be carefully diagnosed to distinguish it from other more readily treated mental illnesses.

To summarize, then, in devising a health care strategy for older women, it is critical to consider the interplay of many socioeconomic factors along with a variety of physical and mental health factors.

In developing recommendations for the Task Force, the subcommittee on the health concerns of older women identified the need for cooperation among the various State, Federal, and local sectors to develop home health care or community-based care which seeks to maintain the independence of older women. Needed are programs which provide respite care to relieve the chronic isolation, exhaustion, and depression in older women who are care givers.

The subcommittee also recommended that health care messages for older women should be transgenerational. Younger women should be encouraged to take charge of their own health care so that as they reach older age they will maintain their healthy status; older women should be encouraged to continue their healthful lifestyles and maintain their independence and self-esteem as they age.

Thus, the key to good health for older women continues to be a combination of successful health promotion efforts throughout life and adequate access to health care when needed.

Women's Health: A Course of Action

Issues Related to Alcohol, Drug Use and Abuse, and Mental Health of Women

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THIS DISCUSSION concerns Chapter 4 of the Women's Health Issues Task Force report (*1*) entitled "Issues Related to Alcohol and Drug Abuse and the Mental Health of Women" or ADM issues—short for alcohol, drug abuse, and mental health issues.

Highlights

Alcohol, drug abuse, and mental health problems are addressed separately within this chapter because these illnesses are organizationally and diagnostically separate.

Alcoholism is not a psychiatric illness per se. However, it may coexist with mental illness. For example, an alcoholic woman may be depressed or phobic. In this case she has multiple diagnoses, including depression and phobia, which classify her as being mentally ill as well as alcoholic. However, if she is only suffering from alcoholism, she does not have a mental illness.

Similarly, being addicted to heroin is a behavioral dysfunction, which may coexist with schizophrenia. The addiction by itself, however, is not a mental disease. On the other hand, a psychotic depression may coexist with the addiction that resulted from the individual's attempt to ameliorate the depression through self-medication with opiates. Some feel that a subset of heroin users in this country may use heroin to mask psychosis that is untreated by the health care delivery system.

The Task Force limited its report to health conditions or illnesses which (*a*) occurred more frequently in women, (*b*) were uniquely manifest in women, or (*c*) required different treatments or responses when manifest in women.

Using these criteria for inclusion, the Task Force wrote at length about depression, a mental illness that occurs more frequently in women than in men. Indeed, two-thirds of the individuals diagnosed as depressed are women. Similarly, 6 of 10 patients diagnosed as phobic are women.

In contrast, schizophrenia does not occur more frequently in women. However, when it does occur in women, it manifests itself later in life and takes a somewhat different form in that it frequently has affective overtones. Senility and Alzheimer's disease, while not unique to women, are serious problems because women live longer than men and thus are at greater risk of these diseases for a greater number of years.

In the area of drug use other than alcohol, tobacco use results in health problems as reflected in the

rising rates of lung cancer in women. Closely parallel to women's tobacco smoking is the rising increase in marijuana use by females. This year, for the first time, the incidence (number of new users) of marijuana use is higher in females ages 12–25 years than in males. Drug abuse treatment clinics also are reporting increasing numbers of young women who use cocaine.

In our society it is acceptable for women as well as men to drink alcohol. Current survey data indicate that 3.5 million American women are using alcohol inappropriately and may be classified as suffering from alcoholism. In addition to the disease of alcoholism itself, excessive alcohol consumption by women frequently results in damage to organs and body systems. Consumption of the same amount of alcohol by a woman and a man is more likely to result in more serious health consequences for the women, even when the factor of body weight is taken into consideration. Further evidence of this gender vulnerability is manifest by the fact that alcoholic women die 15 years earlier than nonalcoholic women and have death rates 50 to 100 percent higher than alcoholic men.

The deleterious impact of alcohol consumption on hormonal functioning and on the offspring of women also is compelling. At the present time the fetal alcohol syndrome rate is 1 to 3 per 1,000 live births. This statistic is particularly disturbing since it is the only form of mental retardation which is entirely preventable.

Like many other illnesses and health conditions, some ADM illnesses appear to be influenced by genetics. Research is continuing to explore the role of environment in the manifestation of these illnesses in women as well as in men. In the area of the genetics of ADM illnesses, as in other types of health research, the Task Force found a predominance of male research subjects—a problem the Task Force recommended receive adequate attention by the scientific community and the Department of Health and Human Services.

ADM Illnesses and the Lifespan

The risks of having an ADM illness are not equally distributed throughout the life span. These illnesses, like other health conditions, are more likely to occur at certain times in life. In youth, suicide attempts and eating disorders are more likely to occur in women than in men, while alcoholism, prescription drug abuse, and depression are more likely to occur in mid-life—although depression in young women is increasing. In later life, there is good news. The majority of women who live to be old will not be depressed, will not abuse drugs, will not be alcoholic, and will not be senile or have Alzheimer's disease.

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The bad news is that ADM illnesses (whether in men or in women) are not likely to be diagnosed by the primary health care provider. As a result, a woman with an ADM illness is unlikely to be treated by her primary care physician and also is unlikely to be referred to a specialist who could treat her. This is in contrast to what happens when a woman has complications due to pregnancy, when breast cancer is suspected, when she has an abscessed tooth, or when she develops a skin rash.

Women with ADM illness also are stigmatized more than men. Society accepts a little depression, but does not accept institutionalization for a psychiatric illness. And having a drug abuse or alcohol problem is profoundly more stigmatizing for a woman than for a man. Fear of a diagnosis that would lead to stigma, combined with the medical profession's inability to diagnose ADM illnesses, results in many untreated ADM illnesses in women. This is unfortunate since most ADM illnesses respond well to early intervention and treatment.

Relationship to Other Chapters

The risks of ADM illnesses vary throughout a woman's lifetime. However, at one time or another, all women are at risk of one or another ADM illness. This risk was reflected in the social factors chapter of the Task Force Report, where we learned that poverty, poor education, and unemployment are associated with many illnesses. We also were told that social expectations sometimes have an ameliorative or deleterious effect on how ADM illnesses in women are perceived and treated.

When the chapter on women's physical health was discussed, we learned that ADM illnesses are some-

times interactive with malnutrition, sleeping disorders, hormonal functioning, and a variety of other health conditions.

From the chapter on older women we learned that in our society women are expected to care for other family members and that this can cause stress and resulting negative health consequences. We also learned that chronic diseases like arthritis and osteoporosis impact on ADM issues.

Finally, the impact of a woman's minority status on her health was discussed at length, and we were appropriately reminded of the numbers of minority women who are in need of preventive and ameliorative health care.

Consumer Role

These highlights from the ADM chapter and the discussion of how these illnesses interact with the life span, social factors, and other health conditions may prompt the question: What can we do about these ADM illnesses to which women are subject? The most important first step is to be an informed consumer. Informed consumers do not use illegal drugs or tobacco. Informed consumers avoid abusing or misusing prescription drugs and alcohol. Informed consumers also are aware of early warning signs of illness in themselves, their friends, colleagues, and employees and seek help quickly. Informed consumers also insist that the health care system they use is competent to diagnose, treat, or refer patients with ADM problems. Informed consumers also work within their community to support those factors associated with all aspects of good health.

Finally, a consumer can insist on honesty in advertising, an issue related to many aspects of women's health discussed at this conference and additional issues discussed in the full Task Force Report.

Reference

1. Women's health. Report of the Public Health Service Task Force on Women's Health Issues. Vol. 2. DHHS Publication No. (PHS) 85-50206, Public Health Service, Washington, DC, May 1985.

Women's Health: A Course of Action

Making a Difference Through Prevention

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IT IS IMPORTANT TO REMEMBER that the simple things count. Our ability to make a difference in preventing some of the problems in women's health is greater than most persons think. Prevention is something we can handle as individuals. We need not be overwhelmed by scientific methods and complex technology. The automobile industry put a lot of money into the research that made seatbelts workable and now we need to do nothing more complicated than buckle up.

Keep the simple things in mind. That is one message. That is something that women have the ability to do right now, today, for themselves, for their families, and for the people about whom they care.

Second message: Professionals are probably members of organizations. They work with other people, and they may have a leadership role. They may carry a message of their own, both in the things that they do as individuals and in their professional roles. Because of this, they have enormous opportunities. One is to use a very traditional mechanism—talking to colleagues. How does something become an agenda item? How is it made important? Each individual has great influence. Mix influence with energy to accomplish much to achieve goals.

There is another opportunity: working through nontraditional networks to accomplish goals. One of the things to learn about particular populations such as minorities or women or anyone in our society is to take advantage of everyday activities. For example, going to the store and shopping, getting a haircut, going to work, or seeing a physician or dentist.

These activities are very basic and we take them for granted. We do not usually think of them in a professional sense as settings for health education. Yet, for example, a major Washington food chain