Healthsharing

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Paul Schwartz

Collective Notes 2

In Brief

Newsfronts 3
Healthwise 5
Health Wanted 5

Letters 6

Features

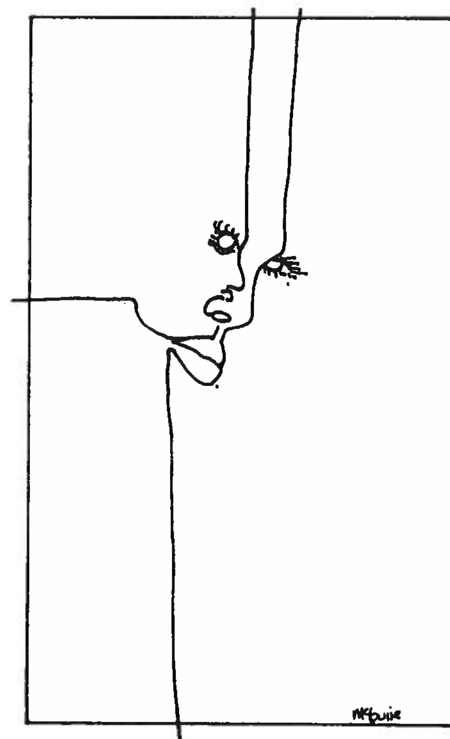
Insurance You Can't Collect 7
The Perils of Pain Killers 11
Standing Still and Taking Stock: The Well Being Interview 15

Reviews

Two Films About Rape: *A Scream from Silence* *Why Men Rape* 18

Resources 19

Collective Notes



"Facts" assault us from all sides. Wherever we turn yet another study, another news item, another rumour confronts us. Finding it difficult to sort one fact from another we slip into the practice of accepting information wherever we encounter it. All too often magazines, books, television and radio shows present information without providing a context, sources, or any framework from which to evaluate the information. This can lead the avid or questioning reader to frustration; it can cause misunderstanding if the information is biased or insufficient; it often thwarts us when we need more complete information but don't know where to turn.

Several *Healthsharing* readers have expressed concern that we have fallen into this pattern. Penny Watson of Newmarket, Ontario has criticized us for not including sources in our news column. She suggested that "for the purposes of credibility in your Healthwise section Vol. 1, No. 1, the statements made about various studies and/or research, should be *fully referenced,* i.e. the name of the study, where and when it was conducted, by whom, etc."

The question of how numerous and extensive references should be was the crux of debate within Women Healthsharing prior to publication of the first issue. We wanted the magazine to be readable and to reach a cross-section of women. This desire led us to try to avoid an academic style. At the same time we wanted *Healthsharing* to be an important and useful source of information for readers.

As a small quarterly journal, *Healthsharing* is faced with maintaining clarity, comprehensiveness, credibility and conciseness. Our Newsfronts column was designed to provide an overview of the range of studies, changes and events affecting women's health in Canada. Each issue we are faced with choosing a limited number of items from among many interesting pieces of news. In our effort to include as many as possible we cut each item as much as possible. To this end we had sacrificed many references.

Your comments have caused us to reconsider our original decision to leave out references. As you will see in this issue's Newsfronts whenever appropriate we have included basic sources within the context of each piece. Because of space limitations and the intent of Newsfronts, each item cannot be comprehensive — if this were the case each short would become an in-depth article. Major articles are chosen to tackle a variety of health concerns. If you would like to see a particular item followed up in a major article please let us know.

Reader Marie Thibaudeau wrote us that "Women have long accepted, without any critical judgement, the gossip of commercial superficial magazines 'for women'." We can't say it any better. With your continued help we will try to avoid shallowness and to provide an insightful, credible Canadian women's health magazine. Thank-you.

HYSTERIA

A feminist quarterly from southwestern Ontario by, for and about women

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HYSTERIA cannot afford to pay contributors, but welcomes them nonetheless. Please send a self-addressed, stamped envelope to the above address, with graphics, news items or outlines of proposed articles. The Fall 1980 issue will be on Women and the Arts.

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Newsfronts

$60,000 Awarded for Operation Without Consent

A Schomberg, Ontario woman was awarded $60,000 against a Newmarket doctor who performed an operation on her without her consent. Olga Hankai agreed to a dilation and curettage (D and C) following a spontaneous miscarriage. While Hankai was under the anaesthetic the doctor, Harry Jackson, also performed a meatotomy (a surgical procedure on the meatus, the opening through which a woman's urine passes).

As a result of the meatotomy urine now sprays backwards into Hankai's vagina.

The jury was told that Jackson, a GP, performed 123 meatotomies in 1978. By contrast, two gynecologists at York County Hospital where Jackson has privileges, performed no meatotomies in the same year. Jackson allegedly instructed nurses to always have instruments for meatotomies ready for use when he performed D and C's.

More Bad News for DES Daughters

Women whose mothers took diethylstilbestrol (DES) to try to prevent miscarriages face a higher risk of losing their own babies to miscarriages, stillbirths or other complications.

A study reported in the March issue of the *New England Journal of Medicine* states that 81 percent of DES daughters who became pregnant were able to have at least one full-term live birth, compared with 95 percent of other women.

Vitamins C and E Against Cancer

A team of researchers at the Princess Margaret Hospital in Toronto report that levels of carcinogens found in the feces of study subjects are lowered in the presence of vitamins C and E.

Dr. Robert Bruce, in an interview with *The Medical Post* (February 12, 1980) described the following results: "When people received vitamin supplementations, the mutagenic compounds present in the feces went down by a factor of four. We also see the same effect on the level of mutagens by adding fibre to the diet. Based on epidemiological data, this is in fact what you get when you shift from a high to low protein and fat diet.

"The problem relates to a deficiency in the western diet of vitamins C and E, fibre and other anti-oxidants. In the presence of those deficiencies, micro-organisms in the body end up generating chemicals that are carcinogenic.

"It now looks like you get an inhibition of the nitrosamine compounds using as little as 100 mg of ascorbic acid (vitamin C) and 100 mg of tocopherol daily (vitamin E), which is not that much more than the recommended daily allowance. But it looks like the majority of people in Ontario aren't getting even the minimum requirements."

On the basis of these preliminary findings, the Princess Margaret team is now in the middle of a two-year study to see if cancer of the colon can be prevented.

Acid Rain Attacks Human Health

Acid rain has been in the news recently because of its environmental effects. New evidence, however, demonstrates that it can have an even more direct effect on human health because of its corrosive properties.

Wolfgang Fuhs, speaking to a recent Toronto seminar on Acid Precipitation, reported that acid rain lowers the pH of the water table, resulting in the corrosion of metal pipes and metal-containing rocks.

A study carried out by Fuhs in the Adirondack Mountains in New York State found unusually high levels of both copper and mercury in the lakes sampled.

Because gastrointestinal symptoms have been attributed to copper toxicity, the effect of acid rain on the frequently used copper in water pipes could be a problem.

There is also a correlation between the pH of lake water and mercury levels found in fish. It appears that under acid conditions, mercury is transformed into a type of mercury easily accumulated in fish.

By eating contaminated fish, humans build up an accumulation of mercury, which can lead to severe neurological disorders and birth defects.

Confronting Unpunished Rapists

Rape Relief, a rape crisis centre in Vancouver, is using a new confrontation tactic against rapists who have not been charged or convicted of the assault.

About 15 women, including the victim, appear at the home of the rapist and chant: "We know what you did. We know who you are. We're watching you. We're going to fight back." The tactic is used only if the victim agrees.

Other techniques used by the centre include distributing leaflets about particular rapists or hanging posters describing a rapist, including a note to women telling them about Rape Relief.

Asbestos Contaminating Public Buildings

Workers and others who frequent buildings constructed or remodelled in the 1950's and 1960's are now facing a massive problem with free asbestos contaminating workplace air.

Asbestos causes cancer of the lungs, stomach and intestines, and is the only known cause of mesothelioma, a cancer of the lining of the lungs and stomach. Large exposures give rise to the respiratory disease known as asbestosis, a scarring of the lung tissue which makes it more difficult for oxygen to be absorbed into the body.

Asbestos was widely used in building construction as insulation. Even ventilation systems were lined with the fireproof

material. However, the cement which holds the fibres together deteriorates over time, and is now releasing asbestos into the building air.

Some offices have been found to have levels of asbestos much higher than provincial standards allow in mines and asbestos production factories (2-5 fibres per cc of air).

In New Brunswick and Ontario, concern about this problem has focused primarily on schools, which have been closed temporarily in Toronto and Petitcodiac, New Brunswick for testing. A large number of Petitcodiac graduates (mostly under 25 years of age) are being investigated.

The Canadian Union of Public Employees is also pursuing compensation for a Toronto school maintenance worker whose cancer they believe resulted from asbestos exposure. The union has also led a fight by Hamilton, Ontario library workers who want their library closed and cleaned up because of asbestos contamination.

Remedial programs, which involve spraying asbestos-lined ceilings and ventilation ducts with an adhesive, have been instituted in some buildings. However, this is only a temporary measure which should not allay the public's fears about the contamination.

Tranqs Fed Women with Migraines

A study recently released by the Addiction Research Foundation shows that tranquillizers and anti-depressants are prescribed to 41% of women with migraines. The report, "Tranquillizers and Mood Elevators in the Treatment of Migraine", was based on a questionnaire study of 1500 people.

The study found that women were more prone to migraine than men, and are also more likely to use drugs to relieve it, including prescription and over-the-counter pain killers. Male sufferers are far more likely to be prescribed specific migraine drugs than the tranquillizers commonly prescribed for women.

One critic of the use of mood-altering drugs for migraine treatment noted: "When you give a drunk a cup of coffee, what you have is a wide-awake drunk. Give a migraine sufferer a tranquillizer and you've got someone with a headache walking around zapped."

Rosemary Dudley, director of the Migraine Foundation, notes that triggers of migraine include cheddar cheese, chocolate, changes in weather, noise, alcohol and prolonged lack of food, as well as tension. Most physicians assume the cause in women to be tension and treat with tranquillizing drugs. Other non-medical treatments are usually ignored.

Talc and Ovarian Cancer

In a report published in the August 18, 1979 issue of *Lancet*, investigators at the U.S. National Cancer Institute suggested that direct passage of cosmetic talc through the reproductive tract may play a role in the development of ovarian cancer.

The risks are difficult to pin down because talc products marketed before 1973 were usually contaminated by asbestos, a carcinogen. A clear link between asbestos and ovarian cancer has been demonstrated in human and animal studies.

Talc particles have, however, been found deeply embedded in ovarian, cervical and endometrial tumors, where no asbestos appears to be involved.

Talc is used in many commercial products which may come into contact with the vaginal opening, including dusting powders, condoms, contraceptive diaphragms, toilet paper, textiles, soap and other products.

The authors suggest that hazardous talc exposure may begin in infancy, with the repeated application of talcum powders. Some of these particles could be expected to reach the surface of the ovaries. Following onset of menstruation, it is speculated that hormonal changes could stimulate changes in the ovarian cells. Additional exposures in adulthood could accelerate this process.

The authors call for further research.

Healer Cleared in Death of Baby

Margaret Marsh, a former MD charged with negligence in the death of a baby delivered at home, was found not guilty in a recent court decision.

Marsh attended the birth in question in July 1978. The birth was breech, and the baby died as a result of hemorrhaging of tissue enclosing the brain.

The trial was notable for controversies around home births and spiritual healing.

In his decision, Judge Peter Millward stated: "I'm faced with evidence of eminent authorities called by both the Crown and defence that the most eminent do make mistakes in detecting the position of fetuses. I'm unable to conclude that any act or omission on the part of Margaret Marsh prior to delivery was indeed negligence."

"Exercises Not Important"

Just when you thought you couldn't be offended any more . . . they came up with *Vagette.*

A report in the November 1, 1979 issue of the *American Journal of Obstetrics and Gynecology* tells of a new "galvanic device for pelvic-floor stimulation" used to strengthen the pelvic floor and perineal muscles in cases of urinary incontinence.

The authors, R.S. Scott and G.S.C. Hsueh argue that because of "poor patient motivation" pelvic floor exercises "play no major role in present management of urinary incontinence in females".

The Vagette, claim the authors, not only has the advantage of saving us exercise, but improves sexual function in some women as well.

What next?

Herpes Treated by Contraceptive Creams

Preliminary research on the treatment of herpes simplex virus with contraceptive creams appears promising. Howard Donsky of Toronto General Hospital reported results in the treatment of twenty patients in a letter to the *New England Journal of Medicine.* Eighteen of the patients responded positively to the application of a cream containing five percent of Nonoxynol 9, the active ingredient of over-the-counter contraceptive creams and foams.

Though venereally-transmitted herpes infections have become epidemic in number recently, no effective therapies have yet been found.

Research will continue with a double-blind study into the long-term use of the Nonoxynol 9 creams.

Healthwise

Getting Off the Wad

by Kathleen McDonnell

So you've heard the rumour that tampons are contaminated with asbestos, too? Just try substantiating this rumour by writing your friendly tampon manufacturer. Chances are you'll receive something like the reply Johnson and Johnson gave recently: "Our *Carefree* tampons are made from a blend of cotton/rayon fibres which are compressed and sterilized. Thank you for writing." Judy Norsigian, of the Boston Women's Health Book Collective, last year wrote all U.S. tampon manufacturers and received across-the-board assurances that tampons are safe. However, since tampons have no "active" ingredients and are not classified as drugs or medical devices, manufacturers are under no legal obligation to reveal their contents to consumers. But we do know that a variety of cellulosic fibres, agents to increase bonding and /or absorbency, deodorants, bleaches and often lubricants are used in making tampons.

If these aren't reason enough for checking out alternatives to "the wad", there are others — not the least of which is cost. A whole box or more per period can get bloody expensive! And don't forget ecological considerations — throwing away *anything* after a single use seems slightly immoral these days.

With these things in mind you may want to check out:

Menstrual sponge: This is an old method being revived by women's health activists. Simply purchase a natural, unbleached sea sponge; avoid any chemically treated bath sponges. Mediterranean silk sponges have the greatest absorbency. You can cut it into pieces that vary from the size of an egg to a lemon, depending on your flow.

Wash your sponge thoroughly and, if you like, boil it for a few minutes (no more than ten or it will become tough) to remove salt residues. Rinse it thoroughly, adding a little vinegar to mimic the natural pH of the vagina. You can sew a piece of dental floss to it, but your fingers can probably remove it more efficiently. Wring it out, pat it dry, and pop it in. When it's full, wring and rinse it out and reinsert. After your period, wash it thoroughly, rinse as above and let it dry in the open air. Store in a clean cloth bag until you need it again.

Drawbacks? Well, as writer Barbara MacKay says, "I haven't yet summoned up the courage to rinse it in a public washroom sink." She gets around this problem by carrying a spare with her in a film canister. Advantages? Other than the advantages mentioned above, sponges are highly portable and come in particularly handy while travelling. Barb says she can't wait to go camping this summer without a box of Tampax strapped to her back. "Just me and my sponge, from sea to me."

Diaphragm: I've stumbled across my very own alternative to the wad — an old diaphragm. If it keeps sperm out, I reasoned, why can't it keep menstrual flow *in*? And it does, with the same advantages and disadvantages as the sponge. (I haven't rinsed it in public either.) On heavy flow days I wear a sanitary pad in addition to or instead of the diaphragm. (Yes, Virginia — some people *still* use pads.) But most of the time it does the job all by itself. You may not want to use the same diaphragm you use for sex, since it will discolour badly.

For me, the "messiness" factor with both these methods is not a negative thing. Women are taught from an early age to be repelled by menstrual blood. Tampons are a wonderful invention in many ways, but they also remove us from this physical fact of our periods. Maybe I'm an oddball, but I like being in touch with my menses. I'm off the wad for good.

Health Wanted

This column is to help you obtain needed information. If you're having a specific health problem and aren't coming up with a solution, if you're working on a research project, if you're exploring a particular concern in a collective, write to Health Wanted c/o Women Healthsharing. We are not able at present to respond to individual inquiries, but we will print your request in Health Wanted so that women across the country can respond directly to you. Be sure to include a complete mailing address.

Endometriosis

One of our readers is looking for information on alternatives to the usual drug and surgical treatments for endometriosis. If you'd like to share any personal experience with this condition, or if you have any leads on alternative treatments, please write Health Wanted c/o Women Healthsharing, P.O. Box 230, Station M, Toronto, Ontario M6S 4T3. We'll pass your comments along.

Tubal Ligation

A Toronto birth control counsellor would like to hear from women who have had irregular bleeding, abnormally painful periods or other complications following a laparoscopic tubal ligation. Please send details of your experience to Michelle Dore c/o Health Wanted.

Letters

We reserve the option to print letters to Healthsharing, *with minor editing for length, unless they are marked "not for publication."*

Dear sisters,

It is with pleasure that I subscribe to your magazine. I will look forward to using your articles in my work with Franco-Ontarian women's groups. One of these groups does have as an objective to inform Franco-Ontarian women on health matters from a feminist, preventative perspective. It is called "Le centre d'auto-santé des femmes d'Ottawa-Vanier" and is loosely modelled on the Montreal experience [see "Nurturing Politics and Health: Centre de Santé des Femmes du Quartier", *Healthsharing*, Vol. I, No. I] although its funding is limited.

Very best wishes,
Carmen Paquette, Pro-Femmes, Ottawa, Ontario

Dear *Healthsharing*,

I enjoyed your first issue but have one suggestion to make. For the purposes of credibility in your Healthwise Section Vol.1, No. 1, the statements made about various studies and/or research should be *fully referenced*, i.e. the name of the study, where and when it was conducted, by whom, etc.

Yours truly,
Penny Watson, Newmarket, Ontario

Hi *Healthsharing*,

Just three weeks home from Mexico where I contracted Hepatitis, A type. Before leaving, I went through regular immunization procedures. Never did I read of or was it suggested that a shot of gamma globulin would prevent possible contraction of hepatitis.

Reasons for not mentioning it to tourists (it is given to CUSO workers and all company employees going outside the country as regulation) is because a) it is too expensive; b) it is not necessary. My lifestyle in Mexico did not leave me open to any unusual risks of getting hepatitis. I was careful. Therefore it is necessary.

The expense of having a two month disease which temporarily destroys your liver would make any cost small for tourists to have to pay for the shot. An active blood donor, I now cannot give again. It's crazy! Cheers from a horizontal position.

F.H. Eger, Montreal Quebec

To the editor,

I have just received a copy of Vol. 1, Number 1 of *Healthsharing*. Although this paper contains valuable information, I am somehow uneasy about some of the selected information you give under the column "Newsfronts". I think that when you choose to select and lift out of context a bit of information from a research report, you should be very careful what information you give and how you phrase it. I am referring specifically to three items: "Nursing Stress", "MD's Admit Sexism" and "Back to the Breast".

The first one should be entitled "nurses' stress". This type of information is useless if you do not state how stress is defined, how it is measured, the number of subjects studied and what this data means, compared to other groups of males and females. The same remarks apply to the second item. Concerning the third, it is a useless piece of information unless you raise the following question: When whites introduce into a culture a new pattern of behaviour, often to solve a problem caused by the introduction of the white culture in the first place (soft drinks, junk food, alcohol, refined food and therefore, lack of vitamins C and D), should they not explain fully and with the appropriate means all the elements in the new health pattern? It means here holding the child in the arms to bottlefeed him. It is the position of the baby that makes the difference, when you are dealing with otitis media, not the breast or the bottle *per se*. It may counter the problem of "selective biased information" if you give the complete source of information, i.e. the title of the report or the article and where it was published.

Women have the right to be well informed about health and your journal will be helpful in the long run if it does this well. Women have long accepted, without any critical judgement, the gossip of commercial, superficial magazines "for women".

I wish your periodical good health.

Marie-F. Thibaudeau
Faculté des sciences infirmières, Université de Montréal, Québec

Dear sisters,

Congratulations on your first issues of *Healthsharing*. It promises to be an excellent forum for sharing information and ideas about health care issues.

I am a feminist and an angry, disillusioned health care professional. I often feel very alone in the provincial, patriarchal community where I reside. I hope that *Healthsharing* will provide a valuable support network for me. Keep up the good work.

In sisterhood,
D.R., British Columbia

Insurance You Can't Collect

Victor Schwartzman

Drawings by Patsy Berton

If you are a woman in the paid labour force you almost certainly pay premiums for Unemployment Insurance out of every paycheque. A compulsory plan run by the federal government, UI is especially important because it provides the only insurance package available to many women covering loss of income due to maternity or illness. It is also a scheme so full of boobytraps and doublethinks that the benefits often self-destruct before a woman can collect a single cheque.

Which brings us to Stella Bliss.

Bliss was a Vancouver office worker in January, 1977 when her employer discovered she was pregnant and fired her. She protested to the British Columbia Human Rights branch, and while waiting for a decision applied for maternity benefits from Unemployment Insurance.

UI's maternity benefits are designed to cover loss of income at around the time of birth. They run for fifteen consecutive weeks. Benefit cheques are 60% of your previous salary, to a maximum weekly cheque of $174. The average UI cheque is about $110 per week.

To qualify a woman must be pregnant... must have worked at least twenty weeks in the past year (or since her last UI claim, if she had one recently)... and must have conceived her child while "attached to the labour force," i.e. working or drawing UI.

The Magic Ten

Bliss' application for benefits was turned down. UI officials told her she'd run afoul of Section 30 of the complex UI Act. Specifically, she didn't have her "magic ten." This is UIC's cutesy name for any ten weeks within the period from between thirty to fifty weeks from the expected date of birth — in simple language, from the time of conception.

To illustrate, the expected date of birth of your baby is January 1, 1980. UIC reviews your work history from January 23, 1979 to June 14, 1979. During that twenty week period, you need at least ten weeks of "labour force attachment," or UIC will think you're having a baby so you can collect fifteen weeks of benefits. Bliss did not have ten weeks, so her claim was denied.

However, justice prevailed — more or less — when she won a favourable ruling from the BC Human Rights branch and got her job back. Unfortunately, four days before giving birth, her employer fired her again!

Six days after the delivery, her doctor declared her fit to work. She needed a job and income, so she went back down to her local UIC office, this time to apply for regular UI benefits. Again she was denied. This time, she'd run afoul of Section 46.

Catch-22, Mrs. Bliss

Section 46 states that during the eight weeks before the birth and for the six weeks after, a woman can receive *only* maternity benefits. During those fifteen weeks a woman can not collect regular UI. Which meant Bliss, who would otherwise have qualified for regular benefits, could not collect them, nor could she qualify for maternity benefits. This meant that about all she could collect was her hat, on the way out of the office. Catch-22, Mrs. Bliss.

By now she was getting angry. It felt like UIC was ripping her off. She went through UIC's internal appeal system. She lost her appeal, which is not surprising since claimants win appeals only 18% of the time. She followed it with an appeal to the Umpire, who is a Federal Court Judge specializing in UI appeals involving policy decisions.

This time she won. The Umpire ruled that forcing her to wait for six weeks after giving birth before being eligible to receive regular UI benefits was discrimination based on sex.

UIC immediately appealed this ruling, and the Umpire's decision was overturned by the Federal Court of Appeal. Determined to see it through, Bliss then took her case to the last possible court of appeal: the Supreme Court of Canada.

Mr. Justice Roland Ritchie wrote in his decision of October 31, 1978, that the UI regulations being questioned formed "an integral part of a legislative scheme enacted for valid federal objectives and they are concerned with conditions from which men are excluded. *Any inequality between the sexes in this area is not created by legislation but by nature.*" [Our italics.]

The Court also pointed out in the unanimous decision that the differential treatment of women written into the legislation was "because they are pregnant and not because they are female."

A spokesperson for the Vancouver Status of Women called the Supreme Court decision a "kick in the stomach" for all women. She pointed out that 30,000 women a year "are denied regular UI benefits simply because they're pregnant... inequalities are sustained by legislation, not by nature."

Bud Cullen, then Minister responsible, promised that the maternity benefits situation would be reviewed. Recommendations would go before Cabinet in "the near future." The recommendations must have gone before Cabinet, right past it and out the window, for that was the last anyone heard of them.

Additional Pitfalls

About 35% of all claims applied for are rejected by UI as not meeting the qualifying conditions. Maternity benefits are no different. And the complex regulations include additional pitfalls, should a woman qualify. For example, an unknown number of women are denied benefits because they were unfortunate enough to have lost their jobs at the wrong time.

Maternity benefits are paid only as the *first* fifteen weeks of a claim. When the woman works right up to the time of birth and then applies, fine. But what if the due date is November 1 and you're laid off in early May? You apply for regular UI benefits because you need to work. Of course no one hires you when they hear you're pregnant. Then, after a summer of unemployment, mid-September arrives, eight weeks before you're due... and UI cuts you off. You *already* collected the first fifteen weeks of benefits, the printed notice informs you — you can't get any more income until six weeks after the birth!

The true story of C., from the files of the Unemployment Help Centre in Toronto, is a classic example.

When C. first began working as a small company's bookkeeper, C. put in a lot of unpaid overtime, straightening out the messy records. Half a year later she discovered she was pregnant. She was single and decided to have the child. An honest person, she also decided to inform her employer.

Her employer told her not to worry. A month later, he told her to place a newspaper ad for another bookkeeper to "help with the load."

Two weeks after the second bookkeeper was hired, C. was told "there was no need for two bookkeepers" and was fired. "The truth of the matter," C. writes, "is that the only reason I was fired is because I am single and pregnant.

"When I applied to UIC in December, 1978, they informed me I would have no trouble collecting unemployment benefits, but it would only be for fifteen weeks. Then I would automatically be cut off and could not receive more until six weeks after my baby was born.

"I still had to prove I was looking for work, which I did. It turned out to be quite futile since every place I approached did not want a temporary person.

"I sincerely hope that my account can help to bring about a few changes in the UI concerning maternity benefits. It is very hard for a single person to get by, but a single expectant mother, it is next to impossible. If I may say, with all honesty I am worried sick about what is going to happen between now and when I either get back to work or get back on regular UI benefits, whichever comes first.

"I have a terrible feeling that UIC will once again kick me in the teeth."

C. survived her ordeal, but with no thanks to UIC. The legislation was painfully clear — she lost fifteen weeks of income exactly when she needed it most.

Higher Unemployment = Tighter Regulations

As our economy worsens, as unemployment increases, the government has progressively tightened the regulations. In 1978, UI was "tightened" in a way that eliminated many people from qualifying for benefits. About seventy percent of part-time workers are women. Previously one had to earn a certain amount of money a week to qualify it as an "insurable week". When qualifying regulations were changed to a minimum of twenty hours worked per

week rather than an amount of money earned per week literally hundreds of thousands of workers, primarily women, were excluded from benefits.

Similarly, "new entrants" to the labour force or people who've drawn UI in the last two years now usually need twenty weeks of work to qualify. Again this hits women the hardest, since they are "last hired and first fired."

There are additional restrictions on UI maternity benefits, as well. If you leave the country during the fifteen weeks around the birth date, you can't collect. If you are an adoptive mother, you can't collect.

The recent seven-month Progressive Conservative government had an attitude similar to the previous Liberal administration. Ron Atkey, PC Minister responsible for UI was quoted as stating his government was considering further changes to maternity benefits to "tighten up the system. The Government does not intend to throw people on the welfare rolls. The intention is to increase the incentives to work." A few months later, however, the *Toronto Star* attributed an 11.4% jump in welfare cases to "tightened unemployment benefit restrictions and the arrival of cold weather."

It can be a cold wind indeed that blows from Ottawa . . . especially for some of us.

Recent statistics indicate well over 750,000 officially unemployed nationally, with only about 40,000 available jobs.

Business As Usual

Lest anyone believe the Liberals softened their hearts while out of power, we were quickly shown that it was business as usual — and as usual you got the business.

The *Toronto Star* reported on March 13, 1980 that "A veteran Bell Canada operator has been denied maternity benefits by Unemployment Insurance officials because her union was holding study sessions on the two days before she was due to stop work" and go on maternity leave.

The two days Carrole Cote missed were January 4 and 5. The Bell Canada strike did not begin until January 21. But UI ruled that by attending a union study session on the last two days before her leave Cote was somehow participating in the strike, despite the fact that the strike didn't actually begin until two weeks later.

And if you're on strike then technically you can't be "available for work". *And* to qualify for maternity benefits, apart from being pregnant you must otherwise be available to work. *And* therefore, if you're about to claim maternity benefits and your union goes on strike, you're cut off.

Why would our government offer a compulsory maternity benefits plan and then try to make sure as few women as possible can collect? Is this logical?

Yes — but only if you assume that the government doesn't really want many people to collect these benefits, it only wants to score points with the voters by offering them.

This is reflected in the manner in which regular UI benefits are administered. Officials dole out benefits so grudgingly (unless you are a man over twenty-four) that the inescapable conclusion is that many officials don't believe there should be a UI to begin with!

UI policy includes singling out married women for extra interviews with "benefit control" officers. These officers work under a quota system that demands they cut off at least half of the women they see. The rationale is that women are "secondary income earners", despite the fact that half of the two spouse families in Canada would be below the poverty line if both spouses did not work. UI constantly charges that women "abuse the system," and yet it has never offered a shred of proof that women cheat or use the UI system unfairly. Rather, UI abuses them.

And Now for Illness Benefits

UI's illness benefits are a vital topic for all women in the paid working force because it is often the only medical plan available. The problems with these benefits are less obviously discriminatory, but they still boil down to the same situation: few or no cheques, and a whole lot of hassle.

Illness benefits run for a maximum of fifteen weeks, depending on the nature of the specific medical problem. Pay is identical to maternity benefits.

There are two key problem areas: 1) assessing the nature of the health problem and how long it will incapacitate the worker, and 2) oodles of red tape. At least the maternity benefits rules are clear cut and available for anyone to read. Illness benefits are far murkier, with decisions based on secret medical guidelines. The result is that UI, as are some provincial Worker's Compensation Boards, is often accused of being too bureaucratic and far too tight-fisted.

B.'s true story highlights the problem. On the advice of her doctor she quit her factory job, since it was worsening an already bad heart murmur. She applied for UI illness benfits while she regained her health. A month later she was notified that her benefits were being denied.

Two grounds were cited: she hadn't submitted a medical certificate (no one told her to), which meant her health claim was "unsubstantiated" . . . and she wasn't qualified anyway because apart from being sick she would otherwise still be unavailable for work because she was pregnant. Never mind she was only two months pregnant.

There was a lengthy series of appeals during which her savings were eaten up. Eventually the unjust penalties were lifted and it looked like clear sailing — until the office notified her that her claim would be processed as a maternity claim rather than an illness claim, even though she was by then only five months pregnant.

The case is still in the process of being processed.

Provincial health plans cover medical costs, but they do not pay the rent. Many people who depend on UI illness benefits at this critical time often get benefits three or four months late, or not at all.

One big problem is with the medical certificate. When you apply for illness benefits, you are given a special yellow form to be filled out by your doctor. She describes your health problem and then mails the form back to UI. Using this form UI officials then consult their secret in-house medical yardsticks and allot what they feel is an appropriate number of weeks of benefits. At its best the process usually takes two months before a cheque is in the hands of the claimant: two months of being unemployed, sick and without income.

The delay is almost entirely due to red tape. Forms must pass through a variety of hands and bureaucratic levels. Complex cases are referred to Regional Headquarters. UI often does not trust your doctor and demands that you go to one of the doctors it hires on a part-time basis. These doctors are often charged with bias against claimants.

It is also common for the UI office to allow only two or three weeks of benefits on the basis of the medical certificate your doctor submits. Then it often demands new forms be filled out for each additional two week period. The forms are mailed to you and you must take them to your doctor, repeating the process over and over. If your doctor is late in returning any of these additional forms, you will be cut off. Your benefits will stop, usually without any notice. After several weeks go by, you contact the office and *then* you are informed of the problem.

Moreover, there are the usual UI ambushes for the unwary. K. was a real person who lived in Toronto. She was a good writer, but lost her job when her company laid off many workers. After months of unemployment — and collecting regular UI benefits without too much trouble — she suffered a nervous breakdown and was hospitalised.

Which was when UI cut her off.

UI officials recognised K. was genuinely ill. That was not the issue. The issue was that she'd suffered her breakdown at the wrong time in her claim. She was hospitalized in her fortieth week of benefits. At that time a person could receive illness benefits only up to the thirty-ninth week of a claim (if you got sick on claim). After that, you could receive nothing.

Some Advice

UI deals with volatile areas. Politicans are under constant pressure from employers, and particularly minimum-wage employers, to keep UI to a minimum. And when $4.5 billion are paid out in a single year to the unemployed, UI becomes an indictment of the governments's own economic policies, increasing the pressure politicians feel to "tighten up" the system, whether it really requires tightening or not.

In the current climate, the best advice to give any woman in the paid labour force should she become sick or pregnant is to contact both UI *and* the locally based UI Help Centre in her area at the same time. Help Centres have sprung up in major cities across the country to help people receive benefits to which they are entitled. These Centres are often successful in handling appeals or problem cases simply because, unlike the average person, the Centre staff knows the rules.

Make certain you understand everything. Remember, it is actual UI policy not to inform you of the most basic regulations. For example, by policy local UI offices will not inform regular benefits claimants how many jobs they are expected to search for each week — and then the office later cuts claimants off because they haven't met the secret number of contacts! This "seat-of-the-pants" insurance is great for the politicians, but unfortunate for the average Canadian.

Above all, never assume that merely because the government forces you to pay premiums for these insurance schemes that it actually wants you to collect the benefits when you need them.

Victor Schwartzman worked for eighteen months with UI as its spokesperson and chief information officer in Toronto. He is now a free lance writer and volunteers with an unemployment help centre.

The Perils of Pain Killers

Leslie Storozuk

Analgesic abuse is rapidly becoming a world-wide epidemic. Thousands of people throughout North America, Europe, Britain and Australia are suffering from the results of misusing pain killers. The medical profession has been following the course of analgesic abuse for some twenty-five years and has issued intermittent public warnings. But the problem continues. And it continues precisely because the very people who are in danger have no idea what the problem is.

The threat of analgesic abuse is a loaded gun aimed at women; each advertisement is an additional bullet put in the chamber. Women must collectively move out of range and empty the chamber.

Analgesics are pain killers. There are different types of analgesics just as there are different types of pain — one would not use aspirin to treat major post-operative pain just as one would not use Demerol for minor headaches. Most analgesics are available by prescription only, a necessary precaution due to their side effects and abuse potential. This, theoretically, exerts control over their use.

Concern about analgesic abuse has traditionally focused on powerful prescription-only medications such as morphine, Percodan and Talwin because problems with these drugs are quickly evident.

However, analgesics which do not require prescriptions, commonly called over-the-counter (OTC) drugs, are also frequently misused and overused. The main OTC's of concern in Canada are acetylsalicylic acid and its proposed substitute, acetaminophen. [For a summary of appropriate uses, dosages, side effects and brand names please see the box on page 13.]

Inappropriate Use

What exactly is analgesic abuse? In very simple terms it is the inappropriate use of analgesics. Because, by definition, analgesics are used to treat pain, their use in circumstances where pain is minimal or absent constitutes inappropriate usage. Prolonged usage for undiagnosed pain is also misuse.

Pain is a *symptom*. Therefore, severe, continuous or unexplained pain should be accounted for as well as relieved. For example, recurring headaches may be caused by tension, particular foods, workplace chemicals, poor lighting, smoking, etc. By not seeking out the cause of the headaches a person with recurring headaches may be putting herself at continued risk, and as well, may become anxious about the headaches — thereby compounding the cause of her headaches. A person's fear of what might be "wrong" with her body is often strong enough for her to keep buying and taking OTC analgesics until there is, in fact, something very definitely wrong.

Reports published in Switzerland and Scandinavia from 1957-1968, the time when analgesic abuse became a concern of the medical profession, showed that although a minority of abusers took analgesics for accepted reasons (especially the treatment of rheumatoid arthritis), the majority of abusers took analgesics to relieve "migraine," depression or to provide psychological lift.

Ironically, inappropriate use in North America tends to shift to the other extreme, with ASA being used for its sedating qualities. For example, in 1972, a non-feminist women's magazine published a series of hints that one could try to combat insomnia. Included in the list was the suggestion that one take an aspirin at night to act as a mild sedative. The truth is that aspirin has no stimulant or sedative properties and should never be used for such purposes.

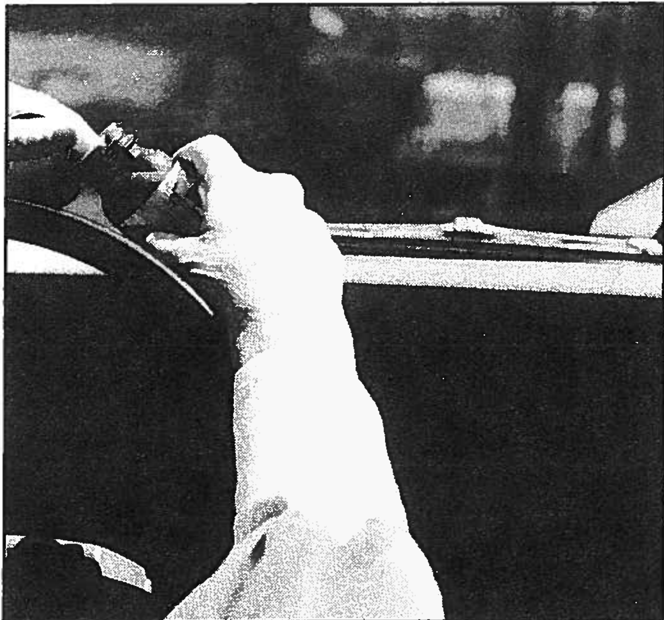
Dangers of the Big Two

Kidney damage is among the most serious problems resulting from analgesic overuse. Two types of kidney lesions have even been so closely associated with analgesic consumption that they are now classed under one general term — *analgesic nephropathy* (from the Greek word meaning kidney). According to a report in the C.M.A. Journal in 1972 analgesic nephropathy is a common cause of terminal renal failure and accounts for 5.5% of all cases requiring dialysis and kidney transplantation in Ontario.

European estimates have found that approximately 2.5% of patients accepted for dialysis have analgesic nephropathy, whereas in Australia, where there has traditionally been widespread usage of OTC analgesics, 25 per cent of dialysis patients have analgesic-induced kidney damage.

These types of lesions have been known to the medical profession for some time but patients usually had some underlying condition which predisposed them to the development of kidney damage (diabetes, urinary obstruction, or both). It was not until 1953 that Spühler and Zollinger first

Leslie Storozuk at work in Ottawa.



Pat Foote-Jones

Various authors including Henderson, Baines and Dr. Priscilla Kincaid-Smith, a leading nephrologist from Australia, have summarized the syndrome as follows: 1. There has been continual use, usually for three years or more; 2. The patients complain of abdominal or loin pain, usually described as "back-ache"; 3. Examination of urine reveals the presence of white blood cells (not normal); patients often have received medication to treat urinary infections even though an infection is rarely present; 4. Blood pressure is often raised, this being secondary to the kidney disease; 5. Patients have personality problems — *"most have prominent psychotic or psychoneurotic abnormalities."* The patients, usually "unintelligent" women of low social class, display marked dependence on people and things. According to Henderson, "They almost long for the tranquility of death." These patients display swings in personality, ranging from friendly extroverts to depressed, angry women. Henderson also feels that more than a grain of paranoia is evident in their personality; 6. Excessive use of alcohol is common and they may smoke heavily; the marital situation and the work environment are not happy and these women often talk of leaving their jobs and their marriages; 7. Anemia is common and so these patients often take supplemental iron and liver preparations.

According to Kincaid-Smith, less common manifestations of the syndrome include premature aging and severe arteriosclerosis. Coronary artery disease is the commonest cause of death in patients with analgesic nephropathy. Baines reports that the syndrome is also associated with an increased incidence of cancer of the urethra. While a 1972 report in *Excerpta Medica* claimed that an underlying neurotic personality predisposes to analgesic abuse, Kincaid-Smith feels that chronic analgesic abuse may cause organic dementia.

Nefarious Onslaught

Who is responsible for this nefarious onslaught against women? One should immediately look to the manufacturers of these agents who annually spend millions trying to convince consumers (women) that Product A is better than

ACETYLSALICYLIC ACID (ASA)

Common brand names of ASA:
Alone — Acetal; Anacin; Arthritic Pain Formula; Astrin; Bufferin; Disprin; Ecotrin; Entrophen; Excedrin; Instantine; Novasen; Sal-Infant & Sal-Adult; Supasa; 217; 217 Strong; **In combination with other drugs** — Darvon N Co; Darvon+ ASA; Dristan; Equagesic; Norgesic; Norgesic Forte; Robaxisal; Robaxisal PH; Robaxisal C 1/8 and C 1/4; Veganin; 217 Mep; 222; 282; 282 Mep; 292; 293; 294; 692.

Uses: ASA is used to treat mild to moderate pain (headaches, general aches and pains); fever; and swelling, joint-stiffness and pain found in arthritic conditions.

Recommended Dosage Range: 325 mg - 10 g daily, depending upon usage. Dosages in the upper range are reserved for arthritic conditions and should not be used without first consulting a physician.

Side Effects:
Low doses — 325 mg - 975 mg daily can: cause stomach irritation, heartburn and indigestion; precipitate or aggravate ulcers; cause bleeding sufficient for various types of anemias to develop (about 6% of iron deficiency anemias are related to the use of analgesics); alter the blood's ability to clot normally (for up to 7 days even after one 325 mg tablet); cause the loss of minute amounts of blood due to small stomach erosions.

Large doses — 10-12 grams or more taken over as little as a 12-24 hour period can: cause severe bleeding; lead to disturbances in acid-base balance (respiratory alkalosis and metabolic acidosis), sufficient to cause death; cause severe kidney damage; cause gastric haemorrhage, possibly fatal.

ACETAMINOPHEN

Common brand names of acetaminophen:
Alone — Atasol; Atasol Forte; Campain 500; Exdol; Exdol Strong; Tylenol; Tempra. **In combination with other drugs** — Atasol 8, 15 and 30; Exdol 15 and 30; Robigesic; Sinutab; Sinutab SA; Sinutab with codeine; Tylenol #1, #2, #3, #4.

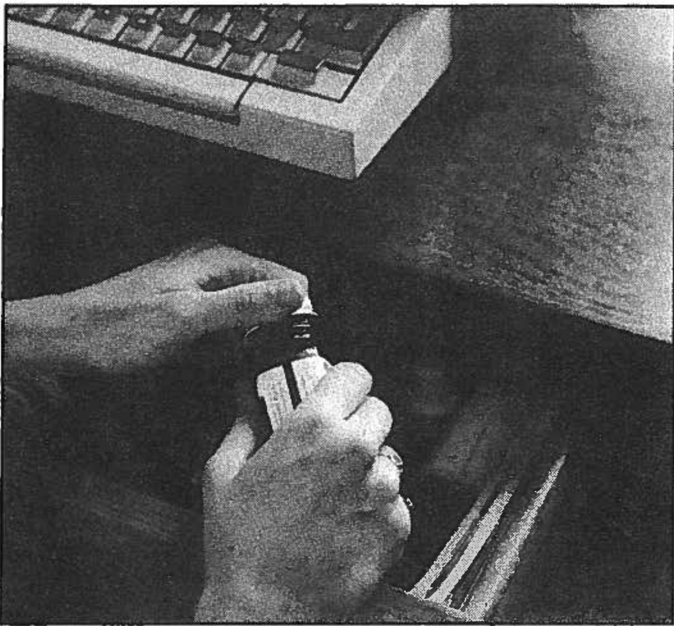
Uses: Acetaminophen is used to treat mild to moderate pain and fever. It is the agent of choice for people with an allergy or an intolerance to ASA and/or who have ulcers. It is of little use in treating arthritis.

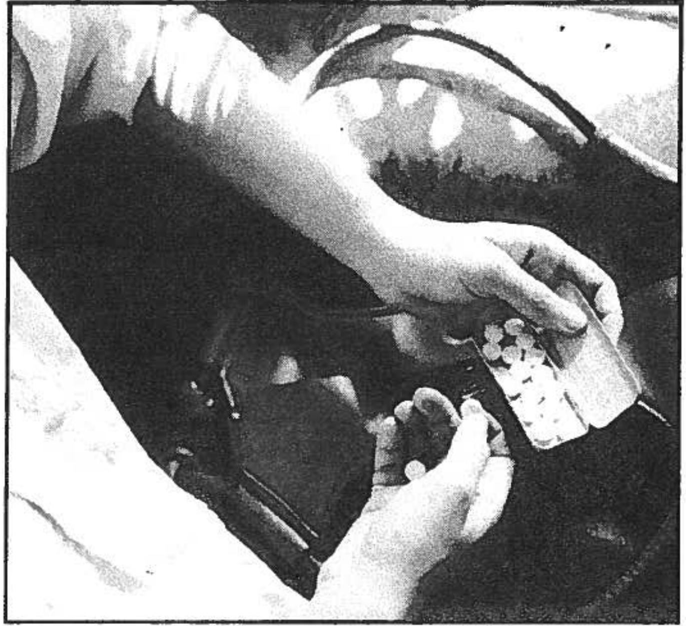
Recommended Dosage Range: 325 mg - 4.0 g daily, for short periods.

Side Effects:
Low doses — Up to 3 grams taken daily for a short time (a few days) generally have few or no side effects. However, 2-3 g taken daily for less than 1 year (to treat chronic pain) have caused serious liver damage. The potential for damage increases if there is underlying liver disease or regular use of alcohol.

Acetaminophen overdose — 12-20 g taken either deliberately or accidentally, is difficult to treat because the symptoms usually do not appear for 2-3 days, while the antidote must be administered within 10 hours of the overdose if it is to be effective.

These drugs should never be treated as candy; if taken inappropriately, they can and do kill! Neither should be used to induce sleep. Neither one should be used for prolonged periods. If pain or fever are still present after 2-3 days of treatment, consult your physician. If chronic ingestion is necessary, insist that your blood be checked regularly. Never exceed the recommended dosages and take the medication for as short a time as possible. Keep the drugs out of the reach of children. **Do not drink alcohol with either agent.**


Pat Foote-Jones


Pat Foote-Jones

reported the connection between this type of kidney damage and abuse of analgesics.

The accumulated statistics also began showing that the people afflicted were changing. No longer was the sex-age distribution fairly equal. It began to surface that the emphasis was shifting to middle-aged women who had no predisposing medical factor which would explain the disease. The one factor they had in common was their *excessive use of analgesics.*

Analgesic abuse has only developed into a widespread problem since the Second World War. More importantly, it has developed into a *women's problem.* According to Dr. Cornelia Baines, in *all* countries analgesic abusers tend to be middle-aged women.

In 1974, in a report prepared for pharmacists at Ottawa General Hospital, Dr. Ian Henderson compiled a series of statistics to demonstrate the severity of the problem. He estimated that the problem exists in: 1% of all *women* who visit a general practitioner for any symptom; 8.9% of all *women* who visit a doctor complaining of urinary tract symptoms; 8.8% of all patients who enter *psychiatric* hospitals; and 14.2% of all *women* attending renal clinics.

Researchers' Nightmare

One of the most perplexing questions confronting researchers is precisely which drug(s) is (are) responsible for analgesic nephropathy. When the first report was published in 1953, most analgesic compounds contained ASA, phenacetin or aminophenazone, in combinations with caffeine, codeine or a barbiturate. From evidence gleaned in later studies, it seemed that phenacetin was responsible for the kidney damage. As a result, Canada, in 1964, began placing warnings on packages containing phenacetin that this ingredient might be harmful to one's health. But it was not until 1971 that phenacetin was officially removed from all products sold in Canada. Similar action was taken in Australia in 1967, but there as here, the removal has not demonstrated the expected results. *Phenacetin is gone, but analgesic nephropathy remains.*

In practical terms, it is very difficult to establish just how many tablets per day taken for a precise period are needed to arrive at the stage where renal dialysis is needed. It is well known that ASA, in excessive doses 20-30 grams or more taken over a period of 12-24 hours will most likely cause renal shutdown. This would be equivalent to taking 30-45 tablets Entrophen 10 (650 mg.) But the amount required over a longer period to arrive at the same end stage is more difficult to establish.

In a study conducted in Switzerland in the late 50's, Horisberger and company tried to determine the amount of analgesics ingested during work by female workers. (By that time they had already concluded that this was a female problem.) They did this by collecting empty wrappers found in garbage cans. Estimating that 30% of the workers used analgesics (a reasonable estimate), they calculated that each of these workers took more than five tablets per day.

But only 3% of the female workers admitted to a consumption of more than three tablets daily. The researchers attributed this discrepancy to the fact that patients did not volunteer the regular intake of analgesics and the authors caution that analgesic abuse might be missed unless one specifically searches for it. This divergence in numbers has always been a problem in using actual tablet ingestion to determine the incidence of analgesic abuse. People are very reluctant to reveal their true consumption or they themselves may not be conscious of regular ingestion.

One of the problems is that OTC analgesics are not taken seriously — more often than not these *drugs* have become synonymous with candy. And so, users tend to be rather nonchalant about quantities ingested. Other people may simply not know that they are taking analgesics even though the ingredients are listed on the package. This labelling is designed to promote consumer education but most consumers do not know that acetylsalicylic acid is aspirin, is Entrophen, is Excedrin, is Instantine, is Anacin, . . .

While analgesic nephropathy is usually taken to be the most reliable indicator of analgesic abuse, kidney damage is actually only one facet of what researchers call the *analgesic syndrome.*

Product B. (Being pathologically fair, we try them both.) Through advertisements, corporations encourage their audiences to self-diagnose and self-medicate.

The association between advertising and increased consumption is not a new revelation. The 1972 *Excerpta Medica* report considered advertising at that time to be nothing more than "efficient advertising." Henderson and P. Carruthers-Czyzewski, the director of Ottawa Valley Regional Drug Information Service, are among the many people working with analgesics who take a more critical view, asserting that present-day advertising is excessive and even damaging.

Constance Holden, in a report published in *Science*, November 2, 1979, explains that the Americans have taken the problem seriously. The Federal Trade Commission, in 1973, brought a combined action against three major manufacturers of OTC analgesics. In the ensuing congressional hearings, the advertising gimmicks used to "gull the public" were scrutinized. The hearings hopefully will result in a ruling that will disallow at least one company from making exaggerated, misleading claims.

Unfortunately, Canadian legislators have not tackled drug companies and so we consumers must improve our own awareness. All advertising claims of improved formulations and speedier action should be viewed skeptically. Bigger, stronger, 'extra-strength' tablets should be used judiciously as it now takes fewer tablets to reach toxic levels. We must also agitate for increased consumer protection as none is looming on the horizon. One must always remember that pain is big $ business and that to antagonize those who contribute financially to medical research would be counterproductive.

Sexism and Bias

In addition to advertising, changing attitudes towards problems of stress, difficulties and pain have been cited as contributors to analgesic abuse. It is very curious that this form of abuse, which Henderson claims is "*the* female oriented addiction", seemed to develop only after WW II. The timing is far too coincidental. Feminists are appreciative of the positive role women executed during the war years, when women expanded their activities to include traditional male areas. At the conclusion of the war, when many women returned to traditional roles tension, stress and frustration presumably mounted. Just then along came analgesic manufacturers who implied that their products would somehow furnish the needed lift.

And, yes, there were changing attitudes towards problems of stress and tension. This was the beginning of the "pill" era — a pill for every ailment, real or imagined — a trend which has been promoted to the present day. It is now the exceptional individual who is not taking some form of tranquilizer/appetite suppressant/tonic/sleeping capsule to maintain "good health".

Unlimited accessibility to OTC analgesics also contributes to our predicament. The best seller in Canada is ASA but, despite its side effects, there are no limitations on its sale. It can, literally, be sold anywhere from hotel tuck shops to large chain grocery stores.

And yet is is a common, informal sentiment among pharmacists that if ASA were to be introduced to the market today, it would almost certainly require a prescription. Dr. Jake Theissen, a Toronto pharmacology professor, speaking at an international conference on ASA held in Banff at the end of April, stressed that ASA should only be available through pharmacists. Kincaid-Smith believes that only by placing such compounds on prescription may we "see a decline in cases presenting with this distressing and lethal syndrome".

As feminists, we should also turn our attention to the profile of the "typical" analgesic abuser and to the label of women as the "prime offenders".

The profile as presented by Henderson and other reflects a definite sexist bias. The concept of analgesic abuse being solely a woman's addiction is itself suspect. For example, once the thought was formalized that women were the "prime offenders", some researchers attempted to prove just that. Horisberger and group, when they tabulated the number of tablets consumed per worker per day, only dealt with female workers. In all my reading, I encountered no author who seriously questioned the sex distribution of analgesic abuse. Everyone is eager to accept that the victims themselves are to blame for their predicament (remember that neurotic personalities predispose to addiction); no one has analyzed the political circumstances culminating in this chemical mutilation of women.

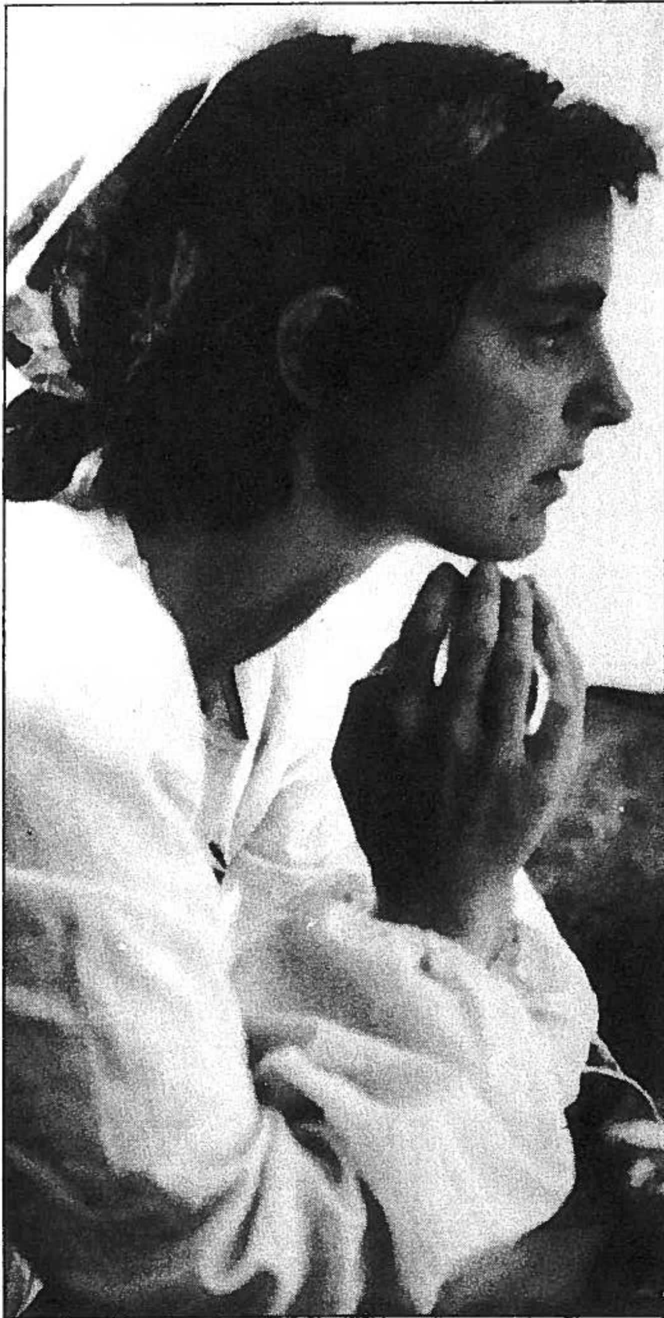
Psychiatric analyses of abuser personalities are presented with no definitions of the terms used. There are no indices to define "stability", "unhappy", "unintelligent". Smoking heavily is made to sound like the crime of the century. Patronizing attitudes are all-pervasive — they extend even to moralizing about women's longing for "the tranquility of death". The researchers have not described analgesic abusers as much as they have, unwittingly, described oppressed, repressed, suppressed women.

Assuming for the moment that the analgesic problem is essentially confined to women, why is it that, considering the severity of the problem — it has been called *"the most prevalent, lethal drug-induced disease"* by Kerr *et al* in the *Textbook of Adverse Drug Reactions*, 1977 — so little action been taken to restrict ASA's accessibility? Why is ASA sold in bottles of 500? Assuming that overuse of analgesics is an addiction, why has no consumer group been implemented to warn/inform the consumer — the woman? AA definitely does not stand for Analgesics Anonymous.

The situation exists and will only escalate because the glint of gold supersedes moralistic concern. Why should anyone worry? The victims are only women. Analgesic use is big business. Unfortunately, some women are paying with their lives. By taking analgesics only when needed, we minimize our exploitation and decrease capitalist profits. By educating ourselves with respect to analgesics, we move ourselves out of range of the loaded gun; with selective usage and by not being seduced by advertising, we empty the loaded chamber.

Leslie Storozuk, B.Sc. Phm., is a pharmacist practising in Ottawa with a varied experiential background. Having completed a hospital residency in 1977, she now combines medical acumen and feminist principles to provide professional, politically-aware counselling. *Infinite thanks to Patricia Carruthers-Czyzewski for her untiring research.*

Standing Still and Taking Stock: The Well Being Interview



Helen Orr

Ruth Mechanicus

In our consumer society we have been conditioned to believe that money can buy most things. One of the things which we have been led to believe we can buy is perfect health. We go to the doctor and, by paying him or her, directly or through health insurance, we expect to be given something that will make us healthy, or at least make us forget our unhealth. This myth discounts the reality that life is complicated and often a hazard to health. We breathe polluted air, eat overprocessed, unnourishing food, get too little exercise, live or work in unsafe, unhealthy environments.

We often ignore the bodily symptoms of stress in our lives, however, and are encouraged to take various kinds of medication for what is, in fact, a very healthy response. If we are under stress, we *should* feel symptoms — we should have a headache, feel fatigued, overeat or be unable to sleep. Tranquillizers will not remove the stress, but they do take away the symptoms so that we can pretend there is no stress and go on piling more upon ourselves. We have bought the illusion that another person or a drug can make us better. But eventually, we may have to pay for that illusion with exhaustion, sickness, addiction or emotional crisis.

What if we talked about a health continuum, rather than about health and sickness? What if we learned to listen to the signals our bodies give us and pay attention to these? What if a woman who is feeling low, or has a tight stomach or headaches says to her doctor, "I want to find out what is going on with me, what my body is telling me!" instead of accepting a prescription for tranquillizers?

Self-exploration and crisis prevention is the thrust of a little-known health-oriented tool aimed at helping people reclaim control and responsibility for their own health: the Well-Being Interview (WBI).

Well-Being Interviews have actually been around since the 1950's. Out of a concern about the "problem-oriented" outlook of most mental health services, the Department of Psychiatry at McGill University and the Montreal YWCA jointly established a Well-Being Clinic, where people could have a mental health "check-up" without having to present an obvious "problem". The Montreal YWCA continued to operate the programme through the 1960's, when the idea also spread to Toronto, where the Y began to offer WBI's to staff and participants in Y programmes. This project was eventually terminated.

Perhaps the best description of a WBI is that it is a "health talk", during which a person can take stock of her life as it is at that moment and explore possible avenues of change. Implicit in the WBI concept is the idea that factors in our environment can be the cause of our unhealth. In this sense it is an alternative to the treatment orientation of the usual medical approach. Since a WBI can be sought without an earth-shattering crisis having occurred, it is a truly *preventive* health tool. WBI's, though they can lead to long-term help, should be seen as quite distinct from therapy. Put simply, you don't have to be crazy, or even particularly upset, to feel the

need for the kind of outside feedback and self-assessment that a WBI provides.

Perhaps a WBI is the kind of heart-to-heart talk we used to have with that member of our extended family we trusted most, back in the days when we still lived in extended families. This kind of contact can take place between mates and friends. It can be sought from some of the other traditional "helpers" in our society — doctors, ministers — if the right kind of relationship exists. But our doctor, minister, mate or best friend may, for whatever reason, not be the best person with whom to talk. In that case, we still have to find someone we can confide in, who will encourage us to explore ourselves, who can be detached as well as sympathetic and who trusts us to make the right decisions for ourselves.

An important point: We are not the receivers of a WBI, but the active instigators. Experience with WBI projects has shown that they are most successful when they are actively sought out by the women themselves. Another related aspect of a successful WBI is confidentiality. It is of utmost importance that the client feel safe and secure, knowing that the interviewer will not talk to others about what she has divulged. A woman seeking a WBI needs to know that she will not be judged by what she has revealed about herself, nor tied by it. The WBI is part of the process of the interviewee's life: what she does with it is entirely her own business.

A WBI is basically a self-assessment tool for a woman. "Where am I at?" is the question she needs to ask herself. Throughout the WBI the interviewer helps her ask that question and formulate answers.

A WBI usually lasts about one hour. There is no formal "agenda" for the interview; whatever the client uses for openers is followed up and explored. The whole tenor is more like an informal conversation than a counselling session. Where and when appropriate, the interviewer may share of her own experience. The interviewer also makes sure that the client's "opener" does not take up all the available time, and will help her explore some of the different facets of her present life: her living arrangements, family life, employment, education, health, financial situation, sexuality, religion, and so on. Areas of strength as well as areas of stress are covered.

We are not receivers of a Well Being Interview, but the active instigators.

WBI interviewers make use of a technique called "active listening", meaning they listen both for what the client says and what she leaves out. Often, the interviewer will gently ask for the gaps to be filled in: "You have talked a lot about your children, but I haven't heard you mention your husband"; "When you talked about your son, you looked very sad. Is that how you feel about him right now?"; "When you talked about your job, your face lit up. Could you tell me a bit more about it?"

At the end of the WBI, the interviewer asks the client what the outcome of the interview is for her. What counts is *her* assessment, not the interviewer's. The main theme of the WBI is: "How do I feel about myself in all the various aspects of my life?" It is like a snapshot that you take of yourself. You stand still and look at yourself at this time in your life, as fully and as honestly as you know how. It is a one-shot deal — one interview, one snapshot — but just as we have snapshots of ourselves at various times in our lives, so we may take another when it feels right for us.

WBI's are a particularly good tool for women, because we have been well trained to ignore our own needs. Women are conditioned, by our upbringing and the society around us, to always think of others — husbands, children, friends, bosses — first. But what about ourselves? During a WBI, with gentle encouragement from the interviewer, a woman gives herself permission to put her own needs first for a little while and to give herself a break from the needs of others.

A woman gives herself permission to put her own needs first.

WBI's can be an important, practical mechanism for crisis prevention in a society marked by constant change in values and lifestyles. These changes affect us in very personal ways: we move, we change jobs, we change partners. Our loved ones change, which requires adjustments from us. Our bodies change, our interests change. We get too heavily into one thing and neglect other aspects of our lives. Truly, life is a balancing act, and often before we know it we are out of balance, and we must make minor or major changes to put our lives back in harmony. A WBI can help us spot these imbalances, which most of us are skilled at keeping just out of sight, a little below the line of our awareness. It is easier not to think about things, not to let yourself feel unease, discontentment, conflict, unrest. We tend to push these things under the rug, till one day they suddenly loom up, big and terrible. They have become *problems.*

The variety of problems women bring to a WBI is as diverse as the women themselves. Some come because they are "intrigued", but don't really know what to say. Some simply want to "talk things over". The women who benefit most from a WBI are those who, consciously or unconsciously, see life as a *process.* These women already have an emotional sense of who they are and they use the interview to test out new areas — how to help change family dynamics, whether to take a job outside the home or change careers, how to cope with aging parents who can't take care of themselves.

Of course, the WBI has its limitations, too. Clearly, it is not the best vehicle for people who aren't able to face their lives and grapple with their own problems, or those who expect someone else to "do it for them". Women who have too many problems in living are not going to have them adequately dealt with in a one hour talk. But a WBI can and does often help these women voice their concerns for the first time and to decide to seek further help.

Some people find it hard to believe that a one hour talk with a stranger can produce any kind of meaningful result. But in fact, those involved with WBI's, both on the giving and receiving end, find themselves continually amazed at what this simple tool can accomplish. One of the most important functions of a WBI is to provide the opportunity for verbal expression of thoughts and feelings. Often the client, through the simple fact of talking to someone else, will be able to arrive at a decision or become clearer about her own priorities. As long as thoughts and feelings are kept inside,

they tend to remain stationary, immobilized in their position. Expression, for most people, seems to be a prerequisite for movement and change. Stepping outside oneself, seeing more clearly, getting rid of unnecessary ballast — all this can happen even in the small space and time of a WBI.

Remarkable insights sometimes emerge from a WBI. For instance, women on psychotropic drugs can be helped to understand what kinds of messages their bodies might be giving them, and what thoughts and feelings they may be trying to suppress. "What was going on in your life when you were first prescribed this tranquillizer?" Similarly, women who have had a lot of illness or surgery are often expressing some kind of stress in a somatic way. Helping these women to connect a period of illness with other events in their lives can lead to a new understanding of themselves.

The client's assessment at the end of the interview is usually positive. Most women feel that the WBI experience has given them renewed energy: "I feel so much lighter"; "I feel as if I can go on again"; "I see much more clearly now". Often there is relief, even excitement, at having unburdened oneself and shared things with another human being: "I am excited about having talked about myself to another woman"; "It's the first time I've ever said these things to *anyone*.".

"It's the first time I've ever said these things to anyone."

Another aspect of the WBI is to hear the *good* news about ourselves. Too often we take our accomplishments for granted. We brush off as of no consequence the fact that we manage a variety of roles and functions. We think "anyone can do this" and tend to set unrealistic expectations of still greater achievements on ourselves. Standing still and taking stock of who we are and what we do in reality, sharing that with another woman and hearing ourselves affirmed is an experience all of us need in order to feel worthwhile.

For many women the main function of a WBI can be simple reassurance: that we're normal, that we're not alone in our problems. Sharing thoughts and feelings with another woman can help us gain perspective on them, and can begin to break down the isolation many women are unwittingly trapped in. Ultimately, what a WBI teaches is that all of us need a support system, people and organizations we can turn to for help and direction when we need it. One of the most frequent outcomes of WBI's is information sharing about various resources available in the client's own community. These resources can run the gamut from social services, drop-in centres and financial aid programmes to self-help groups and feminist literature.

An example of how WBI's can set changes in motion: An interviewer happened to meet up again with a former WBI client. The WBI, the woman told her, was the first time she had done anything purely for herself. "You know, I never looked back. It's been terrific. I took a course in assertiveness training (suggested by the interviewer), found a job I really like, and now my husband is finally beginning to come along himself. He was violently opposed to what I've been doing. His whole conditioning taught him that a wife should stay at home and look after the kids. But he's beginning to change. We are having more fun together now, and our communication is definitely improving. The WBI was the beginning of it all."

A telephone follow-up between two and four weeks after the WBI renews the contact to check out how the client is feeling about the interview in retrospect, and what has been happening in her life since. Was she able to carry on in the direction she decided on during the interview? Have any unforeseen consequences of the WBI arisen? Does she feel she needs anything more, right now, from the interviewer?

Sharing feelings can begin to break down the isolation in which many women are unwittingly trapped.

One pitfall of past WBI programmes has been a fairly high number of no-shows, even when no fees were charged. But in one project, when funds dried up and the WBI's were continued on a fee basis, only two out of 44 women said they were not interested if they had to pay. Two others said they couldn't afford the fee, and were allowed to set their own. All the remaining forty kept their appointments or phoned to change if they couldn't make it. It raises the old issues of valuing what you pay for, of commitment and — for women's services particularly — the problem of providing services for those who can't afford to pay.

Another characteristic of past WBI programmes is that they have tended to appeal mainly to middle-class women. When the Toronto YWCA for instance, tried offering WBI's at a variety of locations the best response came from the predominantly middle-class North Toronto office. The projects operating in the more working-class areas in the city's East and West ends were not very successful. It remains to be seen whether the WBI model can be adapted to women from differing socio-economic backgrounds, and how best to accomplish this.

The WBI concept has untapped potential in a wide range of settings. One possible use is at the workplace, so that employees could go and talk when they feel the need, on the spot. Work-related stresses could perhaps then be channeled into attempts at effective solutions rather than allowed to build up into sick leaves and alcoholism. Certainly something like the WBI could be an appropriate part of the range of services and activities offered at community centres. In these settings, even non-typical clientele such as teenagers could have the opportunity to talk about themselves and their problems, safely and anonymously. WBI's could also be offered in medical settings, so that people with stress symptoms could get more than the usual cursory examination and prescription for tranquillizers.

In sum, a WBI is one tool among many to help people take greater control over their own lives. As women we have too long allowed ourselves to be at the mercy of what others think we should be and do. To begin to change that pattern, so deeply rooted in our culture and our psyches, is a major breakthrough.

Ruth Mechanicus is a counsellor and bioenergetic therapist practising in Toronto. Anyone interested in finding out more about WBI's can contact her c/o Well-Being Associates, 31 Duggan Avenue, Toronto, Ontario M4V 1Y1, 1-416-484-6456.

Reviews

Two Films About Rape: A Scream from Silence (Mourir à tue-tête) Why Men Rape

reviewed by Ida Flint Dancyger
Sharon Zigelstein

Rape is still *the* "silent" crime. Whether committed in a back alley or in the manager's office, society does not rage against this crime. Why? Why are only 10% of all rapes even reported? Why does the victim still hide behind her "shame" and assume the guilt? Why is there only a 1% conviction rate for all rapists?

Is this silence finally being broken? Rape is a crime of violence and degradation, a crime of men against women. The fight against this crime and some understanding of it are explored in two recent National Film Board of Canada films about rape, *A Scream from Silence (Mourir à tue-tête)* directed by Anne Claire Poirier and *Why Men Rape* directed by Doug Jackson.

A Scream from Silence, the first Canadian feature about rape, is a powerful drama about a rape victim and the horror of her experience. This docu-drama portrays a shocking personal story and, at the same time, explores the psychological, social and political implications of rape. *Why Men Rape*, a forty-minute documentary narrated by Patrick Watson, focuses on the rapist in an attempt to understand why men rape. The film is structured around interviews with convicted rapists, experts, students, and the "man on the street".

A Scream from Silence tells the story of Suzanne, a nurse who is brutally raped while returning home from the hospital after working a night shift. The film opens with a brilliant and provocative rape scene shot totally from Suzanne's point of view, which forces the audience to feel her panic and fear as she is raped. The film follows Suzanne through painful and humiliating cross-examination by police and medical personnel, through her gradual physical and emotional collapse. Juxtaposed throughout this gripping drama are discussions between the filmmaker and her editor, documentary footage and a surrealistic court scene.

Convincing performances by Julie Vincent as Suzanne, Germaine Houde as the rapist and Paul Savoie as Philippe, Suzanne's compassionate lover, and stunning photography by Michel Brault movingly dramatize the agony of a particular rape victim. But Anne Claire Poirier set out to do more than tell one woman's story. An experienced and accomplished filmmaker, Poirier is deeply committed to women's issues. Rather than entertain, her films are intended to probe psychological, social and political issues and, through new understanding, bring about change.

For this reason the film's narrative action is interrupted to allow discussion of underlying issues. After the rape scene, director and editor talk about the nature of male sexuality. They question whether violence and domination are inherent in male sexuality and express concern that men will find the rape scene erotic. Later they discuss the psychological repercussions for rape victims, female sexuality and love. They assert the absolute need of rape victims to share their feelings and experiences in order to heal the wounds of rape. While thought-provoking, these scenes slow down the narrative, tend to become repetitive and undermine the audience's own ability to digest and interpret what they have seen.

To give the issue of rape a wider historical and cultural context, Poirier uses documentary footage of ravaged Vietnamese women, a ritual African clitoridectomy, and World War II shots of French women's heads being shaved amidst victory parades. These powerful symbolic images of assaulted and mutilated women underline the political nature of rape as one of many forms of aggressions directed solely against women.

Social rape is dramatized in an unusual court scene. Blindfolded women give evidence of their experiences of rape before a faceless judge who responds to their charges in standard sexist cliches. The audience sees that justice for women is impossible within our male-dominated Canadian legal system. Unfortunately this scene is far too long, comprising almost one quarter of the film. The issues being raised are essential but the technique is too didactic and artificial.

However, *A Scream from Silence* is an important film, made by a filmmaker with emotional and moral courage. The film's outstanding artistic merit is flawed only by Poirier's zeal to say too much. Her artistry and politics have produced a film too intense for English Canadian audiences. *A Scream from Silence* was both well received by critics and widely viewed by audiences in Quebec. The film's abysmal failure at box offices in English speaking Canada is disheartening and can only be attributed to nonpolitical critics and complacent audiences accustomed to Hollywood style entertainment.

In contrast to the emotional impact of *A Scream from Silence, Why Men Rape* is a technically uninspired "talking heads" documentary that approaches the issue of rape in a cool detached way. Patrick Watson interviews ten convicted rapists (including some who murdered their victims) ranging in age from sixteen to thirty-four with diverse educational, occupational and social backgrounds. He talks to lawyers, police and "the average man". In other scenes students discuss their feelings about personal relationships, dating and sex.

The film outlines what has been known for some time that violent rape is pathological, not sexual, behaviour; an act of violence, not lust. The rapists talk about acting out their personal rage against the world by raping innocent females (one victim was a nine year old child). The emotionless recounting of these details chills. We want to hear from men, we want to understand the connection between male sexuality and violence and the association of the male ego with domination. Unfortunately *Why Men Rape* does not address these underlying questions.

Watching *Why Men Rape* is difficult — not because the audience is forced to confront issues or deal with emotions, but because the male-dominated focus tells only half the

story. The film tells of one rapist's attempted suicide, the sexual abuse of another and the parental abandonment of another. We are sure it was not the intent of the filmmaker to empathize with these rapists. However, by ignoring the female victim and focusing solely on these men the film manipulates and distorts the audiences' feelings about the crime.

The other interviews in *Why Men Rape* represent a commendable but unsuccessful attempt to deal with the issue of social rape. Patrick Watson gives evidence that social rape occurs far more frequently than is commonly believed and results in very few convictions. The men interviewed echo the patently false yet widely-held myth that social rape is precipitated by women. "A woman who leads a man on stands a chance of getting raped." Only one man balances this point of view by declaring "women are human beings who have rights and don't necessarily forfeit these rights by accepting a beer from a man".

This film *should* challenge the myths that surround social rape by delving into the male psyche and examining the sexism in our culture and institutions. Instead, the film attributes our society's preoccupation with sex to the old demons of Hollywood, advertising, mass media and pornography.

Both films successfully make a distinction between violent and social rape. Both call attention to the hidden crime of social rape and show that rape is not committed only by psychopaths. They both confirm that feminist contention that rape is a crime of violence, and not a sexual act. However, *A Scream from Silence* goes beyond this and attempts to find out why men act out violence in a sexual way. This in turn leads to a much needed exploration of male and female sexuality.

The audience appeal of these two films is vastly different. *Why Men Rape* knows its audience and therefore will be

distributed and seen widely (it is already solidly booked six months in advance). It raises important issues but analyzes them superficially and does not ask its audience to grow. However, as an educational tool for young people this film has merit and will open the subject of rape for discussion. *A Scream from Silence* on the other hand, is intended to shock a mature audience. Far more than a learning device, the film is an emotional plea for understanding and social change.

A Scream from Silence is available in 16mm. and can be rented from Pan Canadian Film Distributors, 175 Bloor St. East, Toronto. *Why Men Rape* is available free from National Film Board offices across Canada.

Ida Flint Dancyger is a Toronto psychoeducational consultant. Sharon Zigelstein is a member of Women Healthsharing.

Resources & Events

The Canadian Consumers Guide to Prescription Drugs, by Geraldine T. Leonard

This is a concise, easily read handbook that includes over 500 commonly prescribed drugs. For each drug, the following information is given: reasons for taking it, when it shouldn't be taken, precautions in use and possible adverse effects. Leonard's intent is to promote discussion between patient and physician on the use of medication; she gives you the information to do so.

Available for $6.95 from major bookstores — ask for it. Published by Wiley, 1979.

Maternal Health Society

The recently formed Maternal Health Society plans to survey hospital practices in B.C., lobby for change in obstetrical practices and publish a newsletter.

To receive the newsletter and become a member send $2.00 - $5.00 (at your discretion) to the Maternal Health Society, Box 46563, Station G, Vancouver, B.C. V6R 4G8.

The Over 50 Handbook for Safe Medicine Use, by Mary R. Stern.

This is a practical guide to common medications used by older people. There is good information here on side effects, mixing medications, and how aging affects the actions of various drugs on the body. The handbook is presented in clear, large type and easy to follow language.

Available from H.E.L.P., 594 Logan Avenue, Toronto, Ontario, M4R 3B8. Cost of $1.50 each includes postage. Bulk rates available on request.

Women Healthsharing
Box 230, Station 'M'
Toronto, Ontario M6S 4T3

The False Promise: Professionalism in Nursing, by the Boston Nurses Group

The Boston Nurses Group took a hard look at the issue of professionalism in nursing and came up with some insightful comments. They examined how the image of professionalism can be used to manipulate and exploit nurses, and can isolate them from other health care workers. Professionalism on the job, administrators, associations, goals, strikes and alternatives are covered in this analytical, 24 page, 8½ x 11 booklet.

Copies are available for $1.00 from The New England Free Press, 60 Union Square, Somerville, Massachusetts USA, 02143

Prime Time Information Kit

This kit was created by Prime Time, a Victoria, B.C. group focusing on needs of women in middle years. It contains twelve resource booklets on topics such as "How to Say What You Need to Say Without Feeling Guilty", "Natural Menopause", "Shifting Gears in Middle Years" and "Single Women". Each booklet provides information, suggested course outlines and working bibliographies.

Send $10.00 plus $2.50 for postage to Prime Time, #304-620 View Street, Victoria, B.C. V8W 1J6.

Phoenix Rising — The Outspoken Voice of Psychiatric Inmates

A new magazine, published by and for psychiatric inmates and ex-inmates, *Phoenix Rising* is informative, news filled and warmly personal. The first issue contains an interview with an ex-inmate activist, legal advice on involuntary certification, Valium information, profiles of Vancouver and Toronto resource groups, and views from across the country.

Available from Box 7251, Station A, Toronto M5W 1X9. Individual copies are $1.50, subscriptions: free to prisoners and psychiatric inmates while confined; $5.00/year to other individuals and $10.00 for institutions and libraries.

Hysteria

A new Canadian feminist journal is on the market! The first issue, (Spring 80), has articles on "The Birth of Domestic Science", an all woman print shop and a women's writing group.

Individual copies are $1.50, yearly subscriptions for individuals are $5.00 or $10.00 for institutions. Available from the Hysteria Collective, P.O. Box 2481, Station B, Kitchener, Ontario N2H 6M3.

Asbestos: Fighting a Killer

Asbestos: Fighting a Killer is a 20 minute colour slide-tape show produced by OCAW, (Oil, Chemical and Atomic Workers). Although directed at a trade union audience, the health information is relevant to anyone exposed to asbestos.

To borrow the show, contact an OCAW local in your area, or your provincial Federation of Labour, Occupational Health and Safety Division.