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# Healthsharing

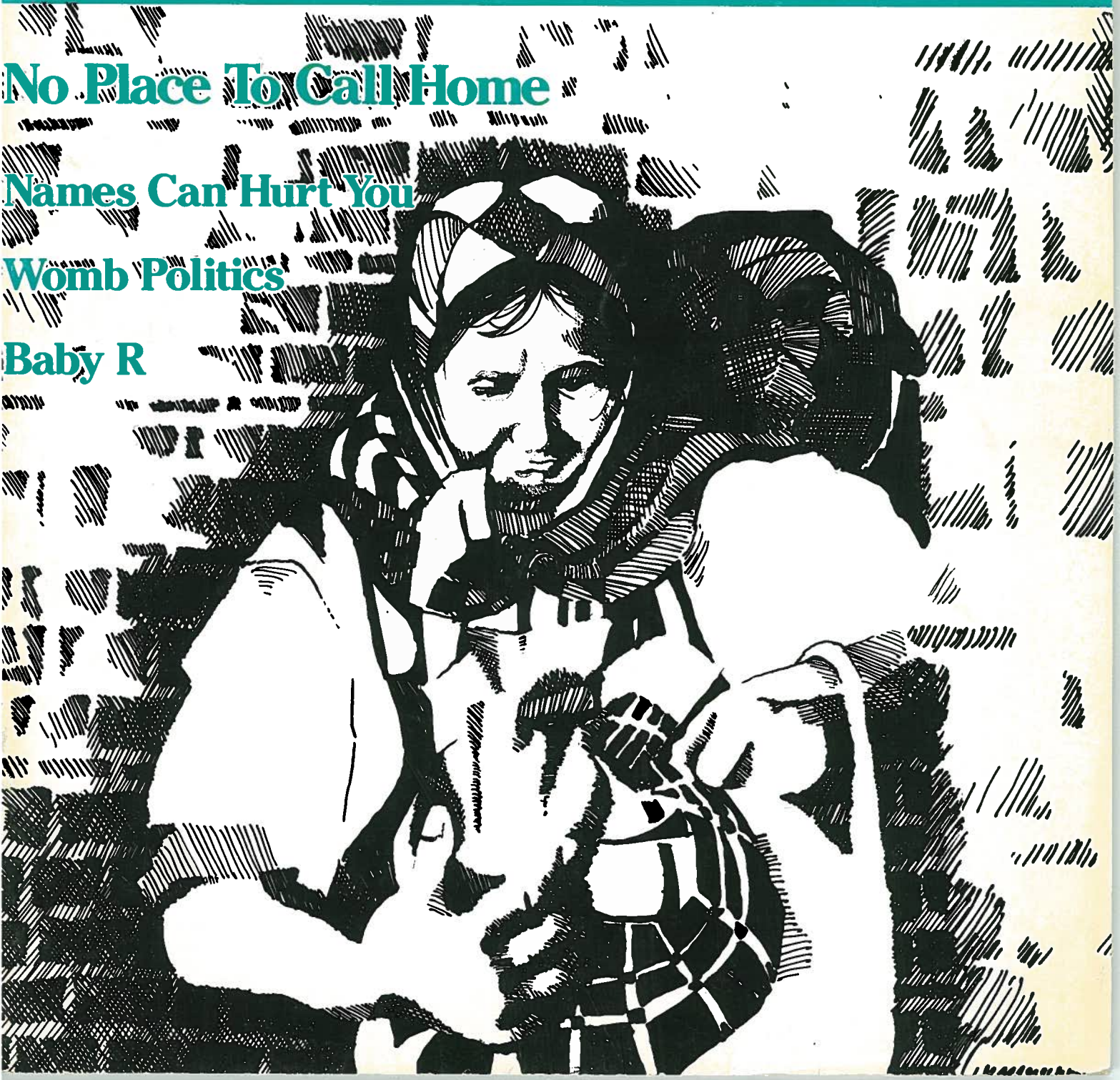
A CANADIAN WOMEN'S HEALTH QUARTERLY

No Place To Call Home

Names Can Hurt You

Womb Politics

Baby R



# INSIDE

Vol 9:2 March, 1988

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Barbara Pasternak

# COLLECTIVE NOTES

## Reproductive Rights Eroded Away

Our fight as women to gain control over our own bodies is taking on new dimensions. Reproductive rights, never clearly acknowledged by modern medicine, are increasingly being threatened by medical and state intervention into conception, pregnancy and birth.

In this issue of *Healthsharing* we look at some of the ways women are being manipulated and at times coerced into participating in medical procedures of dubious benefit and potential harm. An article by B.C. health activist Maggie Thompson, especially raises disturbing questions about our rights as women.

Thompson chronicles the story of "Rose" whose fetus was apprehended to force Rose to undergo a cesarean section to ensure the safe birth of her child. The so-called rights of the fetus are being stacked up against the rights of pregnant women — and women are losing.

Rose's fetus, in a footling breech position, was considered to be endangered by her refusal to have a cesarean section. Her doctor notified the child protection agency and the fetus was apprehended as a "child" in need of protection. Under these coercive circumstances, Rose agreed to the cesarean. The baby was taken away at birth and kept in foster care under the custody of the Superintendent of Family and Child services until a hearing. At the hearing, Judge Davis found that the pre-birth apprehension had been warranted in the circumstances. He then proceeded to extend that initial apprehension into a permanent custody order. In other words, Rose lost her child — for good.

This case, the second we are aware of in Canada in which a fetus has been apprehended under child welfare legislation, has serious implications for women. The judge's de-

cision is made even more Orwellian by the fact that the pre-birth apprehension, allegedly initiated for medical reasons to ensure a safe birth, provided the basis for Rose to lose her child permanently. It is true that Rose had shown limited parenting skills with her other children in the past. It was also quite possible that this baby might have been removed by government from Rose's care sometime after birth. But it is crucial to keep distinct the two issues at stake. To collapse a pre-natal apprehension, where the issue is the woman's insistence on vaginal birth, into a post-natal apprehension, where the issue is the mother's ability to care for her child, is totally inappropriate. The issues are very different and must be dealt with separately. This judgement is a dangerous precedent. Women who want to refuse medical treatment that a doctor defines as in the interest of the fetus may fear that in going against their doctor's wishes they risk losing custody of their child.

Apprehension of a fetus means interference with the pregnant woman carrying that fetus. Are there any circumstances in which a woman's rights should be seen as secondary to those of the fetus? And if so, where do we draw the line? Many situations may pose risks to a fetus — drug or alcohol abuse by the pregnant woman, vaginal birth by a woman with active genital herpes, a breech presentation or a fetus that would require intrauterine surgery in order to survive. But is it ever appropriate to require a woman to undergo surgery or treatment against her will in order to treat the fetus she is carrying?

Women in the U.S. have been required to undergo cesarean sections because of fetal distress or a history of cesareans; one woman was re-

## Pro-Choice Victory

As *Healthsharing* prepared this issue, we were exultant over the Supreme Court abortion decision. The ruling stated what all of us already knew: the old law denied our right to freedom and health. This decision marks a tremendous victory for Canadian women and is testimony to years of struggle by Canadian feminists.

Because of time constraints and nationwide uncertainty about the ramifications of the court decision, *Healthsharing* will not cover the story this time. There are many unanswered questions. Will the ruling improve access to abortion throughout Canada? Can the provinces make insurance coverage of abortions dependent on the existence of abortion committees? Will there be more free standing clinics? What will this mean for Canadian women who have decided to have an abortion?

*Healthsharing* will be following events closely and we hope to bring you on going analysis. We urge you to continue the struggle federally and provincially, but for now, let's enjoy our victory!

quired to have three intrauterine blood transfusions to save her fetus; women have been detained in hospitals so that their fetuses could receive medically prescribed care. And who decides that treatment is required and on what basis? George Anas, in an article in the May, 1987, issue of *The New England Journal of Medicine*, reports that in three out of the first five cases in which doctors sought court orders to require a cesarean section, the women delivered vaginally without a problem. In these cases, either the court order had been refused or was still being decided.

A U.S. survey referred to by Thompson indicates that women who have been subjected to court ordered obstetrical interventions are overwhelmingly Black, Asian or Hispanic. In the 21 court orders reviewed in that article, women were either being treated in teaching hospitals, known for higher rates of intervention and experimentation, or were receiving social assistance.

For years, in rape cases, we have fought against the twisted notion that coerced agreement equals consent. The idea of consent has long been hazy to some lawyers and

judges. Some of the medical profession now appear to have joined their ranks. Although Rose was badgered into agreeing to the operation, Judge Davis found that she had in fact consented to the cesarean section and she "knew what she was doing."

We will be seeing more of these cases as doctors fight to regain ground reclaimed by the natural childbirth movement. It's conceivable that we may, in the not too distant future, be faced with court orders requiring women to give birth in hospitals rather than at home. In addition, the recognition of fetal

rights may lead to the curtailment or elimination of our already limited abortion rights.

In this issue of *Healthsharing*, we also present two interviews with health activists. Both interviews examine the complexities of short-term versus long-term strategies. In "You Can't Get There From Here" a representative of the Midwives Collective of Toronto and a representative of the Ontario Coalition for Abortion Clinics also share their vision for the future — a future in which women's health is securely in our own hands and the words choice and consent

have real meaning for all women.

As we examine our painful and often confusing current reality, we must not forget our vision — the world that we are struggling to create and the dreams that give us strength.

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

## 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.'*

### **Broken immune system**

Regarding the article *Through the Medical Maze* (Fall, 1987), Canadian women and health care consumers generally are well advised to become discerning readers in order to make appropriate decisions regarding their own and their family's health.

Medical myths and phrases such as "no known cause, no known cure" and "not scientifically proven" merely serve as catalysts, prompting further research and reading. There is a striking similarity of symptoms often identified as separate illnesses, and a broken down or damaged immune system seems to be a common denominator, suggesting an interrelationship between many illnesses.

Special priority in medical care is currently given to

broken bones, damaged kidneys, livers, lungs and hearts . . . why not special care and attention for broken immune systems?

*Muriel Hall  
Port Carling, Ont.*

### **Memorial societies**

As a former subscriber of *Herizons* I received your fall issue which I found very interesting.

I would like to correct a discrepancy which appears in the article *When a Newborn Dies*. You suggest that the parents may wish to bury the baby on their own land. In Ontario, at least, this is against the law and to be able to do so involves considerable work and a great deal of expense.

As women are so often the ones who must make funeral arrangements, your readers might want to know about memorial societies which exist in every province except P.E.I.  
*Elly Elder  
Toronto Memorial Society  
Toronto, Ontario*

### **Differences as strengths**

In *No Longer Silently Disabled* (Fall, 1987), Betty-Ann Lloyd addresses differences which

are unspoken and unacknowledged through an invisible barrier. An open dialogue will help, both to address our different needs and abilities and to raise our levels of awareness. By beginning to speak out, we may reduce the assumptions that exclude women who "don't fit in."

I face constant conflict between my able-bodied appearance and my lower-back disability. The frustration of dealing with my own inabilities is often complicated by the vulnerability of re-explaining my needs to others. The decision to vocal about my back problem is often based on circumstance and need.

The connection made between lesbianism and invisible disability reveals a parallel need to continually come out in order to reduce alienation caused by assumptions. The risk of our vulnerability and others' discomfort often discourages our actions. By speaking out, the resulting increase in our level of understanding and ease will benefit us all.

A challenge is issued to see our differences as strengths and to speak out about them.

The special strengths we need to cope with a disability can be viewed in a positive light through asserting the concept of differently-abled. We can revel in our differences.

*Wendy Anthony  
Victoria, B.C.*

### **Thanks**

Thanks for your wonderful magazine. It is an invaluable resource of good articles for us. Wishing you good health and prosperity for the New Year.

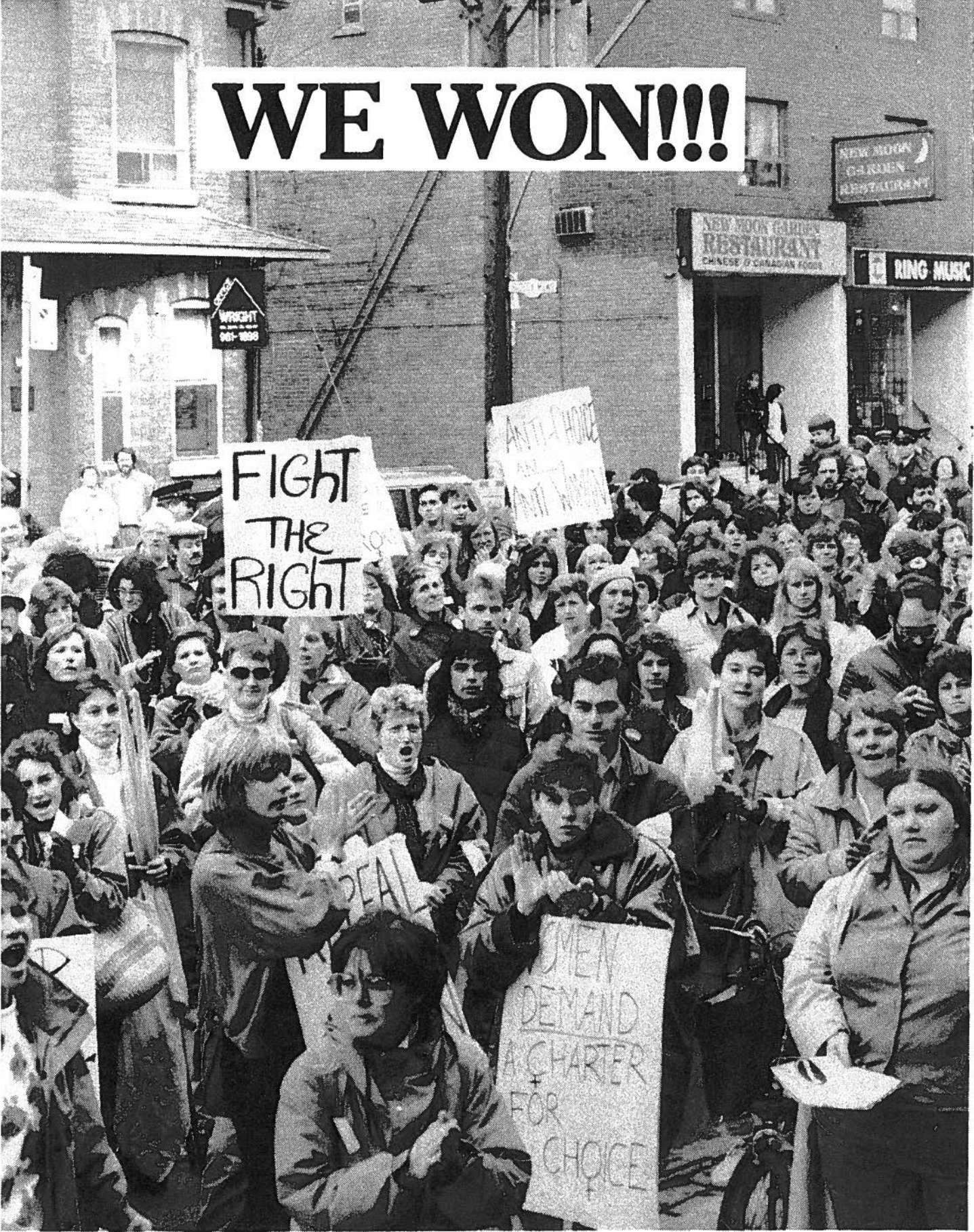
*Susan Hays  
Women's Community Health  
Centre of the Blue Mountains  
Katoomba, NSW, Australia*

### **APOLOGY**

Our apologies to Deborah Clark and Teresa Pitman for spelling their names incorrectly in the *Table of Contents*, to Joanne Dyck for spelling her name incorrectly and to Ann Hauprich and Don Forgay for failing to recognize their co-authorship in the *Table of Contents* of the December, 1987 issue.

Julia Barnett

# WE WON!!!



## UPDATE

### Women in sport and fitness

One of the goals of the Women's Program of Fitness and Amateur Sport is "to increase the number of women in leadership positions in sport and fitness organizations," according to this Canadian Government program.

A leadership and training program, now called Women in Sport and Fitness Leadership (WSFL), was set up in response to a series of studies on women in sports completed in 1981. "These studies demonstrated clearly that women were under-represented in technical and administrative leadership roles in sport and fitness organizations," says the summary of a 1985 survey recently released. Since 1981 steps to correct the imbalance had been taken and the 1985 study was done to determine whether changes had occurred. The WSFL conducted a survey of 85 national sport and fitness organizations. Respondents were asked to contribute "gender-related information on office personnel, national team staff, volunteer decision-making structures, annual operating budgets, and policy with respect to women."

According to the survey results there have been some positive changes. In 1985, 62 per cent of program coordinators were women, an increase from 40 per cent in 1980. In 1985, 24 per cent of the chief executive officers of national sport and fitness

organizations were women, compared with 16 per cent in 1980. The authors note, however, that "94 per cent of these women headed organizations with budgets of less than one million dollars at a time when only 65 per cent of all organizations had budgets of this size."

There are several areas where women remain significantly under-represented. According to the 1985 survey, only seven per cent of all head coaches and 21 per cent of the members of boards or executive committees were women. Of the organizations surveyed, only 12 per cent had an official policy on equality of opportunity and representation for women.

To continue to address these inequities and to promote further change, the Women's Program made several recommendations after the 1985 study and plans have been made to survey national sport and fitness organizations every other year.

BONNIE LAFAVE



### Still Sane in Halifax

*Still Sane* is an art show of 27 sculptures and narratives by feminist artist Persimmon Blackbridge in collaboration with Sheila Gilhooly. There is, as well, a video and a book.

*Coming Together*, a weekend conference presented by and for lesbians, was held recently in Halifax and sponsored two screenings of the video. Close to 100 watched this powerful documentary which portrays Gilhooly's three year struggle, as a woman and as a lesbian, against the male-dominated, male-defined psychiatric system. After each showing Sheila responded warmly and openly to questions and comments from the audience. Throughout the conference women approached her to discuss their own experiences.

Gilhooly experienced 19 electro shock treatments. She was prescribed drugs, sexually abused and given perks for wearing a dress. More than 70 per cent of the estimated

100,000 Americans who receive electro convulsive treatment (ECT) each year are women, according to the video. In 1982 approximately 8,000 Canadians received ECT. One audience member summed up the feeling of the workshop: "If you have a friend or a relative in a psychiatric hospital, visit them. Often."

*Still Sane* speaks to every woman about our present psychiatric system and about how normalcy is defined. It shows the thin line between being on the inside and being on the outside. It also speaks to women about being lesbian in this society and to lesbians about our lives. *Still Sane* demonstrates the power of good feminist political art.

ALEXANDRA KEIR

### Women's coalition in Saskatchewan

On November 28 and 29 of 1987, a group of over 200 women attended a conference in Saskatoon in an attempt to form a women's coalition that would fight back against the human services cuts instigated by the P.C. provincial government. One of the six major concerns identified was the erosion of health care. Some of the specific areas of concern noted were women's reproductive health services, lab services, drug plans, community clinics, dental care, children's services and services for the province's

rural and native populations.

At the end of a strategy planning session a formal coalition was adopted under the name Connections. A steering committee is holding regular meetings to continue the fight back campaign.

For more information, write: Connections, c/o Marg Brown, 2149 Broad St., Regina, Saskatchewan, S4P 2V1.

SHANNON BUCHAN

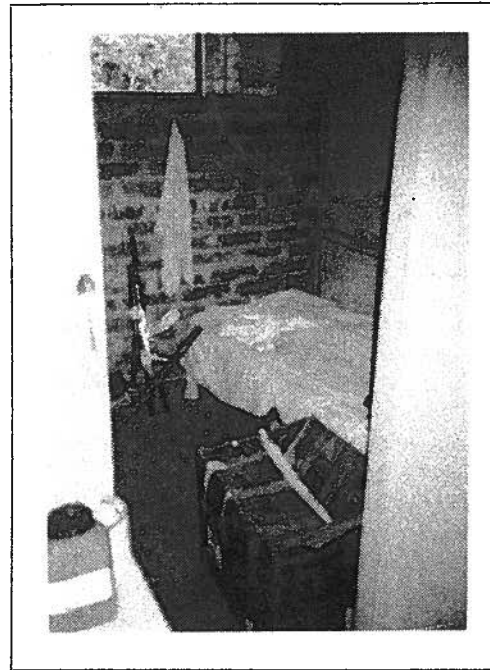
## Canadian aid to Nicaragua

A health post, built by local villagers using funds raised by the selling of crops and livestock, was attacked and destroyed in the fall of 1987. Ray Wiss, a Canadian working for the Ministry of Health in Nicaragua, described the destruction in recent correspondence to members of Medical Aid to Nicaragua (MATN) here in Canada. "I witnessed the results of a Contra attack upon a small community, La Patriota (near Matagalpa). A one-year old and her 70 year old grandmother died, many of the adult men were killed or badly wounded, and the health post was razed to the ground. Homes were riddled with shrapnel and bullet holes, leaving families exposed to the heavy fall rains."

Wiss said, however, that "the spirit that once moved the people to construct the health post remains. With the assistance of the Ministry of Health, a temporary post was established in the church. Meetings were held to plan the rebuilding of the village and new roofing, donated by Tools for Peace, arrived."

"In such communities," said Wiss, "women are playing an ever increasing role. As emergency measures trainer here, I recently taught a first aid brigade made up entirely of women. Since there is no daycare, they brought all their pre-school children with them. I taught the whole course with 2, 3 or 4 munchkins on my back or in my arms as their mothers role-played the various life-saving techniques they will use on their loved ones if the Contras come again."

MATN, founded in 1979 by concerned health professionals and international development workers, has been active in the promotion of a greater understanding and support of the Nicaraguan revolution among Canadians. They have been providing ongoing financial support to Nicaraguan rural health projects, to the training of community health workers, and to Canadian health care personnel employed in Nicaragua. As well, they have made major contributions of medical equipment and supplies to the annual Tools for Peace boat



Ray Wiss

project.

Canadians who wish to obtain further information or offer their support should write to: Medical Aid to Nicaragua, P.O. Box 249, Station C, Toronto, Ont. M6J 3P4.

WHS

### Our Cover Illustration

Barbara Pasternak, a new artist to Healthsharing, drew our cover as well as several other drawings that appear throughout the issue.



## Family link

Dr. Elaine Borins, a psychiatrist and researcher at Toronto Western Hospital, has concluded that there may be a correlation between the reproductive experiences of women of different generations in the same family, according to an article by Carol Thomas in the November, 1987 issue of *Toronto and Region Hospital News*.

Borins analyzed questionnaires completed by

130 women attending the hospital's Women's Psychiatric Clinic. Her original interest was in looking at the connections between the reproductive issues and the mental health issues. The questionnaires included personal and family health histories. Borins found that patients who had reproductive problems and childbirth complications were more likely to have mothers who had similar complications

themselves. "Women who had certain kinds of reproductive calamities had mothers who had had reproductive calamities," said Borins. There were correlations between mothers and daughters who had had stillbirths, miscarriages, hysterectomies and sterilizations.

The reasons for the similarities between generations are not clear. They may be biological, psychological or some

combination of both. Borins is currently working on a comparison study of women who did not seek treatment for psychiatric problems at a clinic. "If we did establish that the reproductive life of the mother and grandmother was significant for a woman," assumes Borin, "it might help us in terms of counselling and preventative measures."

BONNIE LAFAVE

## Move over, Dick Tracy

A new device that's worn on the wrist like a Dick Tracy style watch-transmitter could help Canada's growing elderly population retain their independence from a costly medical system. The device may have special significance for women, who tend to live longer and are more likely to live alone.

At Golden Hospital in Golden, B.C., the Apello Personal Emergency Response System is now in use. Sponsored through the local long-term care facility since early 1987, the system has two components: a signal bracelet and a small box on which the user's telephone sits. In an emergency, the user simply

presses two buttons on the bracelet simultaneously. This transmits a signal to the phone to dial the first of four pre-recorded numbers, including the local emergency number. When a call is answered, a pre-recorded ten second emergency message is delivered.

The only other emergency dialing system on the Canadian market requires a 24 hour monitored switchboard. While this is not a problem for residents of the city in which the switchboard is located, subscribers in small towns must routinely handle the long distance charges needed to check their equipment. In the remote community of Golden,

B.C., however, ambulances have delivered seniors to hospital minutes after they have called, without long distance costs.

"We originally introduced the system as a security measure for people awaiting admission to a long-term care facility," says Golden Hospital administrator Chuck Collins. "But five out of 10 of the users (eight women and two men) now feel so secure, they've chosen to remain in their own homes and have removed their names from the waiting list for long term care."

LYNNE MELCOMBE

## Women and weight

HERSIZE: A Weight Prejudice Action Group, recently founded in Toronto, is committed to increasing the public's awareness of the ways in which our culture's obsession with thinness oppresses women.

We live in a society that is phobic about fat. The effects of weight prejudice are evident in many aspects of life from discrimination in the work place and in housing to personal concerns about self-respect and self-worth. Our society makes those who are overweight feel desperate and most of us desperate not to be overweight.

Popular media has been relentless in its demand that women conform to the thin ideal. While only a small percentage can attain the standards of beauty and thinness reflected in popular media, most women strive to be thin. 80 to 90 per cent of women believe they are too fat. 70 percent say they watch what they eat and 40 per cent are actively dieting.

HERSIZE is dedicated to helping women free themselves from over-concern with body shape and size. HERSIZE activities and services include conducting a media watch, a writing campaign against oppressive media messages about women and weight, the development of educational materials and public speaking.

For more information please call 416-769-2722 or 535-4653 or write c/o Mary Dahonick, R.N., 223 Concord Ave., Toronto, Ont. M6H 2P4.

MARY DAHONICK  
CARLA RICE

## Family planning clinic in Edmonton

On December 15, 1987, the Minister of Hospitals and Medical Care, Marvin Moore, announced approval for a Family Planning Clinic in Edmonton's Royal Alexandra Hospital.

Moore said the clinic will provide greater access to therapeutic abortions and contraceptive counselling for women in Alberta. When the Canada Health Act banned extra billing in 1986, access to abortions was severely limited. Unable to charge more than the 84.75 dollar abortion fee, many doctors were unwilling to perform the procedure, and women were often forced to travel to the United States or to other provinces, at great expense, in order to obtain an abortion. Only Calgary's Foothills Hospital has offered continued access to therapeutic abortions in Alberta.

Moore's announcement was

made just after fee negotiations with the Alberta Medical Association were completed. Clearly, Moore has opted to increase access to abortion by means other than raising the physicians fee. Moore is also said to be reviewing whether tubal ligations and vasectomies will be returned to the medicare fee schedule.

Although opponents of the increased access to abortion

that the Family Planning Clinic will provide launched a fierce letter writing campaign just hours after Moore's announcement, the move to establish the clinic has been met with enthusiastic approval by pro-choice women's advocacy group, who have lobbied hard to obtain such access for the women of Alberta.

ANN GOLDBLATT



# Smokefree

Teaches Women to Quit Smoking

Phyllis Marie Jensen, R.N., PhD.

183 Munro Street, Toronto, Ontario M4M 2B8

(416) 465-1323



Susan G. Cole

## No Place To Call Home

*Inside a ramshackle downtown Toronto house, all 20 chairs in the living room are occupied by women. Actually, all the rooms in the house are in use: the laundry room, where a woman painstakingly folds her laundry; the sleeping room, where a woman sprawls on the bed; the clothing room, where a woman struggles into a coat from the donations pile. But even though about 50 women are milling around, there is an odd absence of energy, no intensity, no spark. The air in the main sitting room is thick with the fog of endlessly smoked cigarettes. One woman waves for someone to change the record, but most of the women are immobile, staring into space.*

This is the scene at 416, a drop-in centre for female ex-psychiatric patients. Every day, 416 gives lunch to 150 women who have no homes, community or support and whose needs are growing more and more difficult to meet. These women are lonely, isolated, stigmatized and vulnerable. Community health care workers are scrambling to fill the service gaps, but no matter how much mortar they shovel into the cracks, more and more women are falling through.

Asked to describe the situation female ex-psychiatric patients face, Pauline Rankine, a worker at a Vancouver group home, states the situation in its bleakest terms. "Think about all the problems that psychiatric patients have," explains Rankine, "and then multiply them five times for women. Now think



Barbara Pasternak

about all the problems women have, and then multiply them five times and you get a sense of what is at stake here. People are not very tolerant of psychiatrically disabled people and there is even less tolerance for women psychiatric patients because there is less tolerance for women in general."

Rankine's description helps us begin to trace the social and political trends that have locked ex-psychiatric patients into their recent crisis. Many of them are on the streets in need of the services 416 provides because of a government mental health strategy known as de-institutionalization. In theory, de-institutionalization was going to take chronic psychiatric patients out of hospitals and hand them over to a caring community. In practice, the hospitals are emptying out, the policy-makers forgot to develop community strategies to pick up where the institutions left off, and it is not at all clear that the community cares.

Ironically, the heart of the de-institutionalization tendency has always been in the right place. In the '60s patient advocates helped to raise public awareness of the ways in which hospital facilities dehumanized residents and perpetuated their helplessness, sparking a movement to integrate patients more closely into communities. Feminists supported the strategy, insisting that women in particular were over-medicalized and over-institutionalized in a system that treated women instead of the social conditions that were driving them mad.

As the grass roots political drive to empty hospitals developed, the public perception that psychotropic drugs eased patient symptoms considerably and made patients less dependent on hospitals created a more general openness to the idea. Add to those conditions the desire of health officials for more funds to upgrade hospital facilities for those patients who needed to be in hospitals and the stage was set for a serious slash in the number of patient beds.

The slash did occur and it is a cross-Canada trend. Toronto's Lakeshore Hospital, to give an example, one of the largest mental health facilities in the country, closed in 1979. It was the last in a series of

closures, the majority of which took place between 1965 and 1975 and depleted the number of psychiatric hospital beds in the city by a full two-thirds. Today in Toronto there are one-quarter the psychiatric beds there were in 1965. On the other side of the country, in Vancouver, the Riverview Hospital, an old prison of a place with 1,306 beds, has finally been shut down.

John Trainer, a researcher at Toronto's Queen Street Mental Health Centre, and a progressive activist in the area of mental health, describes the dilemma he faces now that de-institutionalization has been phased in. "There is no question that putting people in loony bins didn't do anything for them," he says. "Cutting people off from the community is the last thing they need. The hospital is no place to stay. It is not a place to live. It is a place where things are done to you." But he refuses to let it stop at the first half of the equation. "The problem is that while the de-institutionalization began to take place, there was no clear thinking that the people leaving hospitals needed support."

"The biggest problem is the structure of the mental health system," Trainer explains. "Even though this process of moving patients into the community has been going on now for over ten years, 70-80 per cent of the money available for mental health still goes into institutions. Almost all the rest of it goes into private practice psychiatry (OHIP bills to physicians) and only 6 per cent of the money goes to community support. What is shocking is that we are now down to one-quarter of the beds we used to have, and they eat up more money than they ever did. In the '50s, the cost per bed per day was 2 to 3 dollars. Now a bed here at Queen Street costs \$200 per day and a bed at the Clark Institute is as high as \$400."

Trainer says that even though the Peterson government has promised to double the amount of mental health funds that go to community support to 12 per cent, at this point, psychiatric patients are now discharged into a community often devoid of resources and caring. Karen Leman, a worker at the Vancouver Kettle Friendship Society which is a

drop-in for the psychiatrically disabled, is frustrated by the new developments, and believes that many patients are being discharged before they are ready. "These people have no life skills," she says. "They don't have an apartment. They don't know how to buy food. They are used to lining up for food at nine, 12 and six o'clock and almost all of them are on some form of meds [medications]."

"They need homes," insists Trainer. But what is available to ex-psychiatric patients are boarding homes which, according to Trainer, have only just been brought out of their feudal condition, and still could use some management training in basic democracy. Many of the boarding homes run with no consideration for patients' rights, with no resident representation on house committees. Often the boarding home operates exactly like a psychiatric hospital, only drastically scaled down. This is how de-institutionalization becomes re-institutionalization, only in another place.

And even boarding homes are in short supply. Ex-psychiatric patients are not considered desirable tenants or neighbours. This is a group intensely stigmatized in communities that often fight hard to keep psychiatric patients out of their neighbourhoods. The phenomenon is called "Not in My Back Yard," or NIMBY, for short. The situation angers Karen Leman, who says that there is absolutely no history of violence or problems in communities where boarding homes exist. And Pauline Rankine, a worker at a Vancouver group home called Stirling House adds, "There is a sense of mystery around these people, especially that they will be violent. I work in this boarding house and I feel safer here than I do on the street."

*The media are catching on to the homeless issue and CTV's W5 has decided to put together a documentary on bag ladies. The news team comes to 416 to check out the situation. Joy Reid, the director of 416, is fiercely protective of her clients and deeply suspicious of the media but agrees to let the team return to complete filming. The camera man needs to plug in a light.*

*"Mind if I just move in here to*

reach the plug?" he says to one of the 416 women.

"Yup," she says.

"No, you don't understand. I just need to plug this in."

"No, you don't understand," she shoots back. "This is my chair, my space, and I'm not moving."

The camera man looks around for some help, certain that someone there will understand that his need to get his light plugged in is more important in the larger scheme of things than the fact that this woman likes where she's sitting. He gets no action. The women there have never had space of their own. A chair may not seem like much to the camera man, but to them it is utterly precious.

"Remember," says the indefatigable Joy Reid, "these women don't want to know about life skills and therapies. They want a place where they can stay warm, and they want something to eat." Her answer to the rigidity of the boarding house situation is to operate a totally non-structured drop-in centre. (416 has practically no rules. One of the few is that no drugs can be used there.) When asked how many are psychiatrically disabled, she won't answer directly. "Any woman who is out on the street has got to have some emotional problems. You can call them whatever you like."

"A lot of women who come to 416 to have a room somewhere or a tiny apartment, but they come here anyway because they don't want to be alone. A woman's toilet can be clogged up for six months and we don't know anything about it. If I had my way, we'd send someone in to clean their homes once a week or to defrost their fridge every once in a while."

But for that kind of initiative to be meaningful, women need homes and many don't even have a room they can call home. Proof of the desperation of the housing situation was a study done by Allison Guyton for Nellie's Hostel for Women. Called *The Role of Nellie's in Providing Post-psychiatric Care*, the study revealed that a full 40 per cent of Nellie's residents were women with psychiatric backgrounds. Says Guyton about her findings, "We take them out of the



Barbara Pasternak

hospital where they soon encounter the rigid structures of the group homes where they are treated as if they are still sick. Then they go from group home to boarding home to hostel. If we want them to get better, you can't just dump them onto the hostel system."

For the staff at Nellie's, many of whom are not trained to deal with mental health problems, the situation can be critical. "We have a housing shortage in this city," explains Leslie MacDonald, a Nellie's worker. If a landlord has 80 prospective tenants to choose from they are not likely to choose the one who is psychiatrically disabled, and in spite of our Human Rights Act (which makes it illegal to discriminate against the disabled), these landlords can hide their reasons for not renting to ex-psychiatric patients. So, many of the de-institutionalized women wind up here.

"We had a woman here that we

didn't know much about. She started to scream and wail and cry and the police had to come. We realized that if they took her out of here, that wouldn't solve her problem and if we kept her here we would have a problem that we didn't know how to deal with." In the end, the situation was resolved because the woman's family came into the picture but most shelter workers know better than to count on families to save the day.

According to Allison Guyton the answer is the development of long-term stable housing. "We've got to provide them with the basics," she insists. "Resources like the Margaret Fraser House (a 10-bed ex-psychiatric patient residence for women in Toronto) provide important rehabilitative services. So a woman will be taught life skills and in six months to a year, if she's done really well, she leaves. Then she has nowhere to go. If she doesn't do well, she leaves anyway, and then we're all back where we started from. I don't know whether they need life skills first. I say give them long-term housing and then link them with services in the community."

Guyton intends to put her plan into action by developing a 36-apartment community housing base through the Woodgreen Community Centre. She is battling the bureaucracy, battling community prejudice and battling the housing shortage that is plaguing all Torontonians, but she thinks she has the answer, and has no intention of backing down.

But hers is not a housing project for women only.

*"There's a man in here," cries a 416 denizen, flapping her arms in a panic. It was a Family Benefits worker who had invaded the drop-in. "Get him out. Get him out."*

The Kettle Friendship Society is the mainstay of support for Vancouver's ex-psychiatric community. The society runs a drop-in, cooking and nutrition classes, meal programs and a host of other activities that fall under the general rubric of life skills training. It is also a place where ex-psychiatric patients can go with a greatly reduced fear of getting beaten up — if they are men, that is. Women don't come there much.



Barbara Pasternak

"They don't come here because there aren't very many women here," explains Karen Leman. Pauline Rankine is a little more explicit. "I worked at the Kettle and it's open to both male and female psychiatric patients, but it's a completely male-dominated atmosphere, sort of like a pool hall, and the men's behaviour is often not very appropriate. Every time we had a woman come to the centre, she would be harassed sexually."

Chances are it will not have been the first sexual assault she has experienced. The research is distressingly thin but it promises to be bolstered by the work of Toronto researcher and social worker Temi Firsten. She first got interested in the subject when she realized that a large number of women on the psychiatric ward where she worked had been

victims of wife assault. She estimates that 50 per cent of psychiatric in-patients are battered women and 30-35 per cent have been the victims of incest. Firsten was also taken aback by how lightly reports of sexual abuse in the hospital were being taken by the facility's staff. In one incident, two females were raped by the same patient, and since there was no hospital protocol, no action was taken.

Because she was so dismayed by the hospital's inaction and because she was becoming increasingly aware that sexual abuse may be a significant mental health issue for women, she is planning a study to examine psychiatric patients' histories of sexual abuse. The incidence of sexual abuse is hidden in the general population by the things that silence women: the fear they won't be believed, for example, or their easy intimidation at the hands of authority. Those conditions are even more pronounced for female psychiatric patients who are considered to ill to know their own lives and who are thus seldom believed. Firsten has not yet begun the formal study but she is convinced the numbers will be staggeringly high and is prepared to speculate as to why that will be the case.

One of the keys is a phenomenon known as revictimization. In other studies of sexual abuse survivors, especially incest victims, patterns of behaviour have been identified, patterns that lead to the inevitability of repeated assaults. For example a study by Ayella Pines and Mimi Silbert uncovered a syndrome through which incest survivors develop hopelessly low self-esteem, have difficulty making life changes for themselves and, crucially, have difficulty recognizing dangerous situations when they are in them.

Some rape crisis centre workers are becoming aware that many rape victims were also incest victims. (This information has not been made very public for fear that it will be misinterpreted by those who like to think that women ask for it, or like it.) What seems to be happening is that women who have been victimized early in life begin to believe that this victimization is what life is all about. They think it is normal for them, a regular occurrence, or as

Firsten put it, "Sometimes they can't even identify it, because it has happened to them so often, or because this is the only form of sex they've known."

"A lot of women I see are sexual assault survivors," agrees Pauline Rankine. "Sexual assault is very crazy-making. We have to question whether it's a disease of these women or a social problem."

Take the reality of revictimization and add to that the disenfranchisement that goes on when these women are institutionalized, and you begin to understand why Pauline Rankine was insisting that psychiatrically disabled women have women's problems five times over. They are poor, they have no skills and their sense of self is often non-existent. While many of them leave the institutions poor and take to prostitution, some have already started tricking in the hospitals where they exchange sex with patients for cigarettes. In institutions, female psychiatric patients learn to fear authority and grow increasingly passive. Fed and clothed by others and medicalized with drugs (like chlorpromazine) that wreak havoc with their sexuality, they can suddenly start lactating or have their periods come to an abrupt halt, which only increases their confusion about what sex is supposed to be about. When you are not in control of your own body, when you don't have ownership of your own body, then others can take over, literally, and you won't be able to do much about it.

All of this makes the female ex-psychiatric patient painfully vulnerable to sexually assaulting patients, doctors, landlords, pimps and boarding house employees. "If somebody's looking for someone easy to hurt, these women are it," says Pauline Rankine flatly. No wonder they leave the group homes and flock to the hostels. No wonder they avoid mixed drop-ins. No wonder they are desperate for whatever corner of a room they can call their own.

Looking at it from the point of view of ex-psychiatric patients as a group, the situation is not entirely hopeless. The Ontario Liberals have already promised to increase the amount of money funnelled into

community resources and other agencies are studying the situation with unusual intensity. Reva Gershtein's report for the Mayor's Task Force on Mental Health was a progressive shot in the arm especially with its charge to the community to shed some of its prejudices. And John Trainer is still working on Queen Street, plugging for mobile mental health units to deal with the crises of the de-institutionalized populations.

The B.C. government has released *The Mental Health Consultation Report* that promises significant changes in the allocation of mental health resources. The plan is to expand the number of psychiatric beds in local hospitals so that, to give an example, the 20 psychiatric beds closed down at the University of British Columbia hospital will be reopened. Happily, the report also recommends that the Kettle Friendship Society get a hefty infusion of funds. Staff worker Karen Leman was astonished by the attention. "We're 10 years old, we take a low-key approach and rely on our good standing in the community. And we can't measure progress in the ways governments like us to. We can't quantify what we do."

But the nagging problem of what to do about psychiatrically disabled women still remains. After all, they aren't going to the Kettle. Even when scholars and policy-makers commit to examining the problems women have in the mental health system, the difficulties of ex-psychiatric patients tend to be glossed over. Ontario Institute for Studies in Education psychologists Jeri Wine and Paula Caplan led a team of strong feminists in the preparation of a report written on women and mental health for the Canadian Mental Health Association. The document is a stinging indictment of the system's weaknesses. It criticizes the medical strategy of drugging patients, examines the way sexual abuse fits into patient histories and explores the social forces that create the conditions that drive them to insanity. But the report did not include a single word on de-institutionalized women.

The fact is that psychiatrically disabled women are almost completely invisible. Mental health workers

have different theories for why that is. Some say that men act out their problems while women turn inwards to self-destruct. Others, like Pauline Rankine, remind us that these people have psychiatric backgrounds, but they are also, remember, women, and socialized to be women. "Men have less inhibitions about wandering around with their hair uncombed and looking badly dressed. But women have much more pressure. They're proud and care about their appearance."

And if they wander around too much or too visibly, they become easy prey for sexual predators. Male psychiatric patients worry about muggings. Female patients worry about rape.

Rankine is not very optimistic, even with the B.C. plans for phasing in community support systems. "De-institutionalization sounds good on paper. It is a Utopian dream not to have to shut people up in prisons. But unless the community is prepared for this stigmatized group, I think they might be better off in safe institutions. As far as women are concerned, as usual, the resources are seldom allocated to them. They are not a high priority group in anyone's mind and they are not a group that is going to stand up for their rights."

"And most of them know that if you rock the boat, someone's going to think you're really sick."

*Susan G. Cole is a Toronto journalist. She is a contributor and co-publisher of Broadside, a Canadian feminist review*

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# Whose Womb Is It Anyway?

Maggie Thompson

*On September 3, 1987 a British Columbia family court judge ruled that the apprehension of a Vancouver woman's unborn child and the subsequent coerced cesarean section were entirely proper. The Baby R case, as it has become known, is a precedent-setting one. For the first time the B.C. Family and Child Services Act has been successfully used to seize a fetus and thereby force its mother into surgery she did not want. Further, the case relied on a prenatal apprehension as the basis for state custody of the child born. It is a dangerous precedent that will affect all pregnant women because the rights of the mother have been considered secondary to the rights of the fetus.*

*Events as described in the hearing clearly illustrate that the woman involved was treated as little more than a baby container. Along with other members of the Vancouver Women's Health Collective, Maggie Thompson attended the hearings.*



Barbara Pasternak

On July 13, 1987 the New Westminster court room had a pretentious air about it. Fine oak panelling covered all four walls. Court officials were positioned on one side of a solid oak divider. Sheriffs watched over them. On the other side of the divider observers packed into long, uncomfortable wooden pews. The air was thick with anticipation. The case we had all been waiting for was about to begin.

"All Rise!"

In strutted family court judge Brian Davis. He hurriedly seated himself on a high backed leather chair, examined the court room gallery over the upper rim of his half glasses and began to tap his pen impatiently. It seemed he was looking for someone. I immediately felt tense.

"Is Ms. R in the court room?" Davis asked. "Yes, your honour," responded legal-aid-appointed lawyer

Jim Thompson. Thompson turned in the direction of Ms. R. nodding his head. Every gaze in the court room turned to her, a small 37-year-old woman we'll call Rose. The sudden rush of attention seemed to take Rose by surprise. Her eyes turned downwards, her long brown hair shielded her, deflecting glances.

From that moment on the looks, the whispers, the notes passed from person to person all said that people

were already making their judgments. Rose was on trial.

Ministry of Social Services and Housing (MSSH) lawyer Tom Gove, a red-faced, stocky little man, announced he had 10 people waiting to give testimony. He estimated it would take him three days to complete his evidence. Rose's lawyer, Jim Thompson, said he had no witnesses to call and that he was unsure of whether to ask his client, Rose, to take the stand. Rose's prospects looked poor. The testimony that follows recounts the events on the day of Rose's son's birth.

At 3 p.m. on May 20, 1987 Rose entered a Vancouver maternity hospital, in labour. It was her fifth birth, the previous four resulted in healthy babies, all born vaginally. Her fetus was in a footling breach position (its feet rather than its head appearing first), the cervix already quite dilated. In the absence of her own doctor, attending physician Christos Zouves examined Rose and quickly concluded that "the baby would die or would be seriously or permanently injured" without a cesarean section. Rose didn't agree with his assessment. She refused to give consent for the cesarean.

Zouves then phoned the Ministry of Social Services and Housing in order to find a way to force Rose to have the cesarean. He attempted to have her temporarily committed under the Canadian Mental Health Act, put a hospital psychiatrist and MSSH's emergency health team around that there were not sufficient grounds to take such extreme action. They assessed Rose to be competent and able to make her own decisions.

It then became apparent to Zouves that in order to proceed with the cesarean, apprehension of the fetus, declaring the child in need of protection, was his only option. He contacted a ministry social worker, Ivan Bulic, who had never met Rose, to ask how an apprehension could take place.

In virtually every instance, the state is only given the authority to seize or apprehend a child once it is as evidence that the child has suffered abuse or neglect. Once apprehended, responsibility for the well-being of the child is transferred, temporarily or permanently, from

the parent(s) to the State. The State then has the authority to decide what is in the best interests of the child.

In the testimony that continues, Zouves' held that if the fetus was found to be in need of protection, then the ministry was responsible for the fetus, and he could perform a cesarean section without Rose's consent. He went on to say that the fetus needed medical attention to survive, yet the only medical attention he mentioned was the cesarean section.

***I was left with the obvious and terrifying conclusion that on May 20 Rose had no rights.***

For a moment I was stunned. Could this fetus be pregnant, I asked myself?

Continuing testimony, Bulic understood Zouves' plan and recognized its irregularity. He checked with the superintendent of Family and Child Services and was told to ask Zouves whether he was dealing with a child or a fetus. Zouves responded "In my opinion this is a child." Within an hour Bulic had made all the necessary arrangements. He'd had absolutely no contact with Rose. He didn't even leave his office. Everything was done over the phone.

While Zouves and Bulic were discussing their plans, hospital support staff tried to convince Rose to have the cesarean section. After viewing ultrasound images, and hearing news that the apprehension had occurred, she succumbed to the pressure around her, saying "Go ahead, cut me open."

At 10:50 p.m. a healthy baby boy was pried out of her. He required no special postnatal medical attention, showed no signs of distress and was described by the doctor as "vigorous at birth."

The State-approved abuse of Rose which began in the hospital, continued over the five long days of the hearing in New Westminster. MSSH

lawyer Tom Gove carefully planned an attack on Rose, her friends and lover. His case was nothing less than a character assassination designed to make Rose look so bad that the impropriety of events on May 20 would be overlooked.

Day after day, Gove prompted recollections and glib editorial comments from social workers and doctors. Testimony throughout was full of harsh, judgemental, uncorroborated comments about the most minute and insignificant details of Rose's life. Because the courts failed to distinguish between the apprehension of her fetus prior to birth and State intervention in the case of her children, we heard lots of testimony about alleged problems of a mother caring for her children. We heard that on one occasion the cereal Rose fed her first child was not appropriate, that her friends were not suitable, and that, while she displayed love and affection for her children, she could not provide for them. One social worker referred to her behaviour as schizoid. Another remarked that her breath smelled like she'd had two beers. Yet another claimed her friends used hard drugs.

The well-dressed, articulate social workers could remember the most microscopic details, yet they were forgetting one thing, for me a fundamental factor. Nowhere in the hours of testimony, or in Rose's lawyer's flimsy cross-examination, did it appear that her rights as a pregnant woman were being considered or defended. I sat there screaming inside myself "What about her right to protect herself from the wounds a cesarean would inflict? What about her right to liberty and security of the person? What about her right to say no?"

I was left with the obvious and terrifying conclusion that on May 20 Rose had no rights.

For five days Rose and her partner came and went from the New Westminster court room. Each day she made her way through the throngs of the hostile, the curious and the supportive, encountered in the hallways, in the courtroom, even in the bathroom. All the good intentions, the sympathetic glances, all the authority and rancor, the huddles of lawyers, social workers and advo-

cates whispering about her and her chances. Outside, the swarms of cameramen readied themselves for the attack. Once out in the open they rammed their weapons where they could: her mouth, her crotch, anywhere, the closer the better.

By the last day of the hearing, tensions were high, the MSSH's case was reaching its crescendo. Rose tapped her fingers nervously. Glances darted all around the court room. The glances were briefer, sharper and more critical than before.

"This woman is not on trial," said Tom Gove in his summation. The court room broke into sarcastic, nervous laughter. Judge Davis was offended. Unauthorized laughter in his court room was unacceptable. He gave a belligerent lecture about respect and boorish behaviour, and ordered the room to be cleared for a 30-minute break.

While the outcome of the trial seemed to be a foregone conclusion — considering the mood — Davis delayed his decision for six weeks. On September 3 he ruled that events on the evening of May 20 were entirely proper, and awarded permanent custody of Rose's baby boy to the Ministry of Social Services and Housing.

Davis's decision is clearly outlined in this quote:

"The evidence is that the birth was" imminent and it in fact occurred within three hours of the superintendent making the apprehension. The purpose of the apprehension was to ensure proper medical attention for the baby. This is not a case of women's rights, Mrs. R. consented without coercion or threat to the operation . . . This is simply a case to determine what is best for the safety and well-being of this child. It is clear that this child was in the process of being born and the intervention and redirection of its birth were required for its survival. It was at or near term. It required no life support: it was "vigorous" at birth and indeed he was born healthy. . . .

"Under those circumstances, namely where the baby is at or so near term and birth is imminent, the failure to provide necessary medical attention to prevent death or serious injury is sufficient to allow the super-

intendent to invoke the procedure of apprehension. I am satisfied that the apprehension was entirely proper."

Yet it was Rose who received the controversial medical attention, not her son. In essence, Davis contends that the medical rights of a pregnant

**The right of anyone to refuse treatment was, I thought, firmly grounded in Canadian law.**

woman are secondary to the rights of her unborn child or fetus. By implication Davis' ruling concludes that Zouves had the right to pressure Rose, cut her open and take her child.

I fiercely disagree. The right of anyone to refuse treatment was, I thought, firmly grounded in Canadian law. What still stands is the obligation of caregivers to seek free, full and informed consent for medical treatments they deem necessary. Rose was denied her right to refuse treatment. The so-called consent she gave was clearly forced, not free, full and informed.

I agree that during birth the needs of the mother and her fetus have to be carefully weighed. However, the needs of both are far better served when the woman's concerns are fully addressed, when she is fully informed and when she is treated with care and respect. Ultimately, I believe that the woman has the final say.

Indications are that we will encounter more instances of forced obstetrical interventions such as the one Rose experienced. We may see that women are presented with the threat of complying with medical intervention, rather than have the State apprehend before birth.

In Belleville, Ontario in March 1987, a woman who was eight months pregnant, and who seemed to be behaving erratically was committed to a hospital so that her unborn child could be monitored. The Children's Aid Society of Belleville

In that case, presiding Judge Kirkland included in his decision a passage from a previous decision which read:

a local psychiatrist was quoted recently as saying every child should have certain basic rights such as: the right to be wanted, the right to be born healthy, the right to live in a healthy environment, the right to such basic needs as food, housing and education and the right to continuous loving care.

This second hand opinion was used to justify the forceful detention of a woman so that tests assuring her baby's health could be done. The woman's rights were suspended so that the right of the fetus to be born healthy could be upheld.

This case and Rose's case together provide evidence of the increasing attack on women's reproductive rights and of the growing confidence of the State to launch these attacks.

A study quoted extensively in an article entitled "Court Ordered Obstetrical Interventions" by Veronica Kolder, Janet Gallagher and Michael Parsons, printed in the *New England Journal of Medicine* on May 7, 1987, reveals that like Judge Davis and Dr. Zouves, many physicians are prepared to disregard the rights of women during pregnancy and birth. In the study, the heads of fellowship programs in maternal-fetal medicine were asked to agree or disagree with a number of statements. Twenty-six of 57 (46 per cent) thought that mothers who refused medical advice and thereby increased the risk of danger to the fetus should be detained in hospitals or other facilities so that compliance could be ensured. Fifteen of 58 (26 per cent) advocated State surveillance of women in the third trimester of pregnancy who stay outside the hospital system. The U.S. survey reported court ordered cesarean sections in eleven states, hospital detentions in two states and intra-uterine transfusions in one state.

Yet doctors' opinions are not foolproof. The study states that "uncertainty is intrinsic to medical judgments. The prediction of harm to the fetus was inaccurate in six (out of 15) cases in which court orders were sought for cesarean section."



Not surprisingly, the study reveals that it is women of colour, women on public assistance and unmarried women who make up the vast majority of those involved in unwanted obstetrical interventions.

Why do almost half the doctors in the survey dismiss a pregnant woman's decision to refuse medical treatment? I suspect that the primary reason doctors will attempt to overrule a woman's decision to refuse an obstetrical intervention is because they have bought the argument that fetuses should have rights and that those supposed rights should be protected. In other words the competition for rights is no longer between women and their authoritarian doctors. It is now that doctors are hiding behind defenseless little fetuses. The legal sands are shifting beneath our feet and women are being left reached.

Forefront in the legal fight for women's reproductive rights in Vancouver is the Women's Legal Education Action Fund (LEAF). In a fruitless effort to intervene in Rose's case, LEAF hoped to challenge the apprehension by arguing that charter provisions which "guarantee" Rose liberty and security of the person, freedom from arbitrary detention and the right to equal treatment with men had been violated. A report appearing in the *Globe and Mail* on June 10, 1987, stated, "Nancy Morrison, a former provincial court judge who is acting on behalf of the Women's Legal Education and Action Fund, said the apprehension order is invalid because a fetus is not a person under British Columbia statute or Canadian Common Law."

Kate Young, legal counsel for LEAF maintains that Rose's case is a clear example of discrimination against a pregnant woman. When she spoke she presented a useful analogy. "Let's imagine we have a child with kidney disease. His life is in jeopardy unless someone comes forward with a donated kidney. Would the coerced removal of the child's father's matching kidney be considered proper? Of course not."

LEAF plans to apply for intervenor status again when the Baby R case goes to a judicial review, probably some time in early 1988. Young contends it is a crucial case to fight

because "if the British Columbian Family and Child Services Act is extended to include in its mandate the protection of fetuses, that would lead to extended violations against women."

Since Canadian law does not distinguish between a fetus 36 weeks old and a fetus 6 weeks old, this apprehension could be used to justify the apprehension of much younger fetuses. Apprehension of a fetus is simply a disguised way of apprehending a woman. When given responsibility for a fetus the State obviously has directly affected the autonomy and rights of the woman involved.

Few observers seem to recognize that doctors gain from court ordered obstetrical interventions. Without involving social workers and the courts as they have done, doctors would have to bear responsibility for their actions alone. In effect the courts are acting as a kind of liability screen for doctors. The court orders both reinforce the doctors' opinions and let them off the hook should something go wrong.

In an article entitled "Protecting the Liberty of Pregnant Patients," George Annas says that physicians often disagree about the appropriateness of obstetrical interventions and they can be mistaken.

In Rose's case, on the word of one doctor, the Ministry of Social Services and Housing brought all the pressure it could bear to force her into a procedure she did not want. Her baby when born showed no signs of distress, scoring 9/10 on the apgar test, a postnatal grading scale.

The ultimate effect of this and other obstetrical interventions could be disastrous. The fear of having forced procedures, of being unwillingly confined, and of having fetuses apprehended, may be great enough to keep some women away from doctors and hospitals altogether. Apprehension before birth will likely give cause to women to stay away from prenatal care, not encourage it.

And as for Rose, her life goes on without the cameras. She has absolutely no access to her son who could be several years old before the appeal case is settled.

I'm left wondering what might

happen if she gets pregnant again.

*Maggie Thompson is a member of the Vancouver Women's Health Collective.*

*Portions of this article have already appeared in Kinesis.*

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## INTERVIEW

# Visions for Women's Reproductive Care



Amy Gottlieb

Connie Clement (left) and Diana Majury

A royal commission on reproductive technologies has been called for by the newly formed Coalition for a Royal Commission on Reproductive Technologies. The call was initially made by writing the federal ministers responsible for health and women's issues in June, 1987 and contacting potential endorsers across Canada. More recently, an ad hoc meeting was held in conjunction with the Quebec conference on *La maternité au laboratoire* in late October; in November the coalition hosted a lunch for interested members of parliament. The list of individuals and organizations endorsing the call for a royal commission grows.

The statement from the Coalition reads, in part, as follows: "What we

are seeing is nothing less than a revolution in reproduction . . . We believe it is imperative that we begin to explore the social issues surrounding these new technologies and initiate a public debate over what limits we want to place on them; and that the best way to achieve public education, debate and resolution of these issues is through a Royal Commission."

Women Healthsharing declined to add its name to the list of endorsers because members are concerned that royal commissions are unwieldy, require great investments of time and energy and rarely result in positive gains. In the following interview, Diana Majury and Connie Clement discuss why they don't support a strategy asking government to ap-

point a royal commission. They speak as two individuals and do not represent the Women Healthsharing collective. The collective does not yet have a shared position about reproductive technologies or related strategies.

**As feminists concerned about reproductive technologies, why aren't you supporting this call for a royal commission?**

**Connie:** Both Diana and I very much share the concerns which led to calling for a royal commission. It's the strategy of using a commission that we find uncomfortable. In fact, I did tentatively support the call by

lending my own name when the request was first made. Initially I thought we didn't have much chance of having a commission appointed and I thought the call would be a good focus for media attention. I saw the call as a tool to focus public attention and increase feminist debate on this critical topic.

As I thought about it more, however, I realized that the time is very ripe for the government to appoint a commission. And that's where my concerns come in. I see no indications that membership would lie in our favour. No existing government reports in this field have been sympathetic to feminist viewpoints.

**Diana:** It's not just the membership of a commission that has to be considered — we have to think about how we, as feminist individuals and organizations, will respond. To use a commission successfully requires an incredible amount of energy and time. We need clear positions to articulate and we need to sustain the energy long enough to influence not just the commission but the legislation coming out of it. That would mean years of brief writing and presentations at both the federal and provincial levels.

**The coalition has asked that women make up a majority of any commission appointed. They've asked that the commission be headed "by a woman whose expertise and sensitivities lie with the social rather than the legal or medical implications of these new reproductive technologies."**

**Diana:** It's all good and well to ask, but are we likely to get it? I doubt it. The government will have to appoint individuals representing a spectrum of viewpoints — industry, medicine, law, social sciences, maybe consumers. Such pluralistic approaches reduce feminist concerns to one voice of many, and we have little chance of over-riding the mainstream viewpoints.

**Connie:** Who the chair of a commission is and the viewpoints of the membership greatly influence how a commission tackles responding to a

government mandate.

It's likely that someone already well-known and highly respected within mainstream circles would be appointed. A legal expert such as Bernard Dickens at U. of T. or Edward Kyserlinqk at McGill. From a government perspective a medical ethics or legal academic is neutral and can be sold as unbiased; from that perspective, feminists are, by definition, biased.

**Diana:** We're a small voice in this debate. Right now most of the pressure is coming from the industry itself. The experimenters don't want to get shut down. If a commission is called, they're going to mobilize money and research to justify new techniques. The people selling in vitro fertilization, sex selection, embryo transfer — you name it — they're all white, male doctors. They command social respect simply because of that, never mind what they do and don't worry about the health and safety of the women they do it to.

**Do you think feminists can mobilize a similar level of response to a commission?**

**Connie:** Not right now. The best thing about the coalition's call for a commission is that it's become a catalyst to create feminist discussion. I've been in heart-felt discussions about this in Toronto, Montreal and Winnipeg. One thing that I keep hearing over and over is that we're not ready. We haven't had the grassroots discussions needed to mobilize feminist response and create feminist positions.

It's not a simple topic — it's really easy to believe the newspaper and media line that the technology is developing to help infertile women. Unless women have a chance to read and talk together, we can't formulate opinions and analysis.

I think about one of my sister collective members at Women Healthsharing. Last spring when the Baby M decision came down (a U.S. custody case filed by a surrogate mother; see Summer, 1987), she thought we shouldn't print anything in *Healthsharing* because we didn't

have consensus. She knew I thought Mary Beth Whitehead (the biological mother under contract to produce a baby for William and Betsy Stern) had been exploited; she, coming from the point of her own fertility difficulties, reached out in sympathy — rightly so — to a couple she thought was infertile. She knew better than I the extent to which someone might go to have a child. She was outraged, however, when she found out that the Sterns weren't infertile at all. She's since read feminist materials, like Gena Corea's *The Mother Machine*, and is becoming increasingly opposed to the technologies. The technologies are not about helping infertile couples, they're not well tested and techniques like in vitro fertilization rarely even work — they just cost a lot of money and emotional anguish for the couples involved.

**Diana:** When we talk about feminist response, you've got to remember that we need to respond to not just the commission itself, but also the legislation that comes out of it. The ostensible purpose of a commission, for the government at least, is to establish a framework that can be used to draft legislation. Some commissions have given us lots of good data and very progressive statements — the *Badgley Report on the Operation of the Abortion Law* comes to mind. We still cite the report a decade later, but what came out of it in terms of legislation? We're still fighting the same bad abortion law. And we have to remember that even with all the strong data showing inequities of the abortion law, the Badgley report did not recommend repeal of the law. At best, commissions take a safe middle-of-the-road position.

In the case of the recent Fraser Committee (a federal special committee which examined pornography and prostitution), the report itself was not bad — there were, at least, signs of feminist influence. Then the government turned around and used the very worst parts of the report to draft really misdirected pornography legislation. The anti-prostitution legislation that has already been passed is totally awful. We're in a much worse position now than we were before the Fraser Committee report.

**If you think a commission won't help us — and you're even implying that it might be worse to have a commission than not have one — why is the coalition calling for a royal commission?**

**Diana:** As I understand it, there are three important factors in favour of a rationale for a commission: funds are allocated for research and public input; a royal commission has power to subpoena people and documents; and the public profile of a commission is high.

All of this can vary immensely. How important the government thinks this topic is will influence how much money they give for research. It is then, of course, a major question as to which groups and people get the money. Funds may or may not be granted to groups to prepare briefs and cover travel to make presentations — this is, as far as I can figure it out, fairly rare.

What research the commission itself undertakes depends on the membership and the chair. It has the power of subpoena, but there's nothing to guarantee that it uses these powers to get records from clinics.

**Connie:** I admit I'm still in something of a quandary. I think federal level controls are needed and I don't know how to best influence government. Unfortunately, a commission will work well in the government's interests: it will delay the need for immediate action, it will establish a very "balanced" view with input predominantly coming from industry without putting the government in the position of being charged with pro-industry bias.

**Diana:** It's the end result we're both worried about. The Ontario Law Reform Commission Report (1985), the most comprehensive report thus far, is really bad news for women. There have also been narrower, issue-focused reports written in Saskatchewan and British Columbia, and provincial activity is getting underway in almost every province and territory. These reports will be the starting point for any royal commission. It will take an incredible effort to turn a commission around

to address reproductive technology as a women's issue. I'm afraid a commission might solidify the anti-woman positions that have already been taken.

**The coalition has put forward a statement of principles. Do you agree with these principles? Do they counteract or add to your concerns about the call?**

**Connie:** They add to them! The principles are very middle-of-the-road, and they're erratic — some things are included while other very important issues are ignored.

**Diana:** I'd go even further — the statement of principles put forward is, I think, very problematic. They're not adequately thought-out and the wording seems to be deliberately ambiguous. It's very dangerous to be put in a position where our own principles can easily be turned against us.



Amy Gottlieb

Emphasis is placed on informed consent. But what is informed consent? This is a really liberal notion that assumes that the two parties involved are in equal positions — one of the main feminist critiques of the medical profession rests on the power imbalance between doctor and patient. This is compounded when doctors are male and patients are female. Because of power inequality, in part, many progressive organizations have concluded that the concept of informed consent is next

to meaningless — yet the call relies heavily on this concept.

**Connie:** Even the revised principles assume that reproductive technologies are here to stay — they are a given; the best we can do is provide some legislative niceties to lessen harm. The question of prohibiting the technologies isn't even addressed. I don't agree with that. I think that a costly technique, such as in vitro fertilization, with only a 5-10 per cent effectiveness rate should be prohibited from general use. If we were talking about a drug or medical device with such a poor effectiveness rate, government wouldn't approve its sale in Canada. We don't have comparable controls on non-drug, non-device interventions and so the techniques are popularized *before* either safety or effectiveness is demonstrated.

**Diana:** Margrit Eichler has said that these principles were developed as a starting point to gain membership to the coalition and credibility in government circles. She's argued that once a commission is established, this coalition will disband and feminists can form more radical groups to speak before the commission. That's a simplistic response! These principles will clearly be held up as *the* feminist position and used to discount more radical responses. Her call for a coalition even says the principles should be "a basis for the development of appropriate policies and potential legislation."

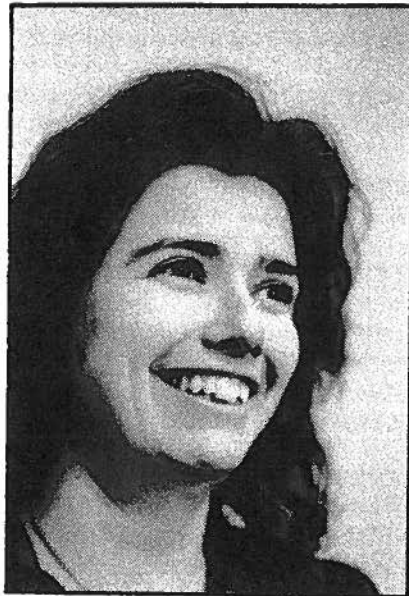
Essentially, the coalition call is a liberal one that will simply reform, with moderate controls, how the technologies are used. I have little interest in liberal reforms when we're talking about exploitation of women, women who are very, very vulnerable because of an experienced and medically-defined fertility problem.

**Connie:** If infertility were really the issue, the last principle (see box) would be first. The call, as it stands, does not imply that a commission should be addressing alternative means of confronting and *preventing* infertility. In fact, the call does not set out a proposed purpose, mandate or scope for a commission should one be established.

**Diana:** A major weakness with the call and the royal commission model is that the coalition is not asking for a moratorium on both legislation and practice while the commission sits. Let's say a commission is established over the next two years — they take a while to set up — it might report five years from now. It's too slow. The technology is racing ahead — it's 10 years now since the birth of the first so-called test tube baby. It has been a decade of firsts: the first twins, triplets, quadruplets, even quintts; the first birth of a child entirely unrelated to its womb mother; the first woman giving birth to her own granddaughter; the first legal case involving inheritance rights of frozen embryos.

Even if the report is good, it's pretty useless if it comes out after the fact. The irony is that this call is both too fast and too slow. It's too fast because women aren't prepped for it — we need popular education, debate, development of analysis and theory from a Canadian feminist perspective. Let's see if we can get money to foster popular debate first.

And it's too late because the technologies are already becoming entrenched. A much stronger strategy would be to define the most damning technologies and those just on the horizon and to make a focused effort to get the federal government to impose a moratorium on these technologies while also making a commitment to analyse social impact and possible controls of reproductive technology.



Amy Gottlieb

The provincial governments are starting to move on this now. Even though we need some federal consistency, perhaps we can more effectively focus our energies at the provincial level, tapping into what is already underway. In Ontario, for example, an interministerial committee has been set up to review the recommendations of the Ontario Law Reform Commission and to put together a package for cabinet. In their words, they're "developing a plan of action." We can't afford to wait for a royal commission.

**Connie:** We haven't even talked about federal/provincial jurisdiction yet. We may want federal controls,

but do the feds have much power to do anything in this area?

We also have to be clear about who the other players are. Industry is front and centre in this debate, just as it has been around the pharmaceutical and Patent Act changes.

The industry is fully aware of the power of social movements and they're well aware of feminist concerns and opposition. The Association Quebecoise pour la fertilité is a good example of industry manoeuvres to discredit us. The association, a support group for couples in in vitro programs, was recently organized by a doctor and now other doctors refer their patients. It doesn't include in its membership individuals who have dropped out of in vitro programs or couples who have chosen not to use the in vitro route. It doesn't offer support to infertile individuals; it provides a means to keep couples in the in vitro programs by alleviating doubt and playing on their hope.

Women who have been in in vitro programs often talk about the way in which their feelings are ignored by staff. The doctor wants to use a woman's anguish that she can't have children, but he (and I use the word he purposefully, because nearly all reproductive technology specialists are male) doesn't want to hear about her anguish at being probed and tested every day or about the emotional cost of waiting and hoping and then still not being pregnant. He doesn't want to hear about the fears and doubts.

How? Who evaluates?  
Define "desirability"

No good models  
legal nightmare +  
hard to make work

Do we want to  
penalize women who  
become surrogates?

Is any experimentation  
okay? what social  
controls are needed 1st?  
Can consent when  
in programs be free?

1. Each reproductive technology needs to be evaluated separately with respect to its overall social desirability. *by whose standards?*
2. In choosing a particular technology, in all instances the safest, least invasive, simplest techniques available should be employed before others are tried. *who controls availability? No mention of effectiveness*
3. Any woman or man has the sole right to accept or refuse all treatments affecting her or his reproductive processes. *How?*
4. Stringent criteria as to what constitutes informed consent/ decision-making must be developed and enforced. *all doctors included here!*
5. Legislative sanctions should prohibit and penalize individuals and organizations who arrange transactions for their own profit involving genetic materials and reproductive processes. *what about not-for-profit transactions? They also need controls.*
6. Gametes (semen, eggs and embryos) can only be used with explicit (informed consent) of the donors. *Long-term also. Individual care only or also monitoring all technologies? who does this?*
7. National standards must be set for compulsory short-term follow up of all reproductive technologies.
8. Everybody has the right to an environment free of agents which create and contribute to infertility.

Unfortunately, if the federal government is likely to hear any consumer voice in the medical wilderness it's likely to be the voices of these infertile individuals who are being organized by the industry. It's critical that feminists offer support to individuals who are infertile, regardless of what choices they make about treatment. This must happen side-by-side with our attacks on the industry. We need to help women and men who have chosen not to opt in, or who have left programs, to find a voice, to link up with each other and to join our movements without feeling that their personal experiences and needs are of little importance.

**It sounds like you think some sort of coalition on reproductive technologies should exist, but this effort isn't what you have in mind.**

**Diana:** Exactly. Feminists have been very slow in responding in numbers to the challenge of reproductive technologies. *Healthsharing* did a thematic issue in 1985; other magazines and newspapers have published articles; recently the Conseil du statut de la femme in Quebec has made this a major focus; several feminist academics have produced good articles such as Somer Brodribb's (published by the sociology department at the Ontario Institute for Studies in Education). It's unfortunate that so few English-speaking Canadians speak French—Quebec women seem to be farther ahead in

analysis of the issues than we are in English-Canada. Even so, our responses have been isolated and small in number.

FINRRAGE is linking women together internationally. It's a wonderful acronym isn't it? FINRRAGE stands for the Feminist International Network of Resistance to Reproductive and Genetic Engineering. Several Canadian women were at the founding meeting, but we're not well connected to it now. Only Louise Vandelaac, from the University of Quebec in Montreal, is formally involved as a key contact.

**Connie:** Some of the leading feminist thinkers about this topic are in FINRRAGE, but it's essentially an organization of academics and theoreticians. It's not a popular network centred around activism. In Canada we need a group to popularize the feminist theory, to help get information about the marginal nature of these technologies out to the public. Such a political group is needed *as part of* our ability to successfully take part in a federal analysis of the issue. It's needed before not after a commission forms.

I hope that the debate fostered by the coalition's call for a commission will be a catalyst to form action-groups. And I think this is starting. It's through debate that our ideas develop, and Diana and I want to emphasize that although we're disagreeing with the strategies taken, we all share a common concern about the potential impact of reproductive technologies; we all come from a point of caring very much about the women used in the widespread experimentation that is passing for medical treatment.

**Diana:** Right. We do share the same concerns, and we want to talk about them. Debate has been slow to start within the coalition, as well as outside it. The model being used is an unusual one. There is a very small steering committee which sets policy and determines actions, and then there is a large group of "endorsers" who presumably support the decision taken by the steering committee. It's not what we generally think of when we think "coalition", although Margrit's December letter en-

courages more debate among all members/endorsers. We need a very active, highly participatory coalition where we can thrash out positions *and* strategies.

**Connie:** Even though Diana and I don't support the call for a royal commission or the list of principles as presently formulated, we do want to work on this issue with members of the steering committee, the coalition endorsers and other feminists concerned about these issues. Whether or not the call is successful, government action about reproductive technology is going to step up in the near future. We need to be ready or we'll find ourselves being entirely reactive. We'll gain more by putting energy into defining *our* issues and specific strategies, instead of putting energy into a broad request to government over which we will have little overall control.

I've barely begun to think what woman-centred legislation might look like, but it's exciting to ponder this. Personally, I'm hoping to begin developing public health and preventive strategies regarding infertility as part of my work — all the medical response is after the fact, and we've done poorly thinking about infertility prevention because it's so vast.

I find myself talking more and more with friends who are coping with fertility problems and trying to better understand their issues. I know I can conceive, but I don't know if I can successfully bear a child to term and I'm at an age where this is very important to me. Unless those of us who choose against intervention, especially women who are defined as infertile, speak up from a position of support for infertile people and find common grounds for action, we're sunk. I'm not sure what a royal commission will offer women who are infertile except to entrench access to lots of dubious techniques and I don't think that's any solution at all.

*Diana Majury and Connie Clement are members of Women Healthsharing. Diana Majury is a lawyer, who teaches and is researching equality law. Connie Clement has recently returned to public health family planning work. Both live in Toronto.*



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Maureen Gans

# Looking Beyond Labels

In December 1986, the American Psychiatric Association (APA) held its final vote to determine which new diagnostic categories would be included in its diagnostic manual. Despite angry protest from psychologists, students, social workers and women's groups, including the National Action Committee on the Status of Women, the APA approved two new and controversial categories. The categories, "self-defeating personality disorder" and "periluteal dysphoric disorder" (PMS) will have profoundly adverse effects on the way in which women will be seen and treated by mental health professionals in both Canada and the U.S.

The APA publishes a manual known as the DSM-III (*Diagnostic and Statistical Manual*, third edition) which lists disorders for making diagnoses of clients. This manual is used by psychiatrists, psychologists and others in the mental health field in both the U.S. and Canada. It is a powerful tool used by therapists not only to make diagnoses, but to map out appropriate therapeutic strategies.

The manual has been referred to as the "Bible" of the APA. Mental health professionals often learn about diagnosis by reading the DSM-III, and once a client has been diagnosed from the DSM-III, that's the label that sticks. The label will be used thereafter if the patient is later seen in hospital, by other therapists, or is institutionalized; in the courts, and even for insurance company claims.

The potential for blind acceptance and misuse of the two new categories concerns many people, particularly feminists, both in and out of the mental health field. The new categories are considered not only questionable in their theoretical validity, but are considered to overlook accepted social factors which contribute to and reinforce the unhealthy behaviour of women described in these categories. The concern, of course, is that women are getting stuck with a label for a personality disorder because they have become just what society has reinforced them to be.

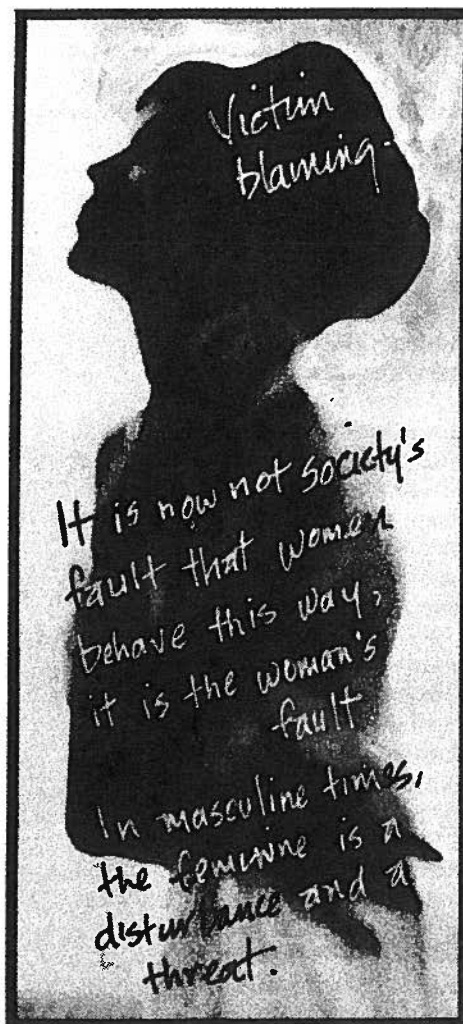
Self-defeating personality disorder is commonly referred to as masochism. In fact, this category was to be called masochistic personality disorder but the uproar this caused within the APA resulted in a name change so as not to confuse it with sado-masochistic sexual practices.

This so-called disorder is controversial because it is merely a description of behaviours — such as powerlessness, nurturing, putting oneself last — which have traditionally been reinforced in women by society.

As Miriam Greenspan points out in her book *A New Approach to Women and Therapy*, if a woman is behaving as she is supposed to (i.e. as a 'normal' unempowered woman) then she risks being labelled hysterical (or now, self-defeating). But if she exerts control and power and is assertive (considered the norm for a man), then she is called 'castrating'. It is a

Catch-22 situation for women: either way we cannot win.

The labelling of women's behaviours as masochistic has a long history. Freud believed that women



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were innately masochistic. He even went so far as to suggest that the discomfort of menstruation and the pain of childbirth proved his hypothesis. This myth is particularly damaging because many women still believe it, even feminists. As Paula Caplan of the Ontario Institute for Studies in Education notes, many feminist therapists even believe women are masochistic. Their attitude to clients is: "Why are you doing this to yourself? You must be enjoying it."

The behaviours described as self-defeating are ingrained in the social and cultural expectations of women. True, many women do remain in situations which are not beneficial for them, and may even be dangerous. But to say they are deriving pleasure from pain, the definition of masochism, does not describe what these women experience.

Women may choose to remain in negative situations as a matter of their own survival. As Caplan shows in her book, *The Myth of Women's Masochism*, women behave this way in order to avoid pain — the pain of rejection or of feeling a failure in society's eyes. Because she is either economically dependent or may feel worthless without a man, a woman may put her husband's feelings and needs above her own so that he won't leave her.

Society has reinforced this type of behaviour in a number of different ways: the job market for women has traditionally been limited and low paying; the media reinforces the nuclear family as the norm; women are the ones most often chastised for not making a marriage work. These all keep her at home, by putting the onus on her to make a bad, even irreparable situation, "good". To label such behaviour as a mental illness, self-defeating personality disorder, is to blatantly ignore society's expectations and pressures on women, and does nothing to promote a woman's growth and understanding in her therapy.

Rather, this label is victim-blaming. It focuses solely on the woman rather than looking at the diverse causes of her unhappiness, and why she may remain in a bad or harmful situation. Such a focus can impede the need for building the self-esteem

that the woman so desperately needs. To quote Caplan:

To a female and a male displaying the same behaviour different motives will be attributed. Rather than being called masochistic, a hardworking father is likely to be admired as a good provider, for example, and the husband of a difficult wife is likely to be called a saint for putting up with her.

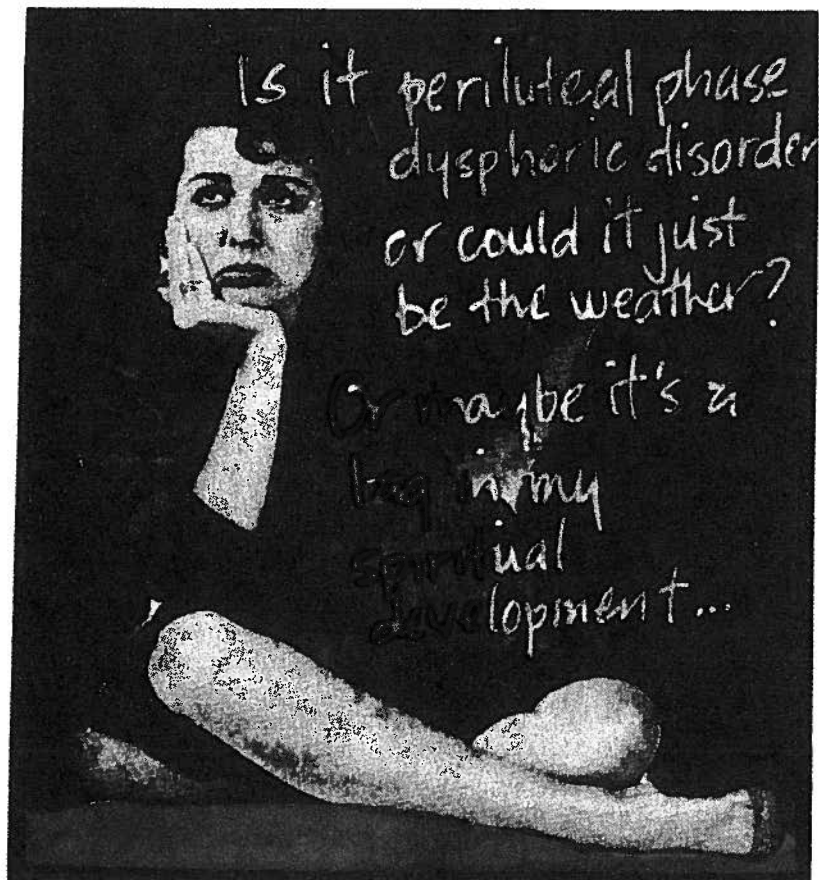
How many women have been called saints for putting up with "difficult" husbands? Chances are they've been called masochists. Ironically, Caplan points out, the APA made no move to create a category to cover men's traditional "macho" behaviour, behaviours that are self-defeating or not good for *them*, such as the inability to develop close relationships or to communicate a wide range of feelings.

The second problematic category, "periluteal phase dysphoric disorder," is nothing short of calling PMS (premenstrual syndrome) a mental illness. It is now generally accepted by most physicians and other health professionals that PMS is a physiological, hormone-based change in

mood or behaviour. To label it a mental illness flies in the face of evidence that dietary adjustments and nutritional supplements can substantially alter this condition. It reinforces the commonly held stereotype that women have no control over their emotions, nor the power to change it.

According to Caplan, since there is no widely accepted definition or description of PMS, the psychiatric diagnosis is left to the subjective opinion of the therapist. (She also points out that although men have fluctuating hormones too, no one seems as concerned with how these changes affect *their* behaviour.

Dr. Susan Penfold of the Department of Psychiatry at the University of British Columbia is concerned with the "excessively subjective" nature of these new diagnostic categories. Penfold believes they are not at all scientific, as the APA claims. Recently Dr. Robert Spitzer, chairperson of the APA Manual Revision Committee, revealed at a conference in London, Ont., that there is low inter-rater reliability (i.e. each of



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several psychiatrists diagnosing a patient will give different diagnoses) and suggested the only way to get this reliability is to ask the client *only* about symptoms, not life experiences.

This paints a very bleak picture of the chances for a woman to be accurately diagnosed. Not only could she be diagnosed as having three different problems by three different psychiatrists, but her past history and her life experiences would not be taken into consideration when the diagnosis is determined. "The whole thing horrifies me," says Penfold.

It is ironic that, according to Spitzer, the DSM-III reflects "an increased commitment in our field to reliance on data as the basis for understanding mental disorders," and that the APA states that the "categories to be included in DSM are to be (a) soundly based on good research, (b) constructed so as to minimize subjectivity in deciding whether or not a label should be applied to a particular patient and (c) atheoretical." Nothing seems farther from the truth in the case of these new categories.

Self-defeating personality disorder is not based on good research. In fact, one study by Spitzer is the only one about the "disorder". According to Caplan, there are at least nine problems with Spitzer's study. Most disturbing is that the category is based on very old *clinical* literature (1916-1950s), and not current *research* literature.

As for the APA statement that the categories are constructed to minimize subjectivity, this, too, is false. Both new categories are subjective labels and depend a great deal on the biases of a therapist. A psychiatrist who does not acknowledge that women are trained to be passive and giving will readily apply the label of self-defeating. And as for PMS, there is no clear-cut diagnosis. And the new labels are certainly not atheoretical. Given the lack of research, they are very theoretical categories indeed.

As a personality disorder is considered within the psychiatric profession as one of the hardest diagnoses to treat, to put "self-defeating" under a personality disorder is to give a

very bleak prognosis to the person labelled in this way. If a person is seen as having a personality disorder, therapy will not address social aspects of the behaviour, only personality traits of the client. It also takes the issue out of the realm of social responsibility. It is now not society's fault that women behave this way, it the woman's fault. It is like rape trials that take the emphasis away from the abuser and put it on the victim.

Interestingly, Spitzer has admitted that psychiatrists have not found acceptable psychiatric treatment for people given either label. This is certainly problematic, considering that the reason for providing a diagnosis is to better define treatment.

Diagnostic labels can be useful if they are well-defined and used appropriately. Treating a woman for the categories of depression or low self-esteem can be worthwhile, especially when recognition is given to social factors that might contribute to her problem. Treating her for self-defeating personality is not treating her; it only labels her. And since a woman with premenstrual problems can often be treated successfully with dietary and lifestyle adjustments, it would be a shame to treat her as if she needed counselling and therapy.

But the way it stands now with the new categories, labels of depression and low self-esteem could be dropped in favour of the newer self-defeating personality disorder. Drug therapy could become the treatment of choice for women suffering from PMS if they are diagnosed as having premenstrual dysphoric disorder.

Before its final vote, the subcommittees recommending the inclusion of the new categories held hearings to present their information and to hear from those who disagreed. One of the proposed categories, paraphalic coercive disorder, was completely rejected because of protests. This category would have provided a diagnosis for men who rape. Like self-defeating personality disorder, it lacked any form of social and historical perspective of rape and could have allowed a criminal to be let off from punishment because he suffered from a personality disorder.



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The categories of self-defeating personality disorder and perilethal phase dysphoric disorder were also voted against. So how did they get through anyway? According to Teresa Bernardez, chairperson of the APA women's committee during the period of revision, Spitzer was furious that the members voted against the categories. He used his influence (and he has a great deal), and a compromise was made — the diagnoses were put in an appendix. The APA, as Bernardez says, are "like people in congress." Things that happen depend on how much protest and influence there is. In trying to please everyone, they compromised. People who did *not* want the categories included couldn't complain because they were put in the appendix, and people who *wanted* them in could not protest because they were put in the appendix. *Time* quoted psychologist Renee Garfinkel on the voting as saying, "The low level of intellectual effort was shocking. Diagnoses were developed by majority

vote on the level we would choose a restaurant. You feel like Italian, I feel like Chinese, so let's go to a cafeteria."

The committee even created a "sadistic personality disorder" to compensate for the "masochistic personality disorder". (The former, we can assume, to be applied mostly to men and therefore we even the score.)

To put these categories into an appendix opened up a whole new host of problems. In the appendix, a warning will precede the categories, stating that they are controversial and should be used for clinical research purposes only. But the fact that they are in the book at all gives the go ahead to use them. Any psychiatrist could be "researching", preparing a paper based on case studies in his/her practice. What we need are properly controlled experiments, not case histories.

Unfortunately the new categories have been given categorical numbers. Each diagnostic category in the body of the DSM-III carries with it a number. It is basically a code, used for paperwork. When a psychiatrist is filling out an insurance reimbursement form, for instance, this number is on the form. Despite the fact that self-defeating personality disorder and peripartum phase dysphoric disorder are still supposed to be under investigation, categorical numbers have been assigned to them. This means that anyone given these unofficial diagnoses has also been given an official number. These numbers/categories hold up in court and in hospitals. It is not too farfetched to imagine a woman being institutionalized for having been labelled with self-defeating personality disorder.

And if PMS is seen as a mental disorder, what about women who use PMS as a reason for "temporary insanity" in court cases? Already this defense has been used by lawyers with female clients accused of murder in England and the U.S., and in London, Ont. This is very dangerous; there is *no* scientific indication that women are so overwhelmed by PMS symptoms that they could do something so extreme. A wonderful report by Dr. G.E. Robinson of the Women's Clinic at

Toronto General Hospital states:

The association between PMS and violent, impulsive or criminal acts is by no means firmly established . . . PMS research has been plagued by methodologic errors . . . Negative symptoms are more likely to be attributed to biologic status. Thus, women experiencing negative moods or aggressive behaviour during their premenstrual phase may attribute this to their menstrual cycle, failing to remember that the behaviour has occurred randomly throughout the cycle.

A great fear is that eventually the warning concerning the use of the categories may be dropped and they will be put into the body of the DSM-IV (to be published in 1990), to be used as full-fledged diagnoses of mental illness.

And then what? We know how popular culture is when it manages to get hold of a hot, new issue. When these psychiatric theories finally manage to move from the obscure journals into everyday use, it is easy to imagine a whole new host of women-blaming books on the market. We've certainly seen this before — think of all the mother-blaming books that have come out since the 1950s. Every problem that every child has is because of his/her mother. And now, every problem every woman has is because of herself.

The inclusion of these categories, then, demonstrates not only the lack of scientific principles in the APA, but also the sexism, stereotyping and differential treatment towards women by the therapeutic professions. Greenspan tells of when she was training as a therapist and how she figured out the diagnostic system. She took sex, class and race and made correlations with diagnostic categories. For example, she found that members of the working class were almost always borderline personalities, middle class males were obsessive, compulsive personalities and women were hysterics. After a few months using this system her supervisors were praising her expertise in diagnoses.

Whether or not these new categories will remain in the upcoming 1990 revised edition of the DSM is going to depend a great deal on pub-

lic response. The American Psychological Association has made a resolution against the use of these diagnoses and plans to create its own diagnostic manual to rival the DSM-III-R.

In the meantime, there is something that can be done. A group of lawyers in the U.S. has expressed an interest in representing anyone who has been given one of these controversial diagnoses. This may take the form of class-action or consumer protection types of lawsuits that prove various kinds of harm have resulted from the application of such harmful labels.

Furthermore, women in therapy should ask their psychiatrists what they have been diagnosed as, and challenge that diagnosis if it is sexist (or not treatable). As Greenspan reveals:

The diagnostician sets the terms. In doing so, he creates the reality he is defining. He tells us . . . what is normal and pathological . . . what is real and what is not.

If the therapist cannot see the woman's reality, the woman should not be afraid to disagree and, if need be, to find herself another therapist.

*Maureen Gans works at Nazareth House, a home for homeless women in Toronto. She is also a research assistant to Dr. Paula Caplan at the Ontario Institute for Studies in Education.*

*Copies of the American Psychological Association's resolution against these diagnoses can be obtained from: The Public Information Officer, American Psychological Association, 1200-17th N.W., Washington, D.C. 20036.*

*Copies of the DSM-III-R can be ordered from the American Psychiatric Association, 1400 K Street N.W., Washington, D.C. 20005, include \$7.50 (U.S.) plus postage.*

*To find out more about potential lawsuits write: Laura Brown, Coalition Against Misdiagnosis, 4527 First Avenue N.E., Seattle, WA. 98105.*

# MY STORY, OUR STORY

## What We Have Here Is a Failure to Communicate

Ruth Latta

The line "what we have here is a failure to communicate." from *Cool Hand Luke* sums up an experience I had a few years ago when I went to the doctor with a lump in my abdomen. The thing had been there for a year. My general practitioner diagnosed it as a hernia and said sometime I'd have to have it operated on. I had been postponing any action until the end of my back-to-school stint. The lump didn't hurt, but I knew it shouldn't be there. My belly looked different on one side than on the other. Now school was over and, reluctantly, I decided to think about it again.

The family doctor, without a word of apology for his misdiagnosis, announced that I had an ovarian cyst and that it would "have to come out right away." He referred me to a gynecologist, who should have been nicknamed Cool Hand Luke. He examined me, diagnosed an "endometriotic cyst", and called me and my husband into his office.

His explanation of what endometriosis was, went in one ear and out the other. The word surgery terrified me. He said something about tissue which lines the uterus growing in other parts of the body, such as the ovaries.

"Dearie, we'll use conservative surgery," he told me. "In severe cases of endometriosis we often remove both ovaries and the uterus, but I won't do that unless it's absolutely necessary, since you *haven't had children*." His manner became stern. "If you'd gotten pregnant in your twenties, as most women do, this condition would never have occurred."

This was no time to explain why pregnancy would have been impractical and undesirable in my twenties, or that, at age 35, my husband and I had pretty well decided to remain childfree. Cool Hand Luke seemed



Bernadine Arsenault

unkind, but I felt it imprudent to challenge him. The man would shortly be holding my sexual and reproductive organs in his hands. If I told him I didn't think I wanted children, he might say, "Then what do you need that womb for, anyway?" I wanted the cyst removed, but my uterus left intact.

Remembering half-heard stories and whispered comments among my older female relatives and their friends, I had the distinct impression that hysterectomy led to weight gain and impaired sexual function. This impression combined with my own experience that my uterus was significant, though perhaps not crucial, to sexual pleasure and my general well-being.

In the two weeks before my admission to hospital I read everything I could find on endometriosis, which wasn't much. Since then I have come upon helpful articles, such as the one in *The New Our Bodies, Ourselves*:

Endometriosis, which can be an extremely painful disease, occurs when some of the tissue which normally lines the uterus (endometrium) grows in other parts of the body. This "normal tissue in an abnormal location," sometimes referred to as growths, nodules, tumours or lesions, most commonly develops in the pelvic area — on the ovaries, external surface of the uterus, ligaments or Fallopian tubes. . . . These abnormally located growths build up and bleed at the time of the menstrual period. They respond to the hormonal influences of the cycle just as the uterus does. Since this build-up has no way to leave the body as menstrual flow, it may cause internal bleeding, inflammation and formation of cysts and scar tissue.

At the time, though, I didn't have

this book. An article in *Ms.* magazine, a publication which I considered a reliable feminist source, added to my confusion.

The *Ms.* article (January, 1981) quoted Dr. John Roch of the John Hopkins School of Medicine as saying what I later learned to be a common medical stereotype. He said that "women are delaying childbearing and the long periods of ovulation without pregnancy appear to predispose them to the development of the disease." The article suggested that there was an "endometriosis prone" personality, the career woman without children who is under great pressure at her demanding job. Dr. Veasy C. Buttram wrote in the 1979 issue of *Obstetrics and Gynecology* that his endometriosis patients were "tense perfectionists with demanding or specific goals . . . are usually well dressed and have trim figures. Once aware of an infertility problem, many of the patients have an obsessive desire to conceive."

This didn't sound like me. At the time the cyst developed I was a part-time student in an undemanding course of studies. As far as being well-dressed and having a trim figure — well, it would be nice! I was unaware of any fertility problem because I didn't want to be fertile; in fact, I was wearing a Copper-7 intrauterine device (IUD).

In retrospect, I think a magazine with the resources that *Ms.* has at its disposal could have commissioned an article which relied less on individual, outdated medical opinions and included more of women's own experiences.

For some women, endometriosis *does* cause severe pelvic pain around menstruation, ovulation or sexual activity. Some have excessive or irregular menstrual flow, a higher than average rate of miscarriage, infertility, cysts, increased risks of ectopic pregnancy (tubal pregnancy) and general debilitation. And some women, like me, experience no symptoms. With some women, the disease may not even be discovered until they have surgery for another problem.

During my surgery my husband was called out of the waiting room by the assistant surgeon. "Do you and your wife plan to have chil-

dren?" she demanded. He said we hadn't decided yet. "We'd like to take her uterus," the doctor said.

"Don't do that, she doesn't want that," my husband said, and they didn't. There was no new development or special reason for removing my uterus beyond what we already knew about endometriosis. "I didn't like their attitude," my husband said later. "It was like taking a car in for an oil change and having the mechanic say, 'Might as well do a grease job while we have her up on the rack.'"

The gynecologist became angry when he found me in tears after the operation. (Later I learned from a nurse that this is a common reaction to the anesthetic.) I felt too ill to be brave and a credit to my sex. A few days after the operation my husband met the doctor in the corridor. "The test results are back and as we thought, she has no reason to fear a malignancy," the doctor reported cheerfully.

"That wasn't what she was worried about," my husband began.

"Oh, they're all worried about that!" the doctor interrupted and breezed away.

My worry, one which has not entirely gone away, is the possibility of a flare-up leading to a cyst on the other ovary, and its loss, along with that of my uterus. From my reading and discussion with another doctor, I learned that there are treatments other than surgery. As the article in *The New Our Bodies, Ourselves* says, "The aim in treating endometriosis is to stop the ovary from working and producing estrogen, and also to stop menstruation." Hormonal treatments exist. Danazol, a derivative of the male hormone testosterone, has been used, but it is extremely expensive, may not relieve pain, and has side effects such as facial hair growth and weight gain. Birth control pills are another form of hormonal treatment. Surgery ranges from "conservative" (removal of growths) to "radical" (hysterectomy, with or without removal of ovaries).

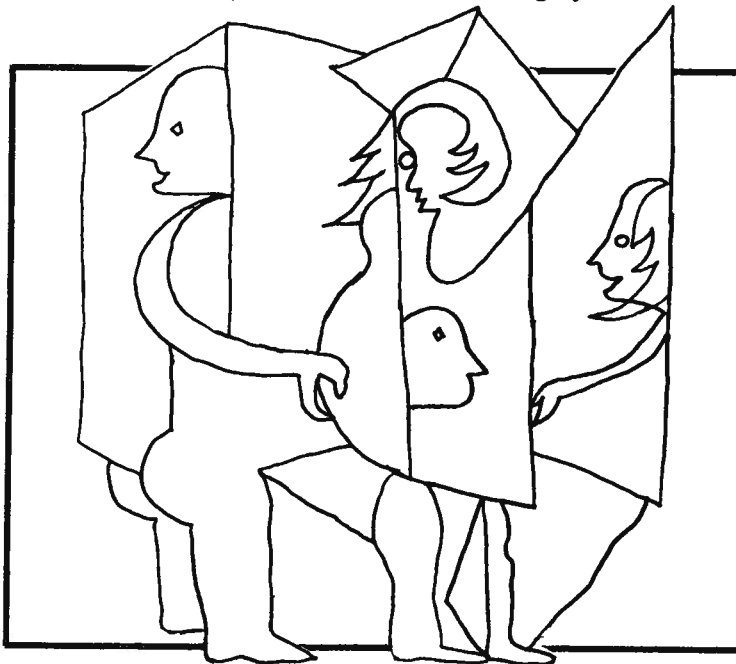
Pregnancy, said the *Ms.* article, is the ultimate cure for endometriosis, though sufferers of the condition have a hard time conceiving. This generalization did not apply to my sister, who, after bearing two chil-

dren, developed an endometriotic ovarian cyst and had it surgically removed. She had no trouble conceiving when she wanted to, and, far from being the stereotypical career woman, had been a full-time housewife for 15 years. A second ovarian cyst developed five years later and, upon her doctor's advice, at 36, she had a hysterectomy which included removal of her remaining ovary.

I began to read everything I could find about endometriosis, and dis-

I felt much worse after the four-week recovery period than I had when I was going around with the mysterious lump in my abdomen. At the checkups, when I complained about the continued pain in the spot where the cyst had been, he lectured me on poor posture and told me about his back problems.

On becoming mobile, I changed to a woman doctor, who believed that the continued pain was due to scar tissue. Surgery for this would only



Bernadine Arsenault  
design concept found in *Mujer 4* — Sexualidad

covered the existence of the Endometriosis Association, an American self-help group, the year after my surgery. Their questionnaire asked whether the respondent had worn an IUD. Both my sister and I had. The association did not say that an IUD was a cause or a contributing factor, but, on the basis of its members' personal experiences, felt that it was worth exploring.

I learned that some women, seeking relief from pain, have turned to alternative forms of healing, such as acupuncture, meditation, visualization, chiropractic treatment and nutritional therapies. The Endometriosis Association has too few reports to evaluate these methods.

In retrospect, I'm glad I had the cyst removed, but at the time, the cure was worse than the condition. My incision was extremely painful. Contrary to the doctor's predictions,

beget more scar tissue, she said. (Since then it has been suggested to me that another cause of pain might have been the transfer of endometriotic tissue — a chilling thought.) When I confided my fears about a future hysterectomy and possibly impaired sexual function as a result, she said, "Well, other women go through that, you know, and they manage. They don't complain."

Well, my sister complains, undergoing hormone treatment for menopause at 37.

I got more comfort out of the printed information of the U.S. Endometriosis Association than anything else. They stated what I now knew, that "official" medical information on the condition is scarce and contradictory. On the curing of the condition through pregnancy, one paragraph from their literature was particularly validating for me.

It is generally recommended that pregnancy not be postponed if it is wanted . . . However, we caution women not to forget that pregnancy is a life choice, and not to rush into it because of fear of not being able to become pregnant later . . . A counsellor sensitive to women as whole persons, not just baby machines, can help you sort through the emotions and confusions that arise.

The Endometriosis Association literature mentioned theories of the cause of the condition (also noted in *The New Our Bodies, Ourselves*), theories which none of my doctors mentioned. One is that remnants of tissue from when the woman was a fetus may later develop into endometriosis. Another is that it may be carried in the genes of certain families or that certain families may be predisposed to this condition. Another is that menstrual blood and fluid flow back into the pelvic cavity and attach to some organ.

The personal accounts of association members showed me that I was not weird or atypical. "I had no pain," wrote one woman, "yet both ovaries had large cysts." A Wisconsin woman, now 60, remembered her years of menstrual cramps and doctors' inability to diagnose: "Now I am 60, and in all these years nothing apparently has been done nor have the doctors' attitudes changed or their knowledge improved." Said another woman, "I didn't recognize the seriousness of the problem at first . . . For all I knew it could have been a name for fallen arches because the doctor made it seem so minor."

The Canadian science writer Heather Menzies, in an article in *This Magazine* (May/June, 1987) referred to her own experiences with endometriosis, an IUD and a tubal pregnancy. She feels that women have become part of the technological system and milieu which presses upon them such "wonders" as the pill and the IUD, with bad effects. The morning after her surgery for an ectopic pregnancy, her doctor urged her to consider the latest technological panacea, in vitro fertilization.

In thinking about women, technology and a book she had researched on this subject, she realized that the personal testimonies of the women interviewed had been lost in the aca-

demical framework imposed on the writing. They had become "statistical units in sociological categories." She saw a strange yet real parallel in the loss of her ability to bear a child without technology, and her adoption of standard, impersonal language and methodology in science and technical writing. She remembered sitting on an examining board, considering the thesis of a graduate student, who, after administering a questionnaire, came to feel that the marginal notes made by the women respondents were more informative and significant than the X marks to the pre-set questions. Menzies urges us to assert our authority to name things as we see and feel them. "The personal is our politics, and it's our science too."

With a mysterious and myth-laden illness like endometriosis, it would seem important that doctors listen to patients' own accounts of their feelings, symptoms and histories, and that they be willing to discuss all possible treatments in order to find one suitable to the patient's needs. To give my new woman doctor credit, she did not tell me that the pain was in my imagination, but referred me for deep heat treatment for the post-surgical pain, and for ultrasound to see if a second cyst was developing.

I'm still worried about a second cyst and a future hysterectomy. Lynn Sharon Schwartz, in *Mother Jones*, (June, 1986, You're Going to Have a New Body) wrote a very personal and disturbing description of her feelings after the loss of her ovaries and uterus. "A wave of heat swirls up and encircles you, making you sway dizzily, and the odd thing, no one has mentioned this [about a hot flash] — it pulsates." Her body "responds to temperatures differently and it sleeps differently, finding different positions comfortable and different hours propitious." With regard to sex, her body feels pleasure in an unfamiliar way. Her "apparatus of sensation is altogether alien." Scary stuff, but I'm glad I know it. No medical article or doctor is likely to tell me this.

In my own case, the post-operative pain came and went as it pleased for two years after the operation, even with deep heat treatment. Oddly enough, my giving up any expectation that a doctor could help me

seemed to be the first step toward alleviation of the condition. For some reason, the pain has gone away. I've thought about lifestyle changes I've made: a switch to a more varied schedule and more interesting work, a way of life involving more exercise and more chance to rest when I want to. I've tried a couple of painkillers and tranquilizers off and on, but don't take anything regularly. I wish I could be sure why the post-operative pain went away, but I can't. I don't know if the pain was due to endometriosis or due to scar tissue after surgery. I'd hesitate to recommend anything in my life to a sister-sufferer of endometriosis because each woman's situation is different.

The endometriosis itself may not be cured, but if it manifests itself again, I feel better informed and better able to seek out an appropriate treatment. With luck I'll make it to menopause without more surgery.

*Ruth Latta is a free-lance writer living in Ottawa.*

**The U.S.-Canadian Endometriosis Association** can be reached at P.O. Box 92187, Milwaukee, Wisconsin, U.S.A. 53202. 1-800-426-2END (for Canadian callers); 1-800-922-ENDO (for U.S. callers).

British women can contact the Endometriosis Society, 65 Holmdene Ave., Herne Hill, London SE24 9LD; the Australian group is the Victorian Endometriosis Association which can be reached c/o 37 Andrew Cres., South Croydon, Victoria 3136.

**Canadian groups have started in several locations.** The contacts about which we know are:

Carol Burman, 929 Eastern Rd., Victoria, B.C. V8X 2Z9 (604) 382-2218;

Karen White-DeRoche, 36 Strathearn Cres. SW, Calgary, Alta. T3H 1R4 (403) 242-1080;

Yvonne Wilkinson, P.O. Box 9198, Saskatoon, Sask. S7K 7E8; Endometriosis-Toronto, P.O. Box 3135, Markham Industrial Park, Markham, Ont. L3R 6G5.

# Visions

## For Reproductive Care

### Interview with Two Health Activists

Recently Women Healthsharing (WHS) spoke with two activists in reproductive health about developments in the pro-choice struggle and the fight to legalize midwifery. The two individuals, from the Ontario Coalition for Abortion Clinics (OCAC) and the Midwives Collective of Toronto (MCT), stressed the importance of working together in the broad reproductive rights movement. They have worked together for the last four years, analysing political developments and strategies within their movements.

In the interview, they spoke about why their groups work together, the importance of shared visions and the complexities of balancing short and long-term strategies to achieve fundamental change. They have chosen to be unnamed, because of their paid work. They speak as individuals and not as formal representatives of their two organizations.

**WHS: Why do you work together? I think some of our readers might feel the abortion and midwifery movements are contradictory, yet here you are as colleagues in activism.**

**OCAC:** We started working together more when we came to see our two issues as interconnected in a broad reproductive rights movement. Whether to have children and how to have children were both central to women controlling their lives. We also discovered similar concerns about the poor quality of existing

care for women giving birth and having abortions.

**MCT:** We share similar views of what reproductive health care that empowers women could be. We have a similar vision of what feminist health care might be like.

**WHS: Tell us about this vision. Are you talking about a utopian vision or something practical?**

**OCAC:** It's utopian, but many aspects are very practical. Each time we talk about this, we come back to a number of common principles of how our vision might work.

I guess the first is that care would be comprehensive: that is, all the stages of women's reproductive lives from the earliest sexuality counselling through birth control, birthing or abortion to menopausal counselling, would be offered altogether in one place.

Another theme is universal access — all services free and available to anyone who wants them.

When we first started working together we found that we shared a certain puzzlement that we were both being criticized for not providing perfect feminist services. We decided the criticism comes from the fact that our current politics are being contrasted to a broadly shared vision of what feminist care should be. To impose such a standard now is a bit too simplistic. You can't jump immediately or directly from the

problems of here and now to that future world. We work in a very imperfect world so we have to make tricky strategic choices and fight where we can.

**OCAC:** Continuity is another important aspect. A woman coming into a centre or clinic would work with the same health care worker through all stages of a particular health concern.

I think this would be good not only for clients, but also much better for health workers themselves. They wouldn't be doing just one little bit of the whole care; they would control their environment a lot better.

This is health care that would empower women. It's all the specialized services they need right at their fingertips — all the information they need to decide what's best, delivered without hassle, or financial restriction.

**MCT:** I remember a physician from Quebec talking about how wonderful her particular health centre is. Women who are pregnant and women wanting abortions sit in the same waiting room and talk to each other. She thought it was very important for those women to have both sides of reproductive choice acknowledged in one place — that a woman having an abortion was comfortable to face a pregnant woman and vice versa and how this acknowledges the validity of both choices.

Women might come to such a reproductive health centre for very different reasons. They might want to use knowledge of ovulation and

menstruation as birth control or to get pregnant. A woman might be there just to understand her body better. So often in the system of care we have now, all of those things are completely separate.

Our vision refers back to the traditional role of midwives. Midwives were involved all through the reproductive cycle. They were involved in birth control, with abortion, with birth; they were helping through the whole of women's lives.

**WHS: Why is your vision for the future important for the reproductive rights movement?**

**OCAC:** These sorts of visions are not really for the future at all — they're really for the present. Visions can be a means of movement building on a number of levels. A clear picture of ultimate goals can seize people's imagination and build enthusiasm. It can attract new people into the movement and give a sense that there is something worth fighting for.

Visions are also a way of counterposing what we would hope for against what the dominant culture has now. We can pose our vision as something very real. "What's standing in the way" becomes a question of insight. Forces opposing women-centred care become clearer: established medicine, the state, the conservative moral majority are all standing in the way. It clarifies the question of not only why things are so bad now but what's preventing us from getting to what would be empowering.

**WHS: Where are some of the tricky strategic decisions you spoke about?**

**OCAC:** One is that we have to be very careful not to get caught by our slogans — the choice slogan is a good example. Both our movements are about women making choices themselves about their own reproduction. The choice concept is very resonant in a democratic political culture and easy to understand. It allows people who have personal qualms about abortion, who carry

anxiety from difficult abortions or who are personally opposed to abortion to say other women have that right themselves.

However, over the years we've come to see some of its limits. One limit is that it's very individualistic. Individual women having choice over their lives is good, but it doesn't directly challenge the underlying social organization of reproduction or of health care and it's easy to pretend that choice in one area — like abortion — means choice in other aspects of life. So we started emphasizing that there's no real choice for women in childrearing and childcare in a society without universal day care, without equal pay and with continuing violence against women. This shift in emphasis hooks our movement into other, broader women's movements. This isn't just a case of sloganeering to make us popular with other movements but really trying to emphasize that there are all these connections.

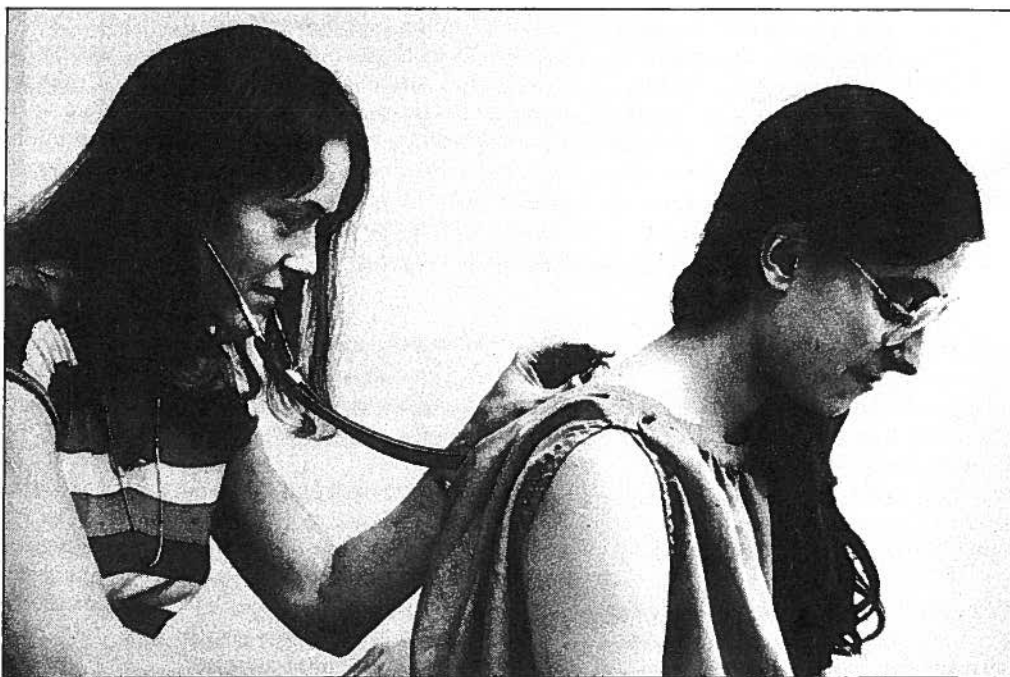
**MCT:** Another shift in strategy can be seen in our defense of midwifery. We initially emphasized the international acceptance of midwives and often used Europe's midwifery delivery systems as examples. Now that legal recognition is coming in Ontario we need to change our emphasis and point out the limitations and weaknesses of the European sys-

tems. We need to promote our own models of autonomous practice and this can't rely on general promotion of any existing system.

**WHS: The Ontario government is currently setting up hospital-based birthing centres and also women's clinics providing abortion services at hospitals. Does this mean that the Ontario provincial government is moving towards your — and our — long-term goal of feminist health care services?**

**MCT:** It would seem not. The government has recently promised to fund several hospital-affiliated birthing centres. We believe that hospital affiliation defeats the purpose of birth centres. Autonomy is central for midwives to practice effectively and also for the women giving birth in these centres. Hospital affiliation reproduces the same hierarchies and limitations in policies and funding which have led women to seek alternatives. We don't believe these birth centres will change the basic problems of medical control and high rates of intervention in the birth process.

**OCAC:** Any initiative that will increase access to quality care for women is a step forward. We welcome



Jennifer Penny

the idea of comprehensive reproductive services being available in one place, but we have a number of practical concerns. First, nowhere has the government indicated that the number of abortions provided will increase to meet the need. All they're talking about is better coordination of the existing system, a system in which the hospital quotas are always full now. The report prepared by Dr. Marion Powell for the government talked about tremendous regional inequality of access — yet proposals for the centres are disproportionately from Metro Toronto. The Powell report also documented very poor quality of care in hospitals, yet the new centres will be based in these same hospitals. The centres will require the usual therapeutic abortion committee approval — any system which keeps the decision of whether or not to perform an abortion out of the hands of women and in the hands of doctors is demeaning and unfair.

Finally, there can't be a workable solution unless the existing clinics in Toronto [run by doctors Henry Morgentaler and Robert Scott] are brought into the publically-funded health care system.

**MCT:** These weaknesses make it clear that the proposals from government won't work in their own terms. But as activists we need to look further, to look beneath the surface appearance of the proposed changes — what do the changes *really* mean?

One way of answering this is to compare the government's proposed centres to our vision of what feminist reproductive care could be. The proposed centres may provide better coordination and more services in particular locations, but they are hardly comprehensive.

Proposals being developed by community based groups for women's health centres in Ontario aren't planning to provide abortions and few have mentioned birthing. The proposals being considered by government now all rely on hospitals, with the same old medical model and fragmented division of care.

Whatever the government rhetoric is, the current proposals don't begin to answer the dilemma of non-exis-

tent universal access — the majority of initial proposals are in Toronto, not in rural areas. The centres will hardly be empowering for individual women — decisions will still be made by doctors;

It reminds me of the time when hospitals believed they could answer women's demands to change obstetrical practices by wallpapering the labour rooms [see *Healthsharing* Winter, 1979 for a critique of hospital birthing rooms]. The changes proposed are superficial and do not challenge either medical domination or, more fundamentally, state regulation of women's reproduction.

**OCAC:** It's very significant that none of the activist movements were consulted by government on this. The request for proposals went to hospital administrators. What is really going on is that these centres are an attempt to diffuse and divert support for our movements. By promising to improve access to abortion through referral centres the government is hoping to weaken the demand for free-standing clinics. By promising birthing centres, the government is hoping to sidestep the more controversial — at least in the eyes of doctors — issue of independent midwives providing home births.

**MCT:** Unfortunately, the proposals are superficial reforms — they don't move us towards the ultimate goals of autonomy and empowerment. In fact, we think their intent is insidious — while the proposed changes are a response to the years of pressure from the women's health movement, they are also an attempt to undercut our radical demands and the challenges posed to medical and state regulation.

**WHS:** What do you see as the way forward, given that the government proposals in Ontario are going ahead?

**MCT:** We — and we hope these concerns are shared by other feminists working in health care — must continue to insist on our bottom-line immediate demands of a network of publicly funded free-standing abortion clinics and fully autonomous

midwifery accessible to all women. Nothing less will do.

We also need to keep fighting for long-term changes — This includes feminist women's reproductive health centres in every community and in every language and culture. The long-term changes need to move us toward a goal of health care that empowers women.

The issues are the same for women all across Canada, although their situations are very different. For a woman in P.E.I. with no access to abortion, these centres might sound pretty good, but I hope feminists in other provinces can understand that the initiatives are no step forward for Ontario.

**OCAC:** I want to end on an optimistic note by recognizing some of our real achievements. The imminent legalization of midwifery in Ontario has been won against sustained medical opposition. Free-standing clinics have been open in Toronto for over three years in the face of government opposition and anti-choice harassment. This must be seen as an ongoing victory for the women

We have made some significant advances, but we still have to fight to make sure that we win our demands on our own terms. Even a formal, legal right to abortion and legally recognized midwifery in all provinces would not be enough without a major commitment of public funds to guarantee free and equal access to all women. Even better access to these services will not be enough without dramatic changes in the health care system to ensure that the quality of care is feminist and woman-identified.

Fighting to win this — and all the other issues that underpin sexual and reproductive freedom in the widest sense — on our own terms means always keeping ultimate goals and visions of what the future can be firmly in mind.

*This interview was completed and on its way to the press when the Supreme Court abortion decision was released. Consequently there may be references which, although historically correct, are now outdated.*



# REVIEWS

## **Towards Happy Motherhood: Understanding Postnatal Depression**

Maggie Comport, *Corgi Books/Transworld Publishers, London, U.K.*  
[Canadian distributor for Corgi is Bantam Books Canada, Toronto, Ont.], 1987, £4.95, 307pp. paper.

Reviewed by Lee Helmer

What do you think of when you think of postpartum depression? For most people it conjures up the image of those "after baby blues" mothers are told to expect three or four days after giving birth. I remember a vague feeling of relief when the blues descended on me the day my milk let down. "Ah," thought I, "everything is progressing as it should."

What I didn't expect was that my cozy blues would steadily grow into a kaleidoscope of symptoms that developed into a lengthy period of postnatal depression. All the books I read during my pregnancy, as well as the people I spoke to, only casually mentioned the existence of anything depressing postpartum, usually dismissing it as something inconvenient that was quickly over.

Maggie Comport's book *Towards Happy Motherhood: Understanding Postnatal Depression* does not make that mistake. Comport provides a welcome and thorough explanation of what mothers can expect, why it may occur, and the ways and means by which it can be prevented. She examines all the current information about postnatal depression (or PND, the term used more commonly in Britain) and provides a useful synopsis of the four general types: mild maternity blues, postnatal exhaustion, postnatal depression, and the virulent puerperal (due to childbirth)

psychosis.

In welcome detail, Comport describes the birthing process and illustrates how it is controlled by western obstetrical practices. She provides a convincing analysis of the link between a woman's lack of control in the birth experience and the possibility of depression. Despite growing and conclusive evidence that naturally occurring birth is safe birth, women are consistently and constantly subjected to interventionist procedures. These include routine induction, accelerated labour, pain relief, fetal monitoring, timed transition stage, episiotomies, cesarean sections, and managed delivery of the placenta. Even in circumstances which warrant one or more interventions, they are nonetheless invasive actions which upset the biochemical, emotional, and physical changes that take place simultaneously to enable progress.

During every pregnancy and birth there are many social, economic, and psychological stresses. Comport succinctly illustrates, for example, how the loss of independent income can seriously impair a woman's self-perception; how society's anti-child values encourage mother-child isolation; how a couple, in adjusting their relationship to include another, can weaken or change that relationship, creating fear and uncertainty. Comport looks at the emotional upheaval that exists when mothers don't instantly love their babies; when they feel pressured to resume sexual relations with their partners; when they realize the low status of their new "job" (childcare); when they are just too tired to do anything but look after the baby.

These "reality" situations do not exactly fit the romantic, idealized notion of motherhood: that of bringing a healthy, quiet baby to a spotless

home filled with everlasting family bliss. The disjunction between expectation and reality can be devastating for a new mother. The resultant stresses from these external factors can, Comport believes, "disrupt biochemical functioning to produce depression . . ."

In the chapter aptly titled "Not All In the Mind," Comport examines how the complex hormonal production and biochemical balance so vital to successful pregnancy and birth can be influenced by a myriad of factors. These include lack of adequate nutrition, allergies, candida, social poisons, food sensitivities, environmental toxins and viral infections of the immune system.

For those women who have suffered, or will suffer, PND, Comport analyzes the traditional responses that are offered by the medical profession. These range from cavalier dismissal of the mother's expressed feelings of anxiety, helplessness and exhaustion, to electro-convulsive (shock) therapy for puerperal psychotics. Treatments include behaviour and drug therapy, psychoanalysis, counselling and admission to psychiatric hospitals. Comport condemns these practices as inappropriately selective; they treat only the individualized symptoms, rather than integrating the body and mind as a whole. She presents a strong argument that the medical profession is acting as an agent for ill-health by alleviating the symptoms while neglecting the root causes.

The final two chapters of the book are uplifting and positive. Comport first provides practical information for partners, friends, family members, and health care professionals to assist them in helping mothers who suffer from PND.

Comport then turns her undivided attention to mothers themselves. In a sympathetic entreaty, without any hint of mother-blaming, she encourages women to understand the variety of forces that are at work pre- and post-natally. She offers down-to-earth and achievable programs for optimal mental and physical health, based on available information and services. She refuses to set mothers up to fail by promising that no one will ever again suffer PND, but,

rather she provides a realistic picture of PND as manageable and possibly even preventable.

Most chapters conclude with easily reproduced summaries suitable for handout in clinic settings, doctors' offices, or mother-baby groups.

*Lee Helmer is a mother and feminist activist particularly interested in women's health issues.*

## Breaking the Trust: Sexual Harassment on Campus

*video sponsored by Western's Caucus on Women's Issues, the University of Western Ontario, Kem Murch Productions, 1986, various video formats \$595, rental \$50, 25 min.*

### Reviewed by Anita Braha

*Breaking the Trust: Sexual Harassment on Campus* is a uniquely Canadian educational video, which comes with a printed guide. It is designed for use on campuses and in school rooms as an educational resource and so it should be. The tone is informative and constructive and the guide provides topics and questions for group discussion. Through personal testimonies and dramatizations we are taken through various scenarios of sexual harassment. We learn what sexual harassment is, who it affects and ways to stop it.

The video's analysis is good and insightful. Sexual harassment is characterized as the abuse of power that it is. Power can be derived from socio-sexual, economic and physical sources, among others. In teaching situations it is exercised over students' grades, recommendations and future careers. The video's producers tell us that a particular trust generally occurs in teaching relationships which fosters the learning process. Sexual harassment stops the learner from being open and distracts her from the learning process; it creates anxiety and intimidation in what should be a positive and receptive relationship. According to the video, destroying this learning relationship is a breach of trust. This is an important point — sexual harassment is an abuse of power, not a sexual activity.

The material in the video is sophisticated yet accessible. Sexual harassment is defined using the University of Western Ontario's definition, and although there are reasons to debate its use as the model definition — if its purpose is to serve as a framework for discussion, it is satisfactory. However, one omission in the definition given deserves attention. That is the failure to include as a prohibited ground of harassment sexual harassment due to sexual orientation. The definition of sexual harassment outlines the grounds upon which complaints can be made. If there is no explicit provision regarding sexual orientation, lesbians and gay men are not being clearly protected.

While the video indicates that men in positions of equal power to women can and do harass women, it fails to state that men in subordinate positions to women also sexually harass female superiors. Men do this by relying on the social subordination of women; even though these men don't have power from a structural position (as a boss, or as a teacher), they derive power from the social hierarchy.

This insidious form of gender warfare is exquisitely exposed in the video. One of the ways this is accomplished is by categorizing the behaviours of sexual harassers into four types: 1) the talkers and body talkers, 2) the therapist types, 3) the touchers, and 4) the threateners. Each type is described and his methods are exposed. This demystifies sexual harassment and pro-

vides a framework for victims to use when trying to decipher the harasser's ploys. But this categorization is not rigid. It is acknowledged that there are overlaps in methods used and that the behaviour and abuse may escalate.

Perhaps the most powerful part of this exposé is the way the deliberateness of the harassers' behaviour is unmasked: demonstrations of harassers choreographing their body movements to violate women's bodies and personal space are shown; examples of teachers using their classrooms as hunting grounds and manipulating their students' trust or awe are given; and reliance on victims' silence is shown. Exposing the deliberateness of the harassers' behaviour allows women to properly place responsibility for sexual harassment on the harasser. He is the one who transgresses appropriate lines of behaviour. Women, victims of sexual harassment, are not in control of what the harassers do. The video and materials make this point nicely.

The video also addresses very well the typical reactions to sexual harassment. A range of these is presented: from blaming the victim to pitying the harasser. This serves to validate women's experiences as undoubtedly women will be able to identify with one or more of the "typical reactions." The presentation makes clear that women are not responsible or deserving of sexual harassment. This is good feminist form and a pleasure to view.

The role and responsibility of institutions to keep working and learning environments free of sexual harassment is also discussed. This is one area where energy constantly needs to be directed. The video makes a significant contribution to educating victims and staff at our schools and campuses. Unfortunately there is still much work to be done. One of the characters in the video says as a call to arms, "Eventually (the harasser) picks the wrong victim." Wouldn't it be nice if eventually he also picked the wrong environment?

*Anita Braha is a feminist currently completing her Bar Admission course in Toronto.*



Rachel Berger

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## RESOURCES & EVENTS

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#### International Feminist Book Fair

The third biennial International Feminist Book Fair will be held June 14-21, 1988 in Montreal, bringing together editors of books, magazines and newspapers with writers, translators, distributors and booksellers from around the world.

For more information about this exchange across continents, languages and disciplines, write: Third International Feminist Book Fair, 420 est. rue Rachel, Montreal, Que. H2J 2G7.

#### Insight Seminars

Dr. Susan Forward, psychologist, lecturer and best-selling author of *Men Who Hate Women and The Women Who Love Them* and *Betrayal of Innocence* is leading a seminar entitled *Reclaiming Your Self-Confidence and Well-Being: Positive Steps to Personal Power* on April 30, 1988 from 1-5 p.m. in Toronto. The cost is \$75.

To register, contact: Insight Seminars, 707 Markham St., Toronto, Ont. M6G 2M2, (416) 537-6464.

#### Endometriosis

*Overcoming Endometriosis: New Help from the Endometriosis Association* is a new book by Mary Lou Ballweg and the Endometriosis Association [Congdon & Weed, N.Y., 1987; distributed in Canada by Fitzhenry & Whiteside; \$14.95 paper].

The 328-page book includes chapters about the disease, treatments

currently used and theories about causation. It includes sections about emotional concerns, current research, financial difficulties in having endometriosis and how women are supporting other women. It is an excellent all-round introduction to endometriosis.

#### Planned Parenthood Scholarship

The Planned Parenthood Federation of Canada is offering a \$2,500 award to university graduates who intend to work towards a higher degree in the field of women and reproductive health during the academic year 1988-89. Applications must be received by May 1, 1988.

For more information contact: PPF Scholarship Committee, Planned Parenthood Federation of Canada, 323 Chapel Street, Ottawa, Ont. K1N 7Z2, (613)238-4474.

#### Conservation Strategies in Canada

This special edition of the Canadian Society of Environmental Biologists newsletter, Vol. 44, No. 2, 1987 offers an overview of conservation strategies and the implementation of the World Conservation Strategy in Canada, federally as well as provincially and territorially.

Limited copies may be obtained free of charge upon request by contacting Canadian Society of Environmental Biologists, Box 12, Substation 11, Edmonton, Alta. T6G 2E0.

This national conference on child abuse is to be held in Toronto May 24-27, 1988. It is designed for professionals who work in the areas of child abuse and adult survivors of child abuse. Conference presenters include dynamic feminist therapists, researchers and activists such as Lucy Berliner, Sandra Butler, Diana Russell and Lucie Blue Tremblay.

For registration information contact: Community Resources and Initiatives, 150 Winona Drive, Toronto, Ont. M6G 3S9, (416)658-1752.

#### Disabled Women's International (DWI)

In 1985 the Disabled Women's International was founded at the UN Decade of Women Conference in Nairobi, Kenya. A \$10 — \$25 (U.S.) membership fee, payable to DIA-DWI, helps to defray costs of the yearly newsletter of which a taped version is also available. Any relevant English original fiction, non-fiction, letters, pieces about the political struggle for equality and/or independence are welcome and must be received by late April, 1988. The editors reserve the right to edit and/or refuse pieces.

Address correspondence to DIA-Women With Disabilities United, P.O. Box 323, Stuyvesant Station, New York, N.Y. 10089, U.S.A.