

ENVIRONMENTAL ACTION • INFERTILITY • HYPOGLYCEMIA • POST PARTUM DEPRESSION

Winter, 1989
\$3.00

Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

Hugging the Trees

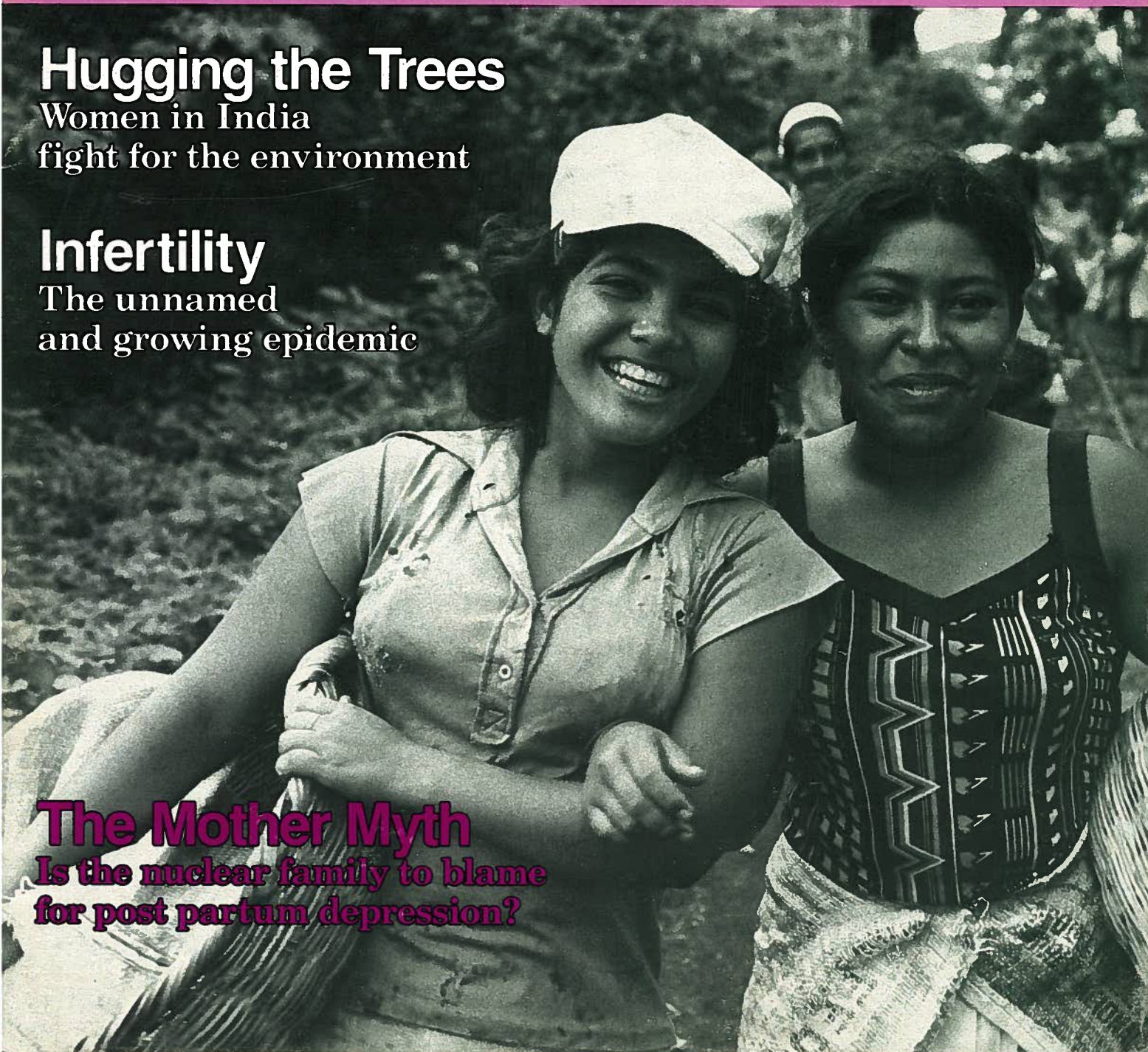
Women in India
fight for the environment

Infertility

The unnamed
and growing epidemic

The Mother Myth

Is the nuclear family to blame
for post partum depression?



INSIDE

Healthsharing

Vol 11:1 December, 1989

Collective Members

Susan Elliott, Deirdre Gallagher, Amy Gottlieb, Lisa McCaskell, Katie Pellizzari

Administration

Jackie Edwards, Amy Gottlieb, Jo-Ann Minden, Katie Pellizzari, Zhang Fengru

Advertising

Susan Elliott

Circulation/Promotion

Jackie Edwards, Rosamund Elwin, Amy Gottlieb

Copy Editing/Proofing

Amyra Braha, Lisa McCaskell

Design/Production

Susan Elliott (coordinator), Pam Bristol, Jill Cameron, Zhang Fengru, Alice Grange, Lisa McCaskell, Jo-Ann Minden, Katie Pellizzari

Editorial

Amy Gottlieb (coordinator), collective members, Noreen Crawford, Jo-Ann Minden

Typesetting

Johanna Householder/Type-A

Printing

Delta Web Graphics

Cover Photo

Deborah Barndt

Editorial, Advertising & Subscription Offices

14 Skey Lane, Toronto, Ont. M6J 3S4
(416) 532-0812

Published quarterly by Women Healthsharing, Inc. Anyone wishing to make a tax-deductible donation (\$10 or more) please send a cheque payable to Women Healthsharing.

Subscription rates are \$12/year, individuals; \$24/year, organizations and institutions. USA add \$2 Cdn or US funds; other add \$3. International Money Orders only.

Women Healthsharing endeavours to print material with which we agree; however, not every article or column reflects the opinion of all collective members or of our funders.

Authors and artists retain copyright, 1989. No part of this magazine may be reprinted without prior permission. Unsolicited manuscripts or artwork should include a stamped self-addressed envelope. A writing guideline is available upon request.

ISSN: 0226-1510. Second Class Mail Registration: 5327.

Women Healthsharing receives partial financial support from the Women's Program of Secretary of State, Employment & Immigration and other sources.

Advertising rates are available upon request.

Indexed in the Canadian Magazine Index and the Alternative Press Index and available on-line in the Canadian Business and Current Affairs Database.

FEATURES

10 "Dear Dr. M"

Surviving the psychiatric system

Karin Singer

17 The Mother Myth

A feminist analysis of post partum depression

Debbie Field

22 Earth, Air and Water

Women fight for the environment in India

Pamela Philipose

29 Thinking Through Infertility

The unnamed epidemic

Jane Covernton

ALWAYS IN HEALTHSHARING

3 Collective Notes

Salvation is in the eye of the beholder

4 Letters

5 Update

15 My Story, Our Story

Healing from within

Lisa Phipps

27 Healthwise

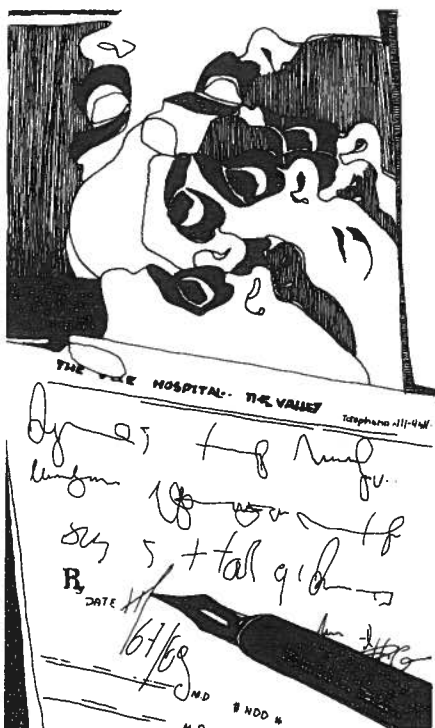
Hypoglycemia

Joan Zwozdesky

33 Reviews

The Nutrition Challenge for Women: A Guide to Wellness Without Dieting

36 Resources and Events



Barbara Pasternak

COLLECTIVE NOTES

Salvation is in the eye of the beholder

Environmental activists argue that a leap in human consciousness is required if we are to comprehend the scope of the environmental tragedy before us; if we are to make the profound changes required to alter the tragic course we are now on. We must see ourselves as one species with a common destiny.

Everyday, images of environmental destruction are bounced off satellites into our living rooms with the flick of a switch. We are overwhelmed. We achieve a frightening new consciousness almost unbearable in its intensity because it comes coupled with a sense of despair. We are immobilized by the colossal dimensions of the problem portrayed by television news. The images are so powerful and our fear so great that we forget that so-called global eye witness news reporting is not neutral, it is not universal or comprehensive. It is a distorted vision of the world.

These days the environmental horrors on TV most often seem to be perpetuated elsewhere, especially in the Third World, with the emphasis on destruction. In the Amazon rain forests wicked cattle barons raze the land while nationalist governments keep out environmental activists. In Africa rapacious government officials, politicians and military leaders allow agricultural practices that lead to drought and famine. We are shown dying children and learn that relief supplies do not reach their destination because of alleged incompetence or thievery. This is a partial version of reality and it distorts the truth. There are racist stereotypes being perpetuated here. When Exxon spilled oil on the Alaskan coast, the owners of Exxon were not portrayed as incompetent or corrupt. Dave Nichols of Loblaw's becomes an environmental hero while the Haida Indians of the Queen Charlotte Islands fighting to preserve their

forests are nameless and faceless.

Television news recently covered a meeting between World Bank officials and Third World finance ministers where the finance ministers denounced the latest loan policy of the bank. Loans to developing countries are now tied to safe environmental practices, a move we are asked to applaud. Yet from the perspective of the developing world, things look quite different. But we can only find that perspective in the fine print in some newspapers.

According to the finance ministers, the West now imposes costly environmental controls in the Third World after raping the planet to its own advantage. Western leaders now preach conservation practices to the developing world while resting on the comfort of their privileged laurels — privileges paid for by colonial exploitation. "Share the wealth if you want to save the planet," is the response from Asian, African and Latin American countries whose leaders object to their economic development being held ransom to the West's destructive environmental practices. They have a point. If you read the fine print.

The media eye distorts reality on a second count. The images of environmental destruction are truly horrific and there is no doubt that the earth is threatened. But where are the images of resistance, of success, of overcoming the odds?

Recently a corporate sponsored conference on the environment at the Ontario Science Centre in Toronto was given full television play. The largely male, business-suited participants celebrated the idea that a safe environment can be profitable. It was a market for so-called environmentally-friendly products, it was a market for corporate self congratulation. If a clean environment is good for business, if it turns a profit, then a solution is at hand. Business is

saved, the world is saved. Rich and still richer.

Meanwhile, the efforts of thousands of people in neighbourhood community groups and the struggling environmental movement are ignored. The organizing efforts of Third World women for example, never make it to television news. Few would know for example that the insult of "tree huggers," hurled at Canadian environmental activists by the logging industry actually comes from India. There, a movement of women environmentalists are popularly and proudly known as Chipko Andolan (the hug the trees movement).

In an article featured in this issue — "Earth, Air and Water: Women Fight for the Environment in India" by Pamela Philipose — we learn about some of these remarkable efforts to save the environment. According to Philipose, it is women who have demonstrated a deep commitment to preserving their environments, organizing against formidable obstacles and with few resources. It is with relief that we read of these heroic efforts by women in developing nations to stand up to the multinational giants. We have much to learn from the innovative tactics they have devised.

Growth of human consciousness occurs when there is a vision of a better future and practical and achievable actions are taken to realize this goal. The news media often fails to show us the human potential for creative and positive action. Television reinforces through news reporting and commercial advertising that we can buy our way out of the environmental crisis. But if our growing awareness and desire to take effective action is reduced to consumerism we may lose the potential at a critical moment in human history. Or if we are paralysed by the vision of doom we will not act effectively. We have awakened; we need to understand what actions will be most effective. Contrary to some views our planet may be saved if we hug trees, if we hug each other, if we organize.

*Susan Elliott, Deirdre Gallagher,
Amy Gottlieb, 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.'

Hospital Merger

I write to bring to the attention of the readers of *Healthsharing* the fact that the women of Toronto are in danger of losing the hospital that has, since its founding, been devoted to women's health care — Women's College Hospital. As I understand what has been going on for some time now, there is a plan to merge Women's College Hospital with the Toronto General Hospital and to relegate to Women's College Hospital the task of caring only for women's needs, that is, gynecological and obstetrical.

As a long-term patient at WCH, I am distressed that this wonderful institution might disappear as a general care facility. At the moment WCH is a place in which I as a woman feel comfortable, at which I am surrounded by efficient and caring women professionals, and that also has a history which is significant for the women of Toronto.

No one has, so far as I know, consulted the users of WCH about the proposed merger with TGH. I strongly suspect that other women feel as I do about WCH, but it is likely that either they are not aware of the negotiations, which are, I understand, well underway, or they have not fully realized what such a change would mean.

I urge your readers to write immediately to the Minister of Health and to the Chairperson of the Board of WCH to protest this plan to do away with Toronto Women's Hospital.

*Johanna H. Stuckey
Toronto, Ont.*

Threat To Health Care
I have recently received and read my second issue of *Healthsharing* — it is excellent.

Your Update "Naturopathy under attack" (*Healthsharing*, Summer 1989) has prompted me to write. The proposed Ontario legislation threatens most non-registered health care practices. Stress management, acupuncture, acupressure, reflexology, all kinds of psychotherapy and counseling and nutritional assessment to name a few.

I urge Ontario readers to write health minister Caplan and contact their local M.P.s if they want to maintain freedom of choice in health care.

*Carolyn Wachsmith
Marmora, Ont.*

Valuable Piece of Literature

Your magazine is one of the most valuable pieces of literature I have ever discovered. The information I have found in its pages has enlightened me on several issues and helped me learn about my own body and health.

*Susan Gee
Whitby, Ont.*

Information On The Thymus

I am writing to respond to Joanne Luitkus' request for information on the thymus (Letters, *Healthsharing*, Fall

1989). The book *Your Body Doesn't Lie* by John Diamond, M.D. has excellent information about the continuing importance of the thymus gland throughout your life.
*Lynne Thunderstorm
Telegraph Creek, B.C.*

Research Impressive

The in-depth research of your articles has quite impressed me! Not to mention it's Canadian! The commercialization and flash of American magazines has often left me hungry for real information. We are educated, literate women capable of understanding a well-presented message. Bravo!
*Jeannine Bastien
Hawkesbury, Ont.*

Thin Times

Congratulations for an excellent article ("Body Image/Body Politics" by Donna Ciliska and Carla Rice, *Healthsharing*, Summer, 1989). Too many women in my practice complain to me that they are over weight. I try to explain to them that the real problem is that we are living in "thin times." They are almost always pleased that I have told them not to lose weight but they seem sceptical about my "diagnosis." I find it tragic that women, never men, ask me for pills which have significant side effects for a non-disease.

*Steven D. Cohen,
Hamilton, Ont.*



UPDATE

PCBs in Inuit breastmilk

In a recent Quebec study of polychlorinated biphenyls (PCBs) in breastmilk, it was discovered that nursing Inuit mothers have PCB levels that are five to 10 times the amount found in their counterparts in Quebec cities. PCBs are organic compounds used in the manufacture of adhesives, plastics, paints and electrical products which find their way into our air, water and food and which may cause serious health problems. Compared to a "tolerable" PCB intake of 1.0 microgram per kilogram of body weight per day, the Inuit women exhibited average levels that were three times this amount up to a maximum level of 14.7 micrograms.

It is almost certain that the high levels are a result of the traditional diet of the Inuit

which consists of fish, land and sea mammals. PCBs are fat soluble and accumulate in the fatty tissue of organisms that absorb or consume them. As fish are devoured by seals, walrus and whale, the PCB levels are magnified tenfold with each movement up the food chain. In a separate nutritional survey of the Inuit diet in Broughton Island off Baffin Island, sizeable amounts of PCBs have been confirmed in sea mammals.

The affected Inuit women live near the north-east tip of Hudson Bay, across from Baffin Island. For them, it is a catch-22 situation. Breastfeeding decreased in the 70s and began to be encouraged again to help combat the outbreaks of infection amongst Inuit children (through production

of antibodies in breastmilk). But the PCBs in the milk have a cumulative effect that can be toxic to the infant's immune system after six months of nursing, increasing their susceptibility to infections. Most mothers cannot afford to stop breastfeeding and the traditional diet is a deeply rooted and fundamental part of their culture.

Professor Albert Nantel, Director of Quebec Toxicology at Laval University, is currently working on a second study to monitor individual women's PCB levels, their infant's immune system and

the breastfeeding period, in order to give specific advice to these women. He warns that breastfeeding should not be abandoned and that the risks must be balanced with the benefits.

As the sea mammal contamination is an extension of global industrial pollution, it is a savage irony that the traditional way of life of the Inuit — with its ecological wisdom — has been desecrated and possibly altered forever.

JO-ANN LOWELL



Jo-Ann Lowell

Women in Active Recovery

Women in Active Recovery, a self-help group in New Glasgow, Nova Scotia, for chemically addicted women continues to make clear the importance of women supporting women in their endeavor for a healthier life. This group, which has been active for almost a year now, fulfills a need for a woman-centered approach to addiction that groups like Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.) can't fill. Many of the

issues women need to deal with centre around incest and self-esteem — issues they are reluctant to talk about in a group with men.

The group of 8 to 10 women consists largely of A.A. and N.A. members. Some attend Adult Children of Alcoholics meetings as well, and all have personal therapists or counsellors. But although they seek out many available avenues for help, the experience within this group is unique in helping women to

trust and respect *women*, a quantum leap for most of them. After the initial caution and wariness the group developed empathy and caring based on the common denominator of shared experiences. This wouldn't have flourished under other circumstances. It became evident that these women are dedicated, resourceful workers in their own recovery.

The group is an 18-month project funded by Health and Welfare Canada, under the

direction of co-workers from the Pictou County Women's Centre. We intend to reapply for further funding in light of the group's success and demonstrated need. There is a plan to write and distribute a pamphlet on how to set up self-help groups in other counties using this group as a model.

LINDA SMITH
COREEN POWOWICH

Montreal AIDS conference

Empowerment emerged as a major issue in discussions among women at the Sixth International AIDS Conference held in Montreal in June. In terms of treatment, research and education, it seems women's concerns are still not a high priority on the mainstream AIDS agenda.

For the most part conference presentations identified women not as individuals whose health is threatened by HIV but as receptacles for the virus and transmitters of the virus to either children or men. For instance there was an inordinate focus on prostitutes and the threat they are alleged to pose to the "general public" in various parts of the world.

A major disappointment was that the more than 6,000 papers presented at the conference contained little new information about the

actual course of HIV infection in women. Men remain the standard for research studies and for many of the treatment trials now being carried out.

The few sessions that dealt directly with women's concerns (in which even the overflow rooms were always standing room only) concentrated on women's day to day experiences with HIV. Women who are HIV positive pointed to the difficulty of being taken seriously, of getting the support and the information they need. African women talked about educating for safer sex when the cost of a condom is beyond the means of most women. Healthcare workers from New York cursed the cruelties of the American healthcare system which forces poor women with HIV infection to delay seeking help until they are seriously ill. And women from different



Shlomit Segal

parts of the world stressed the huge barriers to women being able to practice safer sex as long as men hold the power in heterosexual relationships. As a woman from Africa commented, "Women's rights have to be put in place even if it means an overhaul of the whole system" so that we can deal with this epidemic.

Throughout the conference an international group of women met to share ideas and frustrations and to strategize on how to counter the continuing marginalization of

women's issues at these yearly international AIDS conferences. As a result, a pre-conference meeting for women is being planned for next year's conference in San Francisco. To contact the organizing committee write: International Working Group on Women & AIDS, c/o Cindy Patton, AIDS Action Committee, 131 Clarendon Street, Boston, MA 02116.

MARY LOUISE ADAMS

AIDS education in the Yukon

Residents of the Yukon have been busy learning more about AIDS as we realize that our northern isolation will not protect us forever. The Yukon government now has an AIDS Information Coordinator responsible for promoting

awareness of the disease through advertising and educational campaigns and condom give-aways. A six-month educational campaign culminated with AIDS Awareness Day, September 8th. On this day various

speakers made presentations to schools in Whitehorse and an evening public event attracted more than one hundred people. One of the featured speakers was Sue Johanson, author of "Talk Sex," whose humorous method stresses the important role parents have in discussing sex frankly with their children. The evening finished with the play "Snap Shots," written and acted by three Native youths from B.C., which will be touring the Yukon.

The Family Life Education Program, another department of territorial government, sponsored a workshop with Allan Robertston and Johanson, who conducted the

Canada Youth and AIDS study. The workshop was directed at youth educators to develop skills necessary for AIDS prevention work.

The Family Life Education Program continues their ongoing programs for school children of all ages, dealing with subjects such as sexuality and relationships. Fran Berry, the coordinator of this program, continues to do an outstanding job of helping youth to be comfortable with the issues that are so important and previously untouchable. This education is essential and will hopefully increase in the future.

LORENE BENOIT



Smokefree

Teaches Women to Quit Smoking

(416) 465-1323

Phyllis Marie Jensen, R.N., PhD.

also FEMINIST PSYCHOTHERAPY
and DREAM ANALYSIS

Sharing health in Huron County

In August 1988, Women Today embarked upon an exciting project entitled "Health Outreach." It is the mandate of Women Today to promote communication between community social service groups within Huron County, Ontario, to serve as a resource for community information and referral and to provide health education and training to women in Huron County.

The "Health Outreach Project" fulfilled all the mandate criteria with its four components of facilitator training, public speaking engagements, workshops and educational events held throughout the year. Facilitator training workshops taught the basics of group dynamics and public

education to help women gain the skills necessary for initiating and maintaining self-help groups. The public speaking component included a presentation of "Doing It Ourselves," an inspiring video by Women Today on the effectiveness of self-help groups as a means of health promotion. [Reviewed in *Healthsharing*, Winter, 1988.] The workshop series included topics such as: peer counseling, dealing with conflict, stress and your job and body image. There were over 30 workshops available to groups free of charge. The final component, educational events, was designed to reach large numbers of people with the aim of providing both public education and

important networking opportunities between various agencies within Huron County. "Women and Addiction," "Healthy Lifestyles," "The Health Needs of a Battered Woman" and "A Guide to Healthy Parenting" were all presented in conjunction with existing agencies and

departments in the County.

We look forward to completing the second and final year of the project with enthusiastic participation from both the people of Huron County and its many service providers.

MICHELE HANSEN



WHS graphics file

An experience that lasts a lifetime.



CUSO NEEDS:

Health Lecturers/Researchers

A *Health Educator/Investigator* for a development program in *Nicaragua*. The ideal candidate would be a nurse with maternal/child health background and at least two years of community-related experience. Duties will include investigating the health needs of villagers and recommending action, giving courses to midwives and village health care workers, and training auxiliary nurses to teach. Language training will be given, if required.

A *Health Educator*, with a diploma/degree in nursing/nutrition and at least three years' relevant experience, to work in severely disadvantaged rural communities in *Sierra Leone*. The educator will raise the level of awareness of health, sanitation and nutrition in villages involved in an adult literacy program.

CUSO offers you a challenge. The chance of a lifetime. Two years living in another culture and an opportunity to work with others who are striving to improve their lives.

It's hard work, but rewarding.

We need someone special. Someone who wants more than 9 to 5. Someone willing to try something different.

If you have skills and experience and can live on a modest salary, we probably have a job for you.

Join other Canadians working in the Third World. Join CUSO.

For further information send your resumé to
**CUSO, CH-14, 135 Rideau Street,
Ottawa, Ontario K1N 9K7.**



Episiotomy power for nurses

In June of this year, the Salvation Army Grace Hospital in Windsor, Ontario instituted a new policy empowering some members of the senior nursing staff to perform episiotomies. (An episiotomy is an incision made between the vagina and the anus during childbirth to enlarge the opening through which the baby will pass.)

Dr. Richard Bourke, the head of obstetrics at Grace Hospital, says that he felt there are occasions where it would be suitable for a nurse to perform an episiotomy if a doctor is unable to attend a

delivery. He adds that this is a relatively rare occurrence, and that only nurses with several years of caseroom experience and special training are allowed to perform the procedure.

Routine episiotomy, like other medical interventions in childbirth, is criticized as unnecessary by proponents of a more natural birth experience. Dr. Bourke emphasizes that rather than being done routinely to prevent tearing, nurse-performed episiotomy is indicated in instances of fetal distress, or other unusual

situations. He is careful to indicate that his intention is not to create more opportunities for medical intervention in labour. "It is not the idea that every woman must have an episiotomy, and that if the doctor isn't there, the nurse must perform it," he says.

The response from Windsor's natural birth community has been mixed. A Detroit-based midwife says that some people fear that every time members of the medical profession are given more powers, the potential for abuse outweighs any benefits.

However, she is cautiously optimistic about the new policy.

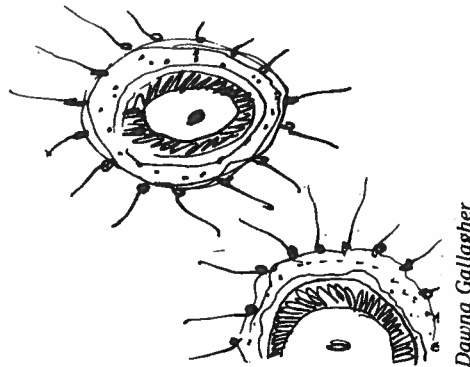
"I think a lot of women would do better (in labour) if the doctor sat in the corner and let the nurses take over anyway," she says. "The research shows that women do better with women — even women they've never met before."

WENDY HAAF

Our voices must be heard by Royal Commission

As we go to press, the federal government has announced the formation of a new Royal Commission on Reproductive Technology. It remains to be seen how useful this commission will be in helping to develop government and social policy which respects the right of women to control our bodies and to make truly informed and safe choices. But we can not ignore it. Despite our legitimate reservations and whatever our differences about strategy in relation to calling for a royal commission, we must see this as an opportunity to reframe the discussion about reproductive technologies and push for a healthy social policy that is accountable to the need of all women.

Upon hearing of the composition of the commission, what first struck us is that the membership is heavily academic. Why is there no lay woman on the commission, or a woman who is infertile or disabled, or who could represent the experiences and perspectives of working class women, immigrant women and women of colour? We also question the strong anti-choice views of at least one of the members and possibly more. The commission as a whole, despite the sympathetic views of a couple of members, may not be open to addressing reproductive technology as a women's issue. But, while taking a sufficiently cautious stance in relation to the commission, women across the country must figure out how to mobilize interest to develop and artic-



ulate clear positions on this crucial issue.

We are also concerned that no budget has yet been set for the commission, which has been asked to report in two years. If this commission is to be anything more than a green light to doctors and the drug and medical industry, we must immediately demand that resources be made available so that the various voices of women across the country will be heard. Letters should be sent to the Prime Minister and the Minister of Health, Perrin Beatty pointing out that the commission will never be credible if it doesn't have a generous travel, research and public input budget.

If the commission is to really look seriously at the social issues involved in reproductive technology, the voices of diverse women must be heard. We must demand that the commission look at setting clear safety standards and testing

procedures for reproductive technologies. We can point out that in vitro fertilization procedures and research continues, despite the extremely low success rate and the potential risk to a woman's health. (If we were talking about a drug or medical device with such a poor effectiveness rate, the federal government probably would not approve its sale in Canada.) We need to educate Canadians about the causes of infertility and push for an examination of alternative means of confronting and preventing infertility. If the medical industry is in part responsible for increasing infertility in both men and women, why should they profit from procedures that supposedly "fix" the problem they have created? And we need to analyze how doctors and the medical industry are profiting from the rapid increase in new reproductive technologies, at the same time as we continue to understand the anguish of infertile women. We need to present an alternative, woman-controlled vision of reproductive health and freedom. We must put the interests of women, as different as we are, front and centre. The commission must hear from us!

Watch for more information and analysis on the royal commission in upcoming issues of *Healthsharing*. If you have some thoughts on this issue please consider publishing them in the magazine.

Women Healthsharing Collective

Quebec nurses' strike

In the month of September, Quebec nurses surprised the Quebec population, the government and even their own union leadership in their greatest display of militancy in the history of this province. After turning down contract offers last June and with a strike mandate of 74 per cent, members of the 40,000-strong F.I.I.Q. (Quebec Nurses' Federation) walked off the job illegally on September 5, 1989.

Nurses' demands included a 10 per cent salary increase for 1989 which would bring their salaries to 85 per cent of other health professionals such as occupational therapists. For many nurses the demands are linked to the very survival of their profession. Low salaries, the lack of full-time permanent positions and poor working conditions have caused an exodus of nurses from the province and in many cases provoked nurses to leave the profession altogether.

The current salary for beginning nurses in Quebec is \$24,325. It takes 12 years to reach the top of the pay scale at which time the salary reaches \$33,139. Given that almost 50 per cent of nursing jobs are part-time, it takes longer to attain the top salary.

The strike settlement has been less than satisfactory and many nurses feel sold out by

their leaders. Despite their gallant attempt to defy the law and stand up for their demands, the union gave in to pressure and accepted the treasury board's offer of increases of 4 per cent plus a 2.5 to 4.5 per cent lump sum payment for the first year, 7.5 per cent for the second and between 4 and 8 per cent for the third year. The lump sum payment will largely be used to pay the stiff financial penalties imposed by the government on striking nurses.

The penalties also include the loss of two days pay for each day on strike and a loss to the union of 12 weeks of union dues. Union leaders may be fined up to \$25,000 each and the union itself from \$20,000 — \$100,000. Furthermore, nurses lose one year's seniority for each day on strike. Many nurses have dropped to zero in terms of seniority. (Seniority is used as a basis for priority for access to job openings within an institution and does not affect the salary scale.)

The government announced that the money gathered from the fines would be given to charities but many charitable organizations have announced that they will not accept money derived from a labour dispute.

The public was largely



Shtomit Segal

supportive of the nurses in their demands since many of them have witnessed the deteriorating conditions in the hospitals first-hand. Despite the repressive measures facing them, and the feeling of little gain, nurses will continue to

fight for more just compensation. The battle may be over for the moment, but Quebec has not heard the last from its nurses.

MARION LOKHORST

Interested in Writing for Healthsharing?

Have you thought about writing a personal column, or re-working some research into a journalist-style article? Have you been wanting to prepare a piece but weren't sure if we'd accept it?

Drop us a line . . . and we'll send you our *Writing for Healthsharing* guideline. It will tell you what kind of proposal we find best to work with, what steps your proposal goes through once you've sent it to us, and the format we prefer for article submissions.

Recollecting our Lives

Women's Experience of Childhood
Sexual Abuse

By The Women's Research Centre

Intensive in-depth interviews with adult survivors and with mothers of children who have been sexually abused provide the framework for this book.

Recollecting Our Lives describes women's actual experience and outlines the types of support, resources and insights that women have found helpful in breaking out of the cycle of abuse.

ISBN 0-88794-019-4

\$14.95 pb

press gang publishers

603 Powell St., Vancouver, B.C. V6A 1H2 Canada

Karin Singer

"Dear Dr. M"

December 30, 1988.

Dear Dr. M,

Almost two years have passed since the day I was allowed to go home. After six weeks on the psych ward my condition had "stabilized." I had suffered a nervous collapse and was admitted to hospital against my will.

It was the culmination of an extended period of acute anxiety and depression brought on by some very bizarre circumstances.

But finally you allowed me to leave. Even though I refused to go on Lithium.* And even though my sense of dignity had taken a severe pummeling in the process.

It's been over 18 months since we last talked, Dr M. A lot has happened...

*Lithium carbonate is prescribed for treatment of manic-depression and, in some cases, depression.

I've moved to a new city with my husband Michael, and have been working at a new and challenging job. Most of the time, I feel pretty good about my life. I enjoy my work and have some good friends here. You know, I feel pretty lucky.

I couldn't have said that the last time we talked. Remember? Depression. Severe burnout. Post-traumatic stress syndrome. During the six weeks in hospital, these were a few of the labels doctors attached to me. Each diagnosis had some validity. But none of them helped me understand what had *really* happened. Nor did they tell me how to get my life back on track again.

At the point I cracked, I had been harassed continually for over six months. Assaulted physically, threatened by telephone at all hours of the day and night, followed home . . . to name only a few of the actions I had tried to overlook. Sharon's violent and strange acts were those of a desperate woman . . . a woman forced to deal with her alcoholism and a failed relationship.

Not long after she and Michael had separated, he and I became intimately involved. I became Sharon's target, her victim, her scapegoat. To complicate matters, she was a colleague and her behaviour affected my job, working relationships and friendships.

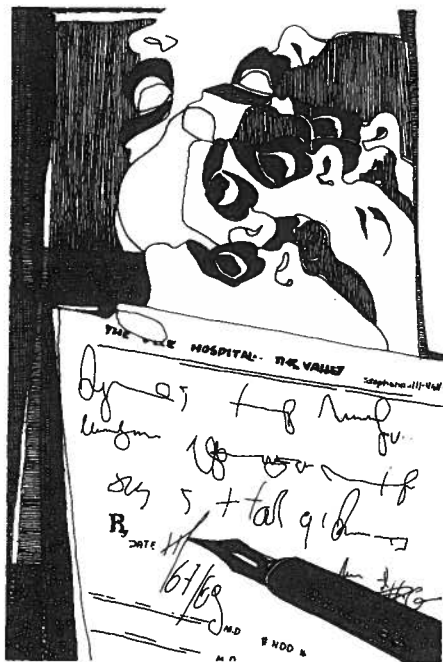
They were a horrible several months. The unraveling of a healthy, competent person. My unraveling. I must admit, reluctantly, that Sharon's abuse struck a chord buried deep inside me. A very vulnerable and negative strand of my soul I had done battle with at various moments in the past.

Ironically, at the point the harassment began I had been feeling more whole, more centred than perhaps ever before. And yet the ghosts of struggles with a sometimes precarious self-image emerged once again amidst the crises and protracted, debilitating insomnia which followed.

When I left the hospital, I knew it would take several months to recuperate from the effects of an acute, stressful situation. I didn't realize I would also have to make sense of a new trauma — the experience of hospitalization itself.

November 28, 1986.

I awaken. I'm dying of thirst. My bed is wet. I'm embarrassed, afraid. Where am I? There is a woman in uniform sitting by the door. She will not let me go to the bathroom alone. She asks someone to make my bed. In the corridor there is a lot of noise. I'm disoriented. I am naked, except for a flimsy green gown which is open in the back. The nurse asks, "isn't there someone you can call to bring some clothes?"



November 30, 1986.

Being on the ward feels like prison. Staff seems to be responsible for crowd control. When some of us walk up and down the corridor for exercise, the doctor cries, "Keep the patients from pacing the halls!" Are we such a hideous sight? With our feet shuffling, droopy eyes and drooling — all side effects of various medications — we must look like members of a club no one would want to join.

The staff has no time to talk. I need to make sense of why I am here. Even Diane, "my" nurse, seems quite judgemental. I must have done something wrong.

I understand they are too busy to really take the time. My job, when I am well, is to act as an advocate for others. I feel like I could use an advocate right now. But I am sedated. It is difficult to think clearly. I cannot focus to read or write. The drugs seem to cause the strangest

reactions . . . Even so, I know vaguely why I am here.

The last episode I remember is Sharon banging on the door of my house early one morning. She is yelling threats at me through the walls. She knows I am alone. She would not leave until I called the police.

Dr. M., I was so ashamed to be there and to need medication. And I felt stripped of my self-respect. In the hospital it was as if I were stopped in time — I had no past, no future. Only that awful present. You had not known me when I was well. No one asked me what had happened. All they saw was a withdrawn young woman in anguish. My diary entry of that day read, "At least if it were the end, there would be some respite from the humiliation I feel."

December 5, 1986.

After breakfast, the orderly tells me to get into a hospital gown to see the doctor. I ask why but he is too busy to answer. Standing in line in the corridor I learn that we are seeing the "physical" doctor.

The doctor is cold, disdainful. Tells me to get on the table. She treats me as if I am dirty, or contaminated. When I try to ask whether the medication (anti-depressants) might affect my period or ability to conceive a child, she is curt. "Ask your nurse. I only do the physical check-ups. Next."

I am angry. That night for the first time I go into the patients' lounge and finally find my voice. I commiserate with a couple of the others. We are talking about how the doctors and staff maintain control. The nurse comes in to tell us to keep our voices down. It is the first time I have really spoken since being here. It felt good to complain. So far, being here only teaches me to hold the anger in, to be numb.

December 9, 1986.

Michael has come to visit after work. We are sitting on my bed. He cradles me in his arms; I lean up against him, feeling the warmth of his body. It feels good to be touched. I can never seem to get warm enough here. The nurse comes in, a disapproving look on her face. She says I should be eating supper with the other patients. Will they ever leave me in peace?

December 18, 1986.

I get a pass to go home over Christmas. By now, I have learned the ropes. Soon after my arrival, I ducked into an open elevator at a rare moment when it was not guarded. The orderly hauled me before the doctor in charge when I returned a few minutes later. She was stern, said I must be punished. I was immediately "certified," meaning legally I could not leave the ward. Since then, I've learned that to have more control over my life while in hospital means being a "good girl."

Being good earns you privileges . . . I can now go outside for a walk if accompanied by another adult. I can go to the mall next to the hospital and pretend to be a "normal" person looking for holiday gifts. Wednesday mornings I go bowling with my floor-mates and it's a chance to be outside. The orderly rounds us up, gives us each a bus ticket. We bundle up in coats and hats — some borrowed from the hospital's second hand clothing depot — and trundle out. I can't help but wonder if it is obvious to passers-by that our motley crew is "the crazies" on an outing.

December 27, 1986.

Back in hospital again. If I'm good I might get a pass for New Year's. Being at home over the holidays reminded me how, while working, I was always in such a hurry. Right now, there can't be any more hurrying. I just can't do it. I feel like such a failure.

December 29, 1986.

My self-esteem is pretty low right now. I have never felt this worthless in my whole life. I know I'm improving, but it is so slow. Today I take the bus by myself to the Y. After my swim, I meet a friend from work for lunch. I feel awkward sitting in the restaurant. Grace is supportive but firm about the job. Do I really want to come back? I'm not sure. I'm not sure I could sustain the pace kept up by my colleagues. I'm frightened by my prospects for the future.

January 3, 1987.

The doctor on the ward says I'm not well enough to leave yet. He wants me to go on lithium. Will not answer my questions about side effects, how



Barbara Pasternak

long I'll be on it. He is impatient, seems angry. When I persist, he declares I am hysterical. As the nurse leads me back to my room I feel dizzy and collapse. Two other patients talking in the hall rush over to help. The doctor sees me from his office and says, "Hah! And she won't follow my treatment!"

Michael spends the afternoon at the library reading about lithium. We learn that it is usually prescribed for manic-depression. I refuse the drug and the diagnosis.

January 18, 1987.

I came home last week. Finally. Am relieved, but nervous about what comes next. What about my job? Several nights I awake in a cold sweat, crying. Hospital scenes parade through my dreams. Michael holds me and caresses my forehead lightly until I slip back into an uneasy sleep.

February 15, 1987.

It's just over a month since I've been home. Tried to take a course during the day, but couldn't keep up with the reading and writing assignments.

Am very low, panicky and sad. I feel like the world has passed me by. When I wake up in the morning, I don't know what day it is. Exhaustion and dread seem to pervade my every waking minute. Don't feel I can talk to anyone about these feelings any longer. It only sounds like complaining, wallowing. Even Michael seems fed up with me.

I go out. Do the groceries and

swim. Noisy places swarming with people still rattle me. Makes it hard to lead a normal life when navigating the Loblaws takes every ounce of courage and concentration I can muster.

Dr. M., sometimes you made good suggestions . . . that I go for long walks by the river each day and watch the swans. That I not drink coffee or eat chocolate. You also tried to get me to "let myself off the hook," to accept the current state of affairs and not think I'd somehow failed.

But for many, many months there were barriers I could not seem to overcome. I could not read very well. The words danced all over the page. My balance was off — and the specialist you recommended had no explanation. I kept asking you if these were side effects of the medication. Why did you not take these concerns seriously? I felt diminished. Did you think I was inventing these problems?

I soon realized there was no model for getting better. I needed to take charge of my own life, make some decisions about my work. But how? Especially when I felt so exhausted all the time. And inadequate. How could I ever go back to work when I couldn't even read the newspaper?

Finally, in a rare bit of personal disclosure, you told me that as a medical student you had spent a year unable to read. But you recovered. And you would help me recover. I had trouble trusting you, because I

felt so bad. I was afraid that I might never be able to work because I could not concentrate enough to read or write well. You were not callous but it was hard for me to imagine that we could have much in common.

In retrospect Dr. M., I think the fact I was a young woman affected how you regarded me. You never took my need to express myself through work seriously enough. Would you have treated a male patient the same way, I wonder?

I appreciate that you did not prescribe drugs carelessly and tried to teach me to relax and be more accepting of myself. But I think the fact you were a male physician, and of a different generation, influenced our rapport.

We talked a lot about finding "structure" for my days, other than my job, like volunteer work or a morning group at the Y. This was tough. I looked but never came up with a place for myself.

March 12, 1987.

Am spending too much time alone. I'm lonely, but afraid of people. My mind races though my body is still. Why can't I just pick up, dust myself off and get going again? I understand, rationally, that recovery is a process. But why the hell is it taking so long? I still cannot do so many things that were just routine before. In my worst moments, I wish I could get on a bus and never come back. The problem is I couldn't leave me behind.



Barbara Pasternak

April 5, 1987.

I feel like I've become one of those people my mother warned me against. The disintegration of a human being. From reliable, caring, responsible and informed — to life as an airhead. All my feistiness has faded. Mostly, I feel like a rag doll. Limp. The medication doesn't make me high, only numb. I can't remember what feeling "well" was like.

Have started writing down what I accomplish at the end of each day. Maybe this will help me gauge progress. I can now feel spring in the air each morning during my walk by the river. Renewal ushers a glimmer of hope.

I eventually did some volunteer work at the local women's centre. It was still a struggle to venture out from the safety and quiet of home. More than a little stimulation made my head spin. But the work was not high pressure and provided a small amount of relief from the isolation I felt. And I did feel more useful and connected to the world as a result.

I think a turning point came in the spring when you told me about one of your patients who had found a job in a doughnut shop. She needed some reason to leave the house each day and to be in a situation where she could not avoid social contact. So I got a job. Over the course of a few months I scooped ice cream, served doughnuts and planted trees. In each of these jobs I learned something. And I was forced to be less withdrawn, if only to say, "Hello, may I help you?" Ice-cream was especially gratifying because people often smiled as they treated themselves or their children.

Around the same time, the real progress started as I became friends with two women who were also off work for health reasons. Spending time with them allowed me to relax, to be myself. I began to like myself again and found I had something to offer them too.

I was finally beginning to find my place in the world again, outside my old workplace. We could talk about what was going on in our lives — we each needed outlets for our frustrations and "healthy" people seemed to tire quickly of hearing our complaints.

QUARTERLY PUBLICATION FEATURES WOMEN ARTISTS

New and established women artists describe their art, their lives, and their philosophies in *Gallerie; Women's Art*.

"A visual feast. The commentary... is as direct and moving, as subtle and as lyrical, as the photos." —*The Womanist*

\$24/year

Mail to:
Gallerie Publications
Box 2901 Panorama Drive
North Vancouver, B.C.
Canada V7G 2A4

Artists write for entry guidelines.

The Woman's Common

The Woman's Common



A Club for Women

- full bar
- restaurant dining
- weekend brunches
- live entertainment
- lounge & library
- cultural events
- films & speakers
- exhibits by women artists

For more information call 975-9079

Open: Tues. - Fri. 4pm to 1am
Sat. 11am to 1am
Sun. 11am to 11pm

Sliding scale membership

580 Parliament St., Toronto, Ont. M4X 1P8

**CRIAW'S
Special Publications
on
New Reproductive
Technologies**

**Our bodies...
Our Babies...**

**Community
Resource Kit**

Each kit contains

- fact sheets on key issues
- information sheets on what you can do about RTs
- A glossary and a list of resources
- Back-up articles
- *Dilemmas*, a publication by the Quebec Council on the Status of Women

Price: \$7.00 + \$1.00 postage

**Reproductive
Technology
and Women:
A Research
Tool**

A bilingual publication which contains a wealth of information for all researchers interested in RTs. This tool contains essays and glossaries in both French and English, extensive bibliographical material and abstracts of key feminist articles and books in English.

Price: \$8.00 + \$1.00 postage

ORDER FORM

of copies

Resource Kit _____

Research Tool _____

Send to CRIAW, 151, Slater St.,
Suite 408, Ottawa, Ont. K1P 5H3.

The bright summer days and new friends brought some fun times too, like long walks and swimming and going to the country at hours when other people were at work. Gradually, as I took some risks with these safe and supportive women, I felt less afraid of other people. And I stopped feeling ashamed for needing an extended period of time to get well.



Without that kind of support I'm not sure I'd be back on my feet today. One of the hardest parts of this whole story was the isolation I experienced from my colleagues and community. I had been harassed by a woman. Had a man abused me, I might have felt greater moral indignation. It was a horrible situation but I was not terribly public or self-righteous about it. Sharon's behaviour — although abhorrent indeed — was occasioned by her pain. Our mutual friends felt torn ... they saw two people suffering. They were not aware of her vicious attacks on me because I kept the details to myself. Consequently, I didn't receive much support from the women I had considered my sisters. At the time, this was bitterly disappointing.

I wish now I had taken steps to stop the harassment much earlier. Before I had to experience the humiliation of hospitalization. Or the label "mentally ill." Instead of trying to

keep the situation under wraps, I might have been strengthened by doing more to stop the attacks.

But it was very difficult to get sound advice at the time. Neither police nor lawyers, therapists or friends could foresee how this perverse saga would unfold. Instead of acting decisively — which would have meant pressing charges after being assaulted — I heeded those "experts" who suggested that taking action might further inflame Sharon. As it turned out, she continued anyway. I was forced to hold my anger in check. Finally, my own body and mind could no longer withstand the pressure and I snapped.

But all this sweet self-knowledge comes in retrospect. Now, two years later, I try to be careful about the levels of stress in my life. Most of the time I am able to function at a reasonably high level. My new job is demanding but also quite gratifying.

I'm also more accepting of the occasional days I need to go at a slightly slower pace. It took awhile to realize that slowing down doesn't mean the world passes you by. After all, everyone has bad days. And I think I'm more compassionate toward others as I become comfortable with my own vulnerability.

There's still room for improvement. Learning to express my anger more honestly remains a struggle. But I have made a commitment not to bottle things up inside. Like most women, I learned not to express anger at a very young age. Un-learning this is important. I know I must not stifle anger because it is unacceptable or unbecoming.

I think I'm now a lot closer to understanding what happened two years ago. You know, Dr. M., it was only much later I realized that not being able to handle a perverse and destructive situation was a healthy reaction, rather than a grave personal failing. I suspect learning to "let myself off the hook" will take a lifetime. Fortunately, there's no hurry. I've got plenty of time.

Regards,

Karin Singer.

Karin Singer is a freelance writer living in Toronto.

MY STORY, OUR STORY

Healing from Within

Lisa M. Phipps

I began a personal odyssey which took the form of a traumatic illness. This story is about how I discovered an inner power and spirit which guided my recovery. Doctors were convinced I had a brain tumour but the illness turned out to be a neurological virus which affected some brain cells causing paralysis in my left arm and leg.

My experience can be divided into three parts: first, the trauma of learning that I was seriously ill and all the emotions that come with that; second, the actual hospital experience and contact with the medical profession; and third, the healing process which is still ongoing. It was in this third phase that I gained the greatest insight into what it was that I needed to make me feel well again — not only to recover from the sickness, but also to find the route to healthy day-to-day living.

While in an observation period of the illness after all the frightening tests were over, I contemplated the reasons why such a thing would happen to me. Like most people, I felt invincible to serious illness and took my health for granted. However, growing up with cancer-obsessed parents caused me to internalize many fears about dying and being ill. Since I witnessed parents using illness in order to have their needs met, I felt I was in danger of following the same pattern.

I now believe that stress accumulated over 30 years from being a responsible, caring and adult daughter (adult even as a child), sister, friend and wife, in other words, all things to everyone except myself, caused a weakening of my immune system which then permitted a virus to enter my body. Sound far-fetched? I soon learned how easily this can happen. I realized that the roles I had been encouraged to play did not al-

low room for self-nurturing nor even consciousness of mind to explore what my needs might be. And I discovered that I'm not alone.

When told of my condition, my first reaction was to deny it; not out of fear for myself (that came later), but out of the fear of being a bother to others. So, I chose to isolate myself rather than let people see me as needy. What I did not realize was that this illness was my own cry for help. I was trying to tell people, particularly my family, that I have needs, too, and getting sick was the only way I knew how to say it. In the past, Victorian women labelled as "hysterical" were also reaching out for help because of a sense of loss in their lives, a loss of themselves. Being diagnosed as ill was a perfect excuse to refuse the needs of others and bring attention to themselves.

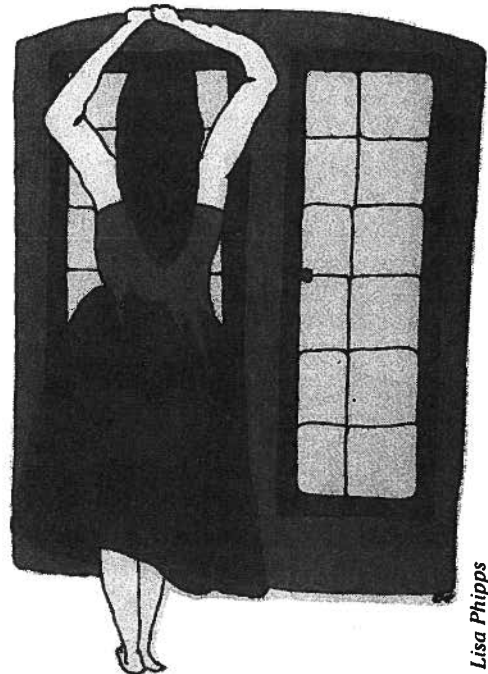
In the meantime, my contact with the medical profession was frightening and depersonalizing. As well as being treated as a "condition" that warranted exploration and treatment, I was also a woman in a predominantly male-ruled environment. Wellness was not the focal point of my hospital stay. Words of Adrienne Rich echoed in my head: "We were, above all, in the hands of male medical technology. The hierarchical atmosphere of the hospital . . . The loneliness, the sense of abandonment, of being imprisoned, powerless and depersonalized . . ." (*Of Woman Born* by Adrienne Rich. This quote describes her hospital experience while giving birth to her son.)

I, too, felt a loss of control and participation in my illness; almost as if the illness was no longer mine. The general attitude from doctors was, the less I knew the better. One response to my questions about the brain was, "You wouldn't understand, anyway." I was also uninformed

about the drugs prescribed to me. I had to do my own research to find out why I experienced the side effects that I did. This patronizing and superior attitude of male doctors towards women patients (and nurses) clearly told me that our health care system is indeed a male realm.

My healing process took off when I decided to play an active part in accepting my illness by *wanting* to heal and vigorously seeking help, instead of simply "wishing" for things to get better. I learned to conjure up active hope, faith and creativity, which is where true healing lies. I moved away from the more accepted and traditional cures (which had up to this point only created fear and negativity) and became more trusting of the spiritual and the emotional. With the support of a loving mate, good friends, self-healing books like Bernie Siegel's *Love, Medicine and Miracles*, music, exercise, a gifted psychic's advice, psychotherapy, art-work, weekly sessions at a relaxation clinic and recording my dreams, I learned to trust what my inner self was saying to me. It told me how to get well and how to be healthier than I'd ever been before. It worked because for the first time I was in touch with my sub-conscious, not just my conscious mind.

Most doctors are aware of the "will



Lisa Phipps

to live" phenomenon, as clearly seen in critically ill patients who outlive their prognoses on nothing more than their own refusal to give up. But these recoveries are viewed as miraculous and not seen as a possibility of our latent human potential to heal ourselves. Doctors are trained as scientists, and in science there is a denial of the spiritual and the emotional.

At this point, I knew that even if there *was* a tumour, I was going to get through this. All my options were now positive ones and I steeled myself for chemotherapy, knowing that as long as I paved the way with positive affirmations, I would heal.

So, my second stay in the hospital for exploratory brain surgery was dramatically different from the first. My new attitude and slowly growing faith in myself gave me the courage to ask for what I wanted, whether it was a request to the surgeon to speak positively to me under the anesthetic, or choosing which family member could visit me and for how long. The difference was that I felt in control. Whatever the prognosis would be, I felt I had become a

different person. I was a winner.

The work I did on myself not only led to recovering faster after surgery, but I also returned home with a new sense of self-worth, a new connection with my *own* feelings and new definitions of privacy by knowing what boundaries people could and couldn't cross.

I want to stress here that my healing could not have been complete without western allopathic medicine. Along with my spiritual work, prescribed drugs and surgery were also necessary and I would not have had the courage to refuse them completely. I had trepidations about taking the plunge into holistic medicine when I was still very sick, so I chose a necessary balance.

I resisted the additional stress of chancing a completely non-chemical cure. While I did experience skepticism from doctors to accept any non-traditional treatment such as positive affirmations and visualization, I still learned to trust the medical profession more than I have and was comforted to know that help is available in an emergency.

My healing process is ongoing and it has been physically and emotionally difficult. I became aware of the needs of disabled people, disabled women in particular, due to my own mobility limitations. Our society as a whole is still oblivious to anything other than what is considered normal, and now I understand how people become isolated and excluded from day-to-day life.

Strong feelings of isolation also came from my altered physical appearance because of drug side effects. Corticosteroids cause the body trunk and face to bloat, and I had only a layer of fuzz for hair — somewhat symbolic to me of "starting anew." I no longer conformed to societal standards of femininity and beauty, and I experienced a sense of loss for the face and body I was accustomed to seeing in the mirror. I prayed every day to feel special again. How sad, I thought, that I have a need to feel "beautiful" in order to feel worthy. I also felt family members' discomfort because they did not know how to relate to me looking the way I did. I was forced to step outside myself to see my role within my family, and that role relied heav-

ily on physical appeal as well as emotional caretaking, neither of which I was capable of having or giving.

It was only with my women peers and my husband that I was able to relax and feel accepted. As I have heard other women claim, feeling unattractive and looking "different" in our society leads one to feel somehow undeserving of happiness and privileges because so much is geared to standardized "feminine" beauty. I wondered how non-conforming lesbian women and women from other countries and cultures felt, and what privileges they have been excluded from.

So I learned how to live in the "now." Up until this time, even before my illness, I had missed the present and wasn't really living at all. The guidance of a woman therapist helps me to stay grounded. I have learned that needs that were not fulfilled as a child can be met now by other people in my life. "Take days to meet your needs and you won't need an illness." (Bernie Siegel).

We, as women, need to learn to reach inside ourselves and pay attention to what's there, to listen to our inner voices and to acknowledge sadness and anger — things women are not trained or encouraged to do. It is there where true healing and self-nurturing takes place. Once we give ourselves permission to love and honour our spirits, we in a sense give birth to ourselves. I am convinced that in rebirth there is new found hope, faith in our Goddesses (which in essence is faith in ourselves) and love. Only this time there is enough love to go around without depriving ourselves, and the quality of that love is richer and truer because it comes from the core.

The strength and effort required to go through the healing process is enormous. Since it is still an ongoing process for me, I am plagued daily by doubts and fears because I am not accustomed to trusting myself or being good to myself, yet deep down I know I am doing what is right for me.

Lisa Phipps is a feminist living in Toronto who works full-time and is currently a part-time Women's Studies student at the University of Toronto.

SUBSCRIBE!

RADIANCE is an upbeat, positive quarterly magazine for women all sizes of large, of all ages, lifestyles and ethnic groups. It's a dynamic resource linking large women with the products, services and fashions just for them.

Each issue features articles on health, media, and fashion along with compelling profiles of successful large women from all walks of life. Poetry and art decorate each issue as RADIANCE encourages and supports its readers to live fully now, whatever their size.



\$22/1 yr. (surface)
\$30/1 yr. (air)
Send U.S. funds
or international
money order to:
RADIANCE
P.O. Box
31703
Oakland, CA
94604
(415)
482-0680

Debbie Field

The Mother Myth

A FEMINIST ANALYSIS OF POST PARTUM DEPRESSION

When I planned to have children, it never occurred to me that I would experience anything but the greatest joy after giving birth. In fact, I felt pity and extreme disassociation from women who were distressed in their post partum (after birth) period. So, along with the other almost unbearable feelings I had after the birth of both my children — depression, anxiety, insomnia, despair and fear of suicide — I was shocked and ashamed. How could I feel anything negative? Both children were healthy and wonderful and I was in a loving and long-standing relationship with my partner.

I write this article to deal with that shame, to publicly empathize with the hell that post partum depression is, even though I had the great luck to pass through the worst of it within six months of my children's births. I write for myself in the ongoing process of understanding what happened to me and to reach out to those who are currently experiencing it. I write to argue for a change in the social definition of what acceptable feelings are in motherhood, to de-stigmatise and help alleviate the pain of post partum depressed women. And since post partum depression is a metaphor of women's oppression as mothers, I write to ask some crucial questions about the problems that isolated nuclear family parenting poses for women.

Had I not been so deeply shaken by the rawness of my feelings after my children were born, I would have continued to believe that parenting should always feel positive, that any

ambiguous feelings towards the children had to be repressed. Like other depressions, post partum can become a valuable gift, filled with insights into ourselves and the contradictions of loving anyone, particularly children.

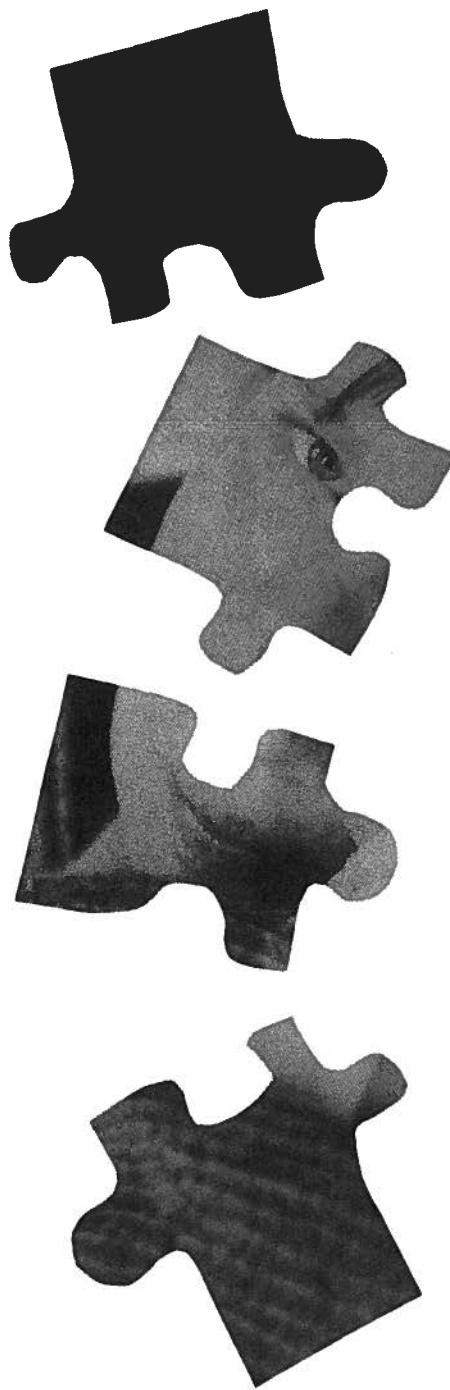
Few extensive studies exist on why post partum depression occurs, how many women experience it, how long it lasts or what the best options are for alleviating it.

Both the medical profession and the self-help movement use three classifications. During the first three weeks of their baby's life, somewhere between 60 and 75 per cent of women experience a day or a week of the "baby blues," with wild mood swings, unexplained rages and inconsolable tears.

At the other end of the spectrum is post partum "psychosis," affecting one in 1,000 new mothers. These women have a complete breakdown with extreme suicidal or homicidal feelings, hallucinations and reality shifts. They are usually hospitalized and/or heavily medicated.

Somewhere between these two, one in 10 women are estimated to have strong feelings of depression, anxiety and fear of homicide or suicide for six months to a year. Though they remain capable of functioning, they are often terrified that forced hospitalization, medication and potential loss of their children are right around the corner.

The creation of these categories



tends to hide the fact that all three conditions bear similarities with each other *and* with the feelings of mothers who are generally happy in their post partum. Because post partum depression relates to the role of mothering, most women will find minutes or hours reminiscent of post partum depression long past the end of the first year when the crisis has passed.

The classifications, with their apparent clinical basis, serve to make post partum depression into a medical condition. Instead of seeing isolated motherhood as the cause of a woman's anxiety, the medical profession defines post partum depression as an illness requiring medical intervention. The most common treatment is anti-depressants. Though extreme cases may require drugs, the majority of women need counseling and strong, consistent family/community support.

Extreme anxiety, not depression, is the most common symptom. Hildi Wolfish, a Toronto therapist with a speciality in post partum, suggests that pre-parenting anxiety is a more accurate term to describe post partum depression.

The anxiety takes different forms. Some women, overwhelmed with concern over the child's health, will run into the baby's room every few minutes to see if she is still breathing. Others, so concerned about cleanliness and germs, do not leave their houses.

For others, the anxiety is not about the child's safety, but their ability to effectively mother. Previously self-contained women become incapacitated with insecurities and doubts about their ability to parent. Eventually she may come to doubt her ability to love the child and this feeds her shame in talking about her anxiety and depression.

Some women experience free floating anxiety — one moment they are calm and content, the next they have broken into a cold sweat, heart pounding, knots in their stomach. This often comes in the night, keeping a woman from sleeping, even when the baby does. Inability to sleep becomes another example of their failure as a person and mother. Rather than situating their insomnia in the reality of a pattern of sleep de-

privation and disruption, never being sure whether the next baby's cries will be in 20 minutes or two hours, the woman blames herself.

All new mothers will recognize these anxieties. The difference is in their degree, and the mother's ability to keep the anxiety from taking over. A generally happy mother may feel anxious for a short time, but it passes. Another woman's anxieties may last for months as she loses all sense of herself, caught in a maze of fears.

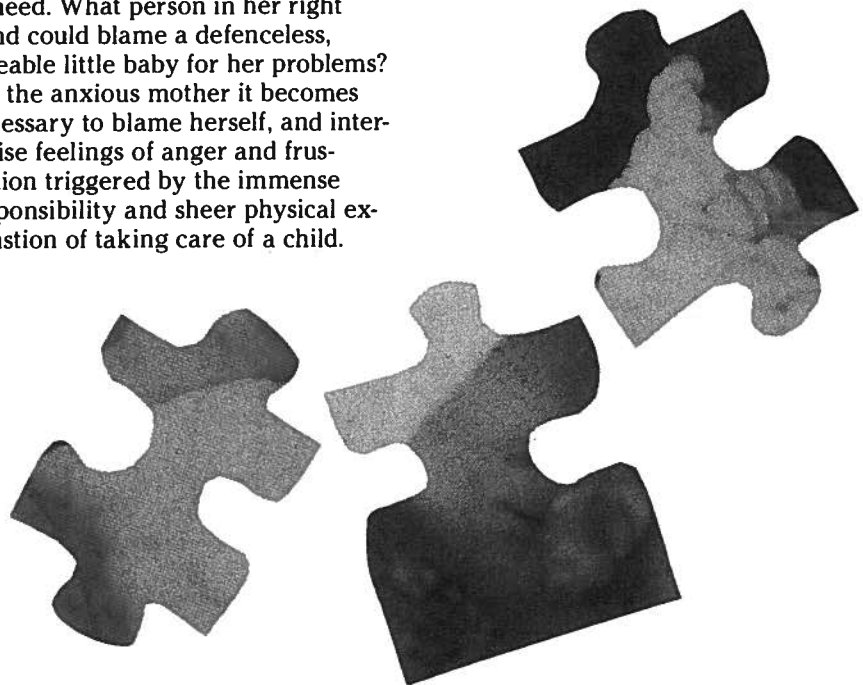
For all the focus on the desirability of men sharing child-rearing, most women continue to take major responsibility, whether as single mothers or in a couple. Women's special claim to post partum depression is an indicator of how strongly we continue to internalize the responsibility of being the primary parent. Planning and worrying, two important components of parenting, become the basis for acute post partum anxiety. Likewise, women's ability to put the child's need before their own, particularly in the early period, leaves them vulnerable to a degree of self sacrifice that borders on self destruction.

Babies are simultaneously wonderful, beautiful balls of love and affection and totally frustrating creatures of need. What person in her right mind could blame a defenceless, loveable little baby for her problems? For the anxious mother it becomes necessary to blame herself, and internalise feelings of anger and frustration triggered by the immense responsibility and sheer physical exhaustion of taking care of a child.

Not letting herself feel anger at the baby, at her sense of deep isolation, the new mother becomes depressed. Her mother, siblings and other relatives, in most cases, live far away and are unavailable for daily support. She knows no one on her street. The few other new mothers she meets, at stores, the park, post natal classes, seem to be having a fantastic time.

She is angry at her friends who are never around when she needs them, and say things which make her feel more like a pariah. She represses all negative feelings towards the others, and tells herself she should be happy, should be making good use of the time off work, should be appreciative of all the love of those around her towards the baby.

The massive energy spent repressing so many real feelings results in full blown depression. She fears she will never return to her energetic, productive self. Everything seems completely bleak. She finds it harder and harder to feel any love for the baby, her companion, her family and friends. A terrifying tower of suicidal feelings develops from the building blocks of more understandable feelings. Placing exhaustion on top of inexperience, guilt, insecurity and fear of being alone, she comes to feel totally trapped.



Some women turn their negative feelings outward, fantasizing hurting or killing the baby. All parents will recognize these feelings, usually in milder forms. Alone all day with a child, it is hard for an adult not to become frustrated and lose patience. The generally happy mother will snap out of her anger while the post partum depressed mother becomes fixated on the idea that she is going to harm the child.

Both the woman who is depressed and suicidal, and the one so anxious and fearful of abusing her child, could be helped. If the social supports were there, for example, if there was someone she trusted to hand the baby to, her depression, anxiety and fear would never get out of control.

The symptoms and diagnosis of post partum depression vary widely. In my reading and through discussions with close to two dozen women of varying sexual orientation, countries of origin, races and classes, I have identified four common characteristics. They are not a formula, but a series of potential indicators.

First and foremost, post partum sufferers are isolated from their extended families, either geographically or emotionally. At no time in history have women been expected to raise children in such a private and isolated fashion. In the majority of third world countries today, as in most pre-industrial societies, new mothers are surrounded and supported by the women of their community. In the 1950s, during the growth of North America's suburban communities, new mothers enjoyed extended support systems based on close proximity of neighbours who were likewise full-time mothers. From the coffee klatch to the car pool, these women shared many aspects of day-to-day mothering.

Now, most women living in "western" capitalist countries raise children alone in their apartment or house, far away from friends or family. Without experienced mothers to guide and assist new mothers, it is harder to learn to become one.

Second, post partum depressed women are usually accomplished,

highly productive and in control of their daily lives. This affects women who have been in the work force for years, used to the social recognition of paid work, as well as women who have worked only in the home. All of a sudden it is impossible to get a meal cooked, let alone finish a sewing project or a letter. This role dislocation can be extremely jarring to a woman's identity.

Most post partum depressed heterosexual women report anger that the life of their male companion remains relatively undisturbed while their life has been completely transformed. Often this anger translates into struggles over when the companion is coming home and when the woman can get a few hours off. A woman, married for years, living a relatively equal life with her spouse, each working and sharing domestic chores, now finds it a shock to be a full-time mom and housewife.

One of the many questions which needs to be researched is whether single mothers or lesbian mothers involved in co-parenting with another woman, face the same incidence of post partum depression. What effect does the absence of struggle with a male partner over domestic division of labour have on the experience of single and lesbian mothers?

Third, post partum depressed women seem to have had problems getting their own most basic needs met when they were babies. This can have different roots — the death of a parent, their parents' preoccupation with economic survival or other siblings. Whatever the reasons, post partum depressed women have often experienced abandonment as children. As a result they have negative feelings about how they were mothered, which leads them to feel inadequate as mothers.

If feelings of childhood abandonment are unresolved it is difficult to be around a needy child. Faced with a crying baby, the adult is reduced to her own past neediness.

The final indicator relates to hormonal imbalances. All women take a hormonal roller coaster ride after birth. But no one knows whether this is stronger for post partum depressed women. They will tell you that their depressions and anxieties feel as if they have a physiological logic



all under one roof

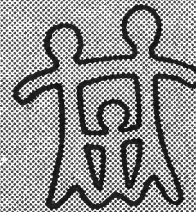
Parentbooks

201 Harbord St. Toronto, Ont. M5S 1H6

Mon. — Sat. 10:30 — 6:00

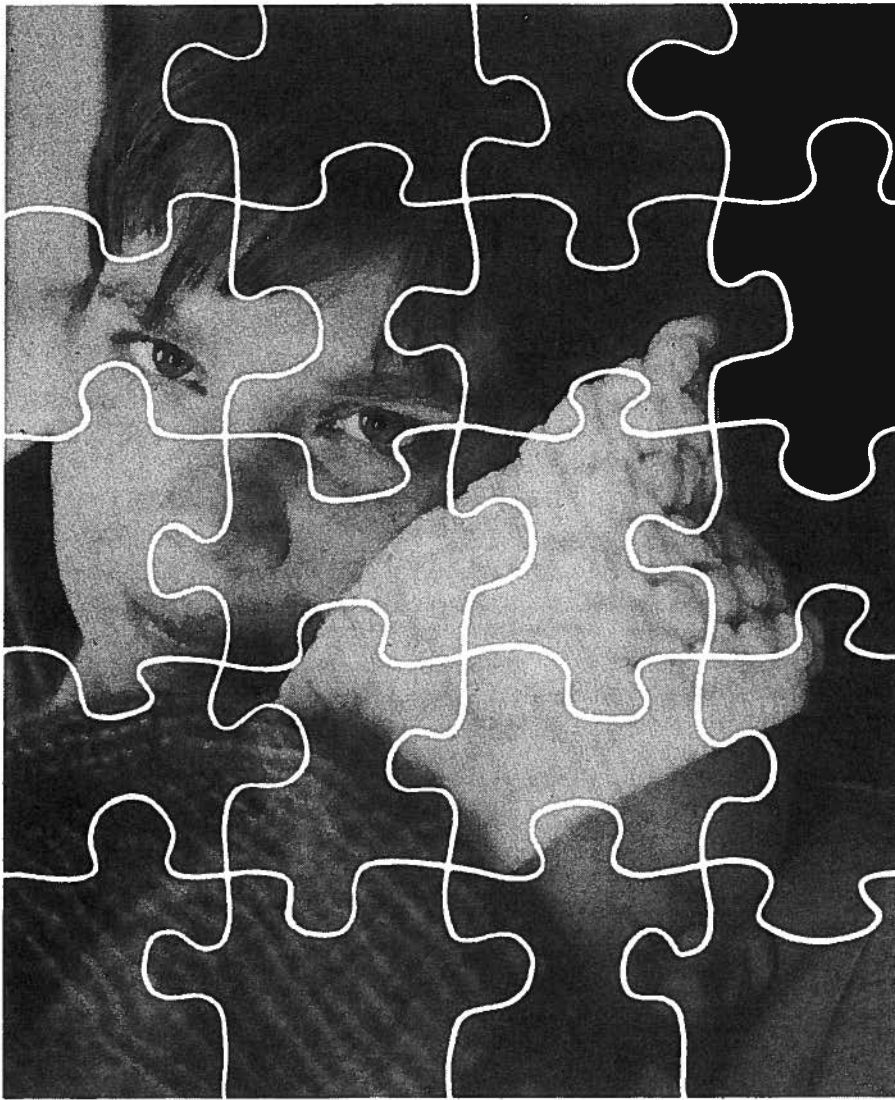
Phone (416) 537-8334

Childbirth Education for Informed Choice



- small classes
- extensive resource library
- individual instruction available
- creative workshops for siblings - to - be

Sheryl Nestel, B.A. CCE
Certified Childbirth Educator
50 Ellsworth Avenue
Toronto, Ontario M6A 2K3
(416) 658-3135



Sara Scythes

equally after the initial period of breast feeding. Exercise was important, enabling me to regularly get out of my head, into my body, helping me to sleep better.

If there is any advice I would give to women in the midst of a difficult post partum period, it is to make sure you are talking, especially to those who can identify with your experience. Through counseling, self-help groups, discussions with friends, family and former post partum sufferers, you can reduce your risk and alleviate the anxiety.

An effective post partum support network would include: a 24-hour hot-line staffed, if possible, by women who have been post partum depressed; affordable therapists to see a woman often, even daily, during her worst periods; a drop-in location, with childcare, exercise facilities, kitchen or restaurant; and availability of alternate treatments such as acupuncture, chiropractic treatments, nutritional therapy and massage.

Women who can't get out of the house need someone to come to them, to talk, cook and clean and take care of the child (or children), whatever the social cost and organizational difficulties of providing such a service.

Since there is no one solution, doctors with expertise in post partum drugs should be part of the support network. Anti-depressants, as a way of getting through the worst, can be very effective, as can the selective use of sleeping pills to break insomnia. If a woman is stuck and drugs work, no one should moralise about how drugs aren't the best way.

As we envision an effective post partum support system, we come up against the major problem facing post partum depressed women — the reality of isolated mothering.

As women, so many of our battles have been about our right to equal employment, equal pay, equal education, equal status in the world outside the home. And though we continue to make substantially less than men, more of us work in the paid workforce than ever before.

But while we have entered the public world, we have been expected to continue our primary role in raising children. The few concessions we

beyond any emotional explanation they can muster. Until research is done, we don't know to what extent post partum depression is hormonal.

Much of the current medical treatment for post partum depression rests on the assumption that some women's hormones just go "snaky" and they need drugs to adjust them. But if the problem is hormonal why are anti-depressants rather than hormones the remedy? Drugs numb depression and anxiety and hide them behind a veil of sedated feelings instead of producing insights and changes in a woman's life.

The medical profession has done virtually nothing to uncover the causes and develop an appropriate therapeutic strategy for post partum sufferers. What stands out is the same shallow, pseudo-scientific response which is characteristic of the

approach to so many "women's problems." Though doctors may legitimately be trying to stop a woman's pain and save her life, drugs are prescribed above all to conceal and suppress the symptoms of a larger social problem.

For me, time healed the hormonal disruptions, while psychotherapy brought insights into my childhood feelings of abandonment. I needed to hear that I would survive and return to my old self and the only advice that consistently worked for me was that my depression, like others, would pass. Returning to paid work affirmed my identity outside of the mothering role. And discussions with my partner clarified his willingness and need to share child-rearing

have been able to wrest from the system, such as childcare, come nowhere close to being substantive social supports for our child rearing efforts.

And so we are caught, wanting it all, being expected to do it all. Post partum depression is a flag, letting us know that a very large number of us, can't in fact manage it all.

Grappling with the contradictions between women's increased activity in the public arena, and her continued responsibility for the private one, theoreticians in the women's and socialist movements have demanded that children become the responsibility of society. Elaborate collective childrearing was tried, and then given up, in the Soviet Union after the 1917 revolution. A more lengthy experiment occurred during the 1950s and 60s in the Israeli kibbutz, where extensive reorganization of child-rearing was attempted. In order to allow women to fully participate in production, children were raised from their earliest months in same age groups, surrounded by consistent and loving staff. Parents and children would spend a few hours a day together, but the great part of their daily maintenance was considered a shared community responsibility. Besides freeing women, the kibbutz system attempted to free children from negative nuclear family patterns.

After the birth of my children, I could see why there was a movement away from collective child-rearing as a model. Cozy and warm in my nuclear family, in love with my babies, I could identify with the strong parental feelings which defeated alternative arrangements.

Now I find myself returning to earlier views on child-rearing. It may be that Soviet and kibbutz models were too rigid, with insufficient time allotted for parents and children.

But as long as we continue to isolate what has for centuries been a collective task — the raising of children, we will continue to have serious problems. To the devastation caused by sexual and physical abuse within the nuclear family, we can now add the anguish faced by a large percentage of women who find isolated mothering too difficult.

Ultimately, post partum depression

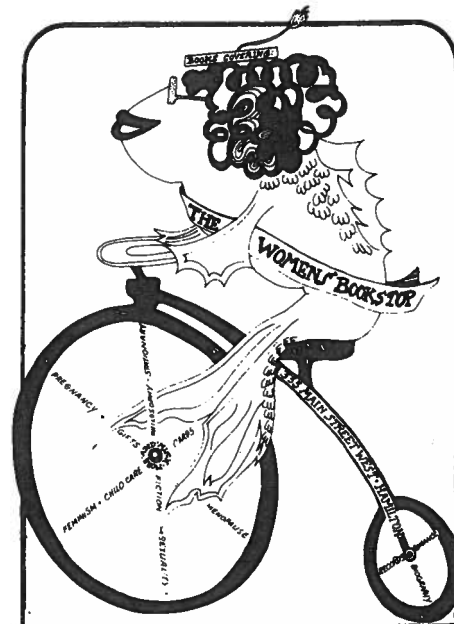
will not be eliminated as a widespread condition that debilitates and sometimes destroys women until we provide some fundamental social supports for women and men who are parenting. This may involve collective arrangements such as past experiments. Other plans which more accurately reflect the cultural preferences of today's society might be more successful, such as a reduced work week which would enable mothers and fathers or perhaps a larger extended family team of adults to raise children. In demanding broader community involvement in childrearing, we not only save women from shouldering too much responsibility, but we also humanize our society, providing more adults with the opportunity to experience the immense satisfaction of parenting.

While we await a revolution in child-rearing, parents can arm ourselves against the worst effects of the nuclear family. Support systems such as daycare, links with other adults raising children and the incorporation into our extended family units of adults who do not have children, all help to break down isolation. Most importantly mothers can remember that what we experience through the sieve of our personal anguish is often the contradictions of current mothering structures.

Resources

The most successful post partum self-help network in Canada is the Pacific Post Partum Support Society. They have published an excellent booklet, *Post Partum Depression and Anxiety: A Self-Help Guide for Mothers* which is available for \$5.00 from Suite 104 — 1416 Commercial Drive, Vancouver, BC, V5L 3X9. Call (604) 255-7999 for more information.

Debbie Field works as an assistant to a Metro Toronto Councillor and has years of experience as an activist in the women's, union and solidarity movements.



333 MAIN STREET WEST,
HAMILTON, ONTARIO
(416) 525-2970
Women's Bookstop

feminist perspectives

No. 14 - Redesigning Health Care for Women, by Monique Bégin, examines the history of the provision of health care in Canada and concludes that neither the conventional bio-medical model nor the daily practice of health care deal justly with women's health concerns. A number of action goals for female users of the health care system are identified, including: the de-medicalization of life; the empowerment of women through reappropriation of the body, self-examination, self-help groups, women's clinics and other practices; and questioning the machine model of scientific medicine and recognizing its cultural and other biases. Published bilingually with *La refonte des soins de santé destinés aux femmes*.

Price \$3.00 + \$1.00 postage each. Order from:

**CANADIAN RESEARCH INSTITUTE
FOR THE ADVANCEMENT OF WOMEN**

151 Slater, Suite 408,
Ottawa, Ontario K1P 5H3

Pamela Philipose

Earth, Air and Water

WOMEN FIGHT FOR THE ENVIRONMENT IN INDIA

It is now a universally established fact that it is the woman who is the worst victim of environmental destruction. And the poorer she is, the greater is her burden. What may spell prosperity for some, spells disaster for her.

Industrialization, the phenomenal growth of cities, the proliferation of a cash economy, all these factors have played havoc with the earth's vast stores of natural wealth — its forests, its rivers, its very air.

What has all this meant for the women of the developing world? In simple terms, it has meant longer hours spent doing back-breaking household tasks, like collecting water, foraging for fodder and fuel. A ceaseless cycle that goes on in good health and bad, in pregnancy or old age, in all kinds of weather. It has also meant industrial disasters which have snuffed out thousands of human lives in the course of a few hours. It has meant that whole communities suddenly find themselves face to face with starvation.

I would now like to take you on a guided tour of India. We'll be making three important halts. The first, which I have called "Earth," is a case study from the northernmost villages of Uttar Pradesh (U.P., a northern state) which lie in the lap of the Himalayas. This region has witnessed a remarkable nonviolent ecological movement, popularly known as the *Chipko andolan* (the hug-the-trees movement).

The second section, which is entitled "Air," deals with the great Bhopal tragedy. Bhopal is a city of approximately 800,000 people in Madhya Pradesh (a state which forms

the heartland of India).

For the third section, we'll travel down to the coastal villages on the southern tip of the subcontinent, in the state of Kerala, which have witnessed a 34 year fisherfolk agitation. This section goes under the heading "Water."

Earth

The Chipko movement clearly demonstrated, as no other movement did before it, that women have a deep commitment to preserving their environment, since it is directly connected to their household needs. It also shows how nonviolent methods can sometimes "move mountains."

The first incident that heralded this new movement took place at Gopeshwar village, in the Chamoli district of U.P. Three hundred ash trees in the region had been allotted to a sports goods manufacturer by forest officials.

In March 1973, the agents of the company arrived at Gopeshwar to oversee the felling of the trees. Meanwhile, the villagers met and decided together that they would not allow a single tree to be cut down by the company.

With the support of Sarvodaya activists (Sarvodaya workers believe in the nonviolent ideology of Gandhi), they walked in a procession, beating drums and singing traditional songs. They had decided to hug the trees that the laborers, hired by the company, were to axe. The agents of the sports company had to retreat in the face of this unexpected onslaught.

The Gopeshwar incident was only the first of a long line of similar ac-

tions, but already the enthusiastic participation of the women was very evident.

Actually, flooding had helped to dramatize the issue, when the Alaknanda River, which runs through the region, breached its banks in 1970. Hundreds of homes were swept away. Sarvodaya workers succeeded in explaining the links between the flooding and the consistent tree-felling by lumber companies, which had resulted in tremendous soil erosion. In 1973, when the floods occurred again, the villagers were quite conscious of the deforestation problem.

A year had gone by since Gopeshwar village had managed to retain its trees. The Forest Department announced an auction of almost 2,500 trees in the Reni forest, overlooking the Alaknanda River. This time it was the women who acted.

It so happened that the men of the village were away collecting compensation for some land taken from them when the employees of the lumber company appeared on the scene. One little girl spotted them and ran to inform Gaura Devi about it. Gaura Devi, a widow in her 50s, was a natural leader, and organized a group of about 30 women and children who went to talk to the contractor's men.

Gaura Devi is said to have pushed her way forward and stood before a gun carried by one of the laborers. She defied him to shoot her first, before touching the trees. "Brother, this forest is our *maika* (mother's home). Do not axe it. Landslides will ruin our homes and fields." She and her companions were successful in forcing the angry contractor and his men



Phyllis Wong Kun

She defied him to shoot her first before touching the trees

to return without their logs. That night, the women of the village stood guard over their beloved trees.

Soon after this incident the U.P. government set up an official committee to inquire into the validity of the Chipko activists' demands. After two years, the committee reported that the Reni forest belt was a sensitive area and that no trees would be felled there. The government banned tree-felling in the area for 10 years.

News of the Reni victory soon spread. The real importance of the Chipko movement was that it did not fizz out. Its message was taken by committed activists from village to village.

In August 1980 a curious thing happened, at another village in Danori Pantoli. The all-male village council had made an agreement with the Horticultural Department under which a nearby oak forest was to be felled in exchange for a cemented road, a higher secondary school, a hospital, and electricity for the village.

On hearing about this deal, the arvodaya activists working there tried to persuade the council to change its stand. The men did not agree, but the women in the village decided they would protect the oak forest at any cost. The men were so incensed by this that they warned

the women they would be killed if they defied the council's decision. Undeterred, a large number of women went ahead, held a Chipko demonstration, and saved the forest. The government soon banned tree-felling in this region as well.

The incident showed just how far the women had progressed. They had new confidence. They now demanded to be members of village councils; they formed *Mahila Mandals* (women's committees) to ensure the protection of forests; they appointed watch-women who received regular wages to supervise the extraction of forest products; they planted saplings.

Today, there is a woman leader in the Gopeshwar (local government), that was unheard of earlier. Little wonder, then, that the image the Chipko movement brings to mind is that of a group of toil-worn women hugging a tree to save it.

Similar movements are taking place in other regions of India too — like the Appiko Movement in the western Ghats region of Karnataka; the Girnar Movement in Gujarat and Goa. The bad news is that, according to the latest satellite data, India is losing 1.3 million hectares of forest per year. The Indian government's ambitious social forestry programmes seem to cater more to the needs of

paper and other wood-based industries than to the fuel and fodder requirements of the people who are being robbed of their forests. So unless more and more Chipko-type movements take place, the harvest will be a bitter one.

Air

"Bhopal" is now synonymous with mass death through industrial pollution. It has become the sharpest indictment yet of the duplicitous and hypocritical policies of multinationals that have one set of safety considerations and criteria for plant and equipment design in the West, and quite another set for their Third World subsidiaries.

Spread over an area of 40 square kilometers, the Union Carbide complex at Bhopal manufactured MIC-based pesticides. (MIC is Methyl Isocyanate.) On the night of December 23, 1984, the highly toxic MIC escaped from the factory, converting a quarter of the sleeping city into a gas chamber.

No one knows how many people really died that night. While the official figure is 2,347, an unofficial UNICEF assessment put it at 10,000. About 30,000 to 40,000 people were seriously injured, and another 200,000 badly affected, of which 75

**No one knows
how many people
really died
that night ...
the worst affected
were the
poorest of the poor**



Phyllis Wong Kun

per cent were slum dwellers, 40 per cent children, 15 to 20 per cent women in the reproductive age group, and 10 per cent elderly women. The worst affected by far were the poorest of the poor. Their patched dwellings offered them very little protection against the gas.

Autopsy findings done on the bodies revealed massive destruction of lung tissue, damaged livers and kidneys, and circulatory systems completely drained of blood. Cyanide was found in the blood and viscera of the victims.

For those who survived, it was almost a living death. Men and women were completely or partially blinded, with continual watering and burning of the eyes, incessant headaches, vomiting, breathlessness, racking coughs. Psychologically, they were anxious and depressed, many had lost their loved ones, many were reduced to poverty because they couldn't work any more.

The manner in which the govern-

ment conducted relief work was singularly ineffective and chaotic — a confusion compounded by controversy over the right line of treatment. Union Carbide did not help matters by its attempts to feed the public with disinformation. Relief funds very often did not reach the hands they were meant for. And the victims, with women figuring prominently among them, began to heckle medical teams. They also held demonstrations outside the residence of the chief minister of the state.

Voluntary agencies did some of the best relief work. For instance, the women of the *Nagrik Rahat aur Punarwas Samiti* discovered for the first time that women exposed to MIC were suffering from severe disorders of the reproductive system, in addition to other complications.

It was left to two committed women doctors — Dr. Rani Bang and Dr. Mira Sadgopal — to systematically document their findings after examining 55 gas-affected women, three

months after the disaster. Their study confirmed that, since the gas exposure, an extremely high percentage of women had developed gynecological diseases like leucorrhea (94 per cent), pelvic inflammatory diseases (79 per cent), excessive menstrual bleeding (46 per cent), retroverted uteri (64 per cent) and cervical erosion (67 per cent).

Those women who were pregnant at the time of the disaster were in a pathetic state. Quite apart from the effects of the poisonous gas itself, hypoxia — or lack of oxygen resulting from lung damage in the mother — is known to cause fetal distress. Most of the victims were given high doses of corticosteroids and tetracycline — both of which could have caused fetal damage. All this was known at the time, but no effort was made to educate the women about the possibilities of the ill-effects and offer safe facilities for abortion to those who didn't want to take chances.

Somehow, the women's movement

in India was not able to make a deep impact on a situation that warranted much more sustained campaigning and relief work. But there have been a few exceptions. Members of *Saheli*, a Delhi-based women's group which works toward providing a social support structure to women in distress, camped in Bhopal for months together, helping to run a clinic which offered medical relief to victims. SEWA (Self Employed Women's Association) of Bhopal, helped give employment and rehabilitation to affected people. The *Chattisgarth Jagruti Sanghatana*, the Women's Centre, Bombay, and the *Sahiar*, Baroda, sent women activists to conduct surveys and highlight the problem in the media.

Today, the gas victims of Bhopal receive very little media attention. They remain locked in their own private hells, face-to-face with the prospect of adverse carcinogenic and mutagenic effects visiting not just the generation of children conceived around the time of the tragedy, but future generations as well. Today, about two years after the incident, mental illnesses proliferate. Surveys revealed that 22 per cent of the screened population suffered from mental disorders.

The damage the Union Carbide complex did to the people of Bhopal cannot be measured in monetary terms. Yet, as the case for compensation comes up in the Bhopal district court, the company has launched an aggressive counter-claim, shifting the onus for the disaster to the government of India, and quibbling over the amount of compensation. Regardless of the ensuing court battle, the real losers are the victims themselves.

Water

The struggle to obtain clean drinking water is written into the lives of so many of my countrywomen that a former member of our Planning Commission once wryly remarked, "If men had to fetch drinking water, then 230,000 villages would not have remained without the provision of drinking water after 30 years of planned development."

By and large, Indian women have not organized enough to fight for their right to clear drinking water.

There have been, however, some remarkable mass actions initiated or supported by women.

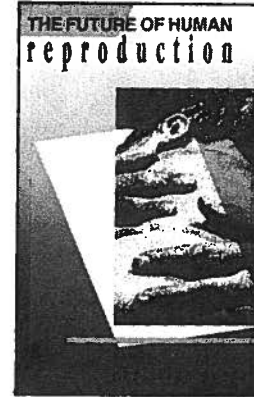
Noted political activist and sociologist Gail Orvedt reported on how a rural women's group, the *Mukti Sangarsh*, tackled the drought situation, aggravated by the failure of the rains for the fourth successive year in the Sangali district of Maharashtra (ironically enough, the wealthiest state of India, where Bombay is capital). Their crops were drying up, their cattle were dying of starvation, there was an acute shortage of drinking water, so the peasant women came out in large numbers for the first time and joined the men in organizing a road-blocking agitation on July 30, 1984. They drove their bullock carts and cattle on the road and held up traffic for several hours. The authorities were forced to sit up, and promised organized relief. In the same state there is a unique body called the *Pani Panchayat* (Water Committee), also dominated by women. The women here corner politicians at public meetings, organize sit-ins and rallies — all on one issue — water.

In Ambur Town, Tamil Nadu (a southern state which has had to face alarmingly frequent droughts), men, women and children protested against the polluted drinking water caused by tannery effluents released directly into the Palar River. They carried pitchers of the contaminated water and broke them in front of the municipal offices. But most of these actions are desperate measures taking place in the face of acute hardship.

A more sustained ecological movement is taking place in a adjoining state — Kerala. The fisherfolk of this state are locked in a 34-year-old struggle with the trawler owners. They are agitating against the government's blind policy of adopting various foreign fishing techniques without taking into consideration local circumstances and needs.

For generations, traditional fisherfolk have caught fish in shallow coastal waters. In the 50s, mechanized trawlers were introduced, in a bid to exploit the rich marine life of the coastal waters. These trawlers use nets that sweep the depths of the sea, disturbing the ecology of the sea

WOMEN'S PRESS



THE FUTURE OF HUMAN REPRODUCTION

Edited by CHRISTINE OVERALL

THROUGH A FEMINIST ANALYSIS, writers explore how reproductive technology poses social, moral, legal and political implications for women's lives.

280 pages \$17.95 pb

Women AND SURGERY

CONFERENCE SEPTEMBER 1990
MELBOURNE AUSTRALIA

A CALL FOR PAPERS

The Women and Surgery Conference will be held at the University of Melbourne, 27 to 29 September 1990.

The Conference is an inter-disciplinary program for researchers, practitioners, activists, students and others who share an interest in women's health as it relates to surgery. We are calling for papers, symposia, workshops on completed research/work in progress/critical analysis of issues. We welcome submissions of abstracts from all disciplines, including sociology, nursing, psychology, gynaecology, obstetrics, anthropology, women's studies, health education. Please submit abstracts of 100-150 words maximum.

Deadline for abstract submissions 28 February 1990. For further information phone Healthsharing Women Health Information Service, Melbourne on (03) 663 3544. Fax (03) 663 4664.

Ecofeminism

The women of Kenya's green belt movement band together to plant millions of trees in arid deforested environments. In India's Chipko (tree-hugging) movement, women work together to preserve precious forests for their local communities. Women in Sweden prepare jam from berries sprayed with herbicides and offer a taste to members of parliament (they refuse the offer). In Canada, women take to the streets with a petition opposing uranium mining in sites near their hometowns. In the United States, women organized the cleanup of rivers and hazardous waste sites. All these actions are examples of a world wide movement known as ecofeminism, dedicated to restoring the natural environment.

The term *ecofeminism* was coined by French writer Francoise d'Eaubonne in 1974 to represent women's potential for bringing about an ecological revolution. Ecofeminism is a response to the perception that both women and nature have been devalued in Western culture and that both can be elevated and liberated through direct political action. The earth is being dominated by male-controlled industrialization, technology, and science. Women are being dominated by the complex set of social patterns called capitalist patriarchy — in which men labour in the marketplace and women labour in the home or in low-status jobs.

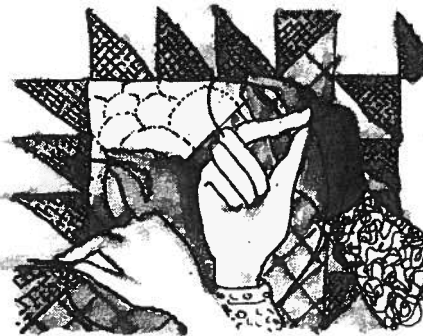
But ecofeminism has its critics. They point out that any analysis stressing women's "special" qualities ties them to a "special" biological or "natural" destiny that thwarts the possibility of liberation. But more and more ecologically concerned women are turning to ecofeminism as the most inspiring way to empower themselves while at the same time restoring ecological balance to the earth.

Caroline Merchant
New Internationalist

Excerpted with permission from *New Internationalist* (May 1987). Subscriptions: \$24/yr. (12 issues) from 1057 McNicoll Ave., Suite 108, Scarborough, ON, M1W 3W6.

basin, gobbling up fish stocks far in excess of their specific requirements. All this, in turn, has drastically affected the yields of the traditional fisherfolk.

One of the main demands of the agitating fisherfolk is a ban on in-shore fishing by trawlers during the three month breeding season, so that marine life in these waters is not threatened. But now the scene is riven with a new class of middlemen and investors — some of whom happen to be powerful politicians in their own right — who have a vested interest in seeing that the trawlers hold undisputed sway over the fishing waters.



Phyllis Wong Kun

Women have been both in the ranks and in the forefront of this struggle. I met some of these women activists, and heard the powerfully moving songs they sang. They are extremely articulate — Kerala having the highest levels of female literacy in India.

One of the biggest challenges facing the Indian women's movement today is to forge links between some of these disparate and scattered struggles, between rural and urban women's groups, and bring about a wider, more broad-based women's liberation movement.

There are some very real problems. The most obvious, of course, are the practical difficulties of keeping in touch and in tune with each other's aspirations and involvements in a sustained manner. India is a large country, and while it may make a very powerful symbol to have a Chipko activist extend a hand of support to a Kerala fisherwoman, there are over 4,000 miles separating them.

There is also the great urban-rural

divide. Most of the urban women activists come from backgrounds that are far removed from that of their sisters in the countryside. Their experiences as women and as activists in the city are, in many areas, totally different and so, too, not surprisingly, their preoccupations. But there are areas of commonality.

The image of a group of women hugging a tree to save it has inspired many a city activist to document the Chipko struggle through books, newspapers, articles, videos and films. It has brought many city activists into the forefront of the campaign against environmental destruction. In the same way, "urban issues" like bride-burning, personal law reform, and issues of health are now increasingly relevant in the countryside as capitalist relations of production become more and more manifest here.

On an international level, too, there is tremendous scope for extending hands of support. Each and every one of the case studies I have cited here have international parallels. To cite a few examples: tree-felling in the Amazon basin; a major industrial disaster in Seveso, Italy, when deadly chemical gases escaped from a chemical plant; drought in Ethiopia; severe fish depletion in Peru; mercury poisoning in Minamata, Japan; the recent accident near Basel, Switzerland involving the pharmaceutical multinational Sandoz, which has led to the Rhine being poisoned right up to the North Sea; and, of course, Chernobyl. The list is endless.

I would like to improvise on a phrase from the feminist poet, Marge Piercy. All the women around the world who take part in movements like the ones I've described are working to make part of the same quilt to keep us from freezing to death in a world that grows harsher and bleaker. More power to their work-worn hands!

This article is excerpted from Healing the Wounds: The Promise of Ecofeminism, edited by Judith Plant, published by Between the Lines, 1989. \$15.95.

Pamela Philipose is a journalist and women's health activist in India.

HEALTHWISE

Hypoglycemia

Joan Zwozdesky

A chance remark by a friend, about how much I've accomplished in my 47 $\frac{1}{4}$ years, reminded me of how bleak my future appeared 15 years ago.

After a year and a half of examinations by a heart specialist, an internist, a nose, throat and ear specialist, a neurologist and any other specialist that various doctors suggested, I was still getting progressively worse with no idea why.

The pounds had melted off my body. I didn't dare drive any more or go anywhere alone, not knowing when I might pass out or go into convulsions.

Finally, one day in 1974, I heard the words that were to give me back my life.

"You have hypoglycemia," stated Dr. Schulte, a chiropractor in Melfort, Saskatchewan.

I knew nothing about hypoglycemia. I had never heard the word. At that time most doctors hadn't either, and many of those who had didn't believe such a condition existed.

Recently I was hospitalized for a sinus infection. Upon finding out that I am hypoglycemic, the dietitian came to my room to help me with my diet. Although some doctors still refuse to recognize hypoglycemia, many doctors and nurses use the word regularly now. The hospital dietitian suggested that a specialist would probably benefit from my 15 years of experience, since knowledge of the condition is still scarce.

Hypoglycemia is not a disease. It is a symptom of a problem the body has in digesting and processing carbohydrates which creates an abnormally low level of sugar in the blood. When your blood sugar drops drastically, it affects every part of your body. The symptoms of sweating, weakness, hunger and "inward trem-

bling" are produced by an increase in adrenalin as the body attempts to offset the falling glucose level. Other symptoms may include headache, blurred vision, mental confusion, incoherent speech, bizarre behaviour or convulsions. All are the result of a slow and severe decline in blood sugar.

Hypoglycemia appears to strike men and women of all ages in all walks of life. I know a teenager, a middle-aged farmer and a retiree who suffer from it. My daughter and her friend, in their 20s, are experiencing symptoms. I realize now that my mother suffered from hypoglycemia for years before she ended up with diabetes. This is often the path it takes. As with diabetes, heredity appears to play a part.

If you experience any of the symptoms or weaknesses described, ask for a blood sugar test for hypoglycemia. If one doctor refuses, try another. There are some who will tell you there is no such disease, some who will work with you. Find one who will.

What advice do I have for someone who has just been diagnosed as suffering from hypoglycemia? Learn all you can about the condition. It's as if a thermostat is broken in your body. You must control it manually from now on. You can only do that if you know the signals it sends out to you and what those signals mean.

Read magazine articles. Talk to your local hospital dietitian. Ask your local librarian. (Mine was most helpful and sympathetic.) Share your knowledge and fears with friends and neighbours who have similar symptoms. A friend and neighbour not only encouraged me but gave me useful tips.

Your doctor or dietitian can't be with you 24 hours a day as your blood sugar fluctuates. Only you can

feel it dropping. Only you can quickly drink a glass of milk or eat a handful of peanuts or a piece of cheese to stabilize it.

If tests are inconclusive, try following the guidelines I live by. (Since blood sugar fluctuates, yours may be normal during a test, only to fall as you drive home.) It's a healthy way to live and certainly won't harm you. Within a month, you will notice a difference in the way you feel.

A simple rule is: Avoid CATSS.

An excess of *simple* CARBOHYDRATES causes a hypoglycemic to overproduce insulin. Most of the carbohydrate in a hypoglycemic diet should be in the *complex* form. Combine carbohydrates with protein during meals and snacks to slow down the release of glucose which makes you overproduce insulin.

ALCOHOL lowers blood sugar. If you are hypoglycemic, yours is dangerously low already.

TOBACCO (smoke) makes you overproduce insulin. Smoke is one of your worst enemies because it makes it more difficult to "read" your body's signals.

SUGAR makes you overproduce insulin. Only use it when your blood sugar is dangerously low to bring it up to a safe level. Then counterattack with protein, otherwise you may be in trouble.



Dawna Gallagher

HEALTH WANTED

The Hormonal Fix

I am currently preparing an international anthology on feminist responses to hormone replacement therapy. I would like to hear from feminists who are taking HRT as well as from others who decided against its use. Please send me your experiences as essays (max 15 — 20 pages) or diary entries, short stories and poetry. All contributions should be written in a way that makes them accessible to a broad range of international readers. Please send two copies of all articles to Dr. Renate D. Klein, School of Humanities, Deakin University, Geelong, Victoria 3217, Australia.

Call For Papers

Canadian Women's Studies/Les Cahiers de la Femme is planning a special issue on women and housing to be published as Volume 11 Number 2 in June 1990. Deadline for submissions is April 1, 1990. Anyone interested in writing an article for this issue contact CWS/cf, Suite 212, Founders College, York University, 4700 Keele St., Downsview, ON, M3J 1P3 or call (416) 736-5356.

Disabled Women's Anthology

A group of women of various disability and ages are planning a positive and powerful book and are seeking materials from women with disabilities. Please send your short stories, essays, poems, quotations, illustrations, cartoons and black and white photographs by December 30, 1989 to Disabled Women's Anthology, 15165 88th Avenue, Surrey, BC, V3S 2S6 or call (604) 588-1237.

Donor Insemination

I am currently writing a book on donor insemination (DI) and would like to talk to anyone who has used DI to have a child. I am particularly interested in talking to lesbian couples and single women. Rona Achilles, 60 Northumberland St., Toronto, ON, M6H 1R3 or call (416) 534-0622 or (416)392-7450.

The second "S" stands for STRESS. If you can't avoid stress, try to control your reaction to it as much as possible. Stress is more harmful when your blood sugar is constantly low.

Some people with hypoglycemia have trouble tolerating caffeine. I find after two sips of coffee or one cup of tea I have difficulty focusing my eyes.

Meat, fish, eggs, cheese or peanut butter will slow down the release of glucose from fruits and juices. It is essential to combine protein with carbohydrate at all meals and snacks.

If you feel weak or dizzy in the morning, keep a glass of unsweetened orange juice beside your bed each night. Drink it slowly before you get up, lying down to rest between sips, as the juice raises your blood sugar to a comfortable level. Then have a protein enriched breakfast as soon as you can.

If you often awake in the wee hours of the morning feeling miserable, the time when your blood sugar is lowest, take a few sips of orange juice. A protein dominated snack at bedtime may overcome this. You will soon fall asleep again.

Perhaps the one most important rule to remember is: NEVER LET YOURSELF GET HUNGRY. You don't need to eat much. But you do need to eat often. For as long as you stay awake, continue to have protein dominated snacks every three hours. (Peanut butter on toast or cheese and crackers make a good midnight snack. A glass of milk instead of coffee as you visit a neighbour will keep your blood sugar at a comfortable level.)

I carry Dextrosol (sugar tablets that can be bought over the counter at most drugstores) and peanuts in my purse. I have a medic alert card and bracelet and I never go on a trip without orange juice and peanuts. (I attended my son's graduation with a thermos of orange juice and a thermos of milk.)

I try not to get overtired. A flu or any illness takes me longer to recuperate from because it lowers my blood sugar. I am more prone to infections than a healthy person and I have to fight harder to rid my body of that infection. But now that I know what to expect, I can cope.

Hypoglycemia, or low blood sugar, can be a very frightening condition to live with if you don't know what it is. It is one of the easier conditions to live with once you understand it. As long as you follow the rules, you can live a normal life.

Perhaps if my condition had been diagnosed earlier, I would not have become as sensitive to carbohydrates as I did. For over a year after realizing what my problem was, I not only had to avoid all carbohydrates, I couldn't even chew unsweetened gum. Two bites of a wiener with a trace of sugar in it caused me to black out. I had to follow a diet of almost pure protein until my body could once again tolerate even complex carbohydrates.

Apparently it is unusual to be sensitive to vegetables. But I had to avoid the starchy ones (potatoes, corn, peas) for over a year. There are days even now when I can eat two peas, only to realize I'd better not eat a third. There are also days when I can eat almost normally.

Hopefully you can become aware of your condition sooner than I did, and arrest it before the symptoms become as severe. But even if you are as ill as I once was, you can live a normal life again. I certainly have.

Joan Zwozdesky is a teacher and freelance writer living in Nipawin, Saskatchewan.

Further Reading:

Hypoglycemia: A Better Approach, Paavo Airola, Health Plus, Phoenix, AZ, 1987.

The Low Blood Sugar Handbook, Edward and Patricia Krimmel, Franklin, Bryn Mawr, PA, 1984.

The Low Sugar Cookbook, Edward and Patricia Krimmel, Franklin, Bryn Mawr, PA, 1986.

Is Low Blood Sugar Making You A Nutritional Cripple?, Ruth Adams and Frank Murray, Larchmont Books, New York, 1983.

Jane Covernton

THINKING THROUGH INFERTILITY

For a child to be born, five complex body systems have to work. A man must be able to produce healthy moving sperm and they must be able to enter a woman's upper vagina. The cervical mucus, a beautiful complex system of its own, must thin and change alignment to let sperm through. A woman must ovulate and produce hormones so that the cervical mucus works and the egg is implanted and maintained in the right place. The tubes have to be open, un-lamaged and flexible enough to dip to the egg as it's released from the ovary. And the uterus has to work to shelter the growing fetus.

When you think about this for any length of time, as the childless do, you can't help but think about that clockmaker, the Old Man in the Sky. When the dance fails, you realize how miraculous it is ever to work. This is how the childless learn to pray, when there's nothing else to do. This is how we slip into childlike bargaining with Him or Her. This is how we lose our certainty about things that once were so certain. How we become re-visionists.

I'm a feminist. I'm white, heterosexual, middle-class, Canadian. I came of age in the 60s and 70s during a time of relative sexual freedom. These things affect my attitudes. My infertility is a life crisis but I will not die from it; it will not imperil the survival of my people. I will not be (literally) cast out. Having said that and living indicated where I come up for me — back inside my feminism — I struggle.



Linda Sabbage

1 Inside

This is loss of control and it's scary. I am one of the people who always moved ahead or moved on. We looked at our lives and said, I don't like this or that, and quit jobs or — not without pain — left relationships. We acted.

Now we're faced for the first time with unhealth and the realization that we can't stop the disorganization of our bodies. Our infertility is the first notice that we're mortal.

We go to doctors, to hospitals, to social workers, with panic in our throats. We stand on gritty sidewalks after each appointment, heads buzz-

ing with the vocabulary of childlessness — luteal phase, biopsy, post-coital test — not understanding, feeling stupid, frustrated, violated by probing hands and helpless.

Why can't we just have a baby? We cry, angry at the loss, the betrayal of the body.

We're angry at ourselves. We're angry at doctors who gave us IUDs with a lecture and a smirk and the smooth assurance of men who have power and are in control. We're angry at the doctors now. They condescend, are casual, too calm. We're angry at our mates who simply won't suffer enough.

We deny what is happening to us. We go along for months at a time thinking, hoping nothing is wrong, making love in a ritual and a trance, believing this month will last and last and last into birth.

We feel alone. No one can ever understand the deeply personal suffering of this breakdown of life. Everyone else grows babies as if it were the most natural thing in the world.

We bargain. Dear God, forgive me my past, please give me a child now. I'll do anything, anything.

Month after month, we're sad, depressed, blue. We bloom with hope and every month we cry. Dear partner we aren't pregnant — again.

In jagged little pieces we accept our childlessness. We realize it is a form of death but a death that casts a scratchy shadow into the future instead of lying flat in the past.

We grieve.

2 "We"

We are one of every six couples in Canada who are infertile and will never hold their own child in their arms. Infertility is epidemic.

3 Inside

We felt like the cutting edge of the feminist revolution. We lived through an extraordinary era, were born to affluence, grew up in a time of change. Sometime in the late 60s or early 70s, while Janis Joplin sang sadly, "Freedom's just another word for nothin' left to lose," all our mothers' values and teachings came into question.

We women of this class and this generation, raised to marry and have kids, suddenly found ourselves wanting — needing — to work, to wrestle with the world, to postpone having a family. My infertility now leads to re-vision. Where did that need come from? Where do society's prevalent ideas come from?

Ta-da. The first women in history to control our own fertility. That made possible this radical fuck-you position: if you didn't like his attitude, you'd walk. And there were no kids to worry about.

We found ourselves unable to say to ourselves or to our men friends, why should we "wait till we get married." Why not? That's what my first guy said to me. Then, the only answer was a shrug.

Then, the family structure was under fire. Radical mentors taught that the family was the basic unit of oppression. Somehow that correctness has slipped from favour.

Our men wrestled bravely, accepted the fierceness, and, for the most part, embraced the changed women.

We never thought we'd pay for our new independence. Now we know: freedom cost. For a growing number of free women, independence translated into childlessness. We didn't know this was a choice we were making.

4 Tattered. Shattered.

Fifteen to 17 per cent of couples are infertile and the numbers are rising. Why?

There's an increase in the absolute number of women of childbearing

age who now want their *first* baby.

There's an increase in sexually transmitted diseases, causing tubal damage and infertility, especially in women who've been around long enough to be exposed to such diseases.

There are more women out in the world of work being exposed to environmental hazards.

We have trouble re-establishing regular cycles coming off the pill.

People like me thought it would simply be a matter of deciding. Fertility was an on-off switch.

6 In fact

For women, the best age physically if not emotionally for having children is 24.

One French study shows a dramatic decline in fertility after age 30. Most other studies show a gradual decline to age 35 and then a quick



We may have had one or more abortions, increasing the risk of pelvic infections and scarring of the tubes.

When we do decide to have family, being older, we have less time, compounding the problems.

5 Me

In my early 20s, I said, "I never want to bring babies into this crazy world." In my late 20s and early 30s, I was getting established in a career, quitting work to travel, falling in love.

and substantial decrease in fertility.

The classic reference is a 1957 study of American Hutterite women, among whom birth control is unknown. There, only 3.5 per cent of women under 25 were sterile. By the age of 34, 11 per cent were sterile. And by 39, one third of all women were sterile. So, in a society where few outside factors put pressure on women's fertility — no pill, no IUD — the aging of the body was dramatic.

Our eggs get old and we have more spontaneous abortions which

we probably aren't even aware of. The spontaneous abortion rate begins to rise dramatically at the age of 35. At the age of 38 the rate is double what it is in the 20s. At the age of 40 it may triple.

As we get older, we may have hormonal deficiencies. Those are treatable. Or the uterus may have aged. That is untreatable.

Older women have had more exposure to infections are more likely

hormonal disorders, breast-feeding and exposure to environmental pollutants or drugs. Exposure to toxic substances such as lead may reduce sperm counts and sex drive in men. Alcohol and tobacco increase the incidence of pregnancy loss in women and reduce sperm counts in men, according to some studies. Some therapeutic drugs affect fertility. And some studies show heroin and marijuana reducing sex drive and sperm



Linda Sabbage

to have endometriosis, the so-called career woman's disease.

We're probably having sex less often.

Menopause hits North American women at a median age of 49.8. Then fertility is finished for good.

7 More fact

The known causes of infertility are many — age is just one factor. Others include: how often you have sex, past infections that damaged reproductive organs, systemic disease,

production in men.

But by far the most common and the most preventable cause of infertility is pelvic inflammatory disease (PID) in women caused by sexually transmitted diseases.

In Canada, nearly half of all women hospitalized for pelvic inflammatory disease are between 15 and 24 years old, and it's estimated in the U.S. thousands of teenagers will be infertile from sexually transmitted disease and pelvic inflammatory disease before they reach their 20s.

8 Sex

In the U.S., reported cases of gonorrhea tripled between 1965 and 1975. The highest rate was among women 20 to 24 years old.

In Canada, the rate peaked in 1976 at 247 cases per 100,000 people. In 1980, it stood at 235 cases of gonorrhea disease per 100,000.

Cases of chlamydia are also rising, particularly among young women. Laboratory reports of chlamydial infection in Canada have increased five-fold since 1980 and females aged 15 to 24 accounted for 44 per cent of all reports.

One researcher, writing in the *American Journal of Obstetrics and Gynecology*, concluded that in 1979, the direct and indirect costs of PID (and resulting ectopic pregnancies) were \$1.25 billion (in the U.S.). He predicted that by the year 2000, half the women who came of reproductive age in 1970 will have more than one episode of PID, more than three per cent will have an ectopic pregnancy and more than ten per cent will be involuntarily sterile because of PID.

But of course, that's pre-AIDS, back when condom was a giggle word.

Scientists don't use the juicy word promiscuous. They simply dryly report the statistical evidence that women who've had more than one sexual partner have a higher risk of tubal infertility. In April 1985, the prestigious *New England Journal of Medicine* published a study linking IUD use, pelvic inflammatory disease, number of sexual partners, and tubal infertility. The evidence now seems conclusive: having more sexual partners increases the risk of infection, leading to more infertility.

9 Me again

It's strange to be one of the only generation ever to experience guilt-free, unfeared sex. Pre-herpes, pre-AIDS, there were only the vaguest rumours of penicillin-resistant strains of gonorrhea. Wasn't that a time? An aberration in history, a blip. It felt like forever.

10 The Pill and IUD

In January 1970, the Pill was getting bad reviews. A U.S. Senate sub-

committee investigating oral contraceptives heard the pill linked to headaches, nausea, loss of hair, mental depression, liver damage, stroke, coronary disease, blood clots, vascular disorders and cancer of the breast, cervix and uterus. The pill has since been cleared of most of those charges. (Unless you're over 35 and smoke — in which case, the risk is cardiovascular problems.) But then the headlines read, "Great Mistake for 18 Million Women?"

Doctors' offices were filled with concerned patients. The stock of the two major oral contraceptive manufacturers fell on Wall Street.

Word started to go out that the IUD would be better. One doctor said to the senate committee, "... intra-uterine devices have been perfected so that they are now 99 per cent effective in preventing pregnancy in the 94 per cent of women who can use them."

By February of 1970, a Gallup poll taken for *Newsweek* showed that 18 per cent of women had stopped taking the pill and another 23 per cent were considering it. The newspapers reported an increase in unwanted pregnancies and abortions among women who'd gone off the pill.

I wasn't reading papers or paying attention to newscasts then. Now, I don't really know why, I think I called it decreased libido, but suddenly I wanted off the pill. IUDs sounded perfect — put them in once and forget them. So effective. The university clinic referred me to a doctor who gave me a little lecture about marriage while he inserted the device. He got it wrong and it had to be hauled out later and another inserted.

I had an IUD for about six years. I think it was a Dalkon shield. I'm infertile and no one can say why. I phoned the university to get my medical records; they were destroyed after seven years. I can't remember the name of the doctor. I figure I'm one of the (how many?) women who are owed by A.H. Robins and will get nothing.

11 Risk

It now turns out that, by using IUDs, women were doubling their risk of infertility. In April 1985, the *New England Journal of Medicine* pub-

lished two strong reports on the connection between IUD use and infertility. One was a study of 159 Seattle women suffering tubal infertility and a matched control group of women with babies. The risk of primary tubal infertility in women who had ever used an IUD was 2.6 times that of women who had never used one. Risk of tubal infertility with a Dalkon shield was 6.8 times as high. The authors reported, "the occurrence of pelvic inflammatory disease found the highest risk associated with the use of a Dalkon shield. Furthermore, the use of the Dalkon shield bears the strongest relation to the occurrence of tubal ectopic preg-



Linda Sabbage

nancy of any IUD," and, "The overall effect of any IUD use was to double the risk of primary tubal infertility."

The authors point out that women who had hysterectomies caused by IUDs weren't included. They wouldn't show up at infertility clinics to be studied; they'd already be sterile.

The link between IUDs and ectopic pregnancies has been recognized since 1929, but I never even knew what an ectopic pregnancy was till I got infertile.

12 You are infertile

Be clear. Guilt is a common response to loss. Avoid piling on more guilt because of your angry thoughts about

the abortions and pregnancies of friends. Being infertile sometimes makes you crazy. Not every thought must be spoken.

13 Working through

The childless have this burden: if we had even two partners or one IUD, we may be presumed guilty. There's a twisted logic that leads to reading infertility as punishment, the same logic that reads AIDS as God's punishment of gays. It's hard for us suffering infertility not to think that way.

14 More re-vision

Are we also being punished for abortion(s)? Maybe an abortion caused an infection and contributed to your infertility? Are we being punished for believing that abortion is a woman's right?

Now the childless may find ourselves silent in any discussion of abortion, long-held political beliefs eroding under pressure. We're the generation who always had whatever we wanted and are discovering limits for the first time. Selfishly (catchword of anti-feminism), we may wish teenage girls would go through with their pregnancies and give us their babies. We note that society does not nurture those who would carry their children to term — despite the right wing rhetoric.

15 Our traitor ideas make us feel adrift, alone.

16 Religious re-vision

The idea that you're being punished is a religious idea, a theological concept. The childless often find themselves newly awakened to their superstitious or religious natures. The most convinced atheist may wonder what God is punishing her. What combination of atonement, good deeds and healthful living could lead to pregnancy?

Even the doctors are superstitious. When you tell them you've quit smoking or finally gotten married after living together peacefully for years, they say brightly, "Maybe that'll do the trick." Lab technicians sing out "Good luck" as you head out clutching a vial of your partner's washed and concentrated sperm, achieved in the tiny room with the tattered copies of *Playboy*.

REVIEWS

17 Try adopting

If you tell aunts and friends you're having trouble getting pregnant, they're likely to say that you should take a vacation or try to adopt, in other words, trick your body. Everyone's heard of someone who got pregnant as soon as they adopted. Maybe this adoption theory used to be a genuine bit of folk wisdom when adoption was easier and infertility treatment less onerous. Yes, people get pregnant all the time. Five per cent of couples who walk into an infertility clinic get pregnant no matter what, some after adopting, some after a vacation, and some after applying cough syrup to their vaginas as one American doctor advocates.

A 1979 California study followed 895 couples who'd been patients at a Stanford fertility clinic over 14 years. There were no more pregnancies among those who'd adopted than among those who hadn't.

Combat the implication that it's your fault if you can't get pregnant. If only we weren't so uptight.

18 Now

I am an infertile woman, now with two upspringing adopted children. Now I'm past anger, guilt and the feeling of being punished, but still, apparently, working through my infertility. My three-year-old says I should get married again so I can have a baby to drink milk from my breasts. I still fantasize that gentle sucking. This month I thought I was pregnant and then experienced what felt like a miscarriage.

Now I've plunged into the pond of thought and surfaced for air. Now I watch the ripples. Start by blaming yourself, stop that, blame society, figure out how to change society so that our younger sisters can make choices.

Jane Covernton is a freelance writer living in Vancouver.

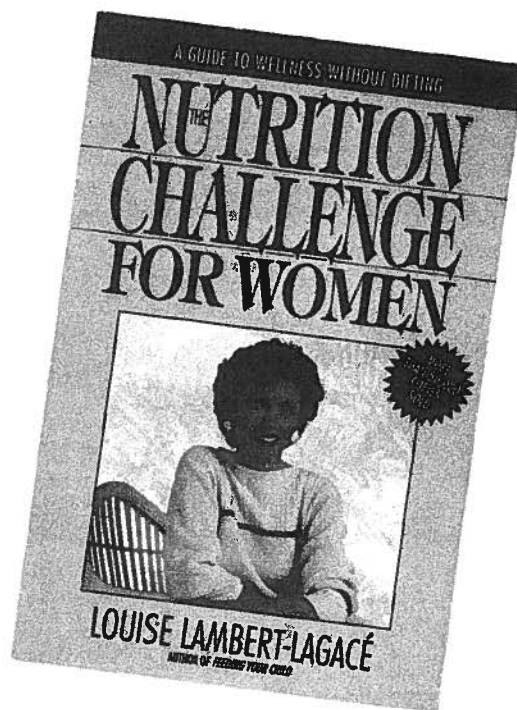
The Nutrition Challenge for Women: A Guide to Wellness Without Dieting

Louise Lambert-Lagacé, Stoddart, Canada, 1989. 208 pp. \$22.95.

Reviewed by Jo-Ann Minden

When I picked up *The Nutrition Challenge for Women*, the first thing I looked for was the author's angle on dieting. This may be what many women are looking for — another solution to the battle with their body — but it is not what serves women best. The diet industry has done more harm, under the guise of "health," than many women and health professionals realize. So when I read in the introduction that the author loves to eat, that food is an important part of her life, and that she hoped this book would provide "an antidote to past and future radical diet restrictions," I knew I was going to like this book. This is what women need to hear.

Lambert-Lagacé, a professional dietitian, has a concept of health which encompasses the body, mind and spirit. Although good nutrition is fundamental to good health, it is not the sole determinant of it. Health, she says, is generated by positive thoughts and actions and there is a significant relationship between positive self-image and a healthy life, between achieving a meaningful life and honest relationships, and health. Seen in this light, it is not surprising that she advocates a ban on the scale and an end to dieting. This may seem contradictory to some, as many of us base our self esteem solely on how we look, and how we look is determined to a large extent on dieting our bodies down to an "acceptable"



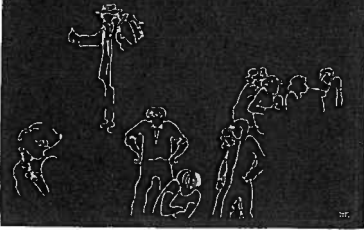
slim shape and size which has nothing to do with a woman's genetic or physiological make-up.

But dieting compromises health. It doesn't work (95 per cent of dieters do not maintain a lower weight), and it sets women up for failure and a poor self image. It doesn't lead to meaningful relationships but often leads to the development of eating disorders which can result in permanent damage to the body and spirit. I cheered when I read things like Lambert-Lagacé's advice, "Forget personal weight . . . give more weight to your personality."

Lambert-Lagacé presents a broad, comprehensive view of nutrition as it relates to women. She recognizes the unique physiological, social and economic parameters which distinguish our nutritional needs from those of men and which are contributing to our poor food habits and less-than-optimal nutritional status. She specifically addresses our changing role and contemporary lifestyle which encompasses the "superwoman syndrome," eating out more, and the

between the lines

CRITICAL PATHS



**Organizing on Health
Issues in the Community**
Keck et al.

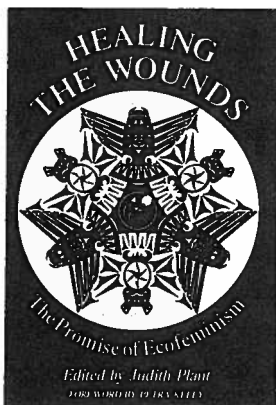
\$11.95 pb. \$34.95 cl.

"I would recommend this for any group involved in a community health project. The examples used are detailed, well-organized and practical."

Planned Parenthood

"A clear and helpful guide."

June Callwood



\$15.95 pb. \$34.95 cl.

Ursula LeGuin, Dorothy Dinnerstein, Helen Forsey and others discuss the vision and challenge of the ecofeminism movement. Their voices are gathered around four themes: ecofeminism, politics, spirituality, and community.

Write for a complete catalogue of titles.

394 Euclid Ave. Toronto, M6G 2S9

greater availability of nutritionally inferior "fast foods." The increase in alcohol consumption and smoking among women today makes it harder than ever to meet our nutritional needs. The fact that the majority of today's poor are women, many of whom are single-parents or live alone as seniors is also recognized as contributing to women's poor food habits. And she blames society's obsession with slimness and fear of fat for yo-yo dieting which lowers our resistance to infection, contributes to chronic fatigue, and ironically often results in a gradual *increase* in weight.

Most women eat too little, either because we want to lose weight or stabilize our weight or because the amount of physical energy needed to get things done in today's labour-saving, high tech world reduces our appetites. As portions diminish and the availability of less nourishing foods increases, women are taking in fewer vitamins and minerals. The author cites research that shows that often $\frac{1}{3}$ of calories consumed by women come from foods such as wine, soft drinks, crackers and cookies. As a result most women are compromising their health, and are not able to function to optimal capacity.

Her "gentle approach" to nutrition includes the gradual addition of foods which offer more vitamins, fibre and minerals to the diet, and the dropping of foods that contain nothing but sugar, salt and fat. Exercise should be integrated into our lives somehow, even if it's just a matter of walking to our destinations whenever feasible, taking stairs, walking after dinner. Avoidance of sugar substitutes is also advocated as it maintains the sweet taste of food without improving the quality of a woman's diet.

Lambert-Lagacé maintains that a diet rich in iron, calcium and magnesium will necessarily include enough of every other nutrient including zinc, B6, fibre, carbohydrates and protein required for well-being. Research is showing that a diet low in fat may be protective against breast and bowel cancer. Food tables included in the book illustrate amounts of these nutrients in different foods.

She offers tips on easier meal preparation and recipes are included with

simplicity and time-saving in mind. Advice on choosing healthy fast foods when eating in or out, packing a lunch, travelling, cooking and shopping for one is provided. Most important, she cautions against fad diets and offers guidelines for evaluating any diet. Her philosophy of spending less time in the kitchen and more time enjoying a meal will appeal to every woman.

I have only two minor criticisms of this book. There is a chapter by chapter bibliography at the end of the book which is in alphabetical order, but there is no direct referencing from the text to this bibliography. This limits the usefulness of the bibliography.

The author also claims that the Body Mass Index (BMI), a measure of a person's body fat based on her present weight and height which corresponds to a "healthy weight" or a risk of disease, is suitable for use with women up to the age of 80 years. This should be 65 years. After this point the BMI loses its reliability as an indicator of this relationship.

By bringing to the fore the long-forgotten elements of pleasure and nourishment that food is meant to provide us with and in addressing the complexity of our relationship to food, *The Nutrition Challenge for Women* has touched on a topic of profound importance. The advice is sound and realistic. Lambert-Lagacé is to be commended for not attaching calories to foods. Her emphasis on food quality not energy content is a positive step in the right direction. She is also to be commended for not advocating supplements except for women who are pregnant or lactose-intolerant. Supplements are expensive, often of questionable content, and too much of some can cause a toxic reaction. Most of us can still improve our health and vitality through the foods we eat, not by taking pills. The personal, yet professional style of this book makes for easy, reliable reading on a topic that is vital for women today.

Jo-Ann Minden currently works as a nutritionist at the Donwood Institute in Toronto. She is Updates coordinator for Healthsharing.

EYE PEOPLE EAR PEOPLE



EYE PEOPLE, EAR PEOPLE Getting Along

by Ghislaine
Meunier-Tardiff

From birth, each of us
perceives the world in two
fundamentally different ways.

For couples, parents, teachers and everyone
whose work involves dealing with other people.
The author was introduced to the theory of
auditory and visual perception when it helped her
son lead a normal life. Her resulting best-selling
book and workshops have helped thousands of
people to communicate better. Over 50,000
copies of the French edition have sold in Quebec.

\$12.95 paper 1-55021-009-2

NC PRESS LIMITED

The Health Book Specialists

Order Department: 260 Richmond St. W. Ste. 401
Toronto, ON M5V 1W5 (416) 593-6284

Call For Resources

Healthsharing



Special Issue Immigrant and Refugee Women's Health

Healthsharing Summer 1990, is a
thematic issue on health concerns of
immigrant and refugee women, with an
expanded resource section. Send us
information on books, magazines,
films, videos and organizations by and
about immigrant women, especially
concerned with health.

A Guide to Feminist Expertise

The CRIAW Bank of Researchers

A computerized database of feminist
researchers working in various fields and
committed to the advancement of women.

The Bank allows you to identify researchers with
whom you may wish to network or who are working
in fields in which you may be seeking expertise.
An indispensable tool for journalists, professors,
action or community researchers, policy makers
and conference organizers.

**MAKE IT WORK
FOR YOU!**

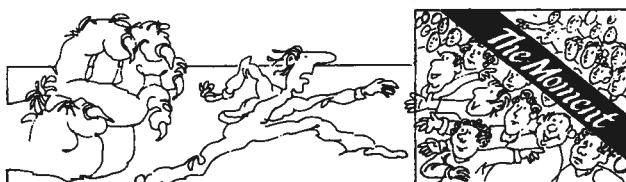
CRIAW

Canadian Research Institute
for the Advancement of Women

151 Slater, Suite 408
Ottawa, Ontario K1P 5H3
(613) 563-0681

N.B. We encourage all
feminist researchers to
register in the bank.
Application forms available
from CRIAW.

The Moment makes learning fun, critical and mobilizing!



GRAB *The Moment* BEFORE THE MOMENT GRABS YOU!

What is *The Moment* ?

- a 16-page educational resource on critical Canadian
issues, designed for group discussion, analysis and action

Who uses *The Moment* ?

- church groups, community educators, teachers, social activists

What's in *The Moment* ?

- a photo-story that looks at how the issue in question plays
itself out in people's everyday experience
- analysis of current events and forces
- alternative approaches to frequently asked questions
- groups, resources and ideas for further action

Please
send me

The Moment

Name _____

Organization _____

Address _____

Postal Code _____

Please send me

_____ subscription(s) for 1 year (\$8 for 3 issues)

Please enclose full payment with your order. Thank you.

The Moment • 947 Queen Street East • Toronto • M4M 1J9

RESOURCES & EVENTS

Substance Abuse Conference

The Alcoholism Foundation of Manitoba is sponsoring a three-day conference *Women & Substance Abuse — Strategies for the Nineties*, to be held in Winnipeg, March 12, 13, 14, 1990. Designed for service providers, health care professionals and the women's community, topics include current research and treatment issues, EAP and women and sexuality, intimacy and abuse. For more information contact the AFM, Women's Centre, 586 River Ave, Winnipeg, MB, R3L 0E8 or call (204) 944-6229.

Reading Guide on Violence

Patterns of Violence in the Lives of Girls and Women: A Reading Guide is a new review of some of the best feminist texts on violence against women. Particular attention is given to the overall patterns of violence in women's lives. Front line workers, students, educators, community women's groups and others will find this 96 page book useful.

Available for \$7.50 plus mailing costs from Women's Research Centre, #101 — 2245 West Broadway, Vancouver, BC, V6K 2E4 or call (604)734-0485.

HIVAIDS Education

The *ABCs of AIDs* is a new pamphlet designed for teens that uses a non-threatening, easy-to-read "A is for . . ." format to draw them in and explain critical information about AIDS. With entries ranging from "E is for Education" to "C is for Condoms" to "H is

for Homophobia" this pamphlet describes what HIV/AIDS is, how it is transmitted and how to lower the risk of transmission.

Talking With Your Partner About Using Condoms suggests how teens and adults can become more comfortable talking about condom use. This pamphlet lists common reasons people give for not using condoms and some possible responses for dealing with resistance.

Both are available from Network Publications, P.O. Box 1830, Santa Cruz, CA, USA, 95061-1830 or call (408)438-4060. Minimum order is 50 for \$14.00. For a preview of single copies send a stamped — \$.25 US postage — self-addressed, business-sized envelope with the titles of these two pamphlets written on the back.

Women and Disabilities

The Disabled Women's Network Canada (DAWN) recently published four position papers on issues of concern to women with disabilities; 1. *Who do We Think We Are: Self-Image and Women With Disabilities*; 2. *Beating the "Odds": Violence and Women With Disabilities*; 3. *The Only Parent in the Neighbourhood: Mothering and Women With Disabilities* and 4. *Different Therefore Unequal? Disabled Women and Employment Equity*.

The cost is \$5.50 each or \$20 for the set (includes postage). Women with a disability who are unable to afford the suggested cost may send whatever they can to help cover shipping costs. DAWN does not have the resources to do billings, so individuals and groups are asked to in-

clude payment — cheque or money order — with their orders. Send payment and orders to DAWN Canada, 10401 Finlayson Dr., Richmond BC, V6K 1W8.

Lesbian and Gay Health Conference

The National Lesbian and Gay Health Foundation will hold its Eleventh Annual, Third International Health Conference July 18 to 22, 1990, in Washington, D.C. Papers are invited. For guidelines contact Toni Young at the Foundation, 1638 R St. NW, Suite 2, Washington, DC, 20009 or call (202) 797-3708.

Women's Health Library

Women's Health Resources in Calgary operates a non-lending library of books, video tapes, articles and pamphlets with information on women's health issues. Open daily Monday to Friday from 8:00 a.m. to noon and 1:00 p.m. to 4:00 p.m. it is located at 1402 — 8th Avenue N.W., Calgary, AB, or call (403) 282-9152.

Reproductive Health

The Canadian Advisory Council on the Status of Women (CACSW) recently published a background paper entitled *Women's Reproductive Health, the Canadian Charter of Rights and Freedoms, and the Canada Health Act*. The CACSW remains firmly opposed to the recriminalization of abortion and suggests that the federal government has the power to ensure equal access to reproductive health care services, including abortion, through the Canada Health Act. Copies are available free of charge from the Canadian Advisory Council on the Status of Women, 110 O'Connor St., 9th floor, Box 1541, Sta. B, Ottawa, ON, K1P 5R5 or call (613) 992-4975.