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The Maine Commission for Women Staff
The Maine Commission for Women

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Inform

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FROM THE CHAIR

Celeste Branham

My two-year term as Chair of the Maine Commission for Women will end on June 30, 1986. When I first accepted the position of Chairperson in July 1984, I did so with the conviction that any chair worth her grain of salt would, if dedicated to the organization, retire as graciously as possible at the end of two years. The selection of a two-year cut-off was fairly arbitrary on my part, but it is grounded in the notion that one reaches the point of diminishing effectiveness fairly quickly and an infusion of new blood periodically into an administrative body such as the MCW is not only appropriate, but necessary. I retire now to preserve the vitality of the Commission, and my own as well.

I will leave with a mixture of regret for projects not yet accomplished and ideas not yet implemented. On the other hand, I feel privileged to have participated along with many others in the steady transition the Commission has made from infancy to adolescence. We certainly have not reached the end of our maturation process, but we are gaining in new-found strength, confidence, influence, and commitment to women.

The Maine Commission for Women has carved out new and exciting territories in the last few years which uniquely affect women and their families. Although some interested observers have argued that we have not been adventurous enough in our representation of women, that we have lacked the lustre of controversy in our initiatives, others have cautioned against provoking an irreparable backlash which may counter the advancement of women's political, social, and economic interests. We have remained somewhere in between in a realistic effort to preserve our longevity, a pressing question the Commission and its friends have faced in recent times and will continue to meet in the foreseeable future.

Upon reflection, the most difficult aspect of my work as Chair, and perhaps the most important, has been the repeated attempts to persuade the "powers that be" of the legitimacy of our cause. As was evidenced by the overwhelming defeat of the Equal Rights Amendment in Maine, public sentiment is that women are well enough off and should not be accorded any special benefits or consideration. The statistics describing the feminization of poverty in this State represent a direct contradiction to that prevailing opinion.

Issues of child care, economic viability, access to non-traditional occupations, work-related education and training, Aide to Families with Dependent Children, violence against women, family planning and reproductive choice, teenage pregnancy, and health awareness are only a few areas in which Maine women and girls are indeed not well off. The Maine Commission for Women is now very actively involved in promoting these issues, and even more energy and resources must be dedicated to that effort in the future.

While we will continue our own work to frame these issues and press this critical agenda, our initiatives must be joined by the many groups and individuals aligned with the Commission's purposes. We are only now on the threshold of increased influence in improving the quality of women's lives. We welcome you to accompany us on this trek.

I am deeply appreciative to the staff of the MCW and to my sister Commissioners for their patience, wise counsel, and support through my term of service. Most especially, I thank them for the greater understanding and respect for womankind I have gained through them.

THIS ISSUE: WOMEN AND HEALTH

For the last several issues we have concentrated on a theme. In this issue we focus on "Women and Health." Under that heading one could address thousands of issues at length: general health, fitness, pregnancy, menopause, breast cancer, cervical cancer, smoking, toxic cosmetics, midwifery, women in the medical professions and so on. The important thing is for the women to start caring about and caring for their own health. We live in a society where we are valued as care-givers often neglecting to give care to ourselves.

We need to learn about our bodies, learn about the medical industry, learn to be "smart" patients and keep our physical and mental well-being. After all, we need healthy women, and lots of them, to do the work necessary to bring about women's equality.

The MCW hopes that you enjoy and benefit from this focus on health. For further information or to give **us** information, please don't hesitate to contact the office.

INSIDE THIS ISSUE

LEGISLATIVE WRAP-UP

The second regular session of the 112th Maine Legislature has adjourned, and, overall, the session was a successful one for the women and families of Maine. Of the 13 pieces of legislation supported by the Maine Commission for Women, we won ten, lost two, and one bill was withdrawn. This session the Commission focused on the areas of child care, violence against women, economic equity, and health. What follows is a brief wrap-up of the session.

CHILD CARE

$50,000 was appropriated to fund a community grant program through the State Office of Child Care Coordination for before and after school child care programs. (LD 1907)—The portion of LD 1907 which would have required employers who received state funds in excess of $200,000 to establish a written policy concerning assistance provided employers in meeting child care needs did not pass. There will be efforts to reintroduce legislation designed to encourage or require employers to assist employees in meeting child care needs.

The State income tax credit for child care expenses will increase from 15% to 25% of the Federal Tax credit over the next three years. (LD 1826).

The bill that would provide tax credit to employers who assist employees with child care costs (LD 1864) was passed by the legislature by **not** funded by the Appropriations Committee and thus will not go into effect.

VIOLENCE AGAINST WOMEN

The Legislature appropriated $17,000 to establish a rape crisis center in Augusta. Three years ago, when the legislature appropriated $100,000 to fund the eight existing rape crisis centers in Maine, there was not a center in Augusta and, until this recent appropriation Augusta remained the only major population area in Maine without a rape crisis center. (LD 1793).

The bill to establish a state-wide toll-free hotline for victims of sexual and domestic assault (LD 2003) received enthusiastic support from the Appropriations Committee and was passed by the full legislature, but was withdrawn when the organizational sponsors encountered planning difficulties. The withdrawal of the bill should not hurt its future chances, and we hope to see this needed legislation reintroduced next session.

Although **not** a bill about violence against women, the Christian Civic League used that issue in an effort to gather support for LD 2092, "AN ACT to Prohibit the Promotion of Pornographic Material in the State of Maine," making the case for a direct link between pornography and violence against women. While studies have differed on this link, the Commission's position is that there are other, more effective ways to combat pornography and violence against women: sex education, provision of rape crisis and battered women's shelters and services, community education about sexual violence, toll-free hotlines (all efforts the MCW is involved in). This bill does nothing to help these efforts, and because of the way the bill is drafted, many of the educational materials used in these efforts could be considered "obscene" and thus illegal. This bill poses a dangerous threat to our ability to choose what we will read or see, while doing little or nothing to stop violence against women. The bill was defeated in the legislature and will now be voted on in referendum on June 10 in the primary elections.

ECONOMIC PARITY

The Welfare Department, Education and Training (WEET) Program received $213,000 in FY 86 and $557,000 for FY 87 which will help maintain services at current level. (LD 1876)—WEET provides training and job development skills for welfare recipients who wish to move from welfare into a job. Our legislature should be applauded for their support of this important program. Maine has responded to Federal cuts in this area more positively than almost all other states allowing this valuable and cost-effective program to continue.

One of the more significant losses of the session was the last-minute defeat of the increase in AFDC benefits. An amended version of the bill calling for a 5% increase was passed by both houses of the legislature and recommended for funding by the Appropriations Committee. However, in a 5-5 tie in the last days of the session, leadership failed to fund the bill. (LD 1896). AFDC benefits presently provide recipient families with a standard of living equal to only **one-half of the federally recognized poverty level.** Unlike Social Security, SSI, and the food stamp program which have annual indexing provisions which provide for cost-of-living increases, AFDC, which is the most basic maintenance program for our poor children, can only be increased by the legislature. The defeat this session demonstrates the urgent need for a statutory requirement of regular cost of living increases in the AFDC program.

HEALTH

Family Planning program will be able to maintain current services because of a $216,000 appropriations by the legislature (LD 2124). This bill, which had wide bipartisan support in both houses and among leadership, was almost lost in the final week of the session in political battling, but it ultimately survived. As the demand increases for Family Planning clinical services and family life education, federal dollars continue to decrease. The struggle for adequate funding for these crucial programs will be an ongoing one.

The Committee on Human Resources worked long hours on drafting a new bill that passed with no problem "AN ACT to Protect the Public Health in Relation to AIDS" (LD 2367, formerly LD 2063). The bill establishes an advisory committee on AIDS which will advise the Department of Human Services on the content and dissemination of educational materials, coordination of services to AIDS patients and their families, and AIDS related policy. This committee will be representative of the community at large and interested groups and will include representatives from high-risk groups. The bill also provides funding and personnel within the Bureau of Health for the dissemination of educational materials, provides for the confidentiality of the results of the HTLV-III test except in certain specific instances and prohibits insurers from asking whether a person has taken the test for HTLV-III virus or what the test results are. The new draft deleted the provisions prohibiting discrimination because the Maine Human Rights Act already prevents discrimination based on physical handicap or perceived physical handicap.

The Nurse Practices Act was revised to reflect contemporary nursing practice. (LD 2061). The bill revised the definition of nursing to encompass increased complexity in nursing care and the shift of demand from hospitals to care in the community. The bill also makes major changes in educational requirements for licensure—beginning in 1995 there will be only two levels of nursing: **Professional**—An RN who will have completed a four-year baccalaureate degree program and **Technical**—An LPN who will have completed a two-year associate degree program. Currently, an LPN completes a one-year program and RN's may have completed a two-, three-, or four-year program. This bill was controversial because of the questions of whether the expense and time commitment of a four-year program would exclude many people from the profession and whether the existing four-year programs will be able to meet the demand for professional nurses. The final draft of the bill requires that before the two-level system goes into effect in 1995, a legislative commission study the above problem and make sure that educational programs are accessible to all areas of the state that credits are transferable and that existing programs can guarantee a sufficient supply of professional and technical nurses.

Beginning next January 15, Martin Luther King, Jr. Day will be an official state holiday. The debate of this bill brought Maine's Civil Rights leaders, past and present, to the State House to lobby for the importance of recognizing in this way the contribution of Dr. King. The opposition was primarily centered around the fact that another state holiday would "cost too much." There were also questions about why Martin Luther King, Jr., when there are other great Americans who are not recognized. In the public hearing and during the debate, it was generally recognized that Dr. King's struggle for civil rights for Black Americans was really a fight for civil rights for **all** Americans and made a direct contribution to movements of many other oppressed peoples, including the women's movement.

Overall, the Legislative Session was a very successful one for the MCW, but there are signs that the 113th Session will be a challenging one. Many incumbent candidates who have supported our issues will not be running again. Thus changing the face (and faces) of the Legislature.

Already the Commission is beginning to work with other groups in the Women's Legislative Agenda Coalition on bills for next year. If you have an issue you think should be persued through the Legislature, please let us know. As the League of Women Voters' says, "Democracy is not a spectator sport."

Many thanks to Mimi Marchev, lobbyist for the Maine Women's Lobby, for her help in preparing this report.

REFERENCES TO ARTICLE ON PAGES 4 and 5

1. *U.S. Department of Health and Human Services, Public Health Service. Report of the Public Health Service Task Force on Women's Health Issues, Vol. 1, Jan.-Feb. 1985, Vol. 100, No. 1.*
2. *Fuchs, Victor. How We Live. Harvard University Press. Cambridge. 1983.*

CANCER: A LONG DAY'S JOURNEY INTO LIFE

by Tinnel Jones

The following article was written by Tinnel Jones. In July of 1983, she was diagnosed as having breast and lymph node cancer. At the time, Tinnel was adamant about not having her physical body altered due to this cancer. She spent a year researching and trying alternate methods of treatment. She became a macrobiotic; practiced visualization; and pursued Eastern medicine treatments. At the end of a very draining winter, she had dwindled down to 96 pounds and received word that her cancer had spread to her bones.

It was at that time that Tinnel made the decision to return to California, her home state, in the pursuit of warmth, a little more comfortable lifestyle, and a new approach to her cancer. Now, two years later, after chemotherapy and radiation, and an intense desire to live, Tinnel has been told she no longer has breast, lymph node or bone cancer. She will move back to Maine this fall. What follows is her story.

Three years ago, divorce and cancer combined to turn my world upside down. Alternating between terror and denial, I embarked on a healing journey that, despite a frightening beginning, has given me the strength not only to reclaim my life, but to boldly assert its value.

You've read this kind of stuff before, right? I had, too—about exceptional women who have triumphed over Major Life Accidents—exceptional meaning that they were "exceptions"—somehow different than you and I. And I always thought, how wonderful to have that kind of courage and tenacity—qualities I was quite sure I did NOT have.

WRONG. We all have it. We just may not have been called upon to use it. I had a fairly trauma-free life until I got cancer and a divorce at the same time. Then it was time to call on that inner strength (that I was sure I didn't have). "But," you say, "I can't call on something I don't believe is there." Right. Neither could I. That's where support groups and networks come in. I KNEW I didn't have any inner strength, whatever that was. And I pointed to the lousy circumstances of my life to "prove" it.

But fortunately my friends and loved ones disagreed strongly. "You do, too!" They saw through the circumstances of my life to the strong, capable woman who is the REAL me. It was that essential me who was wise enough to trust my friends' judgment over mine, clouded as it was by my despair.

They even suggested that I ask for FINANCIAL support from them to make a trip to California (my native state) to seek treatment , something my despair would never have considered. I did ask, and as they gave to me, each one thanked me for the opportunity to contribute to my life. It was the first of many such affirmations of my intrinsic worth I would hear—I was loved, and in my fight to live, I was far from alone. I promised I would not only go to California but would get into a structured treatment program there.

Now I had made a commitment to others. I wasn't yet able to commit to myself—that involved discipline and self-esteem, and I had little of either. But I was determined to keep my word to so many who were obviously invested in my getting well because they cared for me, and for no other reason.

When I reached California after a 3,500-mile drive, I stayed with friends and family and began my search for doctors, therapists and others who would support me. It's amazing how people just dropped into my life. Goethe says: "...the moment one definitely commits oneself, then Providence moves too. All sorts of things occur to help one that would never otherwise have occurred. A whole stream of events issues forth from the decision, raising in one's favor all manner of unforeseen incidents and meetings and material assistance which no one could have dreamed would come her way." And it's true. Once I made a commitment TO MYSELF, the universe lined up with me and sent me what I needed—money, treatment, support groups, love.

But first I had to consider myself worthy of all this 'trouble.' My life was at stake, and saving my life was now my first priority—not 'business as usual.' It required drastic steps—I left my friends, my job, and hardest of all, my three-year-old daughter. As a friend pointed out, however, "if you don't go and take care of YOU, your daughter won't HAVE a mother." My absence from her, though painful, is in the short run; my victory over cancer and my ability to embrace life is the long run. I now say, go for the long run; the short run will take care of itself.

What did I learn from this? I learned, over and over again, that I do not have to take what life dishes out; I can CHOOSE something else if I don't like what's on the menu. I have learned that I am a lovable, worthwhile person in my own right, that I don't have to do anything to prove that—to myself or anyone else.

I have had losses along the way (my hair, for instance—but it grew back several times, so I guess it's stronger than I thought!), but many of them were good riddance. I lost the habit of saying, "Well, what can I do? That's JUST THE WAY IT IS." Now I say, "I know there are at least five ways around this, and I'm going to find out what they are." 'No Solution' is not a solution for me anymore. It's true—success breeds success. The more I solved problems, the more I realized I will always be able to solve problems.

Another one I gave up was "I have to do this all by myself." How arrogant to assume you have all the solutions—or, that because YOU have none, there are none to be had. Reach out! There are tons of people out there whose wisdom and experience are yours, literally for the asking—counselors, friends, women who had your problem and licked it. True to my promise, I found the Cancer Support and Education Center here, whose two-week intensive program featured sessions led by people who HAD beat their cancer. It was exactly what I needed. I was taught how to ask my body what it wanted (instead of living exclusively in my head), and I learned to listen to what it said, then give it THAT. I found tears to release old hurts that had become imprisoned, locked up in my body—anger at life, turned inward.

Even if your first question is "But I don't know how to ask," take heart. There's someone out there who can show you how to do that, too.

And with love. You'll find so much love directed

to you that you'll make the ultimate discovery—you'll start to love you, too! Dr. Bernie Siegel, a Connecticut surgeon and founder of Exceptional Cancer Patients, has observed hundreds of patients and noticed a startling behavior in those who survived. "I am convinced," he reports, "that unconditional love is the most powerful known stimulant of the immune system. If I told patients to raise their blood levels of immune globulins or killer T-cells, no one would know how. But if I can teach them to love themselves and others fully, THE SAME CHANGES HAPPEN AUTOMATICALLY. The truth is: Love heals." If you must see yourself as a lovable person through someone else's eyes first in order to care about yourself (as I had to), fine. If you could have done it in the first place, you wouldn't be in the situation you're in.

I consider the past three years as an investment in myself. The improvement in my outlook, the strength I've gained, that's me—I did that. Oh, yes, I had a lot of help—I asked for it, and it was gladly given. But now I have my own strength. I can't control the circumstances of my life—none of us can. I CAN control my response to those circumstances. Now I know—THERE ARE ALWAYS OPTIONS. And falling apart—sacrificing my health, my life—is one I don't consider any more.

I'm not saying it was a straight line from there to here. Genius, they say, is 1% inspiration and 99% perspiration! Well, so is personal growth. And I did mine often in a state of mind that told me I couldn't do it. However, having a life-threatening illness removes that gray area we're so used to functioning in most of the time: "Should I? Shouldn't I? Maybe tomorrow..." So I learned to tell my mind a thing or two. SO WHAT!? I said. So what if I can't do it today? I did what I could today; there's always tomorrow to do a little more. Chemo and radiation are very fatiguing. I learned that having a bad day didn't mean being resigned to having a bad forever. Like they say in Alcoholics Anonymous, don't try to be God—take it one day at a time. I've learned to throw away the whip and be gentle to myself.

So reach out—discover what others have known all along—you are a priceless, valuable, wonderful woman—and the world is waiting for you to bloom. "Whatever you can do, or dream you can, begin it," wrote Goethe. "Boldness has genius, power and magic in it. Begin it now!"

SOCIAL FACTORS AFFECTING WOMEN'S HEALTH

By Deborah Deatrick

Deborah Deatrick is the Director of the Office of Dental Health for the Department of Human Services. She also serves as President of the Maine Women's Lobby and as Vice-President of the Maine Publ ic Health Association.

INTRODUCTION

Women's health issues in Maine reflect similar patterns across the United States. This article examines the status of women's health from a national perspective, and summarizes a recent report from the U.S. Public Health Service (1985) on women's health issues.

IN RECENT DECADES, women in the United States have undergone a revolution in their self-perception and their traditional relationships to work, money, marriage, and family. These societal changes have implications for every aspect of women's lives, including health and illness.

Differences among women may stem from such enduring characteristics as age, race, or ethnicity as well as from such variables as marital and household status, urban or rural living, education, occupation, and income. Research and service programs planned to meet women's health needs must be aware of these differences.

It is well recognized that improvements in health status are less likely to come from technological "break-throughs" than from improvements in environmental and social conditions, changes in lifestyle and behavior, and participation of people in maintenance of their own health. As leading causes of illness and mortality have shifted from infectious diseases and other acute problems to chronic illness and accidents, the need to focus on environmental conditions and health-promoting behaviors has increased.

Identifying ways of modifying unhealthful conditions and behaviors is particularly relevant to the improvement of women's health. Although women in the United States live an average of about eight years longer than men, they have higher rates of illness, experience more days of disability, and utilize more health services than men—even when pregnancy-related services are discounted. It has been suggested that women's health-seeking behavior and their lifestyle characteristics contribute to their greater longevity.

CULTURAL AND SOCIAL VALUES

Human behavior is shaped by current cultural and social values and societal attitudes. Perhaps nowhere, and at no time, have social values been more diverse, more in flux, and more open for discussion than in the United States in recent times.

Existing sex-role behavior has demonstrable effects on morbidity and mortality. For example, the well-documented greater willingness of women to admit symptoms and seek help may have a protective effect on their health. Women's behavior, which is often less risk-taking than that of men, may protect them from violent accidents and death, but it may also keep them from competitive activities that lead to physical fitness and greater mastery of the environment. Society's expectation of more passive and dependent behavior by women has been associated with the fact that depression is three times as prevalent among women as among men. Social change in sex-role expectations is thought to be a factor contributing to the increase in lung disease.

Changing sexual attitudes have given women of all ages the potential for greater freedom and greater choice in sexual matters. Changing sexual behaviors have had various health outcomes, including a reported decrease in the numbers of women seeking help for frigidity and sexual phobias and an increase in the prevalence of sexually transmitted diseases. Among women of childbearing age, concern about the efficiency and safety of contraceptives has increased as knowledge of health hazards has become more available.

Concerns about physical appearance and youthfulness have long been more important to women than to men. More recently, extreme thinness has become a goal of women of all ages, particularly young women. Dieting has become the norm. Eating disorders, such as anorexia and bulimia, and menstrual disorders associated with reduced body fat are increasingly prevalent.

There is a greatly altered public perception of the role of exercise and physical fitness in women's lives that is reflected in school athletic programs, competitive games for girls and women, and the greatly expanded participation by women in the Olympics. The behavioral changes reflected by this emphasis on physical fitness among women may have long-term positive effects on many aspects of women's health. This recent increase in awareness of health and fitness has included concern for nutritional status, and many more women are now aware of the relationship of diet to healthy functioning at all stages of life.

The communications media have become major agents of socialization in this century.

Research on the influence of the media on health has been limited, but it is thought that the images of youth and beauty that are projected may contribute to excessive female concern about weight. Though cigarette advertising is no longer permitted on radio and television, cigarette ads directed toward women dominate other advertising media. It should be noted that the media have the potential to be used more effectively for educational campaigns addressing such health-related issues as smoking, nutrition, exercise, and alcohol and drug abuse.

ECONOMIC STATUS

Poverty and ill health are interrelated. Disadvantaged people become ill because of poor nutrition, poor living conditions, high levels of stress, and reduced access to health care. As a result of these conditions, illness may occur with greater frequency, causing those persons to miss work or lose jobs and become even poorer.

As a group, women are economically disadvantaged in comparison with men, regardless of age, race, ethnicity, education, or employment status. Poverty rates have long been particularly high among black, Hispanic, and Native American women, especially those who are single heads of households. They are now being joined by the "nouveau poor"—white middle-class women raising children alone and older women subsisting on small, fixed incomes. Overall, almost 78 percent of the poor in the United States are women and children. Among the elderly poor, 74 percent are women. Thirty-five percent of all households headed by women, but only ten percent of those headed by men, were below the poverty level in 1981.

Among women of all races, a greater proportion of low-income women than of high-income women perceive that their health status is "fair" or "poor." Similarly, low-income women utilize hospital services more than high-income women. Low-income women of all races use more ambulatory services than their male counterparts.

Mortality rates long have been used as reliable indicators of health conditions because, unlike perceptions of health or the decision to use services, they do not reflect judgment but rather facts. While national rates of maternal and infant mortality have declined significantly, they continue to be higher for minority women, unmarried women, and rural women—all groups that have high rates of poverty.

PARTICIPATION IN THE LABOR FORCE

The rapid rise in the participation of women in the labor force has been the most far reaching change in recent years.

The long-term effect of multiple roles on the health status of women has received some attention from researchers, but results are equivocal. Studies have shown that gainfully employed women are healthier and generally more satisfied than housewives. It is not known whether this is the case because healthier women take and keep jobs outside the home or whether the jobs, by providing self-esteem, income, and status, result in better physical and mental health.

Contrary to popular belief, symptoms of stress among professional and managerial women are not as frequent as among clerical workers. Symptoms of stress have been found to be more frequent in women with jobs that offer limited opportunities or women who have "dead end" jobs.

Women employed in occupations in which male predominate may have special safety and health problems. Equipment designed for men is often too large for women and thus may be ineffective or even hazardous. In addition, sexual harassment on the job can hinder work performance, increase stress, and lower women's moral.

INTERACTIONS WITH THE HEALTH CARE SYSTEM

Studies have repeatedly shown that women and more likely than men to report symptoms of illness and to utilize health services. What is not clear is whether these statistics reflect real differences in morbidity or some combination of gender-related differences in income and age structure, illness behavior, access to care, and response of the health care system.

While health maintenance and treatment services may not guarantee good health, they can avoid, halt, or ameliorate the progression of many diseases. Differences in access to care by men and women, whites and minorities, and rural and urban dwellers all have been examined, as have differences in the way the health care system responds to women. Some research indicates that women are treated with less respect and dignity, that male physicians may be less sensitive to women's needs, and that psychotherapeutic medications are disproportionately prescribed for women. This may change as the increasing proportion of women graduates of medical schools begin to practice medicine.

A woman's health movement has emerged in recent decades to work toward improving the health care system for women. The movement includes lobbying organizations and caucuses and the development of alternative treatment services for women.

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WOMEN'S PHYSICAL HEALTH AND WELL-BEING

WHILE MOST HEALTH DISORDERS are not sex-specific, some problems are more frequent in women than in men, thus contributing to a significantly higher illness rate among women. This report includes a brief presentation of some of the disorders that are unique to women, or require special prevention and intervention strategies for women. It should be emphasized that while much has been and is being done in all the areas discussed, a great deal of research is still required.

CANCER

Cancer is the leading cause of death among women aged 35 to 54. Most cancer deaths among women are attributed to breast cancer, followed by cancer of the lung, colon and rectum, ovary, and uterus.

The number of deaths from lung cancer in women has risen 600 percent in the past 30 years, and by the mid-1980's lung cancer is expected to supplant breast cancer as the leading cause of cancer death among U.S. women. In fact, among women now entering the age group 65 to 74, lung cancer has already replaced breast cancer as the leading cause of cancer mortality. The National Center of Health Statistics reported that, from 1979 to 1980, the death rate for lung cancer increased 13 percent, compared with a two percent rise in the death rate for breast cancer.

Endometrial (Cervical Lining) cancer is the third most common cancer among women in the United States. The five-year survival rate for this malignancy is 34 percent for white and 35 percent for black women.

REPRODUCTIVE FUNCTIONS AND DISEASES OF THE REPRODUCTIVE SYSTEM

Women today have far more control over the timing of childbearing than ever before. In the United States, 29 million women use some form of contraception. Such birth control methods include oral contraceptives, intra-uterine devices, spermicides, barrier devices, sterilization, and interrupted pregnancies. All of these have varying degrees of acceptability and efficiency. Research on the use of brain hormones that control reproduction, on biodegradable implants containing contraceptive hormones, and on new barrier methods is aimed at expanding the range of contraceptive options presently available to both men and women.

U.S. women make more than 30 million visits to physicians each year for disorders of the reproductive system, excluding diseases of the breast. Many of these diseases are serious—including pelvic inflammatory disease, which may lead to infertility and even death.

Women who contract sexually transmitted diseases (STDs), including herpes and gonorrhea, have more serious physical problems than men because these women incur greater risk of subsequent infertility and cancer. Pregnant women with STDs are confronted by the additional risk of passing the disease on to their offspring.

The incidence of toxic shock syndrome, which once affected three to 14 every 100,000 menstruating women each year, seems to be decreasing. In 1982, as part of an effort to make women aware of the risk factors associated with tampon use, the Food and Drug Administration required tampon manufacturers to print a warning on the boxes used to package tampons.

THE MENSTRUAL CYCLE

Numerous disorders can be associated with menstruation. These range from amenorrhea, dysmenorrhea, certain premenstrual problems, and iron-deficiency anemia to problems associated with premature cessation of the menes and the consequences of menopause.

The causes of "premenstrual syndrome," its nature, and indeed its very existence remain nuclear. Hormonal imbalance, nutritional or chemical deficiencies, and neurobiological dysfunction have been suggested as associated factors.

CHILDBEARING—EARLY AND LATE

In recent years, much research has focused on two extremes in reproductive patterns: adolescent childbearing and delayed childbearing.

Pregnancy in very young teenagers can be risky to the physical health of both mother and infant. Furthermore, early pregnancy affects the education of the adolescent mother, her ability to prepare for an occupation, and income opportunities for life. The health and intellectual development of her children may suffer as well.

At the other end of the spectrum, the proportion of women who give birth to a first child after age 30 has increased from 3.9 percent of all first births in 1970 to 9.5 percent in 1981. From a socioeconomic perspective, these women benefit by delaying childbirth. From a medical standpoint, however, older women have a somewhat increased chance of experiencing complications during pregnancy and of subsequent infertility.

PREGNANCY

Dramatic improvements have been made in the health of mothers and children in the past two decades, due in large measure to better service delivery programs supported by agencies of the Public Health Service and to advances in prenatal and perinatal care based on findings resulting from biomedical and behavioral research. The maternal death rate from pregnancy and childbirth in the United States dropped from 36.9 per 100,000 live births in 1961 to 7.7 in 1981. During that same period, infant mortality dropped from 25.3 to 11.7 per 1,000 live births.

URINARY TRACT INFECTIONS

Urinary tract infections (UTIs) affect one in five women at some time during their lives. Such infections tend to recur and account for more than six million visits by women to physicians each year. Women are about five times more likely than men to develop UTIs. If these infections are not detected and treated in the early stages, kidney damage may occur. It has also been suggested that pregnant women with untreated UTIs may be at risk for premature delivery.

OSTEOPOROSIS

This debilitating chronic disease affects some 20 million Americans, especially older women. It is estimated that about 1.3 million fractures attributable to osteoporosis occur annually in people 45 years of age and older. Current data point to estrogen and calcium deficiencies as the major cause of primary osteoporosis. A recent NIH Consensus Development Panel recommended estrogen replacement therapy where appropriate, calcium and vitamin D supplements, and modest weight-bearing exercise to prevent and control this disease.

WEIGHT DISORDERS

More than 25 percent of American women between ages 20 and 74 are considered overweight. Obesity is known to be less prevalent in women of higher socioeconomic status and is most common in both black and white women in the lower income group.

It has been estimated that one out of 200 American girls between the ages of 12 and 18 will develop some degree of anorexia nervosa and that ten to 15 percent of those with this disorder will die. In bulimia, patients indulge in food binges and then purge themselves either by inducing vomiting immediately after eating or by taking laxatives and diuretics.

SYSTEMIC LUPUS ERYTHEMATOSUS

This potentially fatal connective tissue disorder strikes some 50,000 people each year. Almost 90 percent of its victims are young women. The disorder may affect the kidneys, heart, lungs, or central nervous system and is three times more common in black women than in white women. Although since 1955 the proportion of lupus patients who survive an average of four years after diagnosis has increased from 50 percent to more than 95 percent, many still succumb to the disease.

THE IMPORTANCE OF EXERCISE

A ten-year study of longevity in America has shown conclusively that regular exercise, along with other good living habits, can help increase life expectancy by as much as seven years for women and 11 years for men. Physical exercise contributes to good health by enhancing musculoskeletal strength and flexibility, improving the efficiency of the heart and lungs, and assisting in weight reduction. Among the benefits of weight reduction are prevention of adult onset diabetes, reduction of emotional stress, and strengthening of stamina and self-image.

USE OF COSMETICS, COSMETIC SURGERY, AND MEGAVITAMINS

In order to meet contemporary societal standards of an attractive image, many women use facial cosmetics, diet aids, perfumes, douches, creams and lotions, bath products, special hair shampoos, and hair dyes and conditioners. In addition to using cosmetics, women may choose to alter their appearance through reconstructive or plastic surgery (for example, face lifts, breast reduction, and breast enlargement).

For many women who need reconstructive surgery following cancer or accidents or in order to correct birth defects, such alterations can affect both mental and physical health in a positive way. For healthy women who choose surgical means to improve or alter their appearance, the effects may also be positive but should be balanced with the risks associated with such procedures. For example, silicone implants pose a potential risk since the silicone gels have been known to leak and, in rare instances, to break.

"Fad" diets (for example, liquid protein) may have severe and even fatal consequences. Use of megadoses of vitamins (particularly vitamins A and D) may have adverse health effects as well.

TALKING WITH ME

The Skyward Drug Abuse Program

by Sally Rose

I walked into the entryway and opened the heavy, solid oak door which leads into the front foyer of a well-kept Victorian home. This foyer serves as reception area for Skyward, a women's drug abuse center in downtown Rockland. Having announced my name, I waited a few minutes for my appointment with Amy Barnett and Marcia Jamrog, both Registered Substance Abuse Counselors. While sitting in the foyer, I heard women in the adjoining livingroom. Their voices were getting stronger with each round of the following chant:

"We are the old women
We are the new women
We are the same women
Stronger than before"

Later upon asking the origin of this chant, I was told it was used by the Suffragists at the Seneca Falls Conference in New York in 1848. The eight counselors at the Skyward inservice meeting that day were exploring the use of this chant for their group counselling sessions to help empower their clients.

The Skyward program began in 1978 when Paula Roth took advantage of a new wave of funding for women's programs. The Community Alcohol Services program in existence at the time was dominated by men—98%. Paula believed this was an inaccurate representation of the ratio of men to women substance abusers. In fact, the figures today are 50-50 for recovering alcoholics.

Skyward serves women of all ages, socioeconomic base and substance abuse problems. Their programs are tailored to fit both the abuser and the co-dependent. Their philosophy is when there is a substance abuser in the family, there is also a caretaker who emotionally supports and feeds off the alcoholic personality. 50% of their clientele are women who are co-dependents, and children (as young as six years old) of substance abusers.

I asked these counselors, "Why a center specifically for women?" Amy responded: "As women in this culture, they hold themselves back, they keep themselves down. It is not OK to be strong, powerful, angry. It is not OK to work, be stronger than the man in your life, be sexy, to have work be a priority and drinking really helps that. Because, if God forbid, you should have any inclinations to be anything other than what you're supposed to be as a woman, you have alot to hold back. Either way your self esteem is going to be low. Women are sitting ducks for addiction."

Due to this understanding of society's restrictions on women, Skyward programs offer help in all areas of women's lives. They offer assertiveness training and parenting classes which teach women how to say 'no', to not be a victim.

Marcia's comment on this point: "People come here not just to get the alcohol out of the body, but to learn how to change their behavior in the way they relate to the world. At Skyward we deal with feelings and emotional healing. The two are complimentary. We ask them to look at the things in their life that would cause anyone to drink."

Amy added, "Many of the women treated here are dealing with genuinely having been victimized in their lives. The victimization can be done by social values in schools and families—what women are expected to aspire to. The expectations and roles of women to be a wife and mother—it is very strong today."

At Skyward there is a recognition and encouragement for change. The peer group here can fill in the void that sometimes families create. Women who are feeling like a prisoner can come here, understand their freedoms, and change.

Amy talked about treating the whole person. "Recovery is empowering because we are not just treating an addiction but dealing with the recovery of the whole self—the woman in this society and what that brings with it, the difficulties the culture has set. Society has a lack of acceptance or acknowledgement of women drunks—they are simply disgusting. Boys will be boys but women are supposed to be mothers. There are more women who are secret drunks and they are more likely to drink alone, or to be on medication to deal with stress. Women need to be targeted and recognized as a special group." It is clear that women need to be treated separately because they are considered the invisible alcoholics.

The counselors here also believe prescription drug abuse is very prevalent among women and more easily hidden. There is no smell and it appears to be more legitimate than alcohol because it is justified by the medical system. There is a myth that women are hysterical, that they can't cope so give them drugs.

The Skyward program is closely affiliated with AA. Counselors encourage their clients to come to Skyward for individual, emotional and peer support; but also have very rigid requirements to regularly attend AA meetings. They believe it is the best resource around for on-going treatment.

Another part of their services is a mandatory alcohol and drug education class that is not offered anywhere else. The clients learn about identifying the disease, how it is different from other diseases, what treatment is, and when is it a problem.

Upon leaving Skyward and my interview with Marcia and Amy, I had a strong sense of the investment in women's lives that goes on behind that solid Oak door. Marcia's words were ringing in my ear. "Recovery is a beautiful thing to be part of. We approach treatment in a feminine way—bringing alot of awareness, feeling and emotion. We teach women you have the right to feel better. Skyward offers women an opportunity to be proud of being a women."

POSITIVE BIRTHING IN THE 80's

by Ariel Wilcox

Midwives of Maine (M.O.M.) is a statewide organization of nurse and non-nurse midwives dedicated to the continuation of midwifery and the freedom of choice in childbirth. It is a source of continuing education for parents and practitioners, a force for positive change in childbirth and family health care, and a mechanism for self-regulation of midwives in Maine.

Members of M.O.M. are associated with the Midwives' Alliance of North America (MANA), a professional organization founded to build solidarity among midwives of diverse backgrounds and to promote midwifery as a means of improving health care for women and families. The following article reflects Midwives of Maine's philosophy.

A woman meets a unique challenge in childbearing. She may feel keenly the responsibility of creating a new life. She must reconcile her own life with the needs of her child's. She shares her body, even to the point of the magnificent effort of labor.

A woman's body is well designed for the work of birth, yet her emotional and psychological experience can be anywhere from humiliating to exhilarating. At the worst, she can be uninformed, full of fear and pain and alone, her dignity and her body violated. But a woman who is well prepared, supported and confident, can discover her competence and capability. She can gain increased maturity and self-esteem, trust in her body, and a firm foundation for her new role and relationship with her baby. Other family members similarly benefit through their participation. And successful, normal birthing is most promoted in this manner.

Potential for birth experience and outcome reflects the development of today's resources. Some support woman's ability, such as education and coping methods; others can intervene in the process—medical technology that monitors and accelerates labor progress, for example. Improved health and socioeconomic factors remain the major influence on outcomes and have widened options for individualized experience through their promotion of normal pregnancy and birth. Yet even now a woman's care in childbearing may lack availability of these advantages and may include interventions used inappropriately. Ultimately, a positive birthing depends on the ability of the woman to participate effectively and to obtain resources which best meet her needs. Each birth is a highly individualized event of complex interactions, and the harmony of the physical processes can be supported or disrupted by a variety of influences.

Good nutrition and exercise during pregnancy certainly create important physical resources, minimizing discomforts and maintaining a sense of well-being. Complications which can be avoided include toxemia, placental or bleeding problems, and low birthweight and its associated difficulties for the baby.

Psychological and emotional input can also be essential. Stress levels may be affected by conflict in a marital relationship or by the woman's attitudes, beliefs and feelings about childbearing. Hormones and neurotransmitters are released in response to stress and can inhibit processes such as labor contractions and the supply of nutrients or oxygen to

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the baby. Positive feelings increase production of substances which support blood circulation, muscle relaxation, resistence to infection, and other healthy functions. Awareness of the emotional dimension of birth can encourage good outcomes through facilitation of choice in stress reduction and stress response.

The woman's ability to deliver without intervention is enhanced by physical activities which increase her sense of control and power. Upright positions during labor improve maternal circulation and fetal descent, create more space in the pelvis and pressure on the cervix, and allow the woman to feel active and effective. The intensity and pain of uterine contractions can be an opening force when aided by an opening type of breathing, one that allows sound to be a useful tool; in contrast with controlling and inhibiting techniques. Massage and physical support from her attendants helps the woman to deal with her bodily experience and carry out her work. She can receive comfort and energy from them directly through touch, in addition to their verbal encouragement.

Successful birthing is promoted when the woman feels free to become absorbed in the labor process, free to express herself and respond spontaneously. Her identity, consciousness and intellect must adapt to and harmonize with the biological and sexual expression of her body. This profound experience is associated with a high degree of vulnerability; therefore, the woman's feelings of safety and privacy in her birthing environment are essential. Understanding of the physiology of birth now includes a growing awareness of mind and body interaction, mediated by hormones, neurotransmitters, endorphins, and other measurable responses. This awareness can benefit high risk pregnancy or labor as well, optimizing outcomes and the woman's positive experience.

A positive birthing also has advantages for the baby's physical well-being, and it sets the stage for parental-infant attachment. The alert, responsive newborn is welcomed at a time of peak expectancy and emotion. The parents' feelings of accomplishment strengthen the beginning of their new roles and relationships.

Though today's midwives are establishing the quality of their services and professionalism, they are still a minority facing a political struggle to survive. Yet the art of midwifery can offer insight and tools for improving birth experiences and outcomes, on a basis that responds to the natural integrity of the childbearing process, the individual needs of the family, and the inherent power available to every woman in her birthing.

'Homelike' birthing rooms, 'family centered' hospital policies, and natural childbirth classes belie the growing polarization in maternity care. Cesarean rates are rising and technological practices are becoming the norm, sometimes without complete understanding or proof and often as defenses against possible accusations later of providing less than standard care. Nevertheless, obstetric malpractice suits continue to escalate, demonstrating clients' sense of physical and emotional injury. And then there are the parents who had apparently adequate outcomes but who experienced a frustration of their goals for personal achievement and fulfillment, despite natural childbirth training. There certainly are moral, ethical, and philosophical questions raised by the roles and responsibilities of caregivers and consumers.

THERE IS RECOVERY FROM COMPULSIVE EATING

By Nancy J. Shiller, M.A.C.P.

Nancy Shiller is a psychotherapist in private practice in Portland, Maine. She specializes in the treatment of substance abuse and consults to agencies and schools throughout the state.

I'll eat right, I won't overeat tonight, no cookies today, I'll lose weight this Spring. Is your life full of unkept promises like these? Has your life been a series of diets, losing and gaining repeatedly, full of despair? Do you feel that food is the most intimate friend you have? Maybe what you're experiencing is not an absence of willpower or lack of self-control but an eating disorder. Maybe you're one of many people who suffer from compulsive overeating.

All of us eat from time to time in a manner that is not advantageous for us, we seldom eat for sustenance alone. We eat excessively for the sake of pure enjoyment or in response to anxiety or stress, this is relatively common. Most of us have tried to lose a few pounds in less than sensible fashions. These crash diets and excessive exercise programs are usually short lived. In addition, we misuse food and our bodies without receiving the longterm desired results. Few of us experience any lasting negative consequence as a result of these behaviors.

For others, their relationship with food is far more complex than poor choices in food or an excess of celebration. For these people food is a drug, their relationship is emotional. It is a relationship full of despair, dependency and delusion. These people suffer from an eating disorder, compulsive overeating (obesity), bulimia, or anorexia. All these involve an abusive relationship with food and your body. The compulsive eater overeats, feels out of control, usually feels shame, remorse, guilt or other strong feelings after overeating. Compulsive overeaters suffer from obesity as a result of their eating. The Bulimic suffers from an insatiable appetite. Overeating usually involves binges, followed by some form of purging, vomiting, laxatives, excessive exercise or self-starvation. Anorexia is an endless pursuit of thinness resulting in a fatal fear of food.

If you feel that what you have read thus far may apply to you, ask yourself these questions. Do you often deal with strong feelings such as disappointment, depression, loneliness, anger or joy by fleeing to the comfort of food? Has food replaced people and intimate friends and maybe family? Do you constantly obsess about your weight, never reaching that ideal shape? Do you exercise to offset the effects of overeating, not focusing on health but your appearance? Do you weigh yourself everyday and get anxious over a pound or two; or have you stopped weighing yourself entirely—afraid of what you might see? Have you gone on eating binges feeling like you might not be able to stop or being horrified when you finally do? Are the messages you get from others about your appearance inconsistant with how you see yourself? Do you find yourself not eating at all today because of what you did eat yesterday? Are you using chemicals or vomitting to control your weight? Do you overeat when you're alone, hiding your true eating habits from others? If several of the above questions apply to you, you may have developed habitual patterns of food abuse. Most likely food is interfering with your life and your relationship with food is something you want to change. Like an alcoholic a compulsive overeater invests a great deal of energy in planning, obtaining, preparing, and using their drug (food). Consequences may include difficulties in personal relationships, finances, emotional well-being and health. These diseases can be fatal in extreme cases.

Many compulsive eaters have traveled through the dieting maze. The first diet is successful, but when they resume their old eating behaviors and lose the structure of the diet, they eventually regain the lost weight and a few more pounds. Diets become less successful with each new attempt. This is the beginning of the binge and starve cycle. Overeating becomes bingeing, eating alone, sugary foods or refined carbohydrates in large quantities followed by feelings of remorse, shame and self-hate. They become trapped in a vicious cycle of overeating—self-hate—then eating to relieve the feelings of self-hate. Bio-chemical imbalances develop that set up cravings for these binge foods. The choice of eating or not is gone. It's a habit, an addiction. Self-control and willpower are no longer relevant.

Like other substance abusers—alcoholics, drug addicts,—food abusers may not be able to change their habitual patterns without help. What may have begun as a symptom of underlying problems, has become a problem in and of itself. The individual with an eating disorder did not raise their hand in sixth grade to proclaim they wanted to be a compulsive eater, bulimic or anorexic when they grow up.

The majority of people suffering from these disorders are women. Women who are achievers, hard working, intelligent and independent. These women develop a fierce determination to conquer these destructive behaviors on their own. The result is people who live secret lives involving food. They develop strong denial patterns and live in fear of themselves. These women are crying for help everytime they overeat, purge, starve themselves or step on a scale.

Recovery means telling the secret, breaking the isolation, shifting the focus from appearance and weight to healthful eating. It means reaching out to professionals, family and self-help groups. It involves developing new skills for dealing with unmet needs, expression of feelings, low self-esteem and even family.

Eating disorders are horrible diseases effecting all aspects of your life and those around you. There is help if you have the willingness to reach out to others.

Women's Events Calendar

Sponsoring Organization	*Event Title*	*Date & Time*	*Location*	*Cost*	*For Further Info., Call:*
Feminist Spiritual Community	Women & Power Conference	June 5, 6, 7, 8	Univ. of Southern Maine—Gorham Campus	variable	733-2294
Bus. & Prof. Women	Workplace of the Future Seminar	June 6 9 AM-2:30 PM	Conv. Center Cook's Corner, Brunswick	$20 Members $30 Non-Members	729-0859
Maine Career Education Consortium Westbrook College	Expanding Your Horizons in Science and Mathematics	June 21 8:45 AM-2:45 PM	Westbrook College	$10	781-4116

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