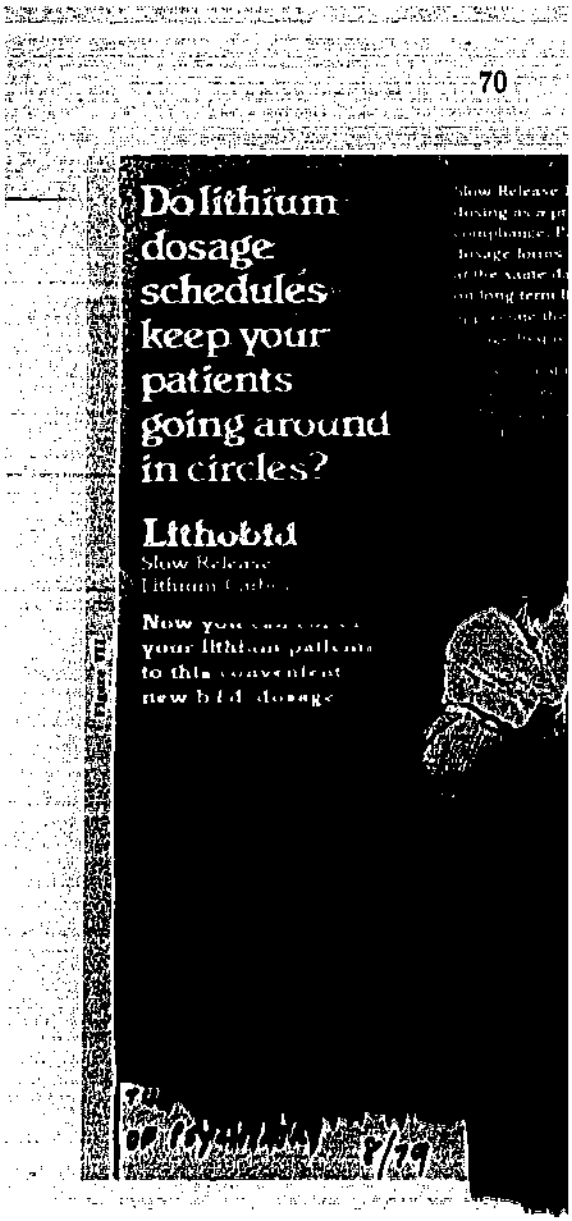


Sundown Syndrome.

PRIVATE PRACTICE 4/2

Darvoce


Cafergot® PRN is appropriate for 85% of your migraine sufferers*...
So why should they take a beta blocker 365 days a year?
CAFERGOT®
(ergotamine tartrate and caffeine) tablets, NF, and suppositories, NF
the one your patient needs...but only when it's needed
CAFERGOT®
CAFERGOT® P-B
MED. WORLD NEWS 6-11-71
SANDOZ PHARMACEUTICALS
EAST HANOVER, NJ 07936


Do lithium dosage schedules keep your patients going around in circles?
Lithobid
Slow Release
Now you can
your lithium patients
to this convenient
new b.i.d. dosage
8/79

DRUG THERAPY 9/78

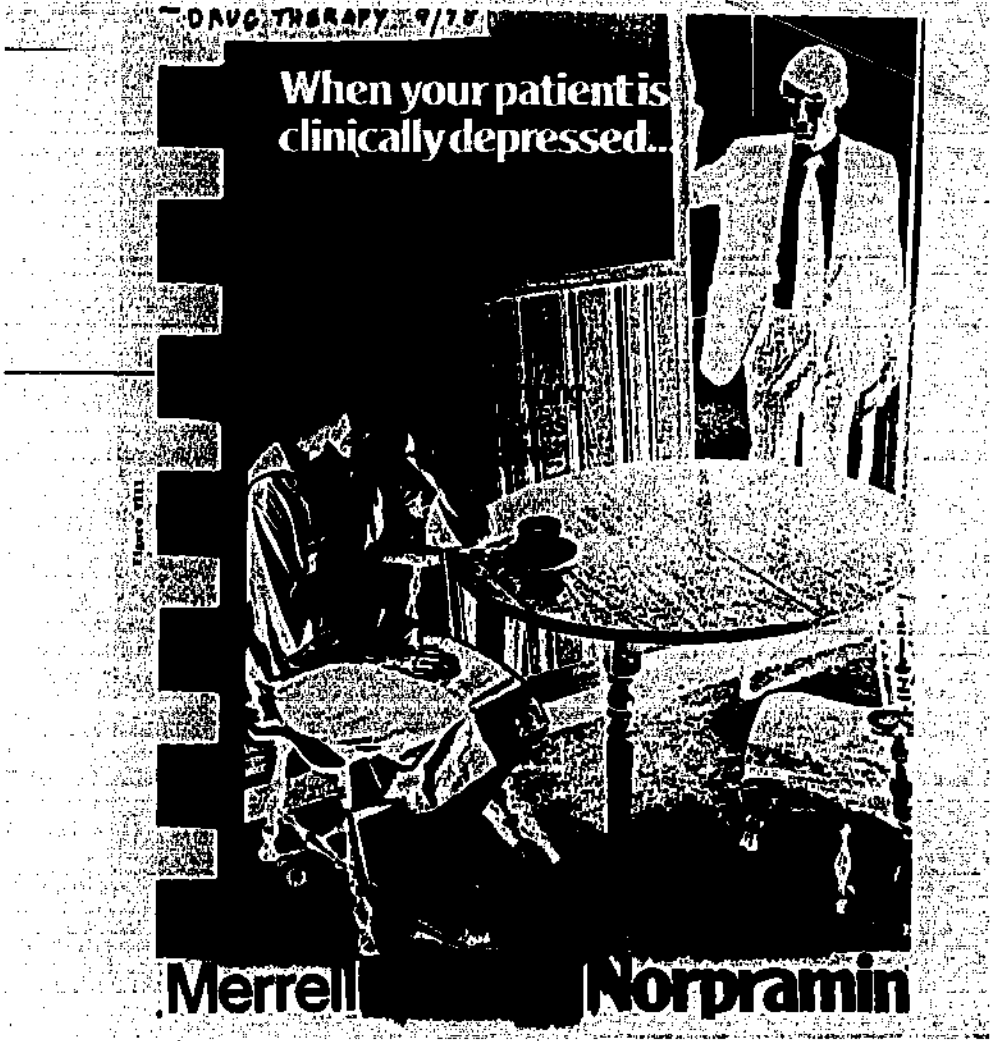


Figure 11

PREPARED STATEMENT OF DORIS DELUFF, EXECUTIVE DIRECTOR, DRUG LIBERATION PROGRAM, STAMFORD, CONN.

Drug Addiction—or its treatment—as social issues go, is not a dinner jacket affair which people clamor to attend. Except for those courageous few who admit their addiction to the drug alcohol, addicts recovered from dependency on other drugs do not tend to surface in the halls of Congress—or in corporate executive suites—attesting to their personal addiction, and, hopefully, their recovery experience. Thus encouraging others who are still struggling through the recovery process—or who have yet to take the first step in that direction.

As someone who has worked in the yet-infant field of addiction for the past 10 years, and one who is, along with many others, battling the constant frustration of pounding on impregnable doors and ears, begging for attention and funds to treat this human cripple, I must express my relief and gratitude for being allowed here today to share with you what I, along with my colleagues at the Drug Liberation Program in Stamford, Connecticut, have learned about treating women substance abusers and dependents.

I need not, I'm sure, dwell on the overwhelming statistics which prove the number of women who are already drug dependents, let alone those who are at risk of becoming one, robbing us, their children and their families of precious and irreplaceable human resources. Suffice it to remind ourselves that in 1976 alone, close to 200,000,000 prescriptions for legal drugs were written for tranquilizers, opiates and sedative hypnotics. That ⅔ of all these prescriptions were written for women. That 57 million of these same prescriptions were for Valium, which is the primary cause of drug-related visits to hospital emergency rooms, according to the H.E.W. And that there were three times more overdoses of Valium than heroin last year, with that drug ranking fourth in emergency room deaths. That 60 percent of all drug-related emergency room visits were made by women, with women accounting for 43 percent of all drug-related deaths.

To help you understand why and how we at the Drug Liberation Program in Stamford, Connecticut, have, since 1972, accumulated considerable experience in treating women, let me briefly describe our agency to you. We are located in Fairfield County, which includes most of Health Systems Agency Region 1, with a population of 831,000 of Connecticut's 3,174,774 people in 1978, and of which 51.5 percent are female. While this region has the highest per capita effective buying power ($8,100) its residents, white, black, Hispanic, run the gamut from the affluent suburbanites to the impoverished, deprived inner-city ghetto dwellers—all of whom are linked by a commuter transportation network to New York City and sit directly astride the drug distribution network radiating from it.

The four towns which are the basic catchment area served by Drug Liberation Program's 7 out of 8 treatment units have a combined population of more than 207,000. But Greenwich is as close to New York as Connecticut gets, and Stamford, although now the nation's second highest concentration of corporate headquarters, is, for its many commuters to New York, a bedroom town. This proximity to our neighbor has its proven effects on the extent of drug abuse in our area. In 1978, Region 1 had 32 percent (5,317) of Connecticut's first and readmissions to drug treatment, although the Region accounts for only 21 percent of the state's population. In 1978, Stamford alone, with a population of approximately 107,000 had 3.5 admissions to treatment per 1,000, a rise of 19 percent over 1977.

Well before the issue of women and drug abuse began to receive the special focus it demands, this became a major concern in our Agency. We took concrete steps to deal with treatment for women—and its improvement. We knew, from experience, that new-traditional approaches to treating women heroin addicts in most therapeutic communities were not only proving ineffective, but were often degrading to those women. The unwillingness, sometimes the inability, to recognize the woman's special needs—and to address them in the treatment process—translated into the unfortunate fact that many women who needed treatment, resisted it. And that those comparative few who did get involved would not remain involved very long. Unless they were willing to endure the double standards imposed on them by overwhelmingly-male staffs whose own attitudes toward women may have contributed more to the problem than the solution.

Yet those men should not be faulted or condemned. The attitudes they owned and mirrored in their treatment programs were, at best, a reflection of society's views.

Our whole staff zeroed in on "Women in Treatment." As a multi-modality program, funded to treat 395 clients in our eighth and final direct grant year through the National Institute on Drug Abuse, we have been described by one of that agency's representatives as one of the largest and most complex drug treatment programs in the nation. Even before the recent addition of our 8th and special treatment unit, the Women's Center in Stamford, for the treatment of women polysubstance abusers, the ratio of our female clients in those units was already higher than those being treated on a nationwide or statewide level. Common sense, if nothing else, dispelled any temptation to complacency. More had to be done—and done differently—for our women clients—and for those women whose involvement in drugs should have made clients of them.

We formed an internal agency task force, of both male and female staff, to take a long, hard look and make recommendations. A series of workshops followed, for all staff. Of very special value, incidentally, were the contributions of one staff member who was hipsent a graduate of a therapeutic community where he met a female resident who later became his wife. The inequities she'd struggled with there—the vivid recollections he still carried of how inappropriately women had been treated in some residential therapeutic environments—were a goldmine of enlightenment and direction for all of us.

Changes in staff awareness and attitudes were the most important factors in the modifications we effected. And, once the changes were made, having enough women on staff to work with women clients toward raising their self-esteem and finding their own identity has undoubtedly played a crucial part. We incorporated into treatment more special groups for the women. We added more family counselling—and client/spouse counselling. We made doubly certain that recreational activities for clients were geared to include and appeal to women. Our education and vocational skills development programs were revamped.

The results of our concentrated efforts on behalf of women in treatment were rewarding. During 1978, and before the opening of our Women's Center, our overall Agency client admissions consisted of 32 percent women (164 out of 515), as compared to 25 percent in the state and 28 percent in the nation. As of August 31 of this year, with the Women's Center having been actively operating since June 1, the numbers of women in treatment at the Drug Liberation Program have increased to 38 percent of our client caseload. Even if we subtract the 20 women then involved in the Women's Center, our overall female percentage is at 34. And we note with gratification, that our female client retention rate has noticeably increased, particularly in the coed residential program, where women have always tended to cut their treatment time well before the recommended duration.

But what about those women addicted to "legal" substances, such as prescription medication, often in combination with alcohol? They'd been out there for a long time now, unnoticed, untreated, with the scope and intensity of the problem growing at an alarming rate, with heartbreaking consequences not only for those women who are themselves more often than not unaware that they are addicted, but for the others around them whose lives are directly affected as well.

From our experience in treating other women, we could anticipate the more obvious difficulties in attempting to treat this particular group. They were not likely to accept treatment at a place identified as a drug abuse agency. They would certainly resist the notion of identifying themselves as addicts, let alone co-mingling with those addicted to street drugs and the life style that must often involve. They would be older than other types of drug-dependent women, we thought, often middle-aged, often with children for whose care they could not arrange during the mother's involvement in treatment. We believed these women would have many more medical and, possibly, psychiatric problems than many of the people using common street drugs. They might well be women who had been encouraged to be dependent on others. They would probably respond better, at least in the initial stages of treatment, to women staff members who would be regarded as less threatening than men at that sensitive period.

We designed our concept of a treatment program for the women polysubstance abuser incorporating accommodations for her children on a residential basis, submitted it to NIDA, and were fortunate enough to be funded for part of this program. Getting it started was not one of our easiest undertakings. Locating the physical facility, one which we could afford, preferably in an accessible but residential neighborhood in what is one of the highest rent areas in this nation, was in itself enough to make a stout heart faint. But located one we finally did: a 13-unit brick apartment building in Stamford.

There were many assurances to be made to our neighbors in surrounding buildings—and much to be done in educating the community, including the medical community, to the concept of—and need for—the Women's Center. Rinse, newspapers, magazines, and talk, talk, talk. We had hoped to renovate at least the ground floor of the apartment building, but as time went on we said, "Forget it!" We'll make do, at least for now, and retain the apartment layout.

And then, of course, came the search for staff, as we envisioned them of course at the low and hardly-competitive salaries necessitated by all the other essentials to be squeezed out of a tight budget that could in no way afford all the kinds of treatment services required for appropriate care of these women and their children. It helps to start with a good track record and community support to fill in the gaps. That we had.

We opened the doors to the residential component of the Women's Center on June 1 of this year. As of August 31, we had seen and evaluated 32 women, 20 of whom had entered into treatment, and a total of seven young children in residence with their mothers. Before I tell you what we have learned about these women, let me describe how the program is structured.

WOMEN'S CENTER

6 Washington Court, Stamford, Connecticut 06902, (203) 359-3040

The Women's Center, a free-standing treatment facility of the Drug Liberation Program, is located in a residential section of downtown Stamford. Specifically designed to meet the treatment needs of women polysubstance abusers 18 years or older, its unique program structure allows women to keep their children with them during their treatment stay. The Women's Center serves the entire state of Connecticut, and is open to out-of-state residents as well.

The purpose of the Center is to offer definitive care to women who have been abusing one or more of a variety of drugs (sedatives, minor tranquilizers, other prescription medications, etc., often in combination with alcohol). This type of total treatment experience in a drug-free milieu is intended to provide maximum opportunity for clients to reconstruct their lives.

Evaluation is done on an outpatient basis and includes an intake interview, urine testing for drugs and alcohol, a psychiatric assessment, and review of any medical/psychiatric/substance abuse information from the referral source.

Routine detoxification can be accomplished within the residential unit, but currently addicted clients with a history of medical problems or complicated withdrawal from substance(s) will be referred to a hospital detox unit initially. An appropriate candidate is started in treatment in one of three drug-free modalities: residential, daycare, or outpatient. During the course of treatment, the client can move from one modality to another as indicated by her progress and the ongoing assessment by staff. Remaining free from chemical dependence is the first priority toward progress in all three of the treatment modalities.

Residential treatment is the most structured, intensive and encompassing mode of treatment at the Women's Center. The total treatment period is six to nine months, as the client begins in a live-in, 24 hour-per-day, 7 day-per-week environment. She will progress through three phases of treatment, each approximately two months, with increasing privileges and responsibility. During the course of treatment she will be involved in individual and group counseling, family evaluation and treatment, parenting (mandatory if children are living in the unit with her), individualized vocational and educational training, assertiveness training, self-help groups, household budget management, recreational and cultural activities. Women with children 12 years or younger are encouraged to have them living with them in the residential phase of treatment, as we believe this increases their chances for successful treatment.

Daycare is a 2 to 6 month treatment experience for women who can remain free of chemical dependence while living at home in a stable environment. Participation is 6 hours daily, 5 days per week, and structured treatment is integrated into the residential program. Women will be transferred into the outpatient modality when they have made appropriate progress. A client in daycare may bring her younger children into the Center for participation in the child care program while she is engaged in day program activities.

Outpatient treatment is designed only for those women who can remain free of chemical dependence, have a stable home environment, and are actively involved in employment, school, raising a family, etc. Clients will be seen in

individual and group counseling weekly, have urines monitored for drugs and alcohol, and be expected to participate in self-help groups. Family evaluation and treatment, vocational counseling, parenting skill training, etc., will be offered as needed.

All clients will have physical examination and routine laboratory tests done through the Women's Center medical staff. Any necessary medications will be carefully prescribed and monitored only by the program. All children living in the residential unit will have the same medical services through program pediatricians and family practitioners.

A child care worker will be in charge of the children each weekday, and will work closely with mothers and individual counselors with regard to parent-child relationships, socialization, etc.

Round the clock coverage by the staff is provided at the Women's Center.

Since this is a national demonstration program funded by the National Institute on Drug Abuse, documentation of our experience at the Center will be used as a formula for the development of similar facilities elsewhere in the country, for the development of abuse prevention programs for the population at risk, and for educational programs for the medical and pharmaceutical professions.

Now let me paint a few representative portraits for you so that you hear the numbers and statistics, you can understand the human drama unfolding in this documentation.

Barbara has been jailed 3 times for forging prescriptions of Valium. Her husband left her and her daughter lives with a relative. Fifteen years ago Barbara's doctor put her on Valium and Percodan to fight the pain of backache and relax her muscles. In the beginning she was relieved that the pills made her feel better. Before long, she couldn't live without them. Mixing increased doses of mood-altering drugs with alcohol—making the rounds of psychiatrists to cope with the emotional and family problems that are inevitable by-products—Barbara became frantic enough to break the law. Most women don't go that far.

Helen, for instance, is married to a man who gets transferred regularly by his corporation. The repeated picking up, moving, relocating, finding doctors, community services, and new friends—knowing that in a couple of years it would start all over again—was finally more than she could bear. Although her public persona is that of a very put-together lady, privately she spends a lot of time drinking and popping pills to quiet the anxiety.

Sylvia comes from a family history of alcoholism. Her mother drank excessively, and abused her as a child. In therapy, she constantly refers to the beatings and the drunken attacks. She was frequently required to take care of her younger brother and sister. She married young to get out of that environment, and when her weak, but loving father died, she began her own substance abuse. What followed was a nightmare of responsibility: for her incontinent mother, for her brother and sister, her own child, and a husband who tended to put her down, feeding into her lack of self-esteem.

It's important to note that low self-esteem is the single common denominator that links the Barbaras, Helens, Sylvias, and almost all the women who fall prey to dependence on substances as a way of coping with life.

Although we are keenly aware that what we've learned about 32 female poly-substance abusers over so short a time can hardly be considered a substantial body of data leading to long-range conclusions, I do believe that considering how really little is generally known about these women, what we've learned to date will be a start, and perhaps to others who may be planning similar treatment programs.

Of the 32 women evaluated, 12 did not go beyond the evaluation process. Six of those were aged 45 to 55, with sufficient support systems in their lives to give them the option of avoiding treatment. Only 2 of the 20 who entered treatment would agree to go into the day care component. Nine are in residential treatment, 9 in outpatient.

How did they happen to come to the Women's Center? Fourteen were referred by hospitals, private physicians or other agencies, such as women's shelters or alcoholism programs; 18 were self-referrals, after having read or heard about the Center from newspaper stories or public service radio spots. They range in age from 20 to 55, with only 2 older than that. The largest concentration is in the 40 to 55 range, (44 percent); 10 are 20 to 30, (31 percent), with an equal number aged from 20–25 and 25 to 30; 10 percent are between 30–40.

Is there a difference in age among those women according to the treatment until they're in? In outpatient, 67 percent are 40 and older. Six of the nine residents

(67 percent) are under 30, with 4 of them under 25; 2 are under 20; Three are aged 30 to 50. That only two have consented to daycare (and they are both between 45 and 50) may indicate that the program's reputation may have to grow before it will attract more women to that kind of daily commitment—or possibly that such a commitment cannot realistically be expected from women who have homes and sufficient support systems, regardless of the fact that the severity of their abuse problems indicates a need for this kind of involvement.

Nine of the 32 women seen are single. An equal number have intact marriages. Eleven are divorced or separated; 3 widowed. And of the 9 women in residential treatment, 5 are single, 3 divorced or separated. Only one has an intact marriage.

The older women in initial evaluation were, in fact, shocked at the thought of entering residential treatment, since they tend to have more stability in their relationships and living arrangements. Those younger, who are also financially distressed, with children, but cut off from their husbands, are far more likely not only to accept being in residence but see it as a means of solving more than their drug abuse problem.

What kinds of drugs have these women been abusing? (See Drug Classification Reference.) Do they tend to use one drug at a time—or sequentially—in combination. Only 5, or 15 percent of these women use a single drug. Eighty-five percent use a combination. For those who are polysubstance abusers, alcohol is the common denominator for 63 percent of the women; 65 percent of this group having abused alcohol anywhere from 5 to more than 10 years.

Of the 85 percent who abused drugs in combination, the greatest number used alcohol and minor tranquilizers, such as Valium (41 percent), with the bulk of that number (69 percent) having abused these tranquilizers for anywhere from 4 to more than 10 years.

Next in usage are opiates of the prescription variety, such as Darvon and its compounds, Percodan and Codeine. (41 percent of the women seen are opiate abusers, with the duration of opiate abuse for 66 percent of those women from 3 to over 10 years). Then come the sedative hypnotics and barbiturates. Some combine minor tranquilizers and opiates of the prescription variety.

Those women who abuse alcohol and other sedative drugs also tend to abuse prescription opiates, such as Darvon and Codeine.

Only 4 of the 32 have used marijuana, certainly a much lower percentage than the population at large. Only two of the 32 have used cocaine.

How many of the women got started on drug abuse through medication prescribed by a physician to relieve somatic symptoms? Close to 44 percent.

What else have we learned about this group? 25 percent are college graduates; 31 percent did not complete high school. Close to 41 percent married at an early age to, as they describe it, "get out of the house." And of their financial status: 9 out of 32 (28 percent) live on under $5,000 a year. Only 4 of 32 are in the over $20,000 category, with the same number in the $5,000 to $10,000 annual range. Close to 62 percent, then, are in the under $15,000 range.

As to their families or origin, we know that 32 percent came from homes where their parents were estranged; an equal number where at least one parent was deceased. Twenty-one percent were either adopted or stepchildren. Only 8 women came from intact families of origin. Almost half of those women have had at least one person in that family or origin who were alcoholics or alcohol abusers. And 30 percent now have children of their own. Six of the nine in residential treatment brought their children into treatment with them. One of these 7 children is an infant. The others are under 5 years of age.

How many of these women have had recent work experience? More than half have not. And, as you might expect, of that half with work experience, regardless of the severity of their abuse problems, 85 percent opted for either outpatient or no treatment whatsoever.

Unlike the women street addict, and as we anticipated, only 3 of the 32 seen have criminal histories, but only one of the 3 entered treatment. She has a 5-year history of forging prescriptions, with her last charge involving 30 such forgeries.

Fifty-nine percent of the total women seen are admitted "doctor shoppers", for the purpose of obtaining prescriptions of tranquilizers and sedative hypnotics . . . or report using physicians with what they describe as extremely "lax" prescribing habits.

We see a typical pattern here. The woman has been able to renew a prescription over a long period. Eventually, her prescribing physician loses patience with her demands and she then proceeds to "doctor shop." The bulk of this doctor shopping

is to obtain minor tranquilizers and low potency opiates such as Darvon or Codeine.

Why and how does her physician become involved in her abuse? He may not routinely question the patient about her past and current medication history. He might unwittingly recommend medication that may prolong the patient's addiction without ever becoming aware of it. Not unusual. As in the case of one client who had been abusing Valium on prescription from one psychiatrist for 12 years. Our agency physician called to ask that psychiatrist if he'd been aware of the mileage his one prescription had received. He assured us that he'd written but one prescription. The pharmacist who filled it, however, subsequently confided that he'd been refilling that one order all this time, because, said he, our client was such a "nice lady."

I can personally attest to how ethical, well-intentioned physicians can, inadvertently, help you to become a drug abuser. In 1963, several years before the subject or abuse reached our consciousness, my husband died of a sudden massive heart attack. He was young. So were my two children: 3 and 5 years of age. He was known and loved by many, including several physicians we'd known for some years. In one's concern for me and my children, he gave me one injection of I know not what on the night of my husband's death which had me out of it completely, for 10 hours. Another, over the course of the next few months, had me on amphetamines (later known as speed) to keep my spirits up during the day, along with a mood elevator, and sedatives to put me to sleep at night. When I was still unable to sleep at night, he actually said, however jokingly, "The trouble with you is that you don't drink enough." and suggested I have a drink before going to bed. Not a pill-taker by nature, I remember asking him if these medications would not keep me from accepting the reality of my loss. His response: "If you had a broken ankle, and I gave you a crutch to use, would that crutch keep your ankle from healing?"

Fortunately, about 6 weeks into this pill regimen, I one day fainted three times while rising from a chair at work. After the third down, a colleague literally carried me to her internist, a conservative gentleman whose medical education had included what, in the early 60's, was an unusual amount of information about the effect of these drugs.

In my semi-conscious state, I managed to respond to his question, "Are you on any medication?" My response almost sent him through his office ceiling.

Please do not assume that my prescribing physician was irresponsible. He was and is today—a highly skilled and respected one. But he, too, was the unwitting victim of inadequate education about alterable drugs. To this day, I still, on entering the Women's Center, say to myself, "There go I, but for the grace of one wise doctor."

Thirty-one percent of the women seen have been hospitalized as psychiatric inpatients, with 6 out of these 10 individuals having had only one such in-patient admission. Equally impressive is the fact that over 68 percent of the total number seen report previous outpatient psychiatric treatment, with 10 of these 22 having been involved from 3 to 5 years plus! Why had they received psychiatric attention? Primarily for depression, relationship problems, feelings of insecurity and somatic complaints.

Among this small group of 32 women drug abusers, the trend appears to be that when such women are treated, they do not receive treatment in drug abuse programs. They receive psychiatric treatment, either as in-patients or out. They wind up in alcohol detoxification units with no after-detox treatment. The majority have not received appropriate treatment or have been maintained on drugs by a physician.

Many of the women who combine alcohol with other drug abuse have been involved in A.A. but report never feeling comfortable talking about other drug usage at A.A. We have recommended this group with A.A. or have involved them in our own Alcohol and Pill self help group at the Women's Center.

The numbers of women polysubstance abusers we have seen to date at the Women's Center may be small but we know there are many more who need treatment—more women than men—because drug abuse is a symptom of other, more serious underlying problems in this country. Women are the unwitting victims of an entire sociological process that makes them vulnerable to drug-induced solutions to their problems. It starts when they are children, and conditioned to be dependent on their parents. It continues into adulthood, when they are expected to defer to husband and children. This is compounded by the transitional period we are in today—where changing roles of women create con-

fliet and confusion about how to balance the traditional mother/wife expectations against the external and internal pressures to break the dependency mold. Many women don't necessarily know how to make the break, or perhaps even want to.

Along the way, when their handling systems break down, they run into fatigue, headaches, anxiety and any number of depression-type symptoms. At that point, most visit doctors (and we know that ⅔ of all individuals seeking medical help are women) and find a new form of sexism . . . in the tendency of many physicians to respond to the same presenting symptom in men with a complete physical examination and to women with medication. The women in our Center simply never stopped medicating—with or without physician help.

CONCLUSION

We are now certain of some things in treating these multi-substance abusers. We know that we must have treatment staff which can carefully and knowledgably screen these women. From a medical standpoint this is important because of the many problems they bring with them, and because we must determine whether their drug usage calls for in-patient or hospital detoxification. From a psychological standpoint we must be prepared for the consequences of past suicide gestures and attempts, chronic depression, and self-medication for tension and depression.

Again, our past experience is that referral of this group to traditional psychiatric facilities presents serious problems for both these clients and for the treatment staff of such facilities, with little or no improvement to be seen.

Our staff must be knowledgeable in alcohol abuse. With the reality of children living in the Center, and their strong need for structure and care, we need child care staff, and staff who can teach parenting to the mothers of these children. Relationships with their children are an immediate issue.

The mothers we are seeing tend to be either over-protective of and fused with their youngsters or distant and shirking their parental responsibilities.

The ability to bring children into the facility is being seen, incidentally, as a very positive feature, even by those without children there. But youngsters can be disruptive to treatment if they are underfoot and must be constructively occupied by a trained and experienced child care worker while the mother, who must still accept the primary responsibility for her own youngsters, must be relieved of that function. These youngsters, aside from food and shelter, will need physical examinations and on-going medical care, as well.

We need staff trained and experienced in providing family counseling, with our particular approach being that involvement with only the nuclear family is of limited value. Involving the extended family wherever possible has proven of tremendous value in treating our other drug abuse clients, enabling them to see certain repetitive patterns affecting their own behavior.

Some of these client services we are able to provide by using resources from the community: two pediatricians, an internist and a family practice clinic at a local hospital have responded to our draft call. But they can pick up only part of the needs. Also ongoing must be our job of educating the community to the problem, to our attempts at solving it. No small part of this job is reaching those women who themselves have serious drug abuse problems and do not recognize them, either through lack of information or a shocked unwillingness to include themselves among those identified as "addicts."

Our ongoing effort to alert community physicians to their role in drug abuse will certainly have to be intensified and expanded around this group of women we will be treating.

Certainly, judging from the numbers of women who need treatment for poly-substance abuse, sufficient treatment capacity does not now exist in enough communities.

In the final analysis, how will we—and others like us, who will attempt to treat this complex women who abuses a multiple of hell drugs—and her children—find the hard dollars needed to do even part of the work laid out for us?

The Congress of this nation, representing its taxpayers, and acting through the National Institute of Drug Abuse, to all of whom I am eternally grateful on behalf of the many addicted human beings we already serve, grants $8,450 of the $5,700 being allowed this fiscal year to treat one drug abuse client in a residential treatment setting.

We cannot possibly provide the quality and intensity of treatment needed by this woman with her many and complex problems, plus provide her with food and shelter for a year, at this cost.

The care of her child—or children—is an additional financial burden which must be supported from still other funds we must somehow try to raise. The minimum security prison for women in Connecticut, where a client was previously incarcerated for her prescription forging, reports that the cost of maintaining one inmate for a year currently costs $17,000. Prisons do not provide treatment—nor do their staffs need to raise any part of those funds. One is hard-put to understand—or deal with—this unjust and illogical disparity.

We in the drug abuse treatment field must accept many of the restrictions and hardships inherent in our particular work—difficulties which do not, somehow, apply to other areas of the health and mental health field also supported by government funds. We cannot easily attract competent and qualified staff on a competitive basis. Those who, for some welcome reason, do enter the drug abuse treatment field, do so with full knowledge that our limited funding is on a year-to-year basis, particularly now that direct treatment grants to our agencies from NIDA are terminating. Any semblance of security in their jobs is conspicuously absent.

Yet the skills they require are, in my opinion, more crucial to the work they must do to treat the whole person—and that person's family—than in many allied fields. The required and time-consuming documentation of services being provided far exceed those demanded of other health and mental health providers.

We know that raising funds is an ongoing and necessary part of our job. But how much time can be spent on begging for funds—and how much of those costs can we realistically raise in today's competitive fund-battle arena?

In our society—in the way we have raised our children and have been ourselves taught, there is little hope, I believe, that our drug abuse patterns will disappear.

As long as you can walk down the aisles of a supermarket and see the price we are willing to pay for "instant" solutions in handy packages.

As long as we continue to insist that we have an indefeasible right to be free of any pain, of any anxiety, of any tension—to be ever "up" and ever "happy."

As long as television parenting of our children teaches them that one analgesic gets into the bloodstream 10 seconds sooner than another and therefore should naturally be the one they choose as soon as they are capable of opening their own aspirin bottles.

As long as so many of our young people continue to believe that it is preferable to self-medicate their way through the unavoidable pains of adolescence instead of learning to cope with them.

As long as millions of dollars are devoted to inculcating in women, in particular, that tranquilizers are the first and unfailing solution to her depression and anxiety.

Then I suspect that we will continue to be a nation of drug abusers. And we will, in all conscience, find it necessary to treat the victims of drug abuse. Or make throwaways of human beings in the same way we tend, more and more, to think of almost everything as a "disposable."

I, for one, strongly agree that we should document and prove the caliber and quantity of treatment services we provide. But should not the caliber and intensity of these services affect the amount of funding dollars per treatment slot?

Why is drug abuse funding per treatment slot the same for every program in the country, regardless of major variations in the cost of living and in the amount and quality of services being provided. Shouldn't serious consideration also be given to the fact that treating a drug abuser's family, certainly necessary, takes time, and money to buy that time?

And should not such effort count in funding considerations? How much we would welcome being allowed to count three, even four families as an equivalent of one drug abuse client in our funded treatment matrix.

And how very, very much we who are providing drug abuse treatment would welcome the chance to treat, without having to beg for the funds to do so. I, for one, find it very hard to be a professional beggar, even on behalf of human beings we cannot afford to throw away. I find it easy, however, to say "Thank you for letting me tell you about it."

DRUG LIBERATION PROGRAM, INC. -DRUG CLASSIFICATION REFERENCE

Narcotic analgesics	Sedatives	Stimulants	Hallucinogens
Heroin	Alcohol	Cocaine	LSD
Morphine	Barbiturates	Amphetamines	STP
Dilaudid	Seconal	Dexedrine	DMT
Panlopon	Nembutal	Benzedrine	Peyote (mescaline)
Methadone	Tuinal	Preludin	Mushrooms (psilocybin)
Demerol	Amytal	Ritalin	
Talwin	Phenobarbital	Tenvate	
Percodan	Non-Barbiturate Sleeping Pills	Caffeine	
Codeine	Doriden (Glutethimide, "Cibas")	Nicoline	
Darvon N	Quaalude (Methaqualone, "Ludes")		
Darvocet	Noludar		
Darvon	Placidyl		
	Dalmane		
	Chloral Hydrate		
	Paraldehyde		
	Benzodiazepines & "Minor Tranqu."		
	Valium (Diazepam)		
	Librium (Chlorodiazepoxide)		
	Tranxene		
	Meprobamate (Miltown, Equanil)		
	Serax		
	Glue		
	Phencyclidine "PCP"		
	Nitrous Oxide		

FACTS ABOUT DRUG LIBERATION PROGRAM, INC.

Drug Liberation Program is a health service agency that contributes significantly to the identification, treatment, education and prevention of drug and substance abuse in the four town area of Stamford, Greenwich, Darien and New Canaan. We have been serving that need as a non-profit organization since 1970, when concerned citizens in the area created DLP as a community-based program.

Each client is evaluated for individualized treatment through a diversity of treatment modes. Services are available to anyone in the four-town service area with a drug-related problem, from the adolescent experimenter to the hard core abuser. There is no fee or direct charge except for the Methadone Program. Contributions are voluntary.

Our team approach to treatment combines the medical skills of full time staff psychiatrists with the counseling skills of professionals and para-professionals. This has resulted in one of the most effective drug-treatment programs in the state and country.

HIGH INTERVENTION FACILITIES

Liberation Clinic.—The centralized intake unit for DLP, functions in the dual capacity of (a) outreach, diagnostic evaluation and referral, and (b) outpatient counseling.

Liberation House.—Provides a 24-hour live-in facility for 40 residents in a psychiatrically oriented drug-free therapeutic community. The program is geared for 12 to 18 months of intensive treatment.

Methadone Maintenance Treatment Program.—Therapeutic in design and treatment, MMTP offers counseling, psychiatric, urinalysis services, etc., to assist addicts in overcoming the problems and handicaps which are usually associated with heroin addiction.

Women's Center.—A separate facility for women 18 and over, offering treatment and an opportunity to reconstruct their lives—to women who are abusing legal drugs and alcohol. They may keep their children in residence with them, or be treated as outpatients.

LOW INTERVENTION FACILITIES

Four Adolescent Programs.—One in each of the towns, assist young people to cope with their world, through counseling and alternative activities that avoid reliance on substances.

Emergency Shelter Programs.—For adolescents in Stamford and Darien.

Tri-Town Co-op.—Serves Greenwich, New Canaan and Darien; treatment and intervention for adolescents who are high at-risk delinquents.

Peer Counseling Training Program.—Serves Greenwich, New Canaan and Darien.

Youth Service Bureau.—Coordinating agency for New Canaan and Darien.

DORIS DE HUFF, EXECUTIVE DIRECTOR, DRUG LIBERATION PROGRAM, INC.

Since early 1975, Doris De Huff has been Project Director, then Executive Director of Drug Liberation Program in Stamford, a drug abuse prevention, treatment, and rehabilitation agency which has been described by both federal and state officials as a model program.

Her work in the substance abuse field began in 1969, when she was asked to become the Executive Director of the State's first community-based drug program in Westport.

In 1976, she was recognized by the Governor with an award as one of Connecticut's Outstanding Women for her contribution in the field of public health. In August of 1978 she was again honored, nationally, with an award for outstanding service and contribution to the field of alcoholism and drug dependency, by the Women's Commission of Alcohol and Drug Problems of North America.

Mrs. De Huff is Chairwoman of the Connecticut Alcohol and Drug Abuse Programs; a gubernatorial appointee to the Connecticut Alcohol and Drug Abuse Advisory Council; a member of the Regional Mental Health Board's Catchment Area 2 Council and former Chairwoman of the Regional Mental Health Board's Planning Committee. She also serves on the Health Systems Agency Mental Health Task Force and was formerly on the Health Systems Planning Committee.

Before entering the field of addiction treatment, she was a magazine editor and an account executive with major New York advertising agencies. During World War II, and immediately after graduation from college, she served for three years as one of the youngest women to be commissioned as an officer in the United States Navy.

Mrs. De Huff, a widow with two children, grew up in New York City and has lived in Westport since 1954.

Education: B.A. in English and Education; completed Teacher Training and Practicum; graduate courses in English and Psychology; U.C.L.A. and Columbia University. Drug Dependence Institute, Yale Medical School Certificates in Group Process and Leadership Training, New Haven Center for Human Relations: Training in psychodrama, diagnostic techniques, and other workshops.

[From the New York Times, Aug. 10, 1979]

OUT OF THE SHADOW OF PILLS AND DRINK

(By Eleanor Charles)

STAMFORD—Disquieting things have been happening to the American Dream. In many cases Mr. Blanding's dream house has become an energy nightmare, and Mr. Blanding himself is on the verge of an executive coronary attack. At least one of the children is tripping out on something or other, and Mrs. Blanding, having achieved the best of all possible worlds, is now a confirmed alcoholic.

This is the picture painted by Dr. Karen E. Grimmell, who sees the real-life counterparts of the fictional Blandings family in similar situations all too frequently. She is clinical director of the Women's Center, an unusual new facility in Stamford for the treatment of women who are addicted to prescription drugs and alcohol.

"It's an extraordinarily complex situation," said Dr. Grimmell. "We are seeing women who don't come to light any other way. They do not use hard drugs. They do not consider themselves drug-abusers and would never go to a traditional drug-treatment center. They are largely middle class and upper-middle class, often the victims of uncaring doctors who overprescribe and even fail to warn them of the dangers of combining drugs with alcohol."

The center, an offshoot of Stamford Drug Liberation Inc., addresses a problem that few such centers in the country have attempted to deal with. These are the women who took courage from Betty Ford when she told the world that she was hooked on pain-killers and alcohol. The former First Lady's candor has brought numerous other women out of the shadows, according to the center's staff.

The women's Center, which admits only those who have been detoxified, is taking shape at 6 Washington Court in a racially mixed residential neighborhood

of downtown Stamford. The space that was once 13 apartments now consists of administration offices, consultation and recreation rooms, dormitories and suites. Courses in money management, household management, child care and being a parent augment the therapy.

The old-fashioned brick building is light and airy inside, sparsely furnished and in homey disarray most of the time. Batches of cookies cooling in the communal kitchen and a playroom containing many cartons of toys indicate the presence of children, the all-important feature that separates this center from almost all similar ones elsewhere in the country.

The children live in private apartments with their mothers. They are assigned housekeeping responsibilities and a full schedule of recreation. Family therapy involves them in consultations, sometimes along with their fathers. In the fall, arrangements will be made for those of school age to be transported daily to nearby school districts.

For many of the children, this is the first time they have dealt with a mother who is not under the influence of pills or liquor. One woman, whose oldest child is 12, had been an alcoholic for 10 years.

The women who have been coming to the center, some from out of the state, supplement the Federal financing on a sliding scale keyed to their incomes. They have been responding to low-key radio spots and referrals and they reflect the grim statistic that the median age of white women in drug-related deaths is 43 years—a stage of life sometimes indentified as the midlife crisis.

Sarah Cook, the center's director, said: "Most are middle aged, a few are still in their 20's, left over from the drug culture of the 1960's, unable to find their place."

In all cases they succumbed to a false panacea, according to Dr. Grimmell, who said: "In our society we are used to being 'treated.' We assume that we are entitled to happiness, that there is something wrong with anxiety. I believe that anxiety is a useful symptom of something else and that it should not be eliminated.

"Sometimes people come to me demanding Valium," Dr. Grimmell said. "I refuse, and they never come back. They will go from doctor to doctor until they find one who will give them what they want."

Statistics from the National Institute on Drug Abuse in Washington show that of the 200 million prescriptions dispensed in the United States in 1977 for Valium, Librium and other legal drugs, two-thirds were written for women. The figures also show that 60 percent of drug-related emergency-room visits were made by women, and Valium, the drug prescribed most in the country, was the primary cause of such visits. Overdoses of Valium were triple the number of overdoses of heroin.

Hoffmann-LaRoche Inc., the sole producer of Valium, said through a spokesman that less than half the amount manufactured was sold as a tranquilizer. A company spokesman said: "It is prescribed as a muscle relaxant for low-back pain, or in cases of epilepsy, or before certain surgical procedures. It is always accompanied by a detailed list of instructions to the doctor regarding when to use it and when not to use it."

According to staff members at the Stamford center, there is a long chain of responsibility—the drug salesman pushing his quota on the doctor, the advertising copy that reinforces a stereotype of the woman who needs "mind-altering drugs, the medical school that is reluctant to recruit educators who stress alcohol and drug problems, the husband who cannot grasp his wife's addiction as a family problem, the doctor who prescribes a physical checkup for the husband but a bottle of pills for the wife.

What the center is striving to accomplish may seem oversimple—the restructuring of a woman's time—until the realization dawns that these women measure the hours only in terms of filling them with the contents of bottles.

Once treatment starts "the issue of identity is a big problem," said Mrs. Cook. "First they were somebody's daughter, then somebody's wife, then somebody's mother, never themselves."

Mary L's husband is an executive who is away from home for long periods. She said: "He would give me a check and tell me to pay the telephone bill if it came—and there was enough for groceries. But he would pay the major bills. I never knew how much money we had. There was a lot of putdown, loneliness and depression."

Despite the similarity in social and economic backgrounds, the difference between working women and housewives is immediately apparent. "Women who work don't come into the residency program, they come in as outpatients," Mrs.

Cook said. "They are much more wary, secretive. Most are married, with children. They worked hard competing to get where they are and they are reluctant to give it up. They are living out the Wonder Woman syndrome."

As for the housewives who are residents at the center, "they all want to go back to school and prepared for careers," Mrs. Cook said. One of them who has six months of treatment ahead said: "My husband and I love each other very much, but he has to let go of his role and I have to let go of mine. I've spent a lot of time being lonely, not knowing what to do with my time. I was a child and he wanted to keep me one."

Because the patients have had unpleasant experiences with male authority figures, they feel more comfortable undergoing treatment with the all-female staff. "How do you tell a man how it feels to be a mother?" one patient said.

Mrs. Cook said: "We try to avoid becoming another control. Hospitals control patients; our approach is unstructured. These women have had too many outside controls already."

Dr. Grinnell said of her patients: "In spite of all the difficulties and disruptions, they are good mothers, women who are ready to change their lives but would never leave their children to do so."

After three unsuccessful attempts to "dry out" in conventional hospitals, the wife of a business executive was optimistic.

"So far I think it has been good for me and the children," she said. "They had a lot of power at home, counting my drinks and taking care of me. Now they are learning that mother is finally coming back. I think the oldest is relieved to be a little boy again."

[From the Connecticut Magazine, September 1979]

Women in Chains

A dependence on prescription drugs shackles millions of women; now, better late than never, help is on the way

(By Doris De Huff)

Last year, Betty Ford stunned the nation with her agonized public admission of addiction to pain pills and alcohol. Comedian Jerry Lewis recently revealed in a magazine interview that he once almost put a bullet through his head while influenced by massive doses of painkillers. Allan Scott Newman, son of actor Paul Newman, died tragically last November from an accidental overdose of alcohol combined with the tranquilizer he was taking for injuries suffered in a motorcycle mishap.

Behind the headlines is a story that carries a common thread of human suffering. In an earnest effort to solve real medical problems, these people were catapulted into a nightmare of dependency and, ultimately, addiction. While they would not want to think of themselves as "junkies," and we would not categorize them as such, they were as "hooked" as any heroin addict with a $200 a day habit.

Prescription drug abuse in this country has reached epidemic proportions. Millions of Americans quietly suffer the torment of dependency on tranquilizers, sedatives, sleeping pills, and other mood-altering legal drugs.

Two-thirds of them are women. And in their shadows are the husbands and children—struggling to keep the family together. In alcohol abuse, there is an accepted ratio of each alcoholic person affecting the lives of four other people (usually spouse and children). If you extend that to the multisubstance abuser, you reach a staggering number of individuals who are touched by this problem—and by direct experience, are passing it along to new generations.

There's Barbara, for instance, whose problem started fifteen years ago with severe backache. Or Helen, whose husband gets transferred regularly by his corporate bosses, and who finally turned to Valium and alcohol to cope with the loneliness. Or Kate, whose doctor husband found it easier to sedate her than to find out why she was getting so many headaches—until she was so tranquilized she forgot to care for her children.

Fictitious names, yes, but prototypes of the millions of real women who are now emerging from a hidden life of shame and neglect, coming forth and identifying themselves as drug addicts.

It is no secret that women in our society must deal with either an actual double standard, or its remnants. Women are the unwitting victims of an entire socio-

logical process that makes them vulnerable to drug-induced solutions to their problems. It starts in childhood, when they are conditioned to be dependent upon parents, and continues into adulthood, when they are expected to defer to husbands and children.

Along the way, when a woman's handling system breaks down, she runs into fatigue, headaches, anxiety, and any number of depression-type symptoms. At that point, she may visit a doctor (two-thirds of all individuals seeking medical help are women), where she is likely to find a new form of sexism.

Studies have shown that women are treated differently from men when they present their symptoms to a doctor. The haste with which doctors routinely medicate women while they give men with similar complaints a complete physical workup has contributed to the enormity of the problem.

Photos of distraught women responding to sedation in order to face life are commonplace in pharmaceutical advertising.

But it is also true that a paucity of information hinders medical understanding of the subject. And it is a sad fact that many women, trying to deal with the misery of their existence, will go "doctor shopping" for more pills, and, in ultimate despair, will even forge prescriptions and risk arrest.

How, then, do you treat a woman who has succumbed to the easy way out? ("If one pill makes me feel good, won't two make me feel better?") With compassion, and a thorough understanding of her physical and psychological makeup.

At Drug Liberation Program we recognize polysubstance abuse as a symptom of deeper, underlying problems. We have just opened our doors at the Women's Center, one of the first facilities in the nation to provide special help for these women, their children, and their families. The Women's Center is designed to encourage women to work out their problems of confused sexuality, low self-esteem, and misdirected mothering, in a nonthreatening environment, under the guidance of female role models. Through therapeutic treatment, women are given a chance to reconstruct their lives, learn to cope with their problems, and return to their families and communities as useful, productive individuals.

[From the Greenwich Review, June 1979]

THE WOMEN'S CENTER . . . HOPE FOR ADDICTS AT NEW DLP FACILITY

(By Phyllis Sbrich)

Barbara is in jail for forgery.

It was her third arrest for writing prescriptions for Valium. Her marriage has disintegrated and her husband is gone. With no mother on the scene, her teenage daughter lives with an aunt.

No one ever dreamed that this tragic story would be the culmination of an accepted medical program of treatment for backache.

It all began fifteen years ago when Barbara developed severe back trouble. Her doctor put her on Valium and Percodan—to fight the pain and relax her muscles—twenty pills every other day.

Now, her life out of control, she is one of two million unwitting victims of an insidious affliction—dependency on prescription drugs.

Barbara is not a "street junkie." She's a middle-aged, upper middle income woman who, at one time, had a happy family and a bright future. What happened?

Like former First Lady Betty Ford, who stunned the nation last year when she admitted her dependence on drugs and alcohol, Barbara had a problem, and though she was dealing with it. In the beginning, she was just relieved that the pills made her feel better. Before long, she couldn't live without them.

What began as a blessing, finally became a nightmare. Mixing increased doses of mood-altering drugs with alcohol—making the wards of psychiatrists to cope with the emotional and family problems that are inevitable by-products—Barbara became frantic enough to break the law.

Most women don't go that far. But the shame and agony they feel at being unable to function are terrifying. And their sense of hopelessness has been complete—with good reason—because until just recently, there was no place for them to go for help.

Today, Connecticut women like Barbara can find help at the Women's Center—a new, unique demonstration program for female poly-substance abusers—just opened at 6 Washington Court in Stamford.

Drug Liberation Program, which has been serving Greenwich, Stamford, New Canaan and Darien for the past eight years, is the parent agency that launched the Women's Center. They knew that traditional drug treatment programs geared to male heroin addicts were not the answer for this type of drug abuser. They drew their experience from the forty-bed coed residential treatment facility, Liberation House, and from work their staff was doing in other treatment components.

Observing that innovative programs for women increased the retention rate of female clients to well above the average for similar facilities, DLP developed a concept for the Women's Center, and presented it to the National Institute on Drug Abuse last fall.

NIDA quickly approved the concept and awarded a grant to DLP to run a pilot program for the nation, where women addicted to legal drugs and alcohol can be treated while their children stay in residence with them.

Dr. Karen Grimmell, psychiatrist and clinical director of Women's Center, says that in today's complex society, women need a special treatment approach where they can deal with confusion about identity and sexuality. "They need a non-threatening environment, and appropriate role models—that is, women who have grappled with the same problems and are handling them successfully. That's why a woman is best treated by women in a facility for women," she explained.

While dual addiction can strike anybody, women are in far greater jeopardy than men. Because of an entire sociological and cultural process that makes women susceptible to drug-induced solutions to their problems, 20,000,000 American women are considered at risk.

The National Institute on Drug Abuse estimates that there are two million drug dependent women, and that five million women, including many of the drug abusing group, are alcoholics. The combination of drugs and alcohol is dangerous, and often lethal. NIDA says that thirty-one million women have used tranquilizers, compared with eighteen million men. Sedatives have been prescribed for sixteen million women, while the figure for men is eleven million. Fewer than half as many men as women have taken prescription stimulants.

It is significant that two-thirds of all people who consult doctors are women. Two-thirds of almost 200,000,000 prescriptions written in 1977 were for women. And a frequent complaint is that women's symptoms are not treated "seriously" by doctors—a situation substantiated by a recent study showing that men were given tests for physical ailments, while women who presented similar symptoms were usually just given medication.

The impact of dual addiction goes beyond the women themselves. As in Barbara's case, it affects the whole family. When a husband comes home to find his sedated wife unable to figure out where the children are, the family is in crisis. Finding help for the woman while her children are being cared for has usually been an insurmountable roadblock to treatment.

Now, the Women's Center has eliminated the hurdle of "what happens to the children." The facility will house twenty residential clients, with their children, twenty daycare clients whose children will be tended in a child care unit, and twenty outpatients. "With the child care burden accommodated, the likelihood of a woman starting and concluding successful treatment is tremendous," Program Director Sarah Cook noted.

Upon arrival, each woman is given a thorough physical and psychiatric examination and evaluation. A team of therapists and counselors devises an individualized treatment program for her, using community agencies on referral, when needed. Family therapy, marriage counseling, vocational guidance, building child care skills, education in household management and the handling of money—all of these are possible components of her treatment.

"It hardly matters whether she's here because she got hooked on pain-killing drugs, or somewhere along the line she began relieving the loneliness of the fifth martini hour with booze and tranquilizers," Mrs. Cook stated. "What does matter is that she is not alone. After years of being hidden, ignored and neglected, help is finally at hand for this tragic affliction."

She added, "We are focusing on the whole woman, someone who is part of a family unit. We want to help her develop a sense of self-esteem as an individual, and to find new ways to cope with her problems without relying on artificial crutches—pills and alcohol."

Because of the research that will be conducted there, one of the exciting benefits due to come from the Women's Center, according to the staff, is the develop-

ment of education and abuse prevention programs for the community at large, and for the medical and pharmaceutical professions.

Dr. Grimmell sums it up. "We see the Women's Center in Stamford, serving Connecticut, as the first important step in resolving a major national health problem."

[From the Hartford Courant, July 15, 1979]

PROGRAM EASES TREATMENT FOR WOMEN ADDICTS

(By Lincoln Millstein)

STAMFORD—The sounds of small children at play fill the air, providing a sense of comfort against what is otherwise the stark backdrop of women addicts trying to reconstruct their shattered lives.

Two young girls are making animals out of dough while down the hall their mother is receiving counseling for her addiction to alcohol and prescription drugs.

The setting is an incongruous one. But the knowledge that her children are near and well cared for allows the woman to concentrate on her therapy, making it more effective.

That at least is the hope of organizers of the Women's Center, a new facility devoted to treating women with the dual addiction of alcohol and drugs. The center opened a month ago.

What makes the Women's Center unique, they say, is that it's the only facility in the country that allows such women addicts to keep their children with them while they undergo treatment.

"The women who come here are immensely relieved not to find a sterile psychiatric hospital," said Arlene Violante, the center's assistant director.

"And the children feel a sense of relief too," she said. "Often the children feel somehow responsible for Mommy's drinking and pill-popping. They develop guilt.

"Here, they can be kids again. This is an entirely new option never available before in therapy," she said.

The prototype program was conceived last year as an outgrowth of the Drug Liberation Program Inc., a drug and alcohol treatment program serving Greenwich, Stamford, Darien and New Canaan.

Counselors at the program's co-education Liberation House sensed an increasing need for more programs for women. The disclosure by former First Lady Betty Ford of her dual addiction to pain-killing drugs and alcohol brought national attention to this problem among women.

The statistics on the problem are staggering. The National Institute on Drug Abuse estimates that from May 1976 to April 1977, 47,700 persons in the United States were admitted to emergency rooms suffering from the effects of mixing alcohol and drugs.

A total of 2,500 persons died.

And 65 percent of all drug-related emergency room visits were made by women.

Of almost 200 million prescriptions in 1977 for legal drugs like Valium, Librium and others, two-thirds were for women. And nearly two million American women have become dependent on prescription drugs.

Five million women, including many who abuse drugs, are alcoholics. Almost twice as many women as men have used tranquilizers. More than twice as many have used sedatives.

The Women's Center, which will serve about 250 women and their children in one year, is an experimental program aimed at addressing some of these drug and alcohol problems.

When Drug Liberation proposed the idea and sought funding for it, the National Institute on Drug Abuse, an agency of the U.S. Department of Health, Education and Welfare, gave it swift approval, apparently recognizing the severity of the problem.

The money pays the rent on a three-story apartment house at 6 Washington St. and salaries for a staff of more than five women. The clinical director is another woman, Dr. Karen Grimmell, a psychiatrist.

"Until she moves far along in treatment, (the woman patient) will have difficulty dealing with men as therapists," Dr. Grimmel said. "Her desire for masculine attention, which she usually attempts to gain by fitting into a stereotype . . .

complicates treatment by a male therapist. A woman needs a role model to help develop her own role in today's complex society."

Dr. Grimmell also said that when a woman knows her children are being cared for, "not only will therapy be more effective but the client is apt to stay in treatment longer."

Also, the women can be taught to be better parents in the program. "For instance, if we observe the mother flying off the handle for no apparent reason, we can tell her to avoid that kind of behavior," Dr. Grimmell said.

There is, in addition, immense benefits for the children of the women addicts who often are "disfunctional" as a result of their family problems. Dr. Grimmell said, "When we observe such a child, we can refer her to special programs designed to address those problems."

The new center will accommodate 20 in-patient "clients." There also is a day program for women who have more stable family lives and an outpatient program. In all programs, child-care is an essential component.

"A mother undergoing treatment generally has the feeling that 'half of me (her children) is at home,'" said Ms. Violante.

At the Women's Center, she will be able to undergo treatment without worrying about where her children are or what they're doing. The elimination of this basic concern should enhance any treatment program's success rate, Ms. Violante said.

The center is now screening candidates from all over the country for its programs.

(From the Bridgeport Post, June 26, 1979)

STAMFORD FACILITY OFFERS HELP TO ADDICTED WOMEN

STAMFORD—The only facility in the Greater Metropolitan Area, including New York, New Jersey and Connecticut, devoted to treating women addicted to prescription drugs and alcohol—who may keep their children in residence with them—has just opened its doors here in Stamford.

The Women's Center, a separate facility of Drug Liberation Program for women 18 years and older, serves not only the entire state of Connecticut, but is available to residents to all other states as well.

Its purpose is to offer treatment and an opportunity to reconstruct their lives to women who are abusing a variety of prescription and over-the-counter drugs (sedatives, tranquilizers, etc.) and perhaps alcohol.

Residents may be treated in a variety of drug free modalities. They may keep their children with them—a unique feature intended to encourage women to enter treatment if they need it, and one which is likely to increase their chances for successful treatment. A day program is offered to women who have a stable family structure which supports them in the morning and evening. They may bring non-school-attending children with them during the day. Out patient clients may do likewise, and all the children can participate in the child care facilities provided at the Center. Clients who come for evaluation and consultation and need detoxification prior to their treatment program will be visited by the counseling staff during their detoxification.

A team of therapists and counselors devises an individual treatment plan with each women. Components of treatment include individual and group therapy, family counseling, continuing education, vocational training and guidance, parenting and childcare skills, education in household and personal money management, assertiveness training, constructive use of leisure time and formation of self-help groups.

The total program is directed at helping women find new ways to cope with problems, develop a sense of self esteem as a woman, and return to useful and productive roles in family and society.

Some of the statistics provided by the National Institute on Drug Abuse, the U.S. Drug Enforcement Administration and the Department of Health, Education and Welfare are: Of almost 200,000,000 prescriptions in 1977 for legal drugs like Valium, Librium, etc., two thirds were written for women . . . 2 million American women have become dependent on prescription drugs . . . 5 million women, including many of the drug abusing group, are alcoholics . . . almost twice as many women as men have used tranquilizers . . . more than twice as many have used sedatives . . . 60 percent of all drug-related hospital emergency

room visits were made by women. An estimated 20,000,000 women live in jeopardy of falling prey to this tragedy.

The Women's Center will accommodate approximately 250 women, and their children, in a year. Moreover, its impact as a nationwide prototype will be considerable. The National Institute on Drug Abuse, which has provided a grant to fund the Women's Center, will use the documentation of the experience of the Center as a formula for the development of similar facilities elsewhere in the nation, for the development of abuse prevention programs for the population at risk, and for educational programs for the medical and pharmaceutical professions.

The Women's Center is located at 6 Washington Court in Stamford. Any individual, doctor, hospital, or community agency may call for referral or information.

PREPARED STATEMENT OF PHYLLIS HALPERN, COORDINATOR OF WOMEN'S PROGRAMS, NEW JERSEY STATE DEPARTMENT OF HEALTH, ALCOHOL, NARCOTIC AND DRUG ABUSE CONTROL.

REPORT ON WOMEN AND PRESCRIPTION DRUG ABUSE AND DEPENDENCY

Data on incidence of prescription drug abuse among women is difficult to obtain in that it continues to be "in the closet" similar to and often combined with alcoholism. The DAWN data released by the Drug Enforcement Administration (DEA) is an indication of abuse and the best information we have. However, it is incomplete in that it covers 24 Standard Metropolitan Statistical Areas (SMSA) leaving many hundreds of hospital emergency rooms outside of the SMSA reporting system and, therefore, uncounted. The DAWN data should be considered as an indication of a much larger problem the true proportions of which are as yet unknown.

DAWN VI TOTAL EMERGENCY ROOM DRUG EPISODES—MAY 1977-APRIL 1978

	Percent	Female	Percent	Male
Total	58.2	69,011	41.6	49,289
White	59.0	43,069	40.9	28,812
Black	52.2	14,507	44.7	11,745

These statistics show that women continue to predominate in the national data on overdose by 16.6 percent over the rate for men. The highest percentage, 59 percent, is found among white women and the lowest 40.9 percent among white men. Those drugs associated with the highest nationwide proportions of female emergency room mentions in DAWN VI are the following:

Generic name	Female	Male	Trade name
Diazepam	14,359	7,077	Valium.
Aspirin	5,248	1,953	Aspirin.
Flurazepam	3,307	1,273	Dalmane.
d-Propoxyphene	2,826	1,281	Darvon/Dolene.
Amitriptyline	2,335	985	Elavil/Endep.
Chlordiazepoxide	2,216	1,056	Librium/Libritabs.
Acetaminophen	1,918	680	Tylenol.
Prazepate	1,242	373	Tranxene.
Perphenazine/Amitriptyline	1,169	407	Triavil/Etrafon.

With the exception of Aspirin, Tylenol and Darvon given for relief of pain, the drugs listed are psychotropic: tranquilizers, sedatives and antidepressants. They are prescribed for anxiety, depression, stress, insomnia, grief and many lesser complaints. These drugs work in that they reduce the symptoms. However, the underlying problems remain as before unless psychotherapy or counseling takes place along with medication. If not, the dependence on drugs as a coping mechanism becomes established, increases as tolerance develops and can lead to the O.D. emergency room episodes reported in DAWN.

52-928 0 - 80 - 7

Women's Center reports

In New Jersey there are two women's centers that are funded primarily to deal with women and prescription drug abuse. Both have been collecting data that provide us with a deeper understanding of this problem. In addition to nationwide DAWN statistics, a clearer picture emerges of the woman who is using from a review of this material.

The Women's Resource and Survival Center is located in Keyport, a town in an economically depressed area on the northeastern shoulder of New Jersey that is separated from Staten Island by the Raritan Bay. Forty-two percent of their clients have an income level of $5,000 or less per year. The population is mostly white, lower to middle class, with a high school education. The Center's survey of over 100 women found that 53 percent of this sample was using one or more prescribed psychoactive drugs when admitted. The largest percentage, about half the total, named Valium as the drug of use. Other minor tranquilizers 18 percent, were followed by antidepressants, 12 percent. The percentages for sleeping pills and pain killers were slightly lower, roughly 10 percent and 8 percent respectively.

About 24 percent were using two or more psychoactive drugs. Slightly over 16 percent were using prescription drugs whose identity was not known to the women users. An equal percentage of the women in the survey 16 percent were using alcohol regularly.

The average age of the women users was 35 years. Fifty-four percent of the women using one or more psychoactive drugs were married and 45 percent were separated or divorced. Fifty-five percent were homemakers, while 37 percent were employed outside the home.

Together, Inc. in Glassboro, South Jersey is in a less economically depressed area. The income level of women clients is spread fairly evenly from under $6,000 to over $18,000 per year. Over 40 percent attended or completed high school and over 45 percent attended or completed college. Almost half of the women are employed, primarily in full-time jobs. They are predominantly 24–34 years of age, white and married.

Data collected over a four year period from a total of 711 women provided the following information on drug use: 355 women, 49.9 percent were using drugs or medication at the time of admission. These women were predominantly in the income range under $6,000 to $12,000. Valium and other tranquilizers were predominant, followed by over-the-counter drugs and alcohol. Over 100 women admitted using cocaine received from a friend, although they were not regular users.

The primary source for the drugs taken by the women was prescriptions from doctors. A small proportion of these 3 percent, were psychiatrists and the remaining 97 percent practitioners or internists.

In March 1979, Together, Inc. ran a telephone survey of 293 women over 18, using random numbers in two adjacent local telephone exchanges. In answer to the question, "Do you use drugs or alcohol to cope with stress?" 22 percent of those responding answered affirmatively. Based on the 1970 U.S. Census report of 57,051 women over 18 in Gloucester County, it is highly possible that at least 20 percent or 11,410 women are currently using drugs and/or alcohol to cope with stressful situations.

Discussion and recommendations

There is no lack of implications in the New Jersey data from women's centers and the National overdose data in DAWN VI. Both New Jersey Centers are marginal to the SMSA and represent small town, middle-America in their demographic characteristics. If we project the 20 percent female drug and/or alcohol users identified by Together, Inc., in their random survey, to all the small towns outside of the DAWN reporting system, we would arrive at a very large number of drug dependent women who are potential overdose candidates over and above the 60,000 reported in DAWN VI.

The truth is that we do not know the real dimensions of this problem and it is time for a major research effort to fill this gap in our knowledge. Perhaps the Federal Drug Enforcement Administration could assist by using their present data base to project a more complete national total for those drugs that rank highest in relation to female emergency room episodes. That information, in addition to existing DAWN data, would be a first step in achieving a more accurate evaluation on which to base an action plan.

From our experience in New Jersey some recommendations come to mind as ways of reducing the dangers of prescription drug abuse dependency and overdose among women.

1. All prescriptions for drugs in the high overdose categories should have the name of the drug clearly stated on the label along with instructions for use.

2. Enclosures similar to those that accompany birth control pills should be in the package stating the dangers of use in combination with alcohol or other drugs, the risk of habituation when used for long periods of time and the risk of death from overdose.

3. The enclosures should include appropriate warnings about use during pregnancy and when breast feeding an infant.

4. In the case of psychotropic drugs the enclosure should recommend their use be accompanied by psychotherapy or counseling on a regular basis.

These recommendations would provide women users with basic information needed to foster responsible use of drugs. They would know the name of the prescribed medication they are taking; the danger of synergism with alcohol or other drugs; the possibility of habituation and death from overdose; possible effects on the unborn or newborn of drugs in their blood that pass through the placenta or into breast milk.

The recommendations suggesting that psychotherapy or counseling accompany drug use is of particular importance in view of the N.J. finding that 97 percent of prescriptions are given not by psychiatrists, but by general practitioners or internists who do not have the time or the training to provide psychotherapy or counseling to women patients on psychotropic medication. Research studies by Myrna Weisman and Gerald Klerman, Marcia Guttentag and Susan Salasin have found that:

1. "Twice as many women as men are diagnosed as suffering from depressive disorders."

2. "It is the young (25–40) married, separated or divorced, working, blue collar mother who is most likely to be depressed."

3. "This woman has less access to social support systems than do other groups even though her life situation is more stressful."

The woman described in these studies matches in her characteristics the women clients of the two N.J. Women's centers. Without a support system of social services, counseling or therapy, medication by itself does not help her solve her problems or reduce her life stresses. This is the woman who needs to be alerted to the value of counseling when taking psychotropic medication for prevention of deepening dependence.

Further insight into her situation is provided by Guttentag and Salasin:

"She must cope with the demands of a job, and with the demands of family responsibilities, including husband, children and household management. She has no hope of rising in her career as do white collar women. Further, she is caught in a traditional family role situation. This means that she must fulfill all of the family role responsibilities ascribed to women, and at the same time, cope with the stresses of her dead end job."

The authors observe that feelings of helplessness and hopelessness are primary factors in her depression and, we may add, to her drug use.

Counseling for this woman should deal with her drug use as a temporary measure and instill respect and understanding of the long term dangers of drug use. With the support of counseling or therapy she would be aided in looking at her problems and in devising ways of dealing with them in order to decrease the stress in her life. Family therapy should be available, hopefully to attain greater cooperation and caring between family members. Group therapy should help her perceive that she is not alone—new friendships with other women may be helpful. Further opportunities for training or education may open her life to new opportunities. With increased self respect and hopefulness, this woman could give up her drug use. She will have gained greater control over her life—a real reward!

In answer to the question, are current treatment services available to women with this specific problem, based on my experience, adequate services do not exist. How can we provide these services through existing agencies at a minimum cost? N.J. State clinics for treatment of illicit drug abuse can treat people with these problems, but women using prescription drugs are fearful of methadone clinics and unwilling to use them.

A real possibility for treatment development should be possible through a small expansion under Title XX of the Social Security Act. Title XX moneys are now available for alcohol treatment. Categorical funding is available for counseling of eligible persons with alcohol problems as well, under the category of counseling in New Jersey. By the simple inclusion of counseling services for dependency on prescription drugs, services could be developed through staff training and program development for the women discussed here today. We respectfully urge this committee to consider this recommendation and the necessary steps for its implementation.

The Complete Book of Women and Pills

Special Health Section #8

An up-to-the-minute report on why women are particularly vulnerable to prescription-drug abuse, eight danger signals of addiction, plus a complete chart of the 12 most abused drugs By Morris E. Chafetz, M.D., with Patrick Young

Alcohol—Use and Abuse

continued on page 6

The 12 Most-Abused Prescription Drugs

In a National Institute on Drug Abuse report, based on surveys of drug-related deaths and hospital emergency-room visits, these prescribed drugs won the "most abused" label. Here's what they are used for and how they can harm—and even kill

DRUG	*MEDICAL USE*	*ILL EFFECTS*
Diazepam (generic name) Valium (brand name)	Minor tranquilizer used to relieve tension and anxiety, treat certain muscle spasms and convulsions and counter the effects of alcohol withdrawal	Tolerance may develop, leading to increased use; may cause psychological dependence; may lower sexual drive, and cause disorientation, trembling; overdose may produce low blood pressure, depressed respiration, coma and possibly death
Flurazepam (generic name) Dalmane (brand name)	Sleeping pill, sedative and antianxiety drug	Tolerance, psychological dependence and addiction are possible; may cause confusion, drowsiness, faintness, unsteady walk; overdose may result in breathing problems, coma and death
d-Propoxyphene (generic name) Darvon (brand name)	Pain reliever	Tolerance; may cause psychological dependence and addiction; drowsiness, insomnia, euphoria, confusion; overdose may produce convulsions, depressed respiration, stupor, possibly death. Use with alcohol or other medicines increases danger. Federal drug officials want to control availability
Chlordiazepoxide (generic name) Librium (brand name)	Minor tranquilizer used to relieve anxiety, tension and the withdrawal symptoms of acute alcoholism	Tolerance; moderate risk of psychological dependence and addiction; overdose may produce somnolence, confusion, diminished reflexes, coma, possibly death
Phenobarbital (generic name) Luminal (brand name)	Barbiturate used as anesthetic, sedative, anticonvulsant, sleeping pill	Tolerance; high risk of psychological dependence and addiction; may produce drunken behavior; overdose may cause coma, fever, loss of reflexes, depressed respiration, possibly death
Amitriptyline (generic name) Elavil (brand name)	Antidepressant	Serious side effects—especially if taken with other drugs or alcohol—may include high or low blood pressure, disorientation, hallucinations, anxiety, insomnia, tremors, seizures; overdose may cause abnormal heart beats, congestive heart failure, severe low-blood pressure, stupor, coma, possibly death
Secobarbital (generic name) Seconal (brand name)	Barbiturate used as painkiller, sedative and sleeping pill	Tolerance; high potential for psychological dependence and addiction; may produce excitement, hangover, allergic reactions; overdose may depress breathing and reflexes, lower body temperature, cause coma, possibly death

2

DRUG	MEDICAL USE	ILL EFFECTS
Seco Amobarbital (generic name) Tuinal (brand name)	Sleeping pill	Tolerance. There is high risk of psychological dependence and addiction. Overdose may depress respiration and reflexes and could cause rapid pulse, coma, possible death
Methaqualone (generic name) Quaalude (brand name)	Sleeping pill and sedative	Tolerance, there is high potential for psychological dependence and addiction. May cause headache, symptoms of hangover, fatigue. Deeper overdose may result in delirium convulsions, coma, accumulations of fluid in the lungs, possibly death
Ethchlorvynol (generic name) Placidyl (brand name)	Sleeping pill	Tolerance, psychological dependence and addiction are possible. May cause vomiting, nausea, gastric upset, dizziness, blurred vision, dumbness. Overdose may result in low blood pressure, difficulties in breathing, abnormal heart beats, coma, possibly death
Doxepin (generic name) Adapin, Sinequan (brand names)	Antidepressant	May cause drowsiness, nausea and vomiting, low blood pressure, overdose may produce stupor, blurred vision, depressed breathing, convulsions, heart problems, coma, possibly death. Use of alcohol with drug increases the danger
Meprobamate (generic name) Equanil, Miltown (brand names)	Minor tranquilizer used as antianxiety drug and sedative	Tolerance, there is moderate risk of psychological dependence and addiction. May cause drowsiness, dizziness, and also result in slurred speech, state of excitement, euphoria, overdose may produce coma, shock, respiratory failure, possible death

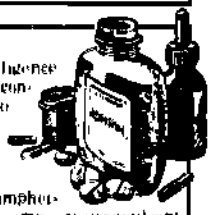
Drugs and Pregnancy

All drugs taken by a pregnant woman reach her unborn child. Some may cause serious damage to the fetus. Therefore, no drug, even aspirin, should be taken during pregnancy without consulting a physician.

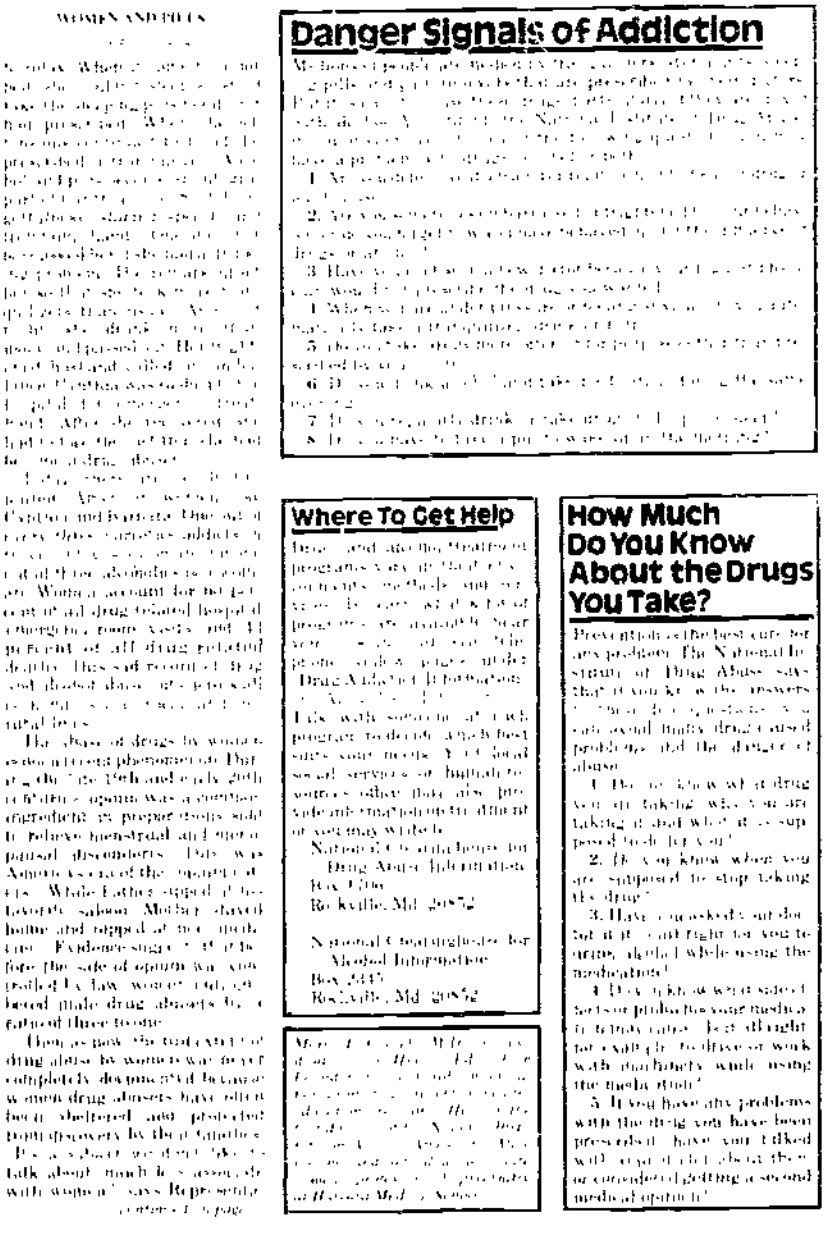
Babies of women heroin addicts may be born addicted, as may the babies of alcoholic women and women who have taken barbiturates during pregnancy.

Excessive consumption of alcohol increases the risk of stillbirths and premature births, and of having an infant who will suffer sleep disturbances or who will be born with the so-called fetal alcohol syndrome. No safe level of alcohol consumption during pregnancy has been established.

Abuse of alcohol and some drugs during pregnancy is also linked to minimal brain dysfunction (MBD) in the child. Five to seven million school-age children are estimated to suffer MBD, which causes learning difficulties in youngsters with normal intelligence and may contribute to antisocial and delinquent behavior.



Use of amphetamines, some anticonvulsant drugs and the sex hormones estrogen and progestin during pregnancy also increase the risk of birth defects. Tetracycline antibiotics should not be taken during pregnancy as they can cause permanent tooth discoloration in fetuses. ●



WOMEN AND DRUGS

Danger Signals of Addiction

Where To Get Help

How Much Do You Know About the Drugs You Take?

Distributed by
N.J. State Department of Health
Alcohol, Narcotic and Drug Abuse

FOR LOCAL HELP
CALL THE NEW JERSEY
TOLL FREE WOMEN'S HOTLINE
800-322 8092

[illegible]

1. DASN

[illegible]

2. CODAP

[illegible]

3. WOMEN'S CENTER REFERRALS

[illegible] ... regional [illegible] ... New Jersey ... [illegible]

4. THE WOMEN'S TASK FORCE

The committee, established by the N.J.D. [illegible] in 1976, represents [illegible] of the State and [illegible]. The Task Force [illegible] to knowledge of women's needs, in their own experience, based on experience and [illegible] program staff as well as [illegible]. [illegible] regional reports are [illegible] needs of two groups of women:

a. Clients in treatment
b. Women staff members

Discussions of these issues usually results in [illegible] agreement on appropriate responses and [illegible] action to be taken by the [illegible] Task Force members, or the entire committee.

In addition, the Task Force has been [illegible] to [illegible] in monthly meetings. [illegible] have been resource people who provided knowledge, skills and assistance to the committee. [illegible] to share the growth experience of the Task Force itself.

NEEDS ASSESSMENT

Using available data, an approach can be established as a framework for women's drug use in New Jersey. Since data sources vary in time and geographic areas, they are only roughly comparable, but many reveal trends that are consistent elsewhere.

5. CODAP

[illegible]

[illegible] ... New Jersey ... [illegible] ... Newark ... [illegible]

[illegible] ... HSA ... [illegible]

[illegible] ... HSA ... [illegible]

HSA		Female		State
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

[illegible] ... HSA ... the highest [illegible] ... New Jersey ... HSA ... [illegible] the percentage of women [illegible].

HSA II is comprised of five counties. Essex and [illegible] to New York and [illegible] with [illegible], [illegible] Newark and Elizabeth. [illegible]. Warren and Sussex counties are in the western part of the State with lower population density.

Prevalence figures as noted in the 1978 Plan for 1976-1978 provide information on HSA's and counties with the highest rates of heroin abuse. The Newark area including Essex, Hudson, Passaic and Union Counties has the highest heroin prevalence rate in New Jersey. It would be consistent, therefore, with these findings that HSA II including Newark has the highest prevalence rate for both males and females. The unique finding in HSA II is that the percentage of female abusers who enter treatment is not only the highest in the State, but that it is higher, by almost 16%, than the percentage for males.

[illegible]

EMPLOYMENT STATUS

[illegible]

PRIMARY DRUGS

Drugs				
Cocaine	[illegible]	[illegible]	[illegible]	[illegible]
Barbiturates	[illegible]	[illegible]	[illegible]	[illegible]
Amphetamines	[illegible]	[illegible]	[illegible]	262
Tranquilizers	[illegible]	[illegible]	[illegible]	[illegible]

[illegible] as primary. [illegible] tranquilizers as their primary drugs.

SECONDARY DRUGS

Drugs				
Cocaine	[illegible]	[illegible]	[illegible]	[illegible]
Alcohol	[illegible]	[illegible]	[illegible]	[illegible]
Barbiturates	[illegible]	[illegible]	[illegible]	[illegible]
Amphetamines	[illegible]	[illegible]	[illegible]	[illegible]
Tranquilizers	[illegible]	[illegible]	[illegible]	[illegible]

[illegible] most fairly used concurrently with heroin [illegible] female [illegible] serious questions in relation to women. Does cocaine affect the fetus when it is used daily by a pregnant woman? [illegible] being nursed by a mother using cocaine? [illegible] research data that deals with alcohol and other drugs were available but not with cocaine in this context.

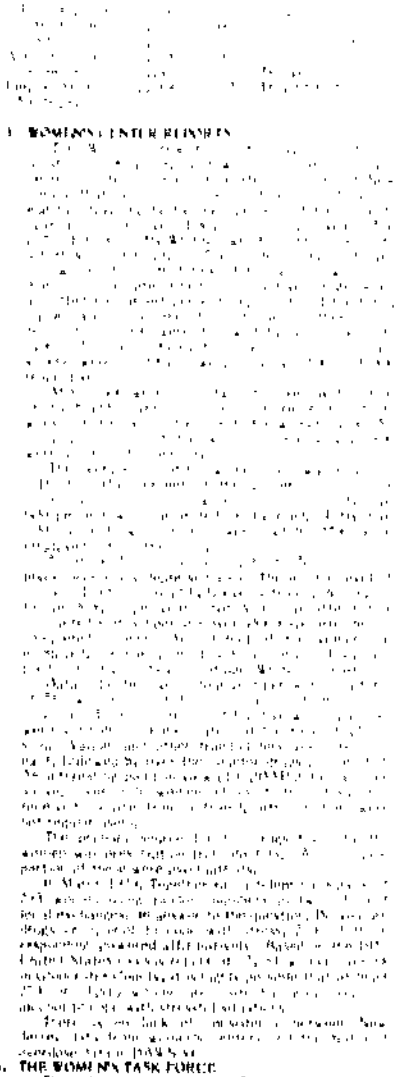
Since alcohol use in women of childbearing age can result in an offspring with fetal alcohol syndrome that includes brain damage, the [illegible] percentage of female clients using alcohol as a secondary drug is significant. The percentage of women using barbiturates, [illegible] is also significant. Amphetamines [illegible]

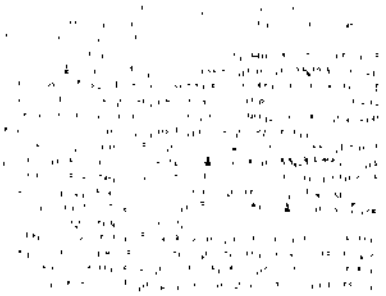
[illegible]

7. DATA FROM THE DRUG ABUSE WARNING NETWORK, DAWN VI, MAY 1977 - APRIL 1978

[illegible]

[illegible]





PREPARED STATEMENT OF BARBARA GIBSON, SENIOR ADMINISTRATIVE ASSOCIATE, ADDICTION RESEARCH AND TREATMENT CORPORATION, NEW YORK CITY

I shall concentrate my remarks today on prescription drug use, misuse, and abuse by middle-aged Black women. I choose to so limit myself not only because this segment of the total population presents unique and distinct implications for policy directions and intervention strategies, but because it further illustrates a pressing need to broaden the scope of Congressional action in attacking what is considered a medical social problem.

The use, misuse, and abuse of prescription drugs by middle-aged Black women is a function of the interaction of the agent (the drug), the host (the middle-aged Black woman) and the environment. Before the clinical horizon is met and symptoms appear there is a presymptomatic period during which the characteristics of the agent, host and environment (the causal variables or determinants) converge to set the stage.

The agent in this case is a wide range of prescription drugs whose nature and classification, in terms of psychotropic effect, tolerance tendencies, and abuse potential, is well documented and presented by others in this and other settings. Its presence and availability is of concern and is crucial as a point of intervention because it is a factor that is within the scope of human control and susceptible to the direct actions of Congress.

The mechanisms by which these drugs are made available and distributed provide opportunities for specific and direct action that would have immediate impact on the problem under discussion. The availability and distribution process, as relates to the host under consideration, middle-aged Black women, has special circumstances that speak to the economic, social and psychological constraints of Black women in general, but poor Black women most specifically. It also brings into consideration those women's access to health care, and the quality of that care when available. Also, these considerations, especially economic condition, health care access and quality of health care, are within the domain of Congressional concern and influence.

Although the literature suggests that abuse of prescription drugs is found in middle class, suburban, white middle-aged women, as well as in, the lower socio-economic setting of the Black urban arena, there are significant differences in how access, availability and delivery of health care, and subsequently prescription drugs, is effected. Within the urban Black arena (the environmental determinant) there is a significantly decreased availability of health care services. The State of New York has approximately one physician for each 1,000 population; for predominantly Black and Hispanic areas of the state, i.e., Bedford-Stuyvesant, the South Bronx, Central Harlem, the rate is one physician for each 16,000 population. Much of the health care is delivered in crowded out-patient departments of under-staffed and over-worked "municipal" hospitals or in "medicaid mills." This has a sharp contrast to the family physician setting in suburbia or rural America.

The Central Harlem resident receives her "treatment" in a supermarket atmosphere where she is a chart number or a medicaid number. Harlem Hospital receives over one million out-patient visits annually. Due to the paucity of general practitioners in the community and the economic status of its constituents it is used as a "doctor's office."

As other hospitals in areas of the medically indigent, its emergency room receives patients who would more suitably be treated in a private physician's office. Instead, emergency personnel make cursory exams, referrals to specialty clinics, and hand out prescriptions. Most clinic referrals are not met and when the presenting problem reappears the patient returns to the emergency room, gets another referral and another prescription.

In the medicaid mill, the physician caters to the patients' expectations. The patient does not feel "treated" unless a prescription is recorded. Perhaps the patient is "ping-ponged" or cross referred within the specialty areas of the clinic to produce multiple Medicaid or Medicare reimbursements. Thus, the female who is experiencing problems related to menopause and complains of general fatigue, aches and pains, hot flashes, cardio-vascular problems, etc. will see a gynecologist, [illegible]ologist, perhaps a dentist and podiatrist. All will bill medicaid separately, and each feels obliged to "prescribe something."

The habits and customs of the host (here the middle-aged Black woman), especially as they relate to her response to illness, are also important. Often, due

to economics, she has become accustomed to self-medicate. When a minor problem appears she goes to the medicine cabinet and gets "one of those pills" prescribed long ago for a complaint long forgotten. Maybe she hasn't medicaid coverage, or the wait is too long or she can't take off from work: at any rate she avoids the complicated, protracted and dehumanizing interface with her available health system.

The psychological characteristics of our "host" play an even greater role in differentiating her from her suburban, middle class white counterpart. These include the widely discussed pressures and stress of being poor, Black and female. I will not delve into all of the ramifications of inadequate housing, poor education, lack of job opportunities, burdensome financial and familial responsibilities, discrimination, alienation and hopelessness that converge to exacerbate the normal anxiety and stress of menopause (with its own set of psychological sequelae).

Our host's perceived loss of youth, feelings of inadequacy, sagging ego, lack of pep and energy, mounting cardio vascular problems, hot flashes, estrogen craving, etc. are heightened by economic and social pressures. Her response is shaped to a great extent in conformance with a life-long pattern of drug taking customs. The pattern of drug consumption does not begin with menopause, but is shaped by societal and personal responses during pre-adolescence and early teens. Our host's environmental background during those formative periods has led to a drug usage context that also is significantly different from her suburban, middle class White counterpart.

It has long been known that drug use among Black females in adolescence is much higher than among White females; it has recently been shown that low income females are more likely to abuse prescribed drugs than middle income females. This is not offered to discount the universality of the problem, merely to underscore earlier statements.

I have purposely avoided the recitation of "startling statistics" that enumerate the billions of needless pills consumed in this country, or to review the literature recounting the horror stories inflicted upon the beleaguered middle-aged American woman, for certainly there are others more qualified and more inclined to engage in such "cadaver counting."

I am compelled by many years in treating the ravages of addiction, my grounding as a Black woman, and my pride and responsibility as an American to implore this Congress to address this problem as it exists, a manifestation of failures in several sectors of American intercourse.

The problem of misuse and abuse of prescribed drugs by middle-aged woman cannot be divorced from the contributory factors that predispose these women to "seek a higher ground." The problem cannot be isolated as a free standing entity extant apart from other societal mechanisms. It is the other side of unbridled expansion of the pharmaceutical industry, haphazard medical practices amid explosion of the health industry, and the American preoccupation with youth. For certain segments of the population it is complicated and worsened by the inadequate provision of health care, economic, social, and cultural deprivation, limited social mobility and a pervading sense of despair and hopelessness.

Need we study how much the patient suffers when we can already exercise some control over the source of the suffering? Need we look all around the problem to find a solution when immediate relief is at hand? By not taking action, Congress has taken an action; an action of acquiescence to the continuance of this problem. Unless more control is placed on the manufacture, distribution, and prescription of drugs with abuse potential, all other efforts and intervention strategies will be seriously compromised.

The continued existence of disparities in opportunities for women and for ethnic minorities precludes any meaningful resolution of this problem and many other "social" problems. Efforts aimed at addressing tangential issues or symptoms, rather than precipitating factors are doomed to be ineffectual. And, by creating the impression of action, then failing in their purported aims these strategies exacerbate the frustration and hopelessness of those affected.

Far too often, American social policy has distorted and emasculated its own objectives and operations by buckling under to pressure groups motivated by personal aggrandisement and prejudices. De facto discrimination and segregation still exists in virtually every area of American commerce and social activity. Schools and housing are still segregated, women and ethnic minorities are

still under represented in the job market and income distribution. Congress must not only recognize the impact that these factors have on the quality of life and their influence on social problems and social unrest, but also take decisive action to change these conditions.

Treating women substance abusers without addressing the factors which drive them to abuse drugs is a no-win policy. Treating addicts with no mechanism to meet the needs that are precursors of their condition is a sham. These problems are not an aberration of the American way of life, they are a direct consequence. They require and call for direct action at the loci of instigation.

Therefore, while we devote our energies to studying the similarities in precursors found in the production of internal morphine like substances and estrogens, the impact of hyperglycemia on female behavior, the actions and interactions of various chemical compounds, we implore Congress to take dramatic steps to insure that each American has an equal opportunity to partake and contribute to the continued growth and prosperity of this great nation.

○