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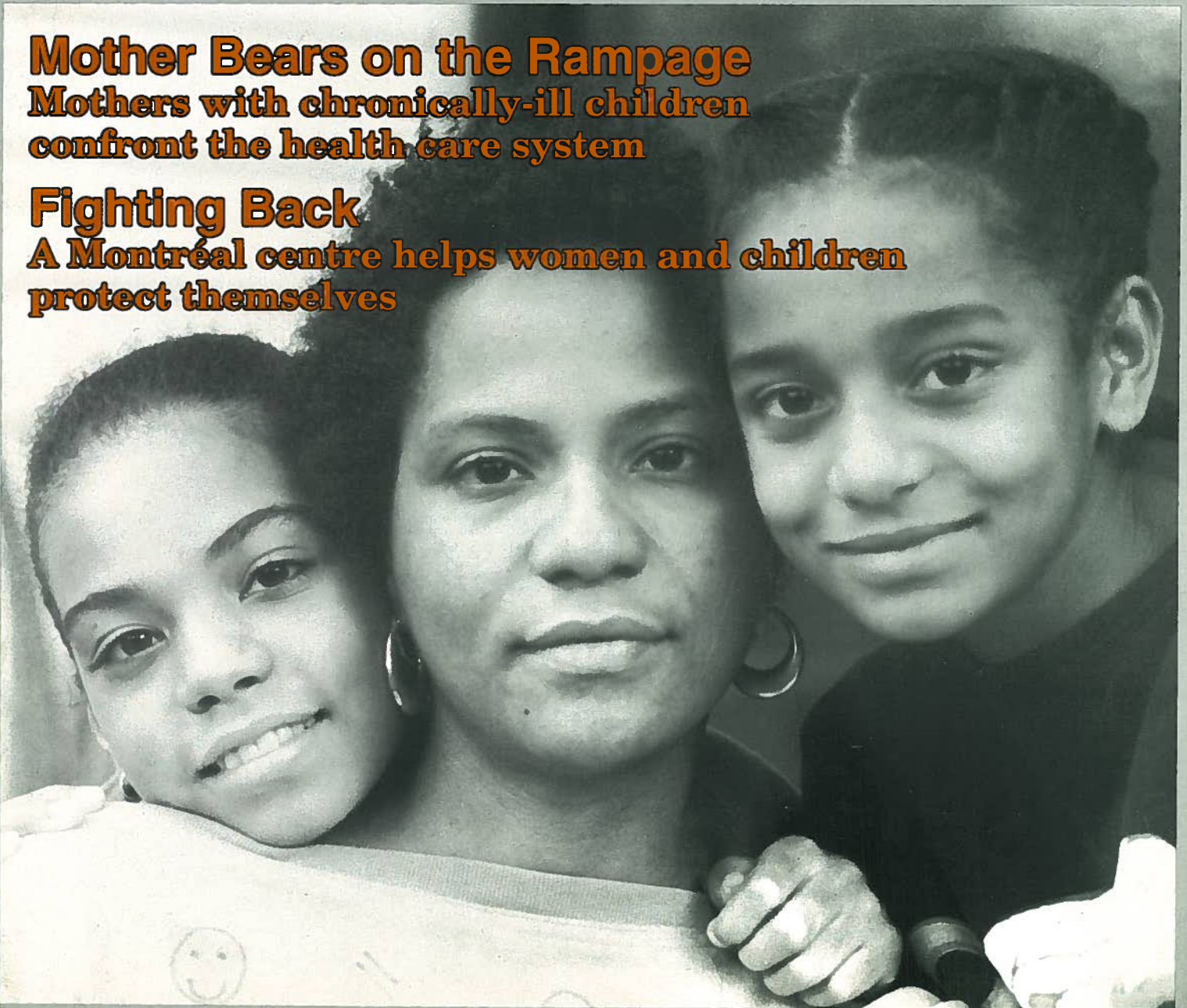
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Healthsharing

A C A N A D I A N W O M E N ' S H E A L T H Q U A R T E R L Y

Mother Bears on the Rampage
Mothers with chronically-ill children
confront the health care system

Fighting Back
A Montréal centre helps women and children
protect themselves



INSIDE

Healthsharing

Vol 12:2 Summer, 1991

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Correction:

Cover photo credit for Spring, 1991 (Vol.12:1) should read: Margie Bruun-Meyer. Our sincere apologies.

HEALTHLINES

"Zero Tolerance"

IT'S BEEN A LONG, HOT AND violent summer.

In June, Leslie MaHaffy a 14-year-old girl from Burlington, Ontario disappeared from her home. Her dismembered body was found two weeks later, encased in concrete, in a lake near the Niagara community of Thorold.

In July, a massive hunt was launched in search of Kayla Klaudusz, the three year old who had vanished while playing in the fenced-in backyard of her apartment building. Her body was found August 2, floating in the Keating Channel of Toronto's harbour. She had been sexually-assaulted.

In August, 29 year-old Karen Marquis was sexually assaulted and killed by a man who broke into her home in Moncton, New Brunswick.

These murders are exceptionally brutal and violent. They are also the types of crimes against women we hear most about. What we rarely hear about are the "silent crimes," the cases of sexual assault, incest, and wife and child abuse which make up the majority of violent crimes against women and children. One reason for this is that the media tend to report those cases which are brutal, easy to sensationalize and perpetrated by strangers. They are reluctant to report on the most common cases of violence against women — violence committed by people we know.

Another reason is that many women and children who are victims of silent crimes remain silent, too frightened to report crimes to police officers who are less than sympathetic and who, for the most part, place responsibility for the assault on the women themselves.

One in 10 of us will be the victim of a sexual or violent attack sometime in our lives. And we know that if we survive, we will have to convince society that we are the victims. Knowing our vulnerability, we can't help but live with some degree of fear. Is it too late to go to the store? Will the man walking so closely behind me pass or attack? If I do go out with this man will

"No!" be enough?

Section 7 of the Canadian Charter of Rights and Freedoms entitles everyone to "the right to life, liberty and security of the person". But how can this be true when so many of us live uncomfortably in this society — a society which so easily ignores violent crimes against women and which is becoming increasingly influenced by the violence against women glorified on television and in magazines and films.

And if we are sexually assaulted, what protection does the law offer to us now? With the Supreme Court of Canada striking down the rape shield protection law, we run the risk of being assaulted again, this time by the legal system. Essentially, the court has ruled that new laws must be drafted that would leave the admissibility of a woman's sexual history as evidence, up to the discretion of a judge. (See Update, *Rape survivors on trial*)

This regressive decision makes an already emotionally-rough process even more difficult and will likely discourage women from coming forward to report sexual assault. Statistics indicate that since the introduction of the rape shield law in 1983, the number of reported sexual assault crimes rose 127 per cent (29,111 cases in 1989 compared to 12,848 in 1982).

Our judicial system may not protect us, but we can find ways to protect ourselves — before the crime. There's the feminist self-defense course, *Wen-Do* which is accessible to all women including those with disabilities. Started in 1972, *Wen-Do* teaches women techniques which allow them to be mentally ready and physically prepared to fight off an attacker. Mentally ready? Yes, because as *Wen-Do* warns: 70 per cent of rapes against women are committed by men we know; and 85 per cent of women who are sexually assaulted (whether intercourse has taken place or not) know their attackers. Women have to be mentally prepared to fight off someone they know.

Another group which offers self-defense courses for women and children is the Montréal Assault Prevention Centre (MAPC), featured in this issue of *Healthsharing*. Focusing on a strategy to empower women, the MAPC has developed a unique approach to prevention and self defense. They steer away from traditional prevention techniques called, "offender control" and "victim control," which they believe don't work because "they focus on women's and children's behaviour as the reason for the assault [and] hold us responsible when we are assaulted."

When we send our children out to play, when we go for a walk or try to feel safe in our homes, we can't help but remember all the Kaylas, Leslies and Karens. But we must also remember the women and children we don't read about, the victims of the "silent crimes" — battering, sexual assault, incest and abuse. We can only hope that our society will soon give women and children the support to allow their silence to be broken and bring this violent war on women and children to an end.

The massacre of 14 women in Montréal and the rising number of violent crimes against women in Canada have finally forced the federal government to examine this issue. (See Update, *Panel on violence against women*) A 10-member panel has been formed to travel across Canada over the next 15 months holding public hearings to examine and identify issues on violence against women and recommend a plan of action for government and community groups.

When announcing the establishment of the panel, Mary Collins, the minister responsible for the status of women, had this to say: "Many still see violence against women as a women's problem, not as society's problem....Violence against women must come to an end....Zero tolerance must be our goal."

While the women's movement, women's agencies and groups, shelters and crisis centres continue to provide the much-needed support for women and children who are victims of violence, we must all take this opportunity to take the government to task. We must use these public forums as vehicles to voice our concerns, our frustrations and our fears. We must let them know that "zero tolerance" is already our goal.

Hazelle Palmer

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 right to edit letters for length, and print them, unless they are marked "not for publication."

Overcoming Cystitis

I am writing to recommend the book *Overcoming Cystitis: a practical self-help guide for women* by Wendy Smith, Bantam, 1987. Like many other women I had a problem with cystitis and found the book full of helpful tips, recommendations, cautions against harmful treatments, tests, etc. It also deals with many things that doctors were either too embarrassed to tell me or simply didn't know. (didn't care?) The medical profession was next to useless in helping me to solve this recurrent problem. I also felt enraged at and victimized by the doctor who called me

"sexy Susan" when I came to get the results of my tests (which involved catheterization). Not at all funny.

Women who have the problem should definitely read the book.

A reader,
Charlottetown, P.E.I.

Accessible to Young Women

In order to support *Healthsharing* and to make it accessible to young women, I am enclosing a subscription for the library of my daughter's school. Keep up the excellent work - I loved the work you did on menopause! J. Gilbert,
Willowdale, Ontario

Disappointed

Delighted with your survival and having enjoyed the Spring issue, especially the valuable article on sex selection, we regret having to express disappointment with another of its articles: the brief commentary on the Royal Commission on New Reproductive technologies, (*Royal Commission*

extended another year, by Megan Williams, *Healthsharing*, Spring, 1991).

While the contents are generally correct, the article sounds more like a government press release than the critical commentary on this expensive and less-than-open Commission one would expect from *Healthsharing*. Where are your questions about why an extension of the mandate was necessary? About what the public is buying for about \$12 million per year? About why learning who is doing research and on what is next to impossible? As part of your Canadian Women's Health Network project, why don't you ask the Commission what research is being done, by whom and with what funding? Why don't you request a list of consultants who have been requested to prepare background and other documents, along with their specific mandates? Why don't you ask for a description of the review process by which the merits of research proposals are assessed?

The women of Canada need to have this information and you would serve them better by pressing the Commission for it than by helping with its public relation activities. The latter, to judge by the most recent Commission "update," are already well controlled. In

the future, therefore, we hope that *Healthsharing* will play a role as an independent and critical observer of the Commission for the women of Canada.

A. Lipman, V. Burstyn,
G. Basen, L. Skye,
Toronto, Ontario

Raise Public Awareness

My mom was diagnosed with endometriosis in 1987 when I was nine years old. She had been experiencing severe pain many years before, but she was unaware that there even was such a disease.

I would like to thank you for publishing such an informative article on [this subject.] (*Endometriosis* by Carolyn DeMarco, *Healthsharing*, Spring, 1991).

I'm sure it will not only help women already diagnosed with endometriosis, but it will help raise public awareness about a disease that has been kept in the dark for so long.

C. Davis,
Toronto, Ontario

Hits Close to Home

I receive many mags and newsletters concerning peace, the environment, social justice etc. But somehow, your magazine hits closest to home! Of course it does, its about me and my own body, the starting point for all social change. "The personal is political!"

L. Valencia-Svensson,
Toronto, Ontario

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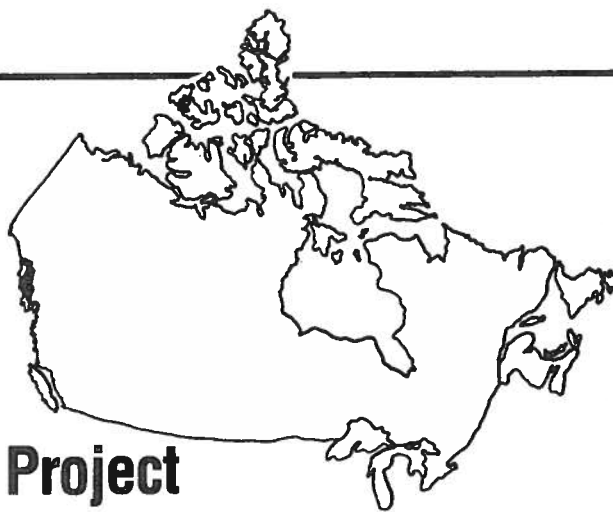
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Psychotherapy for Women

UPDATE



Wanted! Regional Animators for Women's Health Network Project

We reported in the Spring 1991 issue of *Healthsharing* on the Canadian Women's Health Network project - a project, coordinated by Women Healthsharing, which would help to build a national network of women's health organizations and groups and individuals working or interested in this area. The project will sponsor a national consultation, slated for fall 1992 in Winnipeg, (Women's Health Interaction Manitoba has expressed interest in coordinating this event) and will then publish the conference proceedings.

Additionally, the project will support the development of regional databases and information on women's health projects and initia-

tives. This information, will be compiled into regional reports and published in six regionally-specific issues of *Healthsharing*, focusing on the West (B.C. and Alberta), the Atlantic provinces, the Prairies, Ontario, Québec and the North.

We are currently looking for six regional animators to work with the project's coordinator on the regional reports. Specifically, each regional animator will contact women's organizations, health organizations, women's health groups and health activists for information and analysis on what is happening in the women's health field in that specific region. She will then compile this information into a regional survey and

resource bank with the assistance of the project coordinator. The result will be a listing of regionally-based resources and events as well as reports on existing women's health projects and organizations.

We hope that each regional report will include one article on networking issues, such as possible structures for national networking, use of current communication devices, fundraising or cooperative projects. Such an article could be regionally-based or might draw from international experiences or an existing Canada-wide networking model.

Because of the nature of the project, it is essential that each animator is based in the featured region and

familiar with women and health issues. Funding for this project is provided by Health and Welfare, Canada. Regional animators will be hired on short-term contracts and paid \$3,500.

Should you require further information on the project or wish to be considered for a regional animator position, contact: Hazelle Palmer, Project Coordinator, Canadian Women's Health Network Project, c/o Healthsharing, 14 Skey Lane, Toronto, ON, M6J 3S4 (416) 532-0812. Applicants can also fax their résumé to Healthsharing at (416) 588-6638.

Panel on violence against women

Beginning September 1991, a panel on violence against women will hold public meetings across the country. Established by the federal government, it will hear submissions from individuals and women's groups about the effects of violence on women's lives. The panel consists of nine women and one man who are all experts on violence against women.

Their goal, says Pat Marshall, co-chair of the panel and executive director of Metro Action Committee on Public Violence Against

Women (METRAC), is to fill the gaps in present research and combine new information with what is already known, to form a comprehensive picture of violence against women in Canada. Up until now, Marshall says, there has been a "confetti approach" to the problem, and consequently no comprehensive national plan of action has been established.

"For the first time," she notes, "a panel of this sort is not asking "Is there a problem?" but "How do we get the information about the

problem of violence out to the public and federal government?"

One area the panel will focus on is sexual abuse of women by people in positions of trust and authority. The extent of this kind of abuse is still largely unknown, according to Marshall. Through consultation with women's groups, the panel will determine a National Work Plan which will be presented to the government in December 1992.

WHS

On Our Cover



Our cover photo, taken by Maria La Yacona, shows Toronto-based writer Makeda Silvera with daughters Ayoola and Keisha. Makeda's new book, *Remembering G*, a collection of short stories, has recently been published by Sister Vision Press.

Vaginal birth after cesarean

Too many women in Ontario are having cesarean sections reports the Cesarean Birth Quality Committee, set up by the Ontario Ministry of Health. Ontario has one of the highest frequencies of cesarean birth in the world at 20.03 per 100 births. Only Brazil and the United States have higher rates. The committee, composed of members of hospital, medical, nursing and consumer groups, expressed concern that many of the cesareans performed are unnecessary. Repeat cesarean sections account for 40 per cent of all cesareans, despite increasing evidence that vaginal births after cesareans (VBAC) may indeed be safer than a second or third cesarean.

The committee presented the government with a number of recommendations, including: increasing support to women wanting

a vaginal birth after cesarean; increasing education about childbirth and cesareans; and changing fee schedules to support VBAC.

The present fees for cesareans and vaginal births are roughly the same. Vaginal births however, can take hours, whereas cesarean deliveries are often over in less than an hour. This creates a financial incentive for doctors to perform cesareans when they may not be necessary. Carolyn Sufrin-Disler, a Committee member and coordinator of the VBAC/AVAC Association of Canada, who had two cesareans before she delivered vaginally, says, "It's often a struggle for women who have had cesareans to convince doctors and hospitals to agree to a VBAC. Many doctors aren't aware that VBACs are very safe. They're scared of lawsuits, it's inconvenient, and they make less money." Although

Sufrin-Disler says the report does not go far enough in enforcing change, she hopes it will correct many of the current misconceptions about VBACs and put pressure on hospitals to support women who want to deliver vaginally.

For more information about vaginal birth after cesarean, write VBAC/AVAC Canada, 8 Gilgorm Rd., Toronto, Ontario, M5N 2M5.

MEGAN WILLIAMS



Rape survivors on trial

The Supreme Court of Canada has ruled that alleged rape victims can once again be questioned in court about their sexual history. In a 7-2 decision that has outraged feminists, the court ruled that the 1983 "rape shield" law infringed upon an accused man's constitutional right to life, liberty and security of the person and to a fair trial. The 1983 law prohibited defence lawyers from questioning alleged victims about their past sexual activity with someone other than the accused.

Pat Marshall, a lawyer active in the coalition of women's groups which lobbied intensively to uphold the rape shield law, predicts fewer women will report rapes as a result of the ruling. "The rape shield law was the absolute minimum protection. Cross examination of alleged rape victims is already traumatic enough without having a woman's sexual history paraded through the courts," she said in a phone interview.


Statistics from the federal justice department

confirm that more women reported rapes following the enactment of the rape shield law in 1983. The 29,111 sexual assaults reported in 1988 were 127 per cent higher than the 12,848 reported in 1982, the report says. This rise is significantly higher than the increase in reported non-sexual assaults. Without the minimal protection the rape shield law provided, women who have been raped will be less inclined to report attacks. Those who do report rapes may once again find themselves and their sexual history on trial.

Judy Rebick of the National Action Committee on the Status of Women (NAC) says that without the rape shield law, it will now be up to the discretion of individual judges whether to allow questioning about a woman's sexual history. NAC is demanding mandatory judicial education about violence against women and the removal of judges who make sexist remarks.


MEGAN WILLIAMS

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Government admits error about Mème breast implant

Health and Welfare Canada announced several months ago there would be no compensation for women who have had the controversial Mème breast implant. But the government now admits that it may have been wrong in allowing the Mème breast implant to be marketed in Canada, an admission which is encouraging for women seeking compensation from the government.

Concern about the implant began in 1989 when Dr. Pierre Blais, a scientist at Health and Welfare Canada, was fired for declaring the Mème implant unsafe. Women had been complaining for some time

about side effects such as numbness in their arms and total lack of feeling around their breasts after receiving the Mème implant. The foam material used in the implant is designed for air filters, mattresses and aircraft parts, and according to its manufacturer, was never meant to be implanted in the body. Studies show that the Mème implant's polyurethane foam covering breaks down in the body, releasing TDA, a suspected cancer causing chemical into the bloodstream.

Although Health and Welfare Canada asked doctors to stop using the implants in April of this year,



Health Minister Benoit Bouchard refused to acknowledge evidence that the implants were dangerous. Health and Welfare has now admitted that the implant has never even been tested for safety in Canada.

For the more than 17,000 Canadian women who received the Mème implant, 12,000 of whom live in Québec, the government's

admission is a first step towards compensation for the harm done to women. Marcella Tardif, a woman who belongs to a Montréal based group fighting for compensation, says the next step is for the government to compensate women with the implant.

MEGAN WILLIAMS

Boycott successful

Good news for breastfeeding mothers and children in the Third World! Nestlé and other major manufacturers of baby formula have finally agreed to stop distributing the formula to maternity wards in developing countries. UNICEF has taken on the task of working out an agreement to which all the manufacturers will adhere. A tentative deadline has been set for December 1991.


Up until recently, baby formula companies gave out free packets of formula to hospitals with devastating consequences. Not only is the economic burden of purchasing formula crippling for impoverished countries, but the death toll of formula-fed babies is 10 to 15 times higher than those who are breastfed.

UNICEF, together with the World Health Organization, is also planning to implement a "baby-friendly" hospital policy in developing countries. Hospitals which

comply with a list of "ten steps to successful breastfeeding" will be presented with plaques and certificates. The steps include such actions as communicating a written breastfeeding policy to all health care workers; informing pregnant women of the benefits of breastfeeding; teaching women breastfeeding techniques; and fostering the establishment of support groups for women once they leave the hospital.

Elizabeth Sterken from Infant Feeding Action Coalition (INFACT), says the next step is to promote the ten-step policy in Canadian hospitals. This is no simple task. "Government support for the UNICEF initiatives doesn't exist," she reports, "Canadian women and children are being ignored when it comes to breastfeeding education and protection."

WHS



Saskatoon Community Clinic
Community Health Services
(Saskatoon) Association Ltd.

Consultant Psychiatrist

Applications are invited for the position of Consultant Psychiatrist, to practice in a 15 physician family oriented group practice, located in a Community Clinic setting.

This is a consumer sponsored, multi-disciplinary health care centre, located in Saskatoon, an attractive university city with a population of 180,000. There are three major hospitals in the city, two of which have Departments of Psychiatry.

The practice, which encourages patient's involvement in health care, includes two Psychiatric Community Nurses, a Department of Counselling and Social Services and an Occupational Therapist, with several other health care disciplines.

Applicants should hold the Canadian Fellowship. There is a generous competitive salary scale and attractive fringe benefits.

Applications, including resumes and the names of three references should be sent to: Dr Robert Akroyd, Head of the Medical Group, Saskatoon Community Clinic, 455 Second Avenue North, Saskatoon, SK, S7K 2C2

Woman's condom

A new condom for women may be available in Canada by next year, says its American manufacturer, Wisconsin Pharmacal. The condom, consisting of two rubber rings attached at each end of a polyurethane sheath, would help prevent sexually transmitted diseases and pregnancy. One ring fits in the vagina and blocks the cervix in much the same way a diaphragm works. The second ring, much larger, remains outside the vagina, protecting the labia from infection. The condom comes in one size so women do not have to be fitted by their doctor.

Ruth Miller, a nurse with the Department of Public Health in Toronto, says she is pleased to hear the condom will soon be available in Canada. "I'm sure it will

be a useful addition to the not very extensive array of barrier methods. I like the fact that the outer ring protects the vulva from infections such as vaginal warts. Also, polyurethane is less porous than latex, the substance most condoms are made of and will protect better against sexually transmitted diseases." While the arrival of the woman's condom will give women greater control and protection from STDs, there exists a danger that it will also place the total responsibility for all forms of birth control entirely in the hands of women.

WHS

Fetus person at 20 weeks?

At its annual general meeting held this year in Toronto, the Canadian Medical Association was presented with a resolution by its Ethics Committee that would define a fetus as a person at 20 weeks gestation. This is considered the approximate point in fetal development when a "perceived potential" for sapient cognitive awareness is present. The resolution, which ignited much debate and confusion within the CMA, was eventually referred back to the Ethics Committee for further discussion and was therefore not adopted as CMA policy this year.

It will however, be, cause for concern at future CMA meetings. Dr. Alanna Danilkewich, spokeswoman for the Federation of

Medical Women of Canada, says the FMWC is strictly opposed to the Ethics Committee's proposed definition of personhood. "The FMWC never agreed to this report. We feel that fetal rights is a legal, not a medical term. Giving a fetus personhood and thus rights at the arbitrary term of 20 weeks could result in additional depersonalization of women in society. We don't want to see the pregnant woman having only incubator status." If the resolution were to be reintroduced and passed next year, it could influence future Canadian law concerning abortion and the status of the fetus.

MEGAN WILLIAMS

Eat Well, Live Well



The Canadian Dietetic Association's
Guide to Healthy Eating

Do you have questions on nutrition...

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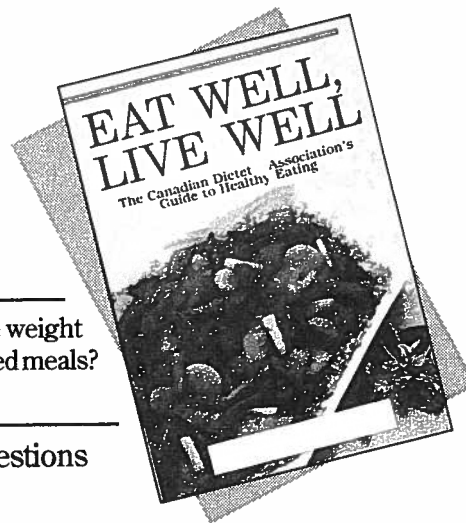
This 200-page book, authored by Helen Bishop MacDonald, R.D., M.Sc., and Margaret Howard, R.P.Dt., outlines CDA's healthy eating message and includes over 150 tested recipes submitted by consumers across Canada.

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Eat Well, Live Well is published by Macmillan of Canada. Look for it in bookstores, or send a cheque or money order to \$19.95, plus \$2.50 handling and distribution and 7% GST (on total) to:

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Margaret de Souza

Holistic remedies can help ease the symptoms of Premenstrual Syndrome

Menstrual myths and taboos have influenced perceptions of menstruation in all cultures and have often left discussions of this normal body function hedged by stigma. Women avoid focusing on menstrual issues because they are concerned that it may jeopardize their progress towards equality.

Primitive societies often viewed menstruation as a "poison," due to the fact that some women experienced immoderate psychological changes prior to menstruation. Once the flow began there were dramatic attitudinal and emotional changes so it was believed that the "poison" was eliminated with the menses.

PMS: What It Is

Premenstrual syndrome or PMS is a physiological condition linked to the interconnected and cyclical activities of the hypothalamus, the pituitary gland and the ovaries, causing a range of symptoms to occur regularly in the premenstrual stage, followed by a symptom-free stage.

In an article published in the Canadian journal about menopause, *A Friend Indeed*, (November 1987), it was reported that 95 per cent of menstruating women suffer from at least one symptom in the premenstrual phase. About 40 per cent experience a variety of mild symptoms but 10 per cent suffer from severe

physiological and psychological distress. PMS symptoms can be classified into physical, emotional and mental symptoms.

Physical symptoms begin with ovulation. A common one is fluid retention, which manifests as abdominal bloating, breast swelling and tenderness, swelling of the extremities, headaches, weight gain, numbness, tingling of fingers, dizziness, fatigue, thirst, frequency of urination and constipation. Another physical symptom is hypoglycemia or low blood sugar which can either create a craving for sweet foods or increase an appetite for high carbohydrate foods like pasta, bread and potato chips. Sensory sensitivities to touch, smell and noise, and infections such as sinusitis, rhinitis, "pink eye," cold sores, sties and sore throat are all symptoms associated with a change in the body's chemistry. A number of women also experience muscle aches and joint pain caused by increased production of prostaglandins which encourage water and salt retention. Other women become clumsy or accident prone; symptoms caused by low blood sugar.

Emotional symptoms are prompted by biochemical changes and fluid retention which also cause changes in the brain. Women may exhibit emotions such as anger, hostility, irritability, mood swings, spontaneous crying spells and loss of control. Low blood sugar and high estrogen levels induce fatigue,

sluggishness and anxiety.

Premenstrual biochemical and hormonal changes may trigger mental symptoms such as anxiety, paranoia, confusion, memory loss, lack of concentration, indecisiveness, impulsiveness and mental fatigue. PMS symptoms can also mysteriously cause women to commit uncharacteristic actions such as vandalism or theft or to make unjustifiable and extravagant purchases.

PMS: What It Isn't

Despite the severity and range of symptoms, PMS is not a disease or a foible of character. There are, however, some illnesses that have symptoms similar to PMS which may result in misdiagnosis. The following are conditions for which PMS has been mistaken:

- thyroid disease because the prominent symptoms are lethargy and anxiety.
- neurological conditions that have headaches, lack of coordination and numbness as their dominant symptoms.
- endometriosis, pelvic inflammatory disease and dysmenorrhoea that have symptoms like abdominal bloating, nausea, severe cramps and pelvic pain
- psychological conditions that are characterized by symptoms of depression, mood disturbances, social withdrawal and tearfulness.
- diuretic abuse which leads to abdominal bloating and weight gain.
- ovarian cysts and tumours

which produce increased estrogen levels. Also low fibre and high fat diets discourage elimination of estrogen from the bowel, suggests Dr. Guy E. Abraham, a California-based physician currently conducting research on premenstrual tension. These estrogen imbalances may cause PMS-like characteristics.

Fortunately, with PMS there are always four to 10 days in a menstrual cycle that are consistently symptom-free. If there is no symptom-free phase, charting and evaluating symptoms will verify PMS or an underlying illness.

PMS: What Causes It?

There is no simple answer to this complex question. Although theories abound, the precise cause of PMS is still a puzzle. Some believe that premenstrual symptoms are caused by a hormonal imbalance. For example, it has been suggested that anger, irritability and anxiety may be a result of a high estrogen/progesterone ratio. Candida albicans or yeast overgrowth also may account for the hormonal imbalance causing PMS. When the yeast is treated, PMS symptoms tend to be relieved.

Others, however, claim that PMS can be attributed to hormonal deficiency or abnormal hormonal absorption or excretion. Still others propose that low levels of serotonin, (a neurotransmitter that sends nerve signals between the hypothalamus and pituitary in the brain, regulating appetite, sleep and ovarian hormones) can cause the fluid retention, hypoglycemia, mood swings, depression and insomnia associated with PMS.

Premenstrual symptoms are also associated with vitamin B6 deficiency which often leads to mood swings, fluid retention and abnormal tryptophan (an amino acid) metabolism which causes insomnia.

Many psychological and cultural influences, such as a lack of adequate support, or daily stress, can also play an important role in the emotional and physical experience of PMS.

While several of these theories are controversial, it is safe to say that an interaction of biological, psychological and social elements

is responsible for the variety of symptoms associated with PMS.

A Holistic Approach

PMS cannot be cured but the symptoms can be relieved. In the hope of offering some kind of "cure" for PMS, many medical practitioners prescribe medication such as tranquilizers to women, some of whom experience side effects from their prolonged use. If

bohydrates, green leafy vegetables and fresh fruit. This will help raise serotonin levels. High fibre foods, such as root vegetables, whole grains, unprocessed cereals and fruits increase the level of estrogen; however, dairy products can cause an imbalance of estrogen. Avoid sugar, salt, caffeine and alcohol during the PMS phase. The latter hinders the production of the brain chemical, serotonin. Salt causes fluid retention, and sugar and artifi-



women select prescribed medication over holistic approaches for relieving PMS symptoms, it is important to know what kind of drugs are being prescribed and their side effects. Women need to be informed and in control of the treatment they choose.

The holistic health options for relieving PMS rely on a number of underlying principles to help you take control of your health by changing certain aspects of your lifestyle. Such changes include diet, exercise, stress reduction and relaxation, the use of non-prescriptive remedies like vitamins, herbs and food supplements and the use of alternative healing methods such as massage, acupuncture and chiropractic medicine.

1. Your diet should include moderate protein, high fibre, complex car-

bohydrates, green leafy vegetables and fresh fruit. This will help raise serotonin levels. High fibre foods, such as root vegetables, whole grains, unprocessed cereals and fruits increase the level of estrogen; however, dairy products can cause an imbalance of estrogen. Avoid sugar, salt, caffeine and alcohol during the PMS phase. The latter hinders the production of the brain chemical, serotonin. Salt causes fluid retention, and sugar and artifi-

cial sweeteners can produce hypoglycemia, giving rise to emotional changes and lower estrogen levels. Caffeine is the culprit that initiates sweet cravings. Caffeine in coffee, tea, cola and chocolate causes breast tenderness, nervousness, insomnia, hunger, irritability and crying spells; it also lowers vitamin B levels, leads to iron excretion and interferes with amino acid and calcium levels. Avoid foods that contain preservatives or pesticides as they can also interfere with the production of serotonin.

Proper diet and regular exercise can also help in the treatment of yeast infections which have been shown to cause hormonal imbalances that may heighten PMS symptoms.

2. Vitamins, herbs and food supplements. A lack of vitamin B diminish-

es the liver's ability to process estrogen. Elevated estrogen can cause a functional deficiency of vitamin B6 and a specific fatty acid called prostaglandin, a biological substance which affects all organs. Evening primrose oil, a product of the seeds from the North American wild flower, contains the essential fatty acid called gamma-linolenic. So, vitamin B6 supplements and evening primrose oil capsules may help alleviate symptoms such as breast tenderness, fluid retention, depression and tearfulness.

Herbs like dong quai, borage and flax seed also help get rid of breast tenderness and fluid retention. Dandelion root tea helps control mood swings and raspberry leaf tea relieves menstrual cramps. It is a good idea to consult a naturopath or herbalist before taking vitamins, herbs and food supplements.

3. Sleep is a critical factor during the premenstrual phase. Lack of sleep or insomnia can cause irritability, anger and depression. Low serotonin levels create an abnormal sleep cycle—difficulty falling asleep at night or awakening too early in the morning. To alleviate such symptoms, follow a sleep routine: get at least eight hours of undisturbed sleep; make the sleeping environment a comfortable, quiet, dark room; take a catnap if possible; exercise approximately five hours before bedtime; and limit bed activity to sex and sleeping only.

4. Stress management is important in our daily living because stress is a natural fact of life. During the premenstrual phase, stress can trigger hormonal imbalances causing PMS symptoms to skyrocket, taking the individual on a crazy roller coaster ride of emotions. It is important at those times to prioritize tasks, postponing stressful ones for the symptom-free phase. Learn to say "no" without feeling guilty; this is a good coping mechanism. Relax and pamper yourself with soothing properties like a heating pad, bubble bath, a good book, a cup of herbal tea, a sauna, a massage or have an enjoyable orgasm, as it also releases tension.

Learn and practice some stress reduction techniques which can be done at any time: slow rhythmic

breathing using a focal point is an easy, invaluable relaxation exercise; imagery is self-guided as you imagine details of a relaxing scene and its pleasant sensations; and, meditation and yoga are beneficial to induce a sense of inner peace and to help deal with stressful situations. Instructions for these techniques are available in books and tapes.

5. Exercise produces endorphins or brain opiates which are the body's natural pain killers. They elevate mood and release tensions. It is advisable to start exercises during the symptom-free phase so the experience becomes pleasurable during the PMS stage. Exercises should be performed on a regular,



Avoid alcohol, sugar, caffeine and salt during the PMS phase

daily basis to be beneficial. Brisk walking, swimming, biking and stair climbing are feasible exercises. Also, riding an exercise bike while listening to soothing music, reading or watching television can be helpful. Exercising in the morning is best because it sets the body's metabolic rate higher during the day while not disrupting the sleep cycle at night.

6. Acupuncturists, massage therapists and chiropractors use alternative methods to promote physi-

cal and emotional healing of the PMS woman. Acupuncture affects the interaction of organ structures and is used to speed up nourishment to the liver, spleen and kidneys. These organs regulate imbalances caused by fluid retention and detoxify the blood.

Massage therapy is a bodywork technique that releases endorphins, providing a calm, soothing state throughout the body as the circulation increases. Massage therapy relieves PMS bloating, muscle aches, joint pains and lower back pain.

Chiropractic medicine can also alleviate some PMS symptoms. Spinal and cervical adjustments lead to the release of the brain opiates which also relieve spasms, aches and tension.

Taking Control

Before embarking on a holistic approach, women must update our knowledge of the menstrual cycle and PMS. This will enable us to become aware of our body's functions and able to diagnose premenstrual symptoms, noting their type, timing and severity. There is no cure for PMS, but by gaining self-knowledge and learning the PMS regimen, we can take control of this part of our lives.

Social attitudes towards menstruation are still negative and PMS is still considered abnormal and a condition to be medicalized. This is false! Although PMS is often known as a "medical chameleon" or "male chauvinists' revenge," women should take responsibility and begin to learn about the causes of PMS and how to reduce its effects. Knowing this will enable easy diagnosis and give women the confidence to refute that "PMS is all in our minds."

Self-diagnosis and a holistic approach to overcoming PMS will lead to a healthful, productive health care plan turning the "PMS blues" into "PMS pinks."

Margaret de Souza is a Ugandan-born Canadian of East Indian origin. She is the head nurse of the Family Life Program at St. Joseph's Health Centre in Toronto.

Montréal Assault Prevention Centre

One of a Kind

My rules

*I have the rule to watch tv and i have
to play and i have the rule scream and i
have the rule to play Nintendo and i have
the rule to ride my bike and i have the
rule to run and i have the rule to tell
and i have the rule to kick and i
have the rule to be free to be safe
and to be strong.*

A child wrote the comments above after participating in a prevention program given by the Montréal Assault Prevention Centre/Centre de prevention des agressions de Montréal.

Three years ago, in Montréal, two feminist groups united to help fill a vacuum in the area of assault prevention. Although as a society we tend to focus on treatment instead of prevention, these two groups felt the time had come to address the need for, and to educate women and children in assault prevention.

The Montréal Assault Prevention Centre, formed in 1988, is comprised of two programs: Child Assault Prevention (CAP), which educates children about physical and sexual abuse through workshops held either at the centre or right in the schools; and ACTION, which teaches women and children how to protect themselves from abusers.

The following is an article by the centre's members which describes their prevention philosophy and the development of their program.

AN IMPORTANT milestone in prevention methods occurred in 1978 in Columbus, Ohio, when a school teacher picked up the phone and called Women Against Rape, Columbus' rape crisis centre. She asked for help in calming the fears of her Grade Two children who were disturbed and terrified after a girl in their class had been raped. At that time in Columbus and elsewhere in the United States and Canada, information sessions for children and their caretakers on how to deal with child sexual abuse did not exist. American feminists were just beginning to look at the sexual abuse of young girls and its link to the sexual assault of women. Canadian feminists were still quiet on the matter.

Women Against Rape immediately began developing a workshop for this group of children based on assault prevention programming they had created for women. The feminist collective had analyzed women's vulnerability to assault in terms of three factors: 1) women

lack information (about sexual assault and how to prevent it), 2) we are economically and/or psychologically dependent (on the very population that assaults us), and 3) we are isolated (from each other, and community resources).

The collective found that in order for women to reduce our vulnerability we would have to educate ourselves and each other and build resources that foster physical and psychological independence and access to community resources. While we learn about assault, we need to develop a capacity to resist violence against ourselves and our peers, through individual and community actions.

The Ohio collective immediately applied this thesis to children's situations and found remarkable similarities. Thus began the development of their analysis of children as a distinct, "oppressed" group, like women—disempowered, disenfranchised and vulnerable to violence, especially sexual violence.

Based on this analysis, the collective developed a program to

help empower children and reduce their vulnerability. The Child Assault Prevention (CAP) project became extremely popular throughout the U.S., and in 1984 Québec feminists learned about and fell in love with one of the only widely-accessible feminist-identified child assault prevention programs available.

In Montréal, a group of women teaching Wen-Do (the Canadian feminist's course on self-defense for women) became interested in the idea of bringing the program to Montréal, as well as incorporating the CAP philosophy into their work with women. In 1985, this group of instructors left Wen-Do in order to make fundamental changes to the

"I learned a lot to-day. For example the yell. We can say NO! when adults or teenagers make you do things we do not want."

content and organization of our courses for women, based on CAP's approach and that of the organization that holds CAP projects together, the National Assault Prevention Center in Ohio.

These self-defense instructors organized a local collective called ACTION, and developed a new self-defense course offered to girls and women of all ages. At the same time, some of these women became deeply involved in launching the CAP project in Montréal. In 1986, they received Secretary of State funding to develop and implement self-defense programming for women with hearing, visual and mobility impairment. The following year, they received funds from the government of Québec to develop and implement a program for teens in high school settings, a program based on the CAP project and ACTION combined.

From their inception, the two Montréal projects, CAP and ACTION, worked closely together. Using the same approach to prevention, each organization helped educate its clientele on the social significance of the other by discussing the link between violence against women and children and

promoting the strategy for prevention espoused by the National Assault Prevention Centre in Ohio.

In 1988, both groups voluntarily merged to form one stronger and more comprehensive unit, the Montréal Assault Prevention Centre (MAPC). The goal in doing so was both philosophical and strategic, recognizing that as a centre we could offer a broad range of assault prevention services to all groups that are considered at risk (children, women, physically challenged, intellectually challenged, lesbians and gays, the elderly, and particular racial or ethnic groups). As such, the projects would be more responsive to the community in which we work and easier for

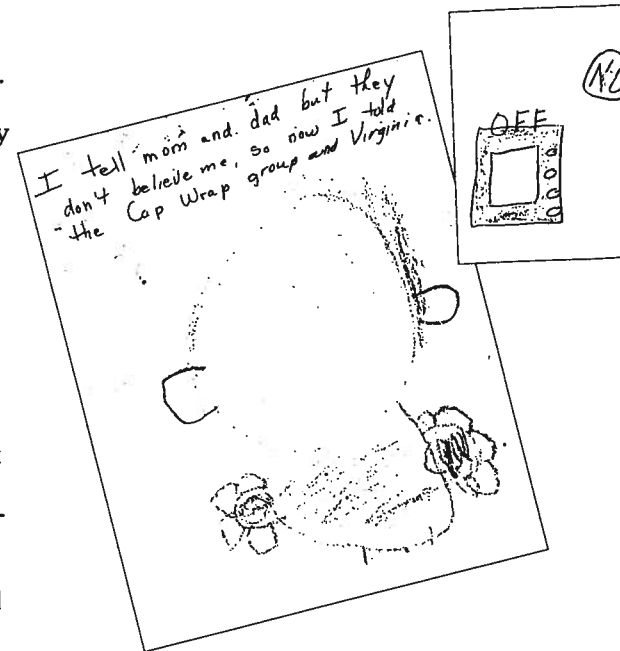
the public to grasp and access. But our other goal was to publicly acknowledge the links between disempowered groups, so as to immediately educate our clientele about the social structure of violence and aggression.

The MAPC now offers a wide range of prevention education services. As well as the self-defense courses for girls and women (ACTION), we are flooded with requests from schools to provide our now well-established CAP program. We have adapted these workshops for adolescents, as well as for children with physical and intellectual disabilities. Most recently we have begun working with adults with intellectual disabilities and have designed a unique program for this group. The CAP program, based on community approach to prevention, works not only with children in the classroom, but also with parents, all school staff and caregivers.

Adult workshops, for parents and adults working with and advocating for children, are designed to provide these adults with the information and unique approach we are using in the classroom. One of our recent projects at the centre has been to adapt these adult

workshops to a multicultural setting. This has involved not only the translation of hand-outs into five languages (other than French and English), but also the redesign of these workshops to make them more accessible to culturally-diverse groups.

WHAT DREW us most strongly to do this work, was the organizational



approach to assault prevention offered by the National Assault Prevention Centre in Ohio—the strategy of empowerment. When designing the CAP program in Montréal, the Ohio collective offered us a critique of traditional approaches to “prevention” which they label: “victim control,” (rules and regulations which control the behaviour of the potential victim) and “offender control,” (which focuses on law enforcement and heavier penalties for offenders).

Both approaches have failed miserably. Victim control is the usual, traditional method of prevention that most girls and women are taught in our society. It most often consists of a series of do's and don'ts: don't hitchhike, don't walk alone at night, always carry your keys between your knuckles, don't talk to strangers. As most women are aware, these rules severely limit our freedom and yet

provide no security from assault. What they do is to shift the responsibility and blame for assault from offender to victim/survivor. When a woman is assaulted while "breaking" one of the rules (e.g. she is walking alone at night), she is then held responsible for the assault.

Offender control, on the other hand, while focusing on the aggressor, is not really prevention at all, as it is an after-the-fact approach. Stiffer penalties for offenders,



greater police presence on the streets and stricter law enforcement are not only after-the-fact measures—that is, they don't prevent assault, they simply deal with it when it has already occurred—but, they also focus on the minority of sexual assaults on women and children: assaults by strangers.

These approaches to assault prevention are based on societal misinformation. They focus on women's and children's behaviour as the reason for assault, rather than on the offender's actions. They focus incorrectly on the rarest form of violent assaults on women and children, violence perpetrated by a stranger. Victim control inhibits our freedom and reduces the quality of our lives, holding us responsible when we are assaulted. Offender control also ignores how law enforcement agencies generally move to blame

the victim and deny the responsibility of the offender.

CAP's alternative approach is based on empowering ourselves: reframing our vision of ourselves so that we can understand our inner and outer strengths; listening to inner voices that help us identify our feelings; and, developing strategies for dealing with different kinds of situations on our own and with others. Through empowerment, we will find ourselves released from our psychological and physical prisons, not only able to walk at night again (of which most of us are most afraid, in spite of all we know), but to live peacefully in our homes, move more freely at our workplace and

Since we are not easily slotted we are often left out of women's groups and forums and excluded from women-only coalitions.

While we are a feminist-identified organization, we have men in our organization and in decision-making positions. This has caused a tremendous rift with the Québec coalition of CAP projects, which believes that assault prevention programming for children should be implemented by women only. We strongly disagree. Our experience with men in our group has been excellent. We have been greatly inspired by the relationship they have developed with children and especially boys in the classroom while they model alternative,

"I wish that every school could get CAPs! Now I know what to say"

schools and become helpmates to our friends and neighbours. It is this fundamental approach to prevention, a strong focus on empowerment, that guides all of our programming at the Montréal Assault Prevention Centre, for children and adults alike.

MORE THAN two years have passed since the centre was formed and we believe that we have been tremendously successful internally and externally. We are a large, comfortable group, with little turnover and a strong commitment to our work and the organization.

As a community-based organization, we maintain strong links to Montréal's diverse communities, both individually and through our ties with other community organizations. Our commitment to remaining grassroots is strong and our perspective on prevention certainly fosters a community-oriented approach.

We have however, experienced difficulty in various feminist milieux, largely because we are committed to working with a variety of groups, and not just women.

nurturing behaviour. As we learn more about the social development of the perpetrator, we have come to appreciate the significance of a positive male presence among children. This experience and our analysis is shared by the National Assault Prevention Centre (Ohio) and other groups in Europe, Central America and Africa who are also using the CAP approach.

Although we sometimes have trouble finding men willing to do the work, as feminists we believe it is time for men to become involved in this crucial area of work with children, work that has for so long been relegated to women alone.

The success and excitement of assault prevention work has led us to long for greater participation in the field. In our experience we have found relatively little emphasis in the feminist community on prevention work. Much time and energy is committed to working around violence against women and children in other ways, such as rape crisis centres, battered women's shelters, etc. Although profoundly important, rape crisis centres and battered women's shelters provide badly needed services after the fact. Increasingly, we are finding

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that assault prevention work must go hand in hand with these other important services.

Despite success stories and an overwhelming enthusiasm by almost everyone who comes in contact with our programming, society continues to deny the value and significance of prevention work. Too much of our time and energy is still spent arguing with panel and conference organizers in and out of feminist settings, about the need for information about the *prevention* of assault. The recent conference on Women and Mental Health, held in Banff this past spring, is one example of an important feminist event that excluded any discussion or presentation of assault prevention issues.

MAPC TAKES a unique approach to the role of children in our organization. Over two-thirds of our employees are parents and half of those are single parents. Children are an integral part of our milieu. We often find children in the office and the events we sponsor and organize are usually designed to accommodate children as much as possible. The staff at the centre regularly exchange child care and we provide support for each other through discussions and problem-solving together. Our pro-child environment stems directly from our philosophy of our work which suggests that part of children's vulnerability to assault is based in their isolated and oppressed position in much of society. We seek to address this problem not only in our work, but in our daily lives as parents and advocates for children. We are currently developing strategies to help parents at the centre integrate their work with their children's lives.

Externally, we are increasing our work to reach a wider range of groups that are particularly vulnerable to assault, including expanding our work with children and adults with intellectual disabilities. We are also beginning preliminary work on designing and adapting self-defense programming for the gay and lesbian community. The designing of sensitive and feminist

self-defense programming for gay men, a group particularly vulnerable to assault, will be a new challenge for us. Another interesting new focus has been our role as "trouble-shooter." More and more frequently we are being asked to come to schools, camps and other places to help discuss and alleviate concerns that arise following incidents such as assault and bullying.

OUR BIG challenge for the future, aside from the regular struggle for financial survival, is to begin working with groups in "perpetrator prevention." That is, programming that will help children and men to develop skills in recognizing and dealing with problems and to channel their anger into constructive decision-making and communication, while building their ability to empathize with others. This is work that we have launched with teenage boys in our high school program and children in shelters for battered women.

Our chosen mandate makes for exciting work and leaves us wide open to making mistakes. But we believe that Ohio's original design and analysis is an excellent guiding light. Yuri Morita, who developed CAP's comprehensive approach to multiculturalism and anti-racism, argues that if we continue to examine our relationship to the program, philosophy and people, and recognize how they intersect and depend on each other, we will continue to approach our goals and objectives.

We hope this article will further encourage individuals and organizations, especially those with a feminist analysis, to continue the struggle against violence and focus more on the need for prevention programming. In this struggle, at all levels, we need to concentrate on what we need to know now, before something happens—for our own protection.

This article was written collectively by members of the Montréal Assault Prevention Centre, CP 237 Succ. Place du Parc, Montréal, Québec, H2W 2M9, Tel:(514) 284-1212.

MY STORY, OUR STORY

An Uncommon Enemy

Margot Henning

MY MORNING TURNED OUT TO be the same for me as for most women. My period started and I reached for the familiar box of tampons. I was unaware that on this occasion, using tampons was going to change my life and hurtle me into a very small group of women who have suffered from Toxic Shock Syndrome. And a smaller group who survived it.

It was a Friday in March, 1988. A week before Easter. The day hinted warmly of spring. Sun, coaxing the snow's melting, brought the feeling of impending life, green—full of colour again. I hastened through the day's work preparing for a week of relaxation, time away from the office, time with the family.

My body seems to be letting go today. As if it holds itself together during the business of schedules, deadlines and commitments. Then when a rest period comes along, I have time to unwind, in sickness or just exhaustion. I'm feeling a little of both.

This is definitely the flu. Saturday night blurs into Sunday, fever and chills. I'm certain it's the 24-hour variety that rolls in like a storm and disappears in the quiet of the next morning. Through the drifting in and out of awareness is emerging this cyclical movement between the warm bath and the bed. I really yearn to be warm now, to prevent this sensation of poison-drenched needles piercing every inch of my body.

Thank God for the sitter. Harold is at work and the world downstairs where the children are, drifts farther from me. Little faces poke through the pain now and then. Tea comes and sits cooling. There is no stillness now. Something is raging at me. Through me. Around

me. Something I can't control. I'm frightened and the void, becoming darker, claws at my skin. My blood, once cleansing, is spreading toxins everywhere.

Tuesday. Fever seems to be down. The fact that my body could no longer writhe as much with the fluids all gone, mistakenly appeared to be an improvement. Harold went to work. I thought I

would try some tea now, maybe toast. I'm going to write a little note with the request and send it downstairs with this puzzled little girl standing by the bed. One thing about shock: it gives the wrong messages to the brain, giving one the illusion that everything is normal. But, that was fine. Anything but last night!

Another worried face appears at the bed. It is the babysitter. She's unable to read my note. There are only scratches on the paper. Should she call the doctor? I will call. The room is empty again and the silence hurts. What causes me to call for help is something external... energy drained out of me which has gathered somewhere and returned...

Arms are holding me, the doctor's face appears, there's light, Emergency doors opening and the noise of the hospital. Everything sucks me further into a state of dizziness. I am folded into a bed like a white sheet glaring under fluorescent bulbs. I will sleep now. But sleep grins from the distance, grotesquely sculptured among the images circling overhead. Pain forces out the voices, movement—the attempts to diagnose what is happening to me, what is making death so attractive now.

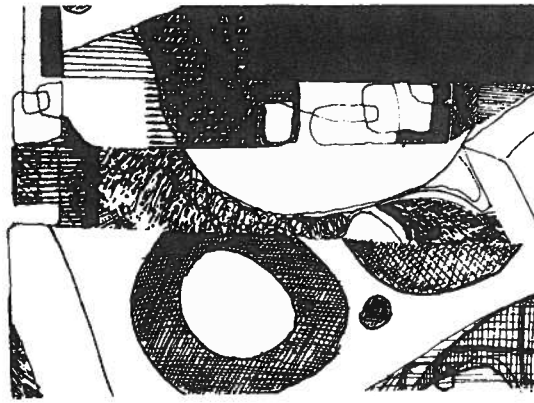
I have heard of nights with no mornings. Nights spent in vigil with the dying and the unanswered questions about the cause. The toxins that were still undetected were beginning the next phase of shutting down the organs, kidneys first. I was alone with the possibility of death that night while at home, my family was told it was severe dehydration and flu. They slept, unaware of the truth.

Wednesday. The doctor called Harold. "The worst seems to be over... her kidneys failed last night but they're doing fine now. We're rehydrating her and I've requested that a specialist see her to try and diagnose this." "I'm coming right over," Harold said, the phone feeling ominous in his hands, echoing unbelievable words.

All the opinions, theories, speculations rattled meaninglessly against a growing fear of the unknown. Where does one focus the anger—the hope for recovery



One of the purposes for writing about this is to reach into the isolation that other TSS survivors are experiencing



from a serious illness when it doesn't have a name? How incredible is the stress endured by those whose loved ones are critically afflicted by an illness not yet diagnosed. There is a strange comfort in at least knowing, because it is the beginning of a way to fight back.

The doctors appear and disappear. I am wheeled here and there for tests. Nurses and orderlies, patients, their visitors, file past blending into my surreal images. I

hear voices discussing my symptoms—the sunburn-like rash all over me and inside my mouth, the test results revealing the toxins and the bacteria causing them. I hear the words Toxic Shock Syndrome and sense some disbelief among staff—an initial reaction, naturally.

Toxic Shock Syndrome... this thing that is burning, piercing, that is strangling my throat with pain. The specialist is beside my bed.

His face fills my view. I focus for an instant and catch a glimpse of understanding. He has named it. Now I must fight. I must somehow force out of me the hallucinations, the distorted racket in my brain, the poison in my blood—come back to the living.

The nurses who give me care on the ward tell me I'm the big success story down in Emergency. They tell me I survived. Some read my chart in fascination and wonder about a tampon that has the potential to wreak such horrendous damage. This wonderfully convenient technological advancement that subjected me to its other attributes. The ones that can cause death.

Good Friday. The noise in my head, sounding like a heavy metal guitar solo, finally stopped.

I am finally aware of my actual surroundings. My mind wanders ahead to a few months from now, after it has digested all the information. Especially the lack of infor-

Toxic Shock Syndrome

The following provides general information about Toxic Shock Syndrome and some precautions to take when using tampons:

- TSS is an uncommon disease. The incidence is three in 100,000 menstruating females in a year. The most common age group is 20 to 30 years old. However, it is important that women are made aware of TSS as the mortality rate is estimated between 3.8 and eight per cent.
- Unfortunately the warning signals associated with TSS are poor. Victims usually have odourless serous vaginal discharge; other symptoms are similar to the flu, e.g. fever, nausea, vomiting and sometimes diarrhea.
- Any brand of tampons may lead to TSS. High absorbency tampons are the worst offenders. The increased volume of blood provides a good culture media; this type is changed less frequently and has a drying effect on the vaginal mucosa.
- Women should change their tampons at least every three to four hours. However, if tampons are changed too frequently, micro-ulcerations can occur in the vaginal wall.
- Use tampons intermittently. Women should only use tampons for two to three days of the period, certainly not on the second or third day when flow is heaviest and colonization of bacteria is

most likely to occur. Never use tampons at night.

- If symptoms of TSS occur, discontinue the use of tampons. Although colonization occurs most often on the second or third day of the period, the toxins will probably not result in TSS until the fifth day of the period.
- TSS is a staphylococcus aureus infection. It has been suggested that vaginal cultures be done routinely for all women to identify high risk persons. However, this is not feasible since 17 per cent of all normal females have staph growing as normal vaginal flora.

The At-Risk-Woman:

- uses tampons continuously during menses
- uses tampons from day two to day four of menses
- is previously healthy
- is between the ages of 13 and 52 (reproductive years)
- is fair-skinned, Caucasian (not proven)
- does not use birth control pills (Most women who use birth control pills have less bleeding during menses due to changes in the lining of the uterus and therefore the culture media is not as good)

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mation concerning the long-term effects of TSS. I think about the time when the doctors are gone and my chart is tucked into a file cabinet and I wonder, "Who'll help me cope with recovering from something of which even the experts know little? Are there other survivors like me who are asking the same question?"

Easter Sunday. Resurrection. Life after Toxic Shock Syndrome certainly seems like a miracle to me, however ravaged I might be feeling. I can go home today on the condition, of course, that the babysitter comes in every day to manage the household while my husband does it every evening allowing me total rest in bed for at least a month.

I feel like the researcher who becomes the subject of the experiment, not knowing what will happen next. There are sources of information which describe the nature of the illness—the symptoms, diagnosis and treatment. But the information seems to stop at the point where my struggle begins; that of discovering what the long-term effects are in an empty, silent vacuum.

The sense of isolation wrestles with the longing inside me to find someone who will share her own experience with TSS. The month in bed is over before I can catch my breath. I go back to work before the skin is finished peeling from me. Too soon, of course. I fumble through the days. I collapse into bed upon returning home. The kids tuck me in and kiss me goodnight. It's difficult to focus, to concentrate. I mix up the words in my sentences—a strange numbness clogs my brain.

Summer comes. The doctor prescribes another month away from the office. There is little strength for working, mothering, catching up. The balance is still far from adequate. We talk about my working part-time, reducing the load. There is definitely not enough space to move towards health.

I'm still hanging precariously by the fear that I'm at risk, that the next time I get the flu it might be TSS, that, even though I will never wear tampons again I'm still susceptible. The anxiety that my husband

and I have about this lasts for a year. We're so scared that I'll get sick again. We eventually overcome the anxiety so it's not so consuming.

1991. It's been about three years now since I contracted TSS. The financial stress of not being able to work for significant blocks of time while still requiring full-time child care is just beginning to ease. I did manage to move into a part-time term position for seven months in that first year of recovery. It was of enormous benefit and seemed to confirm our efforts to re-evaluate our priorities. Life and health were the obvious choices over vacations and home improvements.

My usual energy level still eluded me that first year until the following summer of 1989 when I finally began to feel like myself again. It was a year of particular strain on my family with my husband being a single parent most evenings and the girls struggling with the sudden and prolonged unavailability of their mother.

Today, I am reminded constantly of my physical limitations. There is still pain and the need to pace myself. I'll always wonder about but never really know to what extent Toxic Shock Syndrome contributed to this part of my functioning. I don't know how it has affected other survivors. It is the vacuum situation again.

Perhaps one of the purposes for writing about this is to reach into the isolation that other TSS survivors are experiencing. Perhaps we still need to know what it was like for someone else; still need to share with someone who understands this, albeit, "uncommon" but monumental event in our lives. We deserve that chance. I would like to extend an invitation to other survivors to write to me describing their experience and whether they would also benefit from some type of information-sharing structure that we, as a group, might be able to build.

Margot Henning practiced divorce mediation for five years and is currently a freelance writer and poet. She can be reached at 207 Point West Drive, Winnipeg, Manitoba, R3T 5H9.



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Maureen Gans

Mother Bears on the Rampage

Mothers of chronically-ill children confront the health care system

“I HAD NO IDEA I could get a mother bear syndrome. I will protect my cubs to the absolute end, to the sacrifice of myself and I think that most moms are like that. We may yell and scream at them and tell them they're rotten... but when the crunch comes, we will defend them.” ... mother of a child with a chronic illness.

Good health care is an important issue for us all and a crucial one for those of us who have chronically ill children. What do mothers want, what do they need and what do they have to do in order to get quality health care for their children?

Over the last two years, as part of the research for my Masters thesis, I spoke with a number of women about their experiences with hospitals, nurses and physicians. I expected to hear about some unpleasant experiences. I also expected to hear about frustration and anger at not being able to establish good relationships with doctors and the lack of respect medical professionals have for patients (and parents of patients). All those things were confirmed. However, I also heard stories of determination, persistence, screaming and yelling until finally somebody listened. The women I encountered are “mother bears on the rampage” by their own description, willing to sacrifice everything for the well-being of their children.

Several themes cropped up repeatedly; the importance of being involved in planning a child's

care; the difficulty getting information; the lack of respect for a mother's knowledge; and institutional barriers that make it harder to obtain good health care.

WHEN ASKED, “how involved do you want to be in helping the doctor plan your child's care?” most women said, “very.” And many were. From bathing and feeding to more complex tasks such as feeding through tubes, changing dressings and inserting catheters, many women took over the primary physical care of their children, even in the hospital. Although they were pleased to be allowed this involvement, they also recognized that they were taking over nursing tasks and wearing themselves out.

“I try very hard not to be demanding. I'll make her bed, I'll bathe her... I was even handling the IV pump. So they [nurses] know when I come in that there are certain things they're not expected to do... I can see it when the nursing schedule is put out,” says another mother.

Even though a philosophy of Family-Centred Care (involvement of the whole family in care planning) is being preached at some hospitals, it is not necessarily being practiced. Taking over physical care is not the same as the planning of care, nor does it take the needs of the family into consideration.

Being a partner in planning your child's care makes good sense in

many ways. First of all, you have a feeling of greater control over the situation. If you are in control, you are more likely to stick to the plan of care. Second, you, the doctor and other health professionals can work together as a team. This takes some of the stress off each person by diffusing responsibility. The doctor is still responsible for her actions, but decision-making becomes a shared job. Third and probably most important, you are the expert on your child. You know your child better than anyone and your contributions are invaluable.

“Being her primary caregiver, I know far more than they do about her day-to-day condition,” notes Rita, “and I can see subtleties, I feel subtleties. There is an intuitiveness that I have that I don't even have to look at her, I just suddenly feel there's something not right. These are things that I think they should take into consideration.”

However, being involved in decision-making requires that women have a thorough knowledge of their child's illness. Given that many doctors do not provide this, women often have to first educate themselves and then fight to be involved in the planning of care. All in all, it can be quite time consuming and exhausting.

GETTING information has always been a problem for patients. How many times have we tried to pry an explanation from our doctors, get our



questions answered or even find out where we can read about our illness? Many of us have encountered everything from technical explanations that we could not possibly understand, to actual refusals to give information. For a mother whose child has developed a long-term health problem this can be exasperating and frightening. All the women I spoke with emphasized that accurate information was absolutely essential to their ability to care for their child. Without education, they could not make important decisions about treatment options.

As a person who believes that I have the right to information about my body, I will demand it from my doctor. How do mothers make these demands, though, without fearing that if they come on too strong, the doctor will not "like" them and will give their child poor care? This is a concern for many women; however, the mothers I spoke with firmly believe that demanding information is the only way they will get it. A couple of women even said, "I'm not here to win a personality contest. I'm here to fight for my child."

Women with children who are not seriously ill often had to

switch doctors in order to find someone who would talk with them. However, this option is not available to mothers of children with more serious illnesses that require repeated hospitalizations. The physicians encountered at the hospital may be their last resort; these doctors are the cream of the crop (clinically) and there is really no where else to go. If these doctors do not take the time to educate, then getting information becomes the mother's job. Some women have become experts on finding information and using the health care system effectively.

MANY OF US have felt, at one time or another, that medicine has very little respect for women. Research into what is taught in medical school and what is published in medical textbooks have given us glaring insight into the male-dominated world of medicine. This lack of respect has taken many forms, from disrespect of our bodies and our illnesses, to disrespect of our roles as mothers. This attitude was conveyed in a number of ways to the women I interviewed.

A lack of interest in and respect

for the information parents can give to the doctor and opinions parents have of their child's illness is rampant. Sometimes they were just simple comments, made out of frustration, but clearly indicating a lack of thoughtfulness and sensitivity. Liz, whose child has a prosthetic (glass) eye, was in the emergency department with her husband and child. The physician was unsuccessfully trying to get the eye back in when he blurted out, "Why did you have her eye removed anyway?" Their response was simple and indicated that they were not impressed with his comment, "It was the wrong colour."

Sharon was flying her child to another hospital for a consultation. The day they were to leave, he was coughing and she said to the nurse, "I don't like that cough, bet he's got pneumonia." The nurse told her not to be ridiculous, that he had not been coughing much. When they arrived at the other hospital, the doctor there immediately said, "How'd they let you go with pneumonia?"

The credibility of mothers with chronically-ill children was constantly being questioned, even though they know their children better than anyone. Marg thought

that she was just beginning to build an adequate relationship with her child's doctor and that although the man was irritating because he had a huge ego, "I need him, so I really can't alienate him any more than I already have. But I just thought, Damn-it-all Mister! I've been here for two years with my daughter and you absolutely deny any credibility on my part."

Not everyone had difficult relationships with their child's physicians. Some had doctors who encouraged questions and took the time to answer them. Some doctors

child is. "It's a case of everybody's got a job to do and it starts at admitting... And the phone rings, and they're interrupted. I could [fill out forms] in two minutes. But that's their job. So the control is always taken away."

HOW DO WE demand quality health care? For most of us, it's trial and error as we try to be our own health advocates. An advocate is defined as someone who acts or speaks out on behalf of someone else. Clearly the women I

thing about it."

"You have to be brilliant in this system," observes Pat, "You have to be the most wonderful networker. The system doesn't even know the system."

For those of us who are white and middle-class, we may have learned by example how to "fight the system," to push in order to get what we need. But some women recognize that "parents like myself will always get everything out of the system... My worry is for parents who don't know what to do."

This is why it is especially important to work for changes in health care that will lead to institutions that operate on behalf of the client.

"... medicine has always been considered on a level just below God," explains Nicolette, "and it's a very hard thing for people to learn that they can question professionals and they can expect to get certain answers and I think the more they are in the situation, the more they understand that. I think there are problems for people who are just coming into the system. They need to be treated as a very intricate part of the whole picture and not as somebody who's, like, a fifth wheel, we don't need you, just get out of our way."

The validity of mothers with chronically-ill children is constantly being questioned, even though they know their child better than anyone

could be reached at home if there was an emergency and came right away when called. Some doctors hugged and kissed and had water fights with the kids. But these doctors were few and far between.

THE WAY an institution is operated can facilitate its use or impede it. In the case of our health care institutions, impediments exist everywhere.

Hospitals are notoriously slow. They often seem chaotic. One department doesn't know what the others are doing. There are so many forms to fill out and so many people asking the same questions. Added to this is the fact that most of us don't have any real knowledge of how hospitals operate and who is responsible for what. This makes it frustrating when you are trying to figure out why things take so long.

Hospitals are bureaucracies, like most other large institutions. And like other bureaucracies, hospitals tend to shuffle people from one place to the next and are rarely able to provide a consistent, even flow of information. This can be extremely frustrating for mothers who are waiting for their child's test results, waiting to have their child admitted to the hospital or even trying to find out where their

spoke with act as advocates for their children. They are in the best position to do so because they know their children better than anyone else and because there is so much personal investment.

There is a distinction made between self-advocacy and systems advocacy that might be useful to explore. Self-advocacy means that you are fighting for yourself or your child, to demand what you need. Systems advocacy can exist within an institution if it operates on behalf of the needs of you, the client. Ideally, the "system" caters to the client, serves the client and has built-in procedures to ensure quality service.

Unfortunately, most of our institutions do not function this way. Certainly the health care system seems to cater to the needs of those who work in it. You see the doctor when she is available, you follow hospital procedures set up by an administration and it is your responsibility to do something if quality care is not given. The institution (the hospital and private practice physicians) itself does not advocate for you. Lina mentioned that after she complained to her doctor that something should be done about an incident that happened in the hospital, her doctor said, "You're right. Go do some-

WHEN OUR doctors and hospitals refuse or are unable to provide us with everything we need, where can we go? For information and support, the best place to turn may be a non-profit agency that caters to the needs of people with a particular medical condition. Agencies such as the Cancer Society, the Epilepsy Association, the Spina Bifida Association, etc., exist to serve patients and their families. They usually have information pamphlets, libraries and someone in charge of education. This means that there is often some place else to go when you need more information than your doctor is giving you. It also means there might be support, in the form of a social worker, that the hospital has not offered you. Many of these agencies run support groups that provide an opportunity for you to talk with other people who are having simi-

lar experiences. Getting support around parenting skills and your child's illness and building strategies for getting what you need are two benefits of such groups.

These agencies are greatly underused, despite the fact that they are a wonderful resource for parents and patients (and physicians). Unfortunately, your doctor is not likely to make a recommendation for you to visit an agency such as this. In fact, your doctor may not even know of them. In the hierarchy of the health care system, non-profit agencies fall pretty low. They are a resource you may have to find yourself. Just look in your phone book under the name of the medical condition (e.g., epilepsy) or call your community information centre, if you have one. You could also ask other parents in the hospital or the health nurse at your child's school about local agencies.

FOR THE LAST 15 years and now more than ever, feminists have been demanding quality health care that includes choice, education to enable us to make informed decisions, alternatives to traditional medicine and the demedicalization of life events. Spurred on by such demands, changes in the health care system are slowly being realized. There are medical schools attempting to turn out more "humane" doctors, but until all universities change the mold and until hospitals start taking an active role in advocacy, we are likely to continue having to fight like mother bears for our children (and ourselves).

Meanwhile, we also need to keep in mind that physicians cannot do everything for us. We need to take some responsibility for educating ourselves and our children. What do we teach our children and ourselves about health care? If we as mothers are exceptionally good teachers we might cover basic education about our bodies, how to prevent certain diseases and conditions, concerns about substance abuse, sexuality and maybe even how issues such as poverty, homelessness and the environment are all health con-

cerns. What about things like: how do I know when I need to visit the doctor? What alternatives to traditional Western medicine do I have? How do I know if a baby is sick or just cranky? Where can I go to get more information on a specific health problem? What is realistic for me to expect from my doctor? How does the health care system in my province work? These are all things we need to be teaching our children and ourselves. Unless we understand how the system operates, we cannot get everything we need from it, nor can we decide what changes need to be made.

Maureen Gans is completing her Masters of Education degree in the Department of Community Psychology at the Ontario Institute for Studies in Education. She currently works as Education Coordinator for the Epilepsy Association, Metro Toronto.

Resources

Strategies: A Practical Guide For Dealing With Professionals and Human Service Systems, Craig V. Shields, Human Services Press, Richmond Hill, 1987. (\$12.25, to order, call (416) 764-3387)

Canadian National Institute for the Blind: (416) 486-2500

Canadian Mental Health Association: (416) 789-7957

Canadian Liver Foundation: (416) 964-1953

Canadian Hearing Society: (416) 964-9595, TDD (416) 964-0023

Canadian Diabetes Association: (416) 488-8871

Canadian Cystic Fibrosis Foundation: (416) 960-6268

Canadian Cancer Society: (416) 593-1513

Arthritis Society: (416) 967-1414

Spina Bifida & Hydrocephalus Association of Ontario: (416) 364-1871

Heart and Stroke Foundation of Ontario: (416) 489-7100

Epilepsy Canada (514) 845-7855

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HEALTHWISE

Putting Breast Self-Examination Into Our Own Hands

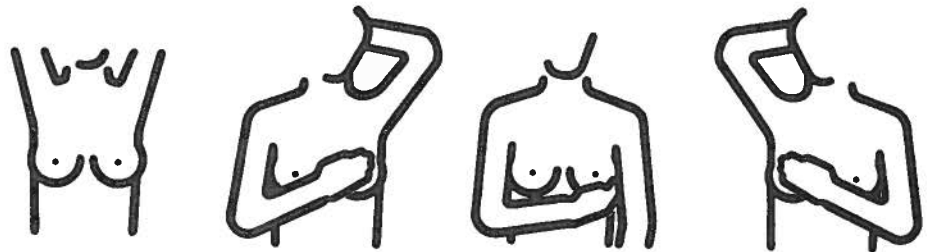
Anne Bokma

IF THE MOST EFFECTIVE MEANS of preventing women from dying from breast cancer is early detection, why do so few women know how to perform a proper breast self-examination? Physicians may perfunctorily prod patients' breasts at their annual physical, but they will not teach women how to check for lumps themselves.

The fact is that the medical establishment does not regard breast self-examination (BSE) to be of particular value, even though earlier detection can save women's lives, says Pat Kelly, project coordinator of the Halton Women's Self Health Project in Burlington, Ontario. "Their attitude is it's just breasts and it's just women," she says.

The Halton Women's Self Health Project is designed to teach women what the medical profession doesn't—how to detect early signs of breast cancer. A first in

Canada, the program is taught to women by women. Trained facilitators conduct three 90-minute workshops to women's groups in their homes. From November 1990 to March 1991 more than 800 Halton women participated in the project,



primarily funded by a \$23,000 grant from the Ontario Ministry of Health. Two women were diagnosed with breast cancer as a direct result of participating in the program and many others had suspicious findings. The program's intent is to change women's attitudes and behaviour when it comes to BSE. Kelly says she was surprised by the number of women in the program who not only didn't perform BSE but didn't go for annual check-ups either. "This group tries to demonstrate that women can and should be actively part of their own health," she says.

The program is especially unique because of the way it is conducted—small settings with all female participants meeting in each other's homes, the screening of an educational video, one-on-one feedback and peer group instruction. One of the most important learning tools in the program is the use of silicone breast models, which demonstrate what normal breast tissue as well as suspicious lumps—some as tiny as

pellets—feel like. Each participant attends three sessions over the space of several months and, by the end, has a thorough understanding of how to properly conduct a 15-minute BSE and has a better chance of detecting breast cancer. Even women well versed in breast care can learn something new. "Everybody walks away with some new information, whether it's to be sure to check under your armpits during the examination or to do a visual exam," says Kelly, noting as well that many myths about breast cancer have also been exploded at the workshops. "For instance, many women think if you breastfeed you won't get breast cancer but that's not true."

Funding for the Halton Women's

Self Health Project ran out in June 1991 and currently the group is evaluating the program and will lobby for additional funds. Kelly hopes the project will be able to sustain a full-time coordinator who could also promote a model for other community groups to adopt.

Since being diagnosed with breast cancer in 1987, Kelly has been actively involved in raising awareness of breast cancer. She believes it is time breast cancer support groups become more political in their lobbying for more funding and research. She points to the success of AIDS activists who have substantial funding in comparison. The U.S. National Institute of Health provided 50 times as much money to AIDS research as it did to breast cancer research. This, in spite of the fact that many more will die from breast cancer than of AIDS. "Definitely more activism is needed," says Kelly, "It's not yet a coordinated effort."

Anne Bokma is an editor at MacLean Hunter Ltd. in Toronto.

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REVIEWS

Who Cares? The Crisis in Canadian Nursing

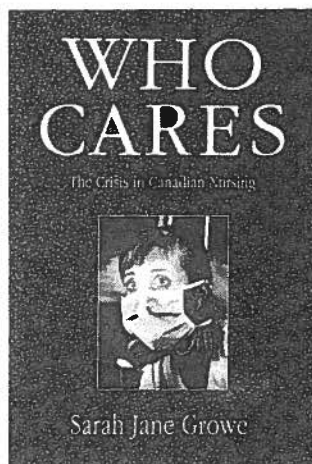
Sara Jane Growe, McClelland & Stewart, Toronto, 1991, 265 pp.

Reviewed by Lisa McCaskell

THE GROWING CRISIS IN THE Canadian nursing profession has received a great deal of attention in recent years. It started with the 1983 Royal Commission of Inquiry into Certain Deaths at the Hospital for Sick Children (known as the Grange Inquiry). And it has continued with media reports of nursing shortages, the often abysmal working conditions for nurses within hospitals, legal and illegal nursing strikes, and political splits within the nursing community over education and economic goals. Everyone has been a hospital patient or has had a hospitalized relative or has a sister, friend, mother or aunt who works as a nurse. Most of us have learned that it is hard to find a nurse in Canada who can truthfully say she loves her job and that she intends to keep doing it until she retires.

In *Who Cares? The Crisis in Canadian Nursing*, Sarah Jane Growe attempts to trace the origins of this crisis and to expose the issues which are troubling today's nurses. She brings to the task considerable skill developed from years of freelance and staff reporting for a variety of Canadian publications, most recently *The Toronto Star*. To gather her data, Growe travelled across Canada conducting 300 interviews with staff nurses, hospital administrators, supervisors, nurse managers, university and college professors and nursing students.

The result is a wide-ranging readable book, full of vivid (and at



times frightening for the non-nurse) vignettes of daily nursing life and often illuminating quotes from front line nurses. Growe has captured the essence of most of the issues affecting nursing today and has done so in the words of the nurses themselves. She devotes a full chapter to the Grange Inquiry, examining the reasons why "nursing was put on trial," and its long-term implications to nursing. She views the inquiry as seminal to the developing consciousness and political maturity of Canadian nursing even though much of nursing has been slow to translate this knowledge into effective action.

Other chapters examine the history of nursing in Canada, the decline of our health care system, struggles within and between various nursing professional organizations and unions, nurses' strikes, the debate over nursing education and the reasons behind the nursing shortage. For the non-nurse reader, much of this information will be interesting and fresh; the nurse reader may find much that is familiar.

Although Growe fleshes out many of the issues she raises, readers at times may be left wanting to see a fuller, more organized discussion of a particular issue. For example, a chapter titled, "*Women's Work: It Ain't Necessarily So*," looks at the connections between so-called women's work and nursing. The chapter begins with the story of Alberta nurse Barbara Jane Howell who "cared too much." Fol-

lowing a doctor's order, Howell administered a fatal dose of morphine to a dying baby and later was brought before a provincial inquiry examining the events leading up to the death. She subsequently lost her nursing license for one year.

The example opens the discussion of the role of feminism in nursing. Growe shows how the association between caring, women and the position of women in society has worked to disempower nurses. She also tries to show how this association has worked against nurses, even in the feminist community, where she says, feminists have counseled nurses that the road to success was medical school.

Unfortunately, this section seems too short and at times simplistic. Growe states that "among nurses, feminism is a dirty word," (p.122) and that University of Toronto nursing students say women become feminists "only because they are 'ugly and can't get a man'" (p.123). Although it is true that many nurses would not consider themselves feminists, she overlooks the gains feminism has won for nursing and how some feminist positions have, over the years, become part of every women's consciousness.

Another flaw in Growe's approach may be caused by her laudable goal to have nurses themselves tell the story. She relies heavily on quotes from nurses to move the text along but the quotes tend to be quite short and consequently at times a little unclear. On some topics the reader wonders if the quotes are really set in the context meant by the speaker; on others they are tantalizing and the reader wants more, to begin to understand how the speaker really feels. For example in the chapter, "*Turf Wars*," describing lack of unity in the nursing profession, Growe paraphrases nurse sociologist Marie Campbell saying that she "is not confident the industrial-relations model can solve professional issues (p.111)." In an earlier chapter on the Grange Inquiry, nurse Phyllis Jensen is enigmatically paraphrased as saying "nurses refuse to acknowledge their own history (p.43)."

Both these statements beg fur-

ther exploration. The women quoted are accomplished feminist scholars who were nurses first. Neither of the quotes does justice to the speakers' ideas or research; nor do they do justice to the nurses they are apparently commenting on. Grove could have made better use of these and other interviews.

This book provides a useful starting point to any investigation of the root of the malaise facing nursing today, especially to the non-nurse reader. Nurse readers may find themselves familiar with much of the information and may also want to quibble with some of the details. Grove has a habit of presenting what is essentially opinion and analysis as fact. This may diminish the credibility of the book among readers who are well versed in the issues facing contemporary nurses.

Despite its minor flaws, the book is an important and useful one in its attempt to have nurses tell their own stories and to draw together a description and an analysis of the most important issues facing nursing and ultimately the entire Canadian health care system today.

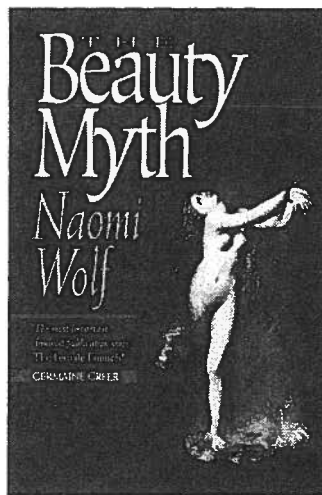
Lisa McCaskell is a registered nurse and freelance writer working in Toronto.

The Beauty Myth

Naomi Wolf, Vintage Books (Random House), Toronto, 1991, 348 pp.

Reviewed by Marni Norwich

IN 1983, TELEVISION ANCHOR-woman Christine Craft filed a suit against her ex-employer Metromedia Inc. on the charge of sex discrimination. The 36-year-old had been discharged on the grounds that she was "too old, too unattractive and not deferential to men." The firing occurred after being subjected to months of fittings and beauty treatments spared her male colleagues. She was also made to purchase a new wardrobe she would never have chosen herself. During the course of her trial, her colleagues suggested she was a lesbian and asked on national television if she was really "unique among women in her lack of appearance skills."



Craft lost the trial, and went on to write *Too Old, Too Ugly and Not Deferential to Men*. "Metromedia was wrong if they thought a woman would never admit to having been told she was ugly," she wrote, explaining how her former employer had no doubt expected her to remain silent out of a sense of shame. Craft was blacklisted in her profession and despite fighting back, the attack on her appearance markedly damaged her self-esteem: "Though I may have dismissed intellectually the statement that I was unattractive, nonetheless in the core of my psyche I felt that something about my face was difficult, if not monstrous, to behold."

"Beauty...has been usefully defined as something that is continually bestowed from the outside and can always be taken away," writes Naomi Wolf in *The Beauty Myth*. And the Craft case illustrates aptly that a very different standard of beauty exists for women than for men. Defenders of the ruling argued that Craft was not fulfilling her job title if she was not bringing in audiences as a result of her appearance. That their beauty did not affect the perceived competence of her male colleagues is evidence of an entrenched double-standard.

Since the Craft ruling, writes Wolf, the profession of image-consultant grew eight-fold, and cosmetic surgery became the fastest growing medical specialty and a \$300-million industry. Professional women are finding it necessary to spend up to one-third of their income on "beauty maintenance."

The time, energy and money

spent in the pursuit of a physical ideal is a drain that women can ill-afford. It is no mystery that 30 years after the onset of the women's movement, the battle for equality rages on. Although women comprise 52.4 per cent of the United States' total population and 54 per cent of college undergraduates, writes Wolf, we are two per cent of top management, three per cent of full professors and five per cent of senior partners. Corporate women vice-presidents and above earn 42 per cent less than their male counterparts. Women earn 54 to 66 cents to the male dollar.

This is no arbitrary glass ceiling, but the statistical manifestation of a complex, all-pervasive backlash to feminism. Naomi Wolf has titled the phenomenon the beauty myth; for the attainment of an elusive physical ideal is at its core.

Borne of a political and economic need to replace the severed yokes of Victorian morality and mid-20th century housewifery, the beauty myth disempowers women at every level, countering newly-won equality with subjugation and stagnation. The ultimate tool of suppression against an emerging class, the myth utilizes the shame and compliance of its victims, the women themselves, in fulfilling its mandate.

Hailed as the direct descendent of *The Second Sex* and *The Female Eunuch*, *The Beauty Myth* counters the persuasive force of our woman-denying culture with solid research and clear-headed, eloquently delivered logic. Wolf emerges as philosopher, poet and visionary, empowering the reader with her commitment to name the truth.

Women are seduced by the beauty myth because it holds the promise of power, writes Wolf. We will continue under this enchantment until we recognize that this power may be revoked as arbitrarily as it is granted, that their beauty has become the Achilles heel of all women, that the beauty myth was created to hold women's progress in check. And it's working.

Marni Norwich is a 30-year-old magazine journalism major at Ryerson in Toronto, and co-editor of the Ryerson literary journal, "White Wall Review."



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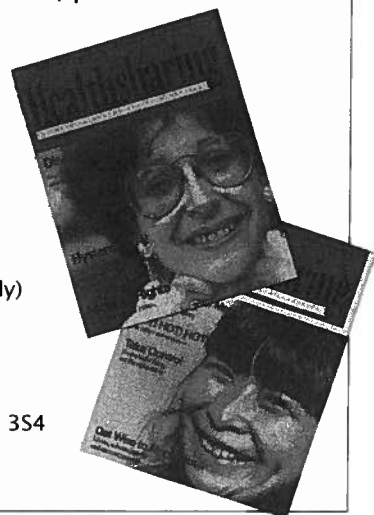
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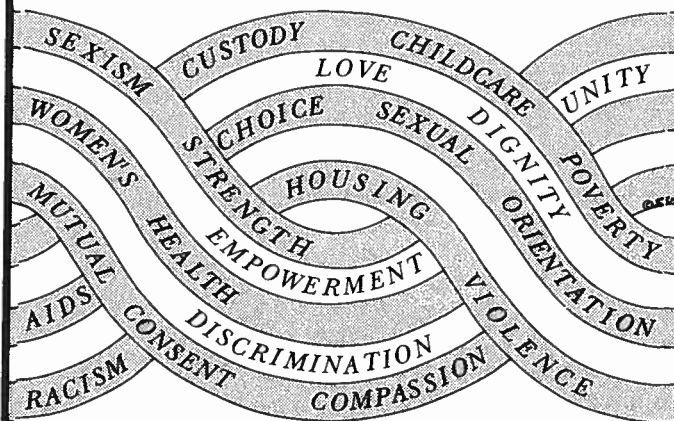
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The Women's Project/Comité E.L.L.E.S
of The AIDS Committee of Ottawa/
Le Comité du sida d'Ottawa.
287 Dalhousie St. Ottawa, Ontario
K1N 7E3

AIDS DOES NOT DISCRIMINATE



RESOURCES & EVENTS

Midwifery in Nova Scotia

The Midwifery Coalition of Nova Scotia is holding a Conference and Annual General Meeting, Saturday, October 4, 1991, 9 a.m. to 5 p.m., Unitarian Church, 5500 Inglis St., Halifax. Keynote speaker is Dr. Barbara Parish: "Midwifery in Nova Scotia: Empowering Families." Child-care available with pre-registration.

For more information contact Deborah Luscomb, (902) 477-7865 or Catherine Slone, (902) 423-2302.

There and Back

There and Back: Sharing Our Stories is a book written as part of the "Easier to Read: Easier to be Healthy" Literacy and Health Project at Lawrence Heights Community Health Centre. A group of women came together to write about an important health issue, being mothers. The stories can be read by individual women or to begin discussion around such topics as addiction, adoption, violence and abuse, parent-child relationships and young motherhood. Excellent for health and social service professionals or as a learning tool for community adult literacy programmes and other educators.

There and Back: Sharing Our Stories is available for \$7.95 plus \$2.95 postage from Lawrence Heights Community Health Centre Press, 12 Flemington Road, Toronto, ON, M6A 2N4, or phone (416) 787-1672 or fax (416) 787-3761

CRIAW Conference

The 15th Annual CRIAW Conference entitled Global Vision Globale/Local Action Locale will be held in Edmonton, Alberta, Novem-

ber 8 to 10, 1991. Keynote speakers are Claire Bonenfant, vice-president of regional councils at the Fédération des femmes du Québec and Glenda Simms, president of the Canadian Advisory Council on the Status of Women.

For further information contact Marcelline Forestier, Conference Coordinator, at (403) 492-8950

STD Handbook Revised

Montréal Health Press, a non-profit women's publishing house has just released a new up-to-date revised edition of *STD Handbook, a book about sexually transmitted diseases*. Clearly written and easy to read, the booklet examines the political and social issues which contribute to the present STD epidemic and provides information on the diagnosis and treatment of all STDs.

Available in English or French (les maladies transmissibles sexuelles), single copies cost \$4. Bulk order rates with per copy costs as low as \$.80 for orders of 500 or more are also available from Montréal Health Press Inc, C.P. 1000, Station Place du Parc, Montréal, Québec, H2W 2N1, (514) 272-5441.

Womenspirit

Womenspirit is a 12-minute video produced by the Native Women's Resource Centre of Toronto that presents family violence in light of traditional native values. During counseling an abused mother of two children is introduced to the women's circle where the elders describe the traditional views of women; that they are sacred and honoured. The children learn about the traditions associated with family life and the native community.

Available for \$45 (\$35 for native groups) from the Native Women's Resource Centre, 245 Gerrard St. East, Toronto, M5A 2G1, or phone (416) 963-9963, fax (416) 963-9573.

Redesigning Health Care

Spirals publishes analyses of various women's issues, research results, conference proceedings and other topics related to the women's movement and to feminist research. Publications include *Redesigning Health Care for Women*.

Available for \$5 from Spirals, Women's Studies Programme, University of Ottawa, 143 Séraphin Marion, Ottawa, ON, K1N 6N5, (613) 564-4019

Working Together

Working Together for Women's Health: A Framework for the Development of Policies and Programs is a publication prepared by the Federal/Provincial/Territorial Working Group on Women's Health with assistance from Anne Rochon Ford. It acknowledges the vital importance of health promotion in improving the overall health of Canadian women and emphasizes the need for research and appropriate services for women.

Available free of charge from ministries of health in the provinces and territories or from Health and Welfare Canada, The Office of the Senior Advisor Status of Women, (613) 957-1943.

Chronic Pain Support

The North American Chronic Pain Association of Canada (NACPAC) was founded in 1986 by Dianne Cachia to help people like herself cope with chronic pain in a positive and constructive manner. NACPAC provides information and peer support with 19 local groups across Canada and encourages members to "focus on becoming a person rather than a patient."

For more information, write to NACPAC, 6 Handel Court, Bramalea, ON, L6S 1Y4.