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Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

Health On Stage

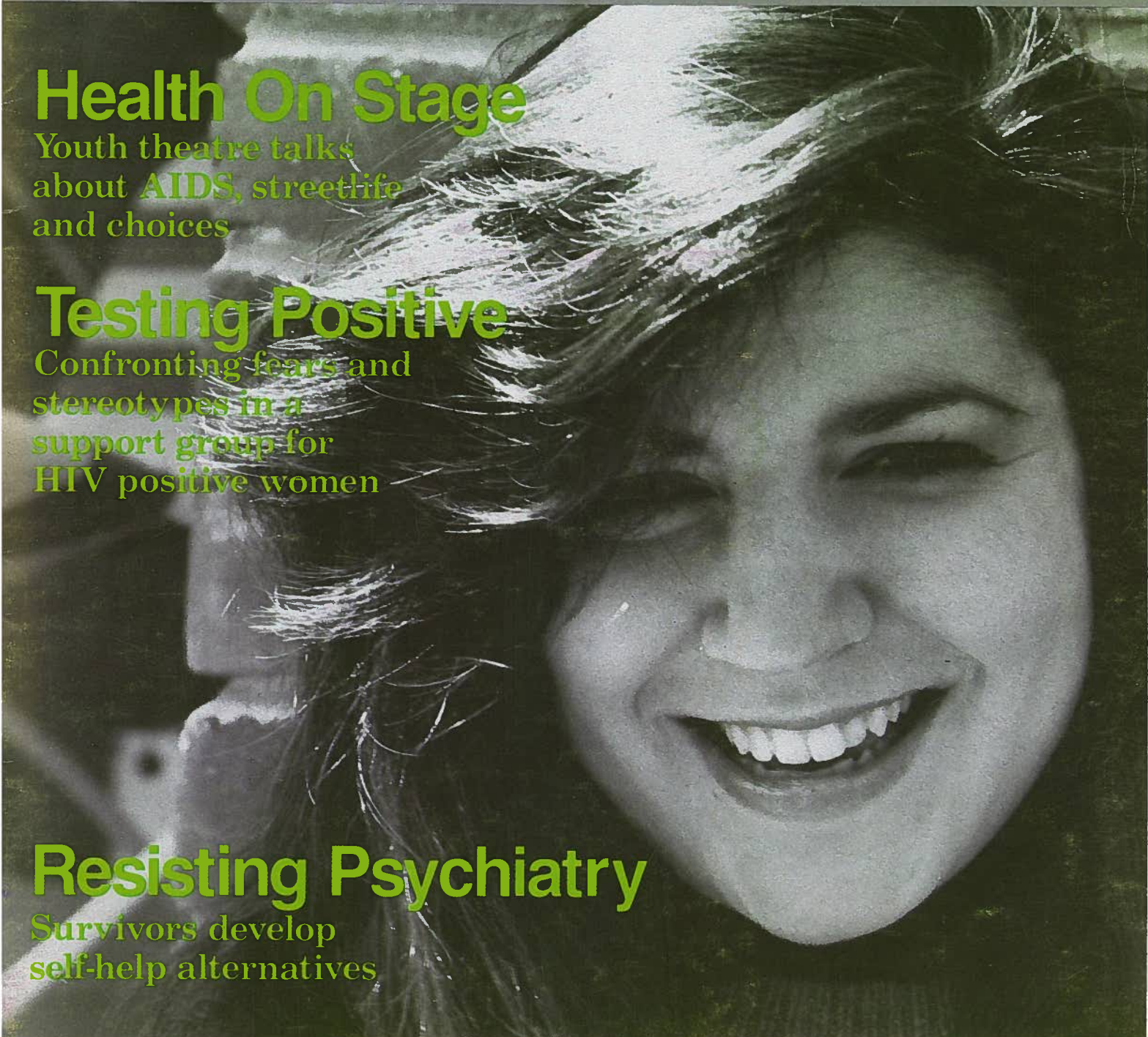
Youth theatre talks
about AIDS, streetlife
and choices

Testing Positive

Confronting fears and
stereotypes in a
support group for
HIV positive women

Resisting Psychiatry

Survivors develop
self-help alternatives



INSIDE

Healthsharing

Vol 11:2 March, 1990

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COLLECTIVE NOTES

Addressing the social causes of health

Fourteen women are murdered in Montreal by a man who declares that women must pay for his unhappiness. In Toronto, a Black woman is shot by a police bullet and paralysed from the waist down. Her crime: she is a passenger in a stolen car. Ten people die in a rooming house fire in Toronto because of a severe shortage of decent affordable housing.

The massacre in Montreal demonstrates the pervasiveness of misogyny and sexism in Canada. It seemed unbelievable. But it proved we are not crazy to fear for our safety every day.

The shooting of Sophia Cook in Toronto is only the latest example of a pattern of racist police violence in this city and across the country. The Donald Marshall inquiry in Nova Scotia and other justice inquiries in Manitoba and Alberta, have all confirmed an insidious pattern of racism and injustice. Native people, Black people and other people of colour across the country live in a climate of fear and anxiety.

The rooming house fire revealed the conditions in which many of the urban poor are living. Poverty is a growing problem not just in Canada's large urban centres but also in rural areas. And women, especially older women, are steadily joining the ranks of the poor.

As a society we are in serious pain. Many of us live with fear and anger, with grave concerns for our future.

Why, you may ask, are you reading this in *Healthsharing*? What has this to do with health? Everything. Poverty, racism, sexism and heterosexism all erode our self-confidence and our right to live peaceful, secure and productive lives. If a member of your community has been attacked by the police, if you are pregnant but not wanting to be, if you fear re-

prisals when you are open about being a lesbian, if you don't have money to pay the rent, if you can't find a job that pays more than you receive on Family Benefits, or if you are unresolved about sexual abuse ... all of these affect your health.

But our health care system doesn't deal with these real causes of illness. We are treated for symptoms — not for the stresses of the environment in which we struggle to survive. We are not treated as whole beings, but as composite parts. Drugs or surgery attack specific symptoms, sometimes successfully, but usually leaving us with an unwanted legacy. Women know this well, from the treatment of menopause as a medical condition, to prescription of anti-depressants for our psychological distress, to unnecessary cesarians and hysterectomies.

This same health care system is now talking about being underfunded. This at a time when the average wage for a doctor in Canada is just over \$100,000 a year. Studies have shown that there is no relation between what is spent on institutionalized health care and the health of a nation. Our health is primarily influenced by economic, social, environmental and nutritional factors. Working class and poor people are sick more often and live shorter lives than the middle and upper classes because they face low-paying hazardous work, poor housing, unemployment, etc.

The problem of our health care system is not that it is underfunded but that it is plagued by inefficiency, wastefulness, and a medical model that stresses cure over prevention. We have grown dependent on expensive technology, and unnecessary surgery is a common occurrence. Canada has the highest rate of gall bladder operations in the world. Hys-

terectomies are as common as tonsillectomies were 20 years ago. Twenty per cent of all Canadian babies are born through cesarian section. The fee for service system of payment for doctors encourages heavy patient load and unnecessary surgery. Doctors, health care workers, consumers — all of us — are hooked on a health care system that we expect to perform miracles, to prolong life, to cure our illnesses.

So what about this idea. Let's put doctors on salary and set strict standards for surgery and use of high tech equipment. With the money that is saved we could launch a program of health prevention to get at the social causes of ill health. We could prevent disease by improving affordable housing, reducing unemployment, increasing wages, eliminating hazardous work and environmental pollution. If we really want to improve health we need real action against racism, sexism, heterosexism and poverty. Health prevention and education must reside in the community and the emphasis should be on community health centres and public health campaigns.

These changes won't come about unless we demand them — unless we start putting different demands on our health care system and on society as a whole. We need to change our expectations of a system that has prided itself on performing miracles. We should expect fewer miracles and more real prevention of disease, so that all Canadians can be served by an equitable community-based health care system — a system that addresses the social and economic realities of people's lives.

We need new approaches. In future we hope to focus on the social causes of ill health, to broaden out the traditionally reproductive focus of the women's health movement. But as we look at the painful reality of injustice, we must not forget our vision — the world that we are struggling to create and the dreams that give us strength together.

*Susan Elliott, Amy Gottlieb,
Lisa McCaskell, Monica Riutort.*

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.'

Sense of Solidarity

Healthsharing is informative, intelligent, exceptionally warm in style and dependable. It conveys to me a strong sense of solidarity and I like that. I need that.

Your magazine is one I look forward to reading and I have been so for years. Finally, I

have done myself a favour and subscribed!
Sheryl Dubois,
Morin Heights, Que.

Shocked

I was shocked to see the Arthritis Society in the resource list "for people looking at alternative diagnosis and treatment" of immune system disorders

(Healthsharing, March 1989). This organization is notorious in its condemnation of alternative views and goes to great lengths to attempt to discredit any fanciful ideas one might have about such things as diet and "unproven remedies." The Arthritis Society is the last place I would suggest anyone look for alternative help.

Do you know something I don't?

Andrea Lowe
Victoria, B.C.

Much Needed Resource

Congratulations on your wonderful journal! A nonsense, non-patronizing and informative magazine such as yours is a much needed resource for women in our

"I'm the doctor, I'm the expert" society.

Andrea Reisch Teopell
Willowdale, Ont.

Cover to Cover

I have been subscribing to your magazine for several years and it is one of the few publications I receive that I read cover to cover.

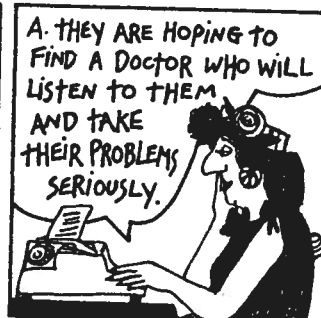
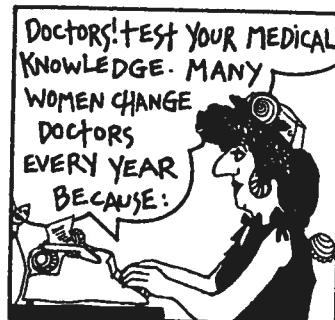
Wendy Vandersteen
Edmonton, Alta.

Super Job

I think the staff is doing a super job ... and find myself waiting for the next issue.

They are super! Keep up the good work.

Connie O'Reilly
Beaconsfield, Quebec



Nicole Hollander: "My weight is always perfect for my height — which varies."

We're Worth More!

- The federal government spent \$11 billion on the military and \$11 million on women's equality. That's 1,000 more.
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- We are worth more than that! Lots of work remains to be done in our fight for equality and social justice. Let's challenge the government. Let's ask them, where's their commitment to women's equality?

For more information write: Brian Mulroney, House of Commons, Ottawa, Canada.

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UPDATE

Montreal massacre mobilizes women across Canada

On one of the worst nights of last December's cold snap, thousands of people poured onto the University of Montreal campus. Friends who had arranged to meet there eventually gave up trying to make out familiar faces underneath hats, scarves and coats. Those who did find each other held on tight. Many cried. Most were quiet as they shuffled in the cold. Journalists, cameras and the police circled around.

We had come out for a vigil in memory of the 14 women murdered by a man who had declared out loud and in a letter that he wanted women to pay for the problems in his life. He then killed himself. He left behind an enraged community ready to tell anyone who would listen that women had had enough and this time we weren't going to close our eyes. "As feminists we're told by the majority of people that we're exaggerating, we're paranoid and it's not that bad," said Isabelle St-Martin, Policy and Education Advisor on Sexual Harassment and Assault at Concordia University. "What we're saying is true — no one is listening."

As more cameras and supporters arrived we began the long march up the hill to the engineering department where the murders had taken place 24 hours before. Turning back and watching the long line of candles, we began to realize that maybe someone was listening.

The first student to speak was a man who mourned the loss of his classmates. He never referred to them as women. When others in the crowd began to name the violence against women, they were shouted down and accused of trying to use the tragedy to further their own political agenda. "We were told to be silent and respect the dead," said St-Martin. "Who can decide who has a right to grieve?"

before, and then the murders, and then we encountered harassment and violence again at the vigil and from the media when we identified as feminists," said Charlene Nero of the Montreal Women's Defense Committee.

Over the next weeks, the media continued to report on the random act of a madman. Women remained acutely aware that it was not about finding some explanation in the killer's past, or gun laws,

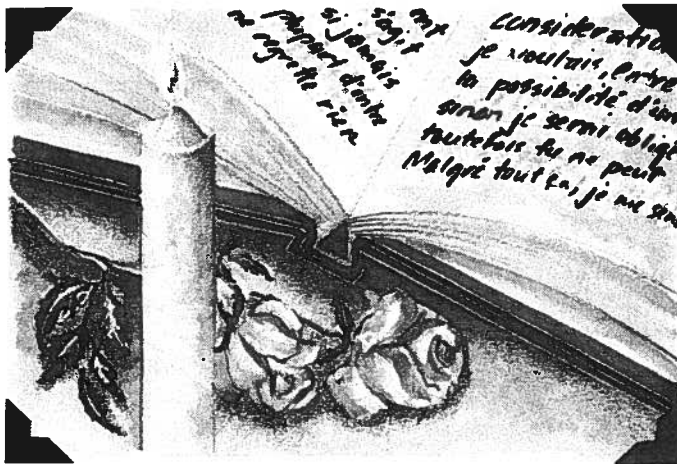
worthy of world attention.

"It's depoliticizing to say that he killed 14 students. He killed 14 women who happened to be studying in a non-traditional field . . . It could have been 14 women in a gas station, or a church, or a shopping centre," said St-Martin.

Many of us who considered our streets safe were suddenly reminded that men do this every day. We found ourselves afraid to respond to the guy on the bus who walked up to us and announced that he was on his way to the engineering school. We found ourselves stopping every time we heard a loud voice on the street, just to be sure.

Periodically, the media tells us about a discussion around the massacre or a memorial set up at the University of Montreal tacked on at the end of this week's news. Diana Yaros, of "mouvement contre le viol" deals with the aftermath of violence against women daily "A lot of people will rally around this and then forget about it. It's something we have to respond to every day with every sexist joke, every situation of harassment. It's not that we weren't horrified, it's just that it takes a massacre to get a reaction." And even then, too many people still miss the point.

KAREN HERLAND



L. Emily Elliott

Many in the crowd seemed to feel that to acknowledge this act as violence against women was somehow to diminish or deny its importance as a national tragedy. Bitter debates split the crowd. Any time any woman began to cry in frustration, reporters found her and cameras followed close behind.

"We encountered harassment and violence

or the patterns of previous mass murderers. The violence is with us always and, although horrifying, it is not remarkable that it finally happened on such a large scale. What was unbelievable was that so many people were still prepared to deny that 14 women were murdered just because they were women, even when it happened in North America, in a major institution and was considered

Struggle for choice on Vancouver Island

While the rest of Canada moved forward into the final decade of the millenium, women on central Vancouver Island in B.C. took a giant step backwards. At the stroke of midnight ushering in the new year, Nanaimo Regional General Hospital (NRGH) stopped providing therapeutic abortions.

The decision to ban abortions at NRGH was made in December when four men and one woman on the hospital board decided at a closed meeting that abortions were inconsistent with the hospital's "dedication to the preservation of life." The decision came in spite of the fact that 87 per cent of the hospital's doctors who responded to a survey initiated by the board said they opposed discontinuing abortions at the hospital.

The Nanaimo hospital, located 120 kilometres north of Victoria, provided more

than 400 abortions annually and was the only major hospital outside of Victoria regularly providing abortions for Island women. Up-Island women needing abortions must now travel to Vancouver, Victoria or Washington state. However, officials at hospitals and clinics in those location doubt whether they have the resources to accommodate all out-of-town women seeking abortions. The Nanaimo hospital board's decision is just one small part of a province-wide trend of decreasing availability of abortion — a trend readily condoned by the B.C.'s avowedly anti-abortion Social Credit government.

For poor women and teenage girls, the cost and time required to travel out of town and stay overnight can put abortion out of reach, even if they can find the space in a hospital or clinic. Shortly after the Nanaimo hospital board announced its decision,

a teenage girl phoned the local sexual assault centre saying she was considering performing an abortion on herself because she couldn't get into NRGH before January 1 and she had no other option. Her call was anonymous, so the outcome of her plight is unknown. However, she was certainly not the first teenager to find herself with an unwanted pregnancy and unable to tell her parents.

Nanaimo's two NDP MLAs immediately called on provincial health minister John Jansen to overturn the Nanaimo hospital board's decision. However, Jansen indicated he would not intervene in the affairs of a local hospital board.

Local pro-choice organizers hope to recruit enough like-minded hospital society members by June to dump some of the anti-abortion hospital board trustees at the annual elections. However,

anti-choice people on central Vancouver Island were extremely organized at last year's elections, and they can be expected to step up their own recruitment drive as they try to stave off a pro-choice win.

LATE BULLETIN: After a month-long barrage of public criticism, the Nanaimo hospital board rescinded its abortion ban. Local pro-choice advocates consider the reprieve a partial victory and say the battle won't really be won in Nanaimo or any other community until hospital abortion policy is taken out of the hands of local hospital boards.

"Until there's a change in provincial government we're left with guerilla warfare at the community level on this issue," Nanaimo MLA Jan Pullinger said.

KIM GOLDBERG

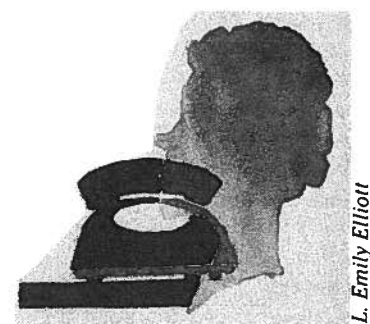
New projects at Women's Health Clinic

A new service for post partum depressed mothers is being offered in Winnipeg through the Women's Health Clinic. The program, which is funded by the United Way of Winnipeg, involves telephone support to the mother in her home. Volunteers who have

themselves suffered and recovered from post partum depression, or who have experienced the challenges involved in mothering, have been trained in peer counseling. By the spring of 1990, we anticipate having 16 to 20 active volunteers

offering one-on-one confidential counseling. While the first phase of the service delivery includes telephone support only, the clinic hopes to add a support group in the near future.

The development of a Women's Smoking Cessation Kit has been funded by the Health Promotion Directorate and is currently underway at the Women's Health Clinic. The Smoking Cessation Kit will consist of a facilitator's manual and a group sessions manual which will provide the information needed to facilitate a six to eight week guided self help group. The content will reflect a woman centred philosophy, integrating practices that address the emotional, physical,



L. Emily Elliott

intellectual, spiritual, social and economic aspects of women's lives. The exercises which will include relaxation techniques, journaling and discussion will hopefully inspire individual and collective solutions for transforming fears around stress, weight preoccupation, and emotional expression and offer insights into the life factors that keep women dependent on cigarettes.

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Chris M. Godi RMT

Yukon vaccination debate

The end of 1989 saw the formation of the Immunization Information Committee (IIC). This Committee was formed in response to an edict from the Department of Health stating that, due to a Whooping Cough epidemic, non-immunized children could not attend any public programs, including school. This finally forced some parents, who had researched the issue to organize a group to voice their concerns. They decided that the risks of vaccination outweigh the benefits touted by allopathic medicine. The response on a CBC radio open line show clearly demonstrated that there are many more concerns and problems with vaccinations than are reported, even in a population as small as the

Yukon. The Pertussis vaccine (for Whooping Cough) is associated with the most problems, but the entire question of mass immunization needs to be seriously reconsidered in the light of increases in immunological related diseases in our society.

As a result of the publicity prompted by the Department of Health's new policy, the Whitehorse Public Library provided a space for the IIC to establish an information file, so that a more complete story can be available to the public. The Immunization Information Committee welcomes any support or information and can be reached at Box 5641, Whitehorse, Yukon. Y1A 5H4.

LORENE BENOIT

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Networking at CRIAW

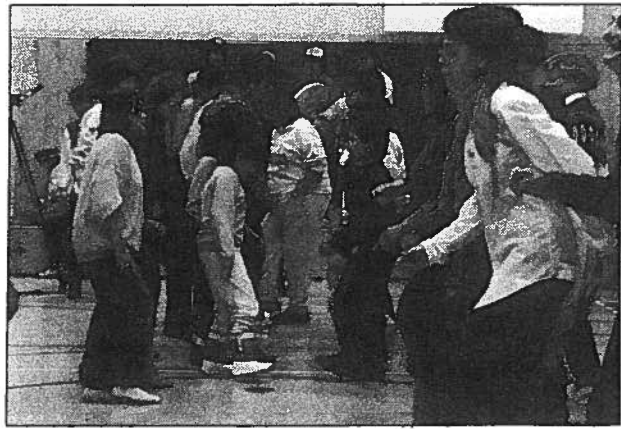
The Canadian Research Institute for the Advancement of Women (CRIAW) held their 13th annual conference entitled "Creating Connections" on November 10 to 12 in Yellowknife. Close to 300 delegates attended, including Northerners, lesbians, midwives, Francophones, immigrant and Native women who came from across Canada and the world to this northern centre.

Some of the highlights of the weekend included a MATCH International workshop on spousal assault which used a popular theatre approach of role-playing for participants to identify forms of domestic, military and global violence. One of the workshop organizers, a South African outreach worker with the Capetown Rape Crisis Centre, left behind a square of fabric as the initial piece for a networking quilt about

violence against women.

The delegates were presented with the film premiere of "Goddess Remembered," produced by Studio D of the National Film Board. It examines recent archeological evidence of widespread early civilizations that were comprised of goddess-worshipping, egalitarian people who lived for thousands of years free of global pollution and territorial conflict as we know it today. The film features a discussion between several well-known women scholars who link these neolithic cultures, to contemporary women's spirituality.

With CRIAW's focus on research and feminism, it was debated how the hands-on approach of the conference would be received by some of the more academic members from "down south." Conference co-ordinator,



Delegates join Native children in a traditional Dene drum dance.

Joann Lowell

Rosemary Cairns stressed that one of the main objectives was to network at the grassroots community level. She confirmed that the overwhelming positive response from delegates was that they had accomplished what they had set out to do: create connections. This was a conference in the North, with an emphasis on the contribution and wisdom of Native women and there was much to learn about the issue of grassroots involvement. Several Native women stated that they are not feminists

because they see the mandate of feminism as "women working for the advancement of women to the exclusion of men" and that "unless we heal the whole community the women cannot be healed." Isabelle Shay, a Micmac Native healer, said she was touched by the positive openness and acceptance at the conference, and she closed the weekend with a circle prayer in which all the women joined hands and were connected as "one" at the final networking dinner.

JOANN LOWELL

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Regrouping for choice

Edmonton's chapter of the Canadian Abortion Rights Action League (CARAL) has spearheaded the Coalition for Choice in response to the proposed federal legislation to recriminalize abortion. The coalition brings together Edmonton and area groups and individuals concerned about the implications of Bill C-43 which will aggravate the already critical situation in this city.

In Edmonton where only 35 abortions can be obtained per week, at least that many women are referred out of province for the procedure every week. Women here must make the decision to abort before they are six

weeks into their pregnancies and wait at least three weeks for the procedure. Abortions can only be obtained in the first trimester in a city which serves most of northern Alberta.

The Coalition for Choice will initially focus on writing to and meeting with local MPs and ensuring that these men have received the video, *Abortion for Survival*. A brief for the federal hearings on the bill is also being prepared. Members hope that the coalition will give a louder voice to local pro-choice women.

MARY HICKMORE

Darien Taylor

TESTING POSITIVE

AIDS is a woman's issue. Gone are the days when we believed that we lived safely on the outside of this epidemic. We grieve and mourn the loss of friends and family members. We offer support and care. We educate and counsel. AIDS forces us to re-evaluate basic patterns in our lives, particularly how we express ourselves sexually. And increasingly, women are testing positive for exposure to the AIDS virus.

Who are these women and what is our experience of living with HIV, the human immuno-deficiency virus which may lead to AIDS? How does our experience differ from that of HIV positive men, many of whom are gay? I want to examine these issues by focusing on a group for HIV positive women in the Toronto area. I will look at the implications of HIV to women's health and the services offered us in our struggle to live knowledgeably and responsibly in healthy bodies.

Since November 1988, a support group for HIV positive women in the Toronto area has met weekly. The group formed in response to a dramatic increase in the number of women who were testing HIV positive. The AIDS Committee of Toronto and Hassle Free Clinic jointly sponsor the group, which is the first support group in Canada exclusively for HIV positive women. (More recently, in Montreal, a city which is experiencing an alarmingly rapid increase in women testing positive to HIV, the Comité Sida à Montréal (CSAM) has started a similar group.)

Since its inception, approximately

20 women have attended the Toronto support group, some continually, some once or twice. These women have concerns which are unique and existing support groups which are largely composed of gay men couldn't meet their needs. But aside from testing positive to the HIV antibody, most of the women have little else in common.

—
***HIV positive women
 can experience
 an isolation much more
 profound than that
 experienced by
 a gay man***
 —

These 20 women tell stories of lovers, wives, mothers, sisters, friends and daughters; of productive working lives, fulfilling relationships and rewarding studies. Stories of physical violence, sexual abuse and racism. Stories of poverty, addictions, eating disorders and destructive relationships. These stories remind us that the health of most women hangs in a precarious balance.

Most women who have attended the group were infected by a bisexual partner. In many cases they were unaware of their partner's bisexuality. Some women were infected by a heterosexual partner from an area where HIV infection is widespread. (Government statistics

label this mode of infection with the interesting name of "sex abroad.") A smaller number of women trace their infection to injection drug use. They were sharing needles and also having sex with a partner who was also an injection drug user. (In this respect the support group does not reflect the predominance of injection drug use as a major cause of HIV transmission in women.) One woman was infected by a blood transfusion. A few women are not sure of the source of their infection.

Roughly one-third of the participants have male partners and a similar number have children, some as single parents. None of the women have partners of the same sex. In all cases where the woman's partner is HIV positive, he has an advanced infection. In the past few months, two of the women have lost their partners to AIDS. None of the women has a child who is HIV positive.

Three women of colour have attended the support group, all of them immigrants. Some of the group members are bisexual, but none considers herself to be a lesbian. Most participants are healthy and asymptomatic, though five women have significant symptoms of immune impairment, such as shingles, pneumonia, chronic diarrhea or significant weight loss. None of the women have died.

At first the support group served the very basic but extraordinarily important function of bringing HIV positive women together for the first

time. Most women who receive a positive HIV antibody test ("AIDS test") do not know any other women in the same situation. As a result, they can experience an isolation much more profound than that experienced by a gay man who tests HIV positive. Lacking a community in which to share their fears and grief, HIV positive women remain isolated, secretive, and fearful. In a society which does not produce or reflect accurate images of women living with AIDS, the existence of the support group is extremely important. It offers HIV positive women the reassuring opportunity to meet other HIV positive women, to hear their stories and to realize that they are not victims but survivors.

Many HIV positive women are not well-informed about their medical condition so they look to the support group to help them access this information. They are often not prepared for the positive test result and have not thought about the possibility of having AIDS. Isolated from a supportive community many of these women do not know how to manage the various aspects of their serious and unpredictable illness. They are often not provided with useful or accurate information by their physicians or health care workers, who may not



perceive them as "at risk." Their symptoms of HIV infection are usually attributed to other causes and they are often discouraged from taking an HIV test.

The mainstream media also contributes to women's ignorance of their condition by representing HIV in women either with sensational accounts of sex trade workers, which incorrectly scapegoat prostitutes as "reservoirs of infection," or with sentimental stories of "innocent victims." Women who test HIV positive don't fit these stereotypes.

In the gay HIV community, a survival strategy which is extremely important is the grapevine of treatment information and personal anecdotes that circulate informally. This information is incomprehensible to the uninitiated, but a matter, literally, of life and death in the AIDS community. "I've been taking hypercin for three months now and my p24 antigen level is negative again," or "pneumovax is back in stock," or "here's the AL-721 home recipe." This is a haphazard, sometimes inaccurate and yet completely empowering involvement in an information network. And it has succeeded in enhancing and extending the lifespan of HIV positive gay men. Most HIV positive women are excluded from it however, because many don't socialize with gay men and aren't situated within the larger AIDS community.

HIV positive women have difficulty accessing information on HIV, but beyond this they face another serious problem: the lack of documentation and education about how HIV manifests itself specifically in women's bodies and women's lives. The clinical model of HIV disease is as an illness of gay men. In women, HIV appears differently — the symptoms are different and so is the development of full-blown AIDS. But as a result of the predominance of the male clinical model, women focus on the wrong symptoms. They watch for the appearance of Kaposi's sarcoma (KS), the purplish cancer lesions which are a common opportunistic infection amongst men with AIDS, or symptoms of the particular pneumonia associated with AIDS, PCP (pneumocystis carinii pneumonia). A woman with AIDS, however, is extremely un-



likely to develop KS and more likely to develop a bacterial pneumonia before she develops PCP.

Discussion within the Toronto support group confirms what doctors are beginning to notice: one of the first ways that HIV manifests itself in women is through gynecological problems. Women experience persistent and virulent yeast infections, irregular menstrual periods and hormonal imbalances. Too often, women have learned to ignore these symptoms as the usual "women's problems." This attitude has unfortunate implications since recent treatment strategies suggest that HIV infection in women can be managed by early control of these gynecological problems.

Unwillingness to look at AIDS as a woman's disease means that women do not have the information that they need about safer sex, intimacy, childcare and their reproductive rights. We often don't ask questions about what safer sex means to a woman's sexual experience. Safer sex often describes a sexuality which is more comfortable to many women, sex that de-emphasizes penetration as the route to orgasm and replaces it with activities that stimulate the entire body and skin, and fantasies that stimulate the imagination. Yet most AIDS education pressures

women to respond to safer sex either by abstaining (if we're young) or by using a condom (if we're older). The condom makes penetration safer, but it doesn't question the primacy of penetration in heterosexual relations, which is an issue that needs to be examined in light of HIV.

Presently, a great deal of conflict is generated about women's reproductive choice. We must pay attention to how this struggle affects the reproductive choices of HIV positive women. Some statistics indicate that a healthy, asymptomatic HIV positive woman has about a 50 per cent chance of having a healthy child, who won't go on to develop AIDS. All babies born to HIV positive women are born HIV positive due to the presence of maternal antibodies. However, after a period of time the child may or may not replace the maternal antibodies with HIV negative antibodies produced by her or his own immune system. This is the information around which HIV positive women's reproductive choices should be made. However, clinical drug trials, which are often the only access to treatment open to people living with AIDS and HIV, discriminate against women on the basis of their reproductive potential. Some exclude women altogether. Early drug trials in the U.S. demanded that women be sterilized in order to participate. Recent drug trials in Canada attach conditions relating to birth control procedures. The recent ddI (another experimental AIDS drug) trials in Toronto require that pregnancy tests be administered to women participants.

Though many of the women in the Toronto support group have chosen celibacy as their response to positive antibody status, HIV positive women need to be aware of their sexual and reproductive options. Women require support in whatever decisions they make with respect to sexuality and having children.

As long as HIV positive women are not provided with an accurate model of their infection, they will continue to ignore its symptoms and AIDS will diminish our lives unnecessarily. HIV positive women will

continue to seek treatment later than gay men when significant damage to their immune system has already taken place. Women with a diagnosis of AIDS live a shorter time than do gay men. If we change the model of AIDS and AIDS education to include women, and if we begin to value women's lives, we prevent the spread of AIDS and for those women who do get it, we will know how to manage the illness better and survive longer.

Women in the Toronto support group are learning about the broad physical and social contexts of HIV and its management *and* their own experiences are voiced and validated. An atmosphere of mutual support and self-help has been nurtured.

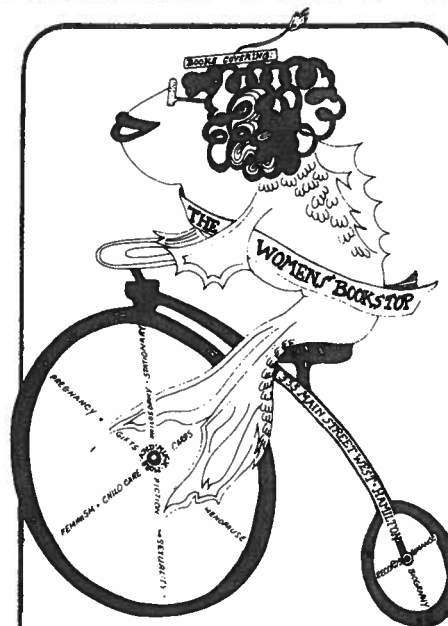
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HIV tends to bring women together but other circumstances of women's lives can set them apart

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As the confidence of HIV positive women grows, many women begin to see the need for more accurate representations of themselves. Some women in the support group now feel that it is part of their personal agenda to educate and inform various audiences about women's experience of HIV. Some have begun writing projects such as diaries, magazine and newspaper articles or correspondence with other support groups for HIV positive women. One woman has appeared on television and in an educational film identifying herself as an ex-prostitute living with AIDS. Others have spoken out publicly at forums, conferences and demonstrations.

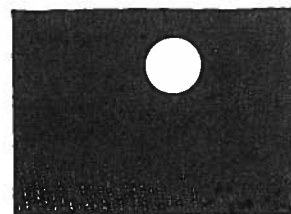
This work is the beginning of a long and difficult process of representing women within the community of people living with AIDS and HIV illnesses. It is very important that the voices of HIV positive women are heard so that we do not



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remain unrepresented, under-represented or misrepresented by others.

Every woman who has attended the Toronto support group for even a short period of time has shown a great willingness to put aside her personal beliefs, moral judgements and prejudices to listen to the stories of other HIV positive women and to offer sympathy, advice and support. Inevitably, even the greatest goodwill does not support women whose lives are in crisis or who feel marginalized by age, race, culture or lifestyle. HIV tends to bring women together but other circumstances of women's lives can set them apart. Thus an ex-prostitute, whose lifestyle is different from other women in the support group, stayed until her drug addiction pulled her away. An immigrant woman who may have felt uncomfortable because no one else shared her language, ethnic background or strong religious beliefs, attended until her childcare arrangements broke down. A battered woman left the group in the midst of her attempt to break with her abusive partner. All of these women faced problems beyond HIV. These are often difficulties that the support group is unable to contain.

Some women may feel more comfortable confronting HIV in a context which is culturally familiar to them, amongst women who share their lifestyle or speak their mother tongue.

A number of community organizations exist for this purpose and provide education and support groups.

Patterns of membership and attendance in the Toronto support group for HIV positive women point to the need for a variety of outreach services for women. Certainly regular attendance at a support group by diverse HIV positive women would expand all members views of what HIV means to women. But in practice, wide-ranging membership is difficult to maintain. The support group can not be responsible for breaking addictions or intervening in an abusive relationship. It cannot force women to confront issues which they are reluctant to face.

For many women a precondition to dealing with HIV is getting other areas of their life in order. HIV provides a very strong impetus to confront such things as alcoholism, addictions or abusive relationships. But it is not enough that women are ready to confront these issues. Our social services system must be ready to provide the services that will facilitate these changes. Yet it is still the case that there are too few daycare spaces available, too few beds in women's shelters, too long a list of people waiting for addiction treatment, too long a list to get into affordable,

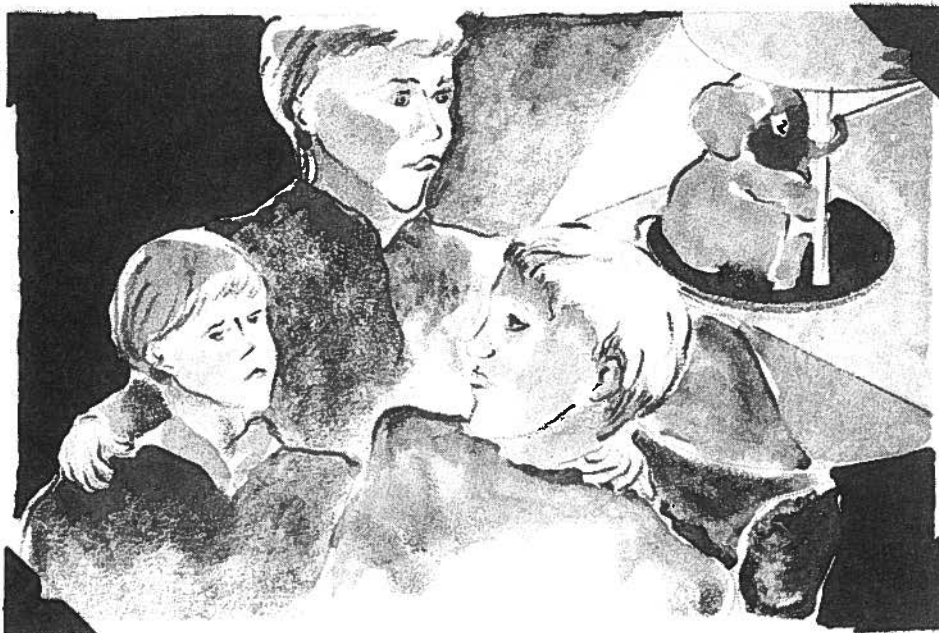
co-op housing, and never enough money. These are problems central to women's lives. They are made more extreme by HIV. Though services exist to help women whose health is jeopardized in these ways, these services are overtaxed, underfunded and they are scrambling to deal with the implications of HIV. Under these circumstances, some women with HIV find it difficult to cope.

Once these pressing needs of women can be met, then HIV positive women will be freer to explore alternative treatments like vitamin supplements, acupuncture and Chinese herbs. Or we may become involved in political issues as they relate to living with HIV. One woman may become interested in the relationship between macrobiotics and viral suppression and start to change her diet. Another might start exercising more. And another may represent an HIV positive woman's perspective within Aids Action Now!, an activist group organized around treatment strategy. Women will become more knowledgeable about non-drug therapies for enhancing their immune system and thereby decrease their dependence on what is too often a paternalistic medical system.

One of the members of the Toronto support group recently visited the offices of *Positively Women* in London, England. She brought back exciting news of an organization run by and for HIV positive women which offers counseling, a support group and publishes pamphlets which announce themselves proudly as "plain-speaking about AIDS and how it affects women, written for women by the experts — women". Such glimpses of an international picture of women responding to their positive HIV status offer encouragement and inspiration for the development of women's groups in Toronto and across Canada.

For Canadian women living with HIV it is a time of uncertainty and hesitation. It is a time of coming to terms with who we are and what we want as women and as HIV positive women. We will be stronger to demand those things that will help us to manage our HIV infection: education, outreach and informed medical response, daycare, support groups





and other social services specific to women with HIV. HIV positive women will also benefit from greater integration within the AIDS community and from access to an increased number of groups which deal with HIV in a way which allows women to be included.

HIV positive women are moving out of their isolation to develop connections with each other and with other people living with AIDS. They speak and write about themselves as HIV positive women, promoting accurate and unsentimental descriptions of themselves. They are making important and caring decisions about the way they want to live and, should it happen, the way they want to die.

Here are some of the women who have attended the Toronto support group:

- A young woman, infected nearly ten years ago by one of her first boyfriends. She is currently enrolled in the clinical trial of ddI, a promising anti-viral drug. Her employers have noticed her physical deterioration and are complaining about her job performance. She believes that her job is the key to her survival but fears she may be fired without notice and lose her medical and insurance plan.
- An older woman from Eastern Europe whose husband recently died of AIDS at home amidst their extended family. When their adult children

learned about what was happening to their parents, they purchased a large house so that they could all live together during this time of crisis.

- A diabetic woman caring for her partner, an ex-prostitute and injection drug user. They live on family benefits and she is responsible for managing most aspects of their daily life including waking her partner for his medication every four hours during the night.
- A health worker with three children who didn't know of her husband's bisexuality until he developed AIDS. She arranged for his admission to a residence for people with AIDS and moved with her children to Whitby.
- A young wife grieving for her husband who died of AIDS during the preparation of this article. Her two year old daughter is healthy, but was born since her mother has been HIV positive. This woman, who seldom speaks during group discussions, has written 85 pages of an autobiography detailing her experience of living with AIDS.
- A black woman from the West Indies infected during a blood transfusion who was initially told by her doctor that she was HIV positive because she came from Africa.
- A woman with AIDS Related Complex (ARC) who is an ex-prostitute and an injection drug user. She held a dinner for other group members at her apartment and then never re-

- turned to the group. After a clean year, she is back on the streets.
- A young student who tested positive during her first year of law school and who is about to begin practising in a prestigious downtown firm.
- The woman who wrote this article.

Darien Taylor is a freelance writer and AIDS activist.

Resources

Two organizations across Canada have specific women and AIDS projects:

AIDS Committee of Toronto
Women and AIDS Project
Box 55, Stn F,
Toronto, ON M4Y 2L4

Vancouver Women's Health
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MY STORY, OUR STORY

A New Dance Step

Lynn Tasker

Having an older brother who also had epilepsy helped. As children, we thought everyone had similar problems to deal with. If not epilepsy then some other form of set back. Now, at 33 years of age, I still believe that almost everyone encounters some form of handicap in their lives be it large or small, physical or social.

At ten years old I was diagnosed as having absence seizures. My brother John, who is two years my senior, has been having tonic clonic seizures for as long as I can remember.

Just for a bit of medical jargon, absence seizures, formerly known as petite mal, is when someone would just blank out for a couple of seconds. If you didn't know what to look for you would think that the person was daydreaming, in my case anyway. Tonic clonic (or grand mal) seizures, on the other hand, is when a person falls down, is unconscious and jerks uncontrollably.

There was a slight chance that I would out grow my absence seizures during puberty ... or 'progress' to the more mature tonic clonic. We all held our breath. Maybe I held mine a little too long. At any rate, one spring day I had a full blown convulsion.

"Welcome to the club!" John declared as I was regaining consciousness. I was very groggy. I didn't know what had happened to me except that I was lying on the floor, felt like throwing up, had a whopper of a headache and had bitten my tongue. No, not swallowed it as an old wives tale suggests. It would be convenient though, if my tongue could be absent while I was convulsing uncontrollably. Just think, my teeth would have nothing to chomp down on when my jaw decided to follow my body's new dance step.

Well, that's the first thing John and

I did. We came up with a new dance step! None of the old 'one-step, two-step' for us. No sir! We called our new dance creation "The EPEE." "The EPEE" is a modified version of 'The Jerk'. Boring around our house? Never! But fun. Boy, did we have fun!

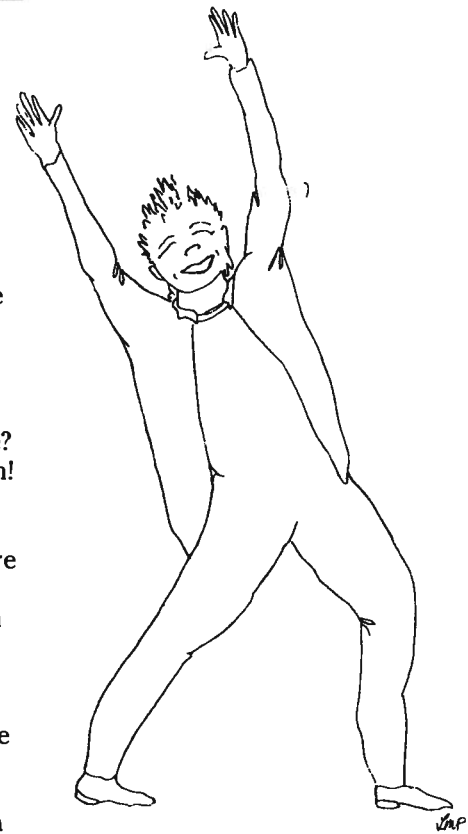
I must mention that absence seizures and tonic clonic are only two of the many different types of seizure disorders. John and I really did play the entire thing up good to have fun with it.

I was lucky. I never felt the loneliness that many other people with epilepsy must feel. Along with all the joking around, though, John and I never lost sight of the seriousness of our problem. It would definitely be a little while before mom or dad would let us borrow the car keys.

We told no one of our 'secret'. We acted like totally 'normal' kids. We climbed trees, rode bikes and went swimming. Now that I am a parent myself I appreciate how hard it must have been for my parents to take the chance on us and not become overly protective. John and I grew up without a handicap. With the exception of a few convulsions a year (John a little more often) we were medication controlled epileptics.

Together with our 'common interest' and the 'Epee' dance, John and I developed a special kind of closeness. Our self confidence was high and we were on top of the world.

My life took a turn during my grade 10 typing class. I had a seizure right in front of everyone. Sure, John and I joked around about ourselves but that was between us. Outside of our immediate family, no one else had ever seen John or I have a convulsion. Now that the fact that I was a 'convulsing epileptic' was out in the open it did not seem to be so funny. I had seen John have convulsions and



Lisa Phipps

knew that I must have looked the same. For someone else to watch my seizure would be like having someone watch you snore. I was not exactly at my best and therefore very embarrassed.

The fog surrounding me was beginning to lift. I realized I was lying on a cold, hard cot in the nurses room at school. Barbara, my younger sister, was sitting beside me holding my limp hand.

"Why was her condition not written down on her personal record!? We do NOT appreciate our students keeping this type of information from us!" a voice was lecturing. They do that well in high school. I turned a pasty face towards Barb, still not quite understanding. Then came the words every person with epilepsy yearns to hear after a seizure: "It's ok, Lynn. You've just had a seizure. Everything will be fine. Go back to sleep and I'll stay with you. You're just fine."

In the background came that droning voice;

"Why wasn't the school informed

she has fits? This is absurd!"

I smiled a weak smile at Barb, and fell into a deep, comfortable sleep. Barb had been around John and me long enough to become an old pro when it came to 'fits'. God, how I hated that word!

The next thing I remembered was that I was waking up in our family room at home with Barb watching TV beside me. Boy, that must have been a pretty 'deep' seizure for me to have conked out that much! I didn't even remember getting out of the taxi with Barb when she brought me home. I looked around at all of the familiar things beside me. This was definitely home. I was starting to feel better now. My nausea had subsided and I realized that I had hardly bitten my tongue. I still had a headache and decided to go back to sleep for awhile. The "Dating Game", which was on TV, just didn't seem to hold my interest, anyway.

The next thing I realized was Barb gently saying;

"Lynn, you've had another seizure. It's ok. You hardly jerked. I'm right here. You're ok. You've just had a seizure."

This couldn't be true! I looked up at Barb with questioning eyes. My mouth and brain weren't communicating so I just stared at her.

I listened to her words with shock! I was only supposed to have a couple of seizures per year — not per day! Since I was too tired to think of any of this, I fell back into a dreamless sleep.

It only seemed a moment later, when again;

"Lynn, you've had another seizure."

I looked up again, a smile upon my lips. I must have looked ridiculous to Barb. A pasty white face (which has just convulsed, remember) with this idiotic grin upon it. Again, I just stared at her. An incredible feeling of *deja vu* hit me. She smiled back.

"Do you understand me?" she asked, knowing what the answer would be. I nodded. I finally asked the time. By then it was 4 o'clock. That made it three seizures in six hours.

When multiple seizure activity happens it is wise to have the person checked out for any brain damage that could have resulted. The next day after having slept the rest of the

'seizure' day, my mother took me down to the nearest hospital for an EEG. This is a really weird brain test in which you get to play 'Frankenstein' for five minutes. Any lucky person with epilepsy has had at least a couple of them. Wires are attached to your head and ear lobes. It would be a lie to say it hurts. Perhaps uncomfortable would better describe it. At any rate, I had to hyperventilate, watch strobe lights and not move for what seemed to be an enormous length of time. After the EEG we were told by our doctor that everything was fine. Whatever caused me to have three seizures in one day will forever remain a mystery.

Another problem with having epilepsy, besides the fact that you have convulsions, is that you cannot do anything in extreme. Or at least you're not supposed to. Don't get overly excited, overly tired, overly intoxicated, overly hungry. Too much stress could cause a seizure as well as missing anti-convulsant medication. Usually an epileptic knows, from past experience, what triggers his or her convulsion. Hunger usually got me as well as stress. I seemed to be fine with most everything else. John, on the other hand, would have a convulsion if he missed two pills in a row.

The day of my 'triple seizure' I could only put down to stress. Then again, don't most kids in grade ten feel a little stressed out? Maybe it was just my lucky day — or unlucky, as it turned out.

I took a couple of days off school. Usually I went back the next day, but these three seizures really left me feeling 'out of it' for the next few days. I spent the time watching the tube and sleeping. I realize now that I was also using my convulsion as a scapegoat. I was sure I knew what was in store for me when I did go back to school; all the kids would have heard about me by then and I had visions of them whispering behind my back: "That's Lynn. She has fits. don't get too close or you'll catch 'ep-il-ep-see' or, "I didn't think that they let retarded people attend a regular school."

Epilepsy had never been 'taught' to me in any school. How then, could I expect the kids at my school to know anything more about it but the ridiculous rumours they had heard.

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Knowing all of this just did not make me feel any better.

The dreaded day eventually came and I had to go to school. I tried my best to look 'average' but every time I looked into the mirror I imagined other wise. Barb and John were wonderful! All three of us walked to school.

I was tearfully quiet when we had to split up to go into our separate classes. All morning people I had never spoken to asked how I was feeling. Did they mean it or not? I couldn't tell, but at least they weren't avoiding me.

Lunchtime finally came. Just as I was just sitting down in the crowded cafeteria I noticed Chris, the most popular guy in school, approaching me.

"Is your name Lynn?" he asked.

"Yes" I said. What the heck did he want?

"Could I see you outside?" he mumbled.

"Sure" I said but I really meant, oh no, oh no, oh no, oh no.

I followed Chris to the football stands. No one else was around. What did he want? He had never spoken to me before today so this had to do with the convulsion. I was sure.

"You had a seizure a couple of days ago. Do you have epilepsy?" he asked, finally.

"Yes." My face was scarlet. How could this guy be so mean?

"Lynn, I have epilepsy, too. No one else knows." he confessed awkwardly.

Instantly my heart went out to this guy, who suddenly was not the most popular guy at school anymore but an only child of a divorced family who also happens to have epilepsy.

I smiled. How nice that he chose me as his release. I knew then that if I had not had a seizure at school he would never have told anyone.

"Does the office know?" I didn't want Chris to ever have to go through the insensitivity that I experienced.

"No. Just my family . . . and now you. We felt it would be easier to keep it quiet."

I told Chris that it was better to let people know. My gym teacher had witnessed my convulsion and then failed me the next term. Her reason? After I returned to school I did not show her a medical form from my doctor regarding the seizures that I had had.

"That's crazy," Chris said, "you

don't need to get a medical form just because you had a seizure. That's why she failed you?"

"That's what she said."

Having my disorder on the school records would have surely helped educate her and others like her.

I convinced Chris to inform the office. In my case, they contacted Barb, but in his case, without any brothers or sisters the office may rush him off to the hospital, not realizing his body was just doing its own dance step. I then told him about John and the 'EPEE' dance.

It occurred to me, as I was talking to Chris, how lucky John and I were to have each other, love and a sense of humour.

Epilepsy is nothing to be thankful for but I realized that day — by the football stands — that it is something I have to tell people about. And, if they're really interested, I'll even show them how to do 'The EPEE'.

Lynn Tasker is a free-lance writer and mother of four young boys.

Epilepsy Facts

An epileptic seizure is the result of a disturbance in the brain's electrical activity. We all have electrical storms within our brains, it is the way brain cells communicate. A convulsion occurs when the electrical storm has gotten temporarily out of control. This temporary disturbance of cells is the only thing wrong with the brain.

Encountering a tonic clonic (or grand mal) convulsion can be upsetting. The best thing to do is to cradle the person's head and speak softly. That's all that is necessary to make the person having a seizure feel reassured and secure.

Gently hold the person's head so they do not hit it upon anything hard and turn them onto their side. This helps to keep the

air passage free and assures easy breathing. Talk to the person. It is very comforting to drift into consciousness hearing the words "It is okay, you're fine, I'm right here."

One out of every 100 people have epilepsy — a disorder that knows no gender preference. Women must be very careful to monitor their medication during pregnancy. Due to the various changes our bodies go through during this time, anti-convulsant medication may need to be either increased or decreased. It is important to check on the various consequences the medication could have on the unborn child. The side effects are extremely rare and of little worry, however pregnancy is best planned ahead — not only with the partner, but the doctor as well.

Thanks to the Epilepsy Association, people are becoming much more aware of this disorder. Discrimination still surfaces, however, and the Association acts by bringing cases to the press, appearing for people in court, making presentations to government committees, and sitting on coalitions which advocate for the rights of persons with disabilities.

The Epilepsy Association has chapters in every province. Members receive a quarterly newsletter covering medical news, medication, new findings and many other topics. All of the chapters' telephone lines are open to anyone who wishes to find out more about the disorder and literature is available upon request.

Angela Browne

RESISTING PSYCHIATRY

A few years ago, the Canadian Mental Health Association in conjunction with the Ontario government launched a major ad campaign to raise public awareness of barriers which exclude the "mentally ill" from the community. Such ads typically featured a school-aged boy expressing concerns that his father, who had been recently discharged from a psychiatric facility, might be shunned by neighbours and co-workers as if he were "still sick." Though the ads were meant to invite people to become involved in the association as volunteers, the terminology reinforced a medical model which perpetuates negative values and stereotypes about psychiatric survivors.

In the winter of 1986, a homeless woman was found frozen to death in the back of an abandoned truck. She was later identified as Drina Joubert and an inquiry was called into her death. Submissions to the inquest and recommendations that followed, painted a picture of the social services system as fragmented, inefficient and unresponsive to the needs of the neediest. Service workers were quoted as saying that if there were better co-ordination of services, Ms. Joubert would be alive today. However, the reality of a whole social system of poverty and homelessness was not addressed.

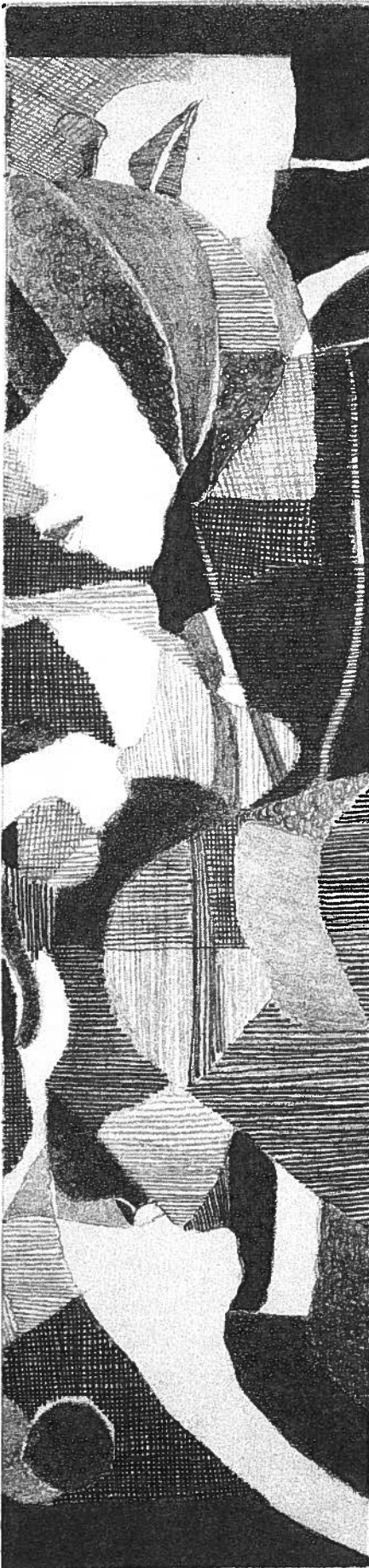
Shortly after the Joubert inquest was completed, a man living in a psychiatric boarding home died. Although John Dimun was being supervised by a physician and an adult protective service worker, no one

noticed that he had developed a severe lung infection. The jury's verdict following an inquest into his death concluded that Dimun died by "natural" causes induced by a self-chosen inappropriate lifestyle." (See "Boarding house tragedy," *Phoenix Rising*, June 1987.) The social and economic context of his life was ignored.

More recently, a housing group, in its bid to house nine former inmates of psychiatric institutions, was faced with bitter opposition from people residing in the proposed neighbourhood. In its coverage of the story, the *Toronto Star* included a photograph of men, women and children holding signs bearing the words, "One more is too many." If the housing group tried to relocate the project elsewhere, similar opposition could be expected.

For every public outcry on the need to redirect more funds to the community, there is a louder, more vocal call to send the dollars and the people back to institutions. While male inmates are portrayed as likely to become violent if allowed out even for a day, women are portrayed as victims, as in the case of Drina Joubert. Public interest articles in newspapers give the message that if the institutions weren't there, former psychiatric inmates would either become violent, suicidal or deteriorate living on the streets.

Although both men and women psychiatric survivors are portrayed falsely, women are more likely to be described as dependent, weak and vulnerable. This image reinforces the philosophy of most social service



agencies that tend to "do for," instead of "do with" the people they work with. This philosophy reinforces the notion that such individuals are sick, rather than victims of poverty, spousal abuse, working in the pink ghetto or devalued in some other way. Most of these agencies carry with them the notion that most or all so-called mental illnesses are biochemical/genetic in origin, even though most of the evidence continues to be speculative (see *Women in the Psychiatric Paradox*, Penfold/Walker, Montreal: Eden Press, 1983).

For various reasons, women become depressed more often than men. They also seek help more often and are prescribed more psychotropic drugs, which can have a negative effect on health. Because of this, many more women feel the need for, and seek out community support services.

Most community-based services, especially those run by hospitals or major charitable organizations (e.g. most branches of the Canadian Mental Health Association), were developed using the traditional charitable model. Giving help is usually a unidirectional action — the "well" party is expected to give help, while the "sick" party is expected to receive it and appreciate what is given to her. This creates a subtle power imbalance and prevents women from becoming involved in solving their problems.

There are many reasons for this adherence to the charitable model. Governments and community health funding bodies prefer to fund projects that are both professionally administered and supervised. Most such administrators come from backgrounds which prevent them from being aware of the day-to-day issues that affect those they "serve." They tend to be white, middle-class and frequently male. Most of the staff hired to run these programs are from a social services background and very few have been through the mental health system themselves.

Many former participants of such programs became frustrated in their attempts to deal directly with the power imbalances within, so they formed their own groups (e.g. On Our Own, Phoenix Rising). These groups are critical of the hierarchical

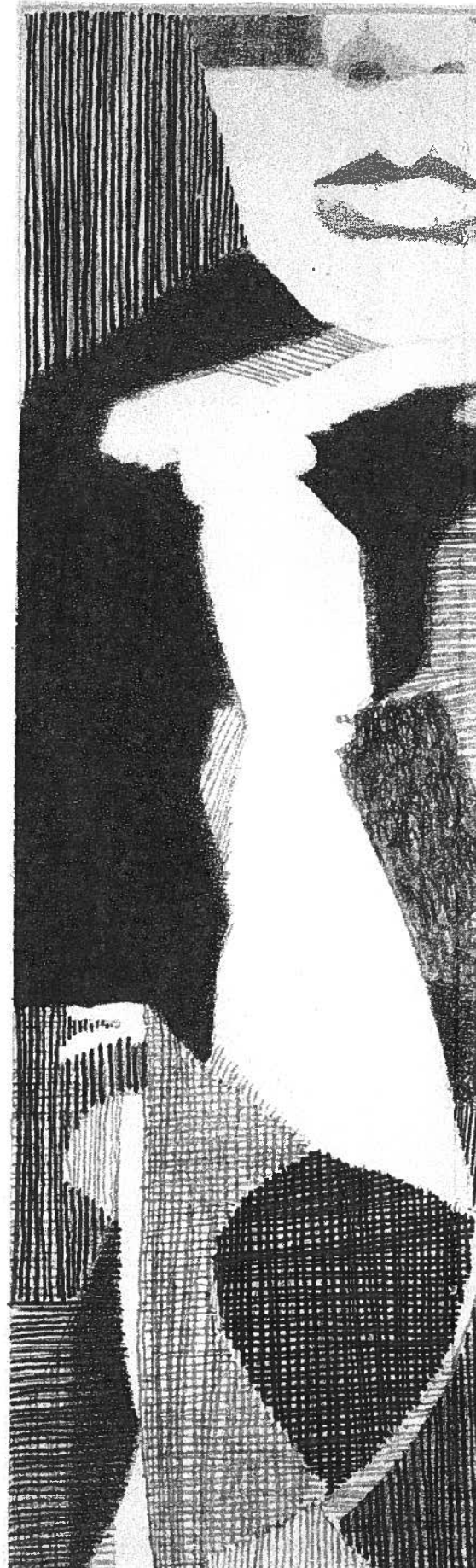
structures and paternalism that exists in most traditional community mental health organizations. It is their view that the self-help approach in a democratically-organized structure is more effective at providing the mutual support that people need to regain control of their lives. Unfortunately, most of these groups are poorly funded and almost as powerless as the individuals within them.

Their leaders have worked hard at advancing the interests of the self-help groups and have gained a few powerful allies such as Ontario MPP David Reville and Ontario New Democratic Party health critic, Carla MacKague, both of whom were once "treated" in the system themselves. One group, On Our Own, developed a drop-in centre, second-hand goods store and quarterly journal, *Phoenix Rising* (see "On Our Own: A Self-Help Model," D. Weitz, *Phoenix Rising*, Spring 1983). *Phoenix Rising* has since become independent of On Our Own and continues to be operated entirely by former psychiatric inmates, as they prefer to call themselves.

Some service providers have begun to realize that the concept of "doing to" or "doing for" is no longer acceptable, due to increased criticisms from the newly formed self-help groups. Some responded to these criticisms by developing a new approach called "empowerment through partnership" (see *From Consumer to Citizen*, Canadian Mental Health Association, 1987). Although a few organizations have achieved this, most are still struggling with a hierarchy that does not want to give up control.

A popular example of this innovation is the clubhouse model, currently practiced at Progress Place in Toronto and at an increasing number of branches of the Canadian Mental Health Association.

The clubhouse format is simple. Members and staff meet at the start of each day to choose tasks to perform. Tasks include clerical, statistics, maintenance, writing reports, sweeping the floor, washing windows and many other things. Lunch and sometimes supper is provided for, and by the members working in the café unit. At the end of the day, staff and members meet again to review the



**Psychiatric
survivors
need
organizations
run
exclusively
for
and
by
themselves**

events of the day, give compliments and make small changes to the program.

Though this program seems to be egalitarian on the surface, there are many other issues that still remain to be addressed. When someone wishes to join a clubhouse, they must attend an interview conducted by a staff member who then decides on the candidate's suitability for the program. This usually includes the humiliating process of the candidate having to admit, either verbally or in written form, that she has been "mentally ill." In contrast, staff automatically become members of the clubhouse upon being hired and in most jurisdictions it is illegal to ask a prospective employee about her psychiatric background.

Since this type of job attracts applicants with a social service training background, it is unlikely that such applicants approach the clubhouse to get help from the other members. By virtue of definition, paid staff are more likely to see themselves as giving help rather than receiving it. It becomes clear that not all members are equal and only some members get paid for their contributions.

Another problem barely addressed is the scope of decision-making allowed for members at the daily meetings. They can decide to bar an unruly member but they cannot discipline staff. They can make Thursday nights euchre nights instead of bowling nights but they cannot decide on directing more money into one activity or another. Final program decisions and personnel matters are out of the hands of clubhouse members. Unless there is a generous supply of program users on the agency board of directors, the clubhouse is not run by its members.

Most discussions and meetings take place with staff present. Personal issues, such as the budgeting of one's own money or finding a room to live in are discussed, but rarely spoken of are general problems of poverty and oppression. Members are expected to adjust to a bad society and stay on their prescribed medication. Problems arising from poverty or discrimination are thought of as being the fault of the woman or her "illness."

Vocational training has become more popular with all community

mental health programs, but it usually comes in the form of supported work placements or transitional employment programs. Transitional employment programs (TEPs) are usually added as an advanced component of clubhouse programs and offer benefits to both employer and potential employee. The employer is guaranteed that a position will always be filled and the employee obtains much needed job experience, without undergoing the problems associated with a job interview.

But TEPs do have their problems. Clubhouse members are expected to seek only low-stress, entry-level positions, such as clerical work, restaurant help and cleaning. Most of these jobs pay minimum wage and offer little advancement. If a clubhouse member already has skills or a university or college degree, she may now want a job that is significantly below her personal aspirations.

The employer, like most members of the general public, likely lacks knowledge and understanding of mental health issues. Although they are told only that the workers are involved in the TEP program, they could assume that you have been labeled as having mental or emotional problems. They may treat such employees differently by being patronizing or nervous. This can create an uneasy feeling in some women, especially if her employer is a man.

Another popular empowerment measure that some agencies use is the members' council. The members/clients of an agency elect their own executive and report to staff with recommendations for program changes and activities. The council may also be in charge of operating social activities in the evenings and may publish their own newsletter. However, the council work of the members is supervised by staff and/or designated volunteers, who are always present during activity nights. If members publish anything controversial, such as challenging the biochemical model, in their own newsletter, the staff can act as final editors and choose to censor such articles.

The council also has no final say in program changes, budgeting, personnel and long range goals. These decisions are made by the agency board

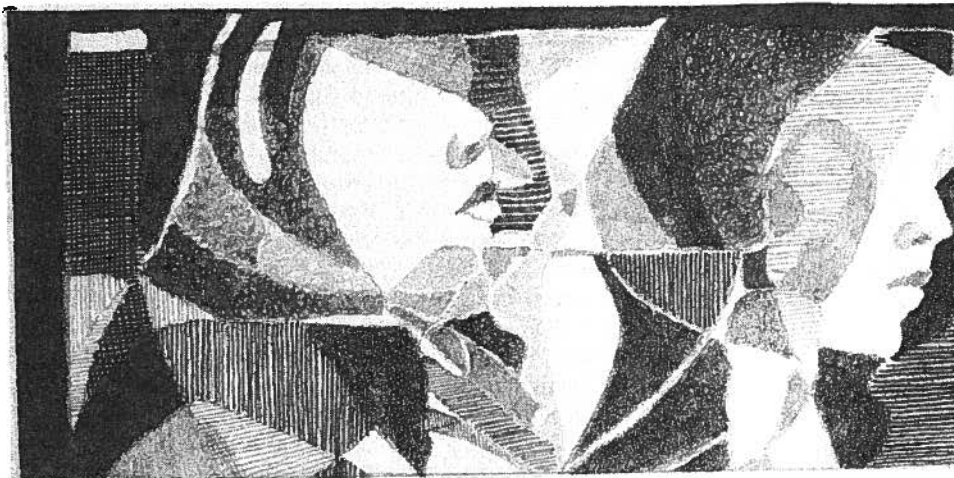
or executive committee. While most boards are now admitting consumers (as they are often called), their small numbers don't produce a sense of representativeness and variety of viewpoints. The result is that vocal individuals don't feel comfortable to seriously challenge certain assumptions made by other board members about what is "best for the mentally ill."

Placing a *significant* number of service users on boards and decision-making committees will not only add credibility to the consumer voice, but can also raise the level of self-respect among many who have lost it through the undermining processes of becoming a patient. With more input from their users, services will also become more relevant and responsive.

of simply doing for the "mentally ill." In seeing a need for a real partnership between those who help and those who turn to mental health agencies for support, Friends and Advocates Etobicoke formed in 1977. Shortly thereafter, Friends and Advocates began new programs in North York and Peel that are run with a similar philosophy to the Etobicoke chapter. Responsibility for the budget, personnel, programs, researching of social issues, the publication of their quarterly newsletter, *Reflections*, and other functions are carried out through the agency's various committees, *all* of which are run, primarily, by psychiatric survivors. Recommendations come from these committees which are then brought to the general membership meetings, where program users, staff and vol-

network of current and former psychiatric survivors. The first task of this group is to create a network of interested persons who wish to attend an upcoming national conference in Montreal. The network will also assist in the development of organized advocacy efforts for and by psychiatric survivors. This network is operated almost exclusively by psychiatric survivors and offers some hope of connecting people who live in remote areas of Ontario.

But, including more psychiatric survivors on the boards of decision-making bodies and agencies is not in itself enough to resolve the central issue of how people can help themselves. Psychiatric survivors need organizations run exclusively, or almost exclusively, for and by themselves. As mentioned earlier, the quarterly



Recently, the national office of the Canadian Mental Health Association published several papers addressing shortfalls within the mental health system. They also examined how their own organizational structure involves consumers (as psychiatric survivors are called there) at all levels of decision-making and in self-directed advocacy. The national office recently opened their board to such interested persons and created a task force to facilitate more constructive participation by consumers. This task force is not directly under the auspices of the Canadian Mental Health Association and the formation of an independent national network is among its many goals.

A few smaller agencies have broken away from the traditional mode

unteers each have one vote. Many of the staff and volunteers have previously been through the system and all participants are encouraged to take on a helping role, as well as receive support from others. Activities include discussion groups, member-run social and recreational events, a quarterly newsletter and social support networks. The Friends and Advocates program has been shown to be effective in reducing hospitalizations among those who belong to the organization. The agency demonstrates that it is possible to develop a partnership between community members and those that have received psychiatric treatment.

Friends and Advocates Etobicoke is currently assisting with the development of an Ontario provincial

journal *Phoenix Rising* is run only by individuals who have directly experienced the system. A new political action group in Toronto, Resistance Against Psychiatry, is also completely ex-inmate controlled.

There are also a number of self-help groups run by psychiatric survivors that tend to be less radical and more accepting of the medical model, such as manic-depressive associations. They have also been fighting for greater representation for their members on decision-making bodies.

In November, representatives from across Canada attended a national conference on "mental health alternatives" in Montreal. The conference itself was meant to be a networking device as participants were mostly

psychiatric survivors. Workshop topics included local organizing, dealing with agencies, obtaining funding, living with or without medication and women and psychiatry. This conference could facilitate the development of a national psychiatric survivor-run organization.

These organizations will not entirely solve the issues affecting women facing these problems, but they are a positive step forward. Increased participation by those who directly experienced the mental health system can give women more control of their lives and will also facilitate the development of more appropriate services.

Mental health self-help groups should also form coalitions with various organizations formed to fight other issues, such as incest, wife abuse, poverty, sexism, heterosexism and racism. Female psychiatric survivors can borrow from the women's shelter movement and develop local projects that enable other women in crisis to seek refuge in a shelter with high levels of emotional support. In her book, *On Our Own: Patient Controlled Alternatives to the Mental Health System*, Judi Chamberlain wrote about her positive experience while visiting Vancouver's Emotional Emergency Shelter, which was then operated by the Mental Patients' Association.

Similar agencies could be developed to deal with related issues of racism, sexual abuse and poverty. Co-operative workplaces and businesses (with the added benefit of child care facilities) could be formed to assist women in getting out of the traditional pink ghetto.

These issues must be resolved for the benefit of both men and women. If we then discover that a small fraction of those labeled "mentally ill" do indeed have clear neurological, biological or nutritional imbalances, we shall attempt to work with them in much the same way. We must oppose potentially harmful treatments, often administered to people in the name of so-called biological psychiatry. Those we refer to as "mentally ill" should have the same rights as everybody else.

Angela Browne is a sociology student, self-help group activist,

freelance researcher and writer who also sits on numerous committees and community boards dealing with mental health and poverty issues.

Further Reading

Women and the Psychiatric Paradox, Susan Penfold and Gillian Walker, Eden Press, Montreal, 1986. An excellent book on psychiatry's particular assault on women.

Women and Mental Health in Canada: Strategies for Change, Canadian Mental Health Association, Toronto, 1987.

On Our Own, Don Weitz, *Phoenix Rising*, Spring 1983.

From Consumer to Citizen, Canadian Mental Health Association, Toronto, 1986.

On Our Own: Patient Controlled Alternatives to the Mental Health System, J. Chamberlain, McGraw-Hill, New York, 1978.

Resources

Phoenix Rising
Don Weitz
Box 165, Station A,
Toronto, ON
M5W 1B2
1-(416)-465-3883

Activists for Real Alternatives
c/o Angela Browne
Box 161
St. Catharines, ON
L2R 6S4
1-(416)-688-5598

This group was recently initiated by the author, and is a political action, self-help group

Friends and Advocates Etobicoke
Pat Black, Director
3107 Bloor Street West
Unit #201
Etobicoke, ON
M8X 1E3
1-(416)-234-9245
The Ontario network run by survivors is called People Unlabeling Network and the contact person is Hugh Tapping, c/o Friends and Advocates Etobicoke

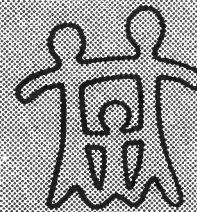
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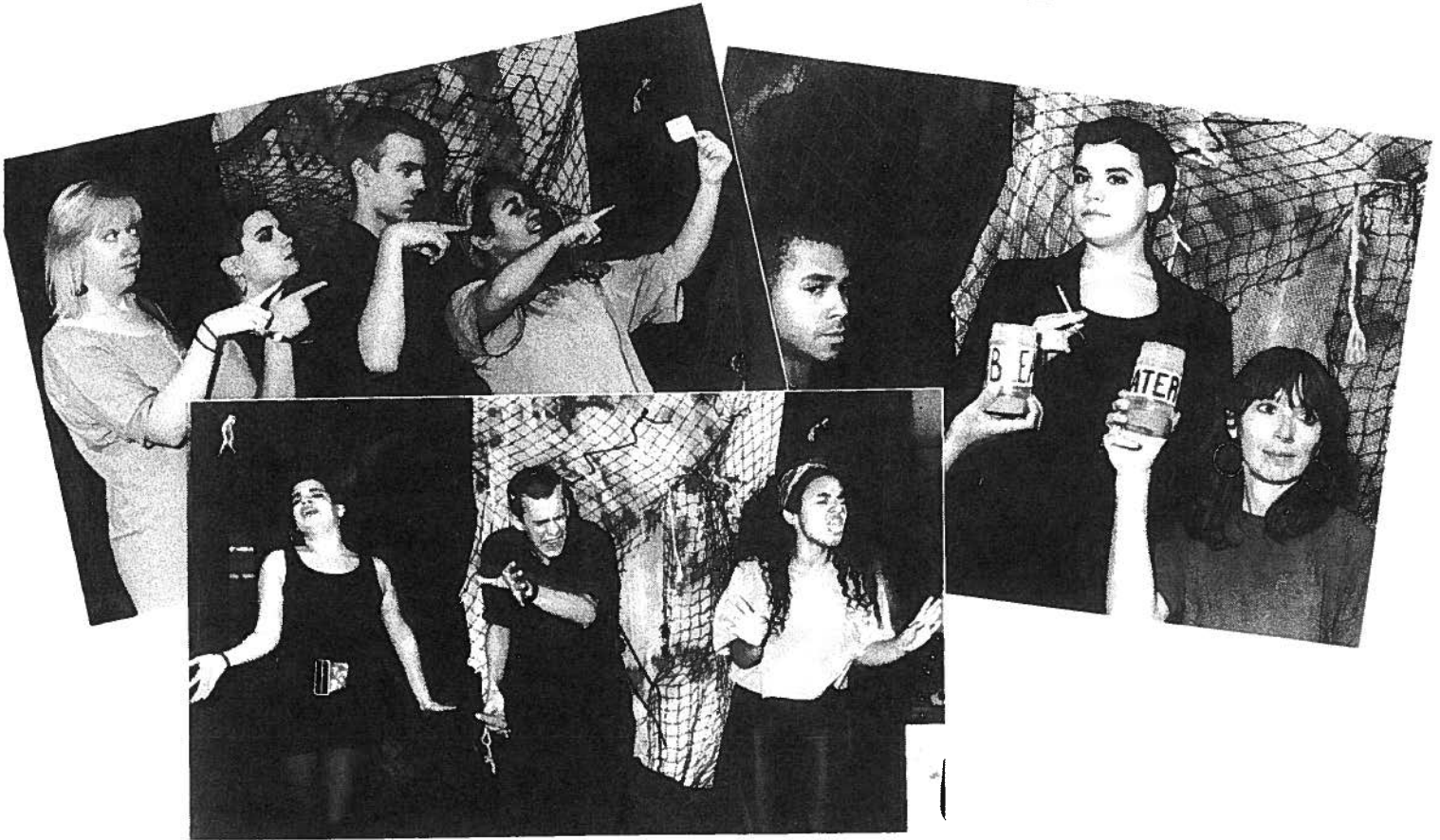


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Health on Stage



PATTY: I think that of anything I've ever done in terms of work, *What's Wrong With This Picture?* is the thing I'm most proud of. Because on a purely personal level it incorporated so much of the way that I want to work and the things I believe in.

JULIE: All the words around theatre are so scary. "Theatre" is scary, "audition" is scary, "show" is scary. It's all like you have to stand out there and be exposed and you're going to be judged. It was important to us to try and get rid of a lot of those things.

FIONA: I would hope that people would come away from a performance of *WWWTP?* with a sense that they have the right to make their own choices in life and that it's up to them to make these choices. Another thing I hope they come away with is information about AIDS and a desire to get more.

ZOE: When *WWWTP?* was done I loved it. What more can I say — it just works really well. I think it works because it's not saying "don't have sex and do drugs." It's fairly realistic as far as theatre goes. It's funny, it's musical and the forum scenes actually get people to stand up and say "stop," which is a hard thing to achieve I think.

ZIGGY: Forum theatre is good because it helps people from the audience share their point of view. If you watch a regular show you sit there and you don't get to participate and if there's things you don't like you can't say nothing because it just goes on. But in forum you get to say what you want to say. I thought it was cool. It gives you a chance to bring out more ideas and express your thoughts more freely.

Second Look Community Arts is a community-based popular theatre group, active in Toronto since 1981. Some of Second Look's first work was with people labeled developmentally or physically disabled. In recent years we've worked (and played) with a variety of other groups of people: sole support mothers, stroke survivors, immigrant women, adult educators, transient women and men, lesbians, teenagers . . .

We use theatre as a means for self-expression, for building confidence, for sharing experiences and to deepen understanding and analysis of a situation or event. In some cases the product, a skit or play, is important; at other times the process is the focus.

In the summer of 1988 a group of 10 young people and adults collectively developed a play for young people called *What's Wrong With This Picture? . . . more than just a play about AIDS (WWWTP?)*. Using music, humour and drama it looks at safer sex, cleaning needles, relationships, homophobia and AIDS hysteria.

WWWTP? was performed for young people in community centres, drop-ins and group homes throughout the summer of 1988. Because of an extremely positive response and demand for more shows, Second Look remounted *WWWTP?* in the summer of 1989. Later, with some of the same people and some additions, we collectively wrote another play, *Spare Changes*, looking at some of the health concerns of young people living on the street.

Beginning with a spoof of media stereotypes of street kids and interspersed with street tips provided by an enthusiastic group of bereted "Street Scouts," *Spare Changes* tells the story of Casey, a young woman confronting the institutional power of Children's Aid, the psychiatric profession and the police, as well as the dynamics she encounters among her peers on the street.

WWWTP? and *Spare Changes* are different from regular theatre — during particular scenes in both plays, audience members can shout "stop," and then come up on stage, take the place of an actor and try out a different approach to the scene. We are using a method known as "Forum

Theatre," originally developed by Brazilian theatre director, Augusto Boal, as part of a method he called "Theatre of the Oppressed."

Forum theatre is designed to provide a "forum" for people with a similar experience or oppression to explore alternative solutions or approaches. In a forum scene you will see characters trying to make changes in their lives and encountering barriers, both institutional and attitudinal. At the end of the scene, they fail, they don't achieve the change they are aiming for. The scene is then rolled back to the beginning and this time, when the frustration becomes too much, audience members can actively intervene to try and change the outcome.

The idea is to "rehearse for reality." If we can practice in a relatively safe environment the situations in which we are likely to find ourselves in real life, then we are more likely to know what approach to take when it actually occurs. In *WWWTP?*, for example, Catherine and Andy are about to make love. Catherine wants to use a condom, Andy doesn't. Audience members can replace Catherine and practice convincing a lover about the importance of safer sex.

The process of developing a forum theatre piece begins with games and exercises to loosen up the mind, the body and the senses. Then we create images of our experience as individuals, moving into collective images that allow analyses and collective search for solutions. Forum theatre is not about telling anybody what they ought to do; it is about people with a common experience experimenting together to uncover the alternatives and choices available to them.

Forum theatre is being increasingly adopted in Canada by people interested in theatre for social change. Women, particularly, have been drawn to this method, because it is a process that gets away from sitting around and talking and moves into a more physical, non-verbal, holistic approach to change. As Lib Spry, a theatre forum practitioner, points out in a 1986 *Canadian Theatre Review* article: "It is not surprising that it is women and the Quebecois who have been the first to use Theatre of the Oppressed in Can-

ada. Clearer about the oppressed roles they play, eager to find ways to change their lives and the society they live in, it is an obvious tool for them."

Following are excerpts from interviews with five women involved in the creation and performance of *WWWTP?* and *Spare Changes*. I talked to them about what the experience was like for them, how they feel about the plays and the audience response and their thoughts about popular theatre in general and particularly, forum theatre.

Fiona Hinds, Zoe Hamilton and Ziggy Junior are part of the Second Look youth contingent. Fiona and Zoe were involved in both plays, Ziggy in *Spare Changes*. Patty Jarvis and Julie Salverson are Second Look adults.

Process

FIONA: I wouldn't want to do something for the community if it didn't come from them. We were doing a play for youth, so we went out to youth groups to find out how they felt about the issues that we were dealing with. The research and outreach to the community were really intense. I had to deal with a whole bunch of things that were brought up for me about my decisions and my life and my sexuality. I had wanted to use condoms with people before and I never had the courage to. I realized now I *have* to and I need help to do that. It was a decision I had to make but I wanted the others to be there and sometimes they couldn't be. It's frustrating, but in the end it's OK.

The play didn't belong to one person, it belonged to all of us. I felt a big part in creating it and I gave myself credit for the work I did. The process is very collective. It gets frustrating sometimes finding out 10 people's opinions and always having to have a meeting to discuss what we want to discuss. Because people wanted different things for the show. Somebody definitely didn't want the show to be horny, someone else wanted it to be really sensitive . . . you have to bring in all the elements



and mold them together and that's hard. But the most frustrating thing is leaving it. After you do it and you're finished and you get to know these people and they get to really know you and then going back to the real world. That was probably the toughest thing for me. Coming out of this nurturing community and going back into the real world.

ZIGGY: We worked hard. The thing I liked most about it was that everybody was so close together. It was a really different experience, something I would like to do again. All the pieces from it were from us. There wasn't a director writing it, or us giving him ideas and him writing what he thought our ideas were, it's us writing it. I felt really good about that.

There were a lot of things that happened to me living on the street that I found hard to deal with. In a way I kind of liked it but it was really scary because I felt like my life was always being threatened. Trying to tell people the scary things that happened to me kind of made me nervous. I guess because I was scared that it happened to me and so just talking about it made me remember it, like reliving it. In a way it helped me to

deal with a lot of the things that I had just pushed in the back of my mind.

ZOE: It was hard because there's so much emotional crap involved with sex, right. And you have 10 people who all have their separate emotional crap involved with sex and they all get together and decide to make a play about all the good and bad crap. It just makes a big heap of something and you have to sort it all out and correlate it and make it into something that looks like a show. That was hard.

Working on *Spare Changes* was like eating, sleeping and drinking street life. It was a bit much because I really felt like I was going backwards. I felt like I just didn't want to deal with being on the street anymore because that was part of my life that I wasn't doing anymore, it was over, and now here I was writing a play about it. But we had a really good group of people, we had the right people doing the right things. I don't know how I managed to live through it because it was a really personal issue to me, it was something that was very much part of my character and I felt really revealed, I felt really unarmed and open about

the whole thing.

JULIE: I remember one morning especially. We spent a whole morning using image theatre to look at a couple that wanted to make love and one wanted to use a condom and the other didn't. We literally spent three hours putting different figures behind those two characters. What are the voices in their heads? What are the voices in *their* heads? We made a mistake because we didn't keep a record of that morning and I think we would have had more material for improvs when people intervene in that scene.

PATTY: I was really amazed how quickly we had to trust each other. On one level we were doing this play about AIDS, but on another level we were really examining ourselves. At times it was hard because sometimes you don't want to deal with AIDS. As soon as we started the project, it seemed like everything in my life had to do with AIDS. I'd sit on the subway on the way home and wonder if the person across from me used condoms. I don't think anybody wants to admit that AIDS is real, but we were trying to make it real for ourselves and for the people who saw the show.

The Plays and the Audience Response

ZOE: I wanted *Spare Changes* to be very practical. I don't care if people leave lifted or enlightened, I just want them to know not to hit a cop in the face because they will go to jail. I want them to see that they can choose who they hang out with and you don't have to be verbally abused or beaten up when you're panhandling.

ZIGGY: I'd like people to not put down people who live on the street. A lot of stereotypes are said about street people, that they're thieves and this and that, when really they're just trying to survive like everybody else. I would like my audience to go away thinking that they got a chance to participate and they had a chance to say something about issues that are happening in everyday life, that in reality they only get to think about and not to say.

When I was on the street, in a way I felt like I was stuck there, that I'd be there for the rest of my life. If I'd have seen a forum when I was on the street I probably would have felt better knowing that somebody else has gone through it and they've made it out.

FIONA: When I think of health I think of mental and emotional health, as well as physical. The AIDS show is obviously about physical health, there are clear issues about cleaning needles and using condoms. But it's also about choices, all the choices we make that directly affect our health. It's unhealthy to make a choice to spend more money on drugs than you do on food. If you panic about AIDS that also affects your health. You have to make a choice about how to deal with all the information you're bombarded with.

PATTY: I think the response was really good. After a show it would be all over and the audience would be sitting talking about it. They might be saying things that I didn't agree with, but they were turning to the person beside them and talking. It was a little thing, but maybe it was the beginning of thinking differently.

We are dealing with questions around sexuality and what we want in terms of relationships, what we

need as human beings to feel loved, how difficult it is to ask for what you want. I would want the audience to think more about how they related to other people and what they want and need from other people. I don't just mean about sex and using condoms. That's part of it, but that's not it.

JULIE: I'd hope that people would be a little less afraid to talk, in any situation, with a lover or a parent or a friend . . . about sex, about what it is to be gay. To me it's important to realize that it is dangerous sometimes. Maybe you get laughed at, and that's hard. Maybe nobody agrees with you, and that's hard. You imagine in your head, "what will I do in this situation?", but you never get to see the scene and you can't play act in your head. In the forum you get a chance to either say something yourself or watch someone else.

I'm proud of *WWWTP?* because you see people in situations a lot, you don't just get facts thrown at you and you're not told "this is the way you have to be and this is what you have to do." It's more like "Here's the possibilities of ways to be that might be safer. You deserve to be protected, you deserve to think about these things."

Spare Changes was very powerful. It was important that there be some kind of debriefing for people after, a time to talk a bit and get out some of their feelings. Because not everyone intervenes and it raises a lot of things for kids who've been through those systems.

Popular Theatre and Forum Theatre

ZOE: Forum theatre works. I'm really surprised. When you're doing a forum for people who are in a particular situation it seems to be a really helpful way for them to yell at the people they want to yell at when it's not right for them to yell at them in real life. It lets them get a better perspective on what's going on, they can step back and pretend that they're that other person going through the same situation, but it's not them. So they lose a certain amount of personal involvement, which is kind of good.

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FIONA: I think it's something that everybody should experience, participating in a forum that directly relates to them. Because you find out so many things, not only about the community, but how systems work and all the red tape and the vicious circles that are happening and that you are a part of. I think everybody should experience this, it would enlighten the world.

I've never seen a forum about women being oppressed by men, but I have experienced doing improv around that and for me it was just so powerful to be able to tell a man exactly what I felt and to stand up for myself. After you do it in a forum it's like you know it can be done, you just did it in front of 25 people, so why can't you do that one-on-one in real life?

I think that a forum on racism would be very challenging. It would have to be handled delicately because all the *isms* that we have inside ourselves would come up. At the same time it would have to be blatant and honest. Because forum is honest or it doesn't work.

JULIE: To me what theatre does is find the common ground. You go, "oh, you're a mother too," or "you're afraid to talk about condoms too." You get a fuller picture of the other person. Then you can talk about an idea that you don't agree on and you already know this person as a person. To me that's a radical political act because I think we're so divided. We're presented with images of people and that's all we're supposed to know. With theatre you look at more parts of a person. It's almost like medicine, we're just beginning to realize that maybe when we treat the nose, it's not just the nose that's involved. Theatre is holistic, it can look at personal fears, the economic situation, all the different pieces involved, not just the one, not just the nose.

The other thing is the whole idea of "play," you're "playing," making a "play." You can try something, if it doesn't work you throw it away and start again. So you get a chance to fail. Where do we get a chance to do that. We're judged every minute, it starts in school and that's it. If you can create an environment with people where they can consider a change in their life, consider saying

"no," saying "what is this?" asking a question and practice it, that's huge.

I could see doing a forum for parents of kids who are dealing with social workers, looking at how to deal with social workers so the parents and kids aren't so split. I remember one woman talking about saying to one of her kids "once you get into that system I can't get at you." I'm terrified of losing anyone into a hospital system, a social service system, a prison system. I don't deal with it very well, I want to yell and scream and drag them out of there and that's not necessarily what's possible.

PATTY: You can see the struggle going on in people's faces as they are sitting there watching. You can see if they don't agree with something or if it makes them go, "No, stop!" In our society we spend most of our time accepting things, this is the way the world works, the way jobs work, the way relationships work. We never stop to say "No, wait a minute, I don't like that or that makes me uncomfortable." In a forum sometimes it's irrelevant to me what people do once they get up there, it's just that moment when something in them says, "No!"

Second Look is planning a video production and live tour of WWWTP? in the fall of 1990. The tour will include southern Ontario and Toronto. Currently, we are working with teenagers, looking at issues related to violence in relationships. We're also holding a series of popular theatre workshops for lesbians and we continue to have ongoing programs for teenagers and adults at Scadding Court Community Centre in Toronto.

Rachel Epstein wears a variety of hats, two of which are as coordinator and collective member of Second Look.

Further reading

Canadian Theatre Review, No. 47, Summer 1986, "Theatre of the Oppressed."

Neighborhood Action: Recipes for Change, Sticks and Stones, Sudbury, Ontario, 1985.

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HEALTHWISE

Cranial Therapy: Relief at Last

Susan Danese

The car accident was more serious than Sharon had originally imagined. In the emergency room, the doctors diagnosed her injury as whiplash and prescribed pain killers and sleeping pills for what they said would be temporary discomfort. Ten years later she was still taking pain killers to deal with daily headaches.

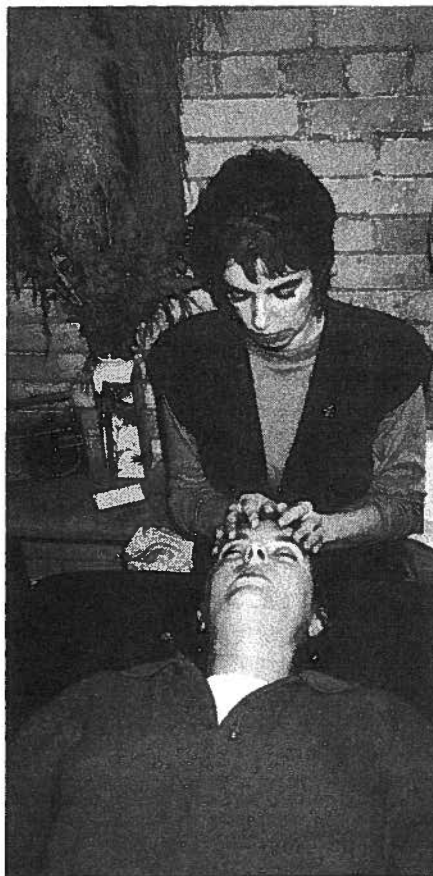
Sharon was desperate to find a release from pain and she consulted several doctors over the years who unsuccessfully treated her symptoms with drugs. She also tried working with a homeopath who tested her for food allergies, but found that her problem did not seem to be food-related. Finally one doctor tried acupuncture and when that failed, suggested she try craniosacral therapy. "After ten years of pain, it took almost six months of craniosacral therapy to relieve my headaches," said Sharon. "I had a lot to work through. There was so much tension in my neck that I had to learn to relax before I could benefit from the gentle head manipulations. Now I only get headaches before my menstrual cycle. It's wonderful!"

Sharon is one of the many people who come to craniosacral therapy as a last resort. Most patients hear of the therapy through a doctor; some come with a referral from their dentist or physiotherapist, while others discover the technique by word of mouth.

The goal of the craniosacral therapist is to release restrictions of movement and to restore normal function to the affected area of the body. She achieves this by first detecting restrictions in the body. By moving her hands over the client's body, the therapist palpates particular spots to assess the patient's personal craniosacral rhythm. It is hypothesized that this rhythm is created by changes in the cerebrospinal fluid which sur-

rounds and bathes the brain and spinal cord and circulates beneath the cranial bones. Fluctuations in volume and pressure of the cerebrospinal fluid are referred to as the craniosacral rhythm.

Once detected, the rhythm will tell the therapist where problems are located in the patient's body and then she can use gentle manipulations on these sites to release the restriction. The technique is gentle, involves no drugs, surgery or medical equipment and is often very successful, especially to relieve chronic pain. Clients tell of relief from pain, restoration of function and mobility, correction of neurological disorders such as ringing in the ears, diffi-



Susan Danese

culties reading and dizziness. Some clients claim that treatment has helped to reduce stress-related problems.

Mark, 8 1/2, falls asleep during his therapy session. His mother reports that he had a difficult delivery. "As a child he had constant ear infections. His ears would fill with fluid which provided a breeding ground for infection. He was always taking antibiotics. The doctors suggested inserting plastic tubes in his ears." Instead she tried craniosacral therapy.

Mark caught a cold the week after his first therapy session. Rather than his usual pattern of developing an ear infection, he shook the cold in days. Within four sessions of gentle manipulation which put him to sleep, Mark was cured of chronic ear infections. His mother has since taken a craniosacral course for lay people to provide some maintenance care for Mark.

According to craniosacral therapists, injury to the skull at birth or later in life may result in abnormal compression beneath the skull. In the early 1900s, an American osteopath, Dr. W. G. Sutherland, became the first person to experiment on the physiological and psychological effects of skull compression. Dr. Sutherland created a helmet which put pressure on different parts of his skull. Wearing it he experienced pain and coordination problems as well as personality changes. Using the knowledge gained from his experiments, he went on to specialize in treating problems with the skull bones.

Another American doctor, John Upledger continued to work in this field and went on to develop the craniosacral therapy technique in the 1930s. He has conducted and published research proving that cranial sutures (the lines where the skull bones are joined together) are soft and living, not calcified and hard, as current medical thought asserts. In 1975, Upledger led an interdisciplinary research team of biophysicists, anatomists, bioengineers and physiologists who concluded that the sutures are soft enough to permit movement in the cranial bones. Dr. Upledger reconfirmed that an impairment of the central nervous system or brain occurs when one or more of the cranial sutures are compressed,



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restricting the natural movement of the cranial bones and membranes which surround the brain and spinal cord. These restrictions can adversely affect cranial nerves. The symptoms arising from restricted cranial sacral systems can be very severe, causing pain and disturbance of function in the body or head as a result of impaired circulation or entrapment of cranial nerves.

Cindy was troubled by a tightening in her throat that inhibited swallowing. Soon her ear began to ache. When the pain became chronic she consulted her doctor. He suggested that Cindy should avoid hard, chewy foods and talk to her dentist. Her dentist saw no reason for the earache as her bite was evenly balanced. In frustration, Cindy consulted an ear, nose and throat specialist who conducted a CAT scan (an expensive, three-dimensional x-ray) on Cindy's head. There were no tumours blocking the throat. Eventually, Cindy's mother suggested she call a craniosacral therapist.

Cindy recounts: "The therapist answered my call personally. He said

that my complaint was not unusual. Every other therapist made me feel like I was being a hypochondriac!"

"The process of the therapy session was a completely different experience. I remained clothed, lying on my back on a massage table. The therapist held my feet for a moment. Then he seemed to scan my legs with his hands. When he rested his palm down over my heart, the spot was sensitive to the touch and seemed to generate a lot of heat. He also placed a hand under my back at the same location. When he worked on my head, he touched spots on my neck that were sore, but he applied very little pressure. His hands went directly to the places that hurt; on the throat and in the ear which he gently stretched upward. It felt like a stretch for my ear canal."

Joe, a premature baby, was diagnosed at birth with wet lung, a condition which affected his breathing. Doctors at the Hospital for Sick Children in Toronto treated him with antibiotics and oxygen. Three months later he was back in the hospital with meningitis. This time he was isolated and given antibiotics. When the infection subsided his mother took her general practitioner's advice and visited the Cranial Therapy Centre because the baby was still vomiting and crying. When Alix McLaughlin, a craniosacral therapist, began work on him, he was still noticeably agitated.

"Within one month he was bright and calm," says his mother. "The doctors at Sick Children's Hospital still can't believe his progress. At 20 months my son can repeat his alphabet, count up to ten and then count down, he recognizes letters and is a content baby."

Joe's doctor, Chris Hassell, is one of the few doctors in Toronto who is familiar with craniosacral therapy. Dr. Hassell saw the baby after the meningitis had passed. "He was still vomiting and uncomfortable," says Dr. Hassell. "There was something within him that wasn't balanced. I sensed that he would continue to get sick unless it was changed."

Dr. Hassell was introduced to craniosacral principals as a medical student at the British School of Osteopathy. In Canada he has made

several referrals to craniosacral therapists and is pleased with the results. "After one month of weekly craniosacral treatments, Joe appeared more placid and socially integrated. The child seems to be at peace with his environment. He's a beautiful baby now," concludes Dr. Hassell.

Unfortunately, craniosacral therapy is not yet well known in Canada. Although about 1,000 health care practitioners incorporate it into their practice in some way, only about 15 therapists practice craniosacral therapy solely. The major training centre, The Upledger Institute, is in the U.S., but also offers courses in Canada. Interest is growing as more and more people begin to turn to non-invasive alternatives to Western medicine. While Western medicine continues to make dramatic advances on some fronts, there are many problems, especially chronic conditions, that seem unsolvable. Perhaps this is why some health care practitioners such as dentists, physiotherapists, chiropractors and massage therapists turn to craniosacral therapy to broaden their capacity to heal. Perhaps in a few years, more people will turn to craniosacral therapists first, before they accept drugs or surgery to relieve their pain.

Susan Danese is a freelance travel writer presently traveling in Europe.

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Leslie Ayre-Jaschke

A Natural Resource

Breastfeeding is the healthiest way to feed a human baby. There is no question that this statement is true. Study after study confirms that breastfeeding is healthier both for the infant and for the mother.

Breast milk is magic. It is a dynamic tissue that contains almost as many living cells as blood. It can actively inhibit and destroy many bacteria, viruses, and fungi . . . virtually all the potential pathogens the newborn must confront. What is involved is an immune regulation and response in a matchlessly precise and efficient way that no drug company can emulate. ("Infant Formula: A Mass, Uncontrolled Trial in Perinatal Care," Maureen Minchin, 1987)

Breast milk is variable among women and changes from hour-to-hour, day-to-day, month-to-month. This flexibility is important, allowing breast milk to meet the changing needs of the baby. For example, the milk needed by a premature baby is different from that of a full-term baby; the mother's breast milk provides the variable nutrients and appropriate volume.

Breastfeeding confers life-long benefits to our children that we are only beginning to discover, such as better jaw and tooth development, protection from allergies, probable protection against juvenile diabetes, Crohn's disease and some kinds of heart disease. These are only a very few of the many known advantages for the breastfed baby. In fact, one breastfeeding advocate has suggested that an honest label on formula (such as appears on U.S. cigarette pack-



BETTMANN ARCHIVE

The classic nursing pose, with the infant supported on the mother's raised knee. Egypt, about fifteenth century B. C.

ages) might read: *Deficient in lactoferrin, lysozyme, leucocytes, immunoglobulins, L. bifidus growth factor, and all other protective elements found in mother's milk. Use of this baby milk increases your child's risk of gastroenteritis, acute respiratory infections, and allergies. (Helen Armstrong, Journal of Human Lactation, June 1989, p. 104.)*

For the mother, breastfeeding soon after birth minimizes the risk of hemorrhage and helps the uterus return to its original size. There is also evidence that breastfeeding provides some protection from breast cancer.

Breastfeeding is a natural resource, providing an environmentally wholesome method of feeding our young. But, if breast milk and breastfeeding are so wonderful, why don't more women do it or do it for longer than a few weeks? In Canada, some poor and working class women and those without post-secondary education tend not to even start to breastfeed and many middle class women wean to the bottle much earlier than is recommended by health professionals.

There are a number of reasons breastfeeding can be difficult for Ca-

nadian women. Breastfeeding is not instinctual, but a learned art. Many of us give birth without ever having seen a woman nursing a baby. Children are not usually educated about breastfeeding but are given dolls with the always-present bottle. Nursing mothers continue to be asked to leave public places when feeding their babies while bottle fed babies are tolerated. Lip service is paid to the superiority of breastfeeding, yet we are continually exposed to bottles and artificial nipples through the media and in the infant care section of stores. How can women and men be open to nurturing their babies through breastfeeding if they never see anyone doing it? What message is given to potential and new parents when a bottle is the international symbol for parents' rooms in airports and other public buildings?

Women are discouraged by employers from having their babies brought to work for feeding. And workplace daycare centres which would facilitate continued breastfeeding, are rarely provided. Even pumping milk is discouraged by the lack of time or an appropriate space.

Often Canadian women feel forced to make the decision between employment and breastfeeding; between employment and caring for their own children, because the two aren't allowed to be combined.

Gabrielle Palmer in *The Politics of Breastfeeding*, says of this situation: *In Britain and in many other 'advanced' countries, there is an apartheid of those who care for their young children and those who do not. Many women who have control over their fertility still want to bear children and this is increasingly becoming a momentous decision. The prestigious worlds of business, academia and politics have grudgingly let women put a foot in the door only on condition that they behave like men. They must hide their reproductive functions . . . (p. 265).*

Women with nursing babies can become isolated since they are not particularly welcome out in public. Humans are meant to be a continuous contact species, requiring frequent feedings, yet our society still expects us to leave nursing babies in order to participate in daily life.

While breastfeeding has had its

While breastfeeding has had its ups and downs throughout history, once women began losing control of birthing to hospitals and doctors the decline of breastfeeding accelerated

ups and downs throughout history, once women began losing control of birthing to hospitals and doctors the decline of breastfeeding accelerated. The attitude still persists in many hospitals that the babies are "theirs," and mothers are denied the constant contact most conducive to establishing breastfeeding. Formula and bottles are regularly used to "solve" breastfeeding problems. Skillful breastfeeding counseling is not available to most Canadian women either from their doctors or in the hospital. Breastfeeding falls through the cracks because obstetricians concern themselves with the birth and usually do not provide much breastfeeding information and pediatricians are concerned with the baby, not the mother. Even well-informed doctors find they cannot do effective breastfeeding counseling because of the time involved.

The historical trend toward making infant feeding more "scientific" led doctors in the past to disregard the many real benefits of breastfeeding and instead to prescribe formulas that could be adjusted and measured. They could remain in control even once the mother and baby were home, since the mother would need to consult with the doctor to make any changes deemed necessary.

Once the majority of babies were bottlefed, which happened very quickly during the 1960s and early

1970s, breastfeeding became archaic, a relic of the past and the knowledge required to work with nursing mothers was rapidly lost both among health professionals and families. Only 25 per cent of Canadian babies were breastfed during this period. When commercial formulas produced by multinational companies appeared, complete with massive advertising campaigns in the early 1960s, breastfeeding seemed doomed. Had it not been for lay organizations such as *La Leche League*, which continued to promote breastfeeding and support nursing mothers, the resurgence of interest in doing things the natural way during the "hippie" era and the energy and hard work of the women's health movement, breastfeeding would have become a lost art in North America. While the rate of initiation of breastfeeding has risen to 70 per cent across Canada (1984), our accepting attitude toward bottlefeeding and our ambivalence about breastfeeding continues to sabotage the breastfeeding efforts of many Canadian women.

In order to make breastfeeding the easiest choice for all women, barriers such as short maternity leaves and the lack of adequate, accessible child care, nursing breaks and support for women wishing to care for their babies must be broken down. Health professionals, educators and consumers themselves must learn about the importance of breastfeeding and how best to ensure success. Good support systems including nursing mothers' groups, parents groups and places to obtain skilled breastfeeding information and help are required. Breastfeeding advocates are starting to become more vocal, but when competing with the budgets available to those who promote formula, it can be a daunting task.

Labour unions and professional organizations also have a role in making breastfeeding possible for all women. The Alberta Association of Registered Nurses is currently considering several resolutions on the marketing of breast milk substitutes, the role of lactation consultants and breastfeeding in the workplace, and is to be applauded for this groundbreaking work. Unions could negotiate for provisions that would help

breastfeeding women, such as nursing breaks, flexible time schedules and longer maternity leaves.

The most important action the Canadian government could take immediately would be to make law the World Health Organization's "International Code of Marketing of Breast Milk Substitutes" (commonly known as the WHO Code). This code seeks to make breastfeeding the community norm by controlling the marketing of breast milk substitutes. Canada signed the agreement in 1981, but the government has chosen to allow the Canadian Infant Formula Association to write its own version and to police itself. This is completely unacceptable and can only lead to further erosion of breastfeeding in Canada. (For further information on this important issue, see *INFACT* in the Resources section).

Individual women can help themselves by learning as much as possible about breastfeeding, both from accurate books and from nursing mothers. Knowledge helps a woman get through the rough spots that most nursing mothers experience. It's crucial to discuss breastfeeding plans with one's physician, partner, friends, family and employer to help them understand its importance to mother and to baby. At the same time, find the best sources of support. These may include prepared childbirth classes that emphasize the importance of breastfeeding; La Leche League meetings where a woman has the chance to immerse herself in a climate of acceptance of breastfeeding as a normal, desirable function; or prenatal information sessions with a certified lactation consultant who can provide accurate information and guidance.

Some childbirth classes are set up especially for single women and breastfeeding concerns can be addressed there. Many La Leche League Groups have single women attending and Leaders make an effort to include information specific to the single parent situation. Information on combining employment and breastfeeding can also be obtained from lactation consultants. La Leche League Leaders can often put an employed mother in touch with another woman who has had practical experience with combining

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breastfeeding and employment.

Couples in non-traditional families may find a lactation consultant the best source of practical information since childbirth classes and La Leche League Groups tend to attract the more traditional type of family and may be less able to address the concerns of, for example, a lesbian or heterosexual couple wishing to share the nurturing of the baby in a non-traditional manner.

Common breastfeeding problems such as sore nipples and concerns about milk supply can be readily handled by La Leche League Leaders who are available by phone and through meetings. More difficult problems, or those requiring extensive counseling time may be best handled by a lactation consultant. Obtaining appropriate information can make a big difference to breastfeeding success so it is important to find someone who can work with the mother (and partner) to find solutions.

Breastfeeding is a tremendously undervalued natural resource that deserves more attention from politicians, the media, health professionals and parents themselves. Profound changes in Canadian attitudes are required to get us to the point where all women will expect to breastfeed their babies and succeed. We can all do our part by becoming more informed about the issue, becoming

active politically and by supporting those around us who are breastfeeding.

Leslie Ayre-Jaschke has been involved with nursing mothers for ten years, both as a nursing mother herself, as a La Leche League Leader (for eight years), and now as a lactation consultant in private practice in Peace River, Alberta.

Further Reading

The Working Woman's Guide to Breastfeeding, Nancy Dana and Anne Price, Meadowbrook, 1987.
The Nursing Mother's Companion, Kathleen Huggins, The Harvard Common Press, 1986.
The Womanly Art of Breastfeeding, La Leche League, 1987.
Counseling the Nursing Mother, Avery Publishing Group Inc., 1989.
Breastfeeding Matters: What We Need to Know About Infant Feeding, Maureen Minchin, Alma Publications and George Allen & Unwin, 1985.
The Politics of Breastfeeding, Gabrielle Palmer, Pandora Press, 1988.

Breastfeeding Support Organizations

La Leche League Canada, 493 Main St., Winchester, ON K0C 2K0. Phone (613) 774-2850. There are hundreds of La Leche League Groups across Canada.

International Lactation Consultant Association of Canada (ILCA Canada) c/o Leslie Ayre-Jaschke, 10409-101 St., Peace River, AB T8S 1K7. Phone (403) 624-1115. ILCA is committed to offering professional service to nursing mothers. Some LCs are in private practice, others are found in hospitals or health units. To obtain the names of ILCA Canada member International Board Certified Lactation Consultants (IBCLCs) practicing in your area, phone or send a SASE to the above address. *INFACT Canada (Infant Feeding Action Coalition)*, 10 Trinity Square, Toronto, ON M5G 1B1. Phone (416) 595-9819. Growing out of the first Nestle boycott, INFACT continues to monitor formula advertising and distribution and lobby for greater recognition of the importance of breastfeeding.

REVIEWS

Shrink Resistant: The Struggle Against Psychiatry in Canada

Bonnie Burstow & Don Weitz (Editors), New Star Books, Vancouver, 1988, 360 pp.

Reviewed by Dianne Patychuk

The occupational therapist, smiling, dragged me away to a "group humiliation session." We grab at our coloured markers and our brown, meat-wrapping paper! She collects all of her contempt, pins it up on the wall, and sweetly vomits abuse all over us — in tones of kindergarten kindness . . .

This is a powerful and disturbing anthology that invites the reader to listen and hear. The drawings, poems and diaries that are given voice in this collection are sharp and clear — expressing the hurt, agony and abuse experienced by women and men as inmates in psychiatric institutions and hospitals in Canada. The editors prefer inmates to the term "mental patients" because of the denial of rights and dehumanization associated with psychiatric treatments. Treatments experienced by the people who speak through this book include mood altering and tranquillizing drugs, electroshock, loss of basic liberties, confinement, punishment for non-conforming behaviour, diagnostic labeling and brainwashing experiments.

Terrified of the hellish drugs that creep into my heart, my mind, my soul like a poisonous snake, constricting itself around me tighter and tighter until I've no strength left to struggle.

With one in five Canadians expected to spend time in a psychiatric facility at some point in their lives, this is an extremely important book. As the contributors show, there are very serious problems with the kind

of "help" our society offers to people who are labeled "mentally ill".

Many of the voices in this book expose the sexism underlying the moral judgements psychiatry makes. For example, Delana was called sick because she was rebellious and had a high IQ. Joan was released only after she agreed to accept the roles of housecleaner, cook and mother. Sheila did not want to be "cured" of being a lesbian but was given 19 shock treatments.

The editors of this anthology, Bonnie Burstow and Don Weitz are active members of the antipsychiatry movement in Canada. They are not advocating reforming psychiatry. They are advocating alternatives to psychiatry itself. Instead of solving the real problems of stress, lack of power, loneliness or abuse, psychiatry individualizes and defines problems as "depression" or "victimization syndrome". Creating alternatives includes building services such as self-help and support groups, safe housing, independent crisis centres where people can get help without fear of being committed and strategies which address the stresses and problems people face.

The focus on alternatives rather than reform is the right strategy, I think. Reforms are slow, minimal in impact and do little to change the underlying problem. The establishment of the psychiatric patient's advocate office in Ontario gives a few people in provincial psychiatric institutions some legal assistance in challenging their prescribed "treatment". Review boards and the courts provide a pro-



cess for challenging involuntary commitments and denial of rights but this is often after the fact and only scratches the surface. Burstow argues that social change will not come from court battles but by the experiences of people such as those in this book being heard and identified with.

The antipsychiatry position of the editors may be seen as radical by those who believe current treatments help some people. But this is precisely the point. Until society has real alternatives to offer, there is no basis for saying current treatment approaches are more effective in meeting people's needs than alternatives. There is increasing scrutiny and evaluation of medical treatments in other areas of women's health, such as cesarian section rates and hysterectomies, but there is a noticeable lack of acknowledgement, use and evaluation of care options in the area of mental health. This is a tragic and serious oversight that *Shrink Resistant* helps to expose and challenge.

This book also describes the fighting spirit that enables people to survive through abuse until some escape is possible.

I pass Suzanne's room as guards, nurses and doctors are forcing a tube down her throat, deeper and deeper until it will reach her stomach and they'll feed her — for her own good . . . She doesn't utter a sound. And a certain grace surrounds her there, on that bed where they've caught her, captive of leather belts and tangled bed-sheets. She doesn't scream. She doesn't try to fight them. There is no fear, and I walk away strengthened. Ankles and arms pinned down she's stripped their almighty power with a defiant peace. And eyes that see beyond the hellish geography of these rooms and walls . . .

Most people in Canada do survive and many become leaders in patients' rights. This book challenges readers and health care workers to recognize and to refuse to cooperate with *anything* that is humiliating to another person.

Dianne Patychuk is a researcher active in community, international and women's health issues.

The Aids Challenge: Prevention Education for Young People

Edited by Marcia Quackenbush
and Mary Nelson, with Kay Clark,
Network Publications, Santa Cruz,
California, 1988, 526 pp., \$24.95.

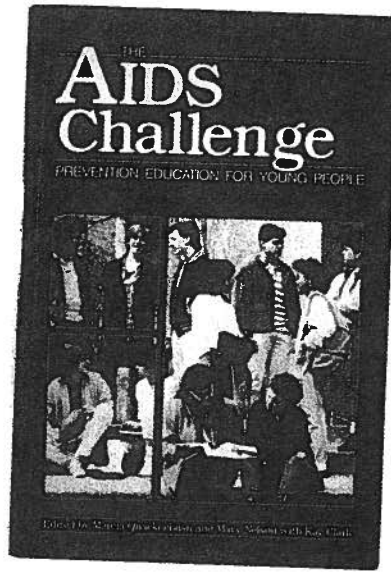
Reviewed by Sue Kaiser

Several years ago when I started working full time in AIDS prevention, I was looking for this book — or more accurately, its Canadian equivalent. While this collection of articles isn't perfect nor Canadian, it fills a gap in resources, and deserves the attention of anyone wanting to develop or motivate prevention for young people.

As time passes, AIDS continues to infect young women and men in all corners of the community, and the need increases for material focused on integrating AIDS prevention messages into all components of their lives. If you believe, as I do, that one of the major barriers to effective prevention for young people is the attitudes of adults who provide and control the information available to them, then this book will be helpful.

The editors of *The AIDS Challenge* have drawn together a wide range of topics and although the articles are varied in style, the writing remains encouragingly open and easy to read. The challenge of presenting educational methodology or research results in plain English is not a small one and the authors and editors have managed to dispense with jargon to the point where some articles are distinctly conversational in tone, even as they cover complex and difficult topics. One example comes from Mary Lee Tatum's article, *Controversial Issues in the Classroom*:

The most difficult conflict within school settings is not apparently about the subject matter of AIDS, but about the philosophy of education. Will we acknowledge that young people wrestle with and make decisions about their own behaviour, or will we simply "tell" young people what behaviour is acceptable, imply what behaviour is not, and assume that in "telling" them we have done our job?



There are more than 30 articles in *The AIDS Challenge*, arranged in sections covering the science of the virus, what makes good prevention education, what topics to teach in the classroom, how to deal with controversy, strategies to involve the whole community and ways to reach minority youth and special populations at risk, such as runaways, gay and lesbian young people, or those with learning disabilities. Throughout, there is a common understanding that AIDS prevention is not possible unless whole communities are involved.

There is lots of practical advice. *Developing Community Support for School-Based AIDS Education* by Debra Haffner sets the stage for effective prevention education by acknowledging that whole communities, not just teachers and schools need to know about AIDS and understand why some teens may be at risk. Haffner suggests concrete activities:

Prepare written information to help support your efforts and distribute it widely. Survey the community's feelings about AIDS education and document the results. Develop fact sheets on the AIDS epidemic and why young people are at risk. ... Hold a series of community forums for the public, press and parents. ... Have key community supporters publicly endorse the program.

Haffner goes on to list some of the questions likely to come from community members, along with helpful answers. This article will be of par-

ticular help to people who haven't already gone through public and controversial discussions of sex and sex related topics — most of us can use support on this!

Much of the educational methodology which forms the basis for assessing effective prevention has been developed in the context of formal, classroom education. While the editors have chosen a large group of articles related to school education, they have searched out and acknowledged the importance of out of classroom messages — both for young people still in school, as well as the many who are not. Unfortunately, the chapter on youth serving organizations, such as YW/MCA's or 4-H Clubs is short. While many such groups have a stated mandate to do health education, and may even have a sound national policy and program, local delivery of the message is haphazard.

Reading through this collection of articles was rather like attending a conference: it offered lots of variety, articulate, experienced presenters and up to date information. And through its conversational tone, the book offers a sense of participation and personal encouragement that marks the best conference experiences. AIDS prevention is difficult, but it is possible and you can be effective in making it happen in your neighbourhood, school or community. Ask your local library, AIDS Committee or public health unit to order a copy — and consider using it as a conference replacement for teachers, community workers, clergy, young people and other key people in your community.

We have come a long way in a few years, and it is helpful to keep this in mind. We must also remember the reason we have traveled so far in such a short time — the magnitude of this epidemic and the very real dangers it signifies. I hope as readers of this book you will also feel welcomed into this community. There is a lot of work yet to do, and we need your help to get it done well.

Marcia Quackenbush, from the foreword to *The AIDS Challenge*.

Sue Kaiser is a community worker in Toronto.

RESOURCES & EVENTS

No More Secrets

Community Resources and Initiatives is holding a national conference *No More Secrets: Exploring Patterns of Women's Re-Victimization*, May 25 to 28, 1990 in Toronto. Conference presenters include dynamic therapists, researchers and community organizers such as Robin Morgan, Shirley Turcott and Judith Jordan.

For more information and registration contact Nancy Johnson, Community Resources and Initiatives, 285 Markham Street, Toronto, ON, M6J 2G7 or phone (416) 323-1328.

AIDS Nutritional Guide

The Toronto Department of Public Health has produced a set of nutritional guidelines for people with AIDS or HIV infection after a year of research with AIDS patients and health care workers. The factsheets cover such topics as problems with bloating or nausea, tempting the tastebuds and eating well on a limited income. There are seven factsheets for patients and one for health professionals.

Available free in person from Toronto City Hall Resource Centre during business hours or by mail for \$2 from the Resource Centre, City Hall, Toronto, ON, M5H 2N2. There is a limit of one set per person since they are produced in a simple format to be easily photocopied.

Moving Forward

The Women's Studies Program at Trent University and women from the community are sponsoring *Moving Forward: Creating A Feminist Agenda for the 1990s*, a conference to be held June 15 to 17, 1990. Aimed

at bringing together feminist activists and academics, the conference will focus upon four areas: Women and Work, Social Justice, Women's Culture, and Health: Control and Safety of Our Bodies. Questions of class, sexuality, race and ethnicity will be addressed through integrated and separate workshops.

For an agenda and registration details, contact Philippa McLoughlin, Women's Studies Conference, Trent University, Peter Robinson College, Box 161, Peterborough, ON, K9J 7B8.

Call for Papers

Resources for Feminist Research is seeking critical perspectives on heterosexuality from a feminist standpoint and from women's diverse locations in lesbianism, heterosexuality, celibacy and bisexuality for a special issue to be published December, 1990. Articles may be written in English or French and should not exceed 5,000 words. Deadline for submissions is May 1, 1990.

For more information contact RFR/DRF, 252 Bloor St. West, Toronto, On, M5S 1V6.

Circumpolar Health Conference

The 8th International Congress on Circumpolar Health will be held on May 20 to 25, 1990 in Whitehorse, Yukon. The conference will focus on "Community Health: Problems and Solutions in the North," by examining common issues of environment, lifestyles and societal roles and their impact on aboriginal health at the community level. The circumpolar format draws upon networking between all of the Earth's polar countries: Scandinavia, U.S.S.R., Alaska, Canada, Greenland and Iceland.

For more information contact the 8th International Congress on Circumpolar Health, 801-750 Jervis Street, Vancouver, BC, V6E 2A9.

Midwifery Hotline

The Midwifery Task Force of Ontario and Secretary of State Women's Division have established a Midwifery Hotline for expectant mothers who are looking for information about midwives and midwifery. Call toll free 1-800-387-9031 or in Toronto 340-2274.

Women and Smoking

Taking Control: An Action Handbook on Women and Tobacco is a 44 page comprehensive resource on women's use of tobacco which traces the short history of women's smoking, outlines the trends and health consequences, and provides practical ways we can all work against tobacco. There are action strategies for smokers who want to quit; for individuals and groups who want to support women trying to quit; and perhaps most importantly, suggestions on how we can all prevent young girls from starting to smoke.

Available in English or French for \$5 from the Canadian Council on Smoking and Health, 1565 Carling Avenue, Suite 400, Ottawa ON, K1Z 8R1 or phone (613) 722-3419.

MediaWatch

National Watch on Images of Women in the Media (MediaWatch) Inc. is a non-profit, proactive, feminist organization concerned with the status and portrayal of women and girls in the mass media. Active and supporting memberships are available. Members receive the MediaWatch Bulletin and other target bulletins.

For more information about membership or a subscription contact MediaWatch National Office, #250-1820 Fir Street, Vancouver, BC, V6J 3B1 or phone (604) 731-0457.

□

For inclusion in this section, send us notice of upcoming events 4 — 6 months in advance.

**"1990 - Making New Contacts"
D.E.S. AWARENESS WEEK
March 25 - March 31**

D.E.S. ACTION CANADA has launched a National Bus Poster Campaign to inform the public about D.E.S., the synthetic estrogen prescribed to thousands of pregnant women to prevent miscarriages. Posters can be seen in 65 cities across Canada.

As a follow-up to this campaign, D.E.S. Action will collaborate with organizations concerned with health and women's issues. We invite you to join us in our efforts by promoting D.E.S. awareness in your community. Let us know how we can help you to help us.

Contact: D.E.S. Action Canada, Snowdon P.O. Box 233
Montreal, Quebec H3X 3T4 (514) 482-3204

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ARE YOU HAVING INFERTILITY PROBLEMS?
ARE YOU HAVING REPEATED MISCARRIAGES OR
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TO FIND OUT MORE CONTACT

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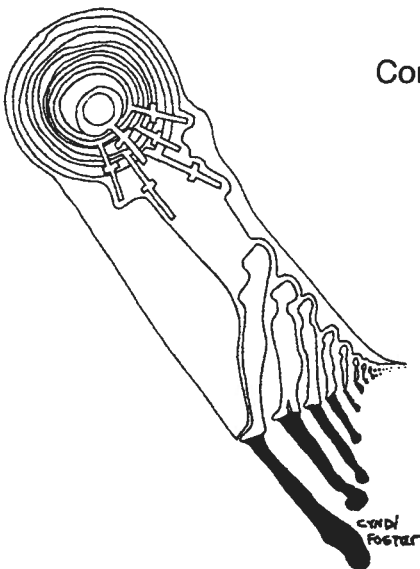
Date: Tuesday, March 27, 1990

Ticket Price: \$15.00

Location: Yuk Yuk's Downtown Club
(Bay and Yorkville)
Toronto, Ont.

Call 532-0812 for tickets and information

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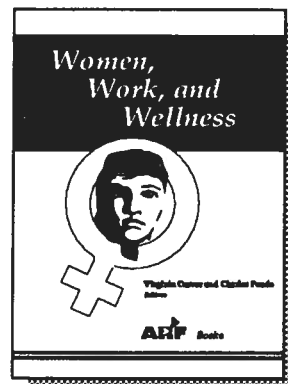
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Half the Kingdom. Seven women explore the challenges they face as Jewish feminists.

Illuminated Lives: A Brief History of Women's Work in the Middle Ages. A witty short animated film that challenges some enduring myths about medieval women.

Older Stronger Wiser. From the series *Women at the Well*, a half-hour documentary that evolved from the oral histories of Black women in Ontario.

Russian Diary. A last glimpse of the Soviet Union just before the transition to Glasnost began.

Unnatural Causes. A five-minute film poem featuring Lillian Allen and challenging the postcard-perfect image of Canada.

For a Studio D resource kit and information about purchasing or renting our films and videos, please contact us at: STUDIO D, National Film Board of Canada P-43, Box 6100, Station A, Montreal, Quebec, H3C 3H5, (514) 283-9533, Fax: (514) 283-5487.

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