The Truth about the Drugs You're Taking, the Sleep You're Missing, the Sex You're Not Having & What's Really Making You Crazy...



Dr Julie Holland

Moody Bitches

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«HarperCollins»

Holland J.

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Overworked? Exhausted? Powering between career, family and friends and frazzled and libido-less as a result? No wonder you're moody! But as New York psychiatrist Julie Holland explains in her radical and eye-opening new book, the first step to overcoming the lows is to accept that being testy is in our nature – we were made to be Moody Bitches.Being a successful modern woman is hard, and for so many of us the constant flux in our hormones and the dip and dives our mood swings take makes it that much harder. For over 17 years, women have visited celebrated psychopharmacologist Dr Julie Holland looking for the miracle cure to eradicate these feelings. Now, in her illuminating and honest Moody Bitches, she details the invaluable advice she shares with her patients, revealing how suppressing our natural emotions is actually damaging. Instead she offers tried and tested alternatives to help keep the moods under control, making exhaustion and low sex-drive a thing of the past.From the meds you can trust to those you can't; from the foods you should be eating, the healthy behaviours you should be practising and the herbal remedies that actually work, Dr Julie imparts wisdom from years of not only professional but personal experience too. Simple yet revolutionary, Moody Bitches is the life-changing self-help book for women and those who love them.

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Dr Julie Holland

Moody Bitches



Also by Julie Holland
Weekends at Bellevue
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Julie Holland asserts the moral right to be identified as the author of this work

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For Sara Starr Wolff, teacher, therapist, and gardener, who wanted what she had, and said what she meant. And for her son, Jeremy, whose shining love and acceptance allow me to blossom.

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Introduction

Women today are overworked and exhausted. We are anxious and frazzled, yet depressed and burned out. Our moods and libidos are at a rock-bottom low, our vital energies drained as we struggle to keep up with work, family, and hundreds of "friends" online. We blame ourselves for how bad we feel, thinking we should be able to handle it all. We dream of being perfect; we even try to make it look effortless, but we were never meant to be so static. We are designed by nature to be dynamic, cyclical, and, yes, moody. We are moody bitches, and that is a strength—not a weakness.

We evolved that way for good reasons; our hormonal oscillations are the basis for a sensitivity that allows us to be responsive to our environment. Our dynamism imparts flexibility and adaptability. Being fixed and rigid does not lend itself to survival. In nature, you adapt or you die. There is tremendous wisdom and peace available to us if we learn how our brains and bodies are supposed to work. Moodiness—being sensitive, caring deeply, and occasionally being acutely dissatisfied—is our natural source of power.

Yet we have been told just the opposite. From a young age, we are taught that moodiness, and all that comes with it, is a bad thing. We learn to apologize for our tears, to suppress our anger, and to fear being called hysterical. Over the course of women's lives, the stresses and expectations of the modern world interfere with our health and hormones in ways big and small, and the result is the malaise so many women feel. There simply is a better way.

Moody Bitches opens the playbook on how we can take hold of our moods and, in so doing, take hold of our lives. By integrating timeless wisdom with today's science, we can master our moods. If we can understand our own bodies, our naturally cycling hormones, and how modern medicines derange our exquisitely calibrated machines, then we can make informed choices about how to live better.

Women's hormones are constantly in flux. They ebb and flow over a month-long cycle and they wax and wane throughout decades of fertility, vacillating with particular volatility during adolescence and perimenopause, the spring and autumn of the reproductive years. Compare this to men's stable hormone levels throughout most of their lives. Our hormonal variations allow us to be empathic and intuitive—to our environment, to our children's needs, and to our partners' intentions. Women's emotionality is normal. It is a sign of health, not disease, and it is our single biggest asset. Yet one in four American women are choosing to medicate away their emotionality with psychiatric medications, and the effects are more far-reaching than most women realize.

Whether it's food, alcohol, drugs, cell phones, or shopping, we all rely on something in order to numb ourselves during difficult times. Whatever the chosen substance, it offers a welcome promise: that things will be different and better once it is consumed. But you can never get enough of something that *almost* works, and because our solutions are usually synthetic, not natural, we come up short. We are uncomfortable in our own skin, with our own desires; we are not at ease in our homes and offices, in our roles as parents or caretakers of our parents. Plowing forward, we think we can outrun the angst if we just stay "insanely busy."

In my psychiatric practice, my patients, like most women, are starved for information about the drugs they're taking and how they can change how they're feeling. *Moody Bitches* is an answer to both problems. I name names (which medicines I love, and the ones I avoid) and discuss the real side effects I've observed—weight gain, libido loss, becoming blasé—and what you can do about them. I share straight talk about enhancing your sex life, the direct link between food and mood, sticking to exercise or sleep schedules, and perhaps the most important piece: tuning in to your body to realign with your natural, primal self.

When I started my practice twenty years ago, women came to me confused by their symptoms and unsure of what to do. They complained of difficulty getting back to sleep or agitation or

tearfulness, but they didn't quite know what was wrong. I helped them put a name to their symptoms and explained that there were medicines that could help. I needed to do more teaching about drug therapy back then, and a lot more hand-holding. I would set aside the last ten or fifteen minutes of the hour-long initial consultation in order to quell the fears of people who were wary of taking something that would alter their brain chemistry.

These days, new patients come to me sure that they need medicine for their nerves or their moods, like most of the other women they know. They want me only to help them figure out which one. The confusion used to be: "I can't understand why I keep waking up at four in the morning"; "It's so hard to get out of bed and I don't really care about anything"; "I'm angry all the time, and I don't know why." But over the years, the conversation has morphed, so that now it usually begins with something like this: "Can you tell me the difference between bupropion and venlafaxine?"; "I can't figure out if I have ADD or OCD"; "Do you know that ad with the woman riding the horse on the beach?"; "Is that new butterfly sleeping pill better than zolpidem?" And the one I hear more than you can imagine from my established patients: "Is there anything *new* I can try?"

The drug companies started direct-to-consumer advertising in the 1980s. Soon after I started my private practice in the mid-1990s, it became less heavily regulated. Ads started springing up on television and in magazines, trumpeting the latest antidepressants and sleeping pills. I went along for the ride as America's use of all prescription psychiatric medications tripled during the nineties, as a direct result of this powerful marketing. By 2006 the antidepressant Zoloft (sertraline) had made more money than Tide detergent, and it became clear to me that something new was happening. Drug companies are spending billions of dollars to turn normal human experiences like fear or sadness into medical diseases. They aren't developing cures; they're creating customers. The problem is not our emotionality; the problem is that we are being persuaded to medicate it away.

The latest news is particularly terrifying. Aripiprazole, a medicine originally formulated to treat people with schizophrenia, expanded into the depression market and is now our nation's top-selling medication, and not just of psych meds. America's number one moneymaking medicine is an antipsychotic. As a psychiatrist, I must tell you, this is insane. There is an ancient Greek word, *pharmakon*, which held disparate meanings—sacrament, medicine, and poison. It is a common saying in medicine that sometimes the treatment is worse than the disease. There are many medications (chemotherapy is a good example) that are helpful or curative at lower doses but dangerously toxic in higher amounts. It is also true that there are powerful medicines that are appropriately used for one diagnosis but are complete overkill for another. Prescribing antipsychotics to treat depression seems particularly out of balance, especially given the risks of irreversible side effects like diabetes or movement disorders inherent in this class of medicine.

We represent 5 percent of the global population, yet we take 50 percent of the world's pills. (We also take 80 percent of the world's painkillers.) Meanwhile, the percentage of people labeled with psychiatric diagnoses is continually growing. Is it possible there really is an epidemic of mental illness and disability happening in our lifetime, or are physicians too quick to reach for their prescription pads instead of offering harder solutions to their patients' complaints? Medical journals are full of only one kind of ad: pages of information on the newest drugs and exactly how to prescribe them. Four out of five prescriptions for antidepressants are not even written by psychiatrists but rather by general practitioners, and more often than not they're prescribed for patients without an actual diagnosis of depression. Particularly troubling: surveys of primary care doctors show they routinely overestimate what the antidepressants can do. They've been hoodwinked by the ads, like the rest of America.

Just as offering your toddler the choice between the red dress and the blue dress moves the conversation forward, beyond "you need to wear a dress," the barrage of antidepressant advertising advances the question from *Should I take an antidepressant*? to *Which one should I take*? Don't let pharma-con change the way you manage your moodiness. I'm here to tell you that there are healthier ways to treat depression, anxiety, and irritability that don't include pills.

It is not solely the right cocktail of neurotransmitters that dictates mood; more than anything, it is how we live our lives. We can improve how we feel by changing behaviors around food, sex, exercise, addictions, and work/family balance. The problem with taking your happy pills and puttering along as before is that it's no better than sweeping dirt under the carpet. I want you to take that rug out back and beat the hell out of it.

But this is not drudgery. It begins with awareness, with the natural process of reconnecting with yourself and your body. Understanding the meaning and utility of your moods is empowering. Reclaiming your authentic, natural self is liberating. It is wholesome and it is healing. Not just for you, but also for your partner, your family, and your community.

This book begins with information about our complex inner workings, revealing the science behind why, as caregivers and nurturers, women have evolved to think and feel differently from men. I explain the wisdom of feeling deeply, and the dangers of cutting ourselves off from that depth. I look closely at why the twenty-eight-day cycle brings on tears and insatiable hunger (and what you can do about it), and how oral contraceptives and antidepressants can disrupt natural phases of desire and connection, potentially leading you to choose "Mr. Wrong," or even to opt out of any mate choice entirely.

The second section delves into relationships and family, with a particular focus on how women's moods mirror critical transition points in our lives. From menarche (the very first menstrual cycle) to mating, from motherhood to menopause, our ever-fluctuating hormones not only dictate but also respond to our behaviors. Testosterone may make you horny to go out and find a guy, but, more likely, seeing a hot new guy will make your testosterone levels rise. We tend to think of love and sex as distinct, but falling head over heels is a physical experience as powerful as any mind-altering drug, and orgasmic sex can trigger hormones that change how attached you are to your partner, complicating your casual hookups. The early stages of a relationship are difficult enough to navigate, but long-term commitment poses its own complications. *Moody Bitches* tells the truth about monogamy and desire, and why it is that your SSRI (anti-depressants like paroxetine or sertraline) is likely not doing you any favors in the bedroom. I also explain the physical and emotional consequences of pregnancy and child rearing; becoming a mother changes not just your body but your brain.

Change is the constant in women's lives, and never more so than in perimenopause, the transitional period before fertility ends that recalls the turmoil of pubescence. *Moody Bitches* unpacks the biology behind the "cougar" stereotype, describes the herbs and supplements that can combat hot flashes, and paves the way for the peace and freedom that await on the other side.

The third section, the Moody Bitches Survival Guide, is an instruction manual for well-being at any age. We begin with a comprehensive introduction to inflammation, the basis of nearly every medical disease, including depression. Stress and inflammation are inextricably linked, and the key to combating both lies in a system you've probably never heard of, the endocannabinoid system. When stress nearly knocks you overboard, your internal cannabinoid system helps to right the ship. Even if you've never smoked a joint, your brain and body use cannabis-like molecules to make you resilient to stress, similar to the way your endorphin system provides you with natural pain relief. These cannabinoids tamp down inflammation and reactivity in the body, maintaining metabolism, immune functioning, learning, and growing. The endocannabinoid system is mentioned throughout *Moody Bitches*, because it is involved in nearly everything we do, like eating, sleeping, exercising, having sex, giving birth, and nursing.

The practices detailed in the survival guide are critical tools for establishing and preserving mental and physical health; they are designed to reduce stress and inflammation and augment the body's own spectacular capacity for producing pleasure. You'll learn about natural nutrition, so you can stop dieting and start eating for health, and normal sleep, so you can prioritize the hours your body needs. In fact, better sleep, nutrition, and regular cardio in the sunshine may just replace your SSRI. The survival guide also includes practical advice on sex that actually works and addresses the main

obstacles women face in reaching orgasm. Getting into and enjoying your body, whether through sex, exercise, or that dreaded word *mindfulness*, will help you achieve the balance and harmony we're all clamoring for.

Moody Bitches is a rallying cry for a new way of living. Our lives are out of sync with nature. I fear that the further away we get from what's natural for us, the sicker we're going to get. Our disconnection is our pathology. We need to get back in tune with our bodies and with the natural world around us. In our digital distraction we've lost a basic truth: fresh air, sunlight, and movement make us feel better. Daily cycles of light and dark will do more for our sleep than any pill, being sedentary is our biggest health hazard, and we miss a lot when our relationships become virtual.

Moody Bitches is grounded in research and informed by my experiences in working with my patients. Health begins with understanding, and my aim is to demystify women's inner lives to enable change. I'm speaking as a psychiatrist, a wife, and a working mother of two children; the prescriptions I share here are what have worked for me, and for my patients.

Our bodies are wiser than we ever imagined, and so much of what plagues them is interrelated. Overmedication has robbed us of our sense of control, and modern life has separated us from the restorative rhythms of nature. It is understandable to respond to the man-made madness of this world with tears and frustration; those feelings of distress are a pathway toward health and wholeness. We need to tune in to our discomfort, not turn it down. Being sensitive, being irritated, and being vocal about our needs and frustrations will improve our lives.

Once we begin to listen to our bodies and align with our moodiness, we can take action. That action might be to try a natural remedy when you had relied on a prescription. It might be to reappraise all that you ask of yourself in your many roles as a woman. The answer for each of us will be unique. But all of us need to stop and listen when we get bitchy. Embracing our moods will, in the end, make us happier.

We need to begin anew, to realign with our bodies and learn how to treat them right. It's time to embody the wisdom inherent in nature, and in our natural animal selves. *Moody Bitches* will show you the way, giving you the tools you need to take care of yourself.

Part One

Moody by Nature

One

Own Your Moods

While I spend most of my workday having one-on-one sessions with my patients, I've made several television appearances as a psychiatric expert over the years. One afternoon not long ago I sat down across from a newswoman in the studio. We were chatting before we rolled tape. She seemed pert, energetic, and emotionally connected. We hit it off immediately and were enjoying the hushed banter that ensues before taping; then I noticed her fingernails were bitten down quite a bit. When I asked her about it, she told me her therapist had consistently recommended she take medication to "calm her nerves," but she was resistant to the idea.

"I bet your anxiety helps you in your work," I offered. "You have to be hyperaware to know what's a good story to cover, and perceptive about when and how to push certain questions during an interview. Also, I would guess you have some obsessive traits that help you stay organized and productive, leaving no stone unturned."

She looked at me like I truly understood her. "Yes." She stared at me, dumbfounded. "Yes!" she repeated. "It's also just who I am: I am nervous, jumpy. I've always been like this. Why would I want to medicate away my own basic personality?"

Why indeed?

More women than ever before are taking psychiatric medications, creating a new normal that isn't normal at all. It is at odds with our biology. Our brains are wired differently from men's brains, and our hormones do make us more moody.

Women feel more, and for good reasons. By evolutionary design, women's brains have developed to encourage empathy, intuition, emotionality, and sensitivity. We are the caretakers and the life givers; our ability to recognize and respond to the needs and moods of others is key to their and our survival, the basis of family, community, and connection. We need to intuit when our children are in danger or in need, or when the men around us might have malevolent intent. We will subordinate when that's safest, but we will also aggressively protect those in our charge, whether family or friends.

Women have always been asked to do difficult work, and our bodies have powerful coping mechanisms to meet these challenges. But living with mechanisms like moodiness and acute sensitivity can be a trying experience on a daily basis. If that weren't enough, like the newswoman I met on set, we are all under constant pressure to restrain our emotional lives and our natural strengths.

The Altered States of America: One Nation, Feeling Like Crap

It's not just that our hormones make us more moody. It's also that the pharmaceutical industry has exploited this biological attribute through advertising. Antidepressants are overwhelmingly marketed to women, stigmatizing depression as a feminine illness, making men less likely to seek treatment, and giving women the go-ahead to take their daily dose so they can cook for their families and dote on their children. Ads for antidepressants (and antipsychotics used to treat depression) are commonplace in women's magazines like *Good Housekeeping* and *Better Homes and Gardens*, and on daytime talk shows. They typically feature pictures of women with sad faces, staring out the window, unable to play with their neglected, frowning children or text their friends. (I wish I were kidding about this last one. The "after" picture for one antidepressant shows a woman now on meds, happily texting someone on her phone.) Many ads now encourage a woman to ask her doctor to consider adding an antipsychotic into the mix after a mere six-week trial of her antidepressant has "failed."

While the number of Americans on antidepressants has skyrocketed year after year, two big bumps are seen historically. The first was when direct-to-consumer advertising broadened in 1997, completely orchestrated by the Big Pharma lobbies. The other jump in sales came after 9/11, when pharmaceutical marketing homed in on women even more. That September, the women I saw in my office were acutely anxious, fearful for the safety of their Wall Street husbands or their children who were in downtown elementary schools near the attack. They were tense, twitchy, and unable to sleep. Coincidentally, the makers of Paxil (paroxetine) came out with a print ad of a woman on a crowded city street, clutching her bag, jaw clenched, surrounded by words like "sleep problems" and "worry," with the tagline "Millions could be helped by Paxil." Drug makers appeared to have found 9/11 to be a marketing opportunity. Glaxo doubled its advertising to $16 million in October 2011, compared with the previous October's $8 million. That's just one month of advertising dollars to hook all the women who had a natural, fearful response to a terrorist act. And it paid off big. They got on their meds and stayed on them.

All of this direct-to-consumer advertising has given many of us, especially people who came of age in the 1990s, an inflated sense that we are lay psychopharmacologists. We've seen enough ads to know which medicines have lower incidences of sexual side effects (bupropion, an antidepressant that does not raise serotonin levels) and which ones report an increased risk of sudden death (aripiprazole, an antipsychotic prescribed for depression, when used in elderly dementia patients). My mother often said, "A little bit of knowledge is a dangerous thing." Gen Xers are quick to stock up on pharmaceuticals garnered from friends, the Internet, and physicians, and dole them out to friends and family. As the *New York Times* explained, "they choose to rely on their own research and each other's experience in treating problems like depression . . . a medical degree, in their view, is useful but not essential."

At this point, everybody and their cat are on antidepressants. Seriously—one of my patients has an underweight cat that was recently prescribed mirtazapine, an antidepressant that can cause increased appetite. In today's insurance-driven health-care system, handing over a prescription is the easiest, quickest way for doctors to get someone out of their office so they can see their next

patient. It also keeps the patients coming back for easy, efficient refills. Unfortunately, shorter doctors' visits, now the norm, mean more time spent alleviating symptoms with pills and less spent digging down to really fix the problem. There is simply no talking about the harder but healthier ways to treat the symptoms. Cholesterol-lowering medicines called statins are a good example. A doctor can spend twenty minutes trying to educate a patient about dietary changes and exercise that could lower cholesterol levels, or can hand over a prescription for a pill being pushed by every drug rep who comes to the office bearing a tray of cheese Danish.

Women are particularly vulnerable to overprescribing. Numerous medical chart reviews consistently show that doctors are more likely to give women psychiatric medications than men, especially women between the ages of thirty-five and sixty-four, who often present with complaints of nervousness, difficulty sleeping, sexual dysfunction, or low energy. A patient recently asked me if he should take Risperdal, an antipsychotic, for his nervousness, because his female colleague told him it had been helping her with anxious thoughts. Risperdal was originally formulated for use in schizophrenia, but people with schizophrenia make up only 1 percent of the world's population. It's obviously better business to target 50 percent of the population: women.

I'm not suggesting that all use of psychiatric medicines is counterproductive. People who don't really need these meds are taking them, while people who are genuinely psychiatrically ill remain undiagnosed and untreated, often due to socioeconomic factors. Clearly there are times when we need to pull out the big guns. Vegetative depressions that last for weeks, when you can't get out of bed, bathe, or feed yourself, are not going to resolve themselves through soul-searching. Manic episodes where there is no sleep to be had for many days in a row will require mood stabilizers. But we've gotten ourselves into a situation in America now where more women are taking antidepressants and antianxiety medications for years on end, and it's lowering the bar for all of us, creating a new normal in terms of invulnerable posturing and emotional blunting, and, more important, it is changing the tipping point for when other women will seek chemical assistance.

Cosmetic psychopharmacology is not unlike cosmetic surgery. As more women get breast implants, the rest of us feel flat chested. And so it is with more women taking antidepressants and antianxiety medications. Suddenly, you're the odd one out if you aren't like your friends, taking something to "take the edge off " or give you a little lift to withstand the slings and arrows on your journey. More women are feeling lousy and finding themselves on psychiatric medications, and staying on them far longer than they were ever meant to be used. And we're not necessarily getting any better.

Made to Be Moody

As women, our interior lives are complex and ever changing. Our neurotransmitters and our hormones—estrogen in particular—are intricately linked. When estrogen levels drop, as in PMS, postpartum, or perimenopause, it's common for moods to plummet as well. Waxing and waning levels of estrogen help us to be more emotional, allow us to cry more easily and even to break down when we're overwhelmed. There are estrogen receptors throughout the brain that affect our mood and behavior, and there are complex back-and-forth interactions in the brain between estrogen and serotonin, the main neurotransmitter implicated in anxiety and depression. Although it's more complicated than I'm making it out to be, it's helpful to think of serotonin and estrogen as yoked. When one is up, the other is likely to be as well. So it is not your imagination. Where you are in your reproductive cycle, monthly and over your lifetime, is an enormous factor in determining what you are feeling.

Think of serotonin as the "it's all good" brain chemical. Too high and you don't care much about anything; too low and everything seems like a problem to be fixed. When serotonin levels are lower, as is seen in PMS, emotional sensitivity is heightened. We're less insulated and end up more cranky, irritable, and dissatisfied. The most common antidepressants, also used to treat anxiety, are serotonin reuptake inhibitors (SSRIs). These are medicines (such as fluoxetine, sertraline, paroxetine,

citalopram, and escitalopram) that block the brain's natural recycling of the serotonin back into the nerve cell, so more can get across to the next neuron. If your serotonin levels are constantly, artificially high, you're at risk of losing the emotional sensitivity that makes you *you*. You may be less likely to cry in the office or bite your nails to the quick, but you're also going to have a harder time reacting emotionally and connecting fully with others, especially sexually.

SSRIs not only affect behavior, they alter perception of the environment. If the "it's all good" chemical is bathing your brain, will you really try very hard to fix anything? At higher doses, SSRIs sometimes promote apathy and indifference. Patients report having less motivation overall. When one of my patients becomes blasé about things, making the big *W* sign for "whatever" about life, it's a sign to me that she might be overmedicated, and it's time to taper down the happy pills. Being more complacent and apathetic can have disastrous effects on your life, both at home and at work.

Sometimes, if I see a patient with crippling depression or anxiety, then prescribing an SSRI is the right call, but even if it is the best initial treatment, it might not be the forever cure. Feeling deeply may, at times, be difficult to navigate, but it's also a powerful tool, in the workplace and at home, and it's essential for growth. We are built to be highly attuned and reactive, and embracing that truth is the first step in gaining mastery of our inner lives and our health.

Hardwired to Feel

Women's brains develop differently from men's, and the distinctions make for profound differences in how we process and communicate emotions. All brains develop along the same pathway in the womb, but things change for boys at eight weeks, once the testes become functional. With testosterone in the mix, a surge in the male sex hormone kills off many cells in the communication centers and grows more neurons slated for action, aggression, and sexual drive. In men, these brain areas take up two and a half times the space they do in women.

Even more brain changes occur after gestation, during adolescence, when sex hormones surge, further differentiating the sexes. As the female brain develops, more space and more brain cells are reserved for language, hearing, and memory. Our memory center, the hippocampus, is larger than men's, perhaps reflecting an evolutionary advantage of remembering details of emotional events and the crucial behaviors of our potential mates, especially what they said they'd do versus what actually happened. Our memories have an influence on our emotions. The hippocampus can calm the hair-trigger responses of the amygdala, the area of the brain devoted to fear, aggression, and anger. The amygdalae are larger in men and have receptors for testosterone.

Ever wonder why you can lose it and then calm down, but those feelings continue to echo for your husband? Women's larger hippocampi and smaller amygdalae may add up to our having better control over our emotional outbursts than men, particularly when it comes to actions involving fear or aggression. We might react emotionally, but then we pull it together, thanks to the hippocampus.

We are not living in a world that is kind to this sort of behavioral response, though. When under acute stress, the amygdala gains in functionality and the hippocampus loses, one reason you panic and can't remember as well when pushed. The biggest problems come with chronic stress, where the hippocampus loses not just functionality but brain cells. It becomes atrophied, can no longer quiet the raging amygdala, and then all responses to stressors are amplified. This is what is seen in posttraumatic stress disorder, and it may well be seen in anyone undergoing chronic stress.

Intuiting the motives and feelings of others is an essential social skill that is employed unconsciously and automatically and has been characterized as quintessentially feminine. The better we are at sensing our body's signs of arousal (feeling our own heartbeat, for example), the better we are at judging emotions in ourselves and others. The insula, thought to be the seat of self-awareness, empathy, and interpersonal experience, helps us to understand others and is noticeably bigger in women. The insula not only helps us process "gut feelings," to figure out what we and others are feeling emotionally, but also enables us to experience and recognize body sensations. What has often been labeled "female intuition" has served women well in their traditional roles as caregivers and

nurturers. The ability to intuit the emotions and desires of others has helped women better predict whether a man may become violent or abandon the children, or whether our nonverbal babies are hungry or in pain.

Men aren't built to be as sensitive as women are. Women have more brain circuitry not only for expressing language and emotion but also for detecting emotional nuance and anticipating what others are feeling. Given that there is such a gender discrepancy with this empathic system, it's likely not your imagination that your boyfriend has no idea what he's feeling half the time (called alexithymia) and has even less facility at communicating it. Testosterone impairs empathy and the ability to intuit others' emotions by reading their eyes. Being aware of or oblivious to others' needs is bound to affect how giving a person is, one reason you might think of him as selfish.

We register conflict more deeply than men, and get more stressed out about it as well. No doubt some of this is learned behavior, as girls are often encouraged to keep the peace more than boys, but there is a strong biological component. When men are threatened, their bodies go into "fight or flight" mode, with adrenaline surging to provide energy to muscles. When stress levels are high in women, "tend and befriend" behavior often predominates. Women are more likely to band together in the face of adversity, creating strength in numbers, huddling together to save the children and one another. Oxytocin, the hormone released in women after orgasm and during cuddling or nursing, encourages prosocial, trusting behavior, while testosterone tends to fuel aggressive, competitive behavior. In both men and women, high testosterone levels blunt oxytocin levels, and vice versa, so there is give-and-take between aggression and bonding. Oxytocin's release affects women more powerfully than men, helping us to be more generous and connected. It also helps us to figure out who is in and who is out of our circle of contacts, our tribe. In hostile environments, or with unsupportive contacts, oxytocin may actually enhance the stress responses, even playing out as aggression toward strangers. Protective mothers' maternal aggression has been linked to oxytocin, for example.

Girls flock together and keep social harmony, often through language. Staying connected via gossip and verbal intimacy leads to a rush of dopamine, one of the brain's pleasure chemicals, and oxytocin. Estrogen triggers dopamine and oxytocin production in pubescent girls. Midcycle, these hormones peak, as do verbal output and desire for intimacy. Whereas women tend to discuss troublesome issues with peers, men tend to process their troubles alone, nonverbally. This may reflect the balance of oxytocin versus testosterone. Testosterone inhibits talking and the drive to socialize. For boys, self-esteem comes from being independent, not interconnected. Boys aren't as communicative, and they aren't nearly as derailed by conflict and competition. It's part of who they are, and, perhaps equally important, who they're expected to be.

The connections between the areas of the brain that process emotion are more active and extensive in women. Women have nine areas devoted to this function, compared with only two in men. Women also have more bilateral processing of emotions in their brains, going left to right, right to left, connecting the analytic and emotional areas, whereas men tend to stay more within each hemisphere. So we could say that women are using their whole brains while men are often using only half of theirs at a time. Women do seem to be better at multitasking than men. Men not only have more difficulty juggling multiple priorities but they are also slower and less organized than women when switching between them.

Men's brains have more linkages with their cerebellum, the control center for movement, so for men, there may be less time between seeing and doing than there is for women. Men tend to outperform women on motor and spatial cognitive tasks, while women are faster in tasks of emotional identification and nonverbal reasoning. We also outperform men on a "lost key" challenge; maybe this is why our families ask us where everything is, and, more important, why we know the answer. Because men were primarily the hunters and we the foragers, it was crucial that we remembered where we last found the good food.

Obviously, we must be cautious in discussing differences between the sexes because there is a large variation within each gender, and nurture and culture factor in nearly as much as nature does. There is interplay between our natural abilities and how we are molded to behave that is impossible to fully tease apart. Case studies of children with ambiguous genitalia who are raised to be male or female even though they possess the opposite genetic material are rare, but they do help to teach us one thing: the influence of biology cannot be underestimated. Often, our own balance of testosterone and estrogen levels dictates how aggressive we'll be in a pickup game of basketball (or if we'd ever be caught dead in a pickup game of basketball) more than anything our parents ever taught us.

The Downside to Feeling Deeply

While biology may provide women with a set of attributes, from brain structures to hormones, that are advantageous in our traditional roles of nurturing and caregiving, there is a downside. These same attributes may also make us more inclined to suffer from depression and anxiety. In childhood, no difference exists in the prevalence of depressive disorders between girls and boys. In adulthood, women are twice as likely as men to experience depression and two to four times more likely to be diagnosed with an anxiety disorder like panic attacks or generalized anxiety.

The increased risk begins early in adolescence as puberty strikes. It ends by age sixty, when hormonal cycling ceases. Although some of the increased incidence of depression in women may result from societal factors like body image pressures, or their greater tendency to seek help for mental health issues, or diagnostic bias among doctors, there is strong evidence that much of the gender difference in mood disorders is linked to hormones.

Some women are more susceptible to hormonal fluctuations than others. There is a subgroup of women who seem to be at risk for what's called reproductive depression, that is, mood changes caused by variations in hormone levels, like those seen prior to menstruation or after delivery. If you're the PMS type, you're also more likely to have postpartum depression or perimenopausal mood instability. Certain women have a specific sensitivity to these hormonal changes while some lucky ones don't, possibly dictated by genes governed by changing estrogen levels. The good news is, when your hormones aren't fluctuating, like when you're postmenopausal, the risk for depression isn't elevated. After menopause, the risks even out, especially two years after the final menstrual period, when the dust has settled. There is truth to the idea that the years after menopause are a real prime time of life for many women, both professionally and personally.

Again, there are likely evolutionary reasons for mood variability being tied to hormonal fluctuations. There is a positive mood state (called euthymia) in the first half of the menstrual cycle, leading up to ovulation, that encourages a woman to connect with mates and conceive. The more depressed, progesterone-heavy state in the second half of the cycle helps to ensure the safety of the product of conception by keeping the woman passive, cautious, and out of danger. Progesterone rises during the second half of the menstrual cycle and surges even higher if an egg is fertilized. It is the main hormone that maintains pregnancy. Progesterone is implicated in premenstrual syndrome, postpartum depression, and dysthymia, a chronic low-grade depression. The increased incidences of depression and anxiety during pregnancy (particularly in the first trimester) and the immediate postpartum period come during crucial periods for the baby, when more cautious and isolative maternal behavior can help ensure the baby's survival. If women develop these behaviors, whether conserving precious energy or avoiding dangerous situations, then these traits will be passed on. Viva Darwin.

Anxious and depressed behaviors have survived in our gene pool for millennia because they are adaptive. They confer an advantage to our survival and that of our offspring. An anxious, obsessive forager will not only find more food, but will also return home safely. She is also more likely to keep her children out of harm's way. Likewise, a depressed woman will more quickly withdraw from wasted enterprises, whether pursuing food or a mate, and conserve her energy. This may be the basis

for seasonal affective disorder, which causes lower energy and motivation when food supplies are most scarce.

When women feel under threat, estrogen helps us to "maintain," to be resilient and bounce back. In this way, estrogen is really acting as a stress hormone. One of the ways estrogen builds resilience is by enhancing serotonin levels, which help to keep us fortified, calmer, more rational, and less emotional. Serotonin activity is greater during higher estrogen levels. When estrogen surges, it causes more serotonin to be made, and it also causes serotonin receptors to be made. But, as with most things in the body, what goes up must come down. The natural process of stress triggering surging estrogen levels has a built-in stop mechanism, which then normalizes our serotonin levels.

SSRIs are the most common treatment for depression and anxiety, but if you're on SSRIs, with steady serotonin levels, you miss out on this natural ebb and flow of serotonin in response to estrogen. You stay more rational and less emotional. Estrogen fluctuations help to keep us sensitive. SSRIs deaden our sensitivities.

More women than men get depressed, and estrogen may have a lot to do with this. Estrogen affects how serotonin functions in the brain. Women are more vulnerable to changes in serotonin levels and more responsive to drugs and medicines that affect serotonin. This is one reason that women may be more affected by sexual side effects of SSRIs than men. So where you are in your menstrual cycle or your perimenopausal staging will have effects on your mood, like how irritable, sensitive, or impulsive you are, as these behaviors are affected by serotonin. As you'll see in the next chapter, it's normal to have times in your cycle when your estrogen is lower, which means your serotonin will follow suit and you'll feel lousy. It's temporary and it's natural. You don't necessarily need daily antidepressants to mask these moods.

SSRIs can do many wonderful things for people with serious depression, and I have to admit that my patients love the way they make them feel, at least at first, but they can also take many sensations away. SSRIs tend to blunt negative feelings more than they boost the positive ones. On SSRIs, you probably won't be skipping around gaily with a grin plastered on your face; it's just that you're less likely to feel tearful, irritable, and hopeless. People on SSRIs report less of many other human traits: an ability to cry, irritation, care about others' feelings, sadness, erotic dreaming, creativity, surprise, anger, expression of their feelings, and worry.

One of my best friends from college told me a story of when she was first prescribed fluoxetine. "It really scaled back my empathy. Since I was a young girl, I've always felt bad if someone else felt bad. It's a big part of who I am. I would let the other kids find the Easter eggs during the hunt, because they seemed to want them more than I did. When I first went on fluoxetine, I remember seeing another woman crying and thinking, *Looks like you have a personal problem. Sucks to be you.* This is what it must feel like to be a dude." SSRIs affect emotional processing and turn down the empathy response. This can have devastating effects on the ability to parent or to maintain relationships.

It's All Right to Cry and Get Angry

Antidepressants can be utilized as a starting point for benefiting from psychotherapy or creating lifestyle changes, but once those behaviors are firmly in place, the medications often can and should be tapered off. If you break your leg, you don't keep the cast and crutches forever. Before you commit to a lifelong SSRI prescription, consider the dynamic emotional range you might be giving up.

My patients on SSRIs will report, "I knew the situation was upsetting. I was supposed to be feeling sad, but I couldn't cry." Crying isn't just about sadness. When we are frustrated, when we are angry, when we see injustice, when we are deeply touched by the poignancy of humanity, we cry. And some women cry more easily than others. It's normal. It's how we're designed, and it doesn't mean we're weak or out of control.

Crying allows us to deeply feel what we're feeling and then move on. It is a crescendo that naturally leads to a denouement of intensity. For most women, this depth of feeling is a birthright, but if you really can't stand crying, or get frustrated because you can't speak when your throat tightens,

here are two tricks that work well instead of meds. Simply think up lists of rhyming words, or subtract sevens from one hundred. Shunting blood away from the emotional centers and over to the rational verbal or calculating areas will mollify most people. (You just have to remember to do it, which means relying on your hippocampus to tamp down your amygdala.)

There are times when it's inconvenient, to say the least, to cry, but there are other times when it's to your advantage. Letting yourself cry can be important in communicating with your partner. A clear, visible sign that we're upset may be just what men need. Women pick up subtle signs of sadness in others 90 percent of the time. Men are better able to discern anger and aggression; when trying to decide whether their female partner is sad, men are right only 40 percent of the time. That's less than if they flipped a coin to help them answer. This is also a reason to express your feelings verbally and not expect your male partner to know how you're feeling by how you look or act. They're simply not constructed for intuiting emotion the way we are. As for families, sometimes it's a good idea to let your kids see you cry, especially if they've scared you with reckless behavior or frustrated you with thoughtlessness. Tears can underscore lessons in how their behavior affects others.

But we clearly have issues around our tears. Have you ever noticed how often women apologize for crying? In part it's because men are uncomfortable with expressed emotion, and so they, and we, have been socialized to shut it down. Another part is that emotion interferes with the forward-momentum agenda so prevalent in our society. The problem with shutting it down is that we're stifling a piece that we need, that our partners and families need, and that the world needs.

Being sad can help us make clear-eyed assessments of our lives. Depressed people are no longer in denial about unpleasant or hurtful truths. SSRIs can create complacency in times when action is needed, perhaps to leave an abusive spouse or a dead-end job. Medication can make a bad situation tolerable and mask the need for change. In one study of medicated women, "these patients continued to lead dysfunctional lives, and their motivation for major lifestyle changes seemed to decrease as depressive symptoms improved." In such situations, the symptoms of depression, unpleasant though they may be, can be the clarion call to action.

Another issue to consider: stuffing down your feelings is going to make you miserable. The suppression of anger in particular is a crucial factor in depression. People who've experienced depression are more likely to hold in their anger and fear expressing it, believing they must hide their feelings to preserve their relationships. Depressed patients have higher levels of anger than control subjects; the more anger, the more severe the depression.

In my office, I see evidence of this link frequently. Many of my female patients have no idea how to express their anger in healthy ways, and their suppressed anger contributes to their depression and, I believe, other medical symptoms as well. They weren't taught as young girls that it was okay to be angry, and they weren't schooled in how to handle this kind of emotion. Sugar and spice don't make space for anything that's not nice. When we don't even know we're angry, we can't converse with the person responsible or otherwise tackle the problem. We cry; we eat; we soothe ourselves a thousand different ways. Instead, we need to fully feel our feelings of anger, figure out where they are coming from, pull ourselves together, and then head out the door for a face-to-face conversation. I had a patient who called me from her office in tears, saying she needed to go up on her SSRI because she couldn't be seen crying at work. After dissecting why she was upset (her boss had humiliated and betrayed her in front of her staff), we decided that what was needed was calm confrontation, not more medication.

In an examination of women's employment reviews, certain words show up repeatedly, like *bossy, abrasive, strident*, and *aggressive*. This is when they lead; words like *emotional* and *irrational* are used when they object. Men are exhorted to be more aggressive in the workplace, but not so with women. What's interesting is that SSRIs reduce aggression, poor impulse control, and irritability while increasing cooperation and affiliative behaviors. Primate research shows that SSRIs augment

social dominance behaviors, elevating an animal's status in the hierarchy. So they may well help women get along, and even get ahead, in the workplace, but at what cost?

I notice in my female patients a certain self-consciousness about being assertive. "I think, maybe" is the way a woman begins her sentence even when she knows damn well that she's right. We hem and haw to seem as if we're unsure, even though we should trust our gut and speak firmly and bravely. Growing up, I was taught, directly and indirectly, how to couch my ideas so they'd be taken as suggestions or opinions and not as statements of facts. I will not teach my daughter to tone down her self-confidence when she speaks. Little girls need every ounce of self-esteem they can get. It's much easier to soften the edges later in life than it is to build up a foundation of self-worth. And girls who hold on to their assertiveness and self-esteem are less likely to grow up to be depressed women.

The H Word

In the nineteenth century, hysteria was a uniquely female diagnosis that became a catchall for many women's complaints that couldn't be immediately remedied. Nearly all physicians were men in the 1800s, and they lumped a number of physical and emotional symptoms reported by women under one heading, derived from the Greek word for uterus, *hystera*. Criteria for hysteria included malaise, headaches, irritability, nervousness, insomnia, fatigue, low libido, high libido, water retention, and, eventually, any behavior undesirable to society, such as organizing the right for women to vote. One treatment for hysteria involved bringing the patient to orgasm, while another, clitoridectomy, involved surgical removal of the clitoris, and was performed throughout the 1880s and into the 1920s.

These days, hysteria has a more specific meaning: excessive expression of emotion, especially vulnerabilities such as despair or panic. If a woman behaves in a way that a man finds uncontrollable or inconvenient, she will be accused of being hysterical, basically being told she doesn't have a right to feel or act that way because it isn't in line with how a man would feel or act. Keep in mind, many a boy grows up at the mercy of his mother's emotions, and so men fear the emotionality of women. This may be one reason that some male doctors are quick to squelch any expression of emotion in their female patients, most easily by reaching for a prescription pad.

While the term *hysteria* is no longer officially used in medicine, there is the increasingly common diagnosis of the "women's disease" fibromyalgia. Symptoms include mysterious muscle aches, joint pain, and exhaustion. Coincidentally, the current treatment for fibromyalgia is antidepressants. Epidemiological studies show a female-to-male preponderance of three-to-one for chronic pain diagnoses like fibromyalgia. Men are less apt to receive a diagnosis of fibromyalgia than women, even if they have the same symptoms.

In my office, I often hear stories of misdiagnosis from my female patients. They offer lists of physical complaints to their male doctors, who are quick to dismiss them as hysterical, though they never utter that word if they're smart. "You're just stressed" is a popular conclusion offered instead, or else they're saddled with the diagnosis of fibromyalgia and treated, conveniently, with the same medicine they'd get if they were "just stressed"—antidepressants. Over the years, I've had multiple patients misdiagnosed with fibromyalgia when in fact they had Lyme disease, lupus, hypothyroidism, rheumatoid arthritis, or, in one case, ovarian cancer.

Women's sensitivities extend to the physical; our bodies feel more pain than men's do. There is overwhelming laboratory evidence that women have lower thresholds for pain, experience greater pain intensity, and have a lower tolerance for experimentally induced pain. Women are also more apt to notice aches and pains in their bodies, due to their neurologic underpinnings, particularly their more active insulae. We have more serotonin receptors to process pain, and our hormones estrogen and progesterone affect endorphin transmission and opiate receptors, leading to higher perceptions of pain.

It is important to note that where we are in our menstrual cycle also affects our pain sensitivity. We are more sensitive not just to social slights before our periods but to physical pain as well. Add to this the fact that many of us do somaticize, that is, focus on how our body feels and convey that to

others. Again, this may be the insula in action. Some of our awareness and discussion of our physical pain may be caused by our experiencing, but not giving a voice to, the psychic pain of feeling put-upon or burdened. Our psyches are silently screaming for attention and relief, but we translate that psychic pain into bodily pain, which is easier to attempt to eradicate with medications and the attention of (often male) physicians.

The study of pain specific to women is in its infancy. In the journal *Pain*, nearly 80 percent of the studies included male subjects only, with only 8 percent studying females only. Medicine is not keeping pace with the pain so many women suffer. Men presenting with the same symptoms as women are taken more seriously and given a more thorough diagnostic workup. You see this in reports of chest pain, in lung cancer, and in general complaints and diagnostic workups. Without a doubt, you see it the most in psychiatric complaints.

Women are still, very simply, second-class citizens in the world of medicine. Until recently, surgeons knew much less about female pelvic anatomy and nerve-sparing surgery for women than for men. This ignor-ance has translated into thousands of hysterectomies (the US performs this operation more than any other country) with avoidable complications, like diminished or absent orgasms or urinary incontinence.

Nearly all medical research, and in particular drug research, is still performed on male subjects, whether animal or human. Later, when the drugs come to market, problems specific to women may surface only after the drug has been in use for many years. Eight of ten drugs withdrawn from the market between 1997 and 2001 posed greater health risks for women than for men. After twenty years on the market, the sleeping pill zolpidem finally has a separate recommended dose for women, half the strength of the usual dose, because it turns out that women metabolize the drug differently, having higher levels in their blood from the same dose. People are finally talking about the fact that women are unrepresented in clinical studies, but until the medical community better recognizes the complexity of the female brain and body—and how they differ from men's—we will be at a disadvantage.

We are not men. We are women. We feel more deeply, express our emotions more frequently, and get moody monthly. It's normal. It's nature's way. And we don't necessarily have to medicate away the essence of who we are to make others more comfortable. In fact, once we better understand our bodies and our own moods, we will realize that as women we have many natural tools for tackling all of the challenges of our busy, complex lives.

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