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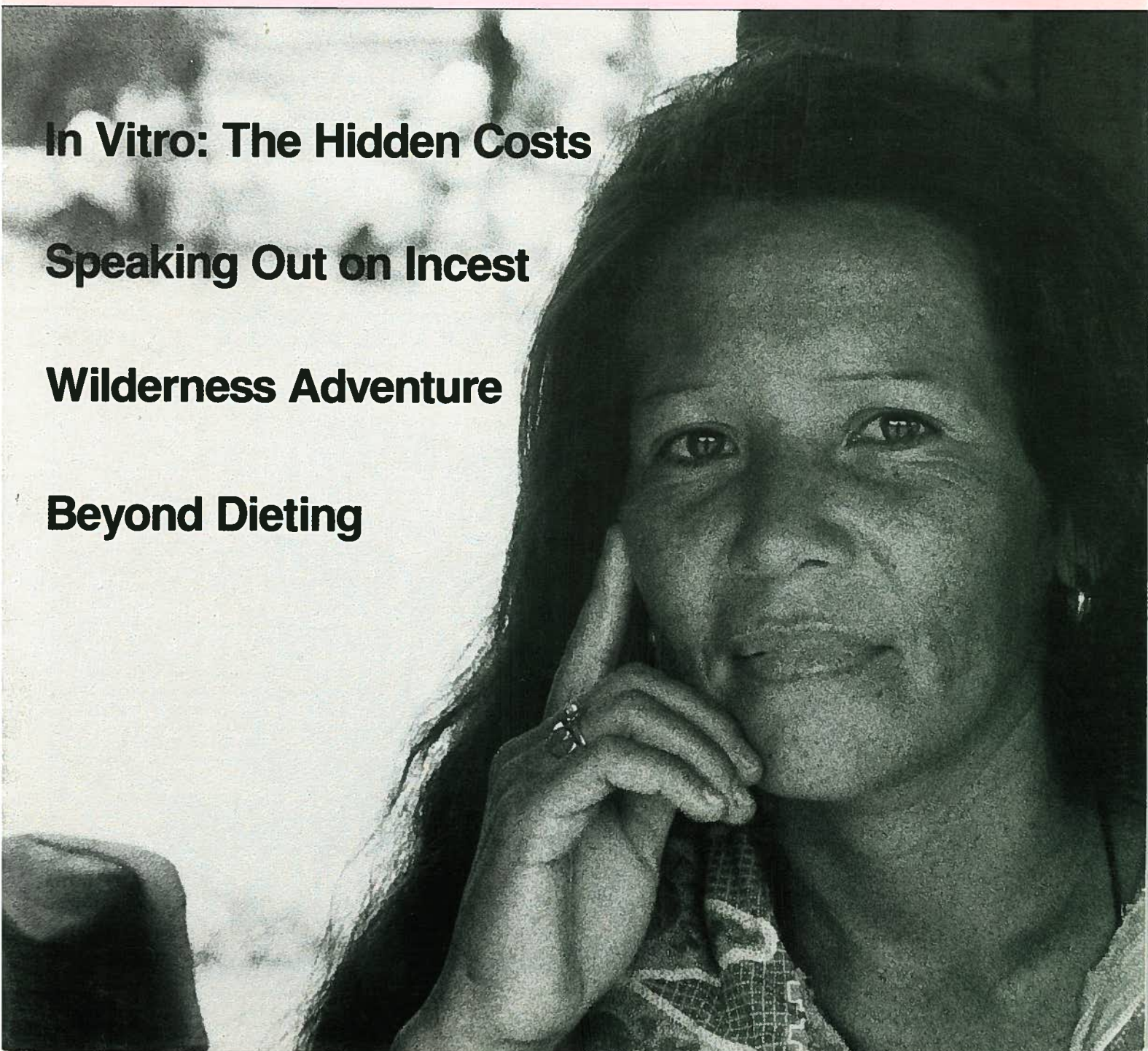
A CANADIAN WOMEN'S HEALTH QUARTERLY

In Vitro: The Hidden Costs

Speaking Out on Incest

Wilderness Adventure

Beyond Dieting



INSIDE

Healthsharing

Vol 10:3 June, 1989

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Dawna Gallagher

COLLECTIVE NOTES

An Apple A Day?

Last March, representatives of the Canadian government leapt into action to protect us from a dramatic health threat. Responding to information that cyanide had been found in two Chilean grapes in Philadelphia, the Canadian government banned the import of all fruits and vegetables from Chile. Politicians appeared to give little weight to reports that it would take 2,000 of the poisoned grapes to make someone ill. "It is better to err on the side of caution," said Health Minister Perrin Beatty as he recalled all Chilean produce from store shelves and issued bulletins advising consumers to throw their Chilean fruit and vegetables away.

The grape scare came hard on the heels of other frightening news about the food we eat. In this case however, government response was much different. In late February a U.S. environmental group, the Natural Resources Defence Council (NRDC), reported that most of the apple juice sold in the U.S. is contaminated with a chemical called UDMH. UDMH is a breakdown product of the chemical maturing agent, daminozide, better known by its trade name Alar.

Routinely sprayed on orchards, Alar had been viewed by many as a boon to farmers and consumers alike. The chemical, which is absorbed by the fruit, and cannot be washed or peeled away, delays natural ripening and prevents bruising thus reducing spoilage and increasing the fruits' shelf life. Farmers get more crop to market and we get cheaper apples. Or at least that's the theory.

Unfortunately, UDMH, which is released when Alar-treated fruit is processed, has been implicated from laboratory studies as being a potent cancer-causing chemical. This finding is particularly significant for children who consume large quantities of ap-

ple products such as apple juice and apple sauce. The NRDC study concludes that heavy consumers of foods containing UDMH residues will significantly increase their risk of developing cancer. The report suggests that one child out of every 1,100 will develop cancer as a result of exposure to Alar. Eleven American cities responded to this news almost immediately by banning apples and apple products from school cafeterias. And the U.S. Environmental Protection Agency immediately stepped up the pressure to ban daminozide. Yet in Canada, despite Health Minister Beatty's apparent concern for our health, response to the report has been cautious, to say the least.

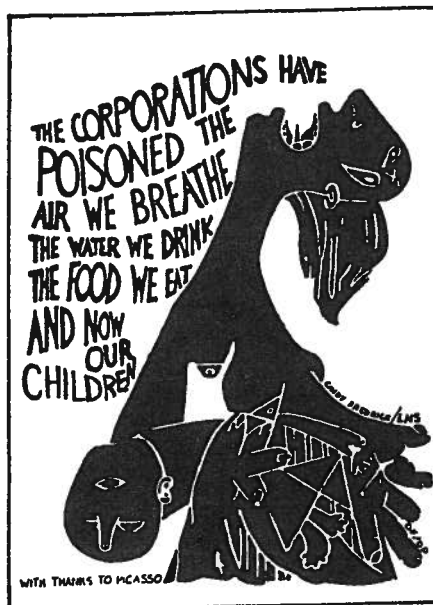
Environmental groups have been questioning the safety of Alar for years and this report should only heighten concerns about chemical contamination of the food we eat. Health and Welfare Canada, however, has steadfastly ignored these concerns and even now denies that we have anything to fear. The gov-

ernment has not announced any plan to eventually ban Alar or other cancer-causing chemicals.

One can only be suspicious of a government which responds so differently to different threats to the nation's health. It did not hesitate to react swiftly and strongly (some might suggest hysterically) to two contaminated grapes from South America. Yet, to a far greater and more insidious danger, government response is negligible. Whose interests is our government protecting?

Food production in most of North America and increasingly in the rest of the world is big business — agribusiness. We all know the benefits — a varied selection of perfect fresh fruit and vegetables year 'round, at least in southern Canada. We can eat strawberries in February, peaches in March, tomatoes never rot and oranges are all the same shape and size and a beautiful hue of orange. That we can enjoy this bounty is a result of radical changes in the way food is produced around the world. Food production in Canada and other countries is a vast profit-oriented industry. Huge farms owned by national and multinational corporations heavily dependent on a worldwide chemical industry intent on turning the highest profit possible are responsible to a large degree for what appears in our shopping carts. This is a food production system to which our government is politically committed. Political and economic reality make it difficult for our politicians to issue ultimatums or to suggest changes to the organization of food production which might make our food safer but also result in reduced productivity, efficiency and ultimately profits. Even when pesticides are banned for use in Canada, chemical companies turn around and export them to developing countries, from whom we import fruits and vegetables.

The United Farm Workers of America have been sounding the alarm for years about the health hazards from the eight million pounds of pesticides sprayed on grapes annually in California. (See Update Vol. 10, No. 2) It is not only the workers who are exposed, the chemical sprays drift long distances in the air and seep into ground water



and eventually into our drinking water. The number of sick and dying children in McFarland, California, a small town which has been officially recognized as a "child cancer cluster" prompted one mother to state "children are our flags — they're dying and that's showing us something is wrong here."

The NRDC report would be a good starting point for a government truly interested in the health of its citizens. But it is just a beginning. There are still many pesticides and growth regulators that are rarely tested for; for some no tests have yet been developed. It has been known for years that very small amounts of various substances can accumulate in our bodies and eventually cause cancer — yet we feel that we have little choice but to go on buying and

eating contaminated foods.

Environmental groups have for years been studying this problem and lobbying for change. Since the Canadian government, despite its rhetorical concern with environmental issues, is so reluctant to take positive action, more people will have to join the struggle. On a personal level that may mean changing our consumption habits such as buying more locally grown seasonal produce or by joining or starting up a food co-op that is supplied by local producers who use fewer chemicals. Many of us could produce some of our own food in community gardens. We can join environmental lobby groups that are working for changes in the way we produce and market food. We can support farm workers' unions such as the United Farm Workers of America

which has been fighting for safe working conditions for its members.

Although the benefits of agribusiness and the industrialization of food production have appeared to be great, we are now starting to learn that the hidden costs are far greater. Many of us grew up eating foods that were far safer than the things we feed our children today. They will be the ones suffering the effects of agribusiness and all that means in years to come. It is up to us to start to change that and to compel our government to begin to seriously address these issues.

Susan Elliott, Amy Gottlieb, Ruth Kidane, Lisa McCaskell, Katie Pellizzari.

LETTERS

We encourage readers to write. Your comments and criticism are just as important 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 edit letters for length, and print them, unless they are marked 'not for publication.'

Vaccinations Universally Good?

We read with great interest the article by Anna Kohn in your current issue. As you may know, proponents of homeopathy are concerned about the attitude that vaccinations are universally good; in fact, our Spring 1988 newsletter was a special issue devoted to immunization and vaccination.

The magazine is in the waiting room of the Vancouver Centre for Classical Homeopathy, and I have run a short article about Ms. Kohn's piece in the current issue of our newsletter encouraging readers to write to you for single copies of the magazine. *Claudette Reed Upton, Vancouver, B.C.*

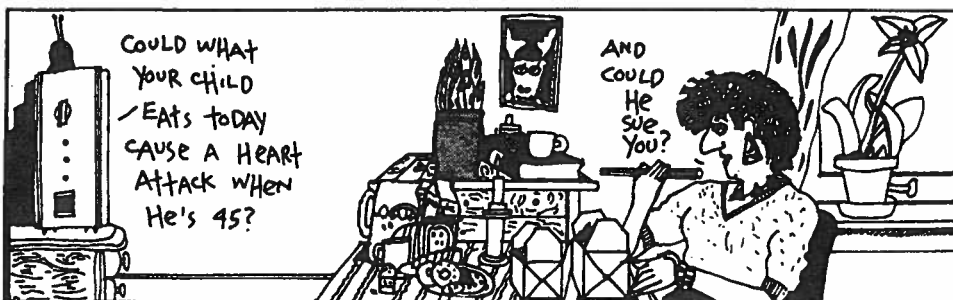
Vaccine Controversy

While I commend you on bringing to light the potential risks of the Pertussis vaccine (Anna Kohn's article, Spring 1989) I feel you did your readers a disservice by not pointing out that the disease, Pertussis or whooping cough, has a high mortality rate and a risk of permanent brain damage. It is also a disease of early infancy so that delaying vaccination will not solve the problem.

"The disease is most common and most severe in early infancy. In the USA, 2400 cases were reported in 1983. Of the affected infants, 73 per cent were hospitalized and 0.7 per cent died." (*Current Pediatric Diagnosis and Treatment*, Appleton and Lange, Norwalk, Connecticut, 1987)

That is, 17 of the 2400 infants died. The text goes on to say that antibiotics do not alter the clinical course of the disease if administered after the whooping stage begins. Furthermore, the risk of permanent brain damage after receiving the vaccine has been estimated to be about 1/310,000, while the risk following the disease is 1/2000 to 1/8000.

What happened to Maureen Kortekaas and her family is tragic. Doctors must learn to recognize which children should not receive the Pertussis vaccine. But we must remain aware of the fact that Pertussis is a severe illness of infancy that can kill or result in brain damage and that we put our children at greater risk by not vaccinating them. *Frances Berkman Toronto, Ont.*



Nicole Hollander/Never Tell Your Mother This Dream

Hit the Jackpot

Congratulations, Healthsharing. Your Spring 1989 issue has hit the jackpot as far as I am concerned. Maggie Burston helped me on my search to better health — I have the "common" immune problems — candida and food allergies and now work with a clinical environmental doctor in Ottawa to build myself back up.

L. Larson
Deep River, Ont.



Gail Geltner

New circulation system

We have just changed our circulation system. Our subscriber files were previously maintained and updated at King West Communications. Their decision to close down their circulation fulfillment business forced us to change our circulation system with great speed (to say the least). We now have an in-house system and hope to continue to provide the readers of *Healthsharing* with prompt and reliable service. Although we aren't anticipating a great number of problems, all changes of this kind take time. If you are experiencing any difficulties with your subscription, please drop us a line as soon as possible and we'll look into it.

UPDATE**Sex differences in depression**

There are more women than men who are depressed and most researchers argue that this finding reflects a "true" sex difference in depression (not merely that women are more willing to seek help for "emotional problems"). Why do women predominate among those who are depressed? How can this observation be explained?

In an article published in the latest issue of *Canadian Psychology* (1989, 1, pp. 39-47), Janet M. Stoppard, Professor of Psychology at the University of New Brunswick began to probe these questions by evaluating cognitive/behavioral theories for understanding depression in women. These theories have been highly influential on mental health professionals' approaches to the treatment of depression.

The cornerstone of cognitive/behavioral

explanations of depression has been the assumption that women are more vulnerable to depression because they lack certain factors that are thought to help resist it. Stoppard notes that these factors all reflect a "male-biased standard of adjustment," such as a sense of personal mastery and self-control and effective goal-oriented problem-solving abilities.

Stoppard reveals that research has not borne out the assumption of higher vulnerability or lesser resistance among women. She concludes that cognitive/behavioral theories have not been able to account adequately for why it is more women than men are depressed.

Therapy with depressed women based on cognitive/behavioral theories goes on despite the inability of the

theories to answer the "why" question. Stoppard argues that therapies based on these theories give the message to their clients that they are "deficient." They risk blaming the victim when they interpret what goes on in the depressed person's life as the product of distorted thought processes or dysfunctional attitudes. Cognitive/behavioral theories do not explore how higher rates of depression among women are linked to women's social and economic conditions and how "negative cognitions" may in fact reflect "negative reality."

Stoppard's article is followed by 11 "invited comments" and Stoppard's "rejoinder" in the same issue of the journal. Beyond acknowledging that the question she raises is indeed

important, few authors engage in debate. Most of their responses point out Stoppard's "errors" in how she selected the literature to review, how she "misunderstood" cognitive/behavioral theories, etc. There is little commitment to developing Stoppard's suggestion that in order to understand why there are more depressed women than men we must look at women's lives from the standpoint of women. It is then that women's actual conditions can become visible and we can begin to identify factors really responsible for their higher rate of depression. Then we will begin to understand what we must do to prevent depression among women.

EVA SZEKELY



Dawna Gallagher

Quebec physicians oppose midwifery

Midwives are facing renewed opposition from Quebec physicians, nearly two years since Quebec's health minister released a report favouring the legalization of midwifery.

The report, released in August 1987, recommends the setting up of experimental midwifery projects geared towards low-income women in health care institutions. It also suggests the establishment of birthing centres and university programs in midwifery.

However, since childbirth is designated as a medical procedure, the government needs approval from the Corporation professionnelle des médecins du Québec (the professional body representing physicians) in order to grant midwives legal status.

In February 1989, the corporation's president,

Dr. Augustin Roy, was quoted as saying, "it would be scandalous to recognize midwives before we deal with women giving birth in poverty." Roy added that a genuine perinatal policy was needed and should be given priority for funding before recognizing a new profession.

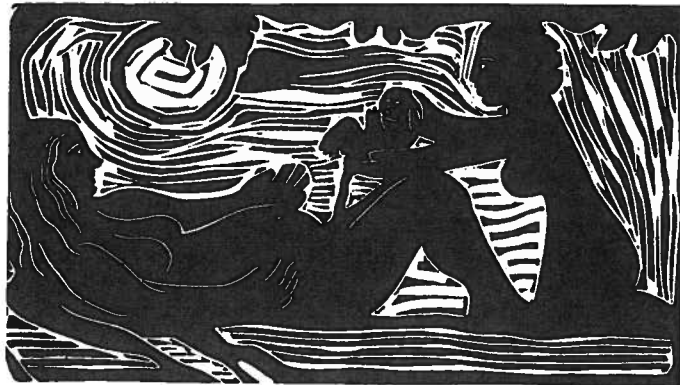
L'Alliance des sage-femmes (Alliance of Midwives), which

represents 200 midwives in Quebec, believes that government-funded midwifery projects for poor women would not interfere with the corporation's priority.

"Midwives spend more time with women discussing nutrition, exercise, relaxation and alternative remedies. We provide comprehensive information about pregnancy

and birth as well as offering psychological and social support. Since we go to the woman's home for appointments instead of her coming to us, we gain an understanding of her milieu and are able to involve her partner and/or family. These factors would likely ensure a healthier pregnancy and baby for low-income women," says Marie-Paul Lanthier, a practising midwife. Lanthier questions why the physicians' corporation had done little in the past to assist low-income women and suddenly now decides they must become a priority. According to Lanthier, the corporation's statement is one more way of resisting the legalization of midwifery.

MARION LOKHORST



Susan Barsel

Support for miscarriages

A Canadian newsletter is available to women experiencing single or multiple pregnancy losses. *Shattered Dreams* was begun by Ontario resident Cathy McDiarmid two years ago.

"After my fifth miscarriage, I looked around for a support group," says McDiarmid. "I had been to a group for women who'd lost full term babies, but it didn't meet my need. They talked about holding their babies, taking pictures, having funerals — things you can't do after an early miscarriage."

When *Shattered Dreams* was born, McDiarmid had no idea how large a gap in services her newsletter would fill. The quarterly publication

crosses international boundaries into the United States, Germany, Australia and India.

Sixty to 70 per cent of women never learn why they miscarried. The lack of research may be due, in part, to the perception of miscarriage as a "woman's problem."

"There's also the problem," says McDiarmid, "of finding subjects for research studies." One recent line of study suggests that women with allergies, migraines and other immune disorders are particularly susceptible to miscarriage. In double blind studies, says McDiarmid, one group of subjects is given a potent drug such as

prednisone to suppress the immune system. The control group receives nothing. Participants don't know which group they are in until the study is over.

"When readers ask if I think they should participate, I don't know what to say. The research may help prevent miscarriage in the future. But what if the drugs save the pregnancy but cause deformity? What about the women in the control group who may continue to experience the guilt and grief of repeated loss?"

"Some of these women have experienced eight or nine miscarriages, and no full term pregnancies. This is not a situation of earning a few

bucks to help someone out with their research. This is life and death."

Shattered Dreams reports on current research, reviews books, publishes stories, poems and letters, and maintains a resource list. But McDiarmid believes the announcement of long awaited, successful births offer readers the most hope.

Subscriptions to *Shattered Dreams* can be obtained by writing Born to Love, 21 Potsdam Road Unit 61, Downsview, Ont. M3N 1N3, or by calling (416)663-7143.

LYNNE MELCOMBE

Northern women at work

In the last few months, the Northwestern Ontario Women's Health Information Network (WHIN) has been busy.

A dinner and discussion to explore the feasibility of establishing a women's health clinic in Thunder Bay was held in late January. The event drew over 60 lively and enthusiastic participants. The consensus was that there is a

definite need for such a centre in Thunder Bay. The next step is to build a broad base of support from across the community.

The "What Can I Do" Resource Kit project is in its final stages of completion. This kit will be a guide for women who want to make changes in the health care system. It will contain sections on how to get onto a hospital

board or district health council, how the structures of the federal and provincial health departments work, etc. A video component is being produced as well. This kit will be available for distribution in April, 1989.

The last chapters of the booklet for women who have to travel out-of-town to give birth are being written. (See *Healthsharing*, Winter 1989.)

The expected distribution date is being moved up to allow for an evaluation of the booklet by women who must travel out-of-town to give birth. The book will be available by September, 1989. To obtain free copies contact Dianne Lai c/o WHIN, 8A N. Cumberland St., Suite 17, Thunder Bay, Ont. P7A 4L1. (807) 455-1410.

HEATHER WOODBECK



Joanne Dyck

Episiotomy study

Twenty-five years ago tonsillectomies were a standard surgical procedure whose benefits were unquestioned among medical circles. In 1989, tonsillectomies are rarely done. A major study now underway in four Montreal hospitals may influence whether episiotomies will go the way of the tonsillectomy or continue to be performed at their current rate. (An episiotomy is a surgical incision to the vagina to widen the birth canal just prior to birth.)

Among women giving birth to their first baby in a Canadian hospital, 70-90 per cent will have an episiotomy. The use of episiotomy in emergency situations is not in question. It can hasten the birth when either the mother or baby are in physical distress. However, since the 1950s, the majority of physicians have performed

episiotomies on a routine basis on the grounds that it facilitates birth, avoids severe tears of the vagina and prevents a woman's bladder, uterus and rectum from descending after giving birth.

According to Dr. Michael Klein who is heading the Montreal study, it has not been proved that the use of episiotomy is responsible for a decrease in these problems. Dr. Klein stated that one of the main goals of the research is to examine whether it is episiotomy that has led to fewer cases of bladder descent and incontinence or whether better health care, improved nutrition and women having fewer babies may be determining factors.

The duration of labour is a factor that has been carefully studied in relation to the procedure. The extra time it takes to avoid an episiotomy has been shown to be safe for both mother and baby. What

has not been systematically examined is whether an episiotomy is less painful and heals faster than a vaginal tear and whether it reduces serious vaginal tears.

How a woman feels about the procedure and how it affects her sexuality are important issues that will be considered in the research. For example, some couples delay having sexual intercourse for several months

due to the pain and discomfort of a healing episiotomy.

Determining the impact of episiotomy (or absence of one) on the physical and psychological health of childbearing women makes this an important and timely study.

For more information concerning the study, call (514) 340-7513.

MARION LOKHORST



Smokefree

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

also FEMINIST PSYCHOTHERAPY
and DREAM ANALYSIS

VDT hazards

Two studies in the past year have indicated again, the potential reproductive hazards connected to video display terminals (VDTs). In a June 1988 study, researchers from a medical clinic in Oakland, California found that women who use VDTs more than 20 hours a week in their first three months of pregnancy, had nearly two times as many miscarriages as non-VDT users. No increase in pregnancy problems was found for women who used VDTs less than 20 hours a week. Although the miscarriage rate of clerical VDT users was nearly two and one-half times greater that of

clericals who did not use computers, the pregnancy experience of managers, professionals and technical or sales staff did not differ greatly with the addition of VDTs. The study points to stress of the typical clerical VDT worker's job as being significant in causing pregnancy problems.

However another study has found a definite correlation between radiation exposure and problematic pregnancies. In April 1988, researchers from six laboratories around the world released results of "Project Henhouse" which found that weak, pulsed magnetic fields similar to VDT

emissions, caused the embryos from exposed chicken eggs to exhibit significantly more abnormalities than unexposed chicken eggs. This confirms results from earlier studies done with mice. These studies call for immediate action which should include the following steps:

- VDTs should be shielded to reduce emissions
- pregnant employees should be given the option to transfer to reduce their VDT hours.
- VDT jobs should be better designed to reduce stress.

JO-ANN MINDEN



Yukon women's conference

More than 150 women attended the 10th annual Yukon Women's Conference in Whitehorse the weekend of March 10th, 11th and 12th. The Conference centred around the theme "Who's in control? Sex, Reproduction and Intimacy in the 1990s," and included workshops, panels, films and videos.

Connie Clement, a founding member of *Healthsharing*, presented an informative and thought-provoking session entitled: "Reproductive Technology — Toying With Mother Nature." She provided up-to-date information on New Reproductive Technologies (NRT) and addressed some of the compelling social, ethical and economic issues that surround these developments.

It is often hard to relate to medical advances when you live in the Yukon and have virtually no access to these services. In the case of NRT however, geographic isolation may be to our benefit. Nonetheless, we were

impressed by the need for involvement, the urgency for all Canadians to become informed about the so-called "advancements" and issues surrounding NRT, and the importance of making our opinions known. We discussed some concerns around a proposed Royal Commission on reproductive technologies, the greatest being who would be appointed to sit on such a Commission and what action could be guaranteed after a report was completed. This related well to the theme of the weekend: "Who's in Control?"

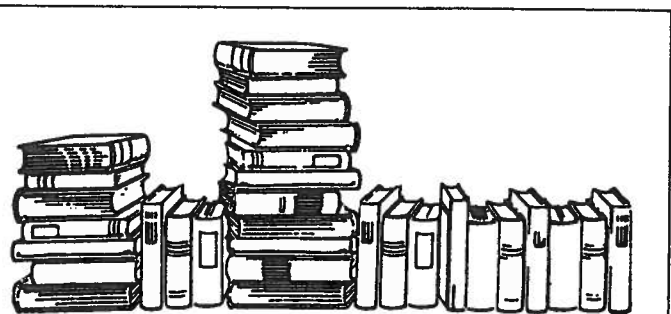
Many of the other workshops over the weekend emphasized that most of our choices from birthing to healing are controlled by economic and political powers that rarely have the best interests of women at heart.

I hope conference participants came away with a strong sense that we cannot sit by and idly accept the scientific experiments and

technologies that are affecting our lives. We must actively question federal allocations of funding, making comparisons between departments such as Defense and Health or Education, as well as allocations within departments. We must question why most health funding supports the allopathic medical model

which promotes surgical intervention and drug therapy rather than a more holistic approach involving proper diagnosis and prevention. And most of all we must question continuously and loudly the basic question — who *is* in control?

LORENE BENOIT



AND THE WINNER IS. . .

Congratulations! to Ms. Jane Murphy, the winner of Healthsharing's mini library of books contest advertised in Vol. 10 No. 1. We thank all our subscribers who gave gift subscriptions and all those who renewed their subscriptions.

Prescription questions

There may be more to "getting what the doctor ordered" than just handing a prescription to the pharmacist.

In a recent case in Calgary, a doctor prescribed a course of antibiotics for a child's ear infection. It was stressed that the treatment was to run a full 10 days to be effective. When the mother had the prescription filled, the pharmacist told her that the

amount dispensed was "slightly" short but that it would be enough and would avoid the needless expense of mixing the full amount. Near midnight, with a sick child, this sounded reasonable.

Within a few days however, it became apparent that the amount of medicine dispensed was more than slightly short; it would in fact run out a day and a half before the

prescribed time. In the course of several follow-up visits to the doctor and pharmacist, the following facts emerged:

Doctors do mean their prescriptions to be followed to the letter and write prescriptions in standard amounts that a well-stocked pharmacy can fill. And while most pharmacists do dispense exactly as prescribed, some draw on their own rigorous medical training to fit dosages to a smaller, more cost-efficient stock of medicines. For example, the prescription in this case called for 225 millilitres of medicine, but the stuff was only stocked in 100 ml units. To provide the extra 25 ml would either require stocking odd sizes or else paying for three units and wasting most of the third. Pharmacists differ on whether the abbreviated prescriptions are proper.

The parties in this case did eventually negotiate a satisfactory settlement. The point for caregivers to note is that they can avoid the problem altogether. This could be especially important for those new to the language or to someone trying to assert their feeling with the person behind the raised counter. Complex checking and calculation are not necessary; just explain your concerns to your doctor and ask her to write "fill exactly as prescribed" on the slip. This way you need not be forced to decide on the spot whether less is enough. And if any difficulties arise at the pharmacy, let your doctor know. A firm word from her to the pharmacist will ensure that you get "what the doctor ordered."

R. KUBIK

Naturopathy under attack

The final report of the Health Professions Legislation Review tabled in the Ontario Legislature last January recommends the deregulation of naturopathy as a health care profession in this province. According to Pat Wales, President of the Ontario Naturopathic Association, deregulation would effectively eliminate the practice of naturopathy in Ontario because approximately 75 per cent of what naturopaths are currently licensed to do would be assigned to the jurisdiction of other regulated health care professions. Anyone performing these procedures who is not licensed under the proposed act will be liable to prosecution. Yet naturopathy has been a regulated profession in this province since 1925 offering the Ontario public a comprehensive system of health care oriented to preventive medicine.

Naturopathy fills a critical health care need by providing a wide range of diagnostic and therapeutic services, based on a complex and distinct body of knowledge. These practices, which include nutrition, botanical medicines,

homeopathy, physical therapies and acupuncture, are designed to stimulate and support bodily functions through non-invasive means.

The proposed legislation will deny Ontario health care consumers access to a viable preventive health care system and severely restrict the range of health care services. The only way our right to seek alternative health care can be protected is through public action. If you are concerned about freedom of choice in health care in Ontario:

1. Write or call Health Minister Elinor Caplan, Queen's Park, Toronto, Ont. M7A 1R3.
2. Write or call your local MPP. If you do not know your MPP's name, call (416) 965-3535 to find out.
3. For further information and to offer your support, contact the Ontario Naturopathic Association at 4195 Dundas St. W., Suite 213, Toronto, Ont. M8X 1Y4, (416) 234-5560, or the Citizen's Alliance to Naturopathy, P.O. Box 277, Station A, Islington, Ont. M9A 4X3, (416) 620-0076.

CAROL D. YAWNEY

Science Morality and Feminist Theory



edited by
M. Hanen
and K. Nielsen

A collection of original essays in Feminist Theory. Stress is put on method, critiques of morality and science and Feminist reconstruction of theorizing in those domains.
November 1987, 434 pp, \$14.00 paper + P&H

University of Calgary Press
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Calgary Alberta, T2N 1N4

Anne Pierre

Into A Wood

*There was a man who was no good ...
Took a girl into a wood ...
Bye bye blackbird ...*

My father was singing in his husky Irish tenor as he drove. I shifted uncomfortably in the back seat of the family two-tone Chevrolet. Those were the only words to the song that he seemed to know. It trailed off, unfinished in its dark intent. He repeated the tune in a low whistle.

Bye bye blackbird ...

I am nine years old. Nine years old, in the bathroom, experimenting with Daddy's razor. I marvel as it cuts a small clearing on the tiny blonde forest of hairs on my forearm. Then on my shin. Just a little patch. It looks clean and smooth. Then I turn the razor to the soft longer hairs that have recently and disturbingly appeared under my arms. Just a little patch. My experiment is finished. I hoist myself up onto the sink to put the razor back in its place on the top shelf.

Later that morning my father summoned me sternly into the bathroom. The illicit razor was in his hand. Caught. Didn't I put it back in the right place? Did I break it? I try to gauge my wrongdoing by the measure of his anger. He locked the bathroom door.

"Did you use my razor?" he demanded. His dark eyebrows knitted closer together. There was no room to step away in the close confines of the bathroom. I backed into the toilet and then stumbled awkwardly over the weigh scale.

Maybe I didn't tighten the handle properly. Is he going to hit me?

"I, I did use it. I'm sorry," I stammered. "I won't do it again."

"Where did you use it?" he menaced. I squinted and ducked against the anticipated blow.

"Show me what you did," he demanded. No blow.

I stretched out a forearm weakly indicating the little denuded patch.

"Where else?"

"My leg."

"Show me."

"Where else?"

"Here." I was crying quietly, caught in my guilt and trespass.

He lifted my arm and brushed a forefinger along the remaining tuft of hairs. His eyes grew distant as he ran his fingers over the bud of my left nipple.

"That's nice," he purred. His eyes blinked now at regular intervals. Blink ... blink ... blink ... blink ... blink ... like the blind eye of a lighthouse. He seemed different.

He touched the pink nipples again.

I came to the slow conclusion that he was not going to hit me.

"Did you use my razor anywhere else?"

"No," I said. "No I didn't."

"What about down here?" he suggested reaching down my pants.

"No, I didn't, I didn't," I pleaded, trying to scoop his hands away.

"Let me see, let me see ...," he said in a low soft insistent voice that I had never heard before.

"But I didn't use it there ..."

I don't know how long I stood half naked in goose-bumps in the bathroom watching his eyes blink as his hands moved over me. My relief at not being hit was clouded by shame and confusion.

blink ... blink ... blink ...

Sitting in the back seat of the Chev, my father was at the wheel.

Was a man who was no good ...

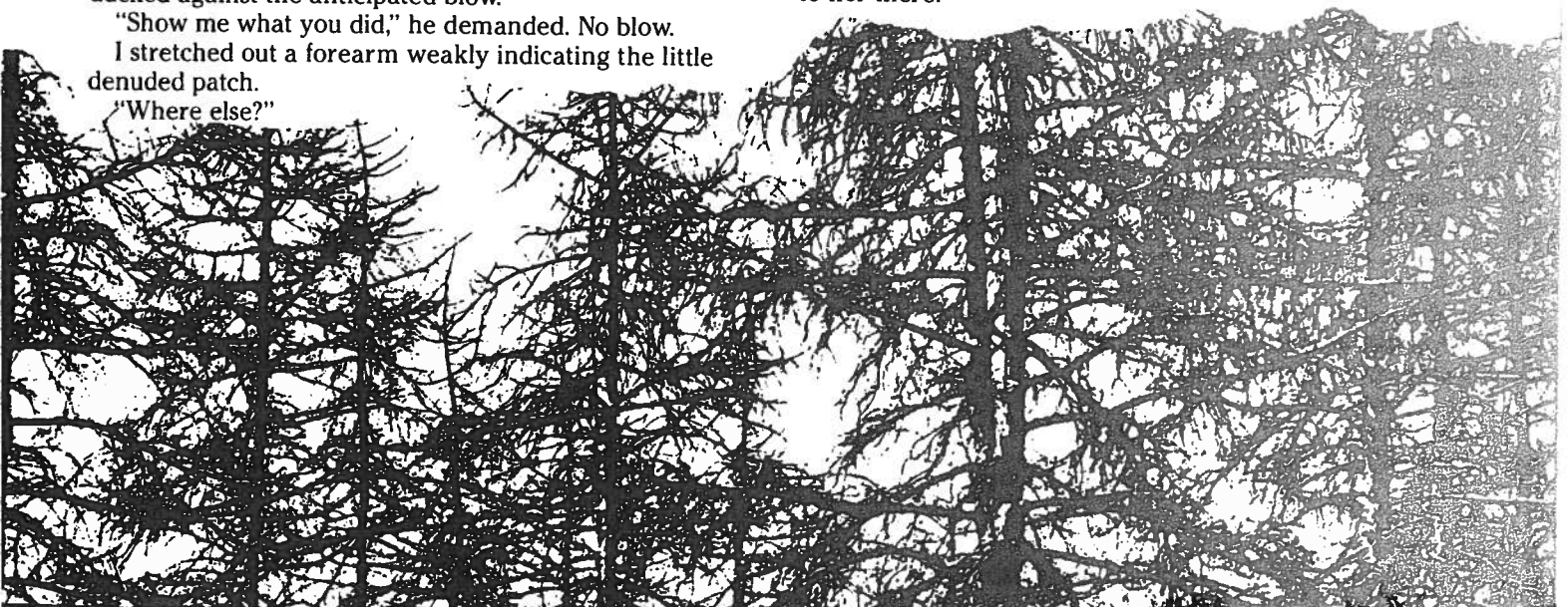
I looked at Mom's impassive face.

Took a girl into a wood ...

I watched my brothers fight over the comics.

Bye bye blackbird ...

I looked out the window and wondered what happened to her there.



I was the girl in the story *Into a Wood*. Unfortunately, the story did not stop there. The abuse continued, and intensified for three years. This is a difficult story to write, but I think that it is important for readers who have not experienced child sexual abuse to understand how destructive it can be. It is important for those who have experienced it, to examine their experience as adults and to be compassionate and caring enough with themselves to heal the wounds of childhood.

Child sexual abuse is a very common experience. A number of scholarly works have shown that one in three girls and one in four boys have experienced highly invasive sexual assault before the age of sixteen. Much child sexual abuse takes place in the family. Most often the perpetrator is a man; usually the father or stepfather. It is a problem that transcends social class and race. It is a problem.

The time has come to speak of family secrets. Children who are experiencing child sexual abuse are frequently too intimidated to be able to speak. Adult perpetrators, especially those within the family, have all the authority, power and privilege. As the story illustrates, they know how to exact the compliance of a child.

"It was a long time ago. Why don't you just forget it?" For too long the sentiments behind these words have underscored our whole approach to the issue of assistance to incest survivors.

Child sexual abuse has consequences for those who experience it. It is not unlike the impact of rape or other sexual assault. Response and recovery is personal and may vary greatly from one person to another. It may affect how we view ourselves



Bernadine Arsenault

Speaking Honestly About Incest

and how we relate to others.

Let us return to the young girl in the story. When my father initiated a sexual relationship, I lost him as a father. I could not trust him to undertake my best interests. If I was nice to him, I could not trust that he wouldn't understand it as a sexual invitation.

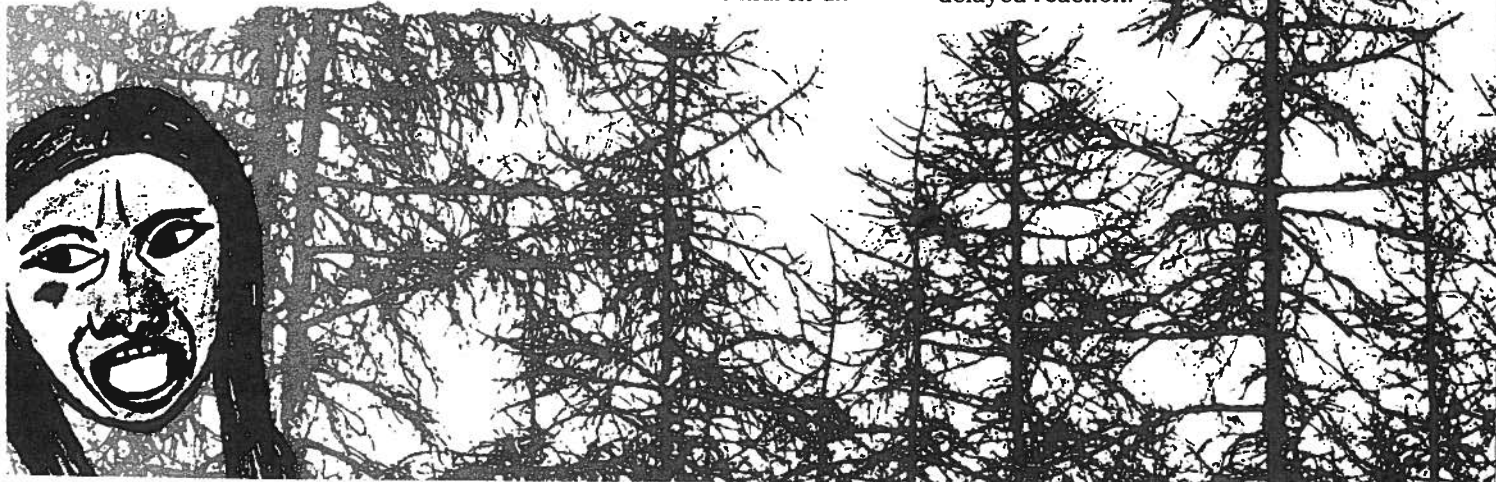
I had a close relationship with my mother as a child. I had been afraid to tell her what Dad was doing. At first I was only afraid of his anger. Later, as I came to understand that what he did with me he also did with her, I was afraid of her anger. I was 10 years old. I needed my mom. I kept silent.

At 12, I was maturing. I started to menstruate. My father was moving closer and closer to intercourse. I was finally so afraid of being raped, that I told my mother about it.

I was believed. This is unusual. In most instances when children dis-

close sexual abuse to their mother, they are not believed. I believe this is because the mother does not have the emotional support to deal with a problem of this dimension nor the economic means to leave her husband. The mother is asked, in effect, to choose between the child and the husband. In the absence of support, she may not have the strength or conviction to act. The child is silenced. And in the silent aftermath the betrayal spreads. Father, mother, brothers, sisters, family, neighbours, community, church are all too often careful to distance themselves from the ugly truth.

Incest survivors are well versed in betrayal. When a parent, someone whom a child must trust for basic survival, is prepared to exploit a child's defenceless trust, for their own gratification, a child may grow up not trusting anyone. There may be a delayed reaction.



Despite my mother's initial supportive reaction, later she decided to mend her marriage with my abuser and suggested I leave. It was years later that I noticed I was constantly looking for a home, and always walking away. I realized that I was not out of the woods.

I have decided to look at how my early family experiences have affected my life. It was painful to confront the feelings of anger, shame, powerlessness and humiliation that I experienced as a child. But neither do I wish to act out that destructive legacy in my adulthood.

At 25, I was afraid to go home. Af-

raid because my father resumed a sexual interest. On my infrequent visits he would attempt to corner me in the basement and run his hand up my blouse. An adult by any measure, and I was still afraid to go home. Later that year, a stranger in a bus ran his hand up my thigh. To my shame, I did nothing. It was too hard to put it together. I went to a therapist to discuss it.

Incest has an impact. The statistics are compelling. Boys who are abused may become perpetrators when they grow up. Girls grow up and find themselves in relationships that mirror their abuse as children. But this

need not be the case. If we as a country, as a culture, can look at child abuse honestly, speak honestly and act, these tragedies of childhood need not cripple their victims nor be perpetuated in succeeding generations.

In writing this article I looked for resources that we might turn to, centres of leadership in this area of social policy. I have been frustrated on both counts. But I can only be impressed with the increasing number of women who are speaking, writing and organizing on this topic.

There are some resources available to adult survivors of sexual abuse, but much needs to be done to investigate and alleviate the problem in the fields of child welfare, social work, therapeutic intervention and justice systems.

If you are an incest survivor who would like to look at the question more closely, these options are readily available:

1. Read *My Father's House* by Sylvia Fraser, a beautifully written account of one woman's experience; *Courage to Heal* by Ellen Bass and Laura Davis, an excellent self-help resource; "The Secret Trauma: Incest in the Lives of Girls and Women" by Diana E.H. Russell, a survey of social incidence and impact of incest.

2. See the film: *To a Safer Place* produced by the National Film Board and available at no cost.

3. Discuss your feelings with people you trust.

4. See a therapist.

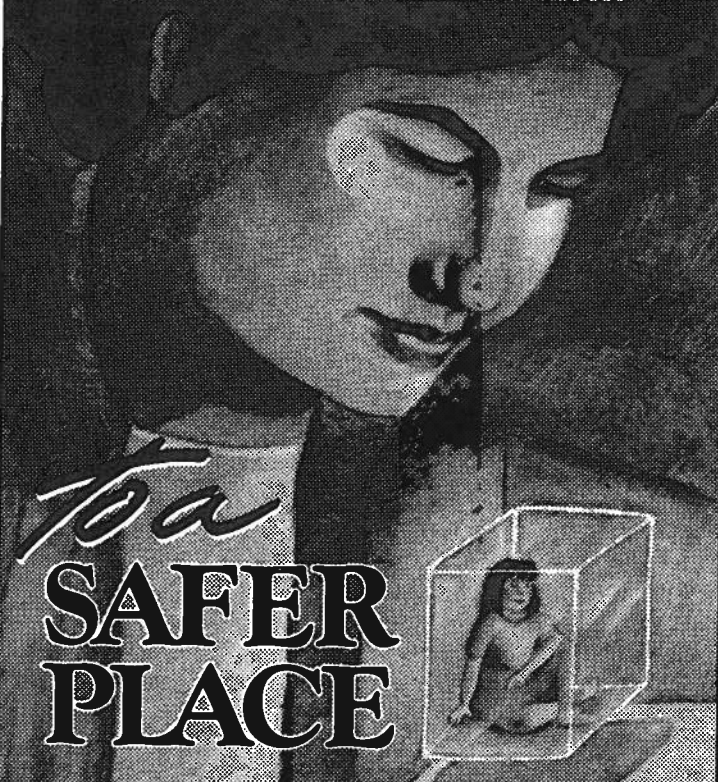
5. Join a group of incest survivors if there is one in your community. Phone your local women's centre or sexual assault centre to find out if there is a group you could join. If not, start one.

Child sexual abuse is a topic that causes discomfort, denial or despair. But the evil of child sexual abuse can only proliferate in the shadow of our reluctance to speak out against it. As survivors, parents, sisters, brothers, social workers and legislators, it is high time we came out of the woods.

Anne Pierre lives in Toronto and works for social change in the area of women's rights and social services.

From the National Film Board of Canada





One woman's account of her life as a survivor of childhood incest



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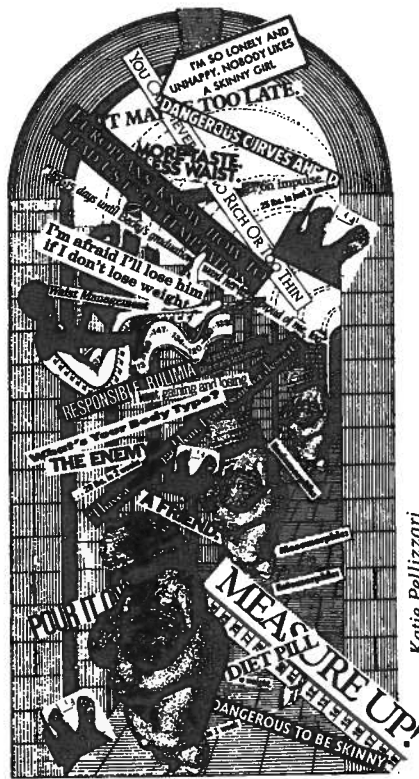
Donna Ciliska and Carla Rice

Body Image/Body Politics

Three months ago, I felt so awful about how fat I looked! I was desperate and determined to lose weight so I went out and joined three weight loss programs at once, paying out over \$3,000 in the process. As usual, I lost weight for the first three weeks or so, leveled off for a short time, became discouraged at the lack of results, figured "Why am I killing myself sticking to these diets?" and went on a binge. So here I am, weighing more than I ever have!

Beyond Dieting participant

You might think this quote is from a very "over" weight woman. [The term "over" weight is used here acknowledging that there is no good word to describe being fat. We have chosen to use the term "over" weight when speaking about the medicalization of body fat to communicate that although a fat woman may be considered at an unhealthy weight according to medical standards, she may be at a weight which is normal and healthy for her. We also use "fat" — not in a negative sense — but to reclaim the word and our right to be/have fat.] This woman was, in fact, 35 pounds higher than the average weight for her height and age by Canadian statistics. Moreover, her comments echo the concerns of any number of women of all shapes and sizes who have struggled with weight and shape issues: whether a woman is fat or is pre-occupied about *having* body fat, she has been bombarded with images of what successful women look like. She has been filled with insecurity around her body and



Katie Pellizzari

By far the majority of participants are heavier one year after beginning a weight-loss program than they were on entry.

as a result is pre-occupied with fears that it does not meet socially constructed ideals.

The woman quoted is fairly typical of the nearly 150 participants in Beyond Dieting — a program in Toronto which offers large women an alternative to the usual weight loss fare. Most have gone, for lifetimes, the rounds of the various clinics, commercial centres and self-help books and articles. Most are like the woman above, in that they are uniformly successful at short-term weight loss and uniformly unsuccessful at maintaining the weight loss. Why is there a need for an alternative to dieting?

Both of us became interested in weight pre-occupation and alternatives to dieting after struggling with weight and shape issues in our own lives. In her early 20s, Donna compared her body to fashion magazine dictates, concluded that it did not measure up and spent money and time on self-managed diets. Later she helped to develop and offer a weight-loss program which incorporated the most up-to-date ideas about diet, exercise and group support. It quickly became evident that the participants were sincerely following the program, would typically lose weight initially, reach a plateau, get frustrated with the lack of progress, binge and end up at a higher weight than when they started the program.

Carla felt the effects of weight prejudice as an "over" weight child and internalized the fat phobic attitudes that were constantly directed towards her. Through the process of

Hersize

Hersize, a weight prejudice action group, was founded almost two years ago, to increase public awareness of the ways that our culture's obsession with thinness and prejudice against fat oppress women. The idea to engage in political work around weight prejudice grew out of the discussion between four women who had personally struggled with weight issues and who were interested in forming an advocacy and education organization to address the issue. From this idea came Hersize, a group dedicated to increasing public awareness of fat oppression, freeing women from overconcern with body size and shape and preventing eating disorders. Today, our activities and services include conducting a media watch and letter writing campaign concerning inappropriate messages regarding women's weight and shape, developing alternative frameworks in which to understand weight preoccupation, engaging in public speaking, publishing a newsletter and developing educational materials.

For more information on Hersize call: (416) 535-4653 or write Mary Dahonick, 223 Concord Ave., Toronto, Ont. M6H 2P4.

confronting and resolving weight issues, we both began to perceive some of the psycho-social and political implications of weight preoccupation.

The Cult of Thinness

The reality in the Western industrialized world is, and has been for most of the 20th century (certainly since Twiggy) that "thin is in." According to one North American study, the ideal (as measured by Miss America contestants and *Playboy* centerfolds) has become thinner and more "tubular" over the past 20 years — down to 76 per cent of average weight, while the average weight for women has gone up about five

What is needed now is for women and men to be able to accept variation in body shapes as we accept variation in height.



pounds. Another study done by Susan and Wayne Wooley of Cincinnati for *Glamour* magazine, found that 75 per cent of females rated themselves as "too fat" even though only 25 per cent could be considered "over"weight. Canada's 1985 Health Promotion Survey, moreover, showed that 45 per cent of Canadians of "normal" weight, and 7 per cent of those underweight still wanted to weigh less.

The wide gap between ideal and reality leads many women to feel that we have failed and that we lack the ability to "measure up." Moreover, most of us learn to internalize this social construction of the female body as our own and vigorously diet and exercise in an attempt to close the gap. Janet Polivy and Peter Herman at the University of Toronto have shown that dieting among women has become the norm — that it is actually more common for young women to be on a diet than not. Even more shocking is a study by a group in Ottawa which found that female children as young as five years of age expressed dissatisfaction with their bodies and fear of getting fat.

The cultural pressure for thinness and the related prejudice against fat contribute directly to low self-esteem among "over"weight women. Fat women are still the brunt of jokes by many professional comics and cartoonists. As early as six years old, children describe the "over"weight as "lazy," "stupid," "ugly," "cheats" and as "less likeable." Health professionals rate them as more disturbed and likely to have less favourable results from treatment than "normal" weight clients. As well, "over"weight obese have lower rates of acceptance

to college, reduced likelihood of being hired for jobs and lower rates of pay. *Industry Week* magazine reported in 1974 that male executives lose an estimated \$1000 in wages per pound "over"weight per year. This leaves us wondering how much more severe the punishment is for fat women who make it to that level!

Prejudice against fat is most often a gender specific form of discrimination. As the statistics have shown, it is primarily women who learn to equate thinness with personal worth and allow body shape to determine self-esteem. It is also primarily women who are most often harmed by fat phobic attitudes. In a culture where women are taught that our social value as women is equated with appearance, we learn that the only way we can legitimately access power as women is by achieving and maintaining the socially constructed ideal of beauty. In other words, we are told it is only when we can approximate the ideal (by becoming obsessed with our appearance and its consequent cycle of diet, over-exercise, binge/purge and starve), that we are entitled to like and feel good about ourselves and perceive ourselves as "successful" and "powerful" women.

"Natural Weight"

As if the negative effects of living in a culture which idealizes super-thin and equates women's value with their physical form were not enough, the fat woman's body supports a physical conspiracy against weight loss. The body does not discern the cultural or internalized preference for the thin ideal. It has built-in survival mechanisms which interpret lower calorie input as famine. Many researchers are working on the theory that there is a "set-point" or biological control for amount of body fat in the body, around which the body allows only slight variation. The adaptive mechanism is such that if you try to create a deficit in the number of calories available to the body (such as by exercise and/or food restriction) the body becomes very "thrifty," shutting down the metabolic rate or the furnace which uses up calories. When that happens, any activity, including rest, uses fewer

calories than if you were maintaining your usual calorie balance. Similarly, an effort to gain weight leads to an increase in metabolic rate so that there is a limit to the amount of weight gained and excess calories are burned off as heat. Simply put, calorie use is influenced by calories taken into the body.

In our culture, the condition of reducing calories to slow down weight gain or promote weight loss is not often viewed as a problem for women. However, the body's attempt to conserve calories is a problem for many weight pre-occupied women. Weight loss attempts become a "no win" situation where, like the woman in the introductory quote, weight loss slows down after a period on the diet causing the dieter to become discouraged and break her diet plan — right at the point where her metabolism is at its lowest. She then eats more than she would normally to deal with her nutritional and emotional deprivation and weight gain takes place at a faster rate than if she had never dieted, usually resulting in a rebound gain higher than before the diet. The body is so adaptive that, unfortunately, it becomes better with practice — faster at slowing down the metabolic rate with each diet and faster at regaining weight after every diet is broken.

The theory of "set-point" is that each of us has a level of body fat, somewhat like height, which was probably determined by a combination of genetics and very early nutrition. Each of us has our own "natural" body weight which may be very different from what our culture tells us is the ideal. Thus, a woman may be at her set-point at 175 pounds, be very physically healthy and highly unsuccessful at maintaining a lower weight. Similarly, someone else may be underweight by the height and weight standards tables, but be at her body's "natural" weight.

Medicalization

"Over"weight is considered to be a major problem in most Western industrialized countries, where anywhere from 10-50 per cent of the adult population is fat, depending on the measurement techniques and standards used. Medical conditions

In a world which accepted and celebrated variation in body shape and size, our buses, subways, theatres would be redesigned for comfort and ease.



such as hypertension, diabetes, cancers and heart disease are commonly cited as related to "over"weight. Unfortunately, many health professionals and the general public translate "related to" to mean "caused by," that is, they assume body fat causes medical problems. Thus, "over"weight, itself, has been labelled as both a physical and psychological disease. In reality there are many "over"weight women who are quite healthy. Some analyses of major population studies have concluded that having a moderate amount of body fat is even associated with some lessening of health risks.

Some of the confusion results from the fact that there are many factors which could lead or contribute to the development and maintenance of a high weight. Sclafani, an American

researcher, has identified 50 known causes of obesity in animals. It is likely that most of these causes and probably other factors, contribute to fatness in humans. Therefore, it is reasonable to expect that some of these factors would be associated with health problems and some would not. Similarly, it appears that the location of body fat is more important than the amount of fat. "Pear" shapes (most women) are much less likely to have diabetes or heart disease than the "apple" shapes (most men).

Given the cultural expectation and the discrimination which exists against fat people, it is surprising that emotional problems are not more common in the "over"weight than in average weight individuals. As mentioned earlier, it is more common for those of us who are fat to dislike our bodies and express dissatisfaction with them. But so-called psychoses, neuroses and personality disorders are no more common among fat people.

Generally, in our society, health care professionals see "over"weight as a danger sign or in very moralistic terms, implying personality faults, weakness of will or laziness. The experience of most Beyond Dieting participants is that health care professionals often treat them as social deviants and attribute any complaints that they have to their

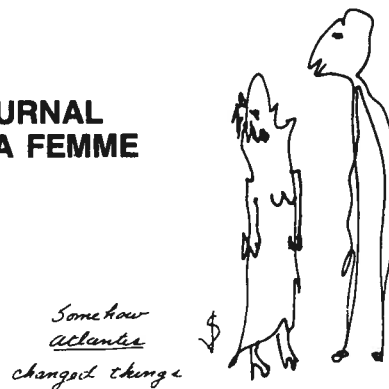
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weight, advising weight loss for anything from a vaginal infection to the common cold. Unfortunately, many well-meaning family and friends use the same rationale in attempting to help motivate fat women to lose weight. Out of ignorance, others encourage weight-loss programs for the "over"weight, assuming that all are able to lose weight and maintain the weight loss with a little work.

Dangers of Dieting

Recently, researchers have begun to question negative effects of the diet craze and have looked critically at claims of effectiveness and lack of harm. It is hard to get information about commercial weight-loss programs but the best clinical programs all have positive results in producing weight loss. The catch is that they all produce similar dismal maintenance of weight loss with a rate of 65-95 per cent regain at the end of one year. By far the majority of participants are heavier one year after beginning a weight-loss program than they were on entry.

Not only are diets ineffective in the long run, but it is now clear that they

have their own set of hazards. In addition to inadequate nutrition and its consequences, dieting has been implicated in the development of weakness, depression, irritability, fatigue, social withdrawal, loss of sex drive, "semi-starvation neuroses," binge eating, bulimia, weight gain and "over"weight and sudden death from damage to the heart. Some of the association of body fat with diabetes and heart disease may be due to repeated dieting, not to the "over"weight itself, as a few studies have shown that harmful fats in the blood are elevated and glucose tolerance is impaired (a sign of diabetes) following a diet.

Susan and Wayne Wooley in Cincinnati have asked the question, "Should obesity be treated at all?" They feel that "over"weight should not be treated because: treatment is mostly unsuccessful, there is evidence for biological control over weight (set-point), a lack of clear evidence that obesity alone is a health risk factor, and that stringent cultural standards of thinness for women have been accompanied by a steadily increasing incidence of severe eating disorders.

The Wooleys suggest that what is really needed is to vigorously treat weight obsession and its associated problems: poor self and body image, excessive or inadequate exercise and disordered eating patterns, metabolic depression and inadequate nutrition caused by dieting. This has become the goal of the Beyond Dieting program.

"Over"weight women from the community are self-referred to the National Eating Disorder Information Centre, where the Beyond Dieting program is located. Even though "over"weight is not considered an eating disorder per se, the women who come often have eating problems as a result of years of dieting. They have unlearned how to respond to hunger and fullness signals, and often do not eat when they are hungry, restrict their food intake for a part of the day or week, then binge for a period of time. Therefore, in addition to educational issues, a primary focus of the time together is in defining what is normal eating, how to relearn hunger and fullness, and how to return to a pattern, amount

As early as six years old, children describe the "over" weight as "lazy", "stupid", "ugly", "cheats" and as "less likeable."



and quality of food intake that will maximize health. This includes getting rid of the "forbidden food" list, which means learning to incorporate the foods that the women usually deprive themselves from eating in order to avoid binging on them when they cannot tolerate the feelings of deprivation any longer.

Another major focus of the group is to generate a feeling of competence and confidence in the body, that even if the participants cannot get to the place of liking their body at its natural weight, they can at least learn to trust that it functions well and appreciate that it allows them to do things they like to do. Many groups and individual exercises are devoted to this purpose, as well as to reducing the relative importance of body shape in determining self-esteem. As Geneen Roth states: "Thinner thighs are not my salvation," my boss, kids, strife in the Middle East will not be changed by reducing three inches from my thighs. Other parts of the program include body image exercises to reduce body dissatisfaction, assertiveness training to develop strategies to deal with discrimination or well-meaning friends who suggest another diet, as well as discussion of appropriate physical activity and strategies for incorporating it with relative ease into daily lifestyle.

A real challenge for the participants is to deal with the ambivalence produced by the information. The first reaction is, "What a relief! I have always known that diets leave me heavier than when I started. Now I don't have to go through that deprivation anymore." Immediately following is the grief reaction over

Beyond Dieting

Beyond dieting was set up to create an affirming alternative to dieting.

The program consists of small groups of eight to 10 women who get together with a trained group leader two hours a week for 12 weeks. Issues are explored and information is shared about cultural pressure for thinness, fear of fat, weight prejudice, health benefits and risks of fat, dangers of dieting and the process of returning to normal eating.

If you have any information about groups or individuals who do counselling in relation to body weight issues, or would like to know if there is such a program in your area, write the National Eating Disorder Information Centre, Toronto General Hospital, College Wing, 200 Elizabeth Street, Room 2-332, Toronto, Ont. M5G 2C4 (416) 595-4156.

realizing that this information means they will never be thin. Much time is spent in the group and in the follow-up support group in dealing with grieving the loss of the dream of thinness.

The formal evaluation of the Beyond Dieting program has indicated that the participants have a significant increase in their self-esteem and a successful return to normal eating followed by dramatic reduction in binge eating. Women reported feeling that the quality of their lives is much improved. Loss of obsessiveness with food allows them more time and energy for family, friends and hobbies. They feel that they no longer have their lives "on hold" — no longer waiting until they lose 50 pounds in order to start an exercise program, go back to school, change jobs, think about their relationships, etc. One woman expressed great anger at herself, her family and society in general for allowing her to keep her life on hold for 55 years. She felt she was finally liberated to live without feeling restricted by her body shape.

Fear of Fat

We do not live in a vacuum. The issues presented here are issues for all women. What is needed now is for a fundamental social and cultural shift to take place, for women and men to be able to accept variation in body shapes as we accept variation in height — as something largely beyond a woman's conscious control. Political action groups such as Hersize, a weight prejudice action group, are working to eliminate discrimination against fat women — discrimination that takes away our power and denies us basic rights.

In a world which accepted and celebrated variation in body shape and size, our buses, subways and theatres would be redesigned for comfort and ease. Fat people would find themselves judged on the basis of their abilities as opposed to their size when applying for jobs. Wages and promotions received would be based on job performance, not on hidden assumptions about body weight. Offices, stores and workplaces would be designed for access and comfort of everyone. Clothes would be designed

in large sizes and available at all stores. Images of fat women would be present in the media, not as a symbol of the exotic or erotic, but as one of many images of strong, creative women.

Each one of us needs to begin accepting and learning to like our natural body size, both as a route to personal health and well-being and as an essential step towards empowerment for all women.

As one Beyond Dieting participant remarked: "I am so liberated! I threw out a whole box of diet books and my scales. My husband would prefer that I were thinner, but agrees that I am much easier to live with since giving up dieting. I am getting on with the important things in life."

Further Reading

It is usually difficult to find these books, but any bookstore will order them for you.

Bennet, William, & Gurin, Joel. *The Dieter's Dilemma*. New York: Basic Books, 1982.

Polivy, Janet, & Herman, Peter. *Breaking the Diet Habit*. New York: Basic Books, 1983.

Schoenfield, Lisa, & Wieser, Barb (Eds.). *Shadow on a Tightrope*. Iowa City: Aunt Lute Book Company, 1983.

Szekely, Eva. *Never Too Thin*. Toronto: The Women's Press, 1988.

Roth, Geneen. *Breaking Free From Compulsive Eating*, New York: Signet, 1984.

Donna Ciliska founded the Beyond Dieting program for the National Eating Disorder Information Centre, while a doctoral student at the University of Toronto. She is currently an Associate Professor at McMaster University, Faculty of Health Sciences and a Clinical Nurse Consultant for the Hamilton-Wentworth Department of Health Services.

Carla Rice is an activist and founding member of Hersize: A Weight Prejudice Action Group. She is also a freelance writer, educator and group facilitator, and is currently working on her Master's in Applied Psychology at the Ontario Institute for Studies in Education.



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HEALTHWISE

Cervical Cap Update

Deborah Redfern

In February 1988, the U.S. Food and Drug Administration, after seven years of testing, gave marketing approval for the cervical cap, a barrier method of birth control used by women in Europe for almost 140 years. Although American and Canadian women have been using caps purchased from England since the early 1980s, the method has never received widespread acceptance here. Perhaps now with the evidence of hundreds of clinical trials and the stamp of approval from the FDA, more women and their health care practitioners may begin to look seriously at the cervical cap as a safe and effective means of birth control.

There is no one reason which explains why the cervical cap has been so slow to catch on in Canada and the U.S. Perhaps the string of disastrous consequences from various IUDs and birth control pills has made women leery of taking on new methods. Doctors who may be unwilling to take the time with women to fit the device and teach them about it may also be partially responsible. And rumours about limited reliability and unpleasant side effects have also probably acted as a deterrent to women. But despite the rumours and detractors there are women all across Canada who have been using cervical caps happily over the years and there are many birth control and women's clinics which provide and fit the caps. The following information should start to answer some of your questions if you think the cervical cap might be the birth control method for you.

What Is It?

Over the years caps have been made of ivory, metal, hard plastic and rubber. Today, although there are different types of caps, the cavity-rim

cap is the most common. It looks like a large rubber thimble and has a firm rib with a hollow groove around the inside. The cap fits directly on the cervix and is held in place by suction. The snug fit of the cap makes the cervix swell slightly (often filling the groove in the rim), which enhances the suction.

Pregnancy Rates

The reported pregnancy rate was found to be similar to that of the diaphragm which *Contraceptive Technology* (1988) gives as 18.7 per cent during the first year of use. Among Canadian studies, rates of 12.9 per cent (Rev, Vancouver) and 16.9 per cent (Johnson, University of Manitoba) during the first year of use, were reported. Most pregnancies resulted from inconsistent use of the cap, dislodgement from the cervix or deciding to get pregnant. About one per cent of pregnancies were thought to be due to failure of the cap.

Drop Outs

Many studies noted a high discontinuance rate. However, reasons for discontinuance differed markedly between studies. In Rev (Vancouver), the majority of women said they "felt unsafe" using the cap; in Schoefield (Calgary), "discomfort to partner" was most frequently mentioned, and in Johnson (Manitoba), "odour" was the major reason for discontinuance.

Reported Advantages of Cap Use

Women liked the cap because it is convenient to carry with them and found it increased their sexual spontaneity. Because no harmful substances are used in this method of birth control, safety is another advantage of the cap. And women reported that the price, \$25, is economical. Many women who had used

both the cap and the diaphragm preferred the cap.

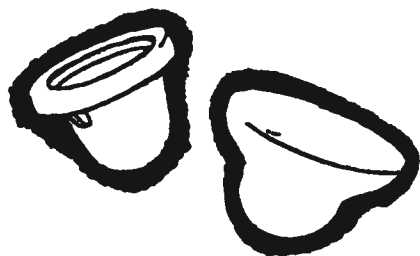
Disadvantages

Among the most common disadvantages women name are: difficulty with insertion and removal, foul odour, concern about reliability, partner's discomfort during intercourse and cap dislodgement. Another disadvantage cited is the length of time to fit the cap and educate users. Fitting the cap alone takes on average 30 minutes, including time for the user to practice inserting and removing it herself. The amount of time given to educate the user about the cap varies — some clinics allot an hour and a half, others a half an hour. (Many doctors would view this process as quite uneconomical — in this hour they could see at least four other patients and prescribe oral contraceptives.) Women who receive a longer session appear to be more positive and confident about using it. A return visit to recheck the placement and reinforce correct use is advisable.

Other Health Factors

In 1983, it was widely reported that the cap caused lesions in the vagina. This was first noted in a study by Bernstein (National Institute of Health), while comparing the cavity-rim cap and the vimule cap, another type of rubber cap with a flanged rim. He discovered that the rim of the vimule cap, which is relatively sharp, could cut into the vagina. This cap is still on the market although not widely used. The same study found that diaphragm users who wore their devices for longer than 24 hours also developed lesions.

However, the cavity-rim cap is associated with cervical changes. Bernstein found changes in the Pap smears of four per cent of cap users — from normal to Class III, a change which indicates a possible precancerous condition. These changes seemed to be caused by either inflammation or human papillomavirus (HPV), the virus which causes genital warts. HPV is routinely found in up to 4.5 per cent of Pap smears for women under 30. For the cap users, most women found their smears reverted back to normal spontaneously. Speculation on the causes of the ab-



L. Emily Elliott

normal smears includes the extended exposure of the cervix to spermicide and the build-up of secretions in the cap when it is worn for several days. Until more is known, it is advisable to limit cap wearing time to 24 hours and to have regular Pap smears.

Where Do We Go From Here?

Longer wearing time (recommended up to three days) was the attraction of the cap for many women in the early 1980s — you could insert it Friday night and other than checking the placement, not have to worry about birth control all weekend. However, the relationship between longer wearing time and cervical changes may mean the end of that practice, thus reducing the cap's attractiveness. With the recommended wearing time reduced to 24 hours, the cap no longer appears to have any advantages over the diaphragm.

But even so, since the FDA approval, there is a fresh-start attitude in the air. What has been needed is an advocate and authority for the cap. It looks like one has arrived. Liz Summerhayes, a nurse-midwife in California, has become the sole U.S. distributor for the British-manufactured cavity-rim cap. Summerhayes believes that establishing the cap's reputation as a safe and reliable method of birth control is critical. To make sure that reputation is fostered and maintained, only experienced fitters will be supplied with the caps. A series of videocassettes, a manual and training centres will provide practitioners with the knowledge they need to become experts on fitting cervical caps. It is not yet known how Summerhayes will deal with Canadian practitioners and clinics who are already fitting and teaching about the cap.

How to Use the Cap

This list of recommendations is compiled from *Contraceptive Technology* 1986-87 and *The Cervical Cap Handbook for Fitters and Users* (Emma Goldman Clinic).

- fill the cap one-third to one-half full of spermicide cream or jelly. Inserting it a half an hour before intercourse seems to enhance the suction.
- the cap should be worn for at least eight hours after the last intercourse.
- remove cap after 24 hours of wear. Three days was the recommended wearing time; past this time the cap can develop an unpleasant odour.



L. Emily Elliott

Since pap smear changes are now associated with prolonged exposure to spermicide and cervical secretions, 24 hours is now the recommended maximum wearing time.

- plan a break of a half or full day between removing and inserting the cap to give secretions an opportunity to flow freely.
- the cap should not be worn during menstruation — theoretically, blockage of the menstrual flow by the cap could lead to toxic shock, although there are no reported cases of this. The menstrual flow or douching may break the cap's suction and allow it to slip off the cervix.
- for the best protection use the cap every time you have intercourse.
- make sure the cap is in place on the cervix before intercourse and again afterwards. If it has slipped off, push it back on immediately and insert an additional application of spermicide in the vagina. Most failures using the cap occur because of inconsistent use or dislodgement. For some women this can happen after a bowel movement, but intercourse is the most common cause.
- replace your cap every six months. A Health and Welfare study found that caps that had been used for

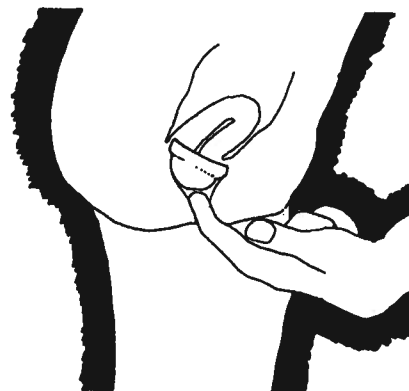
more than a year and worn more than three days at a time showed signs of deterioration and were releasing compounds found in the latex.

No special products are needed to take care of the cap — washing with ordinary soap and water is all that is needed to keep it clean. If the cap develops an unpleasant odour, there are several methods to remove it:

1. soak the cap in one cup of water mixed with one tablespoon of white vinegar or lemon juice for 20 minutes
2. soak the cap in alcohol for 20 minutes
3. put a drop of chlorophyll in the cap when inserting it
4. scrub the cap with baking soda.

Do not soak the cap for long periods as it may swell out of shape.

To make the cap last longer, dusting it with cornstarch — not talcum powder — seems to work. Store the cap away from heat and do not use petroleum products (vaseline) with it; they could damage the cap. Safe lubricants to use are K-Y Jelly or any water soluble lubricant. When the cap is inserted again, always make sure it doesn't have any holes or tears.



L. Emily Elliott

For more information on cervical caps:

The Cervical Cap Handbook, For Users and Fitters available from Emma Goldman Clinic for Women, 715N Dodge St., Iowa City, Iowa 52240.

Liz Summerhayes, Cervical Cap Ltd., PO Box 38003-292, Los Gatos, CA 95301, Tel. (408) 358-6264.

Deborah Redfern lives in Paradise, Newfoundland and works in public relations for the St. John's Status of Women Council.

Linda S. Williams

Behind the Headlines

THE PHYSICAL AND EMOTIONAL COSTS OF IN VITRO FERTILIZATION

In 1978 the first so-called "test-tube baby" was born in England. Since that time it has been estimated that approximately 3,000 IVF babies (babies conceived by means of *in vitro* fertilization) have been born worldwide. IVF Clinics currently exist in almost every country where Western medicine is practiced.

Most women who undergo IVF do not give birth to the baby they so ardently desire. It is estimated that in the U.S. only 4 to 5 per cent of all IVF attempts resulted in a live birth in 1985. In spite of this very low success rate, newspaper and magazine articles as well as the electronic media, tend to focus on these few successes and regularly print pictures of, or conduct interviews with, ecstatic IVF parents. These accounts usually include a brief description of the IVF procedure and sometimes even a limited account of its stresses and strains. However, the harsh reality of the IVF experience is never completely portrayed and the limited accounts which are available tend to be overshadowed by the "happy endings" reported.

This article is an attempt to present the reality of *in vitro* fertilization as it was experienced by 20 Canadian women.

The first phase of the IVF procedure lasts from seven to 10 days and consists of taking Clomid tablets and having blood tests, Pergonal injections and ultrasound scans according to a precise schedule. Most women found the daily routine of having to be at the hospital or clinic very early in the morning for their blood test and ultrasound and having to return in the afternoon for their Pergonal injection very tiring and stressful. Women who continued their paid work during this period had to deal with the added anxiety of being away from their jobs for a large part of the day during the initial phase of the IVF program.

Anne: *You get up so early and you have to be downtown at 7:30 and then you're rushing from the lab to the hospital to have your ultrasound done, and you seem to be waiting there forever and all you can think of is getting back to your job, onto the desk 'cause no one's*

covering you while you're gone for most of the morning. Most times I didn't get back until 11:30. The morning is shot and then you had to leave work at 3:30 or so to get downtown just to wait for the doctor to get in there to let you know if you needed Pergonal or whether you were kicked off the program (cancelled). Then you come home and have supper and kind of hop into bed. You're like a zombie those days. You're tired and you know you have to get up so early again the next morning.

An ultrasound scan must be done with a full bladder and a few women related harrowing tales of having to "hold it" while they travelled to the hospital or clinic for the procedure or while they waited their turn to have it done once they arrived.

Frances: *You have to have a full bladder through the whole thing, for the ultrasound to work. That's very, very uncomfortable too. . .*

You're supposed to drink four glasses of water before you leave the house. I'd leave here at 6:00 to be there for 7:30. The first few times I'd drink four glasses of water here and by the time I got off the train at Union Station I'm just about dead. Then you get there and they've got to do your blood and you wait around. The doctor comes waltzing in about 8:30 and there are 15 of you sitting there with your legs crossed. Like it's awful! But then I got it down to a fine art. I knew just exactly how much water I could drink here and how much I'd have to drink at Union Station. I had it all timed so I could get there with just the right amount (she laughs). I still have problems with my bladder right now and I swear it's because it stretched to oblivion going through that. There has to be a better way, I think.

Two women in the sample experi-

Women undergo a battery of tests including an ultrasound

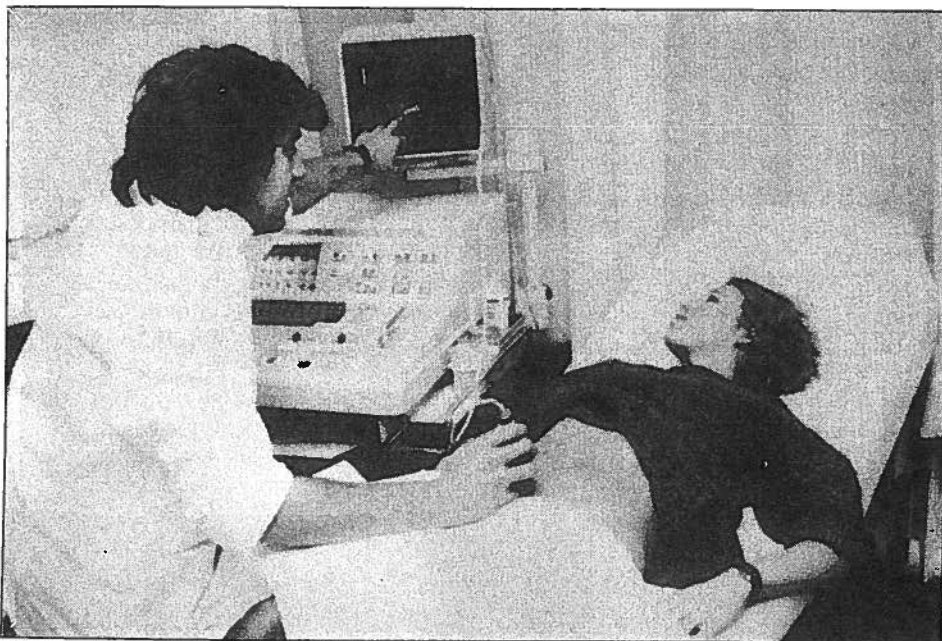


photo courtesy Ditemmas/Alpha Diffusion

enced so much difficulty with the blood drawing which is an essential part of IVF that they both described this part of the process as "torture," and another woman mentioned that she sometimes fainted.

Almost all of the 20 women experienced at least one side effect from the Clomid and Pergonal used in IVF, and most experienced more than one. The most upsetting side effects were extreme mood swings that would leave some women quite literally laughing one minute and crying the next, and excruciating headaches. Other side effects reported included hyperactivity, drowsiness, nausea, weight gain, dizziness, hot and cold flashes and inability to concentrate. One woman reported that her ovaries had become hyperstimulated, one of the most dangerous side effects of Pergonal. (Ovarian hyperstimulation can lead to the development of ovarian cysts with accompanying abdominal discomfort or severe pain. Ovarian cysts may rupture resulting in bleeding into the abdominal cavity which may require surgery and the removal of part or all of the affected ovary. Ovarian hyperstimulation can also lead to temporary or permanent ovarian dysfunction.) These side effects began with the administration of the fertility drugs but often continued into the waiting period following hospital discharge since the drugs would still be present in the women's bodies.

Debra: I had unbelievable, unbelievable headaches. Like nothing I'd ever, ever had in my life. I could not work, I could barely keep my head up. They were pounding, pounding. I was petrified to take anything. I didn't say anything for about two days, and they wouldn't go away. I finally asked the doctor whether I could take something and it would take like three or four aspirins until I could get some relief. I was upset about that.

Janice: I could hardly concentrate on my studies with the Pergonal. I could hardly keep up with my school work but I was maintaining it. I was managing to keep up with it, barely. And I had a term paper to hand in and I couldn't sit down to do it. I knew it had to be done, and I was trying to do it ahead so that if I had to be admitted it would be done, and I just couldn't do it. And the prof was not going to take it late and I was going to get docked a mark for every day late.

A pervasive theme in almost all of the women's accounts of the period prior to hospital admission was a profound fear of being "cancelled" because their hormone levels were not rising or their egg follicles were not developing properly. Each day's blood test and ultrasound scan were perceived as "hurdles" which they had to overcome or "tests" which

they had to pass in order to be allowed to continue in the program.

Janice: It was a waiting game.

There were four of us who would meet and have breakfast together and things like that. When Amy got cancelled that's when I first realized the hurt of being cancelled. All of us lived in the fear all week of being the ones that would be cancelled at any time. I would ask about my levels of estrogen and compare. And you compare size of follicles.

Being admitted to hospital was an extremely important step for the women in this study, for it meant that they had successfully completed the first stage in the IVF process and were likely candidates for egg retrieval surgery.

Most of these women described their time in hospital prior to surgery as tense and emotionally charged, but most also spoke warmly of the camaraderie and support that they received from the other women who were also going through the program. They firmly believed that this mutual support made the extreme stress of this period somewhat more bearable. Although women at this stage of the process are hospitalized they are generally free to wander in and out of the hospital whenever they are not needed for a medical procedure, so this mutual support sometimes took

the form of restaurant or shopping expeditions as well as meetings in each other's rooms.

Anne: *There were five of us girls who made it all the way through the program. We used to get together. We had lunches and dinners together. We did a lot together . . . And I think for us we made it for each other. Most people might find it a little bit hard if you're not outgoing to be able to live with that situation. Because each day you might be meeting someone different and losing someone you're just getting to know who's in the same situation as you. So I think the team spirit was really great for us.*

Worry about possibly being cancelled did not end once a woman was admitted to hospital however. If she should happen to ovulate before her egg collection surgery could be performed she would be cancelled and discharged from the hospital shortly thereafter. The experience of being cancelled at this stage was perhaps even more devastating than cancellation prior to hospital admission.

Lois: *I remember getting in the car and crying all the way home. I'm never going back there! They've had enough! I'm not a guinea pig anymore! (she laughs nervously) . . . I'd had it. I thought — this is it. I'm not doing this again. But about two days afterwards it was, okay, let's go back in (she laughs).*

For women who are not cancelled, the next stage in IVF procedure is the surgical laparoscopy to collect the ripening eggs in the woman's ovaries. Interestingly, only one of the women in this sample made any comment at all about the laparoscopy itself. This surgery seemed to be much less stressful than the period leading up to and immediately following it.

The period following laparoscopy brought a shift in the focus of the women's attention from their own bodies to the fragile eggs which had been surgically removed and new questions now occupied them. How many eggs were collected? Were they "good" eggs? Once the eggs and sperm had been combined in the laboratory, the women then became concerned about whether the eggs

had fertilized and were undergoing proper cell division. Several women spoke of the stress of trying to get information from the hospital staff and of constantly wondering about what was happening to their eggs which they fervently hoped were fertilizing and becoming human embryos. Unless these eggs fertilized and developed properly they would not be returned to the uterus and the attempt at IVF would fail at this point.



photo courtesy Dilemmas/Alpha Diffusion

In Vitro encounter of sperm and egg

The sixteen women who were fortunate enough to reach the final stage in the IVF process experienced a complex and shifting mixture of emotions which made this period the most stressful part of the procedure for most of them. The primary cause of their extreme anxiety was the simple and profound fact that each of these women went home knowing

that she had a number of embryos in her uterus which might or might not implant to produce an ongoing pregnancy. One woman described her feelings on returning home with three embryos in her uterus:

Judy: *I was excited. I was very optimistic. I had been kind of up and down during all the drugs and whether that was just my emotions or the drugs having an effect on my emotions or whatever. I was also tired; it was a lot of running around. It was stressful. But I was very optimistic. I was very excited. I mean there were these little possible Schwartz-Lipmans in there. There were three of those.*

Most of the women who made it to this stage of the procedure reported that they became intensely preoccupied with their bodies and severely limited their movements so as not to dislodge the minute human life that might be developing within them, even though some of them recognized that such restricted behaviour probably had little effect on their chances of pregnancy.

Marilyn: *The weird part of it is that you could have discharged the embryo hours after coming home or a day after coming home. It's microscopic and you can't see it, but every woman you ever talk to, no doctor can understand it, will get up from peeing and look in the toilet to see something wave at you, because you're sure you've lost it (the embryo). So every time you go to the bathroom you don't push and you just walk like you're walking on eggs. . . You don't move. You get up very slowly. You don't want to lift anything. You rub your stomach. You just do these things naturally. I think it's also the reaction to still having Pergonal and Clomid in your body, because your body thinks it's pregnant. Your mind's going, what the hell are you doing? And that's where you're playing basketball with your emotions, you're up and down like a yo-yo.*

Many of the women in this study experienced intense psychological conflict between being hopeful and optimistic that they would become pregnant through IVF while at the same time being realistic about their

chances of pregnancy, which they all understood as very small. Over and over again these women related how they were told by the medical staff and other IVF patients that their mental attitude played an important but never clearly defined role in the possible success of the procedure, and that if they did not "think positive" it would not work. In fact, the idea that positive mental attitude was essential in order to become pregnant through IVF, or, conversely, that a lack of confidence could somehow prevent a pregnancy from occurring was one of the strongest and most pervasive themes uncovered in this research. This way of thinking about IVF created a psychological no-win situation for some of these women, who strove to remain hopeful while at the same time trying to protect themselves from being too hopeful which would make failing to become pregnant even more devastating. The themes of the necessity of being confident that the procedure will work and psychological conflict between hopefulness and realism emerged in the women's accounts of all phases of the procedure, but they seemed to be experienced most acutely during the waiting period.

Marilyn: This is where it's the hardest thing psychologically. You're told you've got to be optimistic. And at the same time you have to be realistic and realistically speaking the chances of being successful are not that great.

The final phase of the IVF procedure is a blood test to see if a pregnancy has occurred. This is done approximately 12 days after embryo transfer. Some women knew that they had not become pregnant because their menstrual period began before the test was scheduled. However, women were generally instructed by the medical staff to come in for this test even if they had already begun to menstruate. Having to do this knowing that their IVF attempt had failed was emotionally upsetting.

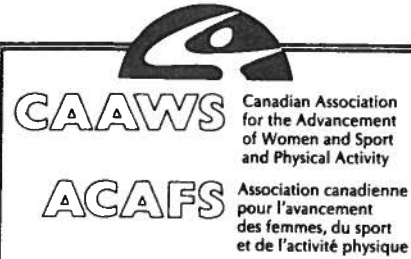
Anne: I always got my period on the day I was going down for the blood test. . . You think to yourself, why couldn't it happen after you had your blood test and you got home but this way you have to go back out and face the world again.

For some women however, the blood test was their first confirmation that they were not pregnant and this news came by phone after the test was completed. This situation was also extremely difficult, especially if the woman received the news when she was at work or in a situation where she could not immediately express grief and disappointment. One woman had not told her family that she was going through IVF and she got the news that she was not pregnant on a day when they were visiting.

Lois: The doctor called and said, 'I'm sorry, it's not positive.' I got off the phone and I wanted to bawl. I was just shaking. And I had to wait until everyone left the house until I finally (broke down). . . I went to bed for two days.

The experience of IVF was extremely stressful both physically and emotionally for most of the women in this sample. Although each phase of the procedure has its unique aspects and stresses, the overall theme that emerged from the women's accounts of their experiences was the idea that the stress was unremitting. One woman expressed this very clearly when I asked her what the most stressful aspect of the IVF experience was for her:

Joanne: Getting through it. Day by day. A friend had been through it and we talked about it and she said 'It's going to be really hard on you.' And I, Miss Naivete then too, said, 'Oh no, after all I've been through, I don't think that will be too bad.' Wrongo, that was really stressful. It was so bad, so stressful. And I consider myself pretty good at coping with things, usually. But at one point, and it was on into the thing too, I think it was even past the laparoscopy, anyways, at one point honest to God I almost packed up and left. I thought, 'I cannot stand this another second.' It was like a time capsule of all of your expectations and all of your stress just jam-packed into five days or six days or whatever it was. And you never got any relief from it. You made it through one day and then you couldn't celebrate because you may not make it through the next



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IVF Procedure

An IVF procedure usually begins around the fifth day of a woman's menstrual cycle when she begins taking one or two tablets of Clomid daily for approximately four days. Clomid is a fertility drug that stimulates the development of egg follicles in the ovaries. Two days after she begins taking Clomid she will also begin receiving a daily injection of Pergonal, an extremely powerful drug that induces ovulation.

Around the time that Pergonal injections begin, daily blood tests will also commence and a daily or every-second-day ultrasound scan will also be required to assess the development of the egg follicles and also to make sure that the ovaries are not being dangerously overstimulated by the Pergonal.

If the blood tests and ultrasound scans show that the woman's hormone levels are rising sufficiently and that her ovaries are developing a sufficient number of egg follicles, she will be admitted to the hospital somewhere between Day 11 and Day 14 of her menstrual cycle for egg collection. However, if the results of these tests show that the ovaries are not responding to the drug regimen, the IVF attempt will be cancelled. This can occur at any point in the procedure up to the time of hospital admission.

Women who are admitted to the hospital will usually have at least one more ultrasound. Daily blood tests will continue and may even be done every few hours around the clock. Once the woman's hormone levels have risen sufficiently and the time of ovulation is near, an injection of HCG (human chorionic gonadotropin) is given to induce ovulation. Timing becomes especially crucial at this point because HCG is known to induce ovulation in approximately 36 hours. Consequently, a surgical laparoscopy to collect eggs is scheduled for 34 hours after the injection. (Some hospitals are now using ultrasound for egg retrieval.) However, ovulation may occur before the eggs are surgically removed and if a woman's hormone levels show that in she has in fact ovulated before egg collection can be performed, her attempt will be cancelled and she will be discharged from the hospital.

The actual laparoscopy procedure involves locating the ovaries and removing eggs by gentle aspiration via a small incision through the umbilicus. The collected eggs are placed in a culture medium and closely observed to make sure that they are sound. Defective eggs are discarded and the rest are incubated for five to six hours and then combined with the prospective father's sperm sample which has been specially treated to increase the chance of fertilization. This stage is also crucial to the success of the procedure since some eggs may not fertilize and even eggs that do fertilize may not undergo cell division, that is, they may stop developing and cease to be living organisms. Approximately 48 hours after the laparoscopy all eggs which have been fertilized and are developing properly are returned to the woman's uterus by means of a thin catheter inserted through the cervix. This procedure is called embryo transfer and it does not require any anesthetic, although it can be painful to some women. The woman remains in the hospital for a few hours lying on her back with the bed tilted so that her feet are elevated and then she is discharged and returns home. Twelve days after embryo transfer a blood test is done to see if the embryos have implanted in the uterine wall and pregnancy has begun. Since implantation does not usually occur, most women will have a negative pregnancy test and will begin their menstrual period either shortly before or shortly after the pregnancy test. The few women who have become pregnant will go on to bear a child.

MY STORY, OUR STORY

day. And so you were just constantly so upset. . . The day-by-day pain of trying to make it through each hurdle with no relief until the end.

In vitro fertilization, because of its low success rate, actually allows only a very few infertile women to bear children while using vast amounts of scarce health care resources. This research provides information on women's IVF experiences which has not previously been available and may help some infertile women to decide if they really want to undertake IVF. However, it also raises some important questions.

Is *in vitro* fertilization a safe technology for women? Given the wide array of drug side effects and the depth of emotional stress reported by most women in this study, I strongly believe that the physical and emotional safety of IVF should be thoroughly investigated by medical researchers who do not stand to benefit from its continued use. This research also makes obvious the need for IVF clinics to provide counselling for those women who do undertake IVF, both during and after their attempt(s).

Although IVF doctors and scientists present IVF to the public as an established technology, it still remains controversial for many Canadians. Most of the ethical, legal and financial issues surrounding its use still remain unresolved. Before we, as a society, can thoroughly evaluate this technology we must understand what it really entails, especially for those whom it affects most directly. Our understanding will not be complete unless we listen closely to the voices of the women who have actually used this demanding and often dangerous technology.

Linda S. Williams currently teaches in the Sociology Department at Trent University in Peterborough, Ontario. Her doctoral research was a study of the parenthood motivation of couples seeking in vitro fertilization.

The above article is excerpted from The Future of Human Reproduction edited by Christine Overall, just about to be published by The Women's Press, Toronto.

Diary of a Migraine

Marie Mason

In 1987 I began a process to control a lifelong problem with migraines. It took a year and visits to more than eight different health professionals until I learned what I needed to know. I still haven't totally licked the migraines and have no concrete answers as to what causes them or what will rid me of them. But the process of taking my problem into my own hands and taking steps to control it through changes in my lifestyle has been a real eye-opener. I've come a long way.

"Your migraines will never 'clear up.' It's a vascular weakness. The problem now is you're uncertain about your future, and people don't handle uncertainty very well." In other words, 'Get on with your life. No one can do that for you.'

In January 1987 I'd gone to my family doctor to get to the bottom of my migraine problem once and for all. They'd increased from once or twice a year in adolescence, to once or twice a month while recently teaching overseas. In particular, I wanted to delve into possible long-term emotional and psychological factors that may have helped trigger my headaches. I was 28 and feeling stuck in my life.

Since I was 15, Dr. G had said to note those foods and incidents which led up to an attack and to avoid common triggers like chocolate, cheese and alcohol. As a teenager, this seemed an insurmountable task. In those years he kept me in painkillers — Florinal — that would dull the pain somewhat if taken at the outset, but they put me to sleep and left me dull-witted the next day.

"If you want a counsellor or therapist, I don't know of any...but I could refer you to the Psychiatric Out-Pa-

tient Clinic. Biofeedback might be useful." At the clinic, biofeedback was barely mentioned. I met with a psychiatrist and psychologist and spoke of periods of depression and very low energy when I felt utterly exhausted. When I arrived in their clinic that's how I was feeling.

"Have you ever felt suicidal? It would be natural in your situation." As well as having recently arrived back from a teaching job in China and suffering from culture shock, my father was seriously ill and another member of our family had just died. It was mid-winter, I was depressed and it felt like everything was coming to a head.

Their conclusions shocked me: "It seems you have a family history of alcohol use and depression. We suggest an antidepressant before beginning therapy."

"Your periods of high and low energy may indicate manic-depression. Medication speeds up the process of getting over depression and may help control migraines. A tricyclic antidepressant isn't toxic or habit-forming. An alternative is to first begin therapy then start medication."

A blood test was required to make sure my thyroid would handle the medication. "There's been no testing to show that my body needs an antidepressant. But I do want the counselling."

"We don't as yet have any such tests, and I don't know any psychiatrist who'd take you without putting you on medication in the shape you're in."

I'd made the mistake of crying during my first visit. It seemed that by saying no to the antidepressant I was, in their eyes, being irresponsible.

"Until you have a test showing I need it, I won't take it." I felt great. By saying no to the medication, no to

authority, I was saying yes to me.

In his book, *Confessions of a Medical Heretic*, physician Robert Mendlesohn warns patients to read up on their condition, then go into a doctor's office wary and defensive. Be obstinate about adequate explanation. Find out for yourself the possible side-effects of medications because doctors can't be trusted.

My family doctor had always said that migraines were not psychosomatic and didn't leave permanent damage. Yet flipping through an encyclopaedia, I read: "Migraine is attributed to repressed emotional stress in a genetically predisposed person and/or specific personality type." It is psychosomatic to a certain extent and "requires treatment as a total person, using psychotherapy to treat the patient's underlying psychic conflicts . . ."

Admittedly, the disorder is complex and not fully understood. One theory concerns a vascular weakness that's as controllable as near-sightedness, i.e., not at all, so you just learn to live with it. Another more modern theory focuses on the two most com-



Dawna Gallagher

mon triggers — particular foods (often unique to the individual) and stress. I kept finding stress and food popping up in the literature. It seemed that dietary factors and stress might be playing an important role in triggering my migraines. I thought I had better check them out. It was a better theory to follow than the one suggesting I 'learn to live with it.'

At that time, my goal changed from trying to eliminate my migraines altogether to minimizing attacks by focusing on the two triggers I could actually control. Though I realized I might have a vascular weakness or hereditary predisposition to migraines, I was convinced I could minimize the migraines with attention to diet and stress.

This was a major breakthrough for me.

I took a night school course in positive thinking and self-hypnosis, where I learned techniques for deep relaxation and visualization (a method of controlling how your body feels by visualizing how you want it to feel), and became more aware of my tension and stress.

The instructor was against all anti-depressants. "Much of what I do is get people OFF anti-depressants."

During this time, I had an attack that left me prone for twelve hours, and angry that my new relaxation skills hadn't paid off. I realized it was going to take time.

I began to wonder if I had a deficiency of some sort that was causing my problem.

The Canadian Wholistic Healing Association recommended a naturopathic physician, Dr. K, who claimed to be able to pick up signs of allergy and deficiency by use of a

'Vega' machine that read electrical waves at various acupuncture points throughout the body.

Though I was tested by Dr. K, I was suspicious of the experimental machine and went back to my original doctor to be referred for a more traditional allergy test. The tests proved inconclusive. Apparently I wasn't one of the 20 per cent whose migraines are largely triggered by a particular food, like chocolate, red wine or cheddar cheese.

Another possibility was *Candida albicans*, a yeast infection with a wide variety of symptoms that include low energy and sometimes migraines.

Two sources recommended Dr. R. "I think you wasted your time and money with the Vega test. I'm doing some accuracy tests with Dr. K, and the machine is only 50 per cent accurate." Unlike Dr. K, he asked for results from each of the previous doctors I'd consulted and prescribed Vitamin C to control any effect from food allergy and symptoms of migraine.

After testing, *Candida* (yeast) overgrowth was ruled out. Instead, Dr. R centred on my digestive system, the first body system affected by stress. He prescribed glutamic acid, zinc and magnesium to correct a constipation problem and to make sure I was absorbing nutrition properly and getting the appropriate energy from it. (I later read that magnesium is also a natural tranquillizer, though I didn't know it at the time.) My spells of extreme, low energy disappeared, presumably as a result of the regimen. It was hard to make specific links because so many things had happened in the past year, but the first real changes did happen around this time.

Dr. R also recommended meditation, suggested some how-to books and offered to go through a session with me. He suggested other changes: "I want you to make a point of getting exercise each day. What are your present health concerns? What do you think is causing them?"

Finally, I had found an M.D., Dr. R, who seriously considered the opinion of the patient, understood the link between the mind and body, the role of lifestyle, the importance of nutrition. Instead of mood-altering drugs

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and painkillers, he advised vitamins and minerals.

A knowledgeable resource person, he was recommending other health-promoters (not necessarily acknowledged by the medical community) and reading materials that would help me make long-term changes in my diet, exercise and attitude to life.

At the same time, I began to see B, a psychologist. In weekly sessions; over a year, while I was simultaneously seeking other help, she gently helped me explore my patterns of thought and behaviour. I spoke and she listened. We laughed a lot. And it was ok. She was great.

Nine months after first approaching my family doctor with the audacity to suggest my migraines might have an emotional, psychological component, I began biofeedback, a method of monitoring my levels of stress and relaxation using a computer-like device the size of a transistor radio.

It was valuable. But it came much too late. By the time I got to biofeed-

back, I had already started with the psychologist and had learned a lot about stress management through other means and was doing quite well.

However, in a pamphlet I picked up at the University of British Columbia Biofeedback Clinic, I was told what I had long suspected: food triggers are accumulative. The effects of a particular food can build up in the body over time, to be suddenly activated by stress.

What were my triggers? I began to wonder about the MSG I had eaten so much of in China, of the soy and tamari sauce. Nothing was obvious, but around this time I started on a macrobiotic diet, suggested by Dr. R. This diet stressed grains, vegetables and beans and a reduction of sugars, medicines and dairy products, a big trigger for many people.

I again decided to say no to a medical authority. This time, to my chosen Dr. R. He had advised me to take approximately nine vitamins a day, and said I'd have to take them

for the rest of my life. I decided that was impractical and unhealthy and weaned myself off the pills.

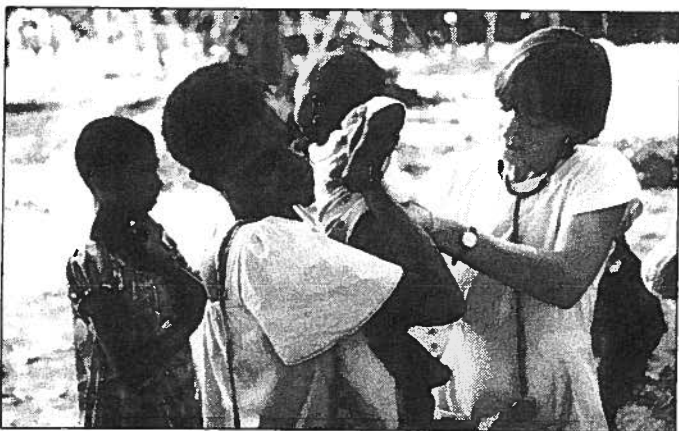
It is now 1989. I haven't had a migraine for almost two years and feel good. I'm listening to my body and my feelings more. Regular exercise and the modified macrobiotic diet I have been on for over six months seem to help. I'm not taking vitamins. I really concentrate on my diet. I've built in visualization as an important tool for ridding myself of stress. Thinking of a desert island helps a lot.

I don't presume to have licked my health problem totally by my own action. Migraines are too unpredictable. But I did well to learn about my ailment, then take action to make long-term lifestyle changes.

If only for my peace of mind.

Marie Mason is a freelance writer and teacher living in Vancouver.

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Agnes Grant

Midlife Adventure

I wear a grey Outward Bound sweat shirt with an Outward Bound pin, proudly proclaiming that I am, indeed, a graduate of Outward Bound.

Many unlikely things have happened in my life; this is the most unlikely. Outward Bound is a wilderness program that challenges even the fittest. I am not "physically fit," in fact, I am physically lazy. I am "overweight." I am 53!

I first became aware of Outward Bound when staff, including my son, stayed overnight at our place on the Yellowhead highway. We were delightfully entertained by their tales of adventure and misadventure. When one of them suggested I enroll for a course I was incredulous. Outward Bound? Me?

The brochure states that the oldest participant to date was 69. Well, fine. When I am 69 my hormones will have quit rioting in my body but at 53, in the middle of menopause?

Yet here I am on the Kab River in northern Ontario trying to stuff my personal effects into a ridiculously small stuff sack. Our group consists of five men and five women. I am very conscious of age and judge them all to be 10 years younger than I am, or more. I eye the large back



photo courtesy George Field

packs suspiciously and wonder who will carry all this stuff. I remember the reassuring words of my son: "There are many kinds of strength; every kind is needed for Outward Bound."

So what will they find for me to do?

I soon learn. The back pack is for me. Each pack contains two bags of personal effects, two sleeping bags, two plastic tarps, two foam sleeping mats and on top of it all, a tent for some of us. Slowly it dawns on me that I will carry this. My partner helps me hoist it on my back and adjust the strap over my forehead. I feel myself crumbling into the earth, but Cathy, our instructor weighing no more than 115 pounds is striding off with her pack and I shamble along

behind. I am amazed that this exertion is not killing me and my amazement increases as I successfully navigate a log jam — and by now I hold my backpack dear because those of us not carrying packs are carrying canoes. I had assumed that surely that would be a man's job until 115-pound Mighty-Mouse demonstrates how to lift, carry and set down a canoe.

The first evening is all that the Outward Bound literature promised. A gorgeous sunset, tents pitched under murmuring evergreens, the river slipping between sandy banks. It is early September and the foliage is alive with colour; early frost has driven off biting insects. Ten participants and two leaders pledge to make this the best Outward Bound

course ever. The evening is spent around the fire getting acquainted with people we will come to love and hate in equal parts during the next nine days.

First, a lesson in environment and hygiene. The forest is a delicate place, we must leave no trace of our journey. Though we may not pass this way again, others will.

We must not pollute the water. No soap is used — it is only on the last day that it is used to scrub the pots and then the water is emptied deep in the bush. No left over food is dumped, what does not burn is packed out, as is the garbage. The bathroom is the great outdoors and we are instructed to dig holes eight inches deep. We receive instructions on which leaves to use as toilet paper or, if we insist on using Kleenex, how to roll it discreetly in birchbark before burning it in the campfire.

Safety is a high priority with Outward Bound so it comes as no surprise that we get emergency first aid training as well as undergoing a series of water exercises. We learn how to right a capsized canoe and how huddling together can help in icy water.

The meals are invariably delicious though we doubt whether we would eat this stuff at home. Breakfast consists of hearty porridge, without milk. There is coffee and hot chocolate but it must be gulped quickly before the porridge is ready because we have only one set of utensils each, a tin cup and a spoon. I fight menopausal nausea and force down the porridge, recalling a time when breakfast was two cups of coffee and a Danish. Our leaders keep reminding us that we must keep up our energy; low energy levels endanger the group. I watch in amazement as tiny Mighty-Mouse eats not one but two huge helpings!

Lunch is on the trail and consists of biscuits of some kind with cheese, jam and peanut butter. There is always fresh water dipped from lake or river, delicious, unpurified, unchlorinated water with a slight leafy-mouldy taste. It is to become one of the greatest pleasures of the trip.

Between meal snacks are generous and tasty — gorp, nuts, dried fruit. "Dinner" is often eaten after dark and consists of a one or two pot meal

of beans, pasta or rice. Tomato sauce, canned fish, cheese, herbs and spices create feasts followed by pots of tea.

Sleeping arrangements are simple. Ten participants, three tents. Dead tired bodies care little about who shares the tent as long as the neighbouring body is warm for the temperatures often drop below freezing. Preparation for night consists of adding layers, not taking them off. Dry socks and caps are essential; life jackets become pillows. It is only at night that we enjoy the luxury of dry clothing and the ordeal of changing into clammy "day" clothes soon becomes routine.

I seem to suffer more at night than the others. For several years now I have experienced hot flashes every night, and I even joked about not having to worry about the cold while on Outward Bound. Not so. No hot flashes but instead teeth-chattering cold. Nights are waking nightmares for me as muscles cramp and the pain becomes excruciating. I keep a lonely vigil, resenting my companions' regular breathing, fearful that my strength will give out. But I do sleep a few hours because at daybreak I awaken so stiff and sore that putting on my socks brings involuntary tears to my eyes.

For me the essence of Outward Bound is pain. We paddle until our backs cry out in protest but the wind is high and to pause means to be carried back where we came from. We paddle until our hands are blistered and our lips crack. We paddle in rain and in the sun until our faces are sunburned and our eyes swollen from the glare. We portage over hills, scramble over boulders with packs and canoes. Muscles scream in protest, lungs feel as though they are bursting, tears stream down our faces but we go back for second loads or stop to help faltering comrades. We draw on our inner resources, each in our own way. One woman sings Christmas carols, I practice Lamaze breathing and silently chant "One, two. One, two," while planning unique revenge on my son, his friends and the founder of Outward Bound.

The men do play a different role in portaging, carrying more and heavier loads while women arrange and load canoes. The men work them-

selves to exhaustion setting canoes down with shuddering sighs and twisted faces. They do not complain or cry but they sit slumped over fighting to control shaking limbs. If their strength fails they feel guilt; occasionally they swear.

But canoes cannot always be paddled or carried. Sometimes water is shallow and we drag, push and pull. We are in muck up to our knees, water up to our waists. We sink into deep, sucking mud holes and stumble over invisible rocks. Sometimes the water is swift and dangerous; then we line and track, waist deep in rushing water and slippery rocks. Discipline and teamwork are essential for the danger is very real.

At the end of the day there is still no rest. Tents have to be pitched, sleeping bags and mats laid out, meals cooked, pots washed, clothes dried out, cuts and blisters tended. Before long it is an effort to comb one's hair or brush one's teeth because these things are not essential for survival.

The essence of Outward Bound is pain

The first afternoon we climb "small" rocks. They are only about 30 feet high and we learn basic skills and even practice a fall. I feel good. At home I have never cleaned the living room window because I am afraid of heights. I could quit right here, but what was the point of doing it all if I don't attempt a real climb?

I don't sleep much that night. We are near a road and the occasional vehicle goes by. How simple it would be to hitchhike into Thunder Bay. I could explain that I am AWOL from Outward Bound. I would have to explain that Outward Bound has my wallet, credit cards and airline ticket, but one phone call home would rapidly restore my rational world.

Grey dawn finds me still in camp choking down my morning mush. Dully I put on my climbing harness and am only slightly surprised to find that, without any help I am able to tie my knots correctly and snugly. I follow the others single file down the

path to certain doom, dully comprehending that I have been assigned to a climb called "Jacob's Ladder." Prepared for the worst my stomach still lurches at the sight of Claghorn — 90 feet of sheer forbidding rock. But I have reached the point of no return.

When the climbing is easy I move swiftly, impatiently. I have heard that some first time climbers take up to four hours to climb Jacob's Ladder, but there is no way I will cling to the face of this rock for that long! But climbing is not always easy and then I am in total, unreasoning despair. I plan more revenge on my son, his friends and heap scorn on the founder of Outward Bound.

I try to ignore the rock, my position, the situation and instead survey the beautiful scenery. I sing "We are Climbing Jacob's Ladder," an old Sunday school song. But all these are mere avoidance tactics and I break into sobs, face pressed against the cold, forbidding rock.

The tears, of course, release the tension and I recall instructions — the rock is friendly, feel it, let it work for you, use all parts of your body. Miraculously a hand-hold appears and I am climbing again. But soon I meet another obstacle and the cycle is repeated.

Pam, the staff member at the top and Dixie, my climbing partner who is handling the ropes, keep up a steady chatter of encouragement. Once Pam disappears and I shriek in panic. She stays with me for the rest of the climb. Her voice is steady and reassuring. What are you doing now? What are you thinking? Do you know what you would like to do next? You might try crying now!

It never occurs to me to quit and I hear other climbers ask how I am doing. The voices slowly but surely draw me up the rock. Never has so much energizing force pervaded my living space. I am at the centre; I am the focus; I cannot fail. Iroquois Indians speak of "orenda," each person's orenda is small and weak but orendas unite making a group strong and capable. I think I understand for the first time, the concept of orenda.

One sunny day the black flies come out, intent on a final feast before freeze up. I have not looked in a mirror since the course began and if my face feels like a monster rising



photo courtesy George Field

Costly Adventures

One major drawback of Outward Bound is the high prices which make it inaccessible to many women, though they do have some programs which cost less. It is unlikely that a course such as this one would be offered more cheaply anywhere. The range of activities requires a wide variety of equipment; the isolation and danger require the equipment meet the highest safety standards. Staff needs to be highly skilled both in wilderness techniques and human relations. For more information call toll-free 1-800-268-7329. In Toronto, call 787-1721. Or write Canadian Outward Bound Wilderness School, P.O. Box 116, Station S, Toronto, Ont. M5M 4L6.

Another school similar to Outward Bound, is Sources of Adventure and Re-Creation. They stress the re-creative powers of the wilderness and seek to provide a shared experience rather than the Outward Bound type of guided, pre-packaged tour. Sources would not be able to offer the same services as Outward Bound at a lower price, but are willing to plan courses with special groups. There could be financial savings through choosing locations convenient to participants or planning fewer activities per course. They are also willing to select leaders suited to particular groups and would welcome inquiries from women's groups. For more information, contact: Sources of Adventure and Re-Creation Inc., P.O. Box 3556, Station B, Calgary, Alta. T2M 4M2.

from the murky depths of a fetid swamp, I do not care. I laugh, almost hysterically one morning when I see some under-arm deodorant tucked in the bottom of an unidentified pack.

After the rigours of the day the after-supper circle draws us together for talk, for song, for comfort. Bodies closely entwined, those who wish to sing, sing. The Beatles' song "All My Loving" and "Amazing Grace" soon become our theme songs. Those who wish to talk, talk. Those who wish to gaze into the fire in privacy are left alone. Philosophical, environmental and social issues are raised but arguments are desultory. We prefer to watch our steaming socks or the dancing northern lights and retire early.

I am at the centre; I am the focus; I cannot fail

After an eternity of packing and paddling we reach the mid-point of the trip — blessed "solo" day. Some dread this day but for me it is the promise of 24 hours of blissful solitude. We take our personal effects, sleeping bag, a rope, a plastic tarp, matches, one tea bag and two squares of trail food. How I have yearned for this day! I am bone weary of inhuman exertion, of sharing a tent with strangers, of getting up at daybreak, of 10 people shouting directions at the other nine, of tears and fears, both my own and those of others.

First I change my dying flashlight batteries and in a gesture of ultimate defiance fling the dead batteries into the bush. I tie my rope between two trees, drape the tarp over it, spread out my sleeping bag. It is late afternoon and the sun is still warm as I drop into a deep dreamless sleep. I awaken before sunrise to the sound of wolves howling across the lake and watch a family of feeding ducks. Later I wash my hair. This is a long process since I have only my tin cup to carry water from the lake to the forest where it is o.k. to rinse. Then I go back to sleep.

Solo time is a time for introspection and self-examination but my

body craves sleep like a marooned sailor craves water. After 24 hours I am refreshed and tranquil. For the first time I feel I will survive Outward Bound. I do not know it yet, but I will experience a burst of energy, a "second wind" that will take me through the rest of the course in comparative ease. I did want to think about why I was doing this, but it is time to re-join the group and first I have to retrieve those batteries.

Last comes the greatest challenge of all — rock climbing. I tell myself that I do not *have* to climb rocks. I tell myself that as a 53-year-old woman I have conducted myself credibly on this trip. I have attempted every challenge; I have not been successful in everything but I have tried honestly and courageously. I do not have to climb rocks to prove anything to myself and others. But I know, my stomach churning at the thought, that I will climb. I feel if I do not try the group as a whole will be diminished.

When at last I reach the top I hardly hear the cheers of the group but I am aware of warm arms and tears other than my own. I inspect my hands curiously and find they are covered with blood from myriads of nicks and scratches and the nails are jagged. I slump under a tree and much later, shaking limbs under control, I confidently descend the rock with ropes, even exaltingly because I know what it is to have conquered fear.

On the last morning we are slowly awakened as Cathy plays "Morning Has Broken" on her recorder, reminiscent of Pan and sylvan glades. I am overwhelmed by the tranquility of the morning, the magnificence of this northern forest and the sensitivity of the young woman who chose this way to tell us we are going home. Rarely has a piece of music moved me more.

I learned a lot from my Outward Bound experience. I learned about my particular strengths as an older woman. Being "old" is as much a state of mind as a physical reality. I was forced to acknowledge that I am a role model and that is a position of considerable responsibility. I feel compassion for those younger women who are seeking to clarify women's roles in a rapidly changing

society but I also feel great respect for this younger generation of women so different from mine.

The experience has left me with a sense of accomplishment which will stay with me for the rest of my life. I learned a lot about my body, which suffered, but responded to every challenge. How can all those dreadful stereotypes of menopausal women have arisen and why do they still persist? I learned a lot from the younger women in the group. I feel cheated that it has taken me so many years to accept my body for what it is. I found that some of the men in the group were nurturing and sensitive but on the whole women were

able to deal with their feelings more readily and openly; for that I am grateful.

I now understand that I set my own limitations and most of the time I do not even know what my limitations are. And I learned that I set my own agenda and then look for a scapegoat. No one made me go on Outward Bound and once there no one made me accept every challenge. My apologies to my son, his friends and the hapless founder of Outward Bound.

Agnes Grant teaches Native Studies and Education at Brandon University in Manitoba.

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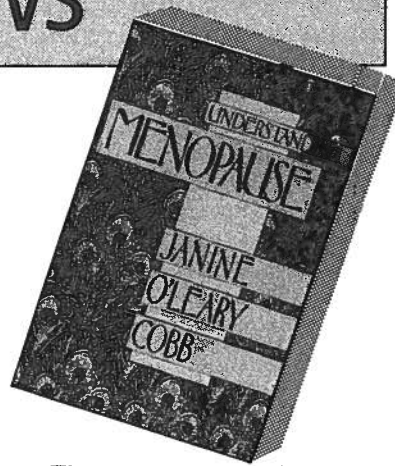
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REVIEWS



Understanding Menopause

Janine O'Leary Cobb, Key Porter Books, Toronto, 1988, \$16.95, 192 pp.

Reviewed by Zelda Abramson

Menopause is a natural process which every woman who lives to a certain age experiences. Despite this fact, medical science treats menopause as a disease and menopausal women are seen as patients in need of ongoing medical management. We are invited, indeed, urged to surrender control over ourselves and our bodies to the medical profession. Moreover, in an agist and sexist society we may be particularly anxious about the process of aging and are easily seduced by the hope that medical treatment will sustain our youth and femininity. Because of society's prevailing attitude, the fact that information is not readily available and a lack of positive role models, menopause is viewed as a difficult and stressful period of transition.

In *Understanding Menopause*, Janine O'Leary Cobb provides us with the information and support we need to redefine and reassert control over this experience. This book is written primarily for women in their early 40s who are unknowingly experiencing subtle changes related to menopause and for women who are presently going through menopause.

Menopause is a slow and gradual process which occurs as the ovaries decrease production of the hormone estrogen. The slowing down process is referred to as the climacteric. A woman is defined as menopausal once her menstrual periods have stopped for 12 consecutive months. Menopause typically occurs between the ages of 45 and 55.

Each woman's experience of menopause is different but not

unique. The vast majority of us will manage without any medical assistance. By educating ourselves about our bodily processes, Cobb believes that women will become less fearful and better able to make informed choices. *Understanding Menopause* succeeds remarkably well in assisting women to achieve this goal.

The format of the book is similar to a text book, with detailed and at times complex material well organized into its 11 chapters. Each chapter can be read independently. The subject matter covers all physical and psychosocial topics related to menopause. Throughout the book brief personal stories provide additional insight and support. Although the language is non-medical, the book will appeal to readers who are seeking out specific information, references and resources. Unfortunately, the print is small and may be difficult for some to read.

There is a helpful glossary which defines medical terms and language. Cobb purposely avoids the use of medical language in the text as it perpetuates sexist and agist views of menopausal women and promotes the notion of menopause as a disease. For example, menopausal "symptoms" are replaced by "signs," "indications" and "ailments." Medical words such as "senile" or "atrophic vaginitis" are inappropriate and the more acceptable term "dry vagina" is used.

Although the book deals with all aspects of menopause, two topics, surgical menopause and Hormone Replacement Therapy (HRT), merit special consideration. "Menopause Under the Knife; Common Surgical

Procedures," is the chapter which examines the politics of hysterectomy and oophorectomy (removal of ovaries resulting in surgical menopause). This chapter is both informative and chilling.

Surgical menopause differs dramatically from natural menopause. The onset is quick and the effects "may be brutal," according to Cobb. Removal of the ovaries places a woman at increased risk for heart disease and osteoporosis (loss of bone mass which is the most common cause of fractures among the elderly). Furthermore, the removal of the uterus and ovaries may have serious ramifications on the quality of a woman's sex life.

North American women are at greater risk of having a hysterectomy because of the greater number of surgeons here than in other Western countries. Moreover, you are more likely to have a hysterectomy if your surgeon is male and if you are poorly educated and hold a low-status job. You are also more likely to have your ovaries out when having a hysterectomy if you are over 40 and your childbearing years have come to an end. The medical explanation for this is that it eliminates the risk of ovarian cancer. Cobb points out that prostatectomies (removal of the male prostate gland) are not routinely performed to eliminate the risk of cancer of the prostate gland even though its rate of occurrence is equivalent to that of ovarian cancer. Removal of the prostate may result in impotency. Apparently, the preservation of male sexual function is accorded a greater importance.

Women about to have a hysterectomy deserve to know the facts. Cobb presents this information in a manner which restores control to women — the right to question, the right to refuse and the right to have a second opinion.

If we trace societal attitudes and treatment of menopause throughout history we quickly realize that negative stereotypes which prevailed in the 19th century are still popular today. In 19th century England menopausal women from the upper class were frequently sedated, as the ovaries were thought to be linked to the nervous system. Menopausal women were considered to be at risk for

mental illness and the ovaries and uterus were removed to treat some of these illnesses.

In 1943 synthetic estrogen was introduced as a treatment for menopausal women. However, it was not successfully marketed until 1966 when Robert Wilson, a gynecologist, promoted estrogen as the preferred treatment for menopause. In his book, *Feminine Forever* (a publication that was financed by a pharmaceutical company), Dr. Wilson stated that with the help of estrogen a woman would continue to be "romantic, desirable and vibrant." Estrogen was the "cure" for menopause and the key to ongoing femininity and sexuality.

Sales of estrogen soared both in the United States and Canada until 1975 when estrogen was linked to cancer of the uterus. To eliminate the risk of cancer, progesterone, the other female hormone, was prescribed in addition to estrogen. This combination is referred to as Hormone Replacement Therapy (HRT).

Today HRT is still the preferred medical treatment. The primary benefits cited are relief from menopausal ailments, specifically hot flashes and thinning of the vagina, protection from osteoporosis and perhaps protection from cardiovascular disease. In addition, HRT is still recommended as an effective way to maintain a woman's youthful appearance.

The facts and issues are confusing and controversial. *Understanding Menopause* provides clear, detailed and objective information which will assist and support women in making decisions. In particular, the book explores non-medical remedies and offers alternatives for consideration.

Most importantly, Janine O'Leary Cobb understands the pressures that women are under during this phase of their lives. She not only encourages us to keep informed, but also to be comfortable with the decisions we make and to share our experiences, feelings and concerns with one another. For Cobb, menopause is not the beginning of the end, but rather a rite of passage to a new and respected phase of women's lives.

Zelda Abramson is a social worker who does group work and counselling in the area of menopause.

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Never Too Thin

Eva Szekely, *Women's Press, Toronto, 1988, \$13.95, 210 pp.*

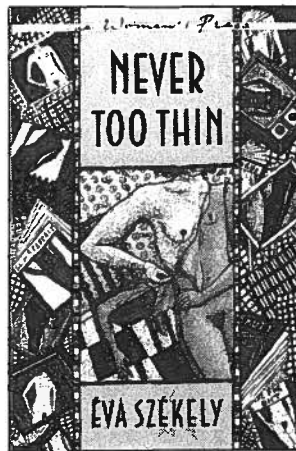
Reviewed by Sheila Nopper

Fear of fat is a major concern for most women in North America. We live in a fat-hating society where a woman's value is based upon her appearance. Historically, women have been economically dependent upon men and our acceptance and/or rejection by men has been determined by how well our appearance conforms to the current standards of beauty. Today beautiful women are thin — and getting thinner. Consequently, over the last few decades, women have been increasingly concerned with food, weight and shape issues.

In her book, *Never Too Thin*, Eva Szekely observes and analyses the relentless pursuit of thinness by five white women by examining their day-to-day experiences within the social, cultural and to a lesser extent, the economical and political context of their reality. Initially, Szekely sees herself as separate from the women interviewed but later realizes that, given similar socio-cultural conditions, she (and each of us) may also become obsessed with having a thin and ever-thinner body. This crucial point is illustrated by the similarities of the women's stories and the author's socio-economic analysis of them.

Four of the women were/are anorexic and/or bulimic; the fifth woman has an ongoing struggle with her weight which fluctuates about 30 pounds depending on her diet and exercise. Although the women's family, geographic and economic backgrounds were varied, none were poverty stricken and all were encouraged to be educated toward a career. Without a doubt, however, their first and foremost ambition was to look good (thin) and to behave as a woman "should" which meant to be happy, a good listener, smart but not too smart (ask men for advice), never express anger and take care of the needs of men.

The women felt lonely, unloved and unhappy. Their pursuit of thinness through diets, exercise, starvation, bingeing and purging was, in



their fantasy, the road to happiness: being thin means being accepted in this society; therefore, thinness equals happiness. When the women lose weight and realize they are still unhappy, their answer is to become even thinner, always believing that when they achieve their desired weight they will "no longer be concerned with food and dieting." This attitude is comparable to the experiences of many women who continue to diet unsuccessfully, each time believing that "this diet will work." It is important to remember that the woman who suffers from an eating disorder started with a "simple" diet, a diet most women in North America have tried — at least once. There is a fine line between women who diet periodically and those who become obsessed with losing weight to the point of eternal starvation and/or bingeing and purging.

For the women in this book and all women who are concerned with food, weight and shape issues, the body becomes the enemy whose compulsive desires for food to nurture and energize must be "controlled." Szekely explores this separation of body from self, self from other and self from society through a feminist analysis of the structure of our society; a society which reduces people to isolated, individual components and ignores the inter-relationships between people and their environment. She challenges the medical model which describes anorexia and bulimia as an illness or some form of personality problem and which blames the individual for her predicament, while absolving all other societal influences from any responsibility. Referring to an article in a popular

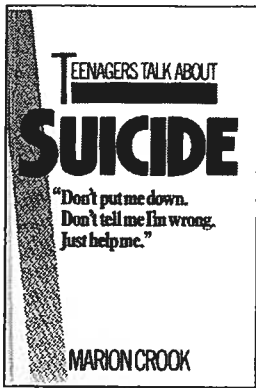
women's magazine which claims that a person can go "too far with dieting" and suggests that anorexia is not "sane and sensible dieting," Szekely questions the sanity and sensibility of dieting at all, when it is well documented that 95 per cent of all diets end in failure.

The media and advertising play a major role in encouraging women to feel inadequate and therefore to internalize prejudices and buy products to correct their imperfection. Throughout the book all of the women interviewed invariably learned how to be the perfect woman, mother, wife, lover and career woman from advertising and articles in books and magazines such as *Chatelaine, Seventeen, Cosmopolitan* and *Glamour*.

Although Szekely periodically mentions classism, racism and heterosexism in association with the relentless pursuit of thinness, I think her analysis would have been enhanced with a chapter to illustrate where these issues are distinct from and interconnect with the social demands that North American society places upon women to be thin. The lesbian community, for example, is not exempt from food, weight and shape issues even though they are not striving to attain male approval: body image is an oppression which affects all of us in many different ways.

While reading the book, I found myself disoriented at times due to the scattered mixture of the women's lives and the theoretical analysis. However, *Never Too Thin* is a well documented book that challenges society's perception of women struggling with eating disorders. By portraying the day-to-day experiences of these women, often using their own words, Szekely connects "us" with "them." We have all experienced similar gender conditioning and stereotyping from our families, our education and the media. To what extent we go to maintain that image is determined by numerous conditions we experience in our personal and collective lives.

Sheila Nopper is a freelance writer and steering committee member of Hersize, a weight prejudice action group based in Toronto.



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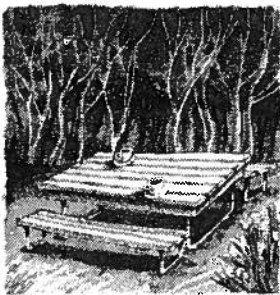
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From Victims to Survivors

The Canadian Congress for Learning Opportunities for Women has published a 34-page booklet, *From Victims to Survivors: New Options for Women Sexually Abused in Childhood*. It provides a general discussion of child sexual abuse, its effects and various courses of action which may be taken by an adult survivor. A resource section lists books and videos available to all women with a further section of resources and services available in Quebec.

Available free of charge from: CLOW, The New School, Dawson College, 3040 Sherbrooke West, Montreal, QC H3Z 1A4

Women's Health Interaction

Depo Provera: From Stories to Struggle is a booklet written in Canadian and Namibian Women's own words demonstrating common concerns about the injectable contraceptive Depo Provera.

In Fertile Ground: Women Creating Reproductive Freedom is a booklet on population control, family planning

and new reproductive technologies organized to facilitate discussions about women and reproduction. Also available is *Infertile Ground: Popular Education Guide*, a booklet which describes various popular education techniques which can be used to stimulate discussion.

Cost is \$5 or \$3 (low income) plus \$1.50 postage and handling. Order from Women's Health Interaction, c/o Inter Pares, 58 Arthur St., Ottawa, ON. K1R 7B9.

Women and Stress

Women, Paid/Unpaid Work, and Stress is a review of research on women, work and stress, showing that 70 to 80 per cent of all illness can be linked, directly or indirectly, to stress and that women are exposed to different and unique stresses. The author also suggests a number of ways to eliminate work stress. Copies are available free from the Canadian Advisory Council on the Status of Women (CACSW), 110 O'Connor St., 9th Floor, Ottawa, ON. K1P 5R5.

Reproductive Health Books

The Vancouver Women's Health Collective has just produced five new books on reproductive health. The attractive spiral-bound series provides clear and concise information to help women make informed choices about their health. Titles are: *Talking About Periods, Infertility: Problems Getting Pregnant, Miscarriage: You're Not Alone, Avoiding Pregnancy, Women Talking About Health: Getting Started with Workshops and Groups*.

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postage and handling for the set of five. Send cheque or money order to Vancouver Women's Health Collective, #302 — 1720 Grant St., Vancouver, B.C. V5L 2Y7. A publication list of their 23 other books and pamphlets is available free upon request.

Canadian PID Society

The Canadian PID Society provides information and support to women with pelvic inflammatory disease and their families, and promotes public education and prevention of PID. They provide counselling and self-help telephone support and distribute a public education booklet on PID, research articles, videos, and other resource materials. For information or support, call: (604) 684-5704 (collect calls are fine) or write: PID Society, Box 33804, Station D, Vancouver, B.C. V6J 4L6.

Clearinghouse on Women's Health

The Women's Health Information Service of the National Women's Health Network is a US based non-profit clearinghouse that provides information on a variety of women's health topics including abortion, breast cancer, fibroids, infertility, mammography, menopause, pelvic inflammatory disease, premenstrual syndrome, urinary tract infections, yeast infections, etc.

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