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Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

Ageism & sexism

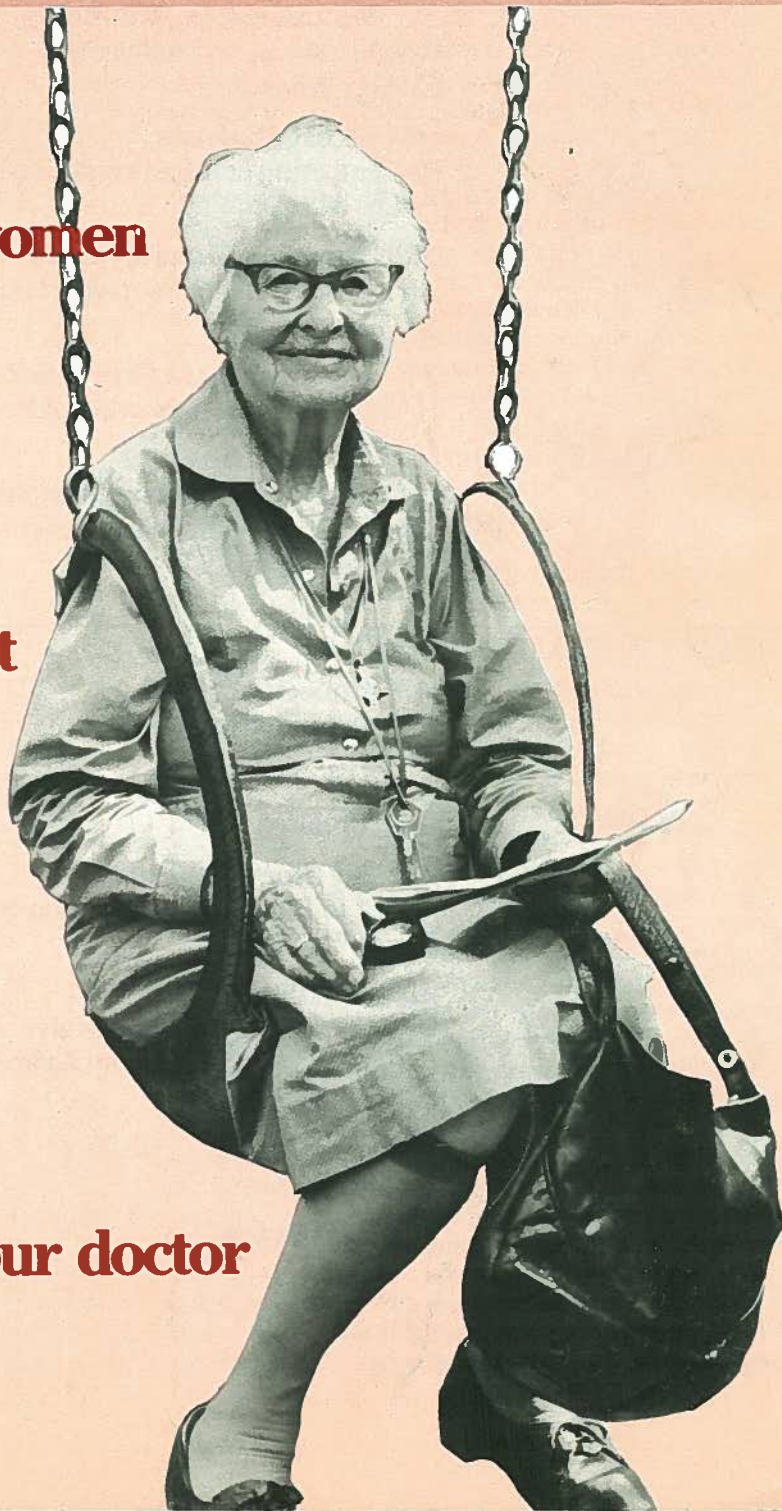
Tough times for older women

Feeling fat

— even when you're not

Sex after Childbirth

Being assertive with your doctor



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Vol 9:1 December, 1987

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COLLECTIVE NOTES

In Transition

Many changes are afoot at Women Healthsharing. Some of you who live in Toronto celebrated with us the move to new offices in October; all of you receiving the magazine by mail will notice new computer labels.

Our new offices are over 200 square feet larger. For the first time we have a small but permanent art and production space and quasi-private offices. Finally, each woman won't have to listen to *every* telephone call. Even better, we're well out of range of the lead smelter which used to be next door, and there is no asbestos in the building. In our efforts to become more physically accessible we've moved from a second-floor walk-up to ground level; we're now seeking funding to obtain a portable ramp and alter inside space.

The computer labels result from contracting Saturday Night Distribution Company to handle our circulation following the example of *This Magazine*, *The New Internationalist* and many other Canadian magazines. Sub-contracting is important because it will free up staff to promote *Healthsharing*, find out what you like through readership surveys and increase retail outlets. Our staff time will move from clerical maintenance into tasks which help us grow.

Less tangible but most important to us, have been lengthy discussions about our organizational process. With some regret we seem to have outgrown the hands-on collective model with which we started ten years ago. But we haven't yet found a model to replace it. Finding supportive, equitable and efficient structures is a problem confronting many feminist and progressive organizations and so we have chosen to tell you a bit about our process, even though we have, as yet, few answers to offer.

Women Healthsharing has become known as the publisher of *Healthsharing* magazine. As a result time required to sustain the magazine and its circulation has increased. Women involved in publishing have been attracted to the magazine and have brought new skills and perspectives to complement those of the health activists drawn to the organization. Although we continue to juggle an ideal of defining publishing as just one aspect of our political health activism, we find that publishing the magazine takes nearly all the time and energy available for Women Healthsharing.

For most of us, the amount of time and energy we're willing to give to Women Healthsharing has decreased dramatically from the all-consuming commitment that was needed in our early years. Increasingly we've relied on staff to carry out the essential publishing tasks. Children, more demanding employment challenges and confidence that paid staff will do work previously done by unpaid collective members, all influence the number of hours donated. Consequently, the collective no longer has its hand in every aspect of the organization. Long gone are the several-collective-member sessions of copy-editing late into the night, the proof-reading with coffee in hand, the slogging over bookkeeping and government grants, the coding by hand of promotional brochures. Oh, these are all still part of producing Healthsharing, but paid staff, contract workers and office volunteers have undertaken these tasks for some years now.

Small collective models, such as the model which Women Healthsharing has used for ten years, rely on lots of information-sharing and problem-solving time (usually lots of very long meetings) and a delicate bal-

ance of specialized skill/Jill-of-all-trades women. At its easiest and most efficient, the small collective model brings together a few women with shared viewpoints and a similar level of competence in different areas. This sort of model can work well to stimulate energy and create a strongly committed group. It's rarely the fastest way to produce a product, yet it can provide a very supportive and caring work environment. The collective model is generally chosen by people who believe that how you do something is as important as what you do, and that how you do something, in fact, greatly influences the outcome of your efforts. However, nearly all collectives find that some imbalance of power occurs and, when inter-personal styles and skill levels vary, long hours are needed to overcome the gap between the ideal and daily experience. Everyone involved must be willing and able to share and accept criticism, and to make changes accordingly.

For some time the small collective model hasn't worked optimally at Women Healthsharing. We've learned that weaknesses in our working together stem from both our personal relationships (how we nurture or fail to nurture each other) and from a structure which hinders us working together at our very best. Non-collective members in particular feel their work is sometimes poorly recognized; each collective member isn't always sure how necessary or valuable she is; work is not shared equally. Staff sometimes wait weeks for a collective go-ahead, but then implement the decision in isolation from the collective; because our group doesn't feel comfortable entering into the hierarchy of employer/employee, our support and training of staff and new unpaid members often suffers. A subtle hierarchy defines collective members as most central to Women Healthsharing, even though some non-collective volunteers consistently donate long hours. Knowledge of organizational history and skills picked up over the years too often translate into power (sometimes invested in and sometimes taken by 'old girls').

We want to maintain a practice in which everyone combines deciding and doing. We want the role of the col-

lective to be more manageable and yet remain enjoyable and stimulating. Through structure and working relationships we want to affirm the equal importance of contributions from staff (permanent and temporary), non-collective volunteers and collective members (some on staff and some not). We are asking what the Women Healthsharing family looks like and what it should look like.

We share all this with you not to alarm readers — far from it. We share this because our problems are common problems. Nearly all of our members have been involved in other collectives, cooperative organizations and social services managed by boards of directors. We agree that Women Healthsharing is among the best we've been involved with — that our tensions, confusions and poor functioning are no worse than the norm and sometimes better, and that we consciously

struggle to improve. Even so, we don't yet have the answers to ensure that we can make Women Healthsharing a consistently loving, skilled and enjoyable family . . . a family that repeatedly produces an informative, thought-provoking, attractive magazine four times each year.

Discussion with members of other organizations is very beneficial. We'd like to continue hearing from other organizations who are developing new models and we'd like to share our experiences with you. Perhaps by talking more openly we can begin to create new feminist visions and new ways of working together and of being in the world.

Connie Clement
Susan Elliott
Alice Grange
Connie Guberman
Diana Majury
Lisa McCaskell

Health

Calligraphy by Linda Lim/Bodywork

LETTERS

We encourage readers to write. Your debate is just as vital as the original articles and columns published in the magazine. Please take the time to share your opinions with other readers.

Healthsharing reserves the option to print and edit letters for length, unless they are marked 'not for publication.'

Acupuncture & menopause

When I subscribed to *Healthsharing* I did so to learn and understand better the hot flushes of menopause that I was experiencing.

Since that time I heard that acupuncture was a possible alternative to estrogen replacement therapy. I have had five treatments with continuing positive effect. My flushes occur less often and with less severity. I must admit that one should be prepared for some discomfort but the

benefits far outnumber the half-hour sessions (each week for five weeks) of mild discomfort.

Thank you. I hope someone else can benefit from my experience.

Judi Ayotte
Markham, Ont.

Hysterectomy unnecessary

Fortunately at the very time that I was being advised for the need for a hysterectomy, you printed an item about HERS (Hysterectomy Educational Resources and Services) in the Winter, 1986 issue. I have long counted on *Healthsharing* as a valuable resource, and on this occasion you have enriched my life in a very personal way.

Congratulations on your excellent work and best wishes for continuing success.
Susan Sharp
Montreal, Quebec

Support for homeopathy

I loved the Summer, 1987 issue, and thanks for the *My Story, Our Story, Benefitting from Homeopathy*, in the Spring, 1987 issue. One so rarely reads/finds such articles and Cy-Thea Sand's sharing is most valuable to those of us who use homeopaths and are interested in the process of healing that it involves and encourages.

Thanks again for being what you are to the womyn who read you.

Mer Spies
Waterloo, Ont.

Not too conservative

Thank goodness I renewed my subscription or I would have missed your excellent September issue. After several years of thinking some of my clients might be too conservative to appreciate your magazine, I've decided to leave it in my waiting room. Let them see the words

abortion, lesbian, etc. Perhaps it's time everyone saw these words, everywhere.

I was particularly impressed with Irene Mock's *Our Stillbirth* article, and, of course, Betty-Ann Lloyd's *My Story, Our Story*. Since Betty-Ann is a friend, I expected to like her work. But I had no advance notice from her about the publication, so it came as a pleasant surprise.

Barbara Mintze's *Through the Medical Maze* has proved very informative, and despite my familiarity with medical articles, I find her instructions useful.

Thank you.
Leah Nomm
Halifax, N.S.

Foot-shaped shoes

I applaud the publication of Anne Rochon Ford's article, *The Ties that Bind: Women and Footwear*. A look at the politics of why women's shoes are designed as they are, with little reference to our comfort, is long overdue. As the article

states, many of the annoying, painful or even debilitating foot ailments we suffer are caused or aggravated by the shoes we wear.

As a chiropodist, I suggest your readers who are looking for alternatives to high-heeled, pointed-toed or 'shoe-shaped' shoes (in contrast to 'foot-shaped' shoes) consider a number of athletic shoes now available.

These include walking shoes made of leather with a good heel support and well-cushioned soles, jogging shoes with mesh or nylon uppers (not quite as breathable as leather but still adequate) or court/tennis shoes (slightly heavier but still giving good support to the foot).

These shoes are being worn by women of all ages — to and from work, on the job, on weekends, shopping, and all those other times we want to be active and on our feet. Comfortable shoes may keep an older woman mobile or a younger woman pain-free.

Fashions will change but our need for comfort will not.

*Ellen Agger
Toronto, Ont.*

Northern outreach needed

I became aware of the excellence of your publication through Susan Elliott. Having read through a few of your issues, I found the health topics you addressed to be hot issues in the women's health forum, written in a concise and informative manner, and easy for the lay person to understand and digest. Hats off to you all: editors, writers, contributors, office personnel, compositors and printers! (If I've left anyone out, please convey my regards personally!)

As a Registered Nurse myself, I am keenly aware of the need for a magazine such as yours in Northern Ontario. Talking with a few of my colleagues in the health care field, I have discovered that

Healthsharing is an unknown commodity up here. I am wondering if there is some way you can become more accessible to readers here in the Sault?

*Susan Donaghue
Sault Ste. Marie, Ont.*

Breast reconstruction debated

I have read your article on Breast Reconstruction (Summer 1987). As a plastic surgeon with great interest in breast reconstruction, allow me to make some comments.

You say "Even the most skillfully reconstructed breast will never look or feel completely natural and will never exactly match a woman's remaining breast." This is inexact. Breasts reconstructed with the patient's own tissues have no foreign bodies in them and can be made to look and feel exactly the same as the opposite breast. I could show you many patients who have breasts that feel entirely normal.

You talk about nipple and areola reconstruction using the woman's own labia, or from the opposite nipple and areola. Though this technique is still done, I get much more permanent results by simply tattooing the areola and doing a small caterpillared flap for the nipple. To get even matching results, I also tattoo the opposite areola so the skin tones are quite identical.

Your next paragraph is dedicated to my specialty, the rectus abdominis reconstruction, where it states that the operation takes up to six hours, requires operative pain in both the breast and abdominal areas. All this is untrue. The operation is done in one to three hours. There is a bit of post-operative discomfort in the abdominal area in the first couple of days but there is no pain in the breast per se.

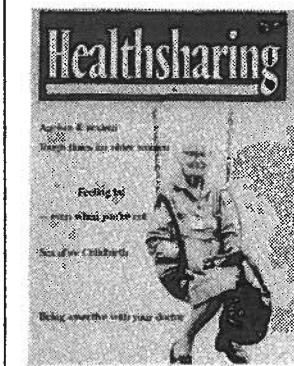
Finally I must state that the

scarring involved is about the same that you get from having a tummy tuck operation. The scars in the breast itself are better and more pleasing than the ones from mastectomy.

In your next section you quote a Rose Kushner saying "sloughing usually occurs if much underlying tissue was removed during the mastectomy itself. Plastic surgeons have devised techniques to avoid the problem by grafting health skin to the chest before the implant is inserted." This phrase is confusing and doesn't make sense. Sloughing is a problem with any flap (a flap is a transfer of live tissue, that bleeds, from one part of the body to another). You don't avoid this problem by simply grafting (placing a patch of skin) on an area that has little or no blood supply.

When you talk about rupture of silicone implants, you make a pitiful quote of a Dr. James Mason, a dermatologist from Waco, Texas, who obviously is not very learned on breast surgery. Though it is true that implants can rupture, the silicone does not travel anywhere in the body. The silicone inside the implants is a very cohesive substance that even if broken, still stays within the boundaries of the capsule.

Finally, I would have stressed in this article the psychological effects of the mastectomy. Nothing is mentioned in your article of the typical post-mastectomy syndrome which is characterized by periods of anger, grief, depression and pseudo-acceptance. This is something quite similar to the loss of a loved one. This grief nowadays is avoided in chosen patients doing immediate reconstructions after the mastectomy during the same operative sitting.
*J. Michael Drever, M.D.
Toronto, Ont.*



Our Cover Photo

Nora Rodd is photographed by Lee Cobourne. Nora, in her 80s, now lives in a Mennonite retirement lodge. For many years Nora worked for the Peace Corps. Working overseas, travelling and lecturing contributed to a still active life.



Libby Oughton

Collective Note

We chose to run Penny Wardell's experiences as a victim of mother-perpetrated incest (page 16) because this does happen. However, Healthsharing has published so little about incest, we feel it is important to acknowledge that nearly all reported incest cases involve a male perpetrator. This does not diminish the confusion and anguish felt by Penny and other women with similar experiences. Ed.

APOLOGY

Our apologies to Irene Mock, author of *Our Stillbirth* in Fall, 1987, for spelling her name incorrectly.

UPDATE

Progress in prostitution awareness

Update from NWT

The Northwest Territories, with its enormous area, arctic climate and sparse population, present many unique problems in healthcare delivery. One such problem has been hotly debated by many women's organizations. The problem: Inuit women being forced to leave their home communities to deliver their babies, sometimes thousands of miles away, in hospitals. This policy applies not only to mothers with high risk pregnancies who realize the necessity of hospital birthing, but also to young, healthy women with a proven history of uncomplicated deliveries.

Imagine yourself in the last month of pregnancy, leaving your husband, children and home, and going to a place with a different culture, a different language, different food, even a different climate. Think of what it would be like to endure the last, sometimes frustrating, often uncomfortable weeks of pregnancy without the love and support of your family nearby.

Inuit women are seeking an alternative to this distressing situation. So far, the best solution would be to set up centrally located birthing centers in each region with doctors or midwives on staff. Women's groups are asking

the government to legally recognize midwifery in Canada, as their services in Canada's northernmost region would be invaluable.

The ongoing formation of regional health boards to take over administration of the health care system from the federal government will at last create an opportunity for women to have direct representation in policy making.

A two-year study, coordinated by Dr. John O'Neill from Winnipeg, Manitoba, will analyse the situation in the Keewatin region of the NWT and determine if the maternal or infant mortality rates would increase if nursing station deliveries were allowed for low risk patients. This study, the first of its kind, will also document the detrimental effect of separation for the mother and infant, as well as the effect on the family members left behind.

Women are eagerly awaiting the results of this study with hope that it will provide the statistical evidence to support a change in the existing policy. Inuit women want the right to choose where their babies will be born.

PAT ALIKASHUAK

A unique forum on juvenile prostitution took place in Mont Tremblant, P.Q. this September. The objectives of the national consultation included: identification of knowledge and service gaps; improvement in the quality of response provided to juvenile prostitutes by various helping professions; exploration of the links between family violence and child and juvenile prostitution; and conceptualization of a national action framework to replace fragmented provincial responses to the problem.

Approximately 100 people attended by invitation only. Streetworkers, social workers, teachers, medical personnel, lawyers, judges, police officers and policy makers at a variety of government levels attended. Also invited were representatives of advocacy groups such as the Alliance for Safe Prostitution (ASP), as well

as five juvenile prostitutes, one from each of the major cities represented.

The most tangible outcome of the conference was a comprehensive report dealing with medical, legal, safety and educational issues. It also addressed early and effective identification and prevention programs for "at-risk" kids.

This report will be presented to various levels of provincial and federal government and organizations working with these juveniles. Conference organizer, Sue Lavergne, hopes that legislative, legal and social agencies will begin to respond with a pro-active rather than a reactive stance, inspiring in the youths themselves, "a confidence in their own ability to become contributing members of society."

LYNNE MELCOMBE

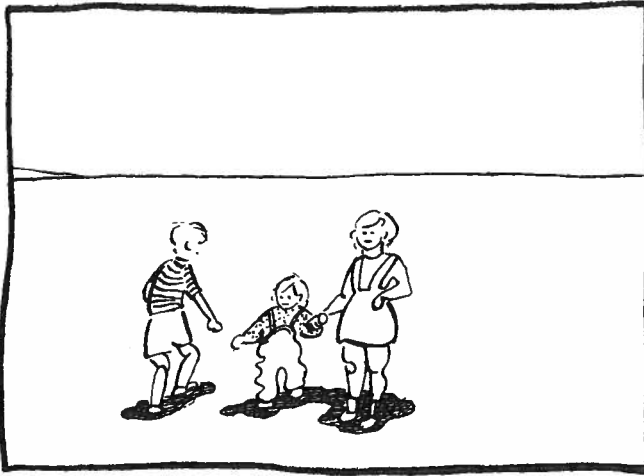
Busy in the Yukon

September 28, 1987 was the first day of the first Re-entry Training Program ever to be held in the Yukon. The 25-week program, a project of the Victoria Faulkner Women's Center, was sponsored by the Canadian Employment Center. It is being offered to some 20 women who wish to enter the paid workforce after an absence of three or more years. During their time away from paid work these women have been engaged primarily in homemaking activities. The group, made up of women with a wide variety of skills and interests, will focus on developing strength and cohesiveness amongst its members, enabling them to

provide each other with the support that is essential in this transition period.

Other Victoria Faulkner Women's Center projects include The 9th Annual Women's Conference, which will be held in Whitehorse on November 6th, 7th, and 8th. Several fall workshops addressing relationships, premenstrual syndrome and menopause are already in progress. Programs planned for 1988 include body image and media skills workshops.

LORENE BENOIT



Mary Firth

Sex selection services

Canada's first private sex-selection services opened this fall in Toronto. Dr. Allan Abramovitch, who recently relocated to Toronto from Houston, Texas, has purchased a franchise to use the Ericsson method. The Ericsson method, named after its Montana inventor Ronald Ericsson, capitalizes on the differing weights of sperm cells bearing Y-chromosomes and X-chromosomes. When semen is filtered through an albumen substance (similar to egg whites), the heavier Y-sperm cells which will create boys settle to the bottom and can be extracted from the sample.

Abramovitch, a 35-year-old urologist, upon becoming aware of sex-selection technologies "realized they were in demand."

Abramovitch charges \$600 for the first insemination and \$500 for each additional insemination with sex-selected sperm. An average of three inseminations are required for successful impregnation for women with normal fertility.

Abramovitch also offers female sex selection, using a technique called the Sephadex method. He can't explain how the method works, but says it is quite effective. He anticipates similar numbers of requests for boys and girls.

"Male preference is only an issue in underdeveloped countries," Abramovitch believes, since there is "no inequality here."

Unfortunately, women's experiences, studies and social statistics all contradict Abramovitch's belief in social equality for women. Preference for boy children is spread throughout the world, and is likely to become evident here as sex-selection services are purchased.

North American surveys show that the ideal family here is two children, specifically an older boy and a younger girl. We can only guess to what extent inequalities and sex role stereotypes will become further entrenched if big brother/kid sister becomes the sibling norm.

The private practice nature of Abramovitch's clinic is likely to exacerbate the for-profit motive behind the service. Thus, it is unlikely that sufficient counselling will be offered to help couples anticipate the complexities and the method's potential drawbacks as well as benefits. Negative social repercussions are not considered.

CONNIE CLEMENT
WITH SUSAN COLE

New Alberta report tame

A long-awaited report from Alberta's first Advisory Council on Women's issues was released on October 13, 1987. Several of the Council's 20 recommendations focused on health.

The report supported the concept of well-woman clinics and proposed funding to study the model of the Calgary Women's Health Resource Centre (affiliated with Calgary's Grace Hospital).

Government coordination of a provincial directory listing every clinic, office, support group and counselling service offering social, financial and emotional support to women was recommended. The report also suggested renewing negotiations between the Alberta Medical Association and the Ministry of Hospitals and Medical Care about establishing an equitable fee for abortion services. Also related to insurance coverage, was a recommendation to reinsure sterilization procedures, which were recently removed from medicare coverage.

The report supported allocation of funds to community-based programs emphasizing health promotion and disease prevention, counselling (regarding

contraception and unintended pregnancies) and services following completion of an unintended pregnancy, whether the resolution was adoption, keeping the child or having an abortion.

Additional recommendations on quality-of-life issues addressed standards of daycare, public awareness about family violence and establishment of a toll-free help line for those in crisis related to violence. The report argued for a study on pay-equity effects and implications, supported increasing the province's minimum wage, and, in general, recognized concerns of Native, immigrant and visible minority women.

Immediate reactions to the report from women's groups have included support for the intentions, but criticism for the reluctance of the Council to call for action instead of repeatedly relying on recommendations for further study. The Council's non-response to the needs of Native, immigrant, visible minority and disabled women has also been strongly criticized.

ANN GOLDBLATT



Smokefree

Teaches Women to Quit Smoking

Phyllis Marie Jensen, R.N., Ph.D.

183 Munro Street, Toronto, Ontario M4M 2B8

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Dating pregnancy

Many unnecessary ultrasound examinations and complications of unnecessary induction of labour and caesarean sections could be avoided. A survey of research on pregnancy dating techniques in the July/August 1987 issue of the *Journal of Nurse-Midwifery* suggests how. A doctor or midwife's decision to order an ultrasound examination or to consider induction of labour or caesarean section often arises out of concern about the age of the fetus. Unfortunately, inaccuracy and misinterpretation of the results of dating techniques can lead to the kind of premature delivery and complications they are supposed to decrease.

The most reliable estimate of fetal age is obtained from the probable date of conception. The most accurate source of this information is

the woman herself. A woman who is monitoring her fertility by taking her basal body temperature (before rising each day) will be able to demonstrate ovulation and a sustained increased temperature consistent with conception. Women who are not monitoring their basal body temperatures can often provide menstrual and coital histories from which conception can be estimated.

This survey provides information pregnant women can use to negotiate with midwives and doctors about the use of tests and procedures, for example, ultrasound. The lack of menstrual and conception dates and inconsistency of estimates of fetal age are the most common reasons given for ultrasound examinations. An ultrasound obtained between 7-10 weeks by an

experienced sonographer may be almost as accurate as probable date of conception but may be less safe for the embryo. Having two ultrasound measurements obtained between 13 and 26 weeks that provide consistent estimates provides a slightly more accurate estimate than the woman's last menstrual period if her menstrual cycle is usually regular. Given their wide range of error, ultrasound measurements obtained after 28 weeks can be very misleading if used in dating pregnancy.

Measuring size and height is another dating technique with a wide range of variation especially in the last weeks of pregnancy. Sizing techniques should be interpreted cautiously if estimates contradict other dating criteria such as date of conception and last menstrual period.

Three conclusions can be drawn from this survey: 1) The information most important for the management of pregnancy is that provided by the woman herself; 2) The estimated date of delivery or due date should be presented as the mid-point in a normal range of four weeks. Women should be reassured that any date within that month could be normal for them; 3) Management or intervention decisions based on estimates of fetal age or growth and development must be made very cautiously because of variable accuracy.

These decisions must be made with the full participation of the woman and recognition of the importance of the information she can provide.

DIANNE PATYCHUK

Quarantine legislation

Premier Vander Zalm and the Social Credit government in B.C have introduced legislation that, if approved, would give medical health officers and other government agencies the authority to quarantine people with communicable diseases. Government officials vehemently deny that The Health Statutes Amendment Act (Bill 34) is targeted at people with AIDS and ARC (Aids Related Complex).

Under the proposed legislation people "infected with an agent which is capable of causing a reportable communicable disease" may also fall prey to the new powers of government. This is clearly designed for people testing positive for antibodies to Human Deficiency Virus (HIV), the virus that causes AIDS. This aspect of the legislation mocks the government's claims to the

contrary.

Community groups, health activists, gay and lesbian groups and human rights organizations have criticised the legislation. All claim that governments should not be entrusted with special powers that represent a violation of individual rights to privacy and civil liberty.

Instead of isolating and regulating individuals, governments should educate people about how to protect ourselves from exposure to HIV. Here the Social Credit government's record is poor. Earlier this year the provincial Ministry of Health cut funding to AIDS Vancouver, a very successful advocacy and support service for people with AIDS, AIDS related diseases, their families and friends.

MAGGIE THOMPSON



Midwifery in Newfoundland

Midwives in Newfoundland are trained nurses. Their usual role is not to attend births, but to provide pre and post natal counselling and support during the delivery itself, for those women who are aware of the service and wish to use it. However just 25 years ago, midwives were licenced to attend deliveries in Newfoundland.

Newfoundland's Midwifery Act, revised in 1970, states that the practice of midwifery is to be controlled by the Newfoundland Midwifery Board. The Board regulates the certification of midwives, issues licences to practice and regulates the areas in which a midwife may work. The Board has been inoperative for about 25 years and therefore the Midwifery Act is considered to be obsolete by officials in the Department of Health.

Because of these conditions, the Department of Health decided to repeal the Midwifery Act. The Alliance of

Nurses and Midwives protested the repeal, citing some advantages of leaving the Act untouched. For example, the Act may be seen to protect people from having an unlicenced midwife set up practice. The main reason for wanting to keep the Act however, is that the 1970 parameters could be challenged and the practice of midwifery could be licenced once again.

If a midwife wanted to set up an independent practice, she would have to give notice in writing of her intention to do so, to the Deputy Minister of Health. The Minister of Health would have to reinstate the Midwifery Board in order to licence and regulate the midwife's practice. The success of such an application may depend on where in the province the midwife wished to work.

Women in isolated regions, like coastal Labrador and St. Anthony, must travel to a



hospital in the latter stages of pregnancy to await labour. Although this often imposes hardship on families, they are generally unwilling to risk home birth. Under an agreement with the Grenfell Association and the Department of Health, midwifery in isolated areas is permitted but with no backup

medical expertise in an emergency, midwives themselves do not like to take such risks.

In Newfoundland, although there is a demand, the movement for the independent practice of midwifery is not yet strong enough to warrant challenging the Act. There must be more demand for their services and medical backup available in isolated areas. Yet as long as the Midwifery Act remains unrepealed, it is inevitable that it will be challenged one day.

DEBORAH REDFERN

Increase in chlamydial infections

During 1986, the Laboratory Center for Disease Control received 9,737 reports of chlamydial infection from 27 laboratories across Canada participating in the World Health Organization virus reporting system. According to the *Canadian Diseases Weekly Report* of August 8, 1987, "This represents a 23 per cent increase over 1985 and a five-fold increase over 1980." The report states that the largest increase occurred in individuals between 15 and 19 years of age. The ratio of women to men with chlamydia in this age group is 10:1.

The increased incidence of the disease in young women is of great concern, the report says, because "Chlamydia trachomatis has been implicated in 50 per cent of cases of pelvic inflammatory disease (PID) involving women under 25 years of age. Chlamydial PID is frequently asymptomatic. Undetected it may lead to tubal scarring resulting in ectopic pregnancy or infertility." Women under 25 years of age make up 44 per cent of all women hospitalized for PID.

BONNIE LAFAVE

MATCH has 10th anniversary

MATCH, a non-governmental organization established to enable Canadian women to develop supportive connections with women in the Third World, celebrated its 10th anniversary this September.

Run by women for women, MATCH raises money from the public which is then matched at a ratio of 1:3 by the Canadian International Development Agency (CIDA), to an annual maximum of \$300,000. MATCH responds to priorities set by women in the Third World, providing funding for a variety of projects, including a long-term literacy program in the Caribbean; two shelters for battered women, one in India and another in Peru; and, most recently, a Disabled Women's Leadership Training Seminar in Maruitius, an island off the east coast of Africa.

Women everywhere are

dealing with similar issues and concerns. Violence against women, child care, employment, access to health care, abortion, birth control and the impacts of new reproductive technologies are all as crucial to women in developing countries as they are to North American women. MATCH strives to facilitate the sharing of information, putting Canadian women's groups in touch with groups of women in the Third World so that they can share their experiences and concerns and strategize together for change. Such links will increase global solidarity among women.

For information about women's initiatives and how you can support MATCH, write to: 205-200 Elgin, Ottawa, Ont. K2P 1L5. Phone: (613) 238-1312.

CARLA MARCELIS

Health collective loses \$\$\$

For the first time in its four years of existence, The Calgary Women's Health Collective will not receive government funding. Funded by the Secretary of State Women's Program since its inception, the Health Collective was told categorically that "health is not a priority of the Women's Program"; therefore, any proposal submitted to the Women's Program by the Health Collective would be rejected. Further, in July, 1987, the Health Promotion Directorate rejected the Calgary Women's Health Collective's proposal for the development of an Alberta

women's health network.

In September, 1987, loss of funding forced the Health Collective to move out of its office into the kitchens and living rooms of its members. The perception of the women in the Collective is that there is no funding available for grassroots women's health groups in Alberta from any branch of government: local, provincial or federal. The recent health care cuts in Alberta, especially those which target women, mark a disturbing trend in the health care system. However, considerable support from the Calgary women's community has helped the women in the

Collective consider how to survive.

In October, 1987, The Calgary Women's Health Collective, along with four other grassroots women's groups, moved into the "old Y." In addition to planning a fundraiser, the Collective has decided to offer direct service for the first time. Members of the Collective will offer feminist therapy with a view to developing a Feminist Therapy Collective in the future. The new address and telephone number of the Calgary Women's Health Collective is: Room 316, 223 12th Ave. S.W., Calgary, Alberta T2R 0G9. (403) 265-9590.

JOAN HOLLENBERG

We are hearing from women's health groups all across Canada which have not received Health Promotion or Women's Program funding.

This endangers the women's health movement immensely. Ed.

New study on Depo-Provera

Women's Health Interaction Manitoba is sponsoring a research study on Depo Provera, Medroxyprogesterone acetate, an injectible hormone. Study team members are interviewing women who have used the drug in the past, those who are currently using it and, as well, those who prescribe and administer the drug.

The purpose of the study is to gain a better understanding of the issues involved. While the drug has been approved in Canada for specific medical uses, it has not yet been approved for widespread use as a contraceptive. In the United States, the drug was turned down for use as a contraceptive after being reviewed by a panel of experts.

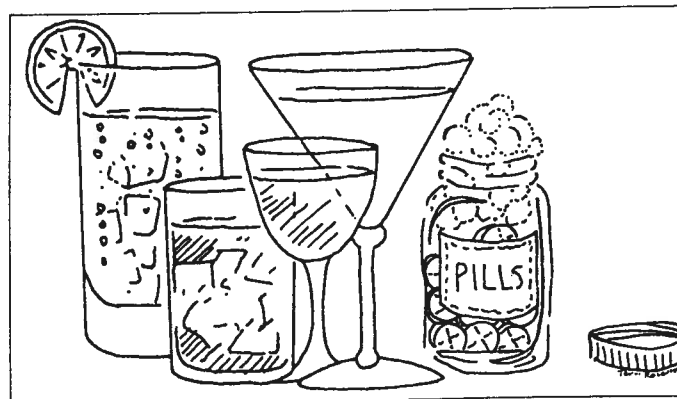
The project is designed to answer some of the many questions about Depo Provera by examining people's impressions and experiences. The researchers would like to hear from women who have had any kind of experience with Depo Provera. Confidentiality of all parties will be preserved. For further information, contact Women's Health Interaction, Research Project, 60 Maryland St., 2nd floor, Winnipeg, Man. R3G 1K7. Phone: (204) 786-2106 or 338-8659.

MADLINE BOSCOE

Women and addiction conference

On September 1, 1987 the first Prince Edward Island Conference on Women and Addiction was held. Ninety-five women from New Brunswick, Nova Scotia and Prince Edward Island attended the conference which was sponsored by Mann House, a residential facility for chemically dependent women in Charlottetown.

Speaker Marilyn Keddy discussed the history of women and drug and alcohol use and the work of members of the Canadian women's movement. She began with Ruth Cooperstock's work in the late 1960s, mentioned the link between alcohol and male violence and concluded with the positive impact of *Women and Addictions: A Resource Kit*. "It is well documented that when women feel that they have choices, their drug and alcohol consumption decreases. We must design and establish programs which support women in making choices," she urged.



Majorie Macdonald from Dalhousie University spoke about feminist counselling, a subject that never fails to create tension in a mixed audience. Dr. Jean Kirkpatrick, founder of Women for Sobriety and author of *Turnabout: New Help for the Woman Alcoholic and Fresh Start*, discussed the difference gender makes in our social, economic and political realities. She talked about what this means for the treatment of chemically dependent women and why current treatment options do

not provide all the answers. She suggested self help as an additional option, looking at the Women for Sobriety program.

In Nova Scotia, the Pictou County Women's Center is working on a grant proposal concerning chemical dependence in women. Women's Health Education Network has designated women and chemical dependence as its main focus for this year.

ALEXANDRA KEIR

Catrina Brown and Don Forgay

An Uncertain Well-Being: Weight Control and Self Control

North American ideals of thinness starve women — lots of women. By age 13, 60 per cent of American girls have dieted. At least 56 per cent of women between the ages of 24 and 54 diet. How many among the women reading this article have never thought they were too fat, started a diet or skipped just one meal to feel a bit thinner? Such a preoccupation with weight is not an individual pathology but a reflection of women's shaky sense of self in a changing world. Weight preoccupation has emerged as a major problem among women today because it is a symptom of a crisis of women's self esteem. Women's bodies are not the problem.

Yet most women today are unhappy with their bodies. They spend a tremendous amount of time, energy and money on diets, exercise, drugs and even surgery in their desire to conform to the ideal of beauty. And for many their attempts to control their body goes beyond this. It becomes a coping mechanism that allows them to gain a sense of control often absent from other aspects of their lives.

"My attitudes and everything around myself were changing," says Carol, a ballet dancer, of a time when she was struggling to get into the Winnipeg ballet. "It was a time when I had lost control of my life. The only thing you can control is you: the way you live, your body, your intake, your exercising. You can control these things and they become a total obsession.

"Thinner has always been better

at the ballet. So I just kept getting thinner and thinner."

Carol remembers describing her progress toward anorexia. While anorexia nervosa is a very extreme form of weight preoccupation (and women in professions such as ballet or modelling are under extraordinary pressure to be thin) Carol's story reveals struggles in self esteem and maintaining control of her life common to many women.

Canadian medical practice persists in treating the more extreme behaviours of weight preoccupied women as 'eating disorders.' While anorexia nervosa and bulimia are categorized as diseases, most women — those who simply diet — are defined as normal and healthy.

Feminists are reexamining the common ground between these so-called disorders and so-called normal behaviour. The weight preoccupation program at the Women's Health Clinic (WHC) in Winnipeg is one of the few Canadian programs open to any woman who believes her concerns with weight and food interfere with her general well being. This program includes self-help groups, peer counselling, outreach and public education. The program was designed for women obsessed with weight and food including anorexics, bulimics and chronic dieters. In its two-year history it has served 135 women.

As a feminist program it differs from a more conservative medical approach by assuming that women can work together to create change in their lives. This concept — central

to most feminist health services — is termed 'empowerment.' Women are empowered through recognizing the need for women to have control over and responsibility for their own health care. Accordingly, the program encourages women's active input and choice; it acknowledges that women are experts about their own experience. The emphasis on empowerment supports women's efforts to increase self esteem and a sense of self-direction.

At one end of the continuum are anorexia nervosa and bulimia, two well publicized behaviour patterns, labelled eating disorders. Ninety-five per cent of anorexics and bulimics are women and this is just the tip of the iceberg of weight preoccupation. These eating disorders are the extreme of a continuum which today encompasses most women in North American society. In one recent survey by Susan Wooley, reported in the May 1986 issue of *Ms*, 75 per cent of 33,000 women who replied described themselves as "too fat" although of these 45 per cent were underweight according to height-weight charts. Other research has indicated that among female college students, 79 per cent experience bulimic episodes and 20 per cent develop bulimia. Bulimia and anorexia were once thought to be problems only among white middle class adolescents. Today they are found in all social classes, minority groups and women of all ages. They are, however, a feature of affluent western societies and remain virtually unknown in the Third World.

Anorexia involves a ritualistic abstinence from food and a fear of fat even when emaciated. Many anorexics' lives are dominated by a sense of inadequacy and lack of self control. The sense of control the anorexic gains by refusing to eat and losing weight can be so important that she will reject food even when she knows she is in danger of starving to death. Bulimia involves repeated cycles of bingeing and purging: an insatiable craving and consumption of vast amounts of food is often followed by self-induced vomiting, laxative abuse, rigorous exercise, periods of starvation and denial of sleep.

Far more common is what we might call a *normal obsession* with weight: the behaviour of millions of women who each year spend billions of dollars on diet and exercise programs and who are constantly aware of, and dissatisfied with, their bodies. Imagine the following situation: Cathy has decided that today she will not eat because she "pigged out" yesterday. She rides her bike to work determined that if she makes herself exercise she will lose weight. All day she feels hungry, but is pleased that she hasn't eaten anything. She feels very in control; however, as evening progresses she can't stop thinking about the food she is craving to eat. If she can make herself not eat for a few more days then maybe she can eat whatever she wants. After pumping out 60 sit ups she goes to bed hungry feeling a little thinner.

Cathy's behaviour reveals a preoccupation with weight. But does she have an eating disorder or is she simply one of the large percentage of women who is dieting at any given time? Only a matter of degree separates the experience of most women from anorexia and bulimia. Weight preoccupied women are afraid of being fat. They often feel fat when they are not, even when they are 'underweight' (according to recent height-weight charts) and have lost a significant percentage of body fat. They may engage in binges of comfort eating, usually when alone, and counteract this by methods like those of bulimics. During a binge they often fear they won't be able to stop eating and feel depressed and demor-

Women's Health Clinic Program for Women Preoccupied with Weight

Philosophy

The Women's Health Clinic in Winnipeg began a program for women preoccupied with weight in the fall of 1985. There was a need for the issue to be addressed within the women's health community from a feminist perspective enabling the empowerment of women. The program has been based on women helping women and self help. A preventive health orientation educates women against extreme weight loss methods. Unrealistic ideals for thinness and body image are challenged and women are encouraged to build a self image not preoccupied with weight.

Target Group

The program was designed for women whose preoccupation with issues of weight, food and control interfered with their general well being. Weight preoccupation is seen to exist on a continuum, including those who are anorexic or bulimic, and chronic dieters.

Control

Women preoccupied with weight focus on their bodies as a way to feel more in control of themselves and their lives. Sensitivity to this recognizes that support to women preoccupied with weight must seek to empower women rather than take control from them. Self

direction, choice and active input are encouraged among the women in the program.

Structure

Support groups are offered on a regular basis, provide an opportunity for women to share their feelings and experience around weight concerns in an atmosphere of mutual support; groups have been run by trained volunteers and the program coordinator. Groups focus on enhancing feelings of self acceptance, not on losing weight. Individual peer counselling has been offered by women trained by the clinic and who had had their own history of weight issues. Opportunities for referral are available as well. Medical support is provided by the clinic's staff, including a nutritionist, doctors, nurses and a health educator.

The program offers an alternative to the medical or psychiatric model (which defines many of these problems as mental illnesses, rather than coping mechanisms). It provides emotional, social and medical supports.

Getting Beyond Weight

A how-to manual about developing and operating self help groups for women preoccupied with weight, written by Catrina Brown, is available from the Women's Health Clinic. To order, write the Clinic at 414 Graham Ave., Suite 304, Winnipeg, Man. R3C 0L8. Cost is \$5 per copy (bulk orders will be charged postage and handling).

alized afterwards. All of these characteristics are features of the psychiatric criteria for anorexia nervosa and bulimia, but such behaviour is much more widespread than among those with eating disorders.

Many women rollercoaster on and off diets, repeatedly gaining and losing weight, throughout their lives. Women report feeling better about themselves when they lose weight but this is a precarious sense of well-

being: 95 per cent regain weight after dieting; 90 per cent gain back even more than they lost. Dieting may even make you fat! As food intake is restricted, the body's metabolic rate falls so that less calories are required to maintain a given weight. Once off a diet more weight may be regained than was lost because the body continues to use less calories. And so, many women enter into an ever more vigilant policing of

their bodies and ever more desperate attempts to lose weight. Cyclical starvation and bingeing, fasting, jaw wiring, gastric and intestinal bypass surgery, lipo-suction and amphetamine abuse take their place among the many ways women's bodies are mutilated in an effort to attain the ideal of beauty.

Most women defend their relentless pursuit of thinness with the supposed truism that being fat is unhealthy. But in fact, this truism is a myth. Some recent studies suggest that up to 30 per cent overweight (as defined by current norms) there is no threat, and possibly even benefits, to health. Many of the physical health problems that arise with anorexia and bulimia are also shared by the normally obsessed or chronic dieter. Some problems appear only with extreme anorexia and bulimia: electrolyte imbalances, gastro-intestinal disorders, dental decay, liver and kidney complications and even cardiac arrest. Other problems are common to many women who diet; menstrual irregularities, premenstrual syndrome, irregular blood sugar levels, dehydration, water retention and fatigue. The cycle of losing and gaining weight can itself put a great stress on the body. Emotional numbing out, low self-esteem, self-hatred, depression and in some cases suicidal tendencies are common among women who chronically diet.

Women's magazines, the fashion industry and the media in general, continually reinforce the centrality of appearance to women's value. Prompting the idea that only thin is beautiful, they imply that we are failures if we are fat. The body ideal marketed by these industries creates what Kim Chernin has called the 'tyranny of slenderness' producing self-hate, guilt and insecurity in the majority who inevitably fail to measure up. Under the guise of messages about fashion and fitness, we are really being told women are not good enough. Success, happiness, social acceptance and self esteem all depend upon being thin.

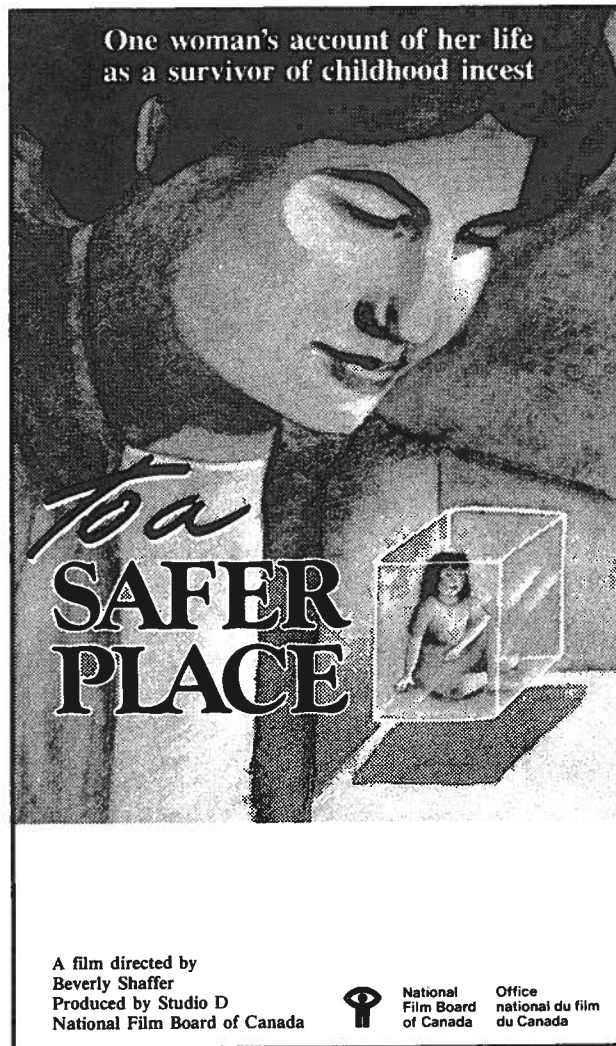
Without underestimating the media's role in the tyranny of slenderness, we have to recognize that in large part the media reflect, rather than cause, the current extent of weight preoccupation among wo-

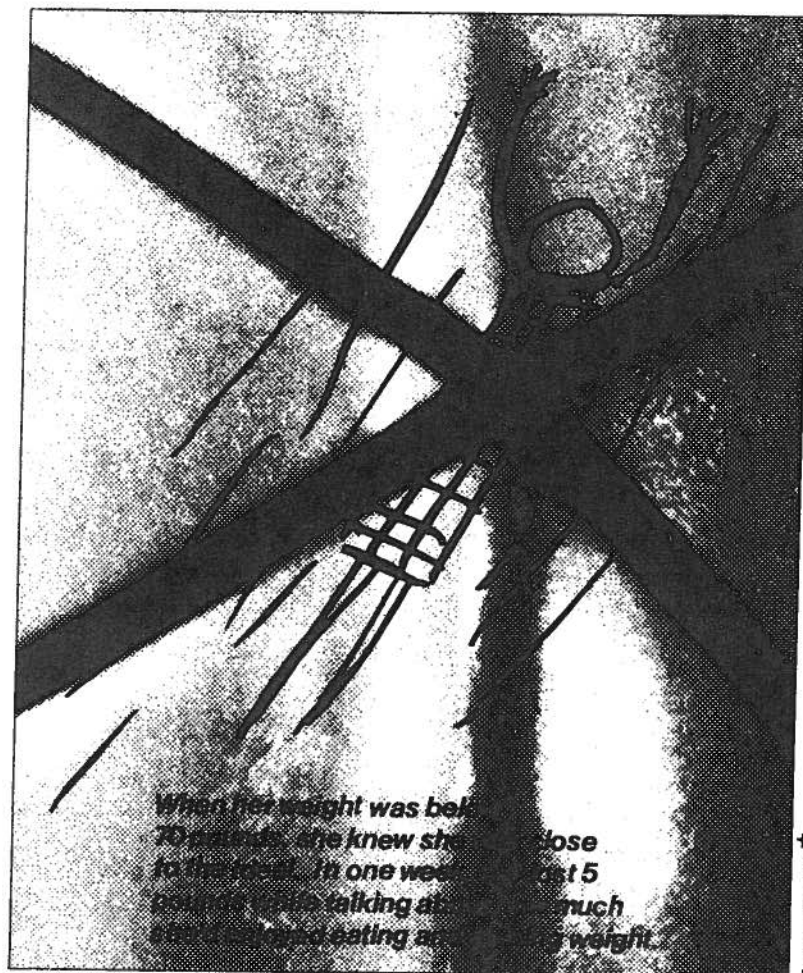
men. To understand such a widespread problem we need to look deeper into the circumstances of women's lives. Not only a psychological but a sociological and historical explanation of the problem is needed.

Today the thin ideal is so widely accepted we often forget that other societies and periods in history have held different viewpoints. Women's social role is generally identified with their bodies and body image has changed as women's roles have changed. In preindustrial society, which emphasized women's role as childbearers, the popular body ideal was a rounded figure suggesting fertility. Industrialization led to dramatic changes in women's role and place in society. A declining emphasis on fertility and increased emphasis on sexuality was symbolized in the shift toward the thin body ideal. Women's increasing economic, political and social emancipation also

contributed to this shift as thinness came to symbolize movement, independence and freedom. By 1920 the ideal of thinness was firmly entrenched in North America. Women's growing participation in the work force and the 'sexual revolution' inaugurated by the pill have, since the 1950s, led to an intensification of what has become a now pervasive and coercive ideal of thinness.

One constant over the past 30 years in the quickly changing whirl of women's lives has been the pressure to be physically attractive. Other than this emphasis on attractiveness there has been little certainty. Women today often face conflicting desires, face conflicting expectations and uncertain possibilities of accomplishing their goals. On the one hand women are encouraged to explore new careers, but still face discrimination in the work force. On the other hand there are con-





Lynne Fernie *

tinued expectations that women fulfill traditional roles as mothers and homemakers, but there are barriers to these as well in an age when most families require two incomes. In such an uncertain environment women can at least hope to gain social approval by being thin.

Women's traditional upbringing and emotional identity does not prepare them for competitive and demanding careers. As girls, women learn to put others before themselves; their lives are shaped by responsiveness to others with self-knowledge and recognition of needs downplayed. For many women, the first step in rebelling against focusing solely on the needs of others is a difficult struggle to recognize personal need. By controlling their bodies women choose a measure of self control that will also earn them social approval. Ironically, many women only perpetuate the denial of self: to gain control of their bodies they must repress and deny both emotional and

physical needs. To lose weight women must deny hunger and emotional associations with food. Some women will learn to ignore the fatigue caused by dieting and sometimes deny themselves sleep in order to burn more calories. In the end all their physical needs are denied including sex. As in rigorous exercise programs, they come to treat themselves like machines to be worked and controlled rather than persons to be satisfied. Weight preoccupation has become widespread because, in the contradictory circumstances of their lives, many women feel out of control: the ideal of thinness *appears* to offer an opportunity for self control.

A very high percentage of women with serious weight preoccupation problems are survivors of sexual abuse. Susan and Wayne Wooley have noted that almost half the women they see in their eating disorders clinic in Cincinnati are incest survivors. For Kate, an incest sur-

vivor, her experiences with bulimia and anorexia have been ways to avoid dealing with troubled sexuality. Becoming anorexic, her anger at the incest was turned against herself. An emaciated child-like body expresses her vulnerability and desire to have her needs recognized; at the same time her childlike body protects her by making her asexual.

Denying her body allows her a sense of control: "Suddenly I felt strong. I didn't care whether I was attractive to guys. I don't want to have to deal with that. I have a lot of anxiety around bodies and feeling dirty. I didn't want to feel attractive. I felt God had punished me: when I wanted attention my Dad bothered me. It had happened to me because I was bad and my body was bad.

"It [anorexia] was my way of showing God I don't care how I look, that I'm not out to gain attention, that I'm not participating in anything sexual. I don't have urges for anything sexual, I'm not a dirty person," Kate remembered. "I could show God I wasn't lusting after men, that I didn't want them to lust after me. The bad part was I ended up lusting after food."

Kate's 'lust for food' took the place of all her genuine needs and desires. She, like many women, used food to numb out her feelings and her needs. But when Kate gives in to her needs by eating, she loses the sense of control that self deprivation has given her. Satisfying her needs became, at the same time, a way of beating herself up and feeling like a failure.

Problems such as familial or personal alcoholism, physical or emotional abuse, lack of attention or autonomy in their family background are common among women with serious weight preoccupation problems. For these women, as for most women preoccupied with weight, the centrality of issues of self esteem and control suggests a treatment approach that focuses on empowerment.

The Women's Health Clinic program encouraged women to challenge the taken-for-granted assumptions of our culture about weight and beauty. Through support groups and counselling women explored below the surface of their obsession with their bodies to recognize

emotional needs and build self-esteem. In a CBC television show entitled *Body Talk*, which featured the WHC program, group members spoke about their experience in the program.

"Before I started to attend the group I really felt that everything was bound up with looks. If you're attractive you are valued, if you're not attractive according to the current standards you aren't of value," said one woman. "Now I can say I'm intelligent, I'm well read. I can list qualities and say, yes, I have value and I don't have to look like the fashion model in the magazines."

Another group member, who went on to become a group facilitator, had this message for other women: "I would suggest that women move away from the diet and self denial syndrome and examine their feelings. Why do they feel inadequate?" Reflecting on her own experience, she suggests that women "try and develop some sense of self worth and deal with their body image as merely one component of their personalities and whole lives rather than the be all and end all."

The WHC program was based on encouraging women to make decisions about their own situation because it was felt that traditional treatment models were counter-productive. On this understanding Marilyn Lawrence, a feminist therapist and author of *The Anorexic Experience*, has criticized the traditional doctor/patient relationship because it often takes power away from women who have already only the most fragile sense of self control. Hospitalization, forced bed rest and forced feeding of women with anorexia or bulimia are very occasionally beneficial to reestablish psychological and physiological functioning. These treatments are, however, over-used and can themselves backfire and exacerbate the problem when women feel their last vestige of control is threatened. Treatments based on behavioural change frequently ignore the causes that lie behind eating disorders.

Today feminist work addressing weight preoccupation as a women's health issue and as a feminist political issue is beginning to challenge the prevailing medical model which

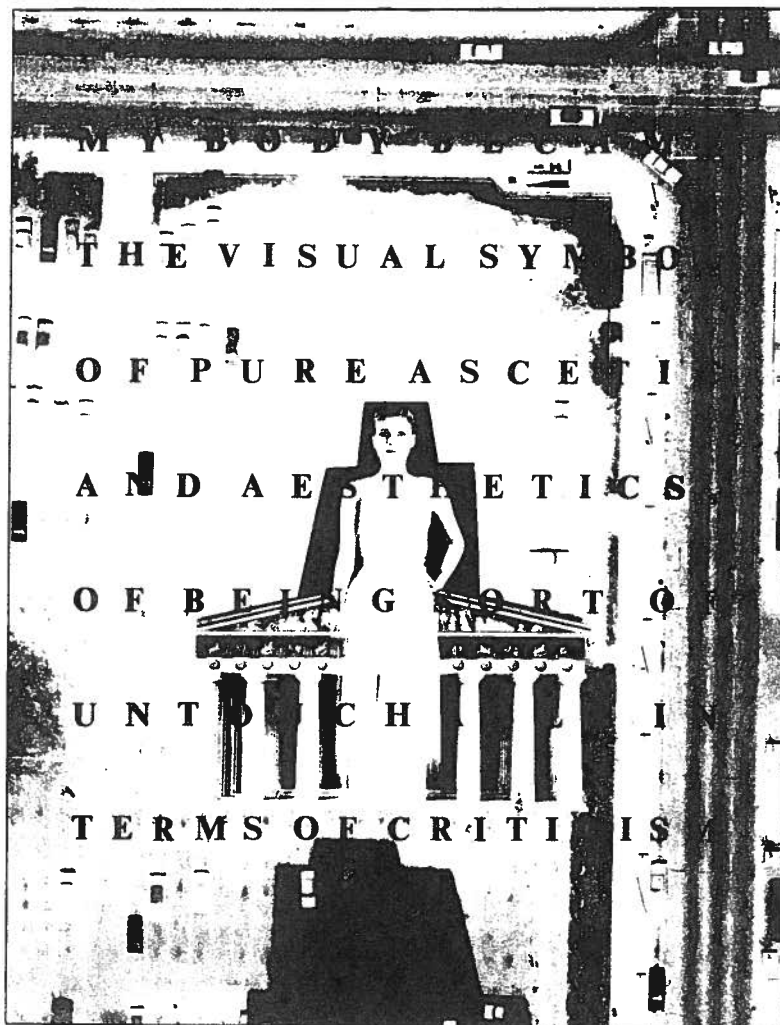
separated eating disorders from the general social obsession with thinness and from the social, economic and political conditions of women's lives. Major feminist writers, such as Kim Chernin, Susie Orbach and Marilyn Lawrence, have all emphasized the importance of the changing roles of women and the emotional consequences of these changes to understanding why women have sought self validation through control of their bodies. Their work is changing our understanding of women's relationship to their bodies. This feminist understanding holds out the hope for a new, empathetic and empowering approach to dealing with weight preoccupation as a women's health issue.

Suggested Readings

Chernin, Kim. (1981). *The Obsession: Reflections on the Tyranny of Slenderness*, Doubleday and Company, New York, 1981.

Chernin, Kim. *The Hungry Self*, Times Books, New York, 1985.
Lawrence, Marilyn. *The Anorexic Experience*, The Women's Press, London, U.K., 1984.
Orbach, Susie. *Hunger Strike: The Anorexic Struggle as a Metaphor for Our Age*, W.W. Norton, New York, 1984.
Orbach, Susie. *Fat is a Feminist Issue*, Paddington Press, New York, 1978.

Catrina Brown founded the Program for Women Preoccupied with Weight at the Women's Health Clinic. She continues to counsel women about weight and self esteem in private practice. Don Forgay, Catrina's partner, is completing an M.A. in Sociology. They both reside in Winnipeg.



Lynne Fernie

*"Altering Image," two panels from a series of seven, photostats, 18" x 24" each, exhibited in *Issues of Censorship* at A Space by Lynne Fernie, 1986.

Penny Wardell

Incest Shadows

Fine China

I'm going to hide so deep inside of myself ain't no one gonna find me. I gotta hide cause if I don't, someone might break me. Sometimes I get hurt so bad, I feel like I'm made of fine china. I wonder why my mommy does things to me? Like one time she put her fingers inside of me down there. I cried inside, cause she told me not to be a cry baby. It hurt me really bad. When I went to the bathroom the next time, it hurt, like it was stinging. Sometimes when I'm in bed alone I touch myself really soft down there, not like mommy does. If she knew I was doing this she would tell me I was bad. A very bad girl. "You're a dirty little girl, Penny." You know what? You're supposed to be gentle with fine china. Touch it lovingly and look after it with care, and I'm sure if you do these things it won't break. Nope, no one is going to hurt me. I'm hiding. Sometimes I stop breathing. Maybe I'll die. Yes, God, I want to die. I know I ain't supposed to be thinking these thoughts, but I gotta. Stop breathing is one way, but I always turn a funny colour, and mommy yells at me, "Penny, you stupid little girl, stop that foolishness right this minute!" Guess what God? I'm gonna find a way, one of these days, and I'm going to be dead. I can't write any more cause I'm breaking up inside, crumbling. I ain't fine china no more cause I'm broke up into a thousand little pieces. Ain't no one gonna be able to put me back together again, ever.

The Bath

I sit in the lukewarm water, moving my hand slowly, watching the ripples spread over my leg. A pink bathroom, a pink tub. I'm behind a closed door. I've goose bumps as the door opens. I shrink some, and fear rushes in so strong my stomach hurts, and I hold myself. I don't look up, just keep moving my hand in the smooth water. Maybe she will go away. Breathing is difficult now, I must go away, far away, then she can't hurt me. I shut the door and cobwebs fill my mind. I feel nothing as a hand starts to wash me so softly. I'm hardly aware of it, but yet I'm frozen in fear. "NO!" I want to scream, "O please leave me alone!" The hand is moving lower past my belly button down . . . I glance at her, the eyes are shut and a low murmur escapes the lips. The hand is beneath the water, moving like a snake it moves my thighs slightly, slowly. The cobwebs in my mind become thick, I disappear. I feel something seep out of me below the water. My body is silenced. The wash is over, the plug is pulled, the water runs fast, so fast, all the dirt goes down, down the drain. She wipes me with a towel. I look in the mirror and disappear into another world. I'm not here. The hand is down there rubbing around, around. I catch myself looking through the foggy mirror at eyes that are closed once again. The rubbing stops, the hands disappear, I'm free. She leaves the pink bathroom. My mind is dead. My body is silence.

Hey God

The water was always so dirty, and not only from my tiny body. Somehow the wish to die was so close. Maybe if I stay real still I'll disappear. But still my breathing goes on. My mom's voice rings loud in my ears. "Bath time!" It's then I wish to God so very hard. But he doesn't hear me, he must be busy. "Hey God, it's okay. I'll be okay I guess. Hey, it's only a bath. Hey God, really, I'll be okay. I'll just disappear inside or I can count the squares on the wall."

My eyes are sticky from crying and my stomach hurts. The water is running. I see some steam escape from the bathroom out into the air. I wish I was that steam. I'll try once more, "O please God, help me." I wait. Nothing. I sigh so deep inside, I'll be okay. The running water stops. I enter the steamy warm bathroom and undress slowly and with care. My skin is clean! I don't wish anymore. I take a deep breath and put my foot into the water. It disappears below the dirt. "Hey God, I understand." My body submerges and the dirty water finds its place in and around me, just in time, as the door opens. "Hey God, I'm not okay!"

Penny Wardell is a writer and painter living in Vancouver.

INTERVIEW

Laura Alper



Shirley Turcotte

*Laura Alper and Haida Paul co-directed **Is It Hot In Here?**, a film about women's experience of menopause. [See review in Healthsharing Winter, 1986.] Here, Laura Alper talks with interviewer Sue Kaiser about the challenges and changes she experienced while making her first women's health film.*

Sue: How did you come to be a film-maker?

Laura: I was practicing labour law when I had the experience of consulting for a film about postal workers on strike. I discovered that I enjoyed my relationship with the postal workers much better as a film-maker than as a lawyer. Since I had been looking for a change, I just started making more films, mostly on labour topics. And I've continued to enjoy it.

Sue: Most of your films so far have been about labour history and working people's struggles. What drew you to making a film about menopause?

Laura: The link really is biographical. When I was working as a film writer in Vancouver, I met Haida Paul who was an editor on the same project. I was pregnant at the time, so many of our discussions related to that. One day, we started talking about hormones. I had been DES exposed* and Haida was on estrogen replacement therapy (ERT). One of us said, "Wouldn't it be really great to make a film about menopause and ERT?"

And so we were started. The National Film Board (NFB) Pacific Studio was interested and came up

*DES, Diethylstilbistrol, is a synthetic estrogen. See *Healthsharing*, Fall, 1983.

with research money . . . eventually, four years later, we had a film.

It was a long time in the making, but although I felt impatient at times, I think the film benefited by the extra time we had to continue research and add to its complexity.

Sue: When you started researching *Is It Hot in Here?* did you expect to learn a lot? Was it difficult to gather accurate information on the menopause issues you wanted to explore?

Laura: In terms of the subject matter of menopause, we really did learn a lot. When we started, we thought of ourselves as trailblazers because there was so little information available. Few people were publicly focused on talking about menopause.

Hormone therapy was the personal focus for both of us. As a result of our research for the film and what

she learned about estrogen replacement therapy, Haida stopped taking the estrogen she had been on.

For myself, the whole issue of hormone therapy was of concern, because of my history with DES. (My mother had taken it when she was pregnant with me.)

It's very hard sometimes for people without science backgrounds to tackle this kind of information, and we really had to work at it. But what we learned we applied to our own lives.

Sue: This is the first film you have made about a women's health issue. Did you know what to expect?

Laura: Haida and I changed a lot in our attitudes and expectations from the beginning to the end of making this film. We changed in terms of what we thought we were doing, what we wanted to do, and how we thought we should go about doing it.

Originally, we thought we were making a very straightforward health information film. Our biggest problem was figuring out how we could get across all this information without having someone stand there with a flow chart and pointer.

Sue: You mean you thought you'd be showing us diagrams of ovaries and menstrual cycles?

Laura: Yes, we did think that. But we ended up with an entirely different point of view. For the longest time we just assumed there would have to be a section in the film where we'd have graphic material — cross sections of ovaries and representations of the hypothalamus with little arrows pulsing away here and there.

It was only when we were editing the film, and trying to fit this information in, that we realized — hey, we don't need to do all this. It's not the issue. And if we present the things that we think *are* the issues clearly enough, then the film will do its job. We wanted to make a film that was a discussion starter, and we felt we needed most of all to provide images of women, strong women,

average women, going through menopause in a variety of ways.

Having women laughing and angry and expressing their feeling on a whole lot of things was far more important than having technical information on the menstrual cycle and hormones. Not that this information isn't important; some of it does come out in the interviews in the film. But the main focus is on the women in the group, talking about themselves and their lives, because this is the part of menopause that our society has been so silent about.

Sue: Hormone therapy and the role it plays in perpetuating a view of aging women as not beautiful and not natural was a major impetus for you in starting this film. How did your perspective about the overuse of ERT change during the film making process?



Laura: Our perspective developed. We made a different film at the end of four years than we would have made if it had been done in the first six months. We both started out angry and inflexible, with strong feelings about hormone therapy. We wanted to make a film that would be the last word on the subject, a film that would even destroy ERT as a fashionable practice once and for all.

While the film is critical of hormone therapy, we feel — we certainly hope — that it permits women to make up their own minds. It's important that women have access to the information, and do not rely blindly on the medical profession to make these decisions for us. It's also important that we as film makers are not preachy about what we have learned or decided for ourselves. That's the general conclusion we've come to about the basis for dis-

seminating information through film, or any other way.

At one time, certainly as recently as 1982 when we started making this film, estrogen replacement therapy was very fashionable. While it is important to be critical of this fashionableness, we didn't want to set out to make women who are on ERT feel guilty about it. We wanted to make sure they could examine the information and make an informed choice.

As an adult going through pregnancy and childbirth, I found lots of good information available. But I also found that people thought there was a best, fashionable way to go through this experience. I ended up feeling quite resentful of the pressure I felt to do things the one, right way. I didn't want to create the same situation for women going through menopause.

The film really is more about women looking at themselves in the context of our culture which makes us feel obsolete once childbearing years are past.

Sue: How did it happen that the women you filmed were together talking about menopause?

Laura: During the year, the Vancouver Women's Health Collective held workshops on menopause, which were well attended. We wanted to capture the spirit and content of these groups. Because of our filming schedule, about 11 days of shooting in the summertime, we set about to create a special group for the film. The collective helped us find women who were interested, and we asked the women to bring others who might be interested.

Sue: Did you run into any surprises because of who the participants were?

Laura: One thing we found that was shocking was how hard it was to find women over 50 who had not had a hysterectomy. This may be partly explained by the fact that many women who were interested in taking part in a menopause workshop were women

who had had difficulty with their menopause, difficulty that may have led to hysterectomy. But this still reflects a very significant fact of life for women: many of us lose our uterus and ovaries to surgery before our natural menopause is complete.

As film-makers, this fact was dis-comforting, since we wanted to show women who had had a wide variety of experiences: hysterectomy with and without ERT, as well as women who had not undergone surgery. Most of the women who had had hysterectomies had also undergone removal of their ovaries, and consequently had been placed on ERT. Many had never questioned that decision.

Sue: How did the camera affect the women who were being filmed? Do you think the camera helps or hinders the experience for the participants?

Laura: Some women were initially reluctant to participate. I'm always amazed when people do agree to participate in a film, because it's asking a lot of them: time, energy, and most of all to talk about intimate things they may have rarely or never discussed before. And to talk about them in public.

All the women who were reluctant were really happy at the end that they had participated. They felt it was an important experience for them personally.

In general, I observed that all the women were surprised at how much they had to say — and pleased with themselves for their contribution to the film. The fact that there was a public document of the experience really validated their experience.

Sue: Did you and Haida feel part of the group experience, or did your role as producers keep you distant from the discussion?

Laura: Making this film was a shared experience with the participants. Haida and I felt really close to the women, and really sad when it was all over. And of course, when everyone else is done, we go on to editing,

and sit and look at people's faces on film, day in and day out, and listen to them talk. We get to know them very well, and also to appreciate the thoughtfulness and courage that went into so much of what they said.

Sue: How do you as a director evaluate the success of *Is It Hot In Here?* beyond the personal satisfaction of tackling a topic of importance to your life?

Laura: Success can get measured on many different levels. When we approached the Pacific Studio of the NFB to make this film, we were very pleased they agreed. It was one of the first films the NFB made on a topic primarily of interest to women that was not made by the women's studio, Studio D. This was a success right at the beginning of the project. Haida has just finished directing another film for the Pacific Studio, this one on premenstrual syndrome. I wrote the screenplay for this new film and it's also an exciting project.

In general, it's hard to get feedback about your films once you have finished production. Most directors are not involved too much in distribution. An advantage of working with the NFB is that we can find out how much the film is being used, and what people are saying about it at screenings or writing about it in letters to the NFB.

I've been able to attend a lot of screenings of *Is It Hot In Here?* during the first 6-8 months of 1987. This has been good, since I get to hear firsthand what people have to say.

Most of the viewers so far have been women between 40 and 60 years of age. Not surprising because the film is really by them. From what I've seen, and what group leaders and health educators have told me, the film works real well as a discussion starter for groups of women. Perhaps because it ends on such a high note, people just want to jump in and carry on the discussion.

During the postproduction phases of the film, we screened it for younger women, and found it generated a great discussion among them as well.

Young women and many of the men who see the film have strong memories of unexplained events

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from their childhood centred around mothers' or grandmothers' lives. They have an "Ah, yes, now I understand" kind of reaction to the film.

They also pick up on a very important point in the film, that menopause happens at the same time as other significant changes in women's lives. A lot has been tied to the physiological menopause, when in fact women are reeling from the emotional, physical and psychological upheavals of caring for aged parents, children leaving home, divorce, loss of spouse through death, etc. Young people viewing the film have noticed this in particular and

talk about it in the context of their families. They seem to show a lot of understanding and sympathy.

Sue: Has making this film changed your view of aging, of becoming an old woman?

Laura: Oh, yes. I think the film is full of tremendous examples of healthy strong women. I hope younger women can value these examples through watching the film. As I got to know these women through making the film, I found myself thinking "If I'm doing half as well as any of

these women when I'm 65 — then great!" My lingering fears of being older have been dispelled through meeting these women. No one would go away from watching them talk and say "Oh, I feel sorry for them."

Sue Kaiser is a community worker with an interest in environmental and women's health issues.

Is It Hot In Here? can be borrowed on film or video tape from the National Film Board office nearest you.



MY STORY, OUR STORY

Dachau Never Again

Diane Pelletier

The bus rolls through the flat fields of oats, hay and wheat into a neat, nondescript industrial area on the outskirts of the village of Dachau. Someone calls, "All out for the concentration camp!" Around me, brightly dressed American teenagers laugh and joke loudly in the sweltering heat as hundreds stream towards the long, low buildings in the distance. These young men, so casual in the sun, are the same age as my father was when he was captured in the Second World War. My father grew up in a mountain valley in the Maritimes. His family was of Acadian, Native and English descent and so my Dad was very skilled with a rifle. He volunteered for the Canadian Army in 1939. The Army made him a sniper and sent him behind German lines to shoot Nazi officers. When he was captured, he was not treated as a prisoner of war, but as a spy and put in a concentration camp.

Dachau, founded in 1933, was the prototype for the hundreds of other camps later set up throughout Nazi-occupied Germany. Dachau, the place where Nazis experimented to perfect assembly line death, is a bland, flat horror. I am numb with fear as I go through the gates into the camp compound.

I walk into the work room, where thousands slaved. It is a museum now. On one wall, in stark black and white, are the names of the hundreds of camps. There, up on the left, is Amersfoort. Amersfoort, in The Netherlands, is the camp where my dad was held. I have never seen the word in print before or heard anyone say it but him. What had been a myth, a story told by parents to children, becomes reality as the earth rocks between my feet. I cannot stand. I weep. Damn you Ernst! Damn you, all of you, who would obliterate this sacred ground



in a tissue of half truths, evasions and fabricated memories.

In the time my father was in the camp, he dropped from 180 pounds to less than a hundred. His hair turned white. The young Canadian soldier who went behind the German lines on a mission became a shambling walking skeleton. Throughout my childhood he screamed in his sleep, screams that left us all shaking and quiet. He never speaks of this time.

Some of the tourists around me are saying that it seems so long ago. Not to me: Dachau is yesterday. I see Dachau in my father's eyes. To speak of Dachau is to risk being superficial, shallow or exploitative. Nothing I say can really speak of what it means to walk on the grave of thousands. I am not Jewish. No Gentile, even the most well meaning, can know what the Holocaust means to the Jewish people. I do not. Yet survivors want us to remember. Survivors — Jews, political dissidents, gypsies, prisoners of war, disabled people and gays and lesbians — want us to be here. This is their memorial.

The crematoria are quiet places, cool in the heat behind thick brick walls. Voices are hushed here. Above us are the rafters where hundreds were hung. Nearby are the gas chambers, not used at Dachau for some reason unknown. These few buildings, set apart by themselves, appear so ordinary. Behind them are mass graves.

Overcome, I rush away to find some peace down a pathway through some trees. A solid grey wall, seven feet high, blocks my way. This is the SS practice range where prisoners were shot methodically en

masse. The deep ditch in front of me was dug to drain away the blood. Such a tidy hell. People were shot for walking on the grass. All around me the soil is dark with ashes. Strawberries, rich, luscious, untouched, grow out of the earth. There is no laughter here. People walk alone or in small groups, heads down, voices silenced.

My father is silent about his experience in the camp, rarely speaking except cryptically. He does not want to remember; he cannot forget. His doctor says that he is like a 95-year-old; he is 65. The doctor says, "The human body is not meant to take such suffering." The human race was not meant to take such suffering.

My father and mother's house is an open house. After Amersfoort no doors could be closed. Even in the '50s, when we barely had enough to eat ourselves, an endless stream of homeless people passed through our family — migrant farm workers, refugees from Argentinian anti-semitism, hitch-hikers, men looking for work, etc. This generosity of spirit and flesh in the face of so much deliberate cruelty is another kind of memory of Dachau.

Loving my father, I am an activist working for human rights. Loving myself, I am a feminist struggling for my own place in the world. Loving my father, I can never hate men. Loving this life, I cannot give in to the despair which could grow out of these mass graves. Dachau (and Auschwitz and Sobibor and all the others), I walk out from your gates back into the 1980s.

I swear "Never again" over and over to the clickety clack of the train back into Munich. Yet the Judengassen (Jewish quarters) in the German cities are empty and here in Germany no one seems to want to remember who lived there. Neo-Nazism and far right racism are on the rise. Countries in Europe and North America are closing their borders to victims of genocide now just as they turned away victims of the Holocaust in the 1930s. I cannot ignore the complicity of Canada, my country, in this crime. I say "Never again," knowing it is a promise that is being broken.

Diane Pelletier is a pseudonym for a feminist writer living in Toronto.

HEALTHWISE

Staying Healthy: Constructive Change

Deborah Clark and Lenny Ashton

Ours is a consumer-oriented society. The myriad of purchasable items is overwhelming! Endless strips of retail stores, supermarket shelves straining under their burdens, the incessant entreaties of magazine, radio and television ads all attest to this phenomenon of consumer orientation. Some people make their purchasing decisions before shopping: they might carry a list of the items wanted, as a safeguard against the allurements of salespersons.

The features of a blender are afforded more consideration than the attributes of a physician.

Consumer orientation insidiously carries over into other areas of people's lives. But, while discretionary retail shoppers take precautions, such prudence seldom extends to the purchasing of services offered by medical practitioners. The features of a blender are often afforded more serious consideration than are the attributes of a physician. This complaisance when dealing with doctors results from failure on the part of the general public to perceive medical services as commodities over which selectivity should be exercised (furthermore, there are virtually no mechanisms by which to facilitate selection). Since, in theory, all physicians are deemed equal in terms of the quality of their expertise, the need for such a consumer-oriented approach is not commonly recognized.

There exists among clients of medical services a sort of vulnerable dependence upon physicians. The following woman's story is indicative of this prevailing trait.

Upon receiving a referral to a surgeon for presurgical examination of a lump on my breast, I arrived at his office at the appointed hour. My state of mind at this time might best be described as controlled terror: frightened of the implications of a breast lump, yet attempting to retain my composure. I was shown into the doctor's office by a nurse, who left me alone with a cold and pompous (I quickly discovered) male surgeon and a male medical student. My discomfort grew as they sat and discussed my file without so much as acknowledging my presence.

"Eventually, I was tersely instructed by the surgeon to change into a gown in the adjoining examination room, which I obediently did. The surgeon and student entered and proceeded to examine me, exchanging questions, answers and hypotheses while doing so. The surgeon then demonstrated for the student the proper manner in which to examine breasts, and observed while the student practiced on me. This entire performance took place without a solitary explanation being offered to, or consent asked of, me! Never have I been made to feel more like a mere specimen. It was humiliating!"

Never have I been made to feel more like a specimen.

Women across the country encounter such situations every day, some more traumatic than others. Too often, people already in difficult and vulnerable circumstances are victimized by the very persons in whom they place so much trust. This blind faith has evolved throughout the history of client-doctor relationships. What is puzzling is that frequently clients comply even when compliance opposes their own instincts: they presume that the doctor must be right. They unquestionably submit themselves to various diagnostic indignities, obey all orders handed down by their physicians, and acquiesce to whatever is prescribed.

Shop around.

Doctors receive training in the fields of anatomy, disease, diagnosis and treatment, with very little emphasis placed on communication skills. As individuals, they possess varying degrees of competence, rapport and integrity with which to compensate for inadequate training. Of course, there are doctors who recognize the importance of good communication with clients and foster this skill in the course of their practice. Although medical associations give lip service to the importance of good doctor-patient relationships, relatively few doctors are able to counteract medical training, social expectations and the constraints of fee-for-service payment schedules to create mutually supportive interaction.

Clients, particularly women, must adopt a more realistic attitude towards the physicians. For this to occur, they must first abolish the notion that doctors are infallible and omniscient. It is sensible to suggest that partakers of medical services discriminate in their choice of physician, just as they do in acquiring

other consumer services and goods.

To attain a confident and assertive position, become reasonably knowledgeable of your body and familiar with its normal functions. It pays to have a healthy interest, not only in the workings of your body, but also in contemporary health issues.

When consultation with a doctor is necessary, a client should not be intimidated by the physician's expertise or apparently tight schedule. The client deserves to be treated respectfully and to receive all the information required. This, admittedly, is a tall order: sometimes it is hard not to be intimidated. The objective is to feel as comfortable as possible in a medical environment. If bringing along a 'buddy' achieves this for you, then by all means do so. If a doctor's communication skills are fundamental to your ease with him/her, then gauge your doctor by that quality.

In other words, shop around for a physician with whom you feel comfortable. A doctor who is open-minded about holistic and alternative approaches to health care is in a position to offer his/her clients the greatest range of choices.

Of course, many women, such as those living in small, isolated communities, do not have the luxury of shopping around, and this is a serious problem.

They unquestionably submit themselves to various diagnostic indignities.

To equip oneself with the knowledge and (it follows) self-confidence essential to effective communication with medical practitioners is a challenging task under average circumstances. There is valuable, up-to-date information and advice available through local health units, public and medical libraries, collectives, self-help groups, health information networks and other special



Joanne Dych

interest organizations. Many of these embrace participatory philosophies, disseminate unbiased data and provide empathetic support and encouragement.

Under distressing circumstances, particularly where time is a factor, it admittedly is all but impossible for a person to remain objective in selecting medical services. Those who are in the grip of shock, pain, fear and desperation are understandably not in a position to exercise consumer ideology. Nonetheless, a person who has practiced enlightened consumerism in daily life, and who has the support and assistance of others, may find critical situations more manageable. The following is an example of how one woman's knowledge-backed assertiveness made a difference in the health care she eventually received.

"My physician had informed me of his intention to have me undergo a barium enema as a means of determining the extent of a digestive problem which was then confronting me. An appointment was scheduled for the procedure.

"The thought of submitting to what I knew was an unpleasant experience inspired me to find out all I could about the condition and related diagnostic procedures. I researched the subject as thoroughly as time allowed, and discovered that the barium enema was not a very successful diagnostic technique for the condition in question, and that alternatives such as ultrasound were more commonly employed.

I confronted my physician with my newly-gleaned information.

"I confronted my physician with my newly-gleaned information and insisted upon the use of one of these alternatives. Consequently, I was not made to endure a distasteful, uncomfortable and totally unnecessary procedure."

Clients must assume responsibility for their own health and cease presenting themselves passively to physicians they regard as all-knowing gods. Only then will their expectations of the medical profession be reasonable and the relationship between doctor and client more fulfilling and beneficial for all involved.

Medical services are multitudinous in quantity and manifold in quality. Let us pick and choose.

Deborah Clarke is a member of the Northwestern Ontario Women's Health Information Network. She is an English major at Lakehead University. Lenny Ashton is a graduate student working on her Master's thesis in Sociology at Lakehead University.

Ella Haley and Ann Hauprich

Elderly and Able?

Few people could understand it when Betty Christensen* lapsed into a deep depression after taking an early retirement from her teaching career two years ago.

"Everyone kept telling me how lucky I was to have so much time to spend with my husband, children and grandchildren. They didn't understand how much my job had meant to me in terms of my personal identity and self-esteem. When my first pension cheque arrived, I couldn't bring myself to look at it, let alone cash it. It was symbolic to me. It said I was old and worthless, that the government had to support me now."

During the next 15 months, Christensen went through emotional hell as she struggled to come to terms with her new identity as a senior citizen. The normally busy and outgoing 60-year-old suffered severe mood swings, became disoriented and even suicidal. Although financially secure, Christensen became paranoid about spending money; she feared she would be a penniless widow 10 or 20 years down the road. As her depression deepened, she withdrew from family and friends whom she believed were incapable of understanding her pain. Christensen was eventually referred to a psychiatrist, who prescribed Valium and other mood-altering drugs in an attempt to brighten her outlook on life.

For Christensen, the solution lay not in drugs or other medications but in finding a part-time teaching job and taking courses that might open

the door to a future career in museum work.

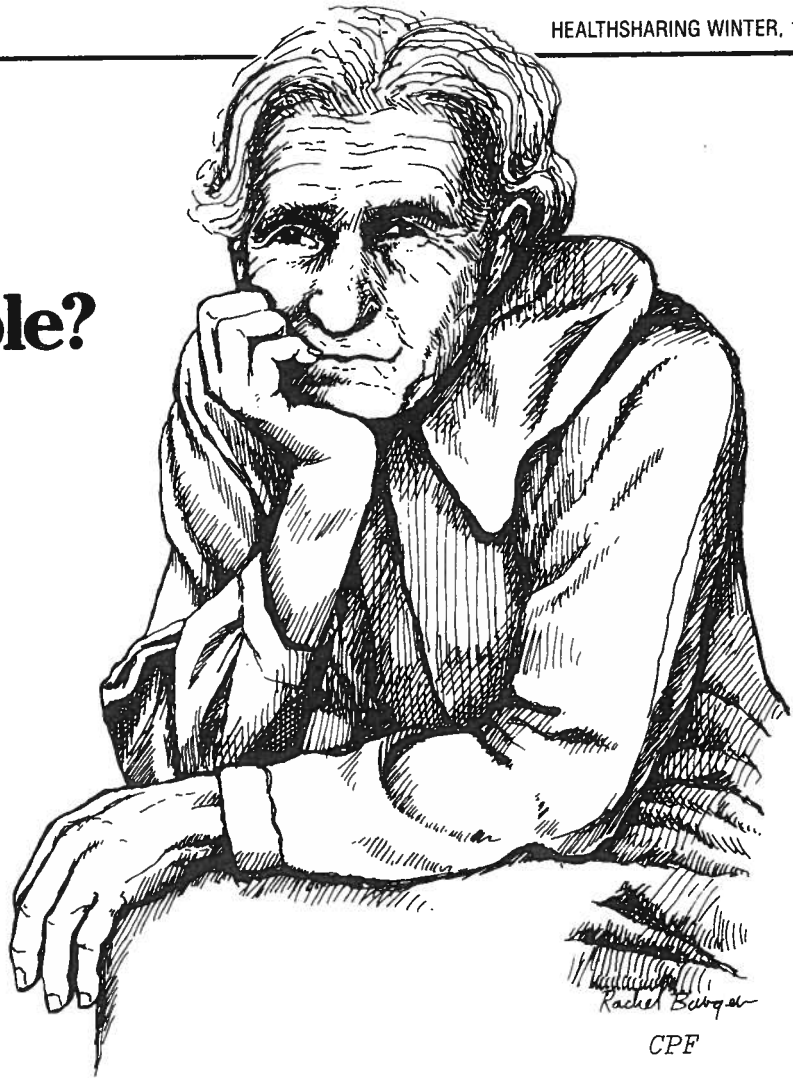
In retrospect, Christensen says: "I guess I never really had time to think about growing old until I retired. My life had always been so full . . . I left high school and went straight to college, taught for a while in a one-room schoolhouse, then got married and raised 10 children before returning to university to earn my Masters degree. After that, I devoted my life to teaching for another 25 years and was so busy with day-to-day survival that I never had time to dwell on what might be. When I retired, things like the children leaving home and the prospect of outliving my husband and spending my final years alone in an old age home suddenly invaded my mind like monsters. All I could think about was the time on the clock running backwards. I saw my life in terms of the years I had left instead of the years I had ahead."

Christensen went through her terrible crisis feeling she was the only

woman in the world to experience such negative thoughts about aging. In fact, she has lots of company. Compared to many other women, Christensen, with her work experience and pension, was better off than most. Because she worked at a well-paying job for many years, she qualifies for a pension. This pension starts before she's 65 and will supplement old age pension in later years. Christensen was particularly unusual in being able to find a job at an age when societal sexism and ageism combine to keep most older women out of paid employment.

Ageism is the attitude that the elderly are a problem. They are perceived as undeserving of public funds and resources. Older people are seen as responsible for their own circumstances of poverty or ill health. Ageism perpetuates the attitude that the elderly have not worked hard enough, saved enough

**The name of lay women mentioned in this article are fictitious; their stories are real.*



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or that they have lived too long. This attitude combined with sexism poses major obstacles for an older woman's well being. It affects her work options, pension plans, support services and, ultimately, her self-esteem.

Dr. Kathryn Greenaway, a psychologist who works with older women at the Guelph-based Homewood Sanitarium and in private practice, describes middle-aged females as one of society's "most maligned, misunderstood, unappreciated and scapegoated groups." Even when older women are seen as deserving, sexism promotes a passive stereotype of women. Even social policies labelled progressive, often view women as victims, not responsible for their own circumstances. Thus, most policies about older women focus on them as patients, clients or dependents.

**Overcoming obstacles;
I know who I am, and
I'm not alone.**

Some women are able to surmount the obstacles of growing older in today's world. One 94-year-old woman commented to a friend, "I'm alright now. I like where I live. I know who I am, and I'm not alone." This woman has highlighted the key factors that affect her mental health.

There is little data on differences in older women's mental health by race or social class in Canada. We do know that older women who are widowed and/or who belong to a racial or ethnic minority are more likely than men to find themselves impoverished. We also know that socioeconomic differences affect older women's quality of shelter, nutrition, social participation, household assistance and medical care. This contributes to their state of physical and mental health. Generally, more affluent women tend to be in better health and to receive more adequate health services. Women with physical and mental disabilities are more likely to have had inadequate incomes during times of disability and so are also likely to be among the most impoverished during old age.

Women on average live eight years longer than men, but this is not necessarily an advantage for them. More than 70 per cent of all women will end their lives outside of couple-relationships as a result of a partner's death, separation or divorce. In addition, women have greater morbidity, lower incomes and are more isolated than men as they grow older.

The fact that many older women have no partner to care for them sets them up for an increased probability of being institutionalized than men. Ironically, many were care-givers to older husbands who predeceased them. The average age at the time of widowhood is 56 years, meaning these women usually have 15 to 20 years ahead of them, during which many must face major life adjustments alone.

In many cases, women cannot rely on support from their children because of the geographical dispersal of families. Faced with health problems, they often have no alternative other than institutional care. It's not surprising then that 70 per cent of the current nursing home population consists of women over 75 years of age.

The importance of middle-aged women preparing financially for their later years cannot be over stressed. Older women have only one-third the income of older men. Particularly at risk for this type of devastating impoverishment are women who have worked solely in the home and lose their income-earning partner at a relatively young age. They have no employment related income or pension and are too young to qualify for the old age pension. Many of them had no choice other than to conform to the "stay-at-home" role.

Maria Petelli held a good office job at Johnson's Wax in 1947 when she was 21 years old. That fall she married, and company rules required her to give up her job. Fortunately, labour law does not permit such practices today. However, many women Petelli's age and older lost the opportunity to contribute to their own pension plans. For them, access to financial resources is through a husband's pension plans. Lesbian homemakers are even worse off

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being invisible and ineligible through a partner's pension program. Many pensions are meagre because they were not indexed to inflation: many do not provide for the widow. Employment opportunities are slim for these women due both to a lack of skills and bias against hiring older people.

Women who have relied on a partner to earn household income, often find they fall into a no person's land trying to obtain health insurance. Because individual health insurance programs are biased towards group plans covering young, healthy people, obtaining insurance can be tricky. Many women either work in jobs that don't offer insurance plans or don't work sufficient hours to qualify for the company health coverage. Middle-aged married women may lose their spouse's insurance coverage when he dies,

yet they're too young for senior citizen income-in-kind programs such as tax grants and free drugs. Although provincial health insurance is available in many cases, large numbers of people remain outside the government plans. The importance of securing health and disability coverage becomes clearer when one notes that older women are more likely than men to experience disability from strokes, visual impairment, hypertension, arthritis, diabetes, osteoporosis, stress incontinence, falls and senile dementia. Among those aged 75 years and up, one in five is diagnosed with dementia or brain disease.

There is a big gap in our knowledge about the older population and their mental health. We do know that mentally ill older people have much longer hospital stays than other patients. Only 8.9 per cent of admis-

sions to psychiatric facilities are for the elderly, but 20 per cent of the patients on the books are 65 years and older. Older patients stay approximately two years in provincial mental hospitals. This is more than three times longer than for the general population. Among nursing home residents, there is a prevalence of serious mental disturbances in over 70 per cent of the population. The bulk of this patient population is female.

From age 50 on, neuroses, affective psychoses and alcoholism are the three leading causes for admission of women to mental or psychiatric hospitals, according to a 1984 Statistics Canada report. Old women are the most likely group to be prescribed mood altering drugs. As well, most elderly take more than one medication for physical ailments. All too frequently multiple drug use causes mental health problems.

Teresa Pereira's family thought her lack of energy and depression were to be expected. After all, she was 75 years old and she had high blood pressure. Pereira herself thought that there was nothing that she could do. By 10 a.m. each morning, she was exhausted and ready to go back to bed. She had so little energy and so little appetite, that she preferred not to see any friends.

Teresa's spirits have greatly improved.

Finally her daughter-in-law encouraged Pereira to go to another doctor. This was a difficult decision: Pereira didn't want changes; her doctor knew her. Reluctantly, she agreed to consult a gerontologist. The doctor found that Pereira's medication for high blood pressure was a major cause of her depression.

Since her medication change, her spirits have greatly improved. Last week, I saw Teresa at an anniversary party. She was smiling and wearing a new dress. She had come sixty miles for the party, and did not seem at a loss for energy.

Drug interactions can create serious complications for people at





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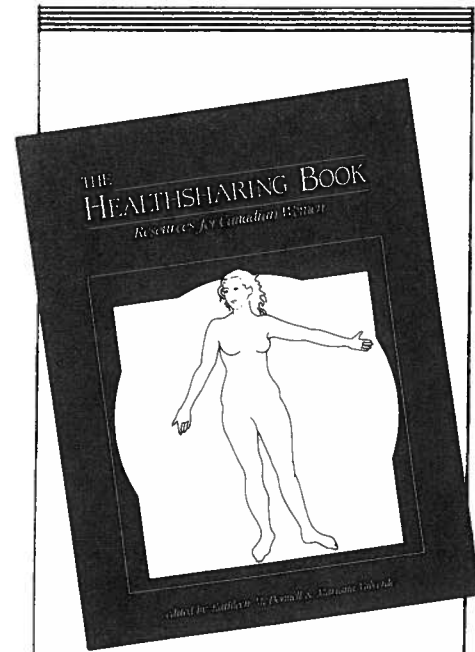
any age. The elderly are especially vulnerable because of their higher medication rate and poorer metabolisms. Seniors consume 50 per cent of prescriptive drugs and 10-15 per cent of all seniors' hospital admissions are drug-related.

Society's expectation that the elderly will be depressed becomes a self-fulfilling prophecy since the expectation has given rise to poor medical treatment and few social programs. Although depression is more prevalent among women than men at all ages, we still know little about depression in women. Many women who experienced depression at a younger age continue to experience it later in life while relatively few women will experience their first bout of clinical depression after age 65. Women's best resources to prevent and combat depression are their abilities to develop close friendships. Women tend to foster a supportive community around them which can help them in times of stress, loneliness and loss.

Studies show that for women aged 65 years and older, depression is lowest among those residing with their spouses and highest among those living with a child or parent. Living with one's daughter or son, and in many cases an in-law, can leave the older woman feeling like a dependent and often the brunt of family arguments. On the other hand, many women in their fifties and sixties care for an aging parent. This, too, is an added stress just when a middle-aged woman is trying to adjust to her changing age.

**That the elderly will
be depressed becomes
a self-fulfilling
prophecy.**

Greenaway believes many of the women referred to her at the Home-wood Sanitarium would not be institutionalized had social resources



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Edited by
Kathleen McDonnell
&
Mariana Valverde

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been available to them earlier on. She says middle-aged women need to know there are others experiencing the same fears about aging. "The message I give middle-aged women is: If you can grow through this difficult period, it will hold you in good stead for what's to come — be it widowhood, health problems or sitting in a rocking chair by a window." Says Greenaway, "You need not be lonely

if you know and like the person in that chair."

Ella Haley is a Ph.D. student in sociology at the University of Toronto. Anne Hauprich is a freelance writer and editor who specializes in health and family life. The Guelph-based mother of two daughters works part-time for the Children's Aid Society.

Staying Mentally Healthy

Women need to make constructive changes for themselves and other women to ensure that more of us are mentally healthy at all ages. Here are a few ideas of what you can do.

- Build a support system around you. Nurture other individuals and your relationships with friends and family.
- Live a physically healthful lifestyle — exercise regularly, eat a balanced diet, get adequate rest.
- When you must take medication learn about potential side-effects and interactions between medications. Never mix your medication with alcohol or other recreational drugs.
- Try to find time or space, at least once in a while, for yourself — trade off babysitting with a neighbour, take one of your coffeebreaks at work to re-centre yourself.
- Practice speaking your mind and putting your emotions into words . . . and encourage those around you to practice the same thing.
- Become an activist or remain one — join a women's health group and bring attention to women's health problems, lobby for improvements in health services and treatment; join the fight for pension reforms that will benefit all people, including homemakers, part-time waged workers, the disabled.

New Report

Women & Mental Health in Canada: Strategies for Change is the title of a report released by the Canadian Mental Health Association, National Office, in April, 1987. The report includes informative sections on women's mental health status, statistics related to treatment and service use, economic factors affecting mental health, specific barriers that hinder women's ability to improve health and an assessment of services and treatments.

The 124-page report is available at a cost of \$5.00 plus handling and postage. Orders can be mailed or telephoned to the CMHA, National Office, 2160 Yonge St., Toronto, Ont. M4S 2Z3 (416) 484-7750.



HEALTH WANTED

Childbirth Experiences

I am interested in learning about your personal childbirth experience for possible inclusion in a book regarding birth culture in Ontario. Please write me a letter describing any aspect of your birth experience whether it be home or hospital birth, cesarean operation, or VBAC.

Please forward your reflections to: Birth Reflections, P.O. Box 2392, Stn. B, St. Catharines, Ont. L2M 7M7.

Crohn's disease

I wish to hear from other women who have had Crohn's disease (regional ileitis), especially alternative means of treatment (alone or in conjunction with steroids and/or surgery). I want to communicate with women who see Crohn's disease as being related to their emotional and/or spiritual health.

Contact: Sheila Norgate, Apt. G, 1054 Pandora Ave., Victoria, B.C. V8V 3P5.

Irregular Periods

I am interested in hearing from women with a history of irregular periods (secondary amenorrhea, oligomenorrhea) for personal sharing and a possible article. I am interested in connections to other health problems, treatment approaches and feelings.

Please write: Elyn Zimmerman, P.O. Box 179, Rhinecliff, N.Y., USA 12574

Cellulite

I would be very interested in hearing from readers about any experiences they have had with successful treatment of cellulite.

Please contact Ruth Ashdown-Smith, via Gianfrancesco Re 29, Turin 10146, Italy.

Teresa Pitman

Is There Sex After Childbirth?

I thought I was prepared for birth — we went to prenatal classes — but in the end I found myself laying flat on my back on the delivery table, my feet in stirrups, no feeling from the waist down, and my baby being pulled out with forceps. I had a huge episiotomy, and it felt like a horse had kicked me between the legs. Sex? I didn't even want to think about it.

"For the next baby I did a lot more preparation, found a new doctor and knew exactly what I wanted. I gave birth to my baby without medication or intervention, nursed right away and was back home in four hours. No episiotomy, just a little tear that needed no stitches. I felt so good, I was ready to make love the next day."

A woman's sexuality is rarely static. It is affected by all the physical and emotional changes she experiences, so that some times her libido (level of sexual desire) is high, and other times it is low. Pregnancy is an obvious time of dramatic physical and emotional change, but giving birth doesn't make everything go 'back to normal.'

The postpartum period will be different for every woman, just as labour and delivery are. Having a cesarean section, an episiotomy, a forceps delivery or other forms of intervention can affect the mother's sexual feelings. The place of birth — hospital or home — and the relationship with the doctor or midwife attending the birth can also be important. A woman who has given birth with minimal intervention, will

usually have less physical trauma and is more likely to have positive feelings about her body and her sexuality afterwards.

Many women, however, find the months after giving birth a difficult time sexually. They may experience physical discomfort or pain, or may simply find themselves disinterested in sex. As one new mother said, "I felt like a switch had been turned off." She was afraid that it would never be turned on again. These problems seem even worse because there is little information available about how childbirth and breastfeeding affect women's sexuality.

Sex? I didn't even want to think about it.

Maria's experience was typical: her doctor advised abstaining for six weeks and being sure to use contraceptives afterwards. She didn't even know what she was supposed to be abstaining from: oral sex? intercourse? masturbation? According to Dr. Joyce Barrett, a family practice physician who frequently speaks on sexuality, this standard advice often leads to fears that sexual activity 'too soon' after the birth will cause serious physical damage. Barrett advises her own patients to follow their own inclinations and express themselves sexually in whatever ways appeal to them and feel comfortable.

One of the most common physical results of giving birth in hospital, and one that is frequently related to sexual problems, is an episiotomy. This is an incision in the perineal tissue at the bottom of the vagina that is stitched together again after the birth of the baby.

A recent study by the Canadian Institute for Child Health found that in half the hospitals surveyed, more than 75 per cent of the mothers received episiotomies during delivery. The percentage tends to be higher for first-time mothers, because they generally experience a longer pushing stage and the vaginal tissues stretch more slowly. Episiotomies are often done to speed up the birth, even though research shows no benefit from shortening the pushing stage when the baby is not in distress. Women who give birth with midwives in attendance are much less likely to be given episiotomies.

Any episiotomy, whether cut straight back or off to the side, can cause problems during sexual activity. The same is true to a lesser extent of accidental tears which may happen during birth but which usually heal more easily than episiotomies. During arousal, the vulva and vagina normally become engorged with blood. This swelling pulls on the episiotomy stitches and can cause considerable pain, even if the incision is healing well. Any kind of sexual stimulation can cause genital swelling — stroking breasts and sucking nipples, touching the clitoris with tongue, fingers or penis, licking or stroking the inner thighs. There

doesn't need to be any contact with the vulva or penetration of the vagina for discomfort to be felt.

After a few months, the scar tissue at the episiotomy site often becomes less sensitive to the swelling of the surrounding tissues. However, many women find this area feels numb and completely unresponsive to any stimulation. One woman described it as "a gap in sensation." Other women experience a burning feeling when the area is touched with some pressure, even when the episiotomy is apparently healed. This can be quite painful during repeated movements of vaginal penetration. Some positions put less pressure on scar tissue; it often helps for the mother and her sexual partner to look at the episiotomy, noticing exactly where it is and what kind of touching causes discomfort. Oral sex and stimulation of the clitoral area with fingers or a vibrator may avoid the sensitive scar tissue. If an episiotomy causes a long-term persistent pain, a woman should insist on medical attention.

For many women breast stimulation is an important part of sexual activity. During the postpartum period, however, the breasts take on a new function: providing food for the baby. According to Masters and Johnson, these changes affect sexual responsiveness. Even when a woman does not breastfeed and lactation is suppressed, the breasts are generally less sensitive to stimulation for about six months after the baby's birth.

I felt like a switch had been turned off. I was afraid it would never be turned on again.

A breastfeeding woman may experience sexual excitement as her infant suckles. Her uterus will contract rhythmically as she nurses, just as it does during orgasm, and the baby's strong sucking may be quite stimulating. Some women are horrified and guilty about these feelings, and may react by weaning the baby or by redirecting these sexual feelings into

their adult relationships. Such feelings are common and normal though, and women should seek to accept them as a fringe benefit of breastfeeding.

A baby's suckling is very strong and a nursing mother's sexual partner may be surprised at how vigorous the sucking or rubbing of the nipples needs to be before the mother responds. Breasts may be so tender and engorged during the early weeks of breastfeeding that touching them is more painful than pleasurable. When sexually aroused, a woman may feel the tingling sensation that indicates her milk is 'letting down.' During orgasm, milk may drip or squirt from her breasts.

Some women and their partners like this, and find the larger, firmer breasts and even the leaking milk very erotic. In other situations, a mother's sexual partner will feel that "her breasts belong to the baby now." Some sexual partners dislike the sweet taste of breast milk and the messiness of unexpected leaking. It may help to know that leaking de-

creases as breastfeeding becomes better established, and usually stops altogether by three or four months.

Another important part of sexual arousal that is affected by childbirth is vaginal lubrication. Normally, as a woman becomes excited, lubricating fluid coats the walls of her vagina. This happens during the postpartum

I felt so good, I was ready to make love the next day.

period as well, but it usually takes much longer, requires more stimulation and less lubrication is produced. Women who are not breastfeeding generally find this response returns to normal within about three months.

Breastfeeding, however, suppresses the ovarian hormones which can mean that decreased sexual re-



Dawna Gallagher

sponse and lubrication may continue for a long time. A vaginal lubricant (such as saliva or K-Y Jelly) may be useful in this situation.

As a result of these hormonal changes, many women find they have little or no sexual desire. Sometimes this improves once the baby is about six months old, starts on solid food and is nursing less. For other women, this disinterest in sex may last through the entire time of lactation, perhaps even longer.

It isn't all in your head.

This lack of libido can be very frightening to a woman who has previously enjoyed her sexuality. Mary, for example, had five babies in 10 years, and breastfed them all until the next pregnancy became obvious. During that entire time period, she experienced very little sexual desire, and began to believe that she would never feel it again. She was relieved and delighted to discover, after her youngest daughter was weaned, that she was once again interested and responsive.

A major physical factor affecting postpartum sexuality is fatigue. New babies are exhausting. The mother may simply have little energy left for sexual activity — she'd rather take a nap.



Dawna Gallagher

Constant tiredness is probably inevitable with a new baby, but some mothers find it helps to nap whenever the baby sleeps, or to have

someone else take the baby (even just for an hour or so) while the mother rests. Bringing the baby into the mother's bed at night, so that she doesn't have to get up for night feedings, can help as well.

Sheila Kitzinger, author of *The Experience of Childbirth*, describes giving birth as a psychosexual event in a woman's life. The experience causes not only the physical changes described above, but emotional changes that can also affect sexual responses.

Heather, for example, had expected a natural, unmedicated birth. Instead, her daughter was delivered by an emergency cesarean section after a long and frightening labour. "I felt like my body had failed me," she says. "It didn't work properly, I wasn't normal. And all those feelings carried over into my sex life."

A vaginal birth can also be traumatic. Sandy was given a large episiotomy and her baby was delivered by forceps while an anesthetist held the gas mask over her face. "It was like being raped," she says. "For a long time afterwards any touching in that area seemed like a violation. I just wanted to protect my body."

Some women find that talking about these experiences helps them to come to terms with the anger and resentment they may feel about their births. It helps to connect with others who have been through similar situations and to share reactions and suggestions.

Even a woman who is pleased with her birth experience often feels dissatisfied with her body during the postpartum period. Her breasts will be larger, may be marked with blue veins, sagging a little or a lot, and the nipples will be darker. Her belly will be soft and flabby and possibly striped with stretch marks. She may have a cesarean scar or extra weight gained during the pregnancy. Many women find it hard to see themselves as sexually attractive when they compare the body in the mirror to the thin, unblemished young woman in the magazine on the dresser.

The extra weight and lax muscles can improve with time and exercise. But stretch marks and scars are permanent, although both will fade to a

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lesser or greater degree gradually. It can take time for a mother to accept her new body. Her partner may also find it difficult to adjust to the changes and so communicating about feelings is very important.

Despite the exhaustion and stress of motherhood, some women find themselves completely absorbed by the baby. Gabrielle, who had been married for several years, wished during the early months of her baby's life that her husband "would just go away. He had done his part, I didn't need him anymore. All I wanted was my baby."

Some women are surprised by the intensity of their feelings for the baby and their desire to focus entirely on the mother-infant relationship for a period of time, but in some cultures a period of isolation for mother and baby of six to 12 weeks is expected. During this time mother and infant are cared for by others, and the mother doesn't put energy into any other relationships. A Canadian woman from the Mediterranean island of Malta described how, as a teenager, she was sent to do the housework and cooking for a relative who had just given birth. Years later, when she had her own child, a young cousin came to do the same for her; she was able to rest and concentrate entirely on her newborn. This total absorption in the baby usually decreases as the baby grows older and less dependent.

Women who give their babies a lot of nurturing — carrying them in their arms or in a baby carrier much of the time, feeding them on demand, sleeping next to them — may find that they are 'touched out' by the end of the day. They don't want any more physical contact or any more demands made on their bodies. Sex becomes "one more thing that I have to do before I can go to sleep."

Sometimes it only takes a short break, a chance to reclaim her body as her own, a walk around the block, a meal in a restaurant, or a long soak in a hot bath, for a woman feeling this way to find her interest in sex returning. This situation also improves as the in-arms-baby who nurses all the time becomes a more independent toddler.

Even women involved in long-term relationships that have been based on an assumption of equality may find that the balance of power shifts after the birth of a baby. The mother may discover that she is expected to do a larger share of the housework during her maternity leave (or if she decides not to return to work) because "she's home all day, anyway." This implies that mothering and caring for the baby is somehow an insignificant contribution and not real work. The overburdened mother is likely to resent the unfairness of the situation.

**Little energy was left
for sex — she'd rather
take a nap.**

Even in lesbian relationships the baby may be seen as primarily the mother's responsibility, and she becomes the one who must make all the arrangements for babysitting, day care, doctor's appointments, diaper service and anything else that the baby requires and that the family can afford. A relationship which leaves one parent free to go to work or out with friends in the evening while the other must find, evaluate and transport to day care, take time off for doctor's appointments and worry about the scheduling and suitability of all these arrangements is clearly unfair. Life changes after a baby, and both partners need to adjust and contribute.

If resentment builds up in this area, the mother may find she is less sexually responsive to her partner. A mother who is disinterested in sex may also feel resentment if her partner pressures her for sex. On the other hand, a woman can feel hurt if her partner makes no attempts to initiate touching or sexual activities, being afraid she is no longer attractive. Talking, both before the baby arrives, and afterwards when problems develop, is the key to preventing serious damage to the relationship. Both the mother and her partner need to express their

feelings, concerns and fears to each other as they experience them.

The single mother faces an even more difficult situation. The baby is totally her responsibility and her financial status may mean she has few options. All her energy may go into meeting the baby's needs, with little left over for her own. When Anne, a single mother, met a new sexual partner she said "it was like being virgin all over again. I'd ignored my sexuality for so long (I just didn't have time to think about it!) that I wasn't sure I could remember how to do it."

Another common experience after giving birth is postpartum depression. More than 50 per cent of mothers will have a brief episode of so-called baby blues, but one in 10 will suffer from real depression. One common symptom of depression is loss of interest in sex. Unfortunately, many women with postpartum depression never seek help and may suffer alone for months. Talking with supportive friends or other new mothers can help lessen the isolation; sometimes professional counselling helps. *The New Mother Syndrome*, a book about postpartum stress and depression by Carol Dix offers practical suggestions for dealing with this problem.

The changes in sexual response during the postpartum period are real. It isn't all in your head. Sexual changes are normal, although every woman's experience will be different. Some women find it takes years for desire to return. Other women find that it returns quite quickly.

Sexual desire and responsiveness will ebb and flow throughout a woman's lifetime. The postpartum period is often a time when sexual energy seems to be redirected into mothering, but that energy has not disappeared forever. It will be there again as the sequence of pregnancy, birth, and lactation is completed.

Teresa Pitman, the mother of four children, teaches childbirth preparation classes, counsels breastfeeding mothers and writes both fiction and nonfiction. She has presented several seminars on how pregnancy, birth and lactation affect sexuality.

REVIEWS

To A Safer Place

National Film Board of Canada, Studio D, Directed by Beverly Shaffer; Produced by Gerry Rogers and Beverly Shaffer, 1987, 16mm and VHS video, 60 minutes.

Reviewed by Joanne Liutkus

To A Safer Place is a film made to address a violence long-shrouded in veils of secrecy and fear of disclosure — the physical and sexual abuse of women and children by the father in families. It is the story of a woman who had been sexually assaulted throughout her childhood by her father, and how she sets out on a journey for herself to understand and resolve some of the trauma. It is not a film about incest *per se*, but a film about all forms of violence: incest, wife assault, child abuse and neglect, and the violence of nonintervention by society.

The film introduces Shirley, an incest survivor who talks about her own son, Jeffrey, and her fears of abusing him because of her own violent upbringing. Here, and throughout the film, she speaks of how, when she needed help, she met disbelief or indifference. She becomes determined to have many questions answered, and goes back to visit her family, namely her mother, two brothers Wilfred and Larry, and her sister Linda. Throughout the film, Shirley is the investigator, questioning her mother about why she did not protect her, her brothers about what their childhoods were like for them, the neighbours who lived next door about why they did not intervene on her behalf when they saw evidence of abuse and neglect, and her male psychiatrist who she was in therapy with as an adult.

Children and adolescents are silenced and punished when they at-

tempt to disclose abuse. They feel pain and anger, and have many questions about their own lives and about their families when they reach womanhood. In the film, Shirley spends time with her mother who is presented as a woman whose power and strength have long since been beaten out of her. The questions Shirley asks her mother are typically asked of mothers whose children have been sexually abused, and are a reflection of our misogynistic and mother-blaming society. They are also the questions which daughters most frequently ask as they struggle to resolve their childhood victimization within that same societal context.

One of the most powerful parts of the film are Wilfred's descriptions of how he was physically and psychologically terrorized as a child and its impact on him as an adult, and the neighbour's perception of Shirley's family which exemplifies the common acceptance of a traditional family structure — patriarchal, private and above the law, even today. Here would have been a perfect opportunity to provide a strong, feminist analysis of the etiology of violence against women and children; the opportunity was not seized and is not regained later in the film.

Women-centred, feminist organizations working with incest survivors have long awaited films on incest and the impact it has on those victimized. *To A Safer Place* is a beginning. Those who work with incest survivors are themselves survivors or know someone who is. Many may feel frustrated with this first attempt since it does not show the full impact of childhood sexual victimization on women, nor does it show how Shirley arrived at the point of no longer blaming herself for the abuse.

Because the father is noticeably

absent, one is left with the incorrect impression that incest is a mother-daughter dilemma resulting from an ineffective mother and a dysfunctional or broken family unit. The film emphasizes the powerlessness of the mother to protect her children, but neglects the role of the father in perpetrating these crimes. We are not shown how Shirley has dealt with her anger and rage towards both her father and the system, which neither protected her nor punished him. The neglect of these all-important areas leaves the viewer hanging and asking what is the impact of incest on Shirley specifically and women in general. Because of the role which Shirley plays as investigator in the film, one can only surmise as to where she has come from, and what happens from here. To cover these issues a much different film is needed.

To A Safer Place is one woman's account of one part of her long and painful journey. Potentially, it may give women sexually abused as children hope that they can get to the point where Shirley is, but the length and pain involved in that journey can never be underestimated, nor can the damage caused by men who sexually and physically abused women and children be ignored. For many women and children, there is no safe place, and there is no end to the journey. More films are needed which can educate both the public and professionals to that reality.

All of those who appear in this film, and they are the actual family members, should be commended for risking themselves to tell their stories and to be open to public scrutiny. Hopefully it will encourage other women to talk about their own victimization and to begin their own journey of healing as Shirley and her sister have done.

Joanne Liutkus is a former staff member of Toronto's Barbara Schlifer Commemorative Clinic, a service for survivors of sexual abuse and assault. She is presently in her first year of the medical program at McMaster University in Hamilton, Ont.

Intimate Partners: Patterns in Love and Marriage

Maggie Scarf, *Random House of Canada Limited, Toronto, 1987, \$27.75*

Reviewed by Sharon Zigelstein

Maggie Scarf's latest book, *Intimate Partners*, is a moving and readable book about intimate human relationships. With wit, insight and compassion, Scarf shows us what goes wrong in our love relationships and demonstrates, through case histories, how change can be effected.

Scarf's data is based on interviews with thousands of couples from varied socio-economic levels and at various stages of the life cycle. Most of the couples interviewed are married or considering marriage. Although the focus of the book is definitely heterosexual, many of the issues Scarf addresses and the concepts that emerge from the case studies would apply to lesbian and gay relationships.

One of the limitations of this focus on marriage is in the area of sexuality. Marital therapy traditionally tends to address the psychological distance which separates couples and to view sexual problems as only one of many troubled areas in a dysfunctional relationship. The belief that sexual difficulties are symptoms that will disappear once the major interpersonal problems of the relationship are resolved minimizes the importance of sexual concerns.

In all fairness, Scarf seriously questions this assumption and expresses dismay at the disregard of physiological considerations (e.g. effects of medication and aging) shown by many therapists in treating sexual problems. In an effort to provide a basic understanding of sexuality, she presents in very readable form, the Masters and Johnson three-stage model of sexual arousal and the sexual exercises known as "sensate focusing" or "pleasuring" developed by Masters and Johnson. However, this section of the book is limited. For deeper explorations of sexuality, readers might consider Sheila Kitzinger's *Women's Experience of Sex* or JoAnn Loulan's *Lesbian Sex*.

As a first step toward understanding what causes breakdowns in



relationships, Scarf explores the meaning of falling in love and the power our past exerts in this area. Buried deeply in our subconscious, with visions and fantasies of our first love, (that is, the oneness we experienced with our mothers) are the inevitable, long forgotten memories of disappointment and the old fears of separation, loss and abandonment. For adults, the act of falling in love reawakens both aspects of this first love. We enter adult relationships with an established set of needs, fantasies and painful conflicts and with the expectation that somehow our partner can meet these needs, fulfill these fantasies and resolve these conflicts. Our intimate adult relationships become attempts to replay issues that originated in our childhood, with the hope, this time around, of a happy ending. Given this scenario, it is not surprising that there are so few happy endings. Our unconscious stock of needs, fantasies and conflicts inherited from our families of origin are the cause of much of the disappointment and frustration we encounter in our intimate partners.

Another 'inheritance' from our original families that can play havoc with our adult relationships has to do with what Scarf calls the "emotional system" of our families. This is essentially the way we learned to relate emotionally to the other members of our family — how we were expected to behave, what roles were assigned to each family member, who was expected to be 'good', who was expected to be 'angry', what a 'real

adult woman' was like, what a 'real adult man' was like and so on. These rules and expectations that we learned as children become the system that 'feels right' to us as adults. Regardless of whether these emotional systems were stable or full of conflict, whether they were liberating or rife with repression and denial, we tend to replicate them in our adult love relationships.

Scarf provides us with an insightful analysis of the concept of the emotional triangle and its effect on intimate relationships. In an unconscious effort to avoid the disruption caused when problems are acknowledged, one of the partners forms an alliance with a third party. Whoever the third person is, she or he serves to obscure the central conflict.

In addition to the exploration of the problems that plague intimate relationships, Scarf devotes a large part of the book to practical advice and tasks that couples can undertake in order to improve their ways of relating and to enhance each partner's understanding of the other's world. She recommends exercises that, while deceptively simple, will help to resolve tension and conflict. The tasks are designed to enable partners to experience what it feels like to be in a different emotional system so as to make change feel less threatening. Scarf shows how a family genogram (a diagram of one's family history) can be an effective method for showing the inherited emotional history of each partner and the struggle involved in trying to resolve the unfinished business of childhood.

In her final chapter, Scarf presents her prescription for a satisfying intimate relationship that integrates personal growth and self-knowledge with feelings of closeness and concern for another individual. The successful intimate relationship fulfills our needs as individuals for growth and autonomy while at the same time it meets the basic human need to connect with another person, without the fear of losing our sense of self. This is the gift we can give ourselves and our lovers.

Sharon Zigelstein is a former member of Women Healthsharing living in Toronto.

The Canadian Women's Movement Archives/ les Archives canadiennes du mouvement des femmes,

is preparing a computerized directory of the Canadian women's movement. This directory will index women's groups by area of interest and geographical location, and will be available soon on computer disk or as mailing labels.

If you belong to a woman's group that received a questionnaire please fill it out and return it to us. If you belong to a group that was not contacted, or know of a new group in your area, contact us.

Lesbian and Gay activists and researchers:

Just published: A listing of the Canadian Women's Movement Archives lesbian and gay collections. This is now available from the CWMA at a minimal charge

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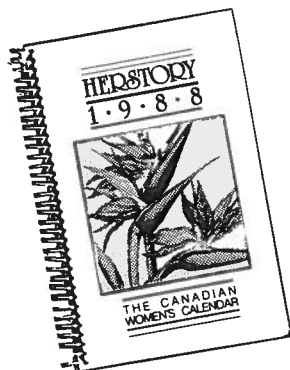
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RESOURCES & EVENTS

Public Health Conference

The 79th Canadian Public Health Association annual conference will be held July 4-7, 1988 in Quebec City. The theme is *Community Health: Dependence or Independence for the Public?*. The deadline for abstract submissions is December 31, 1987.

For information contact, Conference Division, CPHA, 1335 Carling Ave., Suite 210, Ottawa, Ont. K1Z 8N8, (613) 725-3769.

Action Research

The Women's Research Centre has recently published *Action Research for Women's Groups*. The kit includes five papers: Assumptions about Action Research; Making the Decision to do a Research Project; Designing an Action Research Project; Carrying Out an Action Research Project; and Communicating the Findings of an Action Research Project.

Copies are available from the Women's Research Centre, 1666 W. Broadway, Vancouver, B. C. V6J 1X6, (604) 734-0485. The discounted cost for women's groups is \$2.70.

Institute on Addictions

The Alberta Alcohol and Drug Abuse Commission is sponsoring an institute entitled *Bridging the Gaps: Law Enforcement — Communities — Helping Agencies*. It will be held July 3-6, 1988 in Calgary.

Potential delegates and presenters

should contact: Tom Wispinski, Institute on Addictions, AADAC, 7th Floor, 10909 Jasper Ave., Edmonton, Alta. T5J 3M9, (403) 427-7305.

Food Laws in Canada

The Ministry of Supply and Services Canada has reprinted *Health Protection and Food Laws*, a 95-page booklet outlining the major aspects of the Food and Drug Act and Regulations. Topics covered include additives, pesticides, food enrichment, labelling and advertising.

Copies are available for \$5 (Canada), \$6 (other countries) from Canadian Government Publishing Centre, Supply and Services Canada, Ottawa, Ont. K1A 0S9.

Reproductive Technology

The Conseil du statut de la femme in Quebec has published new resources on reproductive technology to coincide with their conference held on October 29-31, 1987. *Dilemmas: When Technology Transforms Motherhood*, a 40-page magazine-format overview, is available in both French and English.

To order, contact Conseil du statut de la femme, 8, rue Cook, 3 etage, Quebec, Quebec (418) 643-4326. *Dilemmas* costs \$3.95.

Taking Care

The revised version of *Taking Care: A Handbook About Women's Health* by Mary J. Breen is now available.

This 200-page handbook on topics such as stress, eating well, menopause, fitness, patients' rights and birth control is written for women with limited reading skills.

Copies of *Taking Care* are available free for individual women. Organizations will be charged handling costs. To order, contact: The Women's Health Project, c/o Peterborough YWCA, 216 Simcoe St., Peterborough, Ont. K9H 2H7, (705) 742-9852.

In Search of Healthy Sexuality

The University of Guelph's annual sexuality conference, June 13-15, 1988, will examine current issues in human sexuality, teaching approaches in sex education, and counselling methods for sexual problems.

For further information, write: Continuing Education Division, University of Guelph, Guelph, Ont. N1G 2W1, (519) 824-4120 ext. 3113.

A Disability Fable

Audrey J. King's *There's Lint in Your Bellybutton!* is a delightful cartoon depiction of life in a wheelchair.

Copies are available for \$16.95 (Canada) or \$20.35 (outside Canada) from Canadian Government Publishing Centre, Ottawa, Ont. K1A 0S9 or through your local bookstore.

Women Healthsharing screens resources before including items in this section.

Send us a sample copy of any new resource whenever possible. Also send us notice of upcoming events. Send notice of events far in advance (preferably 4-6 months).