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A COURSE BY AND FOR WOMEN

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THE FIRST PRINTING SOLD SO FAST WE HAVEN'T HAD TIME TO REVISE THE PRINTED COURSE. WE ARE WORKING ON REVISIONS WHICH WE HOPE WILL BE READY FOR THE 3RD PRINTING. WE WANT TO ADD CHAPTERS ON MENOPAUSE AND GETTING OLDER AND ATTITUDES TO CHILDREN (CHILD REARING ALTERNATIVES, SINGLE WOMEN HAVING CHILDREN, ADOPTING, ALSO NOT HAVING CHILDREN). WE WANT TO EXPAND THE EXISTING CHAPTERS TO INCLUDE MORE ON MONOGAMY, HOMOSEXUALITY, WOMEN'S DISEASES AND HYSTERECTOMIES, THE RELATION BETWEEN MENTAL AND PHYSICAL HEALTH, NUTRITION, ETC., ETC.

WOULD YOU LIKE TO MAKE SUGGESTIONS, WRITE UP YOUR OWN EXPERIENCE, OR OTHERWISE WORK ON THE COURSE? PLEASE WRITE US. THE COURSE IS WHAT ALL OF US MAKE IT.

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Although most of the papers evolved through group discussions, the following people wrote up the papers:

Anatomy and Physiology – Nancy Hawley, Toni Randall, Abby Schwartz

Sexuality – Jane deLong, Ginger Goldner, Nancy London

Some Myths About Women – Joan Ditzion

Venereal Disease – Fran Ansley

Birth Control – Pam Berger, Nancy Hawley, Abby Schwartz

Abortion – Carol Driscoll, Nancy Hawley, Betsey Sable, Wendy Sanford

Pregnancy – Jane Pincus, Ruth Bell

Prepared Childbirth – Nancy Hawley

Post Partum – Paula Doress, Esther Rome, Marty Ruedi

Medical Institutions – Nancy Mann, Barbara Perkins

Women, Medicine and Capitalism – Lucy Candib

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Course Introduction

One year ago, a group of us who were then in women's liberation (now most of us consider ourselves members of Bread and Roses) got together to work on a laywoman's course on health, women and our bodies. The impetus for this course grew out of a workshop on "women and their bodies" at a women's conference at Emmanuel College in Boston, May 1969. After that, several of us developed a questionnaire about women's feelings about their bodies and their relationship to doctors. We discovered there were no "good" doctors and we had to learn for ourselves. We talked about our own experiences and we shared our own knowledge. We went to books and to medically trained people for more information. We decided on the topics collectively. (Originally, they included: Patient as Victim; Sexuality; Anatomy; Birth Control; Abortion; Pregnancy; Prepared Childbirth; Postpartum and Childcare; Medical Institutions; Medical Laws; and Organizing for Change.) We picked the one or ones we wanted to do and worked individually and in groups to write the papers. The process that developed in the group became as important as the material we were learning. For the first time, we were doing research and writing papers that were about us and for us. We were excited and our excitement was powerful. We wanted to share both the excitement and the material we were learning with our sisters. We saw ourselves differently and our lives began to change.

As we worked, we met weekly to discuss what we were learning about ourselves, our bodies, health and women. We presented each topic to the group, gave support and helpful criticisms to each other and rewrote the papers. By the fall, we were ready to share our collective knowledge with other sisters. Excited and nervous (we were just women; what authority did we have in matters of medicine and health?), we offered a course to sisters in women's liberation. Singly and in groups, we presented the topics and discussed the material, sometimes in one large group, often in smaller groups. Sisters added their experiences, questions, fears, feelings, excitement. It was dynamic! We all learned together.

One original version of the course was that we as a group would give the course to a group of women who could then go out and give it to other women. To some extent, that is what happened. After the first time around, those of us who had worked out the course originally, plus women who had taken the course, got together in an enlarged group to rewrite the papers so they could be printed and shared, not only with women in Boston, but with women across the country. Other women wanted to learn, other women's health groups wanted to compare and combine our work and theirs.

So after a year and much enthusiasm and hard individual and collective thinking and working, we're publishing these papers. They are not final. They are not static. They are meant to be used by our sisters to increase consciousness about ourselves as women, to build our movement, to begin to struggle collectively for adequate health care, and in many other ways they can be useful to you. One suggestion to those of you who will use the papers to teach others: the papers in and of themselves are not very important. They should be viewed as a tool which stimulates discussion and action, which allows for new ideas and for change. Often, our best presentations of the course were done by a group of women (we could see a collective at work – in harmony, sharing, arguing, disagreeing) with questions throughout, and then splitting the larger group into smaller groups to continue talking about whatever part of the topic that was especially relevant to the women in that group. It was more important that

we talked about our experiences, were challenged by others' experiences (often we came from very different situations), raised our questions, expressed our feelings, were challenged to act, than that we learned any specific body of material.

It was exciting to learn new facts about our bodies, but it was even more exciting to talk about how we felt about our bodies, how we felt about ourselves, how we could become more autonomous human beings, how we could act together on our collective knowledge to change the health care system for women and for all people. We hope this will be true for you, too.

This course should grow and include other topics, such as menopause, divorce, child care, strengthening our bodies (diet, exercise, karate, etc.) – topics important to the group of women giving and taking the course. The material has been and should be used in ways other than a course. A course is only one way of spreading the word.

We want all your ideas, comments, suggestions, criticisms, etc.

Power to our sisters!!

Nancy Hawley, Wilma Diskin, Jane Pincus, Abby Schwarz, Esther Rome, Betsy Sable, Paula Doress, Jane deLong, Ginger Goldner, Nancy London, Barbara Perkins, Ruth Bell, Wendy Sanford, Pam Berger, Wendy Martz, Lucy Candib, Joan Ditzion, Carol Driscoll, Nancy Mann, Hester Butterfield, Marilyn Slotkin, Linda Borenstein, Martha Reudi, and all the other women who took the course and read the papers.

In reading or teaching this course you may need additional information, pictures, or charts and models. There are bibliographies in several papers and most public libraries carry illustrated books in sections like Sex Education and Young Adults. You can probably avoid spending money on them. The following three books, not in most libraries, have some of the best illustrations and information:

A Child is Born: The Drama of Life Before Birth in Unprecedented Photographs, A Practical Guide for the Expectant Mother, Dell Publishing Co., N.Y.

Birth Control Handbook, Box 1000, Station G, Montreal 130, Quebec (25¢); also available (ten or fewer copies only) from New England Free Press, 791 Tremont St., Boston, Mass. 02118 (10¢)

Understanding, Ortho Pharmaceutical Corporation, Raritan, New Jersey

You can get more information, posters or plastic models from:

the nearest Planned Parenthood office
International Planned Parenthood Federation, 111 4th Ave., New York, N.Y.
Ortho Pharmaceutical Corporation, Raritan, New Jersey
Educational Department, Tampax Incorporated, New York, N.Y. 10017
Health-Pac, 17 Murray St., New York, N.Y.
Women's Abortion Project, 36 W. 22nd St., New York, N.Y.

The above are very different kinds of people. Don't forget that Ortho and Tampax are capitalist organizations, pushing their own products for profit; nevertheless, their educational departments put out some excellent stuff. Planned Parenthood pushes population control and birth control pills.

The local Planned Parenthood can give you the name of the local Ortho representative from whom you can try to get birth control kits (with Ortho contraceptive products). It helps to have a physician call for you. P.P. can also give you the names of gynecologists who may give or sell you different IUDs. It is also good to have the names or doctors to whom you can refer women.

It took a long time to put together this course, but we don't consider it a finished product. As more women use, teach, and learn from the course, it must be expanded and revised to meet our needs. We plan to continue our work and want to have a second edition ready to be printed in six months to a year. The course will be best changed by the corrections and additions sent by those who use it. So send them in: Boston Women's Health Course Collective, c/o New England Free Press, 791 Tremont St., Boston, Mass. 02118

Anatomy and Physiology

Our society has traditionally valued the mental over the physical. Those who contribute to this hierarchy calling the mind noble and the body base do humanity a great disservice. It denies our physical selves. The results are particularly damaging to us as women who are defined as more or less mindless and thus stuck with being "base" bodies. A "base" thing is not worth knowing about, striving to feel good about, so we grow up ignorant, misinformed, unprepared. Only when we are very young can we enjoy using our bodies, playing outdoors and running, and throwing tantrums sometimes when we feel like it. As we grow older, every part of our body is used against us. Nearly every physical experience we have as a woman is so alienating that we have been filled with extreme feelings of disgust and loathing for our own bodies. Every part of our body is an area of real or potential disgust to us – armpits, faces, vaginas, buttocks, stomachs, breasts. The slightest so-called "imperfection" is a source of very private anxiety and fear that we dare not communicate to each other because we are taught to think we are the only ones that feel these things. And the objectified disgust we have for ourselves we feel towards other women and we are filled with disgust at the thought of her (our) body under the clothing (armpits, vagina, etc.)

Our society adds insult to injury by demanding that that the truly "womanly" woman be soft, somewhat weak and awkward – in short, physically unfit. We contribute to this by, for example, wearing high heeled shoes which are unhealthy and also keep us in our place (we can't run). Our physical limitations are actually more apparent than real, however, and exist today because we don't have the opportunity to develop ourselves, and men and the pressures exerted by our male-dominated society tell us what is good, what is bad (a strong woman is considered "masculine" and undesirable as a woman). We want to become physically healthy, strong, and enduring through exercise, proper eating and training (like karate) and proud of our bodies. Pride because we feel good ourselves, not because we look good for others.

What are our bodies? First, they are us. We do not inhabit them – we are them (as well as mind). This realization should lead to anger at those people who have subtly persuaded us to look upon our bodies (ourselves) as no more than commodities to be given in return for favors. In fact we feel we are commodities because our bodies, in toto and dismembered, are used to sell products – useless, mind-destroying products that make millions for businessmen. Our legs, busts, eyes, mouths, fingers, hair, abdomens, and vaginas are used to sell stockings, bras, fashions, cosmetics, hair coloring, a multitude of birth control products that men would not consider using in any form, powders, sprays, perfumes (again to make us smell "nice" for men because our own smells are not good enough), and such obscene things as deodorants for our vaginas. Consequently we view our bodies and those of other women according to how closely they "measure up" to the sexist standards of the society. But our bodies are unique because they - us - will never occur again. Love for ourselves and other women, both of which we have never been allowed to experience, begins to surface when we refuse to objectify ourselves any longer and stop depending on the nowhere identity we have been forced to subsist on for so long.

As women, knowledge of our reproductive organs is vital to overcome objectification. We have been ignorant of how our bodies function and this enables males, particularly professionals, to play upon us for money and experiments, and to intimidate us in doctors' offices and clinics of every kind. Once we have some basic information about how our bodies work by talking and learning together and spreading the correct information, we need not be at the total mercy of men who are telling us what we feel when we don't or what we don't feel when we do (it's all in our minds!). (Going together in small groups to doctors to support each other is incredibly helpful to us and works wonders of "humility" on the minds of many doctors.)

The purpose of this paper is then to help us learn more about our own anatomy and physiology, to begin to conquer the ignorance that has crippled us in the past when we have felt we don't know what's happening to us. The information is a weapon without which we cannot begin the collective struggle for control over our own bodies and lives.

The body contains four major cavities. (These cavities are actually filled with organs and fluids: they aren't to be thought of as huge holes or hollows.) One is the pericardial cavity (peri=around; cardial=heart), enclosing the heart, located just beneath the breast bone. There are two pleural cavities, each

enclosing a lung and located deeper in the chest towards the back. These three cavities are protected by rib cage and breastbone. Finally there is the peritoneal cavity, containing most of the viscera, enclosed and protected by the bowl-shaped bony pelvis.

The pericardial and pleural cavities are separated from the peritoneal cavity by the diaphragm. This is a sheet of muscle which extends from the solar plexus (wishbone) to an opposite spot near the back. It aids in contraction and expansion of the pleural cavities enabling the lungs to empty and fill.

The viscera include digestive organs (stomach, small intestine, liver and gall bladder, pancreas, large intestine or colon, appendix, and rectum), excretory organs (kidneys, ureters or the tubes leading from kidneys to bladder, the bladder, and part of the urethra or the tube extending from bladder to outside), adrenal glands, and some reproductive organs (ovaries, oviducts, uterus).

The organism (ourselves) is composed of many systems (digestive, reproductive, etc.). Systems are composed of various tissues, and tissues are composed of similar kinds of cells. When you eat steak, for instance, you are eating fat (a type of connective tissue) and meat (muscle tissue). The four main tissues are epithelium, connective tissue, muscle and nerve.

Epithelial tissue is composed of cells which are placed very close together. It may vary in thickness from one to several cell layers. Epithelium gives rise to sweat glands, mucous glands, sebaceous glands (secrete oil; responsible for acne), endocrine glands (adrenals, pituitary, thyroid, etc., all of which secrete hormones), exocrine glands (e.g. part of the pancreas which secretes digestive enzymes), and hair follicles. It also covers and lines structures. As skin, it covers our body, and as mucous membrane it lines our mouths and the rest of the digestive tract. Mucous membrane also lines oviducts, vagina, urethra, blood vessels – any hollow organs or parts of organs. It also covers them (e.g. stomach).

Connective tissue is characterized by few cells spaced widely apart. As the name states, connective tissue connects organs and tissues with each other. These cells secrete various compounds into the spaces around them, forming the tough substance of cartilage, ligament, tendon and bone and the more delicate substance of fat and mesentery. Mesenteries are sheets of varying toughness which not only connect organs to one another but which carry blood vessels and nerve fibers from one place to another.

The cells composing muscle tissue can contract when they receive nervous impulses. We move about by using our voluntary musculature. Involuntary muscle, present in such places as digestive tract and uterus, causes peristalsis and labor contractions.

The cells of nervous tissue can generate, transmit and receive impulses. The autonomic, or independent, division of the nervous system controls involuntary processes such as digestion and heartbeat, and the central division supplies our skeletal musculature and performs other functions not pertinent here.

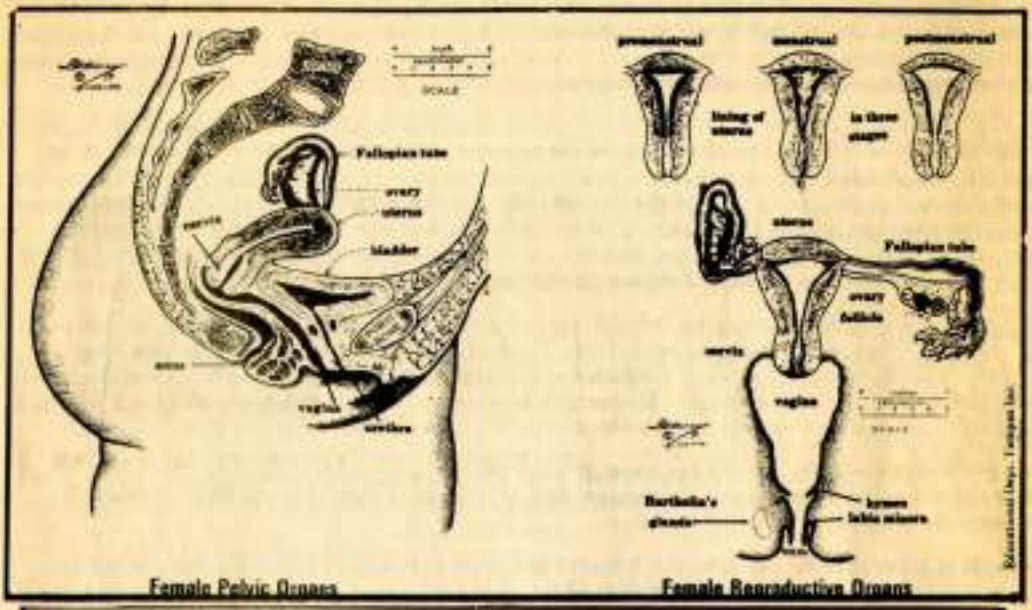
The rest of this chapter will cover the reproductive system. If you wish to study the other systems, they are dealt with in the appendix. The first part of the discussion of the reproductive system will concern anatomy; the second part will deal with ovulation.

Many of the reproductive organs of women and men are similar in origin and in function; they are homologous and analogous to each other. Homologous organs are structures with a common origin, developing from the same embryonic tissue. If they have the same function, they are considered analogous, the implication being that organs with a common ancestry do not always have a similar function. Studies have provided some interesting homologies: ovaries and testes (also analogous), labia majora and scrotum, clitoris and penis (also analogous), bulb of vestibule and bulb and adjoining part of corpus spongiosum penis (also analogous), Bartholin's glands and bulbourethral glands (also analogous). What is more, the embryonic gonad (sex gland, from the Latin "gone" or seed) is "indifferent"; that is, it will become male or female depending on the chromosomes and hormones present at the time.

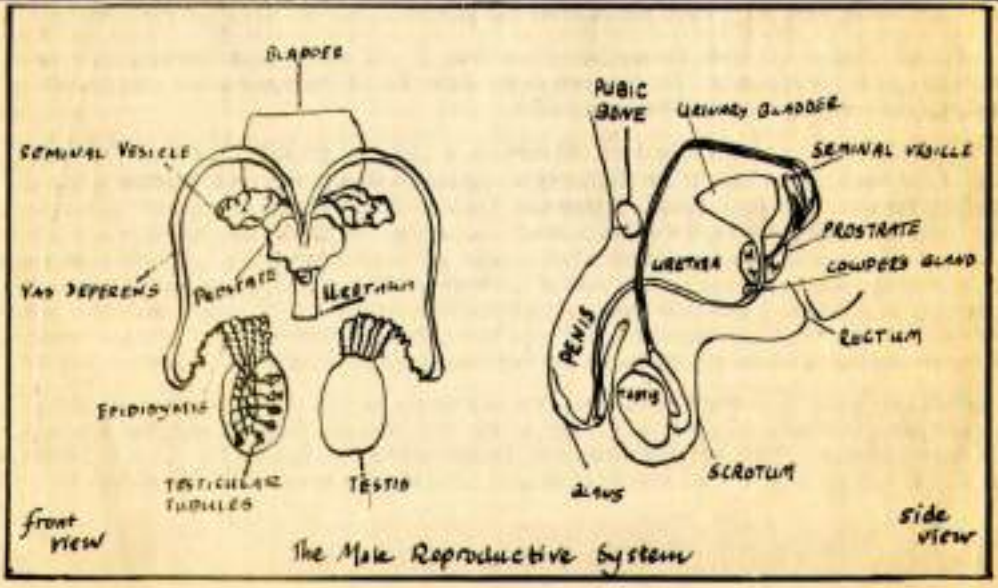
The gonads have a dual function in both sexes. The ovaries produce female germ cells (eggs) and female sex hormones (estrogen, progesterone). They are about the size and shape of unshelled almonds, located one on either side of the body (see diagram). Each ovary lies in a mass of fat which cushions and protects it. The funnel-like end of an oviduct (Fallopian tube) extends towards the side of the ovary

from which the eggs are released (see diagram this page). (It is significant that there is a gap between each tube and the corresponding ovary: very rarely an egg will be fertilized before it can enter the tube, and an abdominal pregnancy will result.) The length of each oviduct is about four inches. Whereas the ovaries are connected to uterus and tubes only by ligaments and mesenteries, the tubes actually open into the uterus. Each opening is so small that only a fine needle can penetrate it.

The uterus (womb) is about the size of a fist. This thick-walled, hollow, muscular organ lies in the lower part of the peritoneal cavity between bladder and rectum (see diagram). The bladder is beneath the abdominal wall, the uterus is behind the bladder, and the rectum is nearest the backbone. The cavity of the uterus is compressed from back to front into a mere slit. The narrowed part of the uterus is called the cervix, and this protrudes into the vaginal canal. You can touch your own cervix; it feels like a large nipple with a small dimple in its center, extending from the top part of the vagina way towards the back. The uterus changes position during the menstrual cycle, so where you feel the cervix one day



Female Pelvic Organs — Female Reproductive Organs

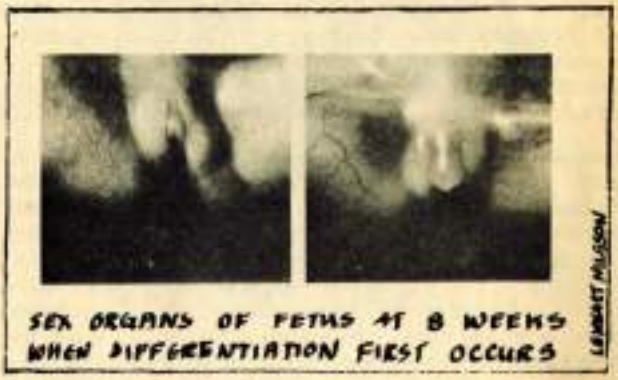


The Male Reproductive System

may be slightly different from where it will be the next! The entrance into the uterus through the cervix is very small, about the diameter of a very thin straw. This is the little dimple that you feel in the middle of the "nipple".

The vagina extends from just behind the cervix (where it ends blindly as the fornix) to the outer genitals, or vulva. Like the uterus and cervix, the vagina is between bladder and rectum (see diagram), and is positioned such that when you are standing or sitting or squatting it extends towards the small of the back (remember your Tampax instructions: "point it towards your waist"). Its walls are ordinarily in contact; i.e. its space is potential, not actual. Its length may average some 3½ inches but it is capable of considerable distension. Its lining is thrown into folds which flatten out as the vagina expands in intercourse or childbirth. Feel your own vagina with your fingers and you may be able to feel the folds. You may also be able to feel some feces in the rectum, through the "bottom" wall of the vagina.

The basic plan of tissue organization is the same in oviducts, uterus and vagina. The innermost lining in each case is mucous epithelium. In the vagina it is quite thick, as this organ undergoes wear and tear in intercourse and childbirth. It is not glandular in the vagina, but is in the uterus. In the tubes, as mentioned, it is ciliated. The next two layers are composed of involuntary muscle, thickest in the uterus, whose muscular contractions must expel the baby at term. The last layer around each organ is a thin sheath of epithelial tissue.



SEX ORGANS OF FETUS AT 8 WEEKS WHEN DIFFERENTIATION FIRST OCCURS

The external genital organs all together are called the vulva (see p. 16). The pubis is a rounded fatty covered mass in front of the pubic symphysis. (The pubic bones are part of the hip girdle; where one meets the other is termed a symphysis. In the diagram, the pubic symphysis is labeled pubis.) Next come the hair-covered labia majora, or major lips. They protect the more delicate inner structures. When they are opened, the labia minor or minor lips are seen, extending from the clitoris back to the sides of the vaginal opening. Each minor lip divides into two portions. One part passes above the clitoris to meet the lip on the other side, forming the clitoral hood. The other part passes beneath the clitoris and attaches to its undersurface, forming (with the other lip) the frenulum or base of the clitoris. You will understand this best if you examine yourself with a mirror.

The clitoris is homologous with the penis, and has analogous functions of erection and orgasm. Erection occurs when blood flows into hollow areas within an organ, causing turgidity and consequent stiffening. The hollow areas in the man's penis and in the woman's clitoris are called corpora cavernosa (literally, hollow bodies). The clitoris has two corpora cavernosa, each surrounded by involuntary musculature and connective tissue. Like the penis, the clitoris is composed of shaft (from root to tip) and glans (the glans clitoridis is the tip of the clitoris, from the Latin glans or acorn; the glans penis is the acorn-shaped tip of the penis). In a woman the shaft is hidden under the hood, but the glans protrudes, looking like a small bump. If you are not sure of the location of your clitoris, feel your outer genitals until you hit upon the most sensitive spot. This is pretty sure to be the clitoris. The clitoris is richly supplied with nerves. For a discussion of the history of society's attitude towards this organ, we refer you to Ruth and Edward Brecher's excellent summary of the Masters and Johnson findings (paperback, **An Analysis of Human Sexual Response**, Signet T3038, pp. 144-145).

The vestibule is the cleft between the minor lips and behind the glans clitoridis. It contains the urinary (urethral) and vaginal openings (orifices). The urinary opening is just between clitoris and vagina, and its position accounts for the occasional irritation felt when one urinates after extremely vigorous or prolonged intercourse. The vaginal opening is beneath the urinary opening. The perineum, or perineal region, is the tissue between vagina and anus; this is what is cut in an episiotomy (the cut to enlarge opening for childbirth).

The hymen (cherry, maidenhead) is seen in a virgin as a thin fold of membrane situated at the vaginal opening. Usually a Tampax can be inserted in the partial opening that remains, and of course men-

strual fluid is shed through that opening. The hymen may be entirely absent even in a virgin, however, and when present may assume many shapes and degrees of thickness. There are little folds of tissue that remain after it has been broken.

The bulb of the vestibule is the name given to two elongated masses of erectile tissue, placed one on either side of the vaginal opening and meeting in front of it. This tissue becomes turgid (swollen) when a woman is sufficiently aroused, contributing to a tightening around the penis.

Bartholin's glands are two small, rounded bodies on either side of the vaginal opening, in contact with the hind end of each mass of erectile tissue (the bulb). They are not easy to see. They contribute very little to vaginal lubrication during intercourse.

We emphasize that you take a mirror and examine yourself. Touch yourself, smell yourself, even taste your own secretions. After all, you are your body and you are not obscene.

In intercourse, as the man's penis moves in and out of the vagina, the minor lips are alternately stretched and relaxed. This is most evident when the two masses of tissue composing the bulb of the vestibule are erect (i.e. when the woman is very much aroused and the vagina is tightened around the penis). Since the minor lips form the clitoral hood, they move back and forth over the sensitive glans clitoridis, stimulating it so that - under optimal conditions - orgasm occurs even though the penis does not directly contact the clitoris. Many of us can't have satisfactory orgasm through pentration alone, however; many of us want direct manual or direct oral stimulation of the clitoris. Either indirect or direct stimulation is perfectly normal; if you can't have orgasm through intercourse alone, as many women cannot, you should not feel inadequate or ashamed of demanding direct stimulation.

Ovulation: A follicle, seen in the diagram on page 44, is a hollow ball of several layers of cells. In the case of a Graafian or mature follicle, there is an egg cell in the center. The ovary contains thousands of follicles, but only about 300 will become mature. The others are termed atretic (their development is abortive); yet they perform the essential function of secreting constant low amounts of estrogen. The diagram shows the sequence of development and decline of a Graafian follicle (as well as picturing an atretic type). Each month one follicle (occasionally more than one), under the influence of hormones, starts growing out of its resting immature state. It develops various cell layers, one of which starts secreting estrogen, and matures an egg cell in the center. It also moves towards the surface of the ovary. At some point it breaks through the ovarian surface, ruptures, and expels the egg. Another layer of cells in the ruptured follicle then starts secreting progesterone. The follicle is now called a corpus luteum (literally, yellow body, referring to the yellowish fat in it when it is almost completely degenerated). When it declines, under the influence of other hormones, it leaves a whitish scar on the surface of the ovary; it thus is called corpus albicans (white body). The egg, meanwhile, is ejected towards the funnel-shaped end of the oviduct and trapped by the funnelings. Peristaltic contractions of the oviduct, similar to those of the esophagus which push food into the stomach, help the egg toward the uterus. The journey takes about 6½ days. If the egg has been fertilized, a process which occurs in the **outer third of the tube, not in the uterus**, it sits at the entrance to the uterus for some 12 hours before implanting on the uterine wall. 50% of the eggs implant on the front wall of the uterus, 40% on the back wall, and 10% on the sides (these don't do so well). There is a possibility that the fertilized egg may implant in the tube while en route to the uterus. This is an ectopic or tubal pregnancy and requires surgery as the tube can rupture. If the egg is not fertilized, it does not implant but is discarded in vaginal secretions (usually unnoticeable). Fertilization, incidentally, is encouraged by waving cilia (hairlike processes extending from cells lining the tubes) which sweep constantly in the direction of the **ovary**, aiding the sperm in their journey up the tube. For some reason the cilia's waving does not hinder the egg's journey in the opposite direction, nor does the peristalsis of the tube hinder the sperm from moving towards the ovary.

These are just the anatomical facts. But knowing these facts about our bodies is only one way to know them and to begin to get in touch with ourselves. Other things to think about:

1. How do we make our bodies physically strong and healthy?
2. How do we develop our bodies to be physically independent and physically safe, especially from men?
3. How do we feel about our bodies (total body and particular parts)? Are we accepting of our bodies? How do feelings about our bodies relate to our feelings about other things – notion of beauty, men, women, work, control of our lives, self esteem?
4. Does our self concept integrate a sense of our physical and mental selves? (conquering mind-body separation)
5. How can we learn to repair our bodies and those of others in a variety of situations?

Sexuality

This paper was written by a group of us in Women's Liberation anxious to share our thoughts and feelings about sexuality with other women. We are experts only in the sense that we are women, and women talking to women about their range of experience and insights has been more informative to us than all of the How-To-Do-It, What-Is-It-All-About books we have ever read.

The paper includes a lot of personal stories – ours and our friends, because we felt that our own voices, our own histories rang the clearest and truest and helped us reclaim the mysterious topic of sexuality as familiar and ours. There are sections in the p per that deal with specific topics, such as celibacy an orgasms, and an introduction that tries to place sexuality in a larger social context.

We have written about sex because sexual relations between men and women are permeated with myths and preconceptions that put the woman down, and not because sexual relations are an absolutely necessary part of a fulfilled woman's life. If the goal of knowing ourselves sexually were to produce bigger and better spasms in orgasm, it would have been a waste of time to write this paper. Orgasms are not that important in life. What is important are loving, giving, free relationships between people.

I.

We are all so oppressed by sexual images, formulas, goals and rules that it is almost impossible to even think about sex outside the context of success and failure. The sexual revolution - liberated orgastic women, groupies, communal fucking, homosexuality - have all made us feel that we must be able to fuck with impunity, with no anxiety, under any conditions and with anyone, or we're some kind of up-tight freak. These alienating inhuman expectations are no less destructive or degrading than the Victorian puritanism we all so proudly rejected. Robin Morgan, a Women's Liberationist in New York, says "Goodbye to Hip Culture and the so-called Sexual Revolution which has functioned toward women's freedom as did the Reconstruction toward former slaves – reinstituted oppression by another name."

We must destroy the myth that we have to be groovy, free chicks. But it is insidiously embedded in our culture. We are told we must be educated to understand that sex is not bad or dirty, that it can be beautiful, fulfilling, and extremely pleasurable. Playboy, Newsweek, and almost all women's magazines are filled with such analyses of our sexuality. Great pressure is being put on us to be both independent (what modern man wants a clinging vine?) and a sex-kitten at the same time.

Why is it that women still resist so much advertised liberation? Why is the advertising still necessary some 50 years after the propaganda for women to enjoy sex as much as men began? Why do women and men still think sex is dirty? Maybe they're right. When women feel powerless and inferior in a relationship it is not surprising to feel humiliated and unsatisfied in bed. Similarly, a man must feel some contempt for a woman he believes to be not his equal.[1]

"Frigidity" or inadequacy in bed is not divorced from the social realities we experience all the time. This male dominated culture embues us with a sense of second best status, and there's no reason to expect this sense of inferiority and inadequacy to go away between the sheets.

SEXUAL FEELINGS

Part of the reason so many people have problems about sex is because sexual feelings are considered separate or different from other kinds of feelings we have. Sex has got to do with the body – that alien part of us residing below the neck that has needs and responses that we don't understand. But all our feelings reside in the body. Fear usually makes its presence felt by your heart pounding, your chest feeling caved in, your stomach turning. Joy is tingly – your head feels a little light, fingers and toes sort of shimmer, and the rest of you feels warm and all in one piece. For some people anger feels like a pounding in the head, hands feel tight and clenched and so on. So what's the big to-do about sex? It's all part of the same body that we live in every day, that defines our feelings for us, that moves us around. It can't be mysterious or alien because it's our own familiar house. A good stretch, running fast, breathing deeply – these are all orgasms of a sort. They are as much a part of "sex" as that restricted set of activities that happen in bed and cause us so much trouble.

To make sex special, different, better, more important is to disown our bodies. It is like saying, "you're only good for me", "you're only a part of me" when you perform on command in this usually tense and phony circumstance. But our bodies **are** us **all the time**. And if this body, which **is** us, feels sleepy or scared or cold in certain settings, it has its own good reasons for doing so. And we (our heads) have no right to punish or reject it or let anyone else punish or reject it for not feeling differently.

The problem is that "sex" and all the preparations leading up to it and after it have nothing to do with sex. "Sex" is about being a "real woman" – being that ridiculous caricature of a person that this society tells us we had better become if we are to extract even the smallest amount of security, pleasure and self-esteem from the world. It's a sexual achievement exam. You make love to your judge, and it's pass/fail. And the irony of it is that it's not even our test – they made up the rules and we swallowed the lies and thought that if we "failed" it was our problem. What we need to do is get rid of all the standards we've previously used to measure ourselves, our sexuality. By talking to each other, taking support from each other, we can set our own standards which will bear the mark of sanity and individuality.

GROWING UP

It seems pretty clear to us as women that from the moment we're born, we're treated differently from little boys. Our toys are different. Dolls instead of chemistry sets. Our clothes are different – little dresses to be kept clean instead of sloppy pants. And slowly, over the years, a distinction is made between boys and girls on every dimension. We're emotional; they're intellectual. They're clumsy; we're graceful and dainty. They're going to go on to become doctors and business men. We're going to get married. The most ambitious among us dreamed of nursing. They're athletic. We're domestic. They have an easily wounded ego. We're good at soothing. In short, men were socialized to think of themselves as intellectual, aggressive and creative, while women are molded as passive, gentle, and emotional. OK, you say, that's not so bad. Separate but equal characteristics. We don't think that's true. We think we've suffered by this characterization of us as passive creatures, noticeably in relation to our sexuality. We're not supposed to be interested in sex – that's for men. We're not supposed to admit it if we are – that's dirty. The ideal woman **responds**, she does not initiate. Men will act aggressively towards us sexually, and we must worry about how to set the limits on the sexual encounter. We're always so busy setting the limits and holding off this powerful sexuality coming from him, that we never get a chance to explore our own. Our bodily functions and our own sexuality are always something of a mystery to us.

As kids, if we are caught masturbating or exploring a playmate, we're told either to stop immediately, or or questioned carefully as to what exactly we were doing. Certain ideas begin to make themselves felt – like young ladies don't do that sort of thing.

> My three year old daughter and I were visiting my parents. We all sat in the living room. Lisa sat on the carpet holding a paper towel tube to her naked vagina. 'What would happen if I peed in this?' she asked in her heaviest, gurgling, teasing, curious voice. 'Don't do it, the pee will come out on the floor,' was what I told her. My father was extremely upset and told me afterwards that I had handled it all wrong. I should have scolded her and told her not to talk that way. Not, he assured me, because *he* cared, but because there are some pretty small minded people out there who will give her a rude awakening if she's not trained now.

We also learn that physical affection is only acceptable in some relationships, but not in others:

> When I was about seven or eight, I had this best friend Susan. We loved each other and walked around with our arms around each other. Her older sister told us not to do that any more because we looked like Lesbians. So we held hands instead.

> When I was small, five or six, I wanted to lift my dress up and squirm out of my pants while lying on the floor watching TV in front of my father. He sort of caught on and yelled 'Don't do that.'

We also learn that a woman's bodily functions are mysterious and slightly smutty:

> When I first got my period, my mother dragged me into the bathroom and told me to take off my clothes. I stood naked in front of her while she grumbled, "You can have kids now so you better be careful."
>
> When I first got my period I came and told my mother. She slapped me across the face, and then congratulated me. Later she told me the slap was an old custom.
>
> The books I sent away for explaining menstruation arrived in plain brown wrapping. My father got to them first, and taunted me by holding them over his head so that they were out of my reach.

The messages go on and on. There's something shameful about our bodies, our sexuality. It shocked and angered our parents, scared us, and added to the growing sense of alienation and mystery we had about our bodies. The messages go on, in different societies, wearing different disguises. In some tribal societies, women are isolated in special huts built outside the community grounds, while they menstruate. They are taboo. Anyone looking at them, caught talking to them, is courting death. The Jews write that a woman is unclean during her period and caution men not to have sexual relations with them during that time.

By the time we're teenagers, we discover that there's only one norm for beauty. A commercial norm that sold products to us as we agonized over breasts, hair, legs, and skin that would not measure up. Again we are left with shame and anxiety. We have body smells and our feet are too big. We lose all respect for our own uniqueness, our own smell and shape and way of doing things. We buy vaginal deodorant, and read Cosmopolitan articles on the Six Ways to be Sexy.

All of this leaves us feeling ashamed and ignorant of our bodies, not wanting to explore them to find out what feels good, what we like and when. All of this leaves us unable to tell the men we sleep with what to do to satisfy us.

They've got us coming and going. First we're supposed to set the sexual limits, deny our responses, and hate our looks. Then, within a few years we're supposed to be experimental and libertine. The more orgasms we have the closer we come to being "real" women. Jump in and enjoy it. That's a lot of confusion, and it's no wonder that so many of us still have serious questions about who we are and what we want.

MASTURBATION

We had a house with old plumbing. The bathtub faucet sprayed a hard stream of water out on an angle. I learned to masturbate with it, had orgasms at 7 or 8 with it. One day, when I was under ten years old, my mother surprised me going at it. She said, "What are you doing?" "Just washing myself." "Oh." I was totally freaked out that she didn't know. I figured it must be something pretty queer if she didn't know. I figured I was part boy and pure queer, and certainly a sinner.

When my father went to the hospital with an infection and there was talk of his having a leg amputation and dying if that didn't work, I got real scared and guilty. I figured it was happening to him because I was masturbating, or at least because I hadn't confessed to my mother. I was sure he would die if I didn't.

We all heard that masturbation was bad and we all felt guilty about doing it. But some of us did do it, which means it must have felt good. Taboos did keep some of us from learning about it until we had sex with men.

I was 14 or 15 years old, and a virgin. I was sitting cross-legged on my bed one day, and became aroused by memories of petting with my boyfriend, and having orgasms. I was also aroused by the sex smell I was exuding. I suddenly realized that *I* could do to my clitoris what *he* had done. I masturbated for the first time, had an orgasm, and wasn't so sure that what I had done was right.

Either way, playing with ourselves didn't feel natural. When we got older, we got sold a myth that masturbating would keep us from enjoying sex with men — it would "fixate" us. But statistics say that women who masturbate are more likely to have orgasms in intercourse than those who didn't.

Masturbation is not something to do just when you don't have a man. It's different from, not inferior to, sex for two. It's also the first, easiest, and most convenient way to experiment with your body. It's a way to find out what feels good, with how much pressure, at what tempo, and how often. You also don't have to worry about someone else's needs or opinions of you. The more you know about your body, the easier it is to show someone else what gives you pleasure.

To masturbate you have to know something about your body, and in particular about your clitoris (klit'-o-ris). This is a small round ball of flesh located above the opening of the vagina, and it is the center of most sexual stimulation. It functions like the penis in the man. When it's rubbed up and down rhythmically, you get excited. The clitoris is where all female orgasms happen, whether by masturbation, intercourse, or fantasy.

Some women masturbate by moistening their finger (with either saliva or juice from the vagina) and rubbing it around and over the clitoris. The amount of pressure and timing seems to vary among women. Some women masturbate by crossing their legs and exerting steady and rhythmic pressure on the whole genital area. A smaller number learn by developing muscular tension through their bodies, resembling the tensions developed in the motion of intercourse. Some ways of doing this is by climbing up a pole or a rope or even chinning parallel bars. Other techniques for masturbating include using a pillow instead of a hand, a stream of water, and electric vibrators. Some women find their breasts erotically sensitive, and rub them while rubbing the clitoris. It's nice sometimes to make up sexual fantasies while masturbating. Some women like to insert something in the vagina while masturbating (like a finger or vibrator), but few women get more satisfaction out of vaginal penetration than they do from clitoral stimulation.[2]

If you have never masturbated, don't feel you are confined to these techniques. Finding what you like to do is what it's all about.

VIRGINITY

The "cherry" that is to be every man's prize on taking a virgin symbolizes a traditional conception of the male-female role. The woman is to be nurtured, watered, trimmed and cared for like the most delicate of cherry trees, raised in the anticipation of the moment when the fruit will be juicy and ripe. Then it will be "plucked", "ravished", consumed by the man, for whom all this preparation was actually intended. The more delicate the tree, the more satisfying the deflowering.

Few of us would choose to look at ourselves this way. It would be a sign of great alienation to see ourselves not as people, but as sexual objects, as trees with cherries. Yet the concept is so imbued in our culture that few men can entirely avoid it. We make ourselves pretty for men. We take infinite pains with the curl of our eyelashes, with our hair. In many ways, our daily actions reflect the fact that we have accepted and internalized this conception of ourselves as sexual objects.

Virginity – the constant preoccupation of teenage and college women – has its base in our perception of ourselves as objects for the eventual enjoyment or consumption of another. One asks oneself not "What will be best for me–spiritually and physically?", but "What will they (other people in general, but especially one's future husband) think of me?" To use one's body in this way, as a physical pledge of the appropriateness of one's conduct in the eyes of others, is to deny oneself in the most basic way. Certainly there are many valid reasons for not going to bed with a man, but the preservation of one's hymen is not one of them.

Men traditionally have made a big production of the bursting of the hymen. Marriage manuals spend chapters on it. Pornographers go wild over it:

> At length by my fierce rending and tearing thrusts the first defences gave way, and I got about half-way in. . . as I oiled her torn and bleeding cunt with a perfect flood of virgin sperm. Poor Rose had born it most heroically, keeping the bedclothese between her teeth, in order to repress any cry of pain. . . I now recommenced my eager shoves, my fierce lunges, and I felt myself gaining at every move, till with one tremendous and cunt-rending thrust I buried myself into her up to the hilt. So great was the pain this last shock caused Rose that she could not suppress a sharp shrill scream, but I heeded it not; it was the note of final victory and only added to the delicious piquancy of my enjoyment. . . I drew her to a yet closer embrace, and planting numberless kisses on her rosy lips and blushing face, which was wet with tears of suffering which the brave little darling could not prevent from starting from her lovely eyes, I drew out the head and slowly thrusting it [sic] in again: my fierce desires goaded me to challenge her to a renewal of the combat. A smile

of infinite love crossed her lovely countenance, all signs of past pain seemed to vanish, and I could feel the soft and juicy folds of her cunt. . ."[3]

This episode, with all its ingredients – the man's energetic thrusts, the difficulty of penetrating the barrier, the woman's screams and half-faints, the man's triumph and the woman's blissful acceptance of her new role – are repeated ad nauseum in most pornography. In The Pearl, the scene occurs at least 24 times. This, in perhaps a gentler form, is what men have been brought up to expect in their first sexual relations with a woman.

Even sadder, and much more subtle, is the way we have come to accept the inequality between the sexes as the norm, and are disappointed when we do not live up to it. Most of that passage is a total misstatement of the way it usually is when the hymen is broken. The hymen is a pliable membrance, often perforated, and easily stretched. First intercourse often takes place with no pain at all. The man need not be a battering ram; the woman need not scream and faint. The mythology distorts reality to make women seem more helpless and men more aggressive than they are, even in today's society.

Why are we urged and expected to feel such pain? Marriage manuals give hints on how the husband can reduce the pain of penetration, but when there is no pain at all, a note of apology creeps into the text. The husbands are assured that the hymen might have been stretched or broken accidentally, in horseback or bicycle riding (unlikely, by the way: the hymen is often stretched before intercourse, but rarely broken). These books hardly ever suggest that a man is not due his quotient of pain. For the pain is what keeps the two unequal.

It is the easiest thing in the world for a woman to stretch her own hymen by inserting a finger into the vagina and periodically exerting a little pressure on the sides of the entrance. By the time she can insert two fingers, there is practically no chance of any pain during intercourse. This stretching process also is usually painless. For many women, it happens quite naturally in the course of petting before they ever have full sexual relations. Some women go to a gynecologist and have him stretch the hymen, but this seems less desirable to us because it looks to an "expert" for a "skill", leaving us once again three steps removed from knowledge of our own bodies.

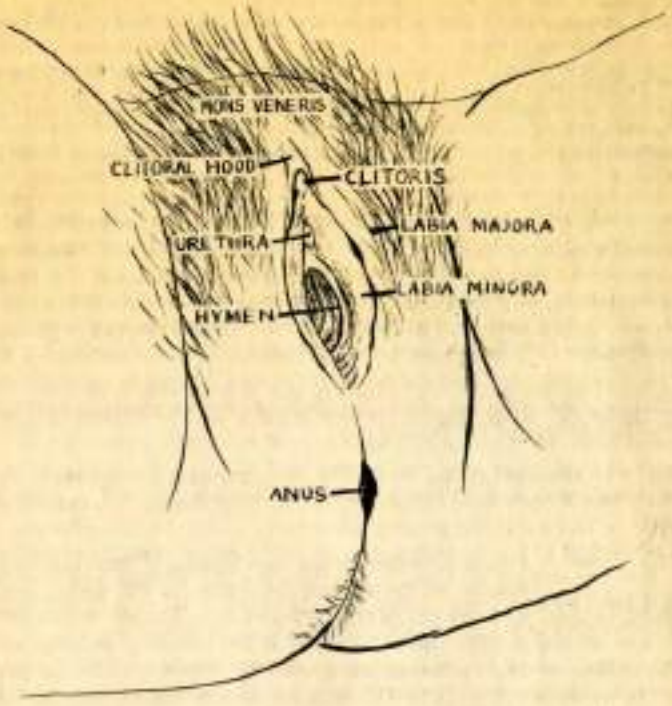
Simple as it is, most of us don't think of stretching our own hymens because we don't have any information, we are uneasy at examining our own bodies, and, most important, we are afraid of depriving men of their drop of blood. We are afraid of having our offering questioned, as not pure enough. The idea of men and women coming together as equals, with neither "offering" greater than the other, rarely occurs to us.

It may seem incredible that most of us are so ignorant on the subject of our hymens, a portion of our anatomy which literature and popular culture makes central to our identities. But this is only one of the ways in which we, by cultivating our ignorance, have set the stage for a relationship with men in which the man sets the terms of the confrontation (by demanding an offering of pain), leads the way from "ignorance" into "knowledge" (thus reinforcing as "teacher" the already inherent inequality) and guides us from our sheltered life into the real world (preserving his own role as the key to that exciting real world). In this process, we often abdicate to the man the definition of our role in the sexual relationship. Because we have no knowledge on which to base our own judgment, he determines the definition of what we should be and feel.

ORGASMS

There has long been a common misconception, still present today, that there are two different kinds of orgasms, one achieved by stimulation of the clitoris, and called a "clitoral orgasm" and the other a "vaginal orgasm" brought on by the penis moving in and out of the vagina. The first was thought to be achieved by masturbation, petting, and intercourse, if the clitoris was stimulated directly. It was considered to be an "immature" kind of orgasm, related to early sexual experiences, while the vaginal orgasm was thought to be more "mature" and to be the ultimate sexual experience for a woman.[4]

There is in fact no difference in the kinds of orgasms women have, either by masturbation, petting, or intercourse. In intercourse, it is the stimulation of the clitoris by the area above the penis which brings on orgasm, along with the pressure on the clitoris that comes from the muscles surrounding it which are moved by the motion of the penis. This does not mean that all orgasms feel alike, and it is probably because intercourse is usually a longer activity and more emotionally intense that many wo-



men thought that the orgasms they had that way were physiologically different.

This false distinction between clitoral and vaginal orgasms was elevated to "scientific truth" by Freud in an early book called Three Essays on the Theory of Sexuality in 1910. Freud was convinced that the pleasure little girls got from playing with their clitorises was of a "wholly masculine character" (whatever that means). Being a man, he assumed that the vagina, into which the man puts his penis, was the true female organ of sexual response. Consequently, he considered stimulation of the clitoris infantile. He proposed that women spend the rest of their lives in the admittedly difficult task of transferring the center of their sexuality from the clitoris to the vagina. The task was difficult, indeed, because it was physiologically impossible. Yet as late as 1951, modern Freudians were still saying that since the mass of women could not afford five sessions of psychoanalysis a week for two years, "female frigidity" (defined as the inability to have that special "vaginal" orgasm) was "a mass problem" which "unfortunately was not to be solved."[5]

Fortunately for women, two scientists, Masters and Johnson, have finally proved Freud wrong. They observed 382 women and 312 men not only during masturbating and intercourse, but also during "artificial coition" – a laboratory procedure that makes accessible to direct vision and to recording on motion picture film, internal changes observable in no other way. What they found was that all orgasms happen in the same way – in the clitoris.

Despite all this scientific evidence, male psychologists persist in treating the orgasm as a subject they can have their own personal theories about. The damaging and degrading images of women that these theories project can best be shown by quoting from one of them. Alexander Lowen, a well-respected psychoanalyst, wrote a book, Love and Orgasm, after Masters and Johnson published their results. Here's what he has to say about our sexuality. The comments in parenthese and emphases are ours.

> The *problem* [?!] of orgastic potency in a woman is complicated [??!!] by the fact that *some* women are capable of experiencing a sexual climax through clitoral stimulation. Is a clitoral orgasm satisfying? [Is a penile orgasm satisfying?] Why are some women capable of having *only* a clitoral orgasm? These questions should be answered if we are to understand the *problem* of orgastic impotence in the female.
>
> Most men feel that the *need* to bring a woman to climax through clitoral stimulation is a *burden* [!!†*]. If it is done before intercourse but after the man is excited and ready to penetrate, it *imposes a restraint* upon his natural

desire for closeness and intimacy. Not only does he lose some of his excitation through this delay, but the subsequent act of coitus is deprived of its mutual [??!!] quality. Clitoral stimulation during the act of intercourse may help the woman to reach a climax but it *distracts* the man from the perception of his genital sensations, and greatly interferes with the pelvic movements upon which his own feeling of satisfaction depends. The *need to bring a woman to climax* through clitoral stimulation after the act of intercourse has been completed and the man has reached his climax is burdensome [oh no!!] since it prevents him from enjoying the relaxation and peace which are the rewards of sexuality [sigh . . .]. Most men to whom I have spoken who engaged in this practice resented it.

I do not mean to condemn the practice of clitoral stimulation [you just did] if a woman finds that this is the way she can obtain a sexual release. Above all she should not feel guilty about using this procedure [after listening to you???]. *However, I advise my patients against this practice since it focusses feelings on the clitoris and prevents the vaginal response. It is not a fully satisfactory experience and cannot be considered the equivalent of a vaginal orgasm.*[6]

The sex Lowen describes was pretty clearly all done for the man's pleasure. Clitoral stimulation gives a woman her most intense sexual pleasure. Yet giving a woman this pleasure is considered a distraction, a burden, a drag on male satisfaction, a restraint. We are to serve the sexual needs of the man we are in bed with and look upon our own satisfaction as something that detracts from the power and intensity of his orgasm. Lowen comes down very strong for a vaginal orgasm. And no wonder. With it, the man can continue to believe in his Superman masculine powers to satisfy a woman in some mysterious inner chamber of her body that only he can reach, while maximizing his own pleasure because he doesn't have to be "burdened" by the knowledge of her frustration.

It is astonishing to be so totally disregarded by Lowen. In a paragraph supposedly about women's orgasms, he talks exclusively about male burden, male pride, male pleasure, male resentment and then has the audacity to tell us not to feel guilty for seeking our own pleasure. How frightening that he can use his moral authority as an analyst to tell women not to go after clitoral stimulation and to write a book whose only effect is to make us deny everything natural about what we need and then make us feel we're frigid or neurotic. There are a lot of Lowens around. They charge a lot of money, write a lot of books, and it will be a long time before our sexuality is written the way we know it.

First we've got Lowen telling us what we're not allowed to do, then we've got the pornographers and a lot of romantic novelists telling us of the ectasy awaiting us. An orgasm is not a mystical experience, it is a physical experience, and here's a description of one.

What happens to the body during orgasm can be divided into four parts. First there is the excitement phase, beginning with the moistening of the vagina. The nipples on the breast become erect, and the breasts increase in size. Other muscles tense, and a rosy glow called a "sex flush" appears on the skin. Excitement is followed by the plateau phase, although it would be hard to say exactly when one phase stops and the next begins. Now the rate of breathing increases. Muscle tension is heightened. Most dramatic is the swelling of the tissues around the outer part of the vagina, which makes the width of the vagina half its normal size, and able to grip the penis. The clitoris elevates like a male erection and the inner lips change in color from pink to bright red. This color change means that the orgasm is going to occur in about a minute if stimulation continues.

Orgasm itself is the third phase. There is a feeling of intense pleasure as the vagina goes into rhythmic muscular contractions until the intensity tapers off. The number of contractions vary with the intensity of the orgasm. The uterus also contracts rhythmically in wave-like motions but this isn't felt.

All the body's muscles respond in some way (even hands and feet contract in a spasm). After the orgasm a kind of final resolution occurs. The swelling of the nipples subsides, sex flush disappears, and the clitoris returns to its normal position. It may be as long as a half hour after orgasm before a woman's entire body returns to the state it was in before she was stimulated. If she has reached the plateau stage without reaching orgasm, it will take much longer.

Orgasm can be a very mild experience, almost as mild as a peaceful sigh, or it can be an extreme state of ecstasy with much thrashing about and momentary loss of awareness. It can last a few seconds, or for half a minute and longer. There is, in brief, no right or wrong way to have one.[7]

It's still possible for some of us to know all of this and still not have orgasms. Here are some of the reasons we think this still happens:

1. We don't notice, or notice and misunderstand, what's happening in our bodies as we get aroused. We don't pay attention to what turns us on. We're too busy thinking about abstractions – how to do it right, why it doesn't go well for us, what he thinks of us, whether he's impatient, whether he can last –

when we might as well be concentrating on the sensations, not thought.

2. We know what we want at a particular moment but we're too embarrassed to indicate what it is. We're especially unwilling to do anything to get our clitorises touched because we buy Freud's line that liking it is proof of emotional underdevelopment. Sometimes we're afraid that the guy will take it as an attack on his manhood. Maybe he won't and we're too tied up to see that. But just suppose he does take it badly and he's upset. Should we play along with his hangup and pretend that what he's afraid of is real?

3. We are afraid of asking too much, asking for more than he can give, afraid he won't hold out as long as we want him to.

4. We rush into it. Or let our partners rush us into it. We end up fucking with great intensity, swept off our feet just like in the movies and swept under the rug when it comes to climaxes. If you're getting passed by, it makes sense to slow everything down drastically and never escalate the situation without a clear and pressing physical impulse that tells you to. At this point we tend to get afraid that something is wrong with us – the impulse will never come. At these times it helps to remember that you have your own pacing.

5. You've never had a climax, so you never will. This has no basis in physiology. The only physical feature common to frigid woman is that they don't have a climax. When you've been feeling hurt, sad, or angry about this for too long, you institutionalize it so you won't have to deal with it any more. You give up. You are hope-less.

6. You've been making it with the same guy for a long time and never or practically never been satisfied. You're (naturally) angry at him for this and consequently you don't want him. You continue to make it with him, but you're not involved in it. You feel you're being used. Maybe you're right. More likely he'd like to please you, but he doesn't know any more about it than you do, and if you're willing to forget it, why shouldn't he? After all, he's satisfied.

7. You're putting up with a lot that you don't want in a relationship – an unfair share of the responsibility, a coldness and a distance, or a kind of cruelty. You're angry, but you don't fight for what you want. Or you fight and lose, but don't leave. You sense you're losing, and you don't know how to win. You're resentful or "fucked over", a term which says a lot about sex in these situations.

8. You expect to be instantly free and at ease with guys you don't know very well or feel very close to. Maybe some people are. If you're not, you're not, and you might as well start from there.

9. You get on the right track, but you expect instant results. You don't recognize how many bad experiences you have to overcome. You get tense and you don't give yourself enough time.

It is hard to feel relaxed and loving in bed when there are so many lies to overcome. But getting preoccupied with the search for sexual success is just another way to hurt yourself. If there are times you'd rather just not deal with it, that's cool too.

FANTASIES

I masturbated to this fantasy: an older woman whom I had never met entered a dressing room I was in. After a brief conversation, I placed her against the wall and explored her body with my mouth. First her breasts, then her vagina. As I fantasized this part, I had an orgasm. Afterwards, I felt very disturbed because making love to a woman had been so intensely pleasurable and I was afraid of being "homosexual", and because the woman I created was older and made me think of my mother. I would decide that it was a bad fantasy to have had, and that I was a little abnormal for having had it.

I imagined I was sitting in a room. The walls were all white. There was nothing in it, and I was naked. There was a large window at one end, and anyone who wanted to could look in and see me. There was no place to hide. There was something very arousing about being so exposed. My heart started to pound and my stomach sort of pulsed in a very powerful way. I masturbated while having this fantasy, and afterwards I felt very sad. I thought – I must be so sick, so distorted inside that this image of myself could give me such intense sexual pleasure. It was more satisfying than making love.

It feels terrible to have fantasies when the part we play in them threatens our self-image. We use them to call ourselves names. Which is too bad because those stories are pieces of us wanting to get listened to, and we keep shutting them off because we're afraid of them, afraid that if we accept them as part of us, then we're "abnormal" or unlovable, or worthless. We call these fantasies "immoral" or "perverse" so we don't have to take responsibility for the fact that we liked them. What does it mean to "take responsibility" for our fantasies? It means, for example, if we are aroused by an image of ourselves that is aggressive, we might at first prefer to deny this. But eventually, we might come to feel that aggressive sexuality is acceptable and that only some left-over myths about femininity have kept us from expressing this kind of aggression. Or, if being sexually humiliated is erotic, we might come to question why it is that humiliation which hurts in other situations is pleasurable in bed. What does this say about how we feel about our bodies, or our "rights" in bed?

Fantasies tell us something about the reality we're in – who we'd rather be in bed with, what we'd rather be doing, what we'd rather be feeling. Taking responsibility for them does not mean name calling or self-hate; it merely means accepting our feelings and then trying to understand them.

HOMOSEXUALITY

Between the ages of nine and eleven, my friend Judy and I would sleep over at each other's houses about once a week. We really dug each other. We'd touch each other's breasts and vaginas with a lot of excitement. We looked forward to playing sexually with each other, but knew very clearly that we shouldn't get caught.

A few years later, I was playing with two or three other girls and we decided to play with each other's breasts. I participated, and with some excitement, but in contrast to my experiences with Judy, I was already feeling pretty scared and guilty.

I was riding on a subway in New York and a sudden wind lifted the skirt of a woman seated across from me. She wasn't even young or pretty, but I was suddenly aroused. It scared me and confirmed my fears that my sexual problems with men were due to the fact that I was latently a lesbian.

I started reading Playboy when I was in college. My boyfriend used to buy it. A couple of times when I was alone, I would flip to the centerfold and the other nude pictures and masturbate. Sometimes I would even put my breasts against the pictures. I felt perverted.

Many of us have had some experiences like these – sometimes it's just a vaguely arousing feeling around another woman, or when looking at a picture. Some of us have even had some sexual play with a friend. But for everyone these incidents were filled with tremendous anxiety and self-hate.

In retrospect, we are angry at being made to feel so terrified at such common childhood experiences. Strong feelings toward anyone we care about have some sexual content to them. Besides, why not explore new and exciting territory with a friend?

But look at the difference between the first memory and the two that followed. It's very clear that as we got older, we didn't feel chummy and exploratory any more. Most of us felt perverse and sinful.

In some respects we were right to feel that way. We grew up in a culture that made us feel that the only important aspect of a woman is her body. It made women into all boobs and thighs and holes to penetrate. Masturbating to an image of a Playboy Bunny is as aggressive and predatory as the men who leer at us on the street. The all-American available girl. Play out all your fantasies on her or in her. What a difference from the friendly and genuine sexual contacts we had with each other as little girls.

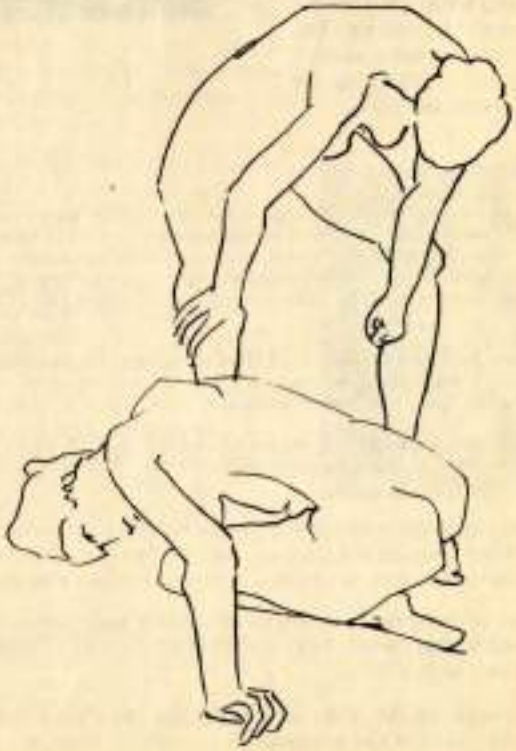
I started reading Women's Liberation literature when I was 25 and happily married with a year-old child. It shattered me. It was the missing link that helped explain the feelings of dependency and unimportance that still remained after many years of therapy and struggle. A few months later, I left my husband. I wanted to be alone and get some strength and identity. I began taking karate and started to get a crush on my female teacher. She was about my age, and was very strong and wise. We never talked much, but I dreamt about her twice. In one dream, I had met her at a party and we just sat next to each other talking and smiling. In the other, I found her badly beaten up and I held her in my lap and nursed her wounds.

The woman who had this dream said that it had nothing to do with power, nothing to do with rape, nothing to do with pornography, but it was still about sex. Many of us have these strong feelings for each other. A woman we know who recently had a love affair with her friend said that it was the first time she felt like an equal in bed. The roles of submission and aggression disappeared. She never felt like she was giving in, or giving up. She didn't have to pretend to feel things she didn't feel. And the sex was really good because each of them could sense what the other needed, just because they were both women.

AN OPEN LETTER TO MY SISTERS

Why shouldn't we be lovers? I wouldn't suddenly begin to let you take me over and do your bidding. I wouldn't try to model myself after you. I could have loving and independence too. You wouldn't mess me over in bed for lack of empathy with my body. I'd know me better by knowing you. I wouldn't be afraid of being left, or feel jealous if you were with someone else. I'd be more secure in our friendship knowing that we were touching each other because we like each other. There's plenty of loving to be made in the world – no need to fear for where the next good time is coming from. Why shouldn't we? Not because we hate men, but because we love ourselves.

It's very romantic to expect that all those hangups with men will disappear with women. But at least



there isn't that old script to follow. There aren't any ready-made roles to fall into. Whatever happens will arise out of the situation and not out of some phony expectations. There will be times in our lives when we will feel more sexual rapport with women; when we're working with them, or living with them, or loving them. Sometimes that choice springs from fear of men. Fears of rape, of powerlessness, of humiliation are common and in our culture such expectations are realistic. An incredible number of women - including middle class well-protected women - have had horrifying experiences of sexual abuse. Out of fifteen women who discussed the topic recently, four had been raped. But violent attacks by strangers are only a small part of the collective humiliation we all have felt.

> One of my first boyfriends felt that I didn't appreciate his penis enough. He forced me to kneel down so that my face was at eye-level with his penis and then made me caress it so that it would become erect. As it began to rise closer and closer to my face, I was supposed to tell him how beautiful and powerful it was.
>
> My boyfriend wanted me to suck his penis. I didn't like doing it because it made me gag. But he would keep pushing my face down on it. The only way I was able to do it was to imagine I was standing in a field of carnations so that I could keep my mind off what I was doing. This used to happen a lot.
>
> I was making out with a guy I had been dating for awhile on a deserted island. I had told him that I didn't want to sleep with him. Suddenly he started taking my underpants off. I told him again, but he wouldn't stop. I suddenly realized that he was much stronger than me and I panicked. I started crying and yelling and he just fought harder. Finally he stopped and said that he thought I was just teasing and that I had really wanted to screw all along.

"Frigidity" with men, or a turn toward female lovers is not surprising when the socially acceptable heterosexual encounters have been so destructive. Psychologists call this abnormal. Fear of men, they say, is abnormal. We say, each of us will have to draw our own conclusions, and deal with our own fears. For some this may mean getting our bodies in shape so that we can fight with men on their own terms. For others, it just means choosing the right male lovers. And some of us may just decide to chuck the whole thing and express our love and sexuality with each other. It may be that what we need to do in order to maintain our integrity as human beings is to move freely through these and other choices given the circumstances of our lives at any particular time, and not be bound by myths and taboos that keep us from doing what is right for us at each moment.

CELIBACY

Celibacy has helped a lot of women we know get closer in touch with themselves because it cleared away the sexual distraction. Sexual relationships quite often produce a lot of anxiety. You question yourself about why you didn't come, or did he like it, or does he really like my body, or wouldn't he rather be in bed with so and so. It's not that it's always inappropriate to ask those kinds of questions; it's just that they take up huge amounts of psychic energy and leave you drained and unfit for other activities and thoughts. Always being into a relationship with a man leaves you defining yourself in terms of the relationship. If there's no man in your life, you must be worthless.

My first reaction to being without a man was frustration and anger. I wanted a man to sleep with. I thought, well, here I am feeling pretty liberated sexually, and there's no one to sleep with. The intensity of that feeling was short lived. I thought less and less about being with a man. I had very relaxed times with my friends during that period. I was never tense and waiting for a phone call. I was not afraid that I would lose someone. I didn't have to think twice about making plans with friends for dinner. I was free. I was not asexual during this time. I was masturbating with much pleasure. I was having different kinds of orgasms, some long and slow and rippley, others short and jerky and tenser. I was exploring my sexuality in a way I had not with men. I had the time and space for a lot of things. It was easier to do the work I wanted to do because of my sense of me being my only obligation. At this point I saw that my initial frustration at not having a man had to do with a judgment I was making of myself. A man meant completion. Without one I could never feel whole. After several months of celibacy, I was feeling pretty whole. I was functioning on approval and good feelings that I supplied from me to me.

We've found this experience to be common among women celibate for a while. A friend of ours was celibate for two and a half years. She didn't masturbate, and she didn't miss sex. A lot of the stories we've heard talk about the growing ease with which it becomes possible to move in and out of sexual relationships. The anxiety of being left by a man diminishes because being alone has been a positive experience. Which is not to say that we're recommending enforced celibacy for everyone. Just that it's not only not the end of the world, some of us have even dug it.

MONOGAMY

So where does all this liberation and independence lead us? Away from the tight, all or nothing kinds of relationships we're used to having with men. Towards thinking of our lives as centered in ourselves and shared in part by others. Towards more love relationships with more kinds of people because we aren't hemmed in and defined by strict roles. Out of the growing list of new options - men, solitude, work, friends - comes less of a need to bank everything on him. It makes it easier to consider having more than one love affair at a time, and easier to allow him the same option. We know a lot of people who are trying to expand their monogamous twosomes to include three, four, or a community of people.

But giving up monogamy is giving up the way we know how to relate to men best. We've all been geared to one man at a time as an Absolute Rule of Relationships. Most of the attempts to break out of that make the people involved pretty anxious.

I was confused about what I wanted from the man I was seeing. I cared about him a lot, and really liked being with him. I was also very much into Women's Liberation and was reveling in feeling creative and independent on my own. I felt some guilt about the times I chose solitude over intimacy. He had a very close relationship with one of my best friends, and one day it seemed that if I allowed them to have an affair, I would have the best of both worlds. I wouldn't feel as troubled about the pitfalls of a tight relationship, while still being able to see the man I really dug. I told them both, separately, that they should sleep with each other if they wanted to. When it pretty quickly looked like they wanted to, I went to pieces. I told them later that I couldn't handle the anxiety, and now wished very strongly that it would not happen. They respected my wishes, but for a long time afterwards, I could not relax when the

three of us were together. I still felt that if he had slept with her, it would have been a rejection of me.

I had been living with a man for a year. We had a pretty loving and open relationship. There was suddenly a lot of withdrawal emotionally and physically, and he wanted to sleep with other women. I felt too weak to leave him, and besides he kept saying that he still loved me but that he didn't want to be owned or to own me and he didn't want to deny his real feelings and impulses towards other women. The problem was I agreed with everything he said. I even believed that sex between us would get better if I gave him some room to move, but I was terrified. He had a short affair with a woman we both knew and it wasn't as bad as I thought it would be. But I was very angry at him. Every time he referred to her I could feel the anger rising and when he wasn't around I was always afraid he was with her. I was afraid he would meet someone else, or a few other people, and I would just be one of many. It all culminated when he told me he wanted to sleep with my closest friend. It was doubly scary because she had been really helpful to me during all the problems he and I were having. It sounded like he had all the answers. We all loved each other. True. We had better times as a threesome than in any pair of two. True. He and she were attracted to each other. True. We all should be lovers. Uh oh. Both she and I were intimidated by the rightness of what he had to say. We found it hard to come up with any reason other than fear of change for not trying it. For the next month we were together most of the time, feeling like three people in love, though they still hadn't slept with each other. Unfortunately, below the surface I was suddenly feeling competitive with her. We had been friends for ten years. She was feeling pressured and angry at him, and he was wondering why we didn't want to share his vision. We finally talked it all out and understood that there was a lot of mistrust of motives and a lot of bad feeling building up. We clearly aren't ready for it.

We have a lot of theories about what we should do to live up to some idealized image of ourselves. But it makes no sense to give up monogamy because that's an impressive achievement, or because we think we have to. Sometimes choices have to be made and getting out may be better than being a weak link in a triangle not of our choosing. We'll be in triangular or communal relationships when we really want to be because they fill more of our needs and make us happy.

CONCLUSION

Accepting the cultural stereotype that has for so long been imposed upon us, we see ourselves primarily as sexual beings. If we look for fulfillment, it is to be fulfilled "as a woman," and by this we mean having children, raising a family, and having an orgasm every time we go to bed. A fulfilled woman, or a "liberated" woman, in the popular mind, is one who radiates sex.

To accept this definition of fulfillment is to be forced into just the straight-jacket society would like to see us in. It means that when we think really deeply (and maybe despairingly) about ourselves and who we want to be, we think mainly about our sexual competence. More women go to psychiatrists asking how to have an orgasm than they do asking how to have fulfilling work.

It takes courage to redefine our priorities. It takes courage just to stop putting on make-up when we think our face is unacceptable, let alone to actually make demands on a hostile world. We shouldn't hate ourselves for not having the courage when we need it – any women who has thought about her own oppression would understand. A lot of us have found that getting together with each other has made it easier.

To any men who happen to read this: This pamphlet was not written for you. Please do not use it as a marriage manual; please do not "try out" the "techniques" you think have been suggested here; please do not suggest to your girl that she read it. If you do want to change your behavior and you are living together, you might start doing half the housework. If you insist on being preoccupied with her as a sex object and want to know specifically what you can do in bed, you might try to become more open to her wants and needs. Listen to what she says, and if you can, do what she asks. In the long run you should try to change your own life, and the society, so that you can be pleased with and proud of yourself without having to exploit her. For either of the sexes to be free, both you and she must be leading worthwhile lives.

But good relationships are difficult, if not impossible, if we don't understand ourselves and our own needs. Asking and being given, telling a need and having it fulfilled, free one to be able to give. This is difficult, if not impossible, when men and women come together not as equals, but as the teacher and the taught, the admired and the admiring, the assertive and the acquiescent. Good relationships must be mutual. They must be built on each partner's feeling as competent and in control as the other.

The goal of this pamphlet, and of the Women's Liberation movement, is to help us move towards a world in which human relationships can be more free, more satisfying. This means freedom from the damaging effects of a traditional sexual caste system; it means freedom from class and racial oppression, and it means freedom for all from want and from alienating work.

No one can ever know the potential of humankind for goodness and for fulfillment until she has explored her own potential. And no one can fully appreciate the possibilities for change in society until she has changed her own life. By looking carefully at our needs, and finding out how to satisfy them in this world, we are fulfilling one part of ourselves and freeing the rest for other satisfying work. We are learning what the world could be like for everyone, in all aspects of their lives.

This pamphlet ought to be more than an experiment in education. It ought to be the beginning, for us, of a revolution.

FOOTNOTES

1. "'Sexual Liberation': More of the Same Thing", by Roxanne Dunbar, in *No More Fun and Games*, Issue Three, was the source of many of these ideas.
2. *Girls and Sex* by Wardell Pomeroy, Delacourt Press, was helpful to read.
3. "La Rose d'Amour", *The Pearl, A Journal of Facetiae and Voluptuous Reading*, New York, Grove Press, 1968, pp. 253-4.
4. Pomeroy, *op. cit.*
5. Edmund Bergler, *Neurotic Counter-feit Sex*, Grune & Stratton, New York, 1951.
6. Alexander Lowen, *Love and Orgasm*, New American Library, New York, 1967.
7. Pomeroy, *op. cit.*

Some Myths About Women

We know there is no universal definition of feminine behavior and character. In some cultures the women are the hard workers and in others the men are. In some cultures pregnancy is resented and children are an imposition; in others pregnancy and children are idealized. To a great extent each culture determines sex roles in its own way and sets up its own mythology which embodies the culture's ideas of sex roles. Common myths about women in our culture are that women are inferior to men, women are sexually passive, females are the beautiful sex, and women are to provide all the nutrient and caring functions in the society. We have learned these myths through institutions of our society, especially the family, schools, and media. We are beginning to challenge these myths and think of ourselves in new ways. We believe that much behavior and feelings that are considered feminine no longer describe us. We are beginning to define ourselves differently, and our new self-definitions embrace a far broader notion about what women are and can be. In this chapter I want to explore some of the prevalent myths that we have outgrown.

What cultural myths concerning feminine sex roles were we taught? How did we learn them? Let's begin with the myth of women's inferiority to men and notice how it's reflected in the following telephone conversation.

Salesman: Hello, Mom.
Mrs. Hunt: Yes, who is this, please?
Salesman: I'm from Prudential Life Insurance Corporation. I understand you just had a new baby.
Mrs. Hunt: Yes.
Salesman: What was it, a boy or girl?
Mrs. Hunt: A boy.
Salesman: So much the better!
Mrs. Hunt is silent. She is into Women's Liberation.
Salesman (giggles nervously): I guess his Dad looks at it that way.
Mrs. Hunt is silent again.
The agent laughs foolishly again and launches into his pitch.

You might think that the male bias reflected in the above conversation is a relic of the past, but the conversation transpired three months ago! In our

culture, primary distinctions between people are made on sex lines. One's genital organs tend to determine the worth and the value of one's behavior. In our culture women are devalued.

With this in mind I'd like to cite two studies. The first is by a psychologist Philip Goldberg. He asked women college students to rate a number of professional articles from each of six fields. Two equal sets of booklets were collated – one attributed to a male author and one to a female. Each student was to read the articles and rate them for value, competence, persuasiveness, and writing style. The identical article received significantly lower ratings when it was attributed to a female author than when it was attributed to a male. This was true for articles from traditionally male fields like law and city planning but also for articles from fields usually considered female, like elementary school teaching and dietetics.[1]

In a second study by Matina Horner, women college students were asked to write a story based on the following sentence. "After first term finals Anne finds herself at the top of her medical school class..." The same sentence is given to men students but the name is changed to John. Most women's stories described Anne as an "unattractive acne-faced girl who is unhappy because nobody likes her". Or they describe Anne as "wise enough not to make this mistake again on the next exam so that the men she likes can do better".[2] These studies do suggest that women have internalized a sense of second rateness, particularly with regard to doing meaningful and competent work in the society.

Most of the important, interesting, and creative work of the society that is recognized is done by men. They are the writers, philosophers, artists, historians, engineers, doctors, politicians, lawyers, architects, and administrators. True, some women enter into these male fields, but most women work in the home as childrearer, and housekeeper or in related fields like teaching, nursing and waitressing. Also open to women is work involving the "sexual sell" such as modeling and prostitution. Our society puts us in contradictory roles, some which we value like child-rearing, teaching and nursing and some which we don't, like "sexually selling" ourselves. What angers us is that all the other capacities of women tend to be underplayed or ignored and consequently women feel inadequate in other areas. And in a sense we don't have a choice. In colonial America this societal division of labor made some sense in that the population had to be maintained and women had to bear many children, so they worked in the home. Work outside the home involved physical strength; men are considered more suited for heavy physical work. But in 1970 most work does not involve physical strength and can be done competently by both men and women. Also women now have more time available for work since they use birth control to limit their family's size. Still, women are told they are not competent in fields outside the home and have internalized this sense.

Since men do most of the innovative work in the society, it is not surprising that women find a male point of view or bias in much of the writing, media, and social institutions that they encounter. A humorous account of how male bias might appear in a biology text is written by Ruth Herschberger in her book Adam's Rib. She writes two accounts of human reproduction. One account is a conglomeration of outpourings from "patriarchal biologists". Here is an excerpt from that section.

> The simple and elementary fact behind human reproduction is that a fertile female egg awaits impregnation in the fallopian tube and the active male sperm must find the egg and penetrate it.
> The female sex apparatus is a depression to receive sex cells; the male organs are advanced in order to expel cells.[3]

She then writes a fictitious "matriarchal biologists" account.

> The simple and elementary fact behind human reproduction is that the active female egg must obtain a male sperm before it can create a new life.
> The male apparatus is a "tiny factory" which continually manufactures sex cells for the female reproductive system.[3]

In a similar way male bias is written into marriage manuals, sex education literature, and medical texts. When we become aware of this dominant male point of view we begin to see male bias everywhere. Most novels have male as opposed to female sexual fantasies. Movies are directed by men who see women through men's eyes. A friend of mine notes how she was listening to a poetry reading of a love poem from a woman to a man. The poem talks about how the woman desires the man's body in a sensual way. My friend notes how she became slightly embarrassed in that she never publicly heard a love poem from a woman before. It is no wonder that women tend to view themselves through men's eyes since they have had very little experience hearing a woman's point of view. And even when we have heard a woman's point of view, we don't value it as much as a man's.

Not only do women tend to view themselves through men's eyes, but they view other women through men's eyes. An artist friend of mine brought her etchings to an art gallery to enter in an exhibition. The male director told her that her work was fine but refused to exhibit her etchings because he was showing too many women artists. My friend replied that she didn't know there was a sex quota. At this point the director's female secretary replied, "Listen, Miss, didn't you hear. We cannot accept any more women's work."

The vision of a male dominated world is of course reflected in the sexual roles that we were taught. This brings us to our second myth – that women are sexually passive and subordinate to men. Let's look at a few passages from Seventeenth Summer, a teenage novel which nicely illustrates the myth. Angis, the heroine, is a sensitive, serious, acne-faced girl who feels unappreciated and unnoticed. During her seventeenth summer Jack picks her as his girl. With Jack she becomes legitimate as a person. She experiences this transformation.

> It's funny what a boy can do. One day you're nobody and the next day you're the girl that some fellow goes with and the other fellows look at you harder . . . and the girls say hello. . . Going with a boy gives you a new identity.[5]

At another point innocent Angis notices couples parked in cars and expresses to Jack her bewilderment as to what is happening. "He says, 'You're a good kid, Angie,' and looks at her tenderly."[6]

Let's look at some of the attitudes reflected in the above passage. One attitude is that man is active and woman is passive. It is Jack who finds Angie. He wakes up the Sleeping Beauty. Jack is the actor and doer. Jack is the sexual initiator. Angie waits to be found. Angie is sexually asleep and numb. Jack embodies energy and Angie receives of it. These are the sexual roles our culture teaches us. Men are taught at puberty that they'll begin to feel sexual, they're allowed to masturbate (well illustrated by Portnoy in the recent Roth novel) and to be hot for a woman. Overt sexual intiative and aggression is encouraged. Throughout childhood girls have no overt acknowledgement of sexual organs except in relation to urination and future childbearing. Rough physical play like tumbling, wrestling, and chasing is discouraged. Girls are taught that they need sex less than boys. Their role is to restrain men and also to respond to them. Girls tend to have little sense of their own sexuality since they are so preoccupied with how men are acting. If they have a sense of their own sexuality they devalue it – it doesn't count.

Unfortunately the relationship that ensues when boy meets girl is somewhat impossible. In the myth the male has carte blanche to take the unwilling woman. Under his charisma she will yield and love it. The man sets the stage and takes full responsibility for the sexual act and the woman succumbs. What is missing is the notion that to have a sexual relationship both partners must be predisposed, actively participate and have some sense of what their sexual needs and desires are. But women have been taught to deny their sexuality throughout their childhood and adolescence.

What is also implied in this notion of a sexually passive subordinate female is that what satisfies a woman is indistinguishable from what satisfies a man. This leaves no room for women to define their own forms of sexuality. Recently this whole notion has been challenged by Masters and Johnson. Their study reached new conclusions about female orgasms. For the woman the orgasm is centered in the clitoris, whether resulting from manual pressure, or indirect pressure caused by the thrusting of the penis during intercourse. The dichotomy between the vaginal and clitoral orgasm is false.[7] Since female satisfaction depends on some clitoral stimulation a woman must have some sense of her sexual self which is real and different from a man's for her to ask for or want this experience.

Let's return to Seventeenth Summer. A second attitude is that a woman needs a man to feel real and socially acceptable. Through her relationship with Jack, Angie gains recognition by other men and women. A woman is affirmed if she's attractive and approved of by men. Her desirability as a person depends on male approval and not her own. This explains the poignant search girls embark on during adolescence. By locating themselves in strategic places in school and during summers, by befriending popular girls to "cash off of", by devoting much time and money to self-beautification of face and figure, and by devoting all intellectual, emotional and physical energy to manhunting, girls strive for their ultimate status, a man. The woman's need for a man becomes perverted in that she expects him to provide her with an identity and a sense of worth which of course she ultimately has to find for herself.

This myth has tragic implications for the emotional development of women, for relationships amongst women, and relationships between the sexes. Women's Liberation is trying to break down these myths in order to find a more real way of being and relating.

Now we come to the myth that women are the beautiful sex. What is pernicious about this ideal of feminine beauty is how it functions in the society. It seems to work against women in that we all are demanded to be beautiful – an impossible demand that breeds insecurity in women. Not only is it unfair to demand beauty from women as a group, but the standards by which we are judged conform to white anglo-saxon notions of beauty and don't incorporate other ethnic and racial groups' ideals. No wonder women tend to feel inadequate about their appearance.

Let me here quote a dialogue from a therapy session between psychologist Albert Ellis and a patient.

"How do you feel about yourself?" I asked
"What do you mean?"
"You know, your intelligence, ability to get along well with others, looks and things like that."
"Oh, I guess I think I'm intelligent enough. And others like me well enough - I think - if I give them a chance to."
"And your looks?"
"Awful."
"Awful?"
"Yes, why my hips are too high. I don't like them. And my back's too thin and my shoulders, they're not rounded enough and - Oh - just everything, awful."[8]

Ellis talked with 27 women patients, ranging in age from 16 to 50, to investigate the possible relationship between women's emotional disturbance and concerns about beauty. Every woman was concerned about her looks. Ellis feels that half of these women would have fewer psychological problems if they weren't concerned with deficiencies of face and figure. He set up a control group of women who were not in therapy and all but one woman had feelings of inadequacy about her looks. Indeed we have internalized society's demand that we be beautiful and hate ourselves when we don't conform to the impossible standards.

Advertisers of fashion and cosmetics industries play on women's vulnerability because their profit depends on women trying to compensate for their physical inadequacies by purchasing products. Women are bombarded by industries' advertisements in magazines, newspapers and TV advertisements which look at women's looks, judge women's looks, prey on women's insecurities, and then offer beauty aides to compensate for major and minor flaws. Women can buy vaginal deodorants, falsies, make-up, plastic surgery, wigs, hip-flattening or hip curving girdles and weight loss courses, to mention a few. As soon as one "beauty problem" is solved, industries create a new flaw to be compensated for. For example, it wasn't until recently that women felt a need for false eyelashes or colorless lipstick for the Natural Look. Women become so hungup on this search for beauty that will make them loveable, sexual, and acceptable that they fail to realize that they are being manipulated as consumers. This trend continues into the seventies engulfing men as well. And why this frantic search for beauty? Society makes it impossible for us to function if we don't. It gets us a man and a job. Why is this crippling us? Because we are forced to be preoccupied by how we appear to others rather than be concerned by how we feel from within. We would like the reverse to be true.

Now for the last myth that women's work is in the home as homemaker and childrearer or in related nutrient, serving, and maintenance jobs such as nursing, elementary school teaching, or waitressing. This attitude is expressed in a letter written by a professional man which appeared in the Confidential Chat Column of the Boston Globe on March 6, 1970. Here are some excerpts.

"Mom, were you a sexpot?"

My problem is how to persuade my wife, a junior college graduate, that it is her job to provide her family with clean clothes, decent regular meals, and a reasonably clean home.

Recently she has built one of her hobbies into such a time-engrossing thing that she actually hasn't time for her home or her family. . . I thought hobbies were what you did "in addition" to required work in your spare time, not instead of.

What protection does the modern husband have? Where does he go wrong? Is the modern girl too emancipated? Is sliding into bed between clean sheets every week too lavish to even dream of? Is coming home to a wife who has given of herself during the day for your comfort a Utopia?

Disillusioned and Disgusted

We cannot know exactly what psychodynamics are going on between this husband and wife, but it seems that Disillusioned has made a common mistake in that he has equated his wife's loving with housework and child care. Rather than considering housekeeping and 24-hour childrearing as work, and rather menial work at that, and realizing that this work and family income earning work can be divided up between marital partners in a multitude of ways, Disillusioned assumes it's his wife's duty to provide these services and that any

other interest that she has that does not concern the home must be subordinate.

When we begin to examine the role of housewife and mother, we can see why Disillusioned's wife has not found it totally fulfilling. A woman spends her day cooking, shopping, cleaning, laundering, ironing, and house cleaning; a set of fragmented tasks that must be repeated daily. Life is a series of errands. Often for middle class women, this takes place in a suburban setting which can be lonely since families live isolated from each other. Also the urban and suburban environments are so spread out that a woman spends much time in a car in order to accomplish what she has to do.

With modern birth control, we have the possibility to define ourselves as more than mothers. Even though children give us pleasure, the role of mother is confining alone. Child care does not provide women with meaningful life time work. What's incredible is that so many women choose it. Why? Part of the reason might lie in the fact that most jobs open to women, particularly uneducated women, are more demanding and less interesting than being a housewife and mother. Another reason is that middle class women find it hard to do housework and childrearing as well as independent work since the society does not provide childcare centers. But most important is the idea that in our society all women are expected to play this role and their motivation to define themselves differently has been suppressed.

Let's see how women are told to become wives and mothers exclusively. A prime influence is parents. Children emulate parents. Little girls begin to notice that mother is at home and daddy is at work; men and women do different kinds of work. Schools influence sex roles. Educational institutions differentiate the sexes and provide different education for boys and girls within the same classroom. Marked sexual differentiation is made as early as kindergarten through the kind of games they play and the kinds of toys they play with. Girls' playing space is the Doll Corner, an area where motor activity is restricted. Her toys are dolls, household cleaning things, make-up sets, food product sets and ironing boards. She gets the message that taking care of baby dolls and doing housekeeping tasks are appropriate behavior – just like mother. Meanwhile boys have larger space to play in and are encouraged to be active and independent. They have trucks, kites, models, and blocks to play with.

As girls enter elementary school they learn their sex roles from books in addition to toys and games. Jamie Kelem Frisof's article entitled "Textbooks and Channeling" analyzes the sex roles men and women play in America as depicted in five Social Studies texts written for grades 1-3. Here is a summary of some of the findings. In the five texts combined men are shown or described in 100 different jobs and women in less than 30. Women's jobs serve people or help men do important work or do work that was once done at home. On one page the child is to match instruments of work with the worker. There is one woman depicted and she had to be matched with a shopping cart. Men go places, struggle against nature, direct large enterprises, make money, and gain respect and fame. Women have few jobs of interest so they might as well be home. But their work at home as housewife and mother is not considered work or as important as men's work. The books lack interesting and competent female figures. Even though girls do better than boys in elementary schools they are taught in these years that their futures are limited.[9]

Another major influence in defining sex roles is the media: television, magazines and newspapers. In the media the role of housewife and mother has been glamorized and romanticized. Major responsibility for the over-glamorization of the housewife and mother role lies with the household appliance and food industries. They've created the image of the happy housewife and make women feel unfeminine and inadequate if they do not feel fulfilled in this role. Why encourage the woman to be at home? Because women at home tend to be the best consumers and the industries want profit. So women are manipulated by advertisements to believe that they will get a sense of identity, purpose, self-realization

and joy by buying things for the homes and staying at home. Rather than look for new means of fulfillment women buy the line and look for fulfillment at home.

We can conclude from this discussion that by the time a girl reaches her twenty-first birthday much of her motivation is directed to be wife and mother. Other roles are made to seem inappropriate or unfeminine.

Women today are trying to break down myths concerning feminine sex roles that they were taught and are beginning to think of themselves in a new way. For this new self definition to be more than just an idea we must work for changes in the society. Here are some possible changes in the realms of work, education, and culture. (Some of these demands are listed in the Bread and Roses Bill of Rights.)

1. Childcare, by men and women, during working hours, provided by the employer and controlled by the workers and the community.

2. Maternity and paternity leave for men and women with guaranteed return and no loss of pay or seniority.

3. Increasing of part-time work and an end of discrimination against part-time workers.

4. Low grade work should be shared by men and women as well as housework. Housework should be recognized as legitimate work which deserves pay.

5. Communities should provide free community controlled childcare centers.

6. Living environments must be redesigned to meet the needs of women.

7. Sex discrimination in school curriculum and texts should be wiped out.

8. Facts about sexual inequality should be taught in schools.

9. An end to advertising which manipulates women to buy products.

FOOTNOTES

1. Goldberg, Philip, "Are women prejudiced against women?" *Transaction*, April 1968.
2. Maccoby, Eleanor, "Is there any special way of thinking, feeling, or acting that is characteristically female?", *Mademoiselle*, February 1970. 277. In her article Maccoby cites the Horner study.
3. Ruth Herschberger, *Adam's Rib*.

4. *Ibid.*
5. Maureen Daly, *Seventeenth Summer*, 1960 ed., p. 57.
6. *Ibid.*, p. 39.
7. Ruth and Edward Brecher, *An Analysis of Human Sexual Response*, 1966.
8. Albert Ellis, *The American Sexual Tragedy*.
9. Jamie Kelem Frisof, "Textbooks and Channeling", *Women: A Journal of Liberation*, Fall 1969, 26-28.

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Venereal Disease

Most people in this country have probably heard at least something about venereal disease, or "VD", as it is often called, by the time they reach high school. You may have seen some films in school about "social diseases", or have heard words like "the clap", "morning drop", "the whites", "a dose", or "pox" "lucs", "siff", or "old Joe". All of these slang expressions refer to one or the other of the two major venereal diseases: **gonorrhea** and **syphilis**. These diseases are very serious, both because they can cause severe damage to your body, and because they are highly contagious and are easily transmitted.

In spite of the fact that adequate treatment is available, venereal disease is a major problem in the United States today. In 1970, there were over 20,000 newly reported cases of syphilis, and over 570,000 of gonorrhea. "Reported cases" are those which are brought to the attention of the U.S. Public Health Service by physicians. These 1970 figures are estimated to represent approximately one quarter of the actual incidence of the two diseases, due to the fact that many physicians do not report their cases, and because many people who have these diseases do not seek medical help. Since most of the available information about venereal disease contains more moral dogma than facts, the readers are often left with questions in their minds. Although it is probably impossible to answer every question a reader may have, this paper is an attempt to discuss, more thoroughly, the necessary preventive and therapeutic aspects of "VD", as well as the related sociology—the reasons **why** venereal disease is a major and growing problem.

How Do You Get VD? Syphilis and gonorrhea are two different diseases. But since they are both acquired through sexual contact with a person that has one of them, they are both classified as venereal diseases. Each disease is caused by a different microorganism (germ). These germs live best in a warm, moist environment, and when taken from this environment to a drier, cooler one, they die in a very short time. They may also be killed by extreme heat. Therefore, unlike cold germs, which can be spread by dirty drinking glasses, other objects, or just in the air, living syphilis and gonorrhea germs **must** be deposited directly on warm, moist surfaces (such as the linings of the genitals or mouth, or on a break in the skin) Sexual intercourse, then, with a person who has a venereal disease provides ideal conditions for the transfer of these germs. But, this means that stories of syphilis or gonorrhea germs being picked up from toilet seats, door knobs, towels, dishes, etc., are **not** true. People acquire **VD only** from other people who have the disease, through intimate sexual contact.

Can You Prevent VD? VD is not a disease that you have only once, like chicken pox, and to which you are forever after immune. You can have VD many times—as many times as you are exposed to it. There is no vaccine available to prevent someone from being susceptible to these germs. If one partner has VD, there is **no** sure way to prevent the transfer of germs to the other partner during sexual intercourse! Washing with soap and water and the use of condoms (rubbers) may help, but neither is reliable protection.

What If You Do Get VD? VD is not difficult to cure in the early stages of the illness, if a doctor or clinic is consulted for treatment. But the treatment plan that is prescribed must be followed strictly, or there is a chance that some of the active germs will remain and cause further bodily damage. Therefore, it is extremely important to know the symptoms of both syphilis and gonorrhea, and to realize that if there is even the slightest possibility that you have VD, medical advice should be sought promptly!

SYPHILIS

Symptoms of syphilis

Syphilis is a very infectious disease that invades every system of the body. If treated early, it can be cured, if not, it can be disabling and fatal. Syphilis is caused by a small delicate germ of the "spirochete" family (that just means it has a spiral shape). Once these germs have entered the body through intimate sexual or physical contact, the disease goes through four stages:

1. **Primary** – The first sign of syphilis is usually a sore called a "chancre" (pronounced shanker). It may look like a pimple, a blister, or an open sore, and it is usually painless. It probably will show up any time from 9 to 90 days after the germs enter the body. This sore usually appears on or near the genitals (where the germs entered), but it may appear on fingers, lips, breast, anus, or mouth, depending on the primary site of contact with the germs. At this primary stage syphilis is very infectious. The chancre is full of germs which are easily passed on to others.

Sometimes the chancre never develops at all, or it may be hidden inside the body, and the infected person will not even know he has syphilis. This is particularly true for women, where the sore frequently

develops inside the vagina, or hidden inside the folds of the labia. In any case, this sore will go away all by itself, even if the person doesn't do anything about it. But the germs are still in the body, increasing and spreading.

2. **Secondary** – The next stage occurs anywhere from a few weeks to six months later. By this time the germs have spread all through the body, and there are many possible symptoms produced at this stage. A rash may appear on the body (sort of like a food or heat rash, or like hives), or it may be just on the hands and feet. Sores may appear in the mouth; joints may become swollen or painful, and bones may hurt. There may be a sore throat, mild fever, or headache. Patches of hair may fall out. Infectious raised areas may appear around the genitals and rear end.

This is the most infectious stage of the disease! If the person has open syphilitic sores on his body at this stage (in his mouth, for instance), the disease can be spread by contact with these sores, even without sexual intercourse. This is a stage where syphilis "imitates" other diseases, and so the infected person may think he has another illness, such as a cold. Or the symptoms may be very mild, and the person may not even notice them. This stage usually lasts 3 to 6 months, but sometimes the symptoms of this stage can come and go for several years. Just like the primary stage, it will disappear all by itself. But the germs remain active in the body.

3. **Latent** – During this next stage, there are no outward signs of syphilis, but the germs may be invading various inner organs, including the heart and the brain. In the first few years of the latent stage the disease may still be infectious, but after that it is usually not. The infected person can go along for ten or twenty years, feeling perfectly healthy, not knowing a thing.

4. **Late** – In this stage of the disease the serious effects of the latent stage appear. Depending on which organs the spirochetes have attacked during the latent stage, a person may have serious heart disease, crippling, blindness, or mental incapacity. Out of every 100 untreated syphilitics, 23 people will be killed or incapacitated in this late stage of the disease.

Diagnosis of syphilis

Syphilis can be diagnosed and treated at any time. Early in the primary stages a doctor can look for subtle secondary symptoms (like swollen lymph glands around the groin), or analyze some of the pus from the chancre if one has developed. Very soon after (usually by a week or two after the chancre has formed, though it may take longer), the spirochetes will be in the bloodstream, and they will show up in a blood test. From then on, through all the stages, a blood test will reveal the infection. It is usually best to have at least **two** blood tests several weeks apart, even if the first one didn't show anything, because sometimes the results are not reliable.

This blood test is given regularly just as a check in lots of situations. For instance, people who go to give blood are always tested for syphilis. The blood tests required before legal marriage are also for this purpose. (One out of every 90 people who take the marriage blood test is discovered to have syphilis.) However, it could be used a lot more than it is now (at school or jobs, for instance, or whenever anyone enters the hospital). In communist China, syphilis has apparently been completely eradicated. This was done by giving a blood test to almost everybody. Consequently, everyone found to have syphilis was adequately treated and syphilis is no longer a problem.

Treatment for syphilis

The treatment for syphilis is penicillin. It may be one high dose or a series of smaller doses for a short period of time. It's just that simple. It is important to have at least two follow-up blood tests to be sure the treatment was complete, since sometimes people have relapses. But the main thing to remember is that the first three stages of syphilis can be completely cured, and even in late syphilis, the destructive effects can be stopped from going any further.

Most states have VD clinics where you can get blood tests and penicillin free of charge. At these clinics they usually ask you for the names of any people you have had sexual relations with since you got the disease, so they can contact those people and give them treatment. (This is called "case finding".) They keep your name and the other name or names secret, and it's usually a good idea to cooperate with them. But if you don't want to tell the clinic people the names, then it's your responsibility to get in touch with anyone you had sexual contact with yourself. It might mean life or death for those involved!

Syphilis and Pregnancy

If a pregnant woman has syphilis, she can pass the germs on to her unborn baby. The germs attack the fetus just like they do an adult, and the child may be born dead or with important tissues deformed or diseased. But if the mother's syphilis is treated before the 18th week of pregnancy, the fetus will probably not be infected at all. (Even after the fetus has gotten syphilis, penicillin shots will stop the disease, but it cannot repair damage that has already been done.) Therefore, it is very important that every pregnant woman get a blood test for syphilis as soon as she knows she is pregnant. That way, if she has the disease, she can be treated for it before she gives it to her child.

GONORRHEA

Unlike syphilis, which goes all through your body, gonorrhea is essentially a disease of the genito-urinary organs. (If left untreated for long, gonorrhea travels through the bloodstream and causes infection in the valves of the heart, or acute arthritis, blindness, and even death. However, this is not too common.) It is caused by a germ shaped like a coffee beam called a gonococcus, which works its way gradually along the passageways of the genital organs. This disease can be transmitted to another person at all stages. The symptoms of gonorrhea are different for men and women, even though the germ causing the disease is the same in both. It takes about two days to three weeks after gonorrhea germs enter the body for symptoms to show up.

Symptoms of gonorrhea in women

The first organs infected by gonorrhea in women are the urethra (the tube through which urine flows out of the body) and the cervical canal (entrance to the womb). Very often, however, a woman may not even know this infection is present. She might feel a little pain when she urinates, or she might have a slight vaginal discharge. Then again, she may have no symptoms at all.

But if the disease goes untreated, various complications can arise:

–The glands in the genital area may become swollen and painful.

–The infection may spread up the urethra into the bladder and cause cystitis. Urination will be more frequent and painful.

–The infection may spread to the rectum and cause proctitis.

–Most serious of all, it may spread and inflame the Fallopian tubes (tubes which the eggs move through on their way from the ovaries to the womb). This is called salpingitis. The woman may feel no symptoms at all at first, and then suddenly have severe pain in her lower abdomen, on one side or both sides. She may also have vomiting and fever. If a woman has a mild case of this, she may feel the same symptoms in much milder form over several months. Her menstrual periods may become irregular. If this disease goes untreated, a lot of scar tissue will develop in the Fallopian tubes. They will become twisted and narrow, so that the eggs can no longer pass through them. If this happens to both tubes, the woman will never be able to have children.

If a pregnant woman has gonorrhea and doesn't get treated before her child is born, the child's eyes can get infected during birth. In the past, this gonorrheal eye infection was a big cause of child blindness. For this reason in the US now, the eyes of every new born baby are treated with drops to kill any gonorrhea germs, just to be sure.

Symptoms of gonorrhea in men

It is much easier for a man to tell that he has gonorrhea. The symptoms for men are early, definite, and obvious. At first he will feel a painful burning sensation during urination, and then a discharge of whitish or yellow pus from the penis appears. This discharge is very infectious, and its germs may be carelessly transferred to the eyes.

If the disease goes untreated, it may spread to the bladder and cause cystitis. Or it may spread to the seminal vesicles or the epididymis (these are organs where the sperm are temporarily stored or where they pass through). In this case it may cause a hard tender swelling in the man's testes. This internal infection will form scar tissue, just as it does in the woman, and it may block the passageway of the man's sperm, making it impossible for him to conceive a child.

Diagnosis of gonorrhea

There is no reliable blood test for gonorrhea. But it is not too hard to diagnose gonorrhea in a man.

There are usually so many germs in the discharge from his penis, that they can be seen and identified under a microscope. If they cannot be seen right away, they can be kept in a laboratory for several days and allowed to multiply. (This is called taking a "culture".) In a woman, though, it is more difficult. The woman is much less likely to think she has gonorrhea in the first place, since she probably doesn't have any symptoms for a while. Also, the germs are spread out in her body more, and much harder to find and identify. If a woman thinks there's even a chance she has gonorrhea, or if she knows that someone she has had sexual contact with has a case of gonorrhea, she should go to a doctor or a clinic at once. Usually what the doctor will do is take a sample of secretions from her sexual parts (the cervix or vagina) with a cotton swab. He will look at the sample under a microscope first to see if he can identify any gonorrhea germs. But almost always it will be necessary to allow the germs in the sample to multiply for several days before they can be identified. Sometimes, however, a woman may have the disease, and yet there were so few germs in the sample that they won't show up in the test, even after several days. Therefore, if a first test shows no germs, it is necessary to repeat the test to make sure.

Sometimes, if a woman thinks she may have gonorrhea, doctors will go ahead and treat her for it, even if the tests don't show anything, just because the consequences of the disease are so serious, the tests are so unsure, and the treatment is so easy.

Treatment of gonorrhea

The treatment for gonorrhea, like that for syphilis, is penicillin. It usually involves one or two injections. The size of the dose has been increased over the years because gonorrhea germs have the ability to build up resistance to penicillin. (Syphilis germs do not have this ability.) For this reason, doctors are also experimenting with other antibiotics to see if they are effective against the spread of this dangerous disease.

Syphilis and gonorrhea together

Often a person will get syphilis and gonorrhea at the same time. If this happens and a person doesn't know it, he might get treated with penicillin just for the gonorrhea, for instance. The penicillin will cure the gonorrhea, but the dose may only mask the symptoms of syphilis: it probably won't be big enough to cure the syphilis. For this reason, anyone about to be treated for gonorrhea should also get a blood test for syphilis before he gets the penicillin dose. Also, he should continue to have periodic blood tests for syphilis for about six months afterward just to be sure.

Protect Yourself!!!!!

1. If you notice any symptoms of VD in yourself, no matter how mild, you should go to a doctor or a clinic at once. (Turn to the last section of this chapter for a quick check list of VD symptoms.) Don't panic, or feel guilty or embarrassed. For a list of clinics in Boston where you can go for free treatment and tests, see the last section of this paper. Or you can go to a private doctor if you have the bread (probably $20-30). In Massachusetts, if you are a minor, you do not have to have your parents' permission to be examined and treated for VD.

2. If you have sexual relations with someone, try and find out if there is any chance they have VD or have been exposed to VD recently. Don't be embarrassed to ask. If two people care about each other they should be looking out for each other anyway.

If you find out you have VD, don't have sexual relations with anyone until you are well. If you had sex with someone when you had VD but didn't know it, you should tell that person right away so they can get treated. It is especially important in cases like this for men to tell women that they might be infected with gonorrhea, because the woman probably won't notice any symptoms in herself until the disease has already done a lot of damage.

3. Don't depend on just one test. If the first test for gonorrhea or syphilis doesn't show anything, make sure the doctor takes another one to be safe. Don't just accept whatever he says. Some doctors aren't careful enough, and it's your life, not his.

V.D. IS A SOCIAL PROBLEM

Once you know what a serious, even deadly, disease VD can be, and how easy the cure almost always

is, it really seems strange that it has not been brought under control better in this country. We saw before that in China syphilis has been completely ended. What about in the United States?

In this country, well over a million people get VD every year. (That means about 3000 new cases of gonorrhea and 300 new cases of syphilis every **day**.) Approximately 4000 people each year **die** in the late stage of untreated syphilis.

Not only are the numbers high, but they are growing rapidly. The number of gonorrhea cases went up 35% from 1963 to 1969. That was a six year period. Then in Massachusetts last year, over a one year period, the number of gonorrhea cases went up 15.4%.

About 12 years ago, people were saying that the VD problem in this country was almost solved. The amount of VD had been decreasing since the Civil War, and it reached an all time low in 1957-58. However, ever since 1958, the number of VD cases has been increasing more and more each year.

This is what we call an epidemic. More people now get gonorrhea every year in this country than get measles, tuberculosis, hepatitis, whooping cough, and encephalitis combined. Strep throat is now the only communicable disease that affects more people than gonorrhea.

The other thing about this epidemic is that it is hurting young people worst of all. People 15-19 years old get VD twice as often as other people. A recent study indicated that one out of every 50 kids in that age group gets gonorrhea. Over half of all VD in the US (56%) hits people under 25.

Why is this? Why is it that things are getting worse and worse? In the first place, like most other things, the VD problem is partly a question of money. Most government money right now is being spent on "defense" to fight the war in Vietnam. Medical research money goes to a lot of things like fancy operations for rich people or to develop chemical weapons like Mace. If this weren't true, there might be money available to develop a preventive vaccine for VD, or to figure out a simple screening test for gonorrhea (this would be especially important for women). Also, more VD clinics and casefinders could be paid for.

Another main reason that we see for the uncontrolled spread of VD is the whole set of up-tight attitudes and laws about sex that exist in this country. On the one hand, just about every business in America uses commercial sex to sell its products. (Buy Ultrabrite, etc.) On the other hand, a lot of adults treat sex as if it were something dirty and sinful that should never be talked about – **especially** in front of kids. This means that a lot of kids - and girls especially - live under a kind of "news blackout" about their own bodies and their own sexuality. They are not told the basic facts about sexual life, reproduction, birth control – or, of course, about venereal disease. All sorts of crazy stories and superstitions get spread. When people are told something, it's usually to preach it and doesn't help. For instance, some of the movies they show about VD in the schools make it look like getting VD is a justified punishment for committing the "sin" of making love with someone before you are married. We know of one high school teacher in Cambridge who once taught a lesson on VD in hygiene class. This was the entire lesson (she didn't say **anything** else): "God punishes those who sin."

In fact, it turns out that a lot of the people who should supposedly be helping to stamp out venereal disease are really much more interested in stamping out "illegal" sex. Attitudes about sexual participation are changing, particularly among young people, and yet in 36 states of the union, it is still illegal for a minor to be treated for VD without his or her parents' consent. Of course a lot of kids will go untreated because they don't want to blow it with their parents. Even though they know that it is kids who are getting hit the hardest by this epidemic, it seems like the people who make the laws care more about punishing a kid for stepping outside their hypocritical rules than they do about saving his life.

Another example of this kind of attitude can be found in some of the public statements of Dr. Nicholas J. Fiumara, the director of the Division of Communicable and Venereal Diseases of the Massachusetts Department of Public Health. He recently (March 1970) issued a statement saying how serious the increase of gonorrhea in Massachusetts was. Then he said that one of the main reasons for this increase was the existence and use of the birth control pill. He has also listed the Massachusetts anti-"fornication" laws as one good method for preventing VD. (That's about as logical as saying that a good method for preventing food poisoning is to outlaw eating.)

Both of these statements show that Dr. Fiumara is anti-sex before he is anti-VD, and he is especially against the idea of women being free from the fear of unwanted pregnancy and being able to be in con-

trol of their own lives and bodies.

Dr. Fiumara and men like him should be fighting to build more clinics, to educate the public, to break down the barrier of embarrassment and silence that surrounds the subject and prevents kids from being able to take care of themselves as they should. Instead, he is sitting around denouncing the birth control pill.

If we look carefully at the history of venereal disease, we find that its main epidemics aren't so much connected to women having control over their own bodies, like with the birth control pill, or with people who really dig each other making love when they are not married. Instead, it seems to be more tied to times and places where rape and prostitution and very common. As you can figure out if you think about it for a minute, rape and prostitution are usually most common during times of wars and invasions, where a lot of men from one country are taken away from wives and girl friends and sent to another country which they are trying to defeat or conquer. Just plain male chauvinism comes out in the attitudes of the guys toward the women of the other country, and they don't have to worry about the laws and social pressure they would feel back home. Also a lot of times racism enters into this situation. If the women are just "niggers" or "gooks", it's considered even more okay to fuck them over. Outright rape becomes a common occurrence, and prostitution also begins to grow.

Vietnam today is a good example of this situation. The Vietnamese report that rape - and often gang-bangs - of village women and girls are such a frequent thing now in South Vietnam, that they almost consider it as part of the "fighting task" of the American GIs.

Prostitution is also very common in those parts of Vietnam which are occupied by the US troops. The normal life and work of South Vietnam is almost destroyed. Huge numbers of women are widows with children and no means of support. Most of the jobs that people can get in those parts of Vietnam are like maids to GIs or selling stuff on the black market. Everything revolves around the war and the American army, and there are no decent jobs left. So a lot of women are forced to become prostitutes in order to survive. And the corrupt Saigon government encourages them in this. The government itself has actually built and maintained "official" whorehouses at every US base in South Vietnam.

North Vietnam and those parts of the south controlled by the NLF are very different from this. There women are respected, and prostitution has been abolished. Recently in the Boston Globe there was an article comparing Hanoi and Saigon. Here are some of the things it said:

> Hanoi is quiet. . . You can safely leave several hundred dollars worth of local currency in your hotel room. The girls are plainly and modestly dressed in long pants and blouses. . . Even Communist diplomats complain they have to go to Laos to find "feminine companionship"
>
> Saigon is sodden with corruption. . . Bar girls, night clubs, and strip joints give a honky tonk air. . . There is a fancy "house" for high officials and generals to meet their girls.

What all this means about VD is that in the North they have venereal disease now more or less under control. But in the South, it is really terrible. Many many women are suffering from this disease either because they have been raped or have been forced into prostitution. And the GIs themselves, frustrated and lonely, disrespectful of Vietnamese women, also suffer from this disease and spread it to others. In fact, there is a new, penicillin-resistent strain of gonorrhea which has grown up because of the war, which doctors in this country have begun calling "Vietnam Rose!" because it originated in Vietnam. Maybe a better name for it would be "American Invader".

Anyhow, this is just one modern example of how male chauvinism and racism and national expansion can help the spread of VD, because they encourage such sick sexual relations and the sexual exploitation of women by large numbers of men. Syphilis was first taken to China by white "explorers" from Europe. The first big epidemic in Europe was spread from Italy where the French and Italian soldiers were fighting a long drawn-out war and messing over the local women. Why doesn't Dr. Fiumara mention some of these problems and this history instead of blaming it on the pill?

Until our government and big business stop sending American boys overseas and until they stop paying them to kill and rape the people of other countries, the people of our own country are going to be sick in many ways – a continuing epidemic of venereal disease is only one of them.

In the meantime, we should all do everything we can to protect ourselves and our friends. So turn to the next page to remind yourself of the possible symptoms of syphilis and gonorrhea, and how they can be cured in an individual. The social cure is going to be harder.

Syphilis

POSSIBLE SYMPTOMS

Primary state (9-90 days after infection): chancre

Secondary state (few weeks-6 months later): rash (all over, or on hands and feet) – sores in mouth – sore throat – mild fever – swollen joints – headache – patchy balding

Latent stage (10-20 years): no outward symptoms at all

Late stage: heart disease – crippling – deafness – blindness paralysis – insanity – death

DIAGNOSIS – Physical examination by doctor
In early primary stage: examination of pus from chancre
After that: blood test

TREATMENT – One or more shots of penicillin or some closely related drug

SLANG NAMES – Pox – Lues – Bad Blood – Siff – Hair-cut – Old Joe

Gonorrhea

POSSIBLE SYMPTOMS

In Women
- maybe slight vaginal discharge
- maybe some pain when urinating
- (later) severe abdominal pains
- infected bladder
- infected rectum
- infected tubes
- sterility
- arthritis
- blindness
- death

In Men
- discharge from penis
- pain during urination
- sore, swollen testicles
- infected bladder
- infected tubes (seminal vasicules or epidedemis)
- sterility
- arthritis
- blindness
- death

DIAGNOSIS – Look at discharge under microscope (usually only works for men)
Examination of "cultures" of germs from the discharge (where the germs have been allowed to grow for several days)

TREATMENT – One or more penicillin shots, or some related drug

SLANG NAMES – Clap – Strain – Gleet – Morning drop – A dose – The Whites

Important Information About Penicillin Treatment

Whenever you get a penicillin treatment for *any* disease, don't drink any alcoholic beverages for 48 hours. Alcohol deactivates the white blood cells, which are the agents that actually kill the disease. Even though the penicillin will still work to stop the growth of new germs in that time, the treatment will be ineffective if the white blood cells are not active.

Boston Venereal Disease Clinics

These are the names of clinics and hospitals in the Boston area where you can be tested and treated for VD. Most of them have special VD clinics arranged for certain hours during the week. The telephone number listed for each hospital is the number to call to find out exactly when their hours for VD are. The Cambridgeport Clinic is probably the one that is the most sympathetic and helpful to kids, but everybody already knows that so you'll probably have to stand in line a pretty long time. (It's up to you.)

Cambridgeport Free Clinic, 10 Mt. Auburn St., Cambridge – 876-0284
Cambridge City Hospital – 354-2020
Beth Israel Hospital – 734-4400, ext. 187
Boston City Hospital – 424-4082
Boston Dispensary – 542-5600, ext. 326
Massachusetts General Hospital – 726-2748
Peter Bent Brigham Hospital – 734-5000, ext. 2362
University Hospital – 262-4200, ext. 5356

Birth Control

I. Making a Responsible Choice of Birth Control Method–Some Obstacles

All of us ought to have the right to make our own decisions about having children: if we will have children, when we will have children and how many children we will have. The spread of contraception has given some of us more choices in these matters, but we have not yet reached the time when all women can make these decisions with freedom. Religion and economic factors play a large part in keeping women from knowing about and/or using contraception. In this society, the right of a woman to know about and/or use contraception is still controlled by the state, not by the individual. Check both the laws and hospital practice in your state to see how available birth control care is to every woman.

We women have a more personal interest in birth control than men do, for we bear the children, and in large measure we are responsible for raising them. Numerous and frequently spaced pregnancies can have serious ill effects on both mother and children. Until men take an unwanted pregnancy as seriously as women do, they will consider contraception a female problem. However, we women must try to shape a society where men will make this their interest too. Clearly there is no ideal contraceptive today. The rhythm method has a high failure rate, the pills have undesirable side effects, etc. As we move into more sophisticated research in contraception, it is important that women insist on male contraceptive research being given equal consideration.

The Senate hearings on the pill have made it all too clear that it is imperative that we women know more about our own bodies and how they function. We have known for a long time that certain interests are making money off of our ignorance. The birth control pill is no different from any other drug in that the main interest of the drug companies is first and foremost to make a profit. The prescription task force of HEW estimated that in 1968 the drug companies spent $4500 per physician per year on advertising and promotion of all drugs.[1] In 1968 women took $100 million worth of birth control pills. In 1969 the sale of oral contraceptives amounted to $120 million.[2]

With such a lucrative product, it is easy to see why the drug companies might want to cover up "unfortunate results" stemming from the pill. As early as the Senate hearings of 1963, it was learned that the entire basis for the FDA's safety decision on Enovid, one of the pills, was data collected on 132 women who had taken the pill for only one to three years. It has been estimated that 132 is fewer than the number of women who will die in 1970 from the blood clotting caused by the pill.[3]

Another area tied in with the drug companies' cover-up is their failure to solicit doctors' reports of complications arising from the pill. On the contrary, the drug companies actually supported those doctors who were ready to publish reports favorable to the pill. In 1966, Dr. Robert Wilson wrote a book, Forever Feminine, in which he advanced the theory that the pill could prevent menopause and make a woman feel young and "sexy" no matter what her age. In 1964, the Wilson Foundation had received $17,000 from the Searle Foundation (G. D. Searle is a major drug company, the makers of Enovid and Ovulen 21). Searle has also given grants to Dr. U. E. Ayre who has done studies to show that Enovid could not cause and might even inhibit cancer of the cervix.[4]

The "population experts" have been the second major ally of the pill, pushing it because of its high effectiveness and not looking so hard at its side effects and hazards. For years Dr. Alan Guttmacher supported the "fertility rebound" theory – that when a woman went off the pill she would experience an increase in fertility – until a 1966 report indicated that the pill had caused sterility, temporary and permanent, in about 10% of the women studied.

The drug companies' cover-up of the hazards of the pill was evident in the patient pamphlets which distorted or denied known risks. Now, after the pill has been in use for ten years in this country, the FDA is finally urging doctors that they disclose to their patients the warnings, adverse reactions and countraindications. But the obstacles to our learning enough to make reasonable decisions do not end with the drug companies' cover-up and the population experts' down-play of side effects and hazards of various methods of birth control. Our doctors themselves don't learn all they should, particularly about the pill, a hormone-affecting medication that their patients will be taking for years at a time. And what the doctors do know, they usually don't pass on. The doctor, trained to treat us as patients, not

people, has given us reassurance rather than the information we need. We can have no confidence in such individuals who do not inform us of the possible dangers of a drug they are administering to us. Some doctors can only be interested in maintaining a kind of MD-priesthood mystique. Dr. Robert Kistner of Harvard Medical School (one of the most ardent defenders of the pill at the congressional hearings) was one of the main witnesses at the pill hearings for G. D. Searle, the major birth control pill manufacturer. When counsel for the plaintiff asked him why he didn't tell his patients of the potential risks involved in oral contraceptive use, Dr. Kistner replied: "Well, if you tell them they might get headaches, they will get headaches."[5] We can't take the place of doctors, but we have to demand to know what is pertinent to our health and safety; instead of relying solely on doctors we must rely on ourselves, our research, our feelings, our experiences and those of other women. And we must learn about every available method of contraception so that we are not at the mercy of the typical doctor who says, "You got headaches? You got cancer? Okay, here's a prescription for the pill"; or, "I don't like the pill; here, take this I.U.D."

No matter what kind of birth control we choose (except condoms), how do we deal with our feelings of legitimate resentment against the burden of total responsibility for birth control? This is painful because it brings home very sharply our vulnerability; we are the ones who get pregnant. From the male point of view, "the chick got herself knocked up". This kind of attitude fills us with such rage that we often take it out on men. We have to begin to be open with each other and with men about this problem.

If we are going to have sex, we must use contraception. According to United States mortality statistics, 100,000 pregnancies would result in about 25 maternal deaths - eight times the death rate associated with the pill from blood clotting. Of those women who terminate their pregnancies through illegal abortions, about 1 in 500 will die. So if we choose to stop using the pill because we are concerned for our health and safety, we'd better be sure that we are protecting ourselves from the higher health risks of pregnancy and abortions.

The only more or less effective methods of birth control, apart from the pill, are the diaphragm with cream or jelly, the condom, foam and condom, or the I.U.D. Other methods can significantly reduce fertility, but are not effective control methods. The fact that there is no effective, safe, and esthetically pleasing birth control method serves to maintain the dependent-submissive relationship women have vis-a-vis men. A women is the one who risks impregnation and if a man doesn't stand by her and support her, she has to face the social indignation and psychological turmoil alone. She almost has to feel dependent on him, to feel that he will not "let her down". And how humiliating if he does! When a relationship which is ideally based on mutual respect and/or love has in it this kind of fear and dependence, we can understand the source of much female anxiety in sexuality. Is it this dependence which is one of the sources of our feeling compelled to "sell" ourselves to a man, pleasing him through consuming a billion dollars worth of cosmetics a year, changing the fashion of our dress every three months, playing the jolly industrious housewife?

We women demand birth control, not so that we can be used by men in demeaning or inhumane relationships; a liberated woman does not mean a "free fuck". Even as these imperfect methods of birth control become more and more available, men have put pressure on women to fuck, and many of us feel ourselves under an external pressure to do so, but with those terrible feelings of guilt, anxiety and disgust. In a submissive, dependent relationship, where women are afraid to make sexual demands, afraid to demand that men touch us where it feels good; in a culture where women have been so conditioned that we have been afraid to experiment with and explore our bodies so we don't always know what would feel good; in a world-historical situation where women have been inferior and powerless - what will it take for us to have pleasurable, fulfilling, guilt-free sexual relations? Far more than just good birth control methods. But that, at least, is a start.

II. Conception—The Process to be Interrupted (see pp. 4-8 as well)

The ovaries (Latin "ova"=eggs), shown in the diagram on the next page, manufacture eggs and female sex hormones; the oviducts ("egg ducts"), each wide as a telephone cord and also called Fallopian tubes (after Fallopio, a 16th century physician who discovered them), extending from ovaries to uterus (from Latin "womb" or "belly"), and the uterus itself, some four inches long. Also evident is the cervix (from Latin "neck"=neck of uterus), protruding into the upper wall of the vagina (Latin for "sheath"). One end of each oviduct extends towards each ovary, and the other end enters the uterus. When a woman

is standing, the uterus is nearly horizontal so that the small end of it (the cervix) points towards the tip of the spine while the bulbous end projects forward. The cervical os (Latin "os" = mouth, opening) is tiny; no tampax, finger or penis can possibly enter.

The ovaries, located four to five inches below the waist and halfway between sacrum and groin, contain some 3000-4000 follicles, hollow balls composed of many layers of cells. However, only about 300 of these will mature egg cells in their centers and release them in the process of ovulation. The other follicles degenerate before completing development. Each month one follicle begins growing, matures an egg cell in its center, and moves closer to the ovarian surface. At some point in the cycle, it breaks through the surface, ruptures, and expels an egg in the general direction of the oviduct. This is ovulation. The egg, trapped by the funneled end of the oviduct, is helped towards the uterus by peristaltic contractions of the tube (similar to esophageal peristalsis). The journey to the uterus takes about 6½ days, and the egg then has about 12 hours to implant on the uterine wall. If it is not fertilized, it won't implant, and the ruptured follicle (which all this time has been secreting progesterone in preparation for a pregnancy) degenerates; the egg is expelled from the uterus. A scar is left on the surface of the ovary from the degenerated follicle; in a pre-pubescent girl the ovary's surface is smooth.

Fertilization is the process of union of egg and sperm. The sperm are ejaculated into the vagina in seminal fluid. They can move an inch in 8 minutes, so that a sperm may reach an egg (in the outer third of the tube) in 1½ hours. The sperms make their way up the cervix into the uterus, and into the tubes, where they are helped towards the ovary by waving cilia. Cilia are hairs protruding from the cells lining the oviducts, and as the tubal cilia always sweep in the same direction they create a current that helps the sperm up towards the egg. Fertilization takes place in the outer third of the tube, not in the uterus. The cervical mucus is thinnest at ovulation, and thus least hinders the entrance of sperm into the uterus at that time. (See Ib)

III. Hormones of the Menstrual Cycle

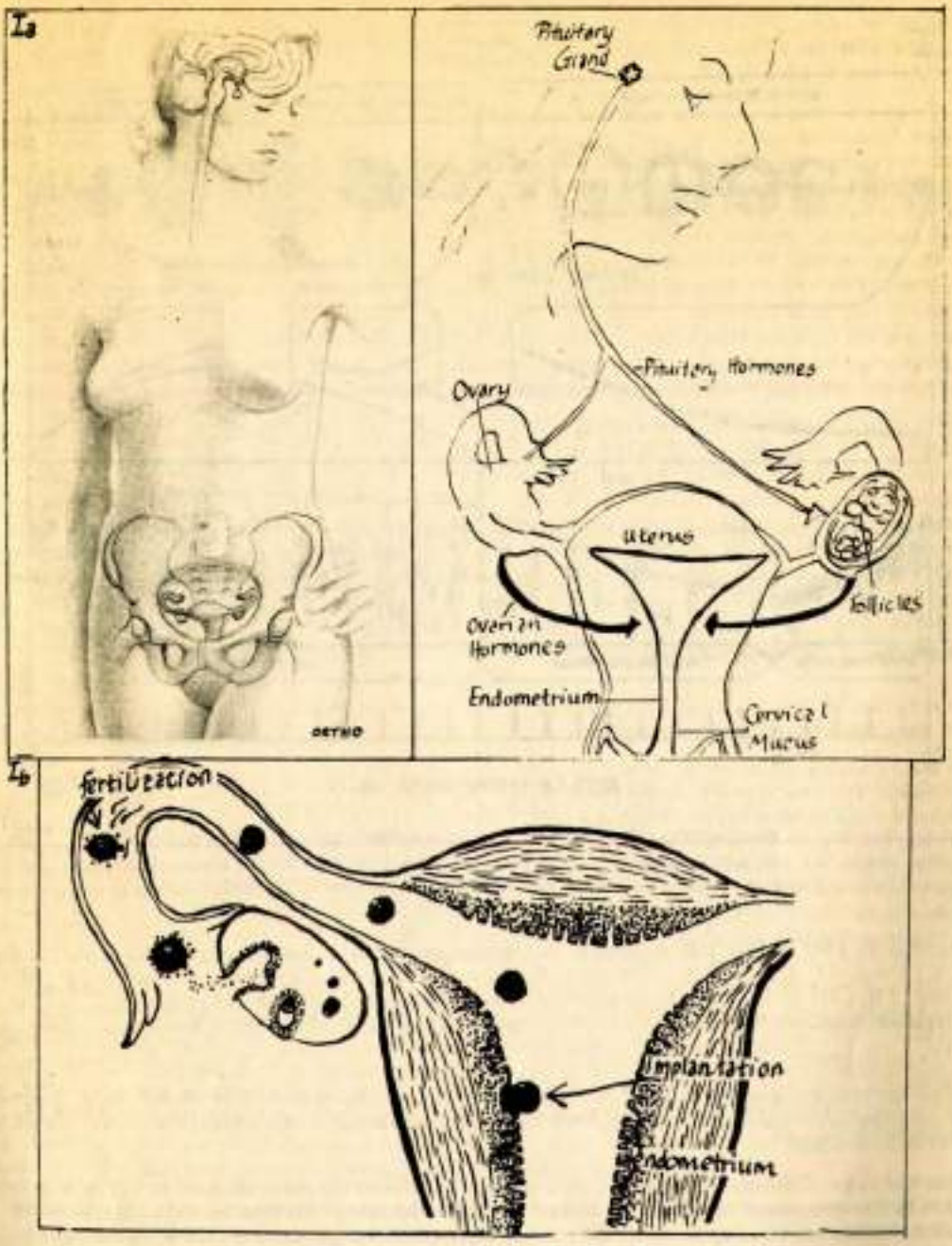
The next part of this chapter will concern hormone effects on uterus, ovaries and cervix. This is necessary for an understanding of how birth control pills work.

The main glands involved in the normal menstrual cycle (Latin "mensis" = month) are the ovaries and the pituitary. The ovaries produce eggs (usually one per month), female sex hormones (estrogen and progesterone) and small amounts of male hormones (androgens). The pituitary is called the master gland of the body because its hormones affect almost all other glands and organs in the body. Its interaction with other glands is controlled by various mechanisms. For instance, by secreting Y, it may stimulate another gland to produce X. However, if X inhibits Y, as the level of X rises, the level of Y will fall. Thus, eventually less X will be secreted. This type of control is called "negative feedback mechanism" and is important for our discussion. (See Ia)

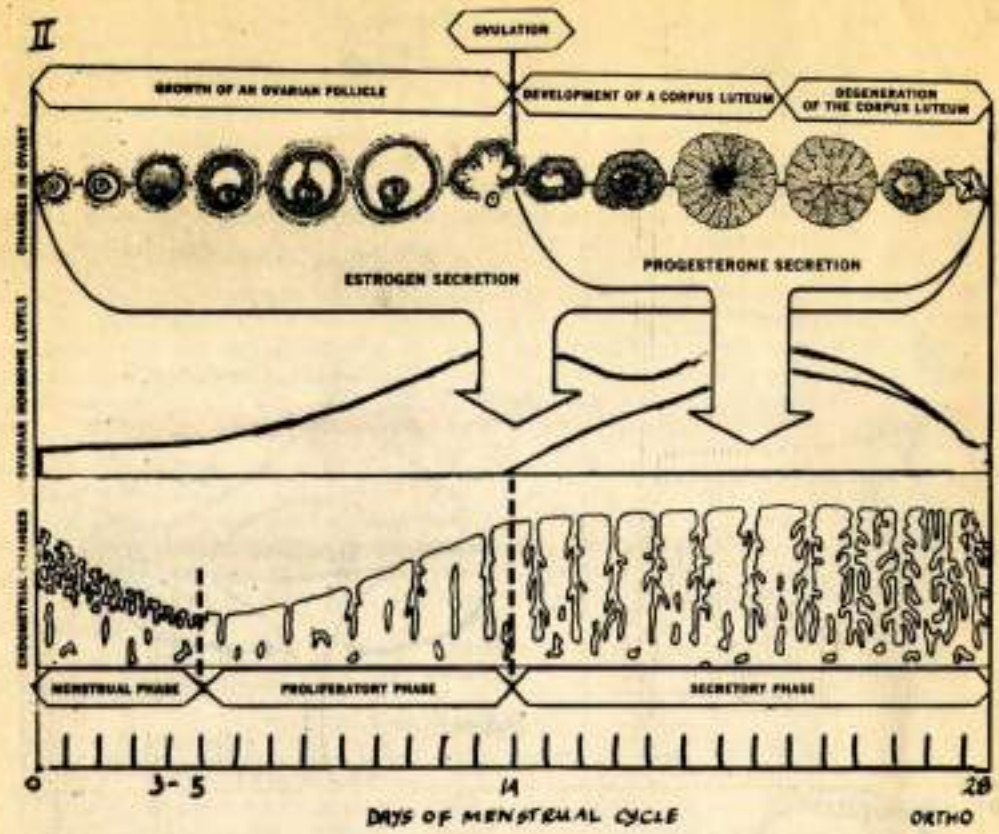
The cycle starts with FSH (follicle-stimulating hormone), a pituitary hormone which stimulates an ovarian follicle to grow. FSH is secreted in greatest amounts during menstruation, is lowest at ovulation, and then rises again. This is logical because FSH must be present in greatest amounts to start each follicle's development; a follicle begins developing during menstruation. Then at the time of ovulation, FSH is needed least; the follicle is doing what it was "meant" to do. Then it must rise again, to a level where another resting immature follicle is stimulated to grow. In a diagram, FSH levels would look like the diagram on page **44.**

What makes the FSH level rise and fall? A rising level of FSH causes rising amounts of estrogen to be secreted by the cells in one layer of the follicle. Because of the negative feedback mechanism, however, increasing estrogen causes a decrease in FSH. A word here about atretic follicles. We have mentioned that most of the follicles in the ovary degenerate before completing development. This is normal, called atresia, but before the follicles die, they are secreting small amounts of estrogen. As follicles are constantly degenerating, there is a low constant level of estrogen being secreted. This keeps the FSH level manageable; only one follicle generally grows each month.

Getting back to the cycle, as the estrogen level rises, not only does it inhibit FSH but it eventually stimulates the pituitary to release two other hormones, LH and LTH. LH, or luteinizing hormone, is a



causative factor in ovulation and in formation of the corpus luteum, the outer layer of the egg cell ("luteum" means yellow, and "luteinizing" is thus associated with the yellow body). LTH, or luteotrophic hormone (again, "luteum", or yellow, and "trophic", or growth), is necessary for the cells in another layer of the follicle to produce progesterone. In other words, it causes growth of one layer of cells in the yellow body or corpus luteum. The corpus luteum would last from day 14 to day 22 in a 28-day cycle, but if no pregnancy occurs, it degenerates. It does so because of another negative feed-



back mechanism. In this one, the rising progesterone level inhibits pituitary secretion of LH and LTH. In other words, the corpus luteum's own secretions are self-hindering. As the corpus luteum degenerates, and as estrogen and progesterone levels decline, FSH production is stimulated and the cycle starts again.

Summary: FSH leads to follicle growth and estrogen secretion. Estrogen leads to FSH decline and LH, LTH rise. LH, LTH lead to ovulation and progesterone secretion. Progesterone leads to LH, LTH decline. LH, LTH decline leads to corpus luteum degeneration and estrogen and progesterone decline. Estrogen decline leads to FSH rise; new cycle begins. Estrogen and progesterone drops cause menstruation.

This has been the ovarian cycle – from follicle growth to ovulation to follicle degeneration. There is also a uterine cycle and a cervical cycle, both simpler to explain and both essential for an understanding of birth control pills.

Uterine cycle: Estrogen causes the uterine lining to proliferate (to grow, thicken, form glands which will secrete embryo-nourishing substances) and maintains this lining. Progesterone is what makes the uterine glands start secreting the nourishing substances, and it also increases the uterine blood supply. (Estrogen also aids secretion but to a very small extent.) An egg can only implant in a secretory lining, not in a proliferative one. The lining is proliferative, under the influence of estrogen, until the egg is ovulated. At that point, the corpus luteum starts secreting progesterone, which changes the character of the lining to secretory. The egg, which takes normally about 6½ days to get to the uterus, thus finds a well-developed lining.

Cervical cycle: The cervical mucus, under the influence of estrogen, becomes thinner and wetter. Under the influence of progesterone, after ovulation, it becomes thicker and dryer. In addition, the two

sex hormones, estrogen and progesterone, affect the content of the cervical mucus. There is a sharp peak in calcium (Ca) and sodium (Na) concentrations at the time of ovulation, and this is apparently very beneficial to the sperm. (About 24 hours before ovulation, there is a sharp drop in CA, and this is the basis of a new test for telling when a woman ovulates.) The thinness and wetness of the mucus at ovulation aid the sperm's entrance into the uterus at that time. (See diagram)

Finally, a note on menstruation. Menstruation is no more than the shedding of the uterine lining as a result of hormone withdrawal. As the estrogen and progesterone levels drop, the lining cannot be maintained, and it is shed. About 4-6 tablespoonfuls (2-3 oz.) of blood may be discharged. Why does menstruation only last a week or less? Because the FSH level starts rising after ovulation and a new follicle starts growing – and starts secreting estrogen. Estrogen, causing growth of the uterine lining, inhibits further shedding. The timing is such that the whole old lining (except for the bottom layer of cells, which will form a new lining) is shed before a new one grows. Menstrual cramps are uterine contractions caused by the uterus trying to discharge "foreign" material which won't support a baby.

An interesting sidelight on the importance of hormones might be mentioned here. At the time of menopause, when a woman runs out of follicles, she gets an estrogen deficiency. Since there is no more inhibition of FSH, the FSH level goes wild, rising from normal (10-80 units) to as high as 350-500 units. Women who want children but who can't ovulate regularly if at all suffer from too low an FSH level. They are treated by injections of a substance called Pergonal – which is actually FSH from "old lady urine" (from women who have menopausal symptoms and lots of FSH!).

Medical researchers were able to study the hormone levels because these hormones (FSH, LH, LTH) maintain their structural integrity (their identity), are bound to albumins under the influence of estrogen, and are then excreted in the urine. Estrogen and progesterone are metabolized by the liver to various compounds also excreted in the urine, and can be detected by anyone with the proper equipment. For instance, estradiol-17B is the basic estrogen made by the placenta, ovary, testis and adrenal. It is excreted in urine as estriol in pregnant women, and as estrone in non-pregnant women. The conversion of estradiol-17B to estriol or estrone occurs in the liver.

IV. Birth Control Pills

How They Work. Currently used birth control pills prevent pregnancy primarily by inhibiting the development of the egg. On the fifth day of your cycle, when low estrogen level usually triggers the output of FSH, the pill gives you just enough synthetic estrogen to inhibit the FSH. So in a month when you are on the pill your ovaries remain inactive, and there is no egg to be fertilized. This is the same procedure by which a woman's body avoids unnecessary menstrual cycles when she is pregnant: the fetus puts estrogen into her blood, thereby inhibiting FSH. So in a way, using much lower levels of estrogen, the pill simulates pregnancy, and some of the pill's side effects are like those of early pregnancy. If ovulation occurs, it is because you have been given too low a dose of estrogen in your pill to inhibit your own FSH level.

Synthetic progesterone is used differently by the two major kinds of pill. With the **sequential** pill, you take pure estrogen for 15-16 days, then a combination of estrogen and progesterone for 5 days. This schedule is more like that of your regular menstrual hormones, but is less effective in preventing pregnancy because all it does is inhibit ovulation. The **combination** pill combines estrogen and progesterone for the whole 20 or 21 days. The addition of progesterone every day provides two back-up effects: increased thickness of cervical mucous makes a barrier to sperm, and improper development of the uterine lining makes implantation impossible should ovulation occur.

For purposes of birth control, then, **combination pills are best**. Combination pills are better also as regards safety and side effects: they generally need to use less estrogen, and the estrogen they do use is consistently counterbalanced by progesterone. (Estrogen has been linked to most of the major and many of the minor side effects of the pill.)

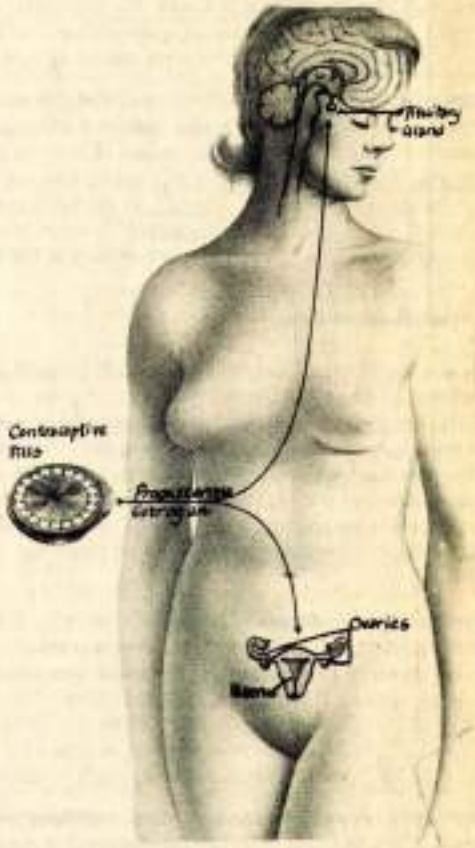
Combination Pills

Description. Small pills which are taken for 20 or 21 days each month. Synthetic estrogen and progesterone are combined in each pill. You take one pill each day. During the days that you are not taking pills, your period usually comes. The **twenty-eighth day pill** is a combination pill for women who have trouble remembering an on-and-off pill regimen, and would do better taking a pill each day. 21 pills contain hormones, 7 are placebos. (e.g. Norinyl 1 FE has seven iron pills. There is some question as to whether iron is good to use, since the placebos have insufficient iron for women who need it, and women who don't need iron shouldn't be getting it.)

Effectiveness. The combined agent pills have a 0.5% pregnancy rate. Pregnancy can occur if you forget to take your pill for two or more days, if you try to juggle your pill schedule (a couple of days left off at the end of cycle is okay, but no more), if you don't use a back-up method of birth control for the first ten days of your first packet of pills, and occasionally when you switch brands of pill (if you switch to avoid side effects, use another method for ten days to be safe).

Simplicity. You must see a doctor to get the pills. Then you have to follow the 20, 21, or 28 day regimen, taking one pill each day. You should see a doctor every six months when you are on the pill.

Application. Unrelated to sexual act. Take one pill each day, at approximately the same time of day, with a meal or after a snack at bedtime to minimize the possible side effects of nausea. With most pills you start on the fifth day of your period (the day you start your period is day one of your menstrual cycle). **If you forget a pill,** take two pills the next day. If you forget two pills, take two the next day and two the next, then keep taking your pills but use another method of contraception for that cycle. If you forget three pills or more, withdrawal bleeding will probably begin, so act as though you are at the end of a cycle. Start a new cycle according to your pill's regimen, using another method of birth control as well, from the day you realized you forgot the pills through ten days of the next cycle.



Reversibility. If you want to become pregnant, stop the pill, after the cycle is completed. If you ovulated regularly before taking the pill, you will probably resume ovulation and become pregnant two to five months after stopping. In some women, the pill's progesterone oversuppresses the pituitary's production of L.H., and you won't ovulate. Ovulation can be made to start, if there are no additional problems, by use of Clomid. If that doesn't work, you may be given pergonal.

Safety. Many of us are uneasy about taking a hormone-affecting medication every day for months and years, when it has been tried on large numbers of women for only fifteen years. Yet many of us choose to take whatever risks are involved because we absolutely don't want to get pregnant. What price do we pay for such perfect protection against pregnancy?

The Pill and Blood Clots. English surveys have shown that more pill users than non-pill users die of blood clots, which can be caused by the estrogen in the pills. The argument that this is not too bad because more women die during pregnancy and delivery (25 per 100,000) than of blood clots on pills (3 per 100,000), is not entirely reassuring. We must find a birth control method that is perfect and safe at the same time. For now, be sure that you see a good doctor before you go on pills, and make sure that he checks your susceptibility to blood clots. (see p.48, list of contraindications)

The Pill and Cancer. No proof that pills cause cancer in the woman who takes them. Estrogen may aggravate existing cancer, so get yourself carefully checked. (see p.48, list of contraindications)

The Pill and Your Children. Infant sexual abnormalities do not seem to be pill-related, but not enough long-term studies have been made. Kids who find pills and eat them might get nauseous but won't be seriously hurt.

The Pill and Venereal Disease. A representative of the Massachusetts Department of Public Health, Venereal Diseases Office, said in October 1971, that 1. women on the pill seem more likely to catch gonorrhea when exposed; and 2. women on the pill who get gonorrhea seem to go into dangerous pelvic inflammatory disease more quickly. These are serious dangers which must be looked into. If you or your sex partner are having intercourse, close body contact or even open-mouth kissing (gonorrhea of the mouth and throat) with more than one person, remember that pills protect you against pregnancy but not against V.D. So wash carefully, use condoms for protection against V.D., get yourself checked for V.D. regularly. See the chapter on V.D.

That's some of the information available to us when we try to make a decision about using pills. Pill scares caused by exaggerated press coverage of things like the 1970 Senate Hearings on the pill cause us much confusion—thousands of women went off the pill in a panic that spring, and who knows how many got pregnant.

How Long to Take the Pill? One woman doctor we heard speak in the spring of 1971 said women could take the pill for ten years. Some women take the pill for 3-4 years and then stop for a while. Others take it for nine months or the length of an actual pregnancy, then stop for a few months. But you have to use another kind of birth control for that time, and that can be hard once you've had the freedom of the pill. Before you go off the pill, find out about the other birth control methods you can use, choose one that you'll use every time.

Advantages of the Pill.

1. Just about complete protection against unwanted pregnancy.
2. Regularity of menstral cycle.
3. Lighter flow during periods (combination pill). This effect pleases most women, bothers some.
4. Fewer menstrual cramps or none at all.
5. Pill often brings a sense of well-being and a new enjoyment of sex because the fear of pregnancy is gone.
6. Relief of premenstrual tension.

Side Effects. In 1963, one out of five women had side effects. By now, the rate is probably lower because the hormone dosages have been reduced. If you get an unpleasant side effect on one brand of pill, change to a different one.

1. Gastrointestinal disturbances: nausea, bloated feeling; usually goes away after two months; is less if pill is taken with a meal or just before bed; use antacid tablets to relieve.

2. Weight gain: androgenic or progestogen-dominant pills like Ortho Novum or Norlestrin can cause appetite increase and permanent weight gain due to build-up of protein in muscular tissue: if you want to gain weight, this is helpful. Estrogenic pills (Enovid, sequentials, Ovulen) can cause fluid retention due to increased sodium. This effect is temporary or cyclic. Watch your salt intake, ask the doctor for a diuretic drug to help stimulate urine production, or change your brand of pill.

3. Headaches and tension from fluid retention. Some women develop bad migraines and have to change or even stop pills.

4. Breakthrough bleeding or vaginal staining between periods: What happens here is that there isn't enough hormone (whether progesterone or estrogen) supporting the lining at a given point in the cycle, and a little of the lining sloughs off. This may also occur if you miss a pill, as a result of the hormone withdrawal. It usually happens a week or so after you start the first month of pills. Often it clears up by the second or third cycle. Some women stop breakthrough bleeding by taking two pills for several days

and then returning to the regular dosage for the rest of the month. This works because the initial hormone level was lower than what you were used to and the uterine lining couldn't be supported on it. So you increase the hormone level and it stops. If it doesn't stop after a few months, you may need to switch pills to find ones that more closely correspond to your own hormone levels.

5. Breast changes: tenderness, enlargement and secretion. Breast soreness should last only a couple of cycles.

6. Rise in blood pressure in susceptible individuals.

7. Sexual desire may be affected, or you may begin to feel depressed.

8. Fatigue: May be due to calcium loss related to muscular activity. The effect of progesterone is to retain sodium and potassium and lose calcium. As estrogen can magnify the effects of progesterone, both hormones are responsible. Fatigue, as in early pregnancy, usually lasts only two or three months.

9. Vaginitis: Can occur with any brand of pills. Vaginitis is defined as a vaginal infection, and may be yeast, fungus or bacteria. The pills increase the sugar and water content in the vagina, so that all atmospheric yeasts or bacteria (or fungi) find the vagina excellent to grow in. It does not always occur, but the point is that any of the pills could make the vagina more susceptible, particularly to monoliasis. The combination pills do this the most. If you get recurrent vaginitis, you may have to go off the pill.

Possible Serious Adverse Reactions. Call doctor immediately if you suspect one of these warning signs: leg pains, blurring vision.

1. Thrombophlebitis and pulmonary embolism, i.e. blood clotting.
2. Neuro-ocular lesions.

Contraindications (conditions which prohibit use of the pill). **This is for pills in general, rather than for combination vs. sequentials.** These contraindications make it absolutely necessary for you to see a doctor for a careful examination, pap smear, and taking of your medical history before you go on the pill.

Note: There are some 50 gynecological endocrinologists in the country, and over 25 of them are in New York or Boston. These are the few people studying the side effects and contraindications of the pill. More people are needed!

1. Diabetes: Some doctors feel that none of the pills can be given to people with diabetes or a history of diabetes in the family such that they might be incipient diabetics. This is because the progesterone in the pills tends to bind the body's insulin and keep it out of circulation, just what the diabetic doesn't need. Other doctors reason that since a pregnancy can be fatal to a diabetic, the risk of birth control pills is worth it. These doctors will give pills to a diabetic, and then keep close watch on her blood sugar count.

2. Cystic fibrosis: Definitely no pills.

3. Hepatitis or other liver diseases: These diseases indicate that the liver isn't functioning properly. As the liver metabolizes the sex steroids (progesterones and estrogens), a sick liver should be pill-less.

4. Migraines and epilepsy: Both are aggravated by sodium storage in the cells of the brain. Sodium storage leads to water retention. This effect occurs especially with the estrogenic pills, which are responsible for more water and salt retention than the androgenic ones.

5. Any disease associated with poor circulation, blood clotting, and heart disease or heart defect, such as bad varicose veins in you or members of your immediate family. The estrogen in the pill, like the estrogen in the body during pregnancy, is suspected of causing blood clots (thromboembolism) and bad varicose veins in women with a tendency to poor circulation. Sequential pills, with often a higher estrogen level and always several days of pure estrogen unopposed by a progestogen, seem to aggravate circulation difficulties more than combination pills do.

6. Undiagnosed abnormal genital bleeding.

7. History of cancer: This and blood clotting problems have been most highlighted in material written about the pills. Not enough long-term studies have been done on cancer and the pill. The estrogen component may help existing cancer to grow, but does not appear to induce new cancer. As no one is sure of what is going on, a family history of ovarian or breast cancer is contraindicative. Under the microscope, the cells of a woman on pills have lesions (breaks) resembling cancerous cells, but the same happens in pregnancy and then returns to normal. This is to say that it is something to think about seriously. It is also a major reason for seeing a doctor every six months when you are on pills.

8. When nursing: You should not take the pill when nursing. Your milk will probably dry up if the pill is administered right after giving birth. The reason for this is that pills inhibit LTH, the pituitary hormone responsible for progesterone secretion, and a nursing mother needs a certain level of progesterone in order to produce milk. N.B.: Check on this. Two major source books on the pill say the new low dosage pills won't affect a mother's milk if she starts pills six weeks after delivery. (Kistner's The Pill; Peel and Potts' Textbook of Contraceptive Practice)

Cost. Visit to the doctor, plus $1.50 to $2.50 for a **month's** supply of pills. About $16-33 **plus** MD's visits per year. One thing to remember is that you pay for the prettier package that is marked with days on which to take pills. If you don't have trouble remembering, get the cheaper brand. Until there is a medical revolution, there won't be clearly marked, cheap drugs. This is something we must fight for. There are over 52 different kinds of pills, but only some 40 different compounds. 80% of these compounds are made by the Syntex Corp. (Maidenhead, England and Palo Alto, California).

Sequential Pills

Description. Same as combination pills: small, must be taken at a certain time each day for 20 or 21 days each month. The sequential pills do **not** have a threefold effect. They **only stop ovulation without providing any backup effects.** The ovulation process is inhibited by the high estrogen content which inhibits FSH. Since the progesterone is given later in the cycle, the cervical mucus stays thin and the uterine lining is suitable for implantation at the time ovulation would normally occur. If the level of estrogen is too low to inhibit ovulation (remember that the estrogen and progesterone levels vary among women), there is **no protection** against an unwanted pregnancy. Therefore, one must be **especially careful** not to miss a pill on the sequential regime. Sequentials are, in summary, good for hormone deficiency (estrogen therapy), but not for birth control. Estrogen and progesterone are given **in sequence**: estrogen for 15-16 days and progesterone and estrogen combined for five days.

Effectiveness. Sequentials have a pregnancy rate of 1.5% if no pills are missed. If you are on sequentials, ask the doctor why, and see if you can switch.

Application time. Same as combination pills, except that there is not as much leeway for missing pills or even taking them at different times of the day.

Reversibility. Same as combination pills, but remember that there is even more estrogen in the sequentials than in the combination pills. (See discussion of effect of estrogen of FSH.)

Safety. More cases of thromoembolism have been reported by women on sequentials. (See discussion under contraindications for combination pills.)

Side Effects. See discussion under combination pills. Sequentials emphasize estrogenic effects like nausea, bloating, breast tenderness, hypertension, headaches, heavy periods.

Brands of Pills (General)

If you choose to take the birth control pill, how do you determine which pill to take? We should be aware that different pills have different kinds, quantities, and strengths of estrogen and progesterone in them. (See Kistner's The Pill for full discussion.) Certain progestogens like Norethindrone produces androgenic (male) effects like hairiness, acne, scanty periods, permanent weight gain. Pills with a less anti-estrogenic progesterone, and pills with more estrogen, have been reported to increase "female" characteristics like bloating, breast swelling, heavier periods. Insist that your doctor discuss with you the composition of the particular brand he is prescribing. Also, see the following partial rundown on the various brands, their contents, dosages, and the specific side effects. The British Committee on Safety of Drugs now advises that only products containing 0.05 mg. or less of estrogen be prescribed because reports of suspected adverse reactions indicate that there is a higher incidence of thromboembolic disorder (blood clotting) with products containing 0.075 mg. or more estrogen than with products containing a smaller dose.

(Brands of Combination Pills—partial listing)

Enovid, Enovid-E. Both contain excessive amounts of progesterone and estrogen. Neither should be used.

Norinyl, Ortho-Novum. These pills are the same. Norinyl and Ortho-Novum 1/50 contain one mg. norethindrone and .05 mg. mestranol. As they are extremely anti-estrogenic, they should not be given to women with much body hair, unless those women like more hair. They produce lighter periods because

they favor a thin endometrium, not very suitable for an egg to implant upon.

Norlestrin. Norlestrin 1 contains one mg. norethindrone acetate and 0.05 mg. ethinyl estradiol. Made by Parke Davis & Co., Detroit. The pregnancy rate is about 0.5%. Norlestrin is androgenic.

Provest. Provest contains 10 mg. medroxy-progesterone acetate and 0.5 mg. ethinyl estradiol. It is made by Upjohn Co., Kalamazoo, Mich., has a pregnancy rate of 0.5%, and is estrogenic in effect, rather than androgenic. Derived from 19-nor testosterone.

Ovelen. Ovelen contains one mg. ethynodrel diacetate and 0.1 mg. mestranol, and is made by G.E. Searle & Co., Chicago. It has a pregnancy rate of 0.5% and is estrogenic in effect.

Demulen. Produced by Searle, Demulen 1 contains one mg. ethynodrel diacetate and 0.05 mg. ethinyl estradiol. Demulen .5 contains 0.5 mg. ethynodrel diacetate and 0.05 mg. ethinyl estradiol.

Orval. Contains 0.5 mg. norgestrel-D and 0.05 mg. ethinyl estradiol. Best for people with low glucose tolerance. May find excessive breast growth.

Notes on Pills

The progesterone from which some of the pills are derived comes from Mexican yams (interesting sidelight). Most important, the key to the pills is their biological activity (the compounds they contain), not the dosage of each one.

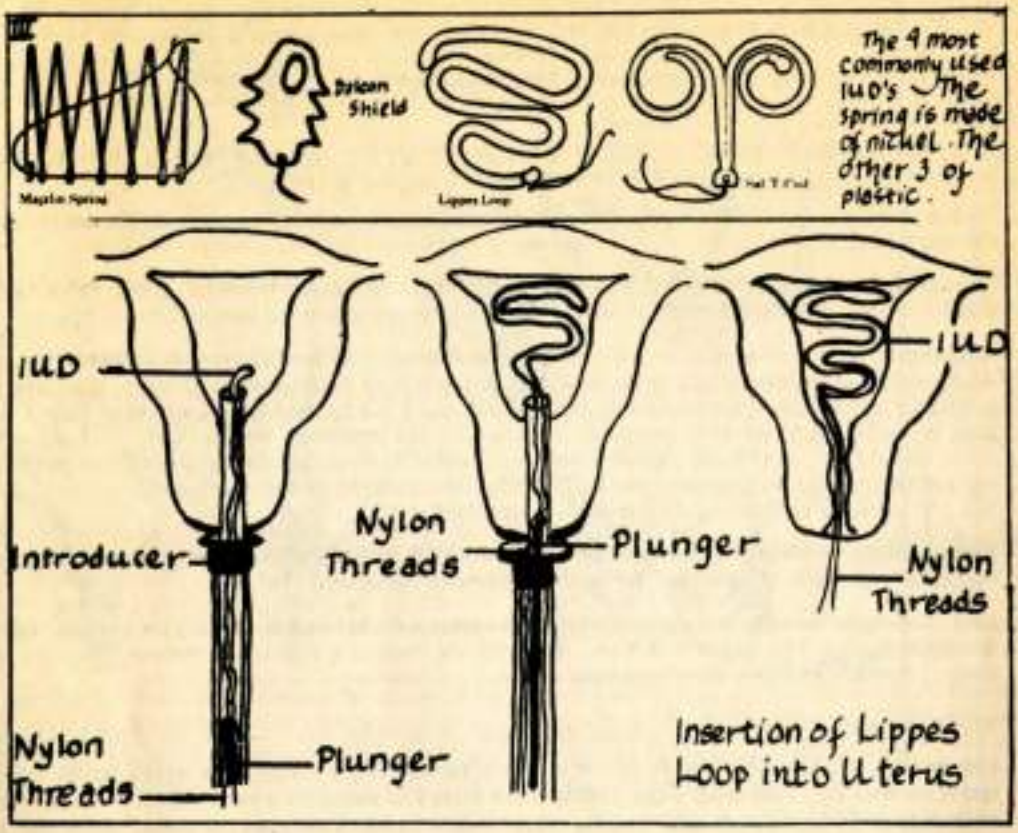
V. IUD or Intrauterine Device ("coil", "loop")

Description. Gold, stainless steel or, most commonly, radiopaque memory plastic devices in different shapes and sizes. They are placed semi-permanently inside the uterus. One or two strings extend into the upper vagina so you can check weekly that the device is still in place. Once the IUD is inserted by a doctor, nothing needs to be done other than weekly checking, unless there are problems or you want to get pregnant.

How It Works. The IUD is a mechanical foreign body inside the uterus which acts as an irritant to it. Doctors think (rather than know) that irritation of the uterus causes tubal hyperperistalsis (very rapid peristalsis of the oviducts), so that an egg reaches the uterus before maturing, or before a proper secretory lining is ready for it. Another possibility is that the IUD might change the nature of the uterine lining so that it cannot support an egg. But a recent study was not able to prove that such changes in the uterine lining could prevent conception.[6] Other studies are being done to determine if the presence of the IUD causes hormonal changes which cause the suppression of ovulation.[7] In a fairly recent theory, the uterine wall responds to the foreign body by sending out macrophages, huge white blood cells which try to get rid of the IUD and, failing that, instead devour egg or sperm or both. Some people find it a little unsettling that no one knows exactly how the IUD works. Others, uneasy with the pill's more generalized effects and the pregnancy rates of other methods, don't mind the IUD. At least the effects of the IUD are local—if something goes wrong, your uterus hurts and you seek medical help.

Effectiveness. Second only to the pill. With Safe-T-Coil, Lippes Loop, Mazlin Spring, pregnancy rate is about 2%. Dalkon Shield is showing a higher failure rate, like 3-4%. (Drug company representatives tend to give lower failure rate for their device.) With Hall Inhiband, an older design, the rate is 3-5% (get yours changed). For 100% protection some women use foam with the IUD, all the time if they feel particularly fertile, or for 7-10 days at mid-cycle (see Rhythm). Many Planned Parrenthood clinics advise women to use another birth control method for the first three months of an IUD, as that's when pregnancies seem to occur most.

Application. Needs to be inserted by a competent doctor. Perforation of the uterus, occurring in 1 out of 2000 women, has been found by the AMA to be primarily the result of faulty insertion by the doctor. The process can be somewhat painful because the uterus is stretched a bit by the device. You may have cramps during insertion and for the rest of the day. Take aspirin, a Darvon or Miltown beforehand, or try shallow panting to keep your mind off it. Does not take long, anyhow—just about five minutes. The doctor does a "sounding" of the uterus to check the size and shape. The IUD can be put in a tipped uterus. If the uterus is small, as it is if you have had no pregnancies, you'll get a small IUD. (If it is too small you won't be able to have one at all.) Just before insertion, the Safe-T-Coil and Lippes Loop are straightened out in a plastic tube like a straw; remember, the diameter of the cervical opening is the size of a thin straw. The doctor gently (we hope) puts the tube into the vagina and up into the uterus through the cervix. When in place, the IUD is released (except that it's your uterus [not your vagina], it is simi-



lar to putting a tampon in place; there's a plunger) and it springs into shape within the uterus. The Dalkon Shield comes at the end of an applicator. No plunger is used: the applicator is twisted and pulled out, the shield remaining in place.

Application Time. After childbirth or during menstruation. Insertion during menstruation is preferred because 1. it is a little easier at that time; 2. insertion can make you bleed; and 3. most important, doctors and clinics want to be sure you aren't pregnant, as an IUD insertion can cause a miscarriage. IUD can remain in place for years, although it should be checked every six months by a doctor.

Reversibility. A doctor must remove it. Chances of becoming pregnant are the same as before using the coil.

Safety. Doctors maintain sterile technique when inserting the IUD so that danger of infection is kept at a minimum. For your safety, be absolutely sure that you do not have V.D. or (have not recently had) pelvic inflammatory disease when you get an IUD. If you are so infected, you will probably become one of the 2-4% of IUD-using women who suffer from P.I.D.

Side Effects.

1. The major drawback is the 8-12% expulsion rate. The Lippes Loop and Safe-T-Coil are expelled much more often by women who have never been pregnant than by women who have had one or more pregnancies. The Mazlin Spring and Dalkon Shield, which are expelled less frequently, have been developed particularly for women who have not been pregnant. If you expel the coil, however, it can be put in again and your chances of expulsion do **not** increase. The reason for checking the coil each week is pertinent here. When it begins to be expelled, it straightens out and cannot always be felt as it passes through the cervix. Hence, if you feel a bit of plastic at the tip of the cervix, in addition to the two strings, call your doctor!

2. Heavier and more irregular periods and more menstrual cramps, usually for the first 3-6 months of using the IUD. This varies among women. Heavier periods are the result of a thicker uterine lining, cramping occurs as the uterus works to shed the thicker lining and, until it grows accustomed to it, the IUD.

3. Breakthrough bleeding. This is from irritation of the uterus. It should not continue more than a few months. If it persists, it can often be corrected by use of a different shape of IUD.

4. Back pain is an occasional side effect. If it persists it can often be corrected by the use of a different shape of IUD.

Contraindications. Endometriosis. Venereal Disease. Any vaginal or uterine infection. Pelvic inflammatory disease. Prohibitively small uterus. Excessively heavy menstrual flow and/or cramping.

Advantages. For many people, psychologically very freeing. You needn't even remember to take a pill. Also good for those who object to chemical substances in their contraceptives. Finally, if an unwanted pregnancy should ensue, the removal of the IUD will result in a miscarriage in two out of three times if done in the first eight weeks of pregnancy. If you want the pregnancy, you can carry the baby to term safely and at the time of birth, expelling both baby and IUD normally. Occasionally (after the first eight weeks), a doctor can remove the IUD without damaging the foetus. You can use tampax with the IUD. Man's penis **cannot** feel IUD or properly trimmed string.

Responsibility. Woman or man must check strings of IUD once a week, feeling tip of cervix to make sure there's no plastic protruding. Be careful not to pull the strings.

Cost. Expensive initially, but nothing afterwards except a doctor visit once every six months. Initially, $35-50 in Boston, $50-100 in New York. Some private doctors in Boston are cheaper than $35. Many clinics are as low as $10, some places free.

VI. Diaphragm

Description. A diaphragm is made of soft rubber in the shape of a shallow cup, with a flexible metal spring forming a circular outer edge. It comes in a variety of sizes measured in millimeters (mm); the range is from 50 to 105 mm, or 2-4 inches. Approximately one teaspoon (¾ inches of cream as it comes out of the tube) or one plunger full of cream or jelly (gel) is put in the shallow cup, around the rim and on the outside as well. Then the cup is pressed together and inserted into the upper third of the vagina over the cervix so that it fits snugly behind the pubic symphysis. For extra protection, insert a little extra cream or jelly after the diaphragm is in place. When it fits properly, you should not be able to feel it, nor should your partner in intercourse, except occasionally. The diaphragm is a mechanical device, although the only protection is the chemical one from the cream or jelly. The diaphragm holds the cream in place and against the cervix.

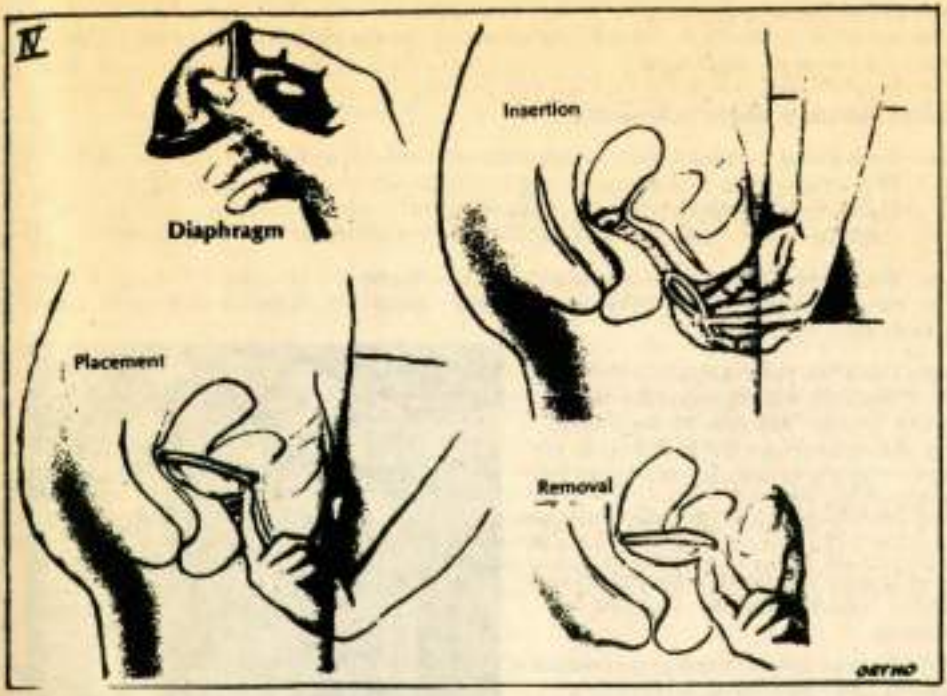
Effectiveness. From 95-98% effective depending on (1) effectiveness of cream or jelly (some are much stronger spermicidal agents than others) and (2) proper fit and proper care. The diaphragm can move somewhat during intercourse, as the vagina expands. Do not use vasoline on it. This corrodes the rubber. Check it for holes. Wash it carefully after use, blot dry and dust with talc. Do not boil.

Simplicity. You need a medical exam to be fitted and a prescription to buy it. It isn't hard to learn how to use it and we should be positive about handling ourselves. It should be put in place less than two hours before intercourse, as one's own body chemicals can destroy the spermicidal effect of the birth control jellies and creams. (The shorter the time, the safer you are.) It should not be removed until at least six hours after intercourse, and can be left in for 24 hours or more. You need to add another teaspoonful of cream with an applicator for each additional intercourse. Application can be made by the man as well as by the woman, or by both of you. Integrate it into your lovemaking.

Advantages. A good method if you have infrequent intercourse. And no side effects! Very effective if you use it right.

Disadvantages. Closely related to sexual act. You must remember to use it every time, be sure not to run out of spermicidal cream or jelly, be sure to have it with you when you need it.

Reversibility. Don't use it if you want to become pregnant.



Comfort. Diaphragm is helpful if you want to have intercourse during your period. It can hold at least 12 hours of menstrual discharge. Discharge of cream or jelly can be a nuisance; try different brands. There is less leakage with foam. Can use a tampon or pad for leakage after intercourse.

Responsibility. Woman is responsible. Even if the man puts it in place, the woman must go to the doctor, be sure it fits right, etc. A woman who always does the whole thing herself (off in the bathroom) can end up resenting the burden and/or pregnant (doesn't bother to put it in).

Cost. Diaphragm costs about $4.50. Medical exam is about $15 at a private office, less at the clinics. Jelly, cream, foam vary in price. 2½ oz. tube has about 12 doses. Total is about $56 yearly.

Life of Product. It should be examined every year for size fitting. It may last a couple of years with proper care; check regularly for holes, tears, etc. (Hold up to bright light or fill with water.) You will need a new size after a pregnancy, or after gaining or losing 15 pounds.

Popularity. In Guttmacher's book, it is stated that just under 25% of all married couples of childbearing age use it. No statistics about unmarried couples, nor breakdown according to class, race, etc.

Brand Names of Jellies and Creams. In choosing one brand over another, you have to consider factors of: (1) effectiveness of the brand as a spermicidal agent; (2) smell and taste of product (oral-genital play); (3) any allergic reactions on part of man or woman. If you don't like what you are using, change. Feel free to try different creams, jellies, etc., as long as you remember the various pregnancy rates. Preceptin and Koromex are good to use. Other names can be found in the Consumer Union Report (available in paperback).

VII. Cervical Caps (no longer made)

This product hasn't been used much since 1950, when diaphragms were generally substituted. It is like a diaphragm only smaller, made to fit securely over your cervix, where it mechanically blocks sperm. It is convenient because it can be left on for days or weeks, must be removed only during menstruation. Spermicidal foam, cream or jelly can be inserted at time of intercourse for additional protection. Unless the woman puts it in every time she has intercourse, there is no chemical protection

on the inside of the cap, as spermicides are good for three hours at most. For this reason, and because the cap is harder to put on than a diaphragm, and because it can slip off during intercourse, the cervical cap is not as effective as the diaphragm.

VIII. Condom (rubber or prophylactic or safe)

Description. Thin, strong rubber (or lamb intestinal) membrane shaped like the finger of a glove. Open end (1 3/8 in. diameter) is rubber ring; closed end is plain, or may have a pocket nipple of teat (less likely to burst upon ejaculation). Length is about 7½ in. The lamb membrane condoms are called "skin" condoms – more expensive, but cut down less on sensation.

How to Use. Put on erect penis just before intercourse, **not** just before ejaculation – the first few drops of the male discharge just prior to ejaculation often contain enough sperm for pregnancy to occur. Remove after intercourse.

Effectiveness. As a mechanical barrier: 5-6% pregnancy rate. Combined with chemical if woman uses foam or cream or jelly: less than 5% pregnancy rate. Foam and condoms are the best method for people before they get to a doctor, if pills are forgotten, if IUD comes out, etc.

Σ The Condom: Lower left-in store package. Lower right-rolled and ready for use. Top-Unrolled, after use.

Cautions.

1. ½ in. of space left between penis and condom on plain-ended condoms to collect ejaculate and prevent bursting;

2. Use lubricant to prevent tearing (spermicidal foam, cream or jelly, saliva, or K-Y Jelly);

3. Man must hold rim when he withdraws so condom won't slip off and sperm won't enter vagina.

4. If accident, cream or jelly should be used as quickly as possible. The 1958 FDA findings show that 1 in 350 condoms is defective. Get brand name condoms, not bargain-types. Brand name condoms are checked by the government. Watch out for pre-lubricated condoms – lubrication can get on the inside and they can slip off.

Simplicity. Very simple to use; purchase over counter; no M.D. exam.

Disadvantages. Has to be put in place just before intercourse; may be interference, though can be integrated into sex play and put on man by woman. Can irritate woman, especially during entrance of penis into vagina, if not sufficiently lubricated (either with woman's vaginal juices, or saliva, K-Y Jelly, or, best of all, contraceptive foam, cream or jelly). Many men find that condoms cut down on their sensation.

Reversibility. No problem, don't use if you want to get pregnant.

VD. Only contraceptive that helps prevent VD spread from penis to vagina contact. Also protects partners from infecting and reinfecting each other with an infection like trichomonas.

Responsibility. Man. Male contraceptive, so doesn't interfere with woman's body processes. Man must be willing to use it. If on long-term relationship with man, may alternate this method with others that woman is responsible for.

Cost. Three for $1.00 just as effective as more expensive ones, difference is that the latter ones are thinner and allow for greater sensitivity. $18-60 yearly ($0.35-$1.25 each).

Life of Product. Shelf life of two years. Some can be re-used five to six times if properly cared for (put in bedside tumbler of water, wash, powder and reroll).

Popularity. Used by one out of four couples who practice birth control. Statistics on unmarried couples not available.

IX. Effective Spermicidal Agents

A. Aerosol vaginal foam (the most effective)

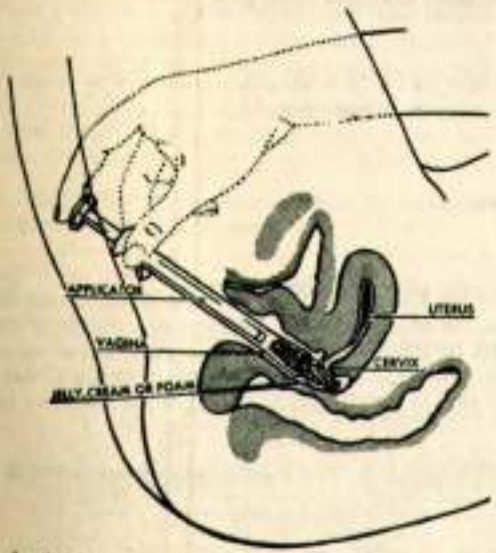
Description. Comes in aerosol can with plunger-type applicator. Be sure to get the applicator kit the first time. Foam mechanically blocks entrance to cervix, and chemically kills sperm.

Application. No more than fifteen minutes before intercourse. Shake the can very well (twenty-five times). Put applicator on top. When applicator is tilted (Delfen) or pushed down (Emko), the pressure triggers the release valve and a column of white aerated cream is forced into syringe, forcing plunger out. Insert applicator 3-4 inches into your vagina and push plunger in. Do this lying down, if possible. Use two applicators full.

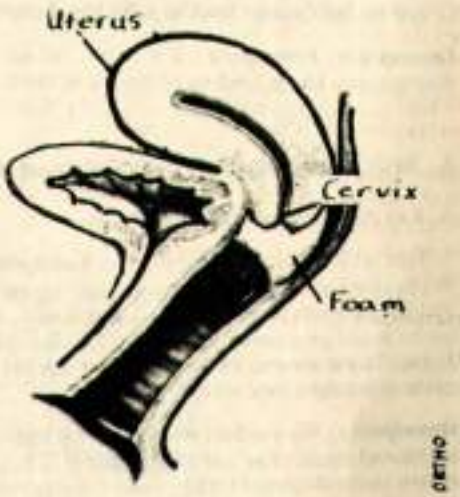
Effectiveness. Less effective than creams and jellies when they are used with diaphragm; when used alone, it is more effective than the creams or jellies used alone. The reason is the different physical properties. Creams and jellies have a tendency to remain as a lump of material after insertion and are distributed by penis during intercourse. Foam disperses evenly throughout the vagina even before intercourse. Thus, the cervix is more consistently blocked by chemical substances with foam than with creams of jellies alone.

Comfort. More comfortable than creams or jellies because no (or less) leakage; disappears within a few hours after intercourse with no residue. Use tampax if you feel drippy. There is a problem if you get to the end of a bottle and are without additional supply of foam; there is no indication that you're at the end, unless you see the gas without the foam! Keep an extra can on hand. Delfer slows up. Emko—a spring on the cap tells you.

Responsibility. Basically, the woman. But either of you can put it in.



Application of spermicidal preparation



Contraceptive action of foam

Cost. 1 oz. bottle (25 applications) is about $3.00; also comes in 2 and 4 oz. sizes which are cheaper per ounce. It is less expensive than creams or jellies (compare number of applications).

Popularity. Growing.

Brands. Emko Foam, which is more widely known, is reputed to have a 20% pregnancy rate and is therefore not an effective contraceptive. Delfen Foam – no accurate effectiveness rate, but is considered to be around 90% effective.

B. Jellies and Creams for Use Alone (without a diaphragm)

Description. Tube which comes with transparent plastic applicator (plunger). Applicator, for which you must pay more, is easily washed with soap and water. Fill applicator (usually screws onto tube) with 2 doses within an hour before, but preferably closer to, intercourse and insert it 3-4 inches into vagina and release plunger; put in another dose for additional intercourse. Action is chemical; spermicidal agents immobilize the sperm cells and also, when in the vagina, form a film or coating over the cervix, which hinders the sperm from entering.

Effectiveness. Less effective alone than when used in combination with diaphragm, because the mechanical effect of the diaphragm is to keep the cream where it belongs – over the cervix, rather than spread throughout the vagina. If you must use cream or jelly alone, get your partner to use a condom.

Simplicity. No medical exam involved and sold over the counter in drugstores and, in some states, in markets; usually with no questions asked.

Application Time. Needs to be put in place just prior to each and every intercourse. Can be a drag if you do it alone, can be fun if you do it together.

Reversibility. Just don't use it if you want to get pregnant.

Responsibility. As seems to be mostly the case, the woman! Get your partner to help put it in.

Comfort. Problems of leakage, allergy or reaction to smell or taste of product. If your vagina is sensitive to one brand, try another. Jelly is gooier than cream. Use tampax if you feel drippy.

Cost. 2½ oz. tube (12 applications) costs about $3.00.

List of Brands. See Consumers Union Report. Preceptin, Koromex A are good.

C. Jellies and Creams for Use with Diaphragm

Description. Everything more or less the same as under part B; also, see description of how to use diaphragm. These tend to be less effective than the ones to be used alone.

X. Birth Control Methods that Don't Work Very Well

A. Rhythm Method (safe period)

This is the only birth control method approved by the Catholic Church. We mention it in such detail because some Catholic couples are trying to use rhythm without the assistance of a doctor or clinic and because too many teenagers and college students, unable to get good contraceptive advice and care, try to avoid pregnancy by timing their intercourse according to some vague idea that there is a "dangerous" time around mid-cycle. **You can get pregnant at any time during your cycle,** because in any cycle you might ovulate early or late.

Description. No product involved. Method based on fact that woman **usually** releases only one egg each menstrual cycle. Egg has active life of 12 hours; sperm about 4-5 days. Therefore, 5-6 days each

month that intercourse could lead to pregnancy: 4-5 days before ovulation (egg release) and half day after. Normal woman ovulates 12-16 days before next menstrual period. Formula as follows:

VIII

THE RHYTHM METHOD

HOW TO FIGURE THE "SAFE" AND "UNSAFE" DAYS

LENGTH OF SHORTEST PERIOD	FIRST UNSAFE DAY AFTER START OF ANY PERIOD	LENGTH OF LONGEST PERIOD	LAST UNSAFE DAY AFTER START OF ANY PERIOD
21 DAYS	3RD DAY	21 DAYS	10TH DAY
22 DAYS	4TH DAY	22 DAYS	11TH DAY
23 DAYS	5TH DAY	23 DAYS	12TH DAY
24 DAYS	6TH DAY	24 DAYS	13TH DAY
25 DAYS	7TH DAY	25 DAYS	14TH DAY
26 DAYS	8TH DAY	26 DAYS	15TH DAY
27 DAYS	9TH DAY	27 DAYS	16TH DAY
28 DAYS	10TH DAY	28 DAYS	17TH DAY
29 DAYS	11TH DAY	29 DAYS	18TH DAY
30 DAYS	12TH DAY	30 DAYS	19TH DAY
31 DAYS	13TH DAY	31 DAYS	20TH DAY
32 DAYS	14TH DAY	32 DAYS	21ST DAY
33 DAYS	15TH DAY	33 DAYS	22ND DAY
34 DAYS	16TH DAY	34 DAYS	23RD DAY
35 DAYS	17TH DAY	35 DAYS	24TH DAY
36 DAYS	18TH DAY	36 DAYS	25TH DAY
37 DAYS	19TH DAY	37 DAYS	26TH DAY
38 DAYS	20TH DAY	38 DAYS	27TH DAY

Thor-Life

1. Keep written record of your menstrual cycle for 12 **consecutive** months. Count 1st day of menstruation as day 1 of cycle, and day before next period as last day of cycle. At end of 12 months, figure number of days in shortest and longest cycles.

2. Subtract 18 from shortest cycle's number and this determines first fertile or unsafe day.

3. Subtract 11 from number of days of longest cycle; determines last fertile day or day on which unsafe period ends.

4. Each month, bring list of 12 cycles up to date by adding cycle just counted to bottom of list and crossing off oldest cycle on top.

A daily record of basal body temperature (measured on a **special** thermometer, which only registers a few degrees, from 96-100° in 1/10 degree gradations which are wide apart and easily read) is used in combination with the chart of cycles. The basis of this is that whatever a woman's so-called normal temperature may be, there are characteristic (though slight) daily variations within each month caused by ovulation. The cycle runs like this: After each menstrual period, temperature on awakening low. It may be still lower on the day associated with ovulation, which is assumed to occur just before or just after lowest morning temperature reading. After ovulation, because of action of newly formed hormones, progesterones, temperature rises several tenths of a degree and remains up until a day or two before menstruation begins. If pregnancy occurs, temperature remains consistently high for several months since progesterone continues to be formed. Suspect pregnancy if BBT (basal body temperature) is high for more than 18 days.

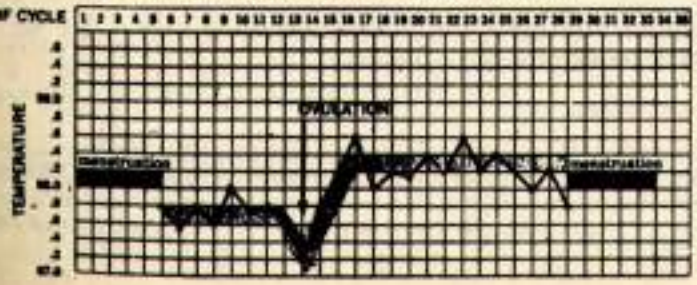
Effectiveness. Depends on regularity of menstrual cycles. If variance of more than 10 days between longest and shortest cycles, not effective because safe period is too brief (true for about 15% of women). Requires a lot of self-control and cooperation between partners. About a 20% pregnancy rate; lower if diligently use thermometer and calendar and always abstain if chance of ovulation. Not good after pregnancy; need several months to recalculate safe period.

Simplicity. Complicated to keep chart of menstrual cycles if irregular and to always interpret slight variations in BBT with accuracy (fever-producing illness or tension leads to rise in temperature, as well as onset of ovulation).

Application Time. No devices, but have to have figures for menstrual cycle for one year prior to be protected at time of intercourse.

IX

Basal Body Temperature during the menstrual cycle



Reversibility. Calculations help tell you period of ovulation, and guide for days for intercourse if you want to get pregnant.

Comfort. Psychological comfort is lousy; calculating safe period cuts down on spontaneity and problem increases, since guilt may be felt if one partner wants to have intercourse during safe period.

Responsibility. Need cooperation from both if to work most effectively. Problems: if relationship is not long-term; if couple are not "practicing" Catholics.

Cost. $0.03 per chart; BBT $2.50-$4.00; M.D. visits if there is variation in cycles and one needs advice.

B. Douche

Some women try to flush out their vagina with water or other special solution **immediately** after intercourse—an effort to remove semen before it enters the uterus. If douche works, it keeps sperm level below number needed to assure fertilization. (Remember only one sperm is needed, but the trip is complicated so many sperm are needed to support odds.)

But douching does not often work: sperm swim fast, and some will reach your uterus before you've reached the bathroom; and the douche, which is liquid squirted into your vagina under pressure, will push some sperm up into your uterus even as it is washing others away.

Douching is the least effective of all methods, and puts exclusive burden on the woman, who must hop up to the bathroom immediately. **Don't use it!**

C. Vaginal Tablets

Description. Tablets are 2-3 times the weight of aspirin. They are round or arrowhead in shape and come packaged in tinfoil or in wax-sealed glass vials. One tablet is inserted as far as possible into the vagina before each intercourse. The tablet needs time to dissolve – 15 minutes to one hour. It may need to be moistened with saliva or a drop of water before insertion if the vagina is dry. While the spermicide is incorporated into a cream or jelly base with foams or jellies, in the tablet it dissolves on contact with moisture and delivers spermicide into upper vagina. The foaming kind of tablet also forms film over cervix. Although they are one of the less effective methods, some physicians think that they are one of the most widely used because they advertise. The ads are usually placed in publications which are more frequently bought by the poor and promise a solution to "your most intimate marital problems." The women who read these ads can be sure of two things: that the product is to be inserted into the vagina and that it will take care of "some problem." The product is not sold with the information that these suppositories are to be inserted before coitus or even that they are a contraceptive device. Since pregnancy is one of the biggest "intimate problems" some of these readers have, they buy the suppository and take a chance. The very same suppositories can be bought with a prescription and are a much more effective birth control method because instructions are included which say to insert one before each intercourse to prevent pregnancy. Birth control laws in some states do not allow advertising contraceptive devices. Thus a large segment of the population which could more effectively use this product is kept in the dark as to how to use it most effectively.

Effectiveness. Less protective than creams or jellies and far less than foams because less sure that it will dissolve rapidly and be distributed evenly. It is **not a reliable** method.

Simplicity. Probably the simplest of all current medical contraceptives. No exam or equipment is needed. But you can also get pregnant pretty easily using them.

D. Vaginal suppositories

Description. Instead of being packaged as a tablet, spermicide is incorporated into a base of glycerogelatin, cocoa butter or soap. In this base, they melt at a little below body termperature. All the rest of the information is just the same as for the tablets. It is interesting that suppositories have been advertised as "feminine hygiene" preparations. Norforms or other "hygienic" preparations **do not** serve as efficient contraceptives.

E. Withdrawal (coitus interruptus or "taking care")

This folk method is practiced without medical initiative and passed on from one generation to another.

Description. Withdrawal of penis far away from vagina just before ejaculation, so that semen is deposited outside vagina and away from lips of vagina as well. No equipment or preparation needed.

Effectiveness. Not highly effective, because fluid released **before** ejaculation may contain sperm as well. But withdrawal is better than nothing!

Simplicity. Application, Comfort. Simple in theory, but hard to apply because of need for discipline by man and split-second withdrawal. Therefore affects psychological aspects of sex—can't relax and lose consciousness. When used over long period, can lead to premature ejaculation by male. Can be hard on woman, also, if she doesn't reach orgasm before the man withdraws.

Reversibility. Don't withdraw to achieve pregnancy!

Responsibility. Man is responsible for withdrawal. He has to feel sure enough of himself so he doesn't feel threatened if sperm lands outside woman. Woman must trust man.

Popularity. World-wide, most used of all methods. 5% of couples in America. Used by a lot of U.S. couples who don't have access to good contraceptive care (teenagers, many college students, poor people).

XI. Post-coital Medication – "The Morning-After Pill"

Some college health services (Yale, for one) and some doctors will give you a series of high-dosage estrogen pills if you come in less than three days after unprotected intercourse in the middle of your menstrual cycle. A lot of estrogen at that point in your cycle will usually affect the uterine lining so as to make it impossible for a fertilized egg to implant. Check the birth control pills section for the side effects of estrogen, and you will see why this is not a method to be used often. The dosage used at Yale is 50 mg. of diethylstilbesterol (two 25 mg. tablets) to be taken together once a day for five days. You might want to get anti-nausea pills at the same time. N.B. FDA reports in November 1971 link diethylstilbesterol taken during pregnancy with vaginal cancer in offspring. So if you get morning-after medication and find that you are pregnant at the end of that month, you might think about having an abortion.

XII. When You Are All Done – Sterilization

Sterilization is a 100% effective, absolutely final form of birth control, available for men and for women. It is legal in all states, although many hospitals are conservative about it and require that the person be a certain age, with a certain number of children, etc., and that the person have the spouse's signed consent. (Other hospitals, notably in ghetto areas, tend to do too many and not entirely voluntary sterilizations. Black women in the south are all too familiar with the "Mississippi Appendectomy" in which their fallopian tubes were tied or their uterus removed without their knowing it.)

In the traditional sterilization operation for a woman, a fairly large abdominal incision is made, a piece of each fallopian tube is cut out and the two ends are tied off. A more recent development is the laparoscope technique, in which a tube with mirrors and lights is inserted through a small incision, the tubes visually located, and the tubes cauterized (burned) by a small instrument inserted through another insertion. The traditional tubal ligation is major surgery, unless entrance can be made through the vagina. It requires a 4-5 day hospital stay and is accordingly very expensive. The laparoscopic sterilization requires only a one day hospital stay and is being done on an out-patient basis (much cheaper, and less convalescing time). Sterilization does not affect hormone secretions, ovaries, uterus or vagina.

Sterilization for the man, called a vasectomy, can be done in a doctor's office. The doctor applies a local anaesthetic, locates the two vas deferns (tubes that carry sperm from testis to penis), removes a piece of each and ties the ends off. The man's genital system is basically unchanged: sperm are made, his sexual hormones stay operative, there is no noticeable difference in his ejaculate because sperm make up only a tiny part of the semen.

XIII. Future Methods of Birth Control

Male contraceptive research. At first a birth control pill was developed for men, but it drained a man's ability to have an erection as well as acting as an antidote to the potency of the sperm-producing cells. Now researchers are working on a sperm capacitation pill in Sweden and California. This will stop the sperm's ability to penetrate the egg. It may be available in two to three years. As yet, no compound has reached serious clinical trial because of, as the British Medical Bulletin states it, "apprehension regarding the risks involved from tampering chemically with the male germ cells."[8] (our emphasis)

Female contraceptive research involves some of the following: (1) Trying to put progesterone on IUDs. This would change cervical mucus and the uterine lining, thus making conception even less likely. (2) Work on a pure crystalloid which will let a small amount of its contents out into the body each day. The body will absorb an amount directly proportional to the surface area of the crystal (crystalloid), which is a long oval and is inserted under the skin. This will be available in about two years, and will be pure chlormadinone acetate (like the minipill). Now it must be replaced once every six to eight months. Hopefully the time can be reduced to once a year by the time it is released. The crystalloid would release 0.35 mgm. per day continuously into the circulation. You could check on the contraceptive protection from time to time by feeling for a little bump under the skin of your arm or thigh. The problem of the body reacting to the crystalloid as a foreign body may be solved by use of silastic, a silicone. (3) There is an injection almost ready for release. This is pure cma: latex crystals with cma attached. The latex isn't well handled by the body, so problems still exist. (4) Doctors can now tell when a woman will ovulate 12 hours before she does. This is done by measuring the sodium and calcium levels of the cervical mucus, using flame photometry and spectrophotometric radiometry.[9] (5) There is research going on in the use of prostaglandins, chemicals which are known to cause uterine contractions. Prostaglandins might be worked into a pill or suppository that could be used once a month to bring on a period whether the woman is pregnant or not.

Some of this research is frightening and confusing. We don't want contraceptives to become one more area in which we are intimidated and frightened into doing things we're not sure of or don't want to do. Each of us has the right to choose a method that is best for us and to understand that method in terms of application, effectiveness, safety, etc. For we alone best know what our needs are.

FOOTNOTES

1. *Health-Pac Bulletin*, March 1970, p. 12. 2. Ibid. 3. Ibid. 4. Ibid. 5. Ibid., p. 11.
6. W. A. Kelley, *Journal of Reproduction and Fertility*, vol. 19, 1969, p. 338.
7. A. Pakrasi and G. G. Ray, *Journal of Reproduction and Fertility*, vol. 19, 1969
8. *British Medical Bulletin*, vol. 26, 1970. 9. Conversation with Dr. Kozusky, 1969.

SUGGESTED BOOKS TO READ ABOUT BIRTH CONTROL

(All are paperbacks except Demarest and Sciarra.)

Demarest and Sciarra, *Conception, Birth and Contraception*, McGraw-Hill, Inc. (New York: 1969), $8.95

Kistner, Robert W., M.D., *The Pill*, Dell Publishing Co., Inc. (New York: 1969).

The McGill University Student Society Birth Control Handbook (available from New England Free Press or from McGill Student Society)

Neubardt, Selig, *Contraception*, Pocket Books (New York: 1968).

Peel and Potts, *Textbook of Contraceptive Practice*, Cambridge University Press (Cambridge: 1969).

Yale University Student Committee on Human Sexuality, *The Student Guide to Sex on Campus*, New American Library (New York: 1971).

Abortion

INTRODUCTION

Abortion is our right—our right as women to control our bodies. In almost every community in this country a woman with an unwanted pregnancy is hassled and obstructed by laws, hospitals, doctors, by high prices and poor communications. The same public whose sex-filled media urge her to be sexy turns on her with a moralistic disapproval which isolates her and forces her to deal with her problem in secret. Some strong and concerned people have changed a few state laws and started some good abortion referral services and humane clinics—but for too many American women legal abortions are hard to get, hard to pay for, and, if they do get them, are alienating and lonely experiences.

Why do unwanted pregnancies happen? Some of us get pregnant without thinking about it because we have been forced to believe that we are acceptable only as sex objects or as mothers. Or, we are taught that sex is not quite right (even though we are taught to be sexy and flirt) so we're scared to ask those who may know where to get birth control and which birth control methods are most effective for help. Or even when we do ask, many of us can't get birth control—it's not legal for unmarried women in Massachusetts* and Wisconsin, not easy for teenagers anywhere, and hard for any of us who can't afford the medical fees and drug prices. And even if we can get the most effective method for pregnancy prevention, it may not be the best method for individual ones of us (for example, we may have a family history of cancer and should not take the pill). And every method except the pill fails to work two percent of the time, or more. Birth control is better than nothing, but there is no such thing as an ideal method, i.e. one which is safe, simple, cheap and 100% effective. Birth control fails us because the methods are imperfect, not because we are irresponsible. Nevertheless the consequences fall on us.

In places where legal abortions are hard to get, the risks are great. Although the risk of death for an abortion done under proper medical supervision during the first 12 weeks is less than for a full-term pregnancy, only an estimated 25% of American women who want abortions can get them legally.[1] And of those, many have spent so long getting there that they are beyond 12 weeks since their last menstrual period, when the procedure gets more difficult and more dangerous.

* Planned Parenthood (617–332-8750) has lists of doctors and clinics who will see single women despite the law, but most of these are in and around large cities like Boston, Worcester, Springfield.

Illegal abortion is one of the most common causes of maternal death in this country. The casualties are difficult to count, because many women who come into emergency wards and die of acute peritonitis (infection spread through the abdomen) are victims of botched or dirty abortions but won't say so because they are afraid of arrest. Many women who recover from such infection find that they are sterile. The risks to our mental health are enormous, too, when legal abortions are hard to get. We have to deal with the fear and trauma of getting a "criminal" abortion, hospital boards which in most states decide whether a case "deserves" a legal "therapeutic" abortion. We have to wait anxiously, to act in secret and we have to go into debt.

When legal abortions are hard to get, poor, non-white women suffer. In our 1969 edition the figures were this: 75% of women who died from abortions (mostly illegal) were non-white, 90% of all legal abortions were given to white, private patients. If you do not live in or near New York State, or in Alaska, Hawaii or Washington State, these figures probably hold for your area.

Figures from the New York City Department of Health for the first year of their liberalized abortion law show that only when legal abortion is universally available do the racial proportions become more fair. Of NYC residents, abortions were performed on 47.7% white, 42.3% non-white, 10% Puerto Rican. When they count along with NYC residents the women with the mobility and money to come in from other towns (3.3%) and other states (55.5%), the percentages change significantly: 73.8% white, 21.9% non-white, and 4.3% Puerto Rican.

When abortion laws are repealed, however, we have to make sure above all that abortions are **voluntary** as well as free and safe. Genocide of poor and black peoples to keep the most oppressed populations in check is a real fear; for instance, in some states laws have been proposed which would make women on welfare have abortions by threatening to stop their payments after a certain number of "illegitimate" pregnancies. We do not know from our own experiences - since we are white and middle class - but we suspect that other women are forcibly made to abort or to be sterilized. Whether or not it is true, it is a fear that should be faced. For this reason it's crucial that whenever we talk about abortion, we talk about the implications for all women. One woman cannot be liberated without the liberation of all women.

In fighting to change the abortion situation, we run up against many vested interests: 1) the legislators who refuse to see the need, who use their power to prevent repeal of abortion laws, saying, for instance, that they don't want to "encourage promiscuity" (don't be fooled by "reforms" either—there have been as many illegal abortions in Colorado after the reformed law as before); 2) the medical profession that finds abortions boring, that is threatened by the idea of abortion on request, that uses the laws to maintain its power by defining the legality of each case, that charges high prices for the abortions they choose to do; 3) the racketeers who profit from illegal abortions as they do from prostitution (against women), drugs, etc.; and 4) the profit-making abortion referral agencies which advertise widely and make $50 or more from every desperate woman.

We are demanding **free, safe** and **voluntary** abortions, for all women who want them, to be carried out in properly equipped hospitals or clinics by humane and qualified personnel, including trained and sympathetic counselors.

Addition, 1971.

When we first wrote this paper our militancy for free abortions on request made us neglect something which a year of New York experience has made us recognize—the emotional side-effects of abortion for an American woman at this time in history. In saying that the medical procedure of a pre-12 week abortion is safer than a tonsilectomy, we made it sound like the emotional experience is similar, too. This isn't true. In the first place, there can be a physiological post-abortion depression similar to post-partum depression in women who deliver babies. We must make sure that every woman who has an abortion is aware that this depression might happen. But, more than that, the American woman who has an abortion, no matter how easy it is to arrange, comes from a culture which overvalues motherhood and which is uneasy about sex, particularly premarital sex.

If you are young and unmarried, the pregnancy may come from one of your first experiences with sex, and the abortion becomes a kind of punishment for you. Or, suddenly finding yourself in a crisis situation when you need more support and comfort than ever before, you realize that you can't tell your parents or even your friends, and so even though you are relieved to end the pregnancy you are left with the loneliness. A lot of times an abortion marks a critical point in your relationship with the man—maybe you wanted to stay together and have the baby and he has rejected you, maybe he wants you to have the child and you're rejecting him. Even if he stays with you, you feel miserable at being so vulnerable to his leaving you to handle it yourself. Maybe, married or unmarried, you or he or both of you are filled with romantic feelings that having a baby would make everything all right.

Maybe you want to have a baby but you just can't afford it financially, and you feel resentful and bad about that. Maybe the abortion clinic you go to is overcrowded or the doctor is rushed, remote or even judgmental—you feel like an object, not a person, and that depresses you. And there is often a fear, even though with a doctor-performed legal abortion there is little or no danger, that if you want to get pregnant some day you won't be able to.

And for many of us it is scarey to take control, to say no to "nature's" alternative instead of letting fate decide. These are the growing pains of becoming new women, free and strong and in control of our bodies.

Those are some of the reasons why you might feel sad and depressed about having an abortion even if it's easy to get. You are likely to feel mostly relief and happiness at getting rid of such a burden, but if you do feel bad, don't put those feelings down—let them rise, deal with them, and work to make sure that other women who seek abortions get the emotional support they need at every step of the way.

HISTORY

One of the myths that anti-abortionists use to influence legislators and to harass and scare the woman with an unwanted pregnancy is that abortion violates some age-old and god-given "natural law". One look at history shows that they are lying or terribly misled. Until one hundred years ago almost no one - not even the Catholic Church - punished abortion in the early stages of pregnancy. Lawrence Lader says that "the Greek city states and ancient Rome, the foundations of Western civilization, made abortion the basis of a well-ordered population policy." (Abortion, p. 76) Christianity infused the fetus with a soul, but during eighteen centuries of debate the Church went by the conveniently loose view that the fetus became "animated" by the rational soul and abortion was therefore a serious crime only at forty days after conception for a boy and eighty days for a girl. (No methods of sex determination were specified.) English common law by the thirteenth century settled into a fairly tolerant acceptance of abortion up until "quickening", the unspecific moment usually in the fifth month when the woman feels the fetus move. In the United States for a long time the common law inherited from Eng-

land protected the right of abortion of early pregnancy.

Suddenly in the nineteenth century things tightened up. In 1869 Pope Pius eliminated the distinction between an animated and non-animated fetus, and since then the Catholic Church has called all abortion murder and punished it severely. Anti-abortion laws were first passed in England in 1803 and became stricter through the century. Connecticut in 1821 punished abortion of a fetus by poison after it had quickened, but as in other states a succession of laws followed which culminated around 1860 in outlawing all abortions except those "necessary to save the life of the woman."

There were three main reasons why abortion suddenly became a "crime". The first was quite decent: abortion until recently was a dangerous operation, methods crude, antiseptics scarce, even hospitals dirty. It was in part the mid-nineteenth century wave of humanitarianism which pressed for abortion laws to protect women. The second motive of the anti-abortionists was less laudable. As biologists in the nineteenth century began to understand conception, women began to practice more effective contraception. Catholic countries like France began "losing" the population race, and the Church wanted to keep its mothers running. So the Church itself turned to biology and used the idea that "life" and therefore soul-infused human life begins at fertilization. This reasoning also spread to England and the U.S. It so happened that English and American industries needed workers, the huge farmable territories of the new world needed farmers, and the Civil War had depleted America's labor crop. Abortion laws saw to it that woman took her place beside the other machines of a developing economy.

The third reason for the sudden emergence of anti-abortion laws is the most dangerous: it is the idea that sex for pleasure is bad, that pregnancy is a punishment for pleasure, and that fear of pregnancy will reinforce "degenerating" modern morals. These ideas had long fought for supremacy in the Catholic Church, and showed in 1869 that they had won. The English and American puritanism which still perverts our minds flourished in the nineteenth century; it is significant that the 1873 U.S. federal law which banned from the mails any literature, medicine or article to do with contraception or abortion, was engineered and executed by Anthony Comstock, fanatical secretary of the New York Society for the Prevention of Vice. Today the idea that sex is bad is worked with cruel sadism on the victim of an unwanted pregnancy by her community and, worse, by her doctors, many of whom underneath it all feel that a little humiliation and a little pain might teach a girl a lesson. It is partly this thinking which slows down development of quick and painless methods of abortion. And in a majority of states, including Massachusetts, puritanism still works to keep abortion laws and practices rigid. The legislators of morality, undaunted by Prohibition, cannot stop sex but do send hundreds of thousands of American women a year underground for dangerous and often fatal criminal abortions.

ABORTION PRACTICES IN SOME OTHER COUNTRIES

Not all countries have stayed with the nineteenth century's obsolete and cruel abortion regulations. Law and practice opened up abortion to both rich and poor in Scandinavia beginning with Iceland in 1934. We should notice that pressure for abortion reform in Scandinavia, as in England, came from not only the general public but also national medical associations and distinguished doctors, whereas in the U.S. the medical profession has been a major obstacle to change. Abortion in Scandinavia is not given on demand, however: there are strictly defined categories of legal abortion, mostly medical categories, but also humanitarian (e.g. victims of rape), "eugenic" (e.g. for cases of predictable fetal deformity), and in Norway and somewhat in Sweden, social (e.g. where poverty, too many children already, alcoholism, etc., would make the birth of the child a misfortune). A Scandinavian woman has to go through a lengthy bureaucratic procedure to "qualify" under one of these categories; as a result, few foreigners come to Scandinavia for abortions, many Scandinavian women go to Poland instead of waiting around at home, and the women who do get legal abortions are often past the time limit for a simple operation and must undergo more serious surgery and therefore more risk.

In Russia and the Communist Eastern European countries ideology values a woman's independent contribution to society and counts her an equal with the right to control her own reproduction, and the economic conditions have made workers desirable and housing scarce. So despite the Catholic Church, Russia off and on since the 1920s and since the '50s Hungary, Poland and the rest of the Eastern Bloc, have legalized abortion on demand and perform in some cases more abortions than live births. (Abortion rates will go down as contraception spreads.) The results of Eastern European abortion policies have been striking: Hungary's one-child family proves that abortion works as population control; fatality rates are miniscule,

far lower than for childbirth or for simple tonsilectomy in the U.S.; and criminal abortion, unlike criminal abortions in Scandinavia, have been greatly reduced. Contraception, however, is spreading at varying speeds and with different amounts of government support in these countries, with, as of 1965 (Lader) the USSR being the most ambivalent and Poland requiring contraceptive classes of all women who have abortions.

Japan, where there are no religious or moral obstacles to abortion, actually arrived at abortion on demand as a matter of national survival. Countless troops were returning home after World War II to a devastated economy and a baby boom resulting from war-time nationalism. The Eugenic Protection Law of 1948 and two later amendments, along with low abortion costs, instituted abortion as the national method of population control. It worked fantastically, cutting the Japanese birthrate to less than half in fifteen years. Japanese experience with abortion demonstrates again that legal abortion is safe, that legal abortion kills criminal abortion, and that the psychological consequences of abortion in a society where abortion is legitimate are only good.

Two side issues are worth noticing. First, Japan has had a lot of trouble popularizing contraception because abortion is so effective and so cheap. Second, the 13 February 1970 issue of Science magazine reports that Japanese Prime Minister Sato has reversed his position on population growth because the shifting age of the Japanese population (older) means there are fewer workers for the factories making cars and cameras for America; he urges Japan to strive to bring the birthrate up to the "average" level. This attitude is ominous: profit, short-term economic development, and assiduous exploitation of all available resources are clearly the motives at work. Woman in Japan is still the tool of economics and nationalism, which come also before any consideration of world population growth.

England legalized abortion in 1967. Although there is a statutory list of indications, and the doctors have held on to the final word, in effect abortion in England is on demand.

U.S.A.: ABORTION REFORM OR REPEAL, AND MEDICAL CONSERVATISM

Since England, Japan, Eastern Europe are out of the question for all but the richest of American women, we have to move from these topics to face our own abortion situation, which has improved in some states* but has a long way to go. Inertia, the strong Catholic minority, puritanism, an extremely conservative medical profession, sexist legislatures and the American woman's ambivalence towards sex and towards her rights regarding her body, all tend to keep our abortion rigidities operating, even in the twelve "enlightened" states where reform along Scandinavian lines has been achieved. As this paper is being written, it looks like a number of states are moving towards either legislative or judicial repeal of their abortion laws. We are including the following discussion of the shortcomings of abortion reform not only for historical interest, but also because we suspect that many of the factors which give women in reform states such a hard time won't be changed merely by repeal of restrictive laws.

By mid-1971 twelve states (Arkansas, California, Colorado, Delaware, Georgia, Kansas, Maryland, New Mexico, North Carolina, Oregon, South Carolina, Virginia) had modified their abortion laws according to the American Law Institute guidelines wherein abortion is permitted for five reasons: if the pregnancy is the result of rape or incest, if the mother has rubella (german measles) or is under fifteen years of age, or if her health is seriously endangered by the pregnancy. The important word there is "health" which can be interpreted as mental health, allowing for abortion on psychiatric grounds. The abortion permitted under these laws is called a "therapeutic abortion", as though none other than a hospital abortion can be considered therapeutic. Oregon adds to the ALI statutory list a provision for risk to existing children and environment. A number of states have reform actions under way.

But reformed abortion laws in the hands of the American medical profession are just as bad as the old laws, and often worse. The whole notion that a certain woman "deserves" an abortion is an insult, and opens the woman up to the degrading procedure by which doctors and hospitals judge whether she falls into some category of qualification. And the medical profession hides behind the list of qualifications, using it more to turn women down than to accept them. According to Larry Plagenz (Modern Hospital, July 1969), the number of abortions in some California hospitals has increased six-fold since the law changed, while some have stopped altogether, and meanwhile the statewide rate of 100,000 yearly illegal abortions continues unabated. Dr. George Cunningham, Chief of the Bureau of Maternal and Child Health, stated in the same article that "hospitals that want to can make the procedure for obtaining an abortion complicated, time-consuming and expensive. One me-

* New York has a "near repeal" statute; Alaska, Hawaii and Washington State have "limited repeal" laws, with residency and other requirements attached.

thod is to require two psychiatrists' statements when the law requires only one." The "abortion committee", rarely required by law, is the shield used by hospitals in many states. After a case has been approved by two or more specialists, it must be passed by a committee of three or more rotating senior staff members, and a unanimous vote is often required. As it is not uncommon even in non-Catholic hospitals for there to be a Catholic or a conservative doctor on the board, most cases are turned down. (We object not to a doctor's refusing on personal grounds to perform abortions, but to his being able to stop other doctors from performing them. Any individual doctor trained for years to save life, and persuaded by religious or other convictions that a fetus is "life", could understandibly reject the idea of destroying it.)

Even if a case seems "deserving", the hospital has often already filled its weekly, monthly or yearly quota of abortions, set in accordance with the Ob/Gyn profession's unofficial ratio of abortions to live births for a given year. Another obstacle to the approval of this "case" (remember this is a woman) is the availability of a hospital bed. Medical people piously assert that they can't make full use of the existing law for fear of being flooded with abortion requests, which would fill up the beds. But they are likely to see each woman one way or another, either for delivery or for emergency treatment after a botched illegal abortion; and in these cases she'll be taking up a bed for five or more days. Abortions do not have to be so bed-consuming: it is our doctors themselves who say that an abortion patient must be hospitalized for two nights, whereas in England women leave the clinic six hours after the operation and in Rumania they leave after two hours (not to mention the speedy departure some of our same doctors urge on their illegal abortion patients). A further obstacle to moving abortion out of the hospitals into out-patient settings is current medical insurance policy, which does not cover out-patient health care.

The case might also be rejected because the hospital is a teaching hospital, and although teaching hospital staffs tend to be more liberal than most, they want to do only so many abortions because abortions are "dull" and "uninstructive". Clearly the doctors are resisting the notion of themselves as public servants. They resist also the idea that as public servants they might perform on demand – for they are steeped in a professional tradition in which the doctor knows all and the patient nothing. Whereas this might be true with appendectomy, it is not true with abortion. Dr. Lonnie Myers of the National Association for the Repeal of Abortion Laws quotes a poll of all doctors' views on abortion, in which the only group which came out consistently for abortion on demand was the plastic surgeons. Plastic surgeons, the only doctors whose patients decide what is to be done, do not consider operating on demand a threat to their professional sanctity. Women must see to it that Ob/Gyns, who came out on the opposite end of the poll, start to feel this way not only about abortion, but about the whole range of their services to women. (By the way, this is not a plug for plastic surgeons; we abhor both their cosmetic type of work and the fantastic rates they charge.)

Doctors show also by the fees they charge that they do not consider themselves public servants. Women, always the major health consumers, really bear the brunt of abortion costs. For a purely medically indicated D&C, a doctor charges about $200, while he gets $300 and up for the same technique when it happens to be a therapeutic abortion. If he is doing it illegally, he gets upwards of $1000 for the risk he is taking. The cost of a therapeutic abortion in Washington, D.C. in March 1970 was about $600, half for doctor's fee and half for hospital charges. Medical insurance does not always cover the cost of a T.A., especially employee insurance, university health plans, and almost all plans for the single woman (who can sometimes get the hospital to list her operation as a simple D&C). There has been a suspicion voiced that doctors play down abortion because delivery is more remunerative, but actually there is a lot of money in the abortion business, as some London Ob/Gyns are discovering, and as the underworld has known for a long time.

In many places medical conservatism will hold out for a long time against both abortion on demand and abortion for low fees. The individual doctor does not break out of the system because he has been forced to work hard for sub-standard pay for many years, and just as he starts to make more money, which he has come to think is his due, he doesn't dare risk his job by performing abortions or by urging his hospital to allow more of them. Medical conservatism feeds on itself.

So even in many reform states a legal therapeutic abortion is almost impossible to get. The clinic patient without a private doctor and psychiatrist and money to help her over the obstacles gets little benefit from reformed abortion laws. And even for the more wealthy woman, the procedure is lengthy and degrading: as in divorce proceedings where infidelity must be proved or faked, so in obtaining an abortion on the usual psychiatric grounds a woman must feign mental illness and often finds herself labeled psychotic.

Clearly the only just alternative is the repeal of

all restrictions on doctor-performed abortions (until methods are developed which can be applied by non-doctors). The same recalcitrance that doctors have shown in reform states will operate to hold down abortions in repeal states until women get together and press for abortion clinics, shorter or no hospitalization, low fees, and, most important, for abortion on request. As long as abortion is up to the doctor and not to the woman, it will be harder to get them than it should be.

THE ABORTION SITUATION IN MASSACHUSETTS – OCTOBER 1971

(Groups using this book elsewhere can substitute local information.)

Although Massachusetts is a Catholic state with the most backward birth control laws in the country, the Mass. law on abortion is vague and therefore quite liberal. It states merely that unlawful abortion is illegal, implying that there is such a thing as "lawful" abortion. Physicians in the state, especially in Boston, have long considered therapeutic abortion lawful under certain circumstances. This interpretation of the law has been approved by the Mass. Supreme Judicial Court in the 1961 case of the Commonwealth vs. Brunelle. In later cases (Commonwealth vs. Wheeler, vs. Nason, vs. Corbett), the court allowed the physician to procure an abortion for a patient in case of a threat to her life or to her mental health. Although the inclusion of mental health as grounds for abortion seems liberal, the problem in Massachusetts rests in the final clause: "... if his judgment corresponds with the general opinion of competent practitioners in the community in which he practices." The "general opinion of Massachusetts doctors has been most conservative, and they have not made full use of the court's interpretation of the law. (See the section on medical conservatism.)

As a result of the doctors' hesitation, only about 2500-3000 hospital abortions were performed last year in Massachusetts, almost all of them in six major Boston hospitals. At least 90% of the therapeutic abortions are done under the mental health provision of the court. The protocol for establishing eligibility varies from hospital to hospital. In general most require the consent of the woman's gynecologist, two psychiatrists, the chief of gynecology and/or the abortion committee of the hospital. Even in the more liberal hospitals the qualification procedure is long, insulting, expensive, and often leaves a woman two or three weeks more pregnant with the hospital door shut in her face.

The Boston abortion is expensive, from $350-$500 for clinic patients who are under twelve weeks since their last menstrual period. Private patients pay $600 and up by the time the doctor and hospital bills are paid, even more if a number of psychiatrists are seen. Some medical insurance plans like Blue Cross/Blue Shield will pay for a therapeutic abortion, but for married women only. Welfare usually covers its recipients.

Where to Go for Counseling and Referral

A few years ago an American woman with an unwanted pregnancy was doomed to a lonely and dangerous trip underground for an illegal abortion. Although things aren't perfect today, enough attitudes and state laws have changed so that YOU CAN GET A LEGAL ABORTION. If there is no chance of getting a legal abortion in your state, you can go elsewhere, probably to New York. DO NOT RISK YOUR LIFE BY GOING TO AN ILLEGAL ABORTIONIST! You don't have to do that any more. Remember--**early abortion** (before 12 weeks since your last menstrual period) **is safer and it is easier to obtain**. So if you think you're pregnant and you don't want to be, don't delay consulting one of the agencies mentioned below. And if you're pregnant and don't know how you feel about it, counselors at many of these agencies can help you think it out.

In New England the group seeing the most women about unwanted pregnancy is the Pregnancy Counseling Service at 3 Joy Street, Boston, 523-1633. If you live far away from Boston you can first call your local Planned Parenthood or Clergy Consultation Service (an organization of clergy-people from many faiths which has been helping women with unwanted pregnancies for many years). If you can't get local help, call the P.C.S., who can counsel you by phone if necessary. P.C.S. is a non-profit agency with volunteer counselors trained to help you sort out your feelings about the abortion if you want one. They also do cheap pregnancy testing. Women who come to P.C.S. are usually directed to clinics or hospitals in the New York City area, unless they qualify for an want a legal Massachusetts abortion. P.C.S. can help you work out financial arrangements, and only very rarely has to turn someone down because of money. Financial arrangements are harder after 12 weeks: hospital costs are inflexible, though doctors sometimes waive their fees. P.C.S. also tries to arrange rides to New York where needed. P.C.S. is, of course, broke, and welcomes volunteers and contributors.

The P.C.S. is currently working with the Florence Crittendon Home for Unwed Mothers to open up one wing of the Home as an abortion clinic (total service for the unwed mother!), to be serviced by doctors who are willing to take advantage of Massachusetts' vague abortion law. A woman across the street from the Home has collected

over 1000 signatures opposing the clinic—uneasiness about abortion runs deep in our culture, not just in the medical establishment.

Since the New York abortion law went into effect on July 1, 1970, many exploitative agencies for counseling and referral have cropped up: AIA, Med-Ref, 5th Avenue Women's Pavillion, Prestige Placement are a few. They make profits of $25-$150 per woman. Some are now subpoenaed but not yet shut down. Such usless, profiteering agencies exist all over the country, with ads in local papers everywhere.

But there are trustworthy, non-profit services in many areas. Check Information for a local Planned Parenthood, Clergy Consultation Service (see paragraph on New England resources), or Women's Liberation group. If you can't find local help, you can call these national offices: New York Planned Parenthood (212—541-6800) or National Clergy Consultation Service (212—254-6230) will tell you where to call near you for counseling, advice and referrals. The Abortion Rights Association of New York, Inc., 250 West 57th St., New York 10019 (212—541-8887) has an up-to-date list of reliable New York abortion clinics which have hot lines which accept emergency calls collect. You can call the Abortion Rights Association or send them 25¢ and ask for their "Listing of Selected New York State Abortion Clinics", which they will send immediately.

In the Western U.S. the cheapest legal abortions are available in Seattle, Washington, for $80 under 10 weeks LMP if you are over 18 (or under 18 with a parent's consent) and if you can get around the state's not-too-stringently enforced residency requirement. California has no residency requirement but it is expensive—$250 and up for a private, under 12 weeks abortion, with only a low number of cheaper clinic abortions done even in liberal San Francisco. A good place to call to see if you can get an abortion in Washington, California or your own state, is the California Association to Repeal Abortion Laws (San Francisco: 415—387-6480). In Seattle, try the Abortion Referral Service, 4224 University Way, NE (206—634-3460). Near Los Angeles, we found the following service advertised in the Zero Population Growth newspaper: "The Problem Pregnancy Counseling Service (714—639-7470), a non-profit public service agency doing pregnancy tests, counseling and referrals".

In the Mid-West, most woman still go to New York State, but some places are opening up. The Midwest Medical Center in Madison, Wisconsin, is a new abortion clinic which is operating despite opposition from conservative parts of the community. Between this clinic and the Wisconsin Hospital, about 50% of Wisconsin-area women can get legal abortions locally, according to Madison ZPG member Ann Gaylor. For information and referrals for legal abortions in Wisconsin (which has no residency requirement right now), call Ann Gaylor (608—238-3338). A good information service in Minnesota is run by Bob McCoy, a long-time abortion-repeal activist who can be reached at the Minnesota Council for Legal Termination of Pregnancy (612—545-8085).

Even if you go out of state for your abortion, it is important to be in touch with a local doctor or clinic for a post-abortion check-up, for birth control, and in case you have any complications. It is also good, if you can, to be in contact with a sympathetic local agency, women's group or clergyperson to talk about any post-abortion feelings you may have. If there is nothing like this in your community, start something!

THE NEW YORK ABORTION — OCTOBER 1971

There is presently no New York residency requirement, though this may change, and New York City costs are lower now than elsewhere in the state. Out-patient clinics take women up to 12 weeks after their last menstrual period (LMP). Besides sound medical care, clinics avoid hassles and extra expense of hospitals, and some also give good, supportive counseling. The whole clinic procedure, including pap smear, blood tests, counseling, abortion, and recovery time, can take as little as 3-4 hours. Women 4-6 months pregnant are directed to hospitals where the saline or hysterotomy procedures are done. (Doctors don't do abortions by any method between 12 and 16 weeks LMP, except very rarely a late D & C.) The saline takes three hospital days, the hysterotomy up to six days. Most hospitals also provide counseling.

Whatever the method, and whether or not counseling is available, **it is a good idea to go to New York with one or two friends. Women friends can be particularly supportive at a time like this.**

Typical costs: **Suction** (up to 12 weeks LMP)—$150-$200. **Saline** (16-20 weeks LMP)—$300-$400. **Hysterotomy** (20-24 weeks LMP)—$700-$900 total.

ABORTION METHODS

When legal resources fail her and a woman can not get to New York, the woman with an unwanted pregnancy starts asking friends of friends, nurses, taxi drivers, in a frightened and hysterical nosing around which ends her up on a doctor's table if she is lucky, in the hands of a nurse, or worse, of some semi-medical quack if she is less lucky, at the mercy of her own mutilating hands if she is desperate,

and in the emergency ward of a hospital if the "operation" turns bad.

It is important for a woman to know the whole range of abortion methods, both so she will know what she is talking about with her doctor, and, more important, so she can judge the methods of an illegal abortionist and find the courage to walk out if her life is in danger. (Don't pay in advance if you can help it.)

I. Timing

When the embryo is one month old it is a tiny mass of tissue, with no resemblance to a human being. At the end of the first month the embryo is about the size of a small pea. By the end of the second month, the growing embryo, by this time called a fetus, is a very fragile one inch long mass of differentiated tissue acting as a parasite within the mother's body. When the fetus is three months old, it has attained a length of about five inches. (Birth Control Handbook, Montreal)

The earlier the abortion is done, the safer it is for the woman and the easier it is on the doctor. Even doctors who will perform abortions willingly have some cut-off point, ranging from when the fetus takes clear human shape ("pulling out an arm and then a leg" is deeply disturbing to one local Ob/Gyn), through the time near twenty weeks when the fetus moves (making abortion far more dangerous for the woman), to the time of "viability" around 28 weeks when the fetus could survive if born. Hospital abortions in Boston are almost never done after the fourth month, illegal ones rarely after the third.

II. Medical Techniques for Abortion

A. Up to three days after unprotected intercourse: see p. 59 for information about "morning after" pill.

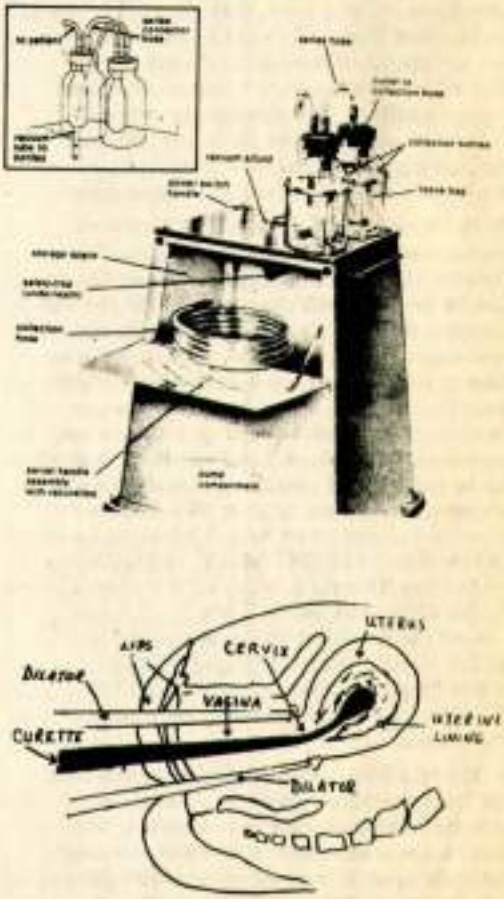
B. Up to 12 weeks: **Vacuum Suction**

The suction method is now the most commonly used medical technique for the termination of pregnancy. The procedure involves the dilation or opening of the cervix. The cervix is dilated by passing a series of plastic or metal dilators, each slightly larger than the next into the cervix. When the cervix is dilated a sterile tube attached to a vacuum aspirator is inserted into the uterus. The aspirator, working on the same principle as the vacuum cleaner, sucks up the excess fetal tissue from the uterine wall. The fragments are then drawn out and down the tube by means of the vacuum sump. This whole process rarely takes more than 5 to 7 minutes. Except for the cramping of the uterus, the procedure is painless.

C. Up to 12 weeks: **Dilation and Curettage**

The suction method is now much more frequently used than the Dilation and Curettage and is considered better because it causes less physical trauma to the uterus. However, some doctors who have been performing the D & C for years prefer to continue using this method. The procedure, which is done on women for various reasons including infertility, involes the dilation of the cervix and the scraping of the womb with a curette. The cervix is dilated by means of graduated dilators starting at 2 mm. and proceeding to about 12 mm. at ten weeks pregnancy and to 14 mm. at twelve weeks. The doctor uses the curette, a metal loop on the end of a long thin handle, to scrape gently the internal uterine wall, removing the fetal tissue with forceps. The patient is totally anaesthetized, and requires from six hours to two days of recuperation, during which time there might be some bleeding.

Operating unit for vacuum curettage.



D. 12-16 weeks

In England during this period, doctors use a combination of the vacuum aspiration and D & C with forceps methods; the operation is over a hundred dollars more expensive. In the U.S. a woman should wait until she is 16 weeks pregnant and can have a saline injection because after 12 weeks the uterus tilts in such a way that it becomes difficult for the doctor to get all the fetal tissue out. Also, and more important, the uterine lining becomes so soft and spongy that the chance of the curette or aspirator going through the uterus increases as does the chance of hemorrhage.

E. After 16 weeks: **Saline Injection**

With this method, a long needle passed through the locally anaesthetized abdomen withdraws some of the amniotic fluid and replaces it with an equal amount of concentrated salt solution. Rarely do patients react unfovorably to the injection of the salt solution. However, if a woman should become hot and have cramps or a burning sensation in the pelvic area the procedure is stopped. The woman's head is raised; she is given water to drink. When the symptoms have subsided, the procedure will be continued. Afterward the patient may complain of cramping and be nauseous. This kind of reaction seems related to minute quantities of salt getting into the abdominal cavity; it is easily treated and has no lasting effects.

Contractions will start some hours later. Generally they will be as strong as those of a full-term pregnancy. No general anaesthesia is given, but demerol or sleeping pills are administered. The salt injection is the simplest part of the procedure. The longest and most difficult part will be the labor. The breathing techniques taught in the childbirth section of this book might help the contractions more bearable. After 8 to 15 hours of labor, the fetus is expelled in a bedpan in the patient's bed.

Unmarried women under 20 are the largest group having saline abortions in New York. The experience may be painful and emotionally harrowing. It is essential that women going through this procedure have good counseling before, during and after the saline abortion. (The above section is based on an unpublished account by Sonja Hedlund on saline abortions in NYC.)

F. After 20 weeks. **Hysterotomy**

A hysterotomy may be performed if it is 20 weeks or more since LMP, or if for some reason a woman can not have a saline or a D & C. In a hysterotomy, the fetus is removed through a small abdominal incision, usually below the pubic hair line. This is major surgery, requires several days' hospitalization and convalescence, is therefore more expensive (at least $1000 here), and in the U.S. often condemns a woman to caesarian births thereafter. Although as major surgery the hysterotomy involves more risk, it does not affect a woman's reproductive system at all (unlike the hysterectomy, or removal of the uterus, with which it is often confused).

G. In order to give a woman more confidence about what may or should go on before and after the abortion, we have included the following observations:

The doctor should know about the woman's medical history before performing the abortion: how many previous pregnancies, any history of asthma, T.B., heart disease, acute kidney disease, bleeding or clotting problems, epilepsy or major operations may make it necessary for the abortion to be performed in the hospital.

Another thing which should be checked is blood type. "If a woman has an Rh negative blood typing (and the man was not Rh negative), the fetus will be Rh positive. Some doctors recommend that an Rh negative woman receive an injection of a blood derivative called Rhogam within 72-96 hours after the abortion. This will protect her from the possibility that she may build up antibodies in her blood which would counteract against the blood of the fetus in possible future Rh positive pregnancies. These antibodies are produced if fetal blood passes into the woman's blood stream. Many doctors feel that the expensive injection (it may run as high as $100) is unnecessary before the 12th week of pregnancy." (N.Y. Women's Health and Abortion Project)

Anesthesia

For a vacuum aspiration (suction) abortion a patient may have a choice of getting a local anesthetic or general anesthesia. A paracervical block (or local anesthetic) is an injection of novacaine or xylocaine on either side of the cervix. This will minimize the discomfort arising from the cramping as the last dilators are inserted. A local anesthetic is both cheaper and safer than a general anesthia. You might choose general anesthesia if you knew you wanted to be put to sleep. It is more expensive, more risky and your recovery time will be longer.

III. The Doctor-performed Illegal Abortion

Many illegal abortions up to 12 weeks are performed by doctors who give D & Cs or vacuum aspiration abortions in hidden offices. Many do it for profit but some do it because they believe abortions should be done but are scared to court arrest by doing them in the open. The cost ranges

from an occasional humane hundred or so, to the usual $600-$1000. Except for a more hasty departure afterwards and the use of a local instead of a total anaesthetic, the abortion performed by a skilled and conscientious illegal abortionist who keeps his tools clean is just about as safe and comfortable as a hospital abortion. While on the whole the rural woman has a harder time than the city woman in finding an illegal abortion, Lawrence Lader describes the abortion practice of some small town doctors who have some kind of understanding with the local police. Lader also tells of the woman whose unsympathetic gynecologist told her to go elsewhere and then at the end of her long and panicked search turned out behind face mask and gown to be her illegal abortionist.

IV. Methods of the Unskilled Abortionist

The dirty D & C. The D & C in the hands of hurried incompetents with no anaesthetics, no antiseptics and dirty tools is frightening and dangerous.

The catheter method. Catheters are narrow tubes sold at drug stores for drawing off urine. The catheter is inserted into the uterus through the cervix, a dangerous procedure when attempted by an amateur. Germs introduced into the uterus by the catheter cause an infection which the uterus contracts to expel, thereby "spontaneously" aborting the fetus.

The high douche. Forced douche or injection under pressure of over-the-counter chemical agents like soap, turpentine, Lysol, vinegar, lye, will produce an abortion if the solution reaches the fetus or sufficiently irritates the uterus.

Both the catheter method and the high douche work on the theory that an infection or dangerous substance will kill the fetus before it kills the woman. They can result in permanent disability or death.

Air pumped into the uterus. This method causes air embolism (air into the bloodstream) and **sudden and violent death.**

V. Self-induced Abortion

The most unskilled abortionist of all is the woman herself.

External means. Woman try extremely hot baths, severe or prolonged exercise, violence to the lower abdomen, and various long sharp tools of self-mutilation. Except for the occasional knitting needle abortion we hear about, which may be myth, none of these methods work.

Drug store abortifacients. The woman can also get from her "friendly" druggist a number of abortifacients which, all expensive, endanger her life to varying degrees and almost never work.

1. Soap-base pastes and douche solutions are among the most dangerous. Soap goes directly to the uterine veins to cause blood vessel blockage, **shock** and **death.**

2. Desperate women douche with almost any liquid they can think of, running the risk of **severe burning of tissues, hemorrhage, shock, death.**

3. Tablets of potassium permanganate, a caustic tissue-destroying agent which damages the vagina walls and can cause **massive hemorrhaging, ulcers, and infection,** are sold despite a FDA prohibition.

4. Among the useless folk remedies sold are quinine pills and Humphrey's Eleven pills, which women take in massive expensive doses (literally hundreds of pills) because once a woman who thought she was pregnant took some around the time when her period was due, and lo and behold her period came.

5. Women also take quantities of birth control pills, which actually support the pregnancy if anything, and are suspected of causing genital deformity in the fetus.

6. Castor oil and other strong purgatives are used to no abortive effect.

Of the several hundred thousand women in the U.S. who yearly get illegal abortions or try to abort themselves, between two and five thousands actually die. Thousands more spend time in the hospital with sceptic abortions, peritonitis, gangrene, air embolism and other acute repercussions. Unknown numbers of them find themselves infertile later on when they want to plan a pregnancy. (At a 1969 Abortion Conference in Boston sponsored by the Unitarian Universalist Women's Federation, it was disclosed that 10% to 20% of a local infertility clinic's patients have had previous sceptic abortions.) And many thousands of women escape from the frightening experience physically whole but with a new cynicism and very rarely any better contraceptive techniques than they were using when they got pregnant.

FUTURE PROSPECTS

Even as abortions become more readily available around the country there are still some things to look out for: Decent working conditions should prevail in the clinics; good abortion counseling and birth control instruction should be available; health insurance programs and welfare should cover abortions for married and single women; costs should be kept down by the elimi-

nation of profit-making referral agencies and the scaling down of doctors' fees.

Women's groups—there is so much that we can do. We should be pressuring legislatures and hospitals to provide abortions locally. We should be starting abortion counseling and referral services where there are none. If there is a service in your area, make sure the women are getting supportive counseling and not just referrals; do what you can to help the women who need to deal with post-abortion feelings; start a fund to lend money to women who can't afford the abortion prices and travel costs, particularly for teenagers.

1. New York Times, 6/28/70, and Zero Population Growth National Reporter, July 1971, p. 3. Estimated 1.2 million abortions performed annually; projected total of legal abortions for 1971 is 300,000 (compared with 8,000 in 1965).

TWO PERSONAL EXPERIENCES

Probably the most insidious mistruth about abortion is that of the so-called post-abortion guilt feelings on the part of the woman. In fact, many women have been taught to expect, and in some perverse way, may welcome, the "cleansing effect" that anticipated post-abortion guilt offers them, as though they have to atone for their crime. For as long as this society fails to recognize and refuses to sanction the right of a woman to have an abortion whenever she chooses to do so, the fear of post-abortion self-recriminations represses her as surely and as effectively as any prohibitive law is capable of doing. The problem then is, how to get women to face the reality of post-abortion feelings while shaking off the shackles of superimposed guilt feelings. Ironically, guilt, the psychologists tell us, grows out of anger – anger at ourselves for feeling inadequate and unwomanly, but also anger at a society which reveres us as mothers and child-raisers, but despises our rights to make the decision not to have a child. Perhaps then sharing my personal experience might in some way show my sisters that guilt and its attendant emotions need not follow an abortion.

"I'm sorry," the voice said to me over the phone; "the test was positive." From that moment on, I was a changed woman. I was going to become a mother. But was I really, in the true sense of the word? Any woman who has ever conceived understands the mixed emotions I was feeling. Understand, then, the thrill I felt in knowing that life was beginning. My body is constructed to bear children, and it was fulfilling that purpose. But then, I was forced to ask myself, is that my purpose as a rational, as well as a biological human being, and was I not reacting to a societal stimulus as well as a biological one in feeling good about being pregnant?

For me, the answers to these questions resulted in my decision to abort my pregnancy. For I realized that these vague biological stirrings inside of me could never justify giving birth to a child I did not want, and was not prepared to raise. Neither was I willing to subject myself to the ordeal of pregnancy and waiting only to relinquish the child at the end of it all. It's all crystal clear to me now, the re-telling of it. At the time, my decision was not so well thought out, but rather grew out of the conviction that I could not, under my circumstances, continue with an unwanted pregnancy. For me the fetus represented an undesirable growth that had to be expelled and with it also any guilt feelings about what I intended to do. Not once then did I ever think of the fetus

as a human being, but rather as an entity that contained some of the properties and carried the potential for human life, in much the same way that a fertilized egg contains the properties and potential for life. If then, the destruction of a fertilized egg is within our power, why not a fetus?

Finding an illegal abortionist was not easy. The few legal avenues that are open did not even occur to me (I had my abortion over two years ago), although I'm sure I would not have qualified for a so-called therapeutic abortion. As millions of desperate women before me, I went underground. My search led to a registered nurse (I was told) who did illegal abortions. My contact was a woman who had recently undergone an abortion by the R.N. and who seemingly had suffered no physical ill effects from it. The negotiating was done entirely through my intermediary and after settling on the price ($400), the date was fixed. All the while I was not able to pry out of my contact many details about the procedure, which really panicked me. There was no one else to ask, so I went into the thing "cold turkey" and all of my dreaded fears about the physical pain were realized. The woman came to my apartment, spread me out on the kitchen table and inserted a cathether tube up my vagina into my uterus. This, I was told, would in time start the contractions in the uterus which would lead to the expulsion of the fetus. When I questioned the abortionist further, she put me off as though I were undeserving of anything more than what she had just done for me for $400. I had to be content with her vague instructions about what to do when the bleeding began while trying to stifle my anxiety about complications. The entire procedure took about 15 minutes and her attitude was one of do the abortion and run. It was apparent that with the exception of my two friends (who were as ignorant of the process as I was) I was strictly on my own. And so began a 48 hour ordeal of pain and anguished waiting for it to be over. At that point I had little regard for myself as a worthwhile human being, I was someone to be scorned and avoided – I was a walking, bleeding catheter tube. On Sunday the contractions began, and by the middle of the afternoon it was over. The force of the uterine contractions had dislodged the catheter tube and it slipped out easily and along with it the fetus. Looking at the fetus was an experience I will never forget. I had been approximately two months pregnant and at that stage the fetus had acquired some of the characteristics of a human being as we know it. It was about an inch long and I am unable to remember its color. I do remember staring at it in a curious, somewhat detached way; it looked so strange, and indeed it was. Its appearance did not shock or repel me, partially due to the fact that by that time I had shut myself down emotionally and was feeling only relief that it was over. It was only much later that I was able to internalize how I felt and continue to feel, and then to verbalize, as I have tried to do here. Even now, my total emotional reaction to it escapes me, except in one vitally important way. At no time, even in the shadow of societal taboos, did I believe that I was doing something "wrong" or committing some "offense against nature". When, in fact, it is my nature and my right to determine my destiny as a woman. Since that time my confidence in the rightness about my decision has grown and along with it a sense of dignity and self-determination about myself as a woman.

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I had my second child in March, stopped nursing him in October and became pregnant in December. Right after making love - too lazy to put in the diaphragm - I realized that I had miscounted and was possibly ovulating. In a panic I remembered from a long time before I filled the sink with water and washed myself out. Around the time my period was due I began to feel the sensuality I know means for me either pregnancy or some kind of minor cyst (which stimulates pregnancy hormones). My doctor gave me an intensive dose of progesterone to induce bleeding if I wasn't pregnant. I didn't bleed and went back to him; he confirmed the pregnancy. I told him I didn't want to be pregnant and asked him his position on therapeutic abortions. He outlined the procedure – hospital board approval and recommendation of two hospital psychiatrists (my own wouldn't do). He implied that I would pass the board because he was on it and said he'd contact the psychiatrists he felt would be most sympathetic to me. He added that I would have to pay $700 in advance to Peter Bent Brigham. He also suggested that I consider having a tubal ligation, after all I was 32, had two children, etc., and it would make the doctors more sympathetic to giving me an abortion. I told him that for me a tubal ligation was a major decision, whereas having a D & C seemed relatively minor. His reply: from a medical point of view a tubal ligation was a minor operation, whereas the D & C was something equivalent to major.

So I set my mind toward a therapeutic abortion. Emotionally and intellectually I was for it: (1) I didn't want to bring up a third child, there was too much I wanted to do; (2) I had been writing a paper about women choosing whether or not they wanted to have children and how many they wanted to have, and here I was faced with the necessity of living out these beliefs we have that women

should have the power to choose their own lives; (3) So important, the whole idea of abortion was made easier because I knew from much talking with women and my reading how many women go through abortions; and that knowledge would definitely have sustained me through whatever I was going to have to experience, whether it be therapeutic if I could get one, a trip to England, to Montreal, even an illegal abortion if that became necessary. In spite of this generalized feeling of support, I realized that though some of my close friends had had abortions, I had never really asked them the specifics and knew very little about what had happened to them; and I began to ask them to talk about their experiences. I also felt for the first time what it meant to be really fertile, and learned that even with birth control methods, there's a fairly high incidence of pregnancy. It seems so obvious that we should have back-up abortions.

Meanwhile I was incredibly depressed. At the same time that I knew in my gut I didn't want to have another child, I felt terrible that I didn't want this pregnancy. I am used to welcoming and looking forward to pregnancy, and it was unnatural in the deepest way not to want to be pregnant (I had been infertile, gone through three years of trying to get pregnant, had an operation for ovarian cyst removal and became pregnant in three months, had a first beautiful pregnancy, and a few years later a good second one). I found it impossible to stop being depressed.

The day I was supposed to call my doctor to find out if he had made appointments with the two psychiatrists, I began to spot. The world turned over. A miscarriage? I called the doctor, he said "Run around the block a few times" and come see him the next day. I jumped up and down often, happy as the spotting increased, feeling crazy to be hoping so for a miscarriage.

The next day the doctor said: "You're miscarrying. I could try to give you some hormones, but there's a 90% chance you're going to lose it, and under the circumstances, go into the hospital tonight and I'll give you a D & C." A little later I said to him again, "It's all crazy" and he answered "It sometimes happens like this. I had a girl once who was getting on a plane to go to England (——) when she started to bleed. I had her in the hospital in no time.

I went into the hospital at five, and at eight was taken up to the operating room (same floor as deliveries). For 45 minutes, I, and anesthetist and the nurses waited for my doctor. I asked one of the nurses what the doctors' attitudes were toward D&Cs. She answered that doctors didn't seem to mind doing them because they were medically necessary, but that she had seen doctors' eyes as they were doing therapeutic abortions (D & Cs) and she felt their distaste. Some nurses refuse to work during therapeutics. It's clearly written on the chart whether it's a therapeutic or a D & C (same thing). She said one doctor came into the operating room where a woman was waiting to have a therapeutic, took one look on her chart and walked out, not performing the operation.

Since I had eaten lunch and couldn't be completly anestbetized, and since anyway I wanted to be aware during the D & C, I had my first spinal which was clumsily done. Finally I became totally numb from my waist down. Earlier in the hospital room I had felt nauseous at the idea of being scraped out. Here in the operating room I felt nothing physical, but had a lot of other feelings: my doctor seemed cold and distant, I joked trying to make some connection with him but couldn't. I cried because I had miscarried and had to be scraped out and I was very tired. I felt guilty too because I was glad of the miscarriage and felt I was playing the part of someone who was sorry.

I spent three hours in the recovery room, a dull neutral time it felt like, but now, thinking about it, I was probably recovering in all kinds of ways. I had been in that same room after the births of my two babies when I had felt high, joyful and totally relaxed; now was so different, no experience of birth before, a nothingness of feeling.

It took a day or two to recover physically from the D & C. And it was only after talking to many people and thinking very hard about all my ambivalent feelings – the guilt, the anger at my husband that it was I who had to go through all these hassles, the contradictory feelings about the abortion-miscarriage – that my two-month depression disappeared, convincing me even more that though it can be a hellish bitter struggle to get into reasons for depressions, once the reasons are found and talked over, the depression begins to disappear. And women have to look into themselves and talk together to an enormous extent to untangle our feelings which are so wrapped up in body processes that we confuse physical with psychological. We have to talk together too because we are socialized not to feel and express deeply negative things concerning our bodies and wills. The wish to do away with a pregnancy was hard for me to cope with and confused me for a long time. After this experience my mind is clearer.

Pregnancy

INTRODUCTION

We, as women, grow up in a society that subtly leads us to believe that we will find our ultimate fulfillment by living out our reproductive function and at the same time discourages us from trying to express ourselves in the world of work (often by pointing to our reproductive roles as a reason for doubting our seriousness). Because our opportunities, hence our motivations, are limited we ourselves often begin to believe that in motherhood we will find greater satisfaction than as student, worker, artist, political activist, etc. Often we look forward to pregnancy and motherhood as a time when we can put our identity crises on the shelf and relax, secure in the legitimacy of our maternal roles. Both we and our children fare better when conception is chosen freely out of a desire for a child to love and care for and not as a means to fulfill other important needs for identity, security and social approval.

Instead, more or less haphazardly, we get pregnant, and it's **during** the pregnancy that we become involved in the struggle to come to terms with who we are. Because often we are not aware there is a struggle; because we don't know what it's about and/or have no language to express it or we may understand our ambivalence and feel guilty, we experience serious depression during pregnancy or after childbirth.

Consequently, when we live through these depressions, nightmares and fantasies, we think we are the only one to have them. As soon as we are able to talk to other women about them we find we're not alone! (At a meeting where a group of us met to discuss our feelings during and after pregnancy four out of five of us there told of fantasies about taking up knives or about people entering our houses to kill our children. We all discussed the various forms of depression we had felt, usually subtler than suicidal wishes and less easily identified as depression.) In our isolation we feel guilty for our "unmotherly unnatural" feelings. When we meet and talk together we discover as a common experience that we have strong negative feelings about having children. Most important of what we are learning is that our feelings are shared, are legitimate. We all have them to some extent, we shouldn't shrink from them (they don't go away), and we must accept them as legitimate as a first step in dealing with them. Having the courage to recognize, express and share these feelings is the beginning of the struggle to understand **why** we have them.

Often we are not free of our own psychological needs even in "choosing" to stop the pills or whatever and become pregnant. Societal pressures on men as well as women persuade us that we must demonstrate our fertility and immortalize our man's seed by having children. We produce the children, and we see them as extensions of ourselves, as our possessions, not people. Further, our limited opportunities and lack of legitimacy in other areas make the traditional role of mother the

course of least resistance for many of us. For some of us and most of our third world sisters, very real economic pressures make pregnancy and motherhood a nightmarish rat-race for survival. The mentally "healthy" pregnant woman must be secure in knowing that all material needs (adequate housing, food, clothing, toys, etc.) will be provided, either by herself, her family or the society.

We should not have to make the choice that many of us are forced to make today – one of commitment to motherhood or to serious work. If we want to be with children, we should first try out caring for friends' children or helping in a playgroup or preschool. We should have some space to examine our feelings about being with children, including feelings of possessiveness that all of us who grow up in this society are taught. Maybe we'll decide that we don't want the full time responsibility of rearing or adopting children, but decide to be part-time parents. We should talk with friends who have borne children and those who have adopted; both are alternatives which we should examine. In addition, there should be guaranteed income for all individuals in our society, so that women who want to have children alone are not forced to be financially dependent on a man; there should be childcare at the job or in the community that lasts for 24 hours and is community controlled; there should be communes with all members sharing childcare equally; and there should be maternity and paternity leaves until we have our strength back and the baby is sleeping through the night. Further, we believe that half-time jobs should become the norm so both parents can lead fully human lives and participate in the raising of their children and the life of their community.

PREGNANCY

Why become pregnant? Why have a child? We as women are talking about having versus not having children. Some of us feel strongly that there are no good reasons for having children. Some feel it's self-indulgent for us to have our own children but all right to adopt children who need homes. And some believe that giving birth to and rearing our own children can be a creative, even revolutionary act. These are vital questions to ask and try to answer before discussing pregnancy. But I wrote this paper at a different level of consciousness: it gets at the negative reasons we have for wanting children. It talks about how it feels to be pregnant and describes what is happening to and within our bodies. Basically it assumes: (1) that a wanted pregnancy is good, and (2) that it's necessary and exciting to have some control over the process both by learning as much as possible about ourselves and by changing attitudes and institutions to be more responsive to our needs when we decide to have children.

It's essential to realize that we as women can be whole human beings without having children. It's possible for us to be complete both physically and emotionally, just as men are. We should be free to decide whether or not we want to have children, and if we do, how many we want to have. And we should be able to decide how much time we want to spend rearing children. For the first choice to take place, we must become aware of the many factors that hinder our freedom to choose. For the second decision to be possible, we must work together to change many kinds of attitudes and institutions, making them more flexible and responsive to our needs; and we must develop day care centers and new kinds of communities to free us from our traditional roles. Only these kinds of societal support will enable us to live out our choices with confidence and freedom.

As things stand now, a woman as mother is not free, for the bearing and raising of children demands much time and emotional energy. In order for us to fully come to terms with pregnancy, we should thoroughly consider what having a child means to us personally. Once we become aware of societal and religious pressures and expectations weighing on us, and realize to what extent our thoughts and emotions have been grossly and subtly directed, then we can begin to extricate ourselves from binds we don't want and positively choose our own attitudes towards having - or not having - a child.

Some biological pressures: Women are physically different from men in that they are **able** to bear children. A particular biological process is begun and completed when we become pregnant and give birth. The biological process quickly acquires social significance; it becomes difficult to separate the two. And though we are human beings capable of choice, in many societies women still breed like animals. We are trapped and defined in advance by the biological efficiency of the reproductive process: it is so easy to get pregnant. It is biologically preferable that strong healthy young women in their teens and early twenties be the bearers of children. And when people are young, sexual feelings are surprising and newly intense. As a result, we become pregnant, married and unmarried, before we have a chance to develop fully as autonomous human beings.

As for societal pressures, in this society we are persuaded on many levels that we have no choice, we don't need to have a choice, we don't want to

have a choice. This society has a vested interest in keeping us non-autonomous, and many mechanisms develop which come to determine how we should feel and act. The Catholic Church tells Catholic women they should have as many children as possible. Consumerism and advertising convince all of us from our birth that we must be pretty to attract men so we can get married and have a home and children. Then there are attitudes such as: all women are good for is to bring up children (and be sexual objects on the side), and the ensuing glorification (by men) of Motherhood. Mixed in with these attitudes and best expressed by the Victorian and Puritan traditions, of which we are still victims, is the gut feeling that our physical functions in general are base and unclean. We are not free to be sexual beings, men think, but we must justify our sexuality by becoming pregnant. Women, who menstruate, carry their children in their wombs like animals, give birth with obvious effort and discomfort, are thought to be close to "nature"; but men are threatened by this physicality, and create myths about women which we partially come to believe, though our experience tells us these myths are false. Women are not predestined to be mothers.

More specifically, here are some common phrases expressing these "cover-up" attitudes: "Earth mother . . . You're not a whole woman until you've had a child . . . The most intense exciting experience of a woman's life is to give birth . . . The fulfillment of having children." And from a very middle class booklet handed out by a Boston area doctor and written by a man: "A woman is likely to glow and look more beautiful during this period while her body is fulfilling its ultimate physical function. For each woman pregnancy has its own unique mystery, emotional response and contentment. Yet, while every mother-to-be differs in these respects, there are innumerable experiences which are common to all. They bind every woman into that exclusive sorority called Motherhood." And later: "Doctors who devote their practice to the care of pregnant women report again and again how amazing it is to observe a girl become a woman physically and emotionally in nine months. For many, the prospect of motherhood makes them mature. They become poised, proud, confident, and beautiful. Nature, in her own mysterious manner, seems to have devised an intricate balance that prepares the body for a baby and the mind for acceptance of motherhood. A conscientious woman responds to these responsibilities. She uses them to become a better person and a contributor to the growth of society."

These words are loaded in many ways. We find vague emotional words, such as "ultimate", "beautiful", "mystery", and they are used by a man in a biased way. Does our fifth pregnancy have its own 'unique mystery'? Is it 'nature' which prepares our minds for acceptance of continual motherhood? Are we "poised and proud" when bearing an unwanted third child? Most important, the definition of us is biased in traditional ways. To be a woman equals motherhood which equals fulfillment of destiny as preordained by Nature. These are the definitions most ingrained into us and they provide us with socially-backed positive attitudes toward childbearing that are a far cry from more individual thought-out attitudes.

These traditional definitions are often used by us as an excuse not to go out and tackle a world we have been ill-prepared to face up to. Excuses are not autonomous choices. We get pregnant for so many unconscious reasons: to hold onto or possess our man, to keep a marriage together, to prove we are not sterile (a sin), to please our family (and so often because the man insists on having his own children), to produce something of our own, to extend our own ego, to compete (women as products, as tools for producing babies, babies as products). Then there are other reasons which in practice can turn out to be constructive or destructive: we want to relive our own childhood as a parent; to prove to our parents or ourselves that we can do better; we are curious. Often what happens is that we end up exerting our own limited power over our kids, taking out our frustrations and disappointments on our children, expecting and even demanding that our children live out our lives where we feel we have failed. This is especially true of our parents' generation.

Some women, to escape jobs that are unrewarding or difficult, take refuge in repeated pregnancies. Someone suggested that babies provide the only opportunity for tenderness in some people's lives. So we find that under the guise of being "a contributor to the growth of society" we "intentionally" become pregnant because for so many there is little else we feel we can do well (because being out of the house is made dull or difficult for us by the system).

Then too there is the matter of guilt. If you have made your choice, you must constantly keep defending it. If you decide not to have children, you must keep making that decision and fight for it, justifying your choice to yourself and others, convincing yourself that you are not physically and emotionally sterile, a non-woman. If your intellectual, political arguments against having children are well thought out, your emotions (and society's judgments as society stands now) will confuse you especially as you get older, and remain at least partially unfulfilled in your chosen work, as you have been persuaded from birth that you will.

Next, the question of childrearing. What choices do we have today as to how and by whom we want our child to be brought up? What facilities do we provide for women in all categories who need free time and time to work as children are growing up? It does not have to be true that the woman who bears and gives birth to the child has to bring her up too; that only she, because she is a Woman, is emotionally equipped to care for children. From our births we are socialized into tender nurturant home roles, and men are encouraged to be tough, to go out into the world. These roles should be changed. Also our society has limited itself to the family as a viable child-rearing unit, a family in which the man is the breadwinner and the woman - super-cheap home labor - raises the next breadwinning breeding generation. It is very important that we question a set up so limited and limiting. Keep in mind too that 15-20% of the babies born at Boston City Hospital and Boston Lying-In have unmarried mothers. What provisions other than debilitating welfare have been made for these mothers and children? What provision do we make for us who autonomously decide to have children and rear them without men?

Finally, we should ask the question: What are the positive reasons for having children? The answer of each of us depends on her goals, principles and history. Each of us must make the choice to conceive a child with a sense of deep responsibility. Having children raises important questions such as: In what ways do we as people become more conservative in order to protect our families? What are the mental effects of being parents (for instance we are often forced to be more authoritarian than we would like to be)? In what ways does the nuclear family put pressures on both parents and children which inhibit our mutual growth, which destroy meaningful communication over a long period of time?

Once these and similar thoughts have been broached, we will begin to think in a clearer way about the necessity of escaping from our roles. We can be partially freed by our knowledge, then by our efforts to change all kinds of institutions. Because pregnancy has enslaved us in the past, that does not mean it must continue to do so. A pregnancy positively chosen can be a deeply joyful experience.

Pregnancy and childbirth have been shrouded by both men and women in mystery and fear. We have been forced into thinking that most physical discomfort and pain resulting from pregnancy is our "lot". So we submit to the experience and don't feel altogether legitimate in expressing questions, hesitations or fears. Or perhaps we never learned how. Society has emphasized the joys and been condescending, unsympathetic, or ignorant about the trials. Surely there are happy simple pregnancies, but even then our bodies change so greatly that we are bound to have questions. During pregnancy the normal functioning of the body as we experience it is called into question as it is during an illness. How irrelevant that doctors tell us it is normal for a woman to be pregnant. What do they mean by normal?

Basically three main things are happening during pregnancy. (1) Something is growing in the body. (2) Our bodies change physically both to make this growing possible and as a result of this growth. (3) We go through all kinds of psychological and emotional changes during this time. We owe it to ourselves to know as precisely as possible all that is happening to us, so that we know what questions to ask, how to pursue demands we might make on doctors and friends in order to lessen any discomforts we might be feeling and to insure that we get humane treatment. There are many things we don't know about this crucial event, and it's difficult to get information as a result of our long-standing inertness, and of doctors' attitudes toward us as we climb on the medical conveyer belt of pregnancy.

In this part of the chapter, pregnancy will be discussed as follows: (1) signs; (2) procedure for detecting pregnancy: tests and the pelvic examination; (3) some thoughts on what it feels like to be pregnant, both physically and emotionally; (4) some common changes taking place in the body and possible complications to be aware of; (5) possible doctors' attitudes and future examination schedule; (6) demands. In an appendix there will be a discussion of (1) the growth of the fetus from week to week, (2) infertility, possible reasons and what to do, and (3) miscarriages, possible reasons and ways of coping.

Most important: Though your pregnancy will have many things in common with other women's experiences, it will also be unique. Experience your own pregnancy. Talk to other women who have been pregnant and who are pregnant at the same time as you, but remember there's no "right" way to be pregnant. Try to learn about everything that happens, everything you don't understand. Remember that when we talk about experiencing signs and emotions, there are many exceptions and many combinations. Each pregnancy will probably be different and the first will be unique, for everything that happens is new.

Signs. You might have none, some, or many of the following early signs of pregnancy: if you have

had regular periods you will miss a period (amenorrhea). You might have nausea or more rarely vomiting, but they will disappear much before or by the 10th or 12th week. Breasts enlarge, tingle, and may hurt. The nipples may darken, and the area around them might become larger and darker. You may feel constantly exhausted. You will probably feel you have to urinate more often (frequency). If you feel this need, either alone or with the signs mentioned above, demand that a urine specimen be taken to be studied, for (1) if you feel the need to urinate more often it's either a sign of pregnancy or you might just have a urinary tract infection, or (2) if you are pregnant you become more susceptible to urinary tract infections. You should specifically demand that you doctor check your urine sometime during the first three months of pregnancy.

If you have irregular periods, you might not realize for 3-4 months that you are pregnant if you have none of these signs. You might or might not gain weight, but generally by the fourth month clothes don't fit too well around the waist. During the fourth or fifth month you can feel the first movements of the fetus, like a fluttering inside.

Procedures for detecting pregnancy: Tests and Pelvic Exam. You will see the doctor when you recognize some of the signs as pregnancy; or you might find you are pregnant while being checked for some other thing.

There are two main kinds of pregnancy tests, biologic and immunologic. Both use a hormone (HCG—human chorionic gonadotropin) secreted by the developing embryo and found in the urine of pregnant women. It can be detected as early as three weeks after conception. Both kinds of tests use urine. In the biologic tests when the urine containing this hormone is injected into laboratory animals - rats, mice, rabbits, frogs - it causes them to ovulate. This process takes a few days, whereas the fastest immunologic test takes only a few seconds. When a drop of urine is mixed on a slide with a drop of serum hostile to it and two drops of another substance, the mixture won't coagulate if the hormone HCG is in it. These tests are 95-98% accurate, but can be false if they are performed too early before there's enough hormone in the urine, if there are technical errors in handling or storing the urine, or if the test animal doesn't respond as it should. Usually the diagnosis of pregnancy can be made without these tests, but they are really useful if your periods have been irregular and you specifically want to know soon. The tests become unreliable after the 16th week of pregnancy because then the amount of HCG goes down as it is not needed any more by the growing fetus.

Then there's the pelvic examination: if you are pregnant, (1) the doctor can feel that the tip of the cervix has become softened, (2) he can see that the cervix has changed from a pale pink to a bluish hue, (3) the uterus feels softer, and (4) the shape of the uterus changes: where the embryo attaches itself to the inside of the uterus it makes a bulge which can sometimes be felt on the outside of the uterus. The doctor will most likely put one gloved lubricated finger into the vagina as you lie on your back on an examining table. If there is pain, say so. During a pelvic, it's most important to be relaxed for tension increases your own discomfort. Relaxation involves trust and that is sometimes difficult to have.

From the 16th to the 18th week the doctor can feel the fetus in the uterus. Its heart tones can be heard around the 18th-20th week, at approximately twice the rate of the mother's.

What pregnancy feels like. What does it feel like to be pregnant? Some pregnancies are comfortable, others are not. Up until the fourth month, except for some possible signs, you don't feel the changes going on within, for the placental system is developing within the uterus as well as the complicated system of the fetus. Then, as the fetus begins its bulkier growth, your waist becomes thicker, your stomach starts to swell below the waist, and occasionally you can feel the slight movements of the fetus from within (4th-5th month: called "quickening"). Very very gradually the bulge becomes larger. It feels hard to the touch, for the uterus is a strong muscular container and is completely filled. Toward the sixth or seventh month you can feel the movements of the fetus both from the inside and the outside as it changes position, turns somersaults, sometimes putting pressure on the bladder, sometimes on the obturator nerves at the top of your legs. You can put your hand on it and feel bumps – the knees, hands, elbows and feet – moving around, like a pillowcase seen from the outside with a cat moving inside. Each baby will lie in a certain position. Occasionally it hiccups, sometimes regularly for a few minutes. All of these movements get stronger and stronger, toward the very end of pregnancy they lessen and stop as the head settles into the pelvis.

As your body gets heavier, you tend to walk differently for balance, often leaning back to counteract the heavy front. Some women become very large, others barely show even at the end of pregnancy (fairly rare); some women really broaden, others remain narrow. Your breasts will become larger, you'll probably have to wear a bra if you don't already, or get a bigger one, for it's a good idea to support the breasts in order that they

go more quickly back into shape after you've had the baby, or later on have stopped breast-feeding. If you plan to breast-feed, massage your nipples to toughen them.

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It seems presumptuous to tell how you will feel individually, but we as woman do have many feelings in common. Feelings during pregnancy are so dependent on how we usually feel about ourselves, how much we want to be pregnant, to have a child, how we feel about the man. Some **positive** feelings: sometimes at the beginning of pregnancy there's an increased sensuality, a kind of sexual opening out toward the world, and heightened perceptions. Expectation. Great excitement, especially when you find out you are pregnant and then feelings of power and elation, when you feel the quickening, the first signs of life you are able to feel, though the fetus has been moving around for several months. And there are many **questions**: what is going to happen? How will the experience change me? What will I learn? Will I be able to cope well? And throughout the pregnancy there will be **negative** feelings and thoughts, during general depression and especially if a woman feels threatened, angered, and upset by it. The depressions are perhaps related to all the underground anxieties we have in relation to our own mothers and our childhoods. Anger about the takeover of our bodies by something tiny, invisible. This anger can be most intense at the beginning if there is nausea, and toward the end when it seems to have gone on too long and we want to be free and light and empty again. Anger that a cycle has begun over which we have no control. Resentment that some part of our freedom might be curtailed, has been curtailed. And there are many **fears**: with a first baby there's very simply fear of the unknown. No matter how much one knows about the physiological changes and events in the body, there's something incomprehensible about the beginning of life. There are fears that the child will be deformed, that one will die, that the child will die, that the whole thing for some reason won't happen at all. The fears might express themselves in nightmares, or in waking violent fantasies. One woman felt that though she had convinced the world she was beautiful, she had been deceiving everyone, and the child by being deformed would reveal to the world how ugly she really was. And then we feel **guilty** that we have these fears, for don't they in some way suggest that as mothers we will be inadequate? We can't allow ourselves these depressions because we are supposed to be strong, maternal, natural, accepting, etc. It is vital that we realize that our fears and depressions are legitimate, and we can and should feel free and right in expressing them. Talking together and sharing these experiences is vital in breaking down our societal isolation as well as the isolation that our fears impose upon us.

You might feel surprised after the first five months that there are still so many more to go, and very impatient. Or maybe glad that the pregnancy is going on so long, so that motherhood and the responsibilities it entails be postponed. If the pregnancy is good there's a completeness in the symbiotic relationship: the mother is glad to carry the child, and the child is protected from the world. And then there's a possible numbness, a kind of self-protectiveness against something happening. Some women don't think of the baby as a person, but as a fruit or vegetable, so that they won't have to begin to think of anything serious happening to something like themselves. Pregnancy makes some women feel dependent on other people.

It's important to know that these fears and doubts can occur during a good pregnancy too, for in a very real sense, your body has been taken over by a thing and a process which is not within your control, and you must come to terms with that, not passively, but actively, by knowing what the fetus looks like as it grows, what is happening to your body, and what your specific fears are. Talk to friends and try to sort out the inevitable old wives tales from the realities.

Some women want to know how they will look,

how they will feel about their changing changed bodies, how a man will feel about them. An important reason for this question is that we are taught that women must be sexually attractive: in this society we must be slim, firm, well-groomed. We are also taught that we are to become mothers: a pregnant woman is fulfilling her expected role, doing her duty though she might not be a creature of traditional sexual beauty in the process. Thus as our bellies become larger, we must make a transition from one role to another, and sometimes our images clash. Again, the way in which the woman feels about herself is important here. She might feel ripe, fertile, filled, beautiful. Or she might think of her body as swollen, distended, deformed, and really hate it. These feelings seem to depend on how much she feels she is in control about what happens to her body and how much she accepts its changes. How the man feels depends partly on the relationship between them: if either has negative feelings it's best if they can talk about them and realize they are legitimate and changeable. Talk can also lead to some deep good questioning about the conventional ideas of beauty that we're all brainwashed with on some level. Some men are turned on by pregnant women. Some men even participate in women's pregnancies by experiencing nausea and other symptoms. Other men are repelled, disgusted, threatened for a lot of reasons, and hostile. Two people will have to work these complex feelings out individually.

What about making love during pregnancy? Traditionally, doctors have asked that women abstain from intercourse four to six weeks before giving birth and up till six weeks after; altogether women had to abstain for three months. According to a recent Siecus Study Guide (No. 6: Sexual Relations During Pregnancy and the Post Delivery Period), this abstention was based on four unproven beliefs: (1) the thrusts of the penis against the cervix induces labor, (2) the uterine contractions of orgasm will induce labor, (3) membranes may rupture, leading to infection and (4) the sex act is physically uncomfortable. Masters and Johnson have some evidence that the contractions of orgasm could set off labor, but the women in their study were close to term anyway. The Siecus pamphlet concludes that intercourse toward the end of pregnancy is not inevitably dangerous! But you shouldn't make love if you have any vaginal or abdominal pain, if there is any uterine bleeding, if the membranes have already ruptured (then there is danger of infection), or if you have been warned that miscarriage might occur. In the latter case you should not masturbate either, as your orgasm might bring on the miscarriage. Also sometimes oral-genital contact isn't good as air blown into the cervix might endanger the baby.

During pregnancy, some women want to make love more often, some less. Masters and Johnson report an increase in sexual desire during the second trimester, and a decrease during the third. Many booklets and manuals mention that new and groovy positions can be tried. When you are pregnant, it is not usually comfortable (sometimes not even possible) to have the man above you; it might be better for you to be on top, for him to be behind you. It's possible that the woman or man might feel that the presence of the fetus is a hindrance and that the act is no longer as private or free as they want it to be. Or maybe you will want to use pregnancy as a time to be free from making love. On the other hand, especially at the beginning of the pregnancy, both women and men might feel freer for there is no worrying about conception, and making love can become more fluid and more natural.

To sum up, when we think of the complex feelings we have during pregnancy, we learn most by accepting and working with them. Then we come to know ourselves. A lot of our negative feelings, fears, and anxieties during pregnancy can be directly linked to specific forms of repression that society has inflicted upon us and our mothers before us. If our mothers were afraid because of ignorance, we will probably have absorbed much of their fear. We must become articulate, and learn together who we are so that we can choose to be the best that is in us, so that we can change traditional attitudes toward motherhood which deny

us knowledge and control over ourselves.

Changes and Precautions. As the pregnancy advances, our bodies change in many ways. The skin over the abdomen can become stretched and lines of stress will appear. By mid-pregnancy the breasts, stimulated by hormones, are functionally complete for nursing purposes. After about the 19th week a substance called colostrum may come out of our nipples, but because of high hormone (estrogen-progesterone) levels, there is no milk. Our breasts are larger and heavier.

There are changes in our circulatory system. Total blood volume increases 30-50% as the bone marrow produces more blood corpuscles and you drink more liquid. Because of the increase in blood production, our bodies need more iron; many doctors prescribe iron pills at this time. The heart changes position and increases slightly in size. Its peak load happens about the 30th week, then blood pressure tends to go down. Any of us who have a history of heart trouble should be aware of this.

The flow of urine is reduced because of hormonal changes, but both early and late in the pregnancy, partly as a result of pressure from the enlarged uterus, and because you drink more liquids, there's a frequent need to urinate. Again, urinary tract infections are more common, as the flow of urine can be slowed down and the functioning of the kidneys changed.

Movements of the bowels and the entire digestive system can be slowed down because of pressure from the uterus, so indigestion and constipation occur sometimes. Also as a result of pressure, the veins in the rectum (hemorrhoidal veins) become dilated. Varicose veins in the legs are common.

Sometimes we salivate more - it is not known why - and our gums tend to bleed more easily than usual. It is a good idea to have teeth checked, if possible, in the early months of pregnancy.

The joints between the pelvic bones widen and are made moveable about the 10th or 11th week, stimulated by a hormone called relaxin. Posture changes because we must lean back. Occasionally the separating bones come together and pinch the sciatic nerve which runs from the buttocks down through the legs. Backaches are common: there's more pressure on the spine.

Some of us get cramps in our legs (calves, feet and thighs). Sometimes in the morning you wake up and have sudden cramps which quickly wear off.

Many of us tend to put on weight greater than the weight of the fetus, uterus, enlarged breasts, amniotic fluid. The body tissues retain more water (edema) and feet, hands, toes and ankles can swell up. This weight gain can strain the heart if it is excessive.

There's a "disease" of pregnancy called toxemia. It's divided roughly into three stages: toxemia, pre-eclampsia and eclampsia. Signs of toxemia are a sudden weight gain, suddenly rising blood pressure, albumin in the urine, and edema, swelling of the face and the limbs. For the past forty years studies have been done on the subject. Doctors have conflicting opinions about causes of this disease. Exciting work is being done in California by Dr. Tom Brewer. His strong and convincing thesis is that toxemia can be prevented if women adopt a balanced diet. We must eat foods containing protein above all, like meat, fish and dairy products. We must get all the vitamins, in whole wheats, vegetables and fruits. We need calcium and iron. If our diet is balanced, it's okay to eat salt. At all costs we must avoid diet pills and diuretics.

Finally, the uterus changes greatly. Its size increases five to six times, its weight increases twenty times, and its capacity increases 1000 times. In the beginning it grows because it is stimulated by hormones. After eight weeks, the growth of the embryo-fetus determines its size. The greater part of the uterine weight is gained before the 20th week. During pregnancy it contracts painlessly (Braxton-Hicks contractions). It's possible for you to feel the hardening caused by the contractions, which last only moments but are repeated often.

This is by no means an exhaustive detailed list of body changes. But it does indicate that drastic processes are going on in our bodies and keeping in mind that we are in some ways adapted to bearing children, we must realize that we've got to be aware of possible difficulties.

Pregnancy examination procedure and possible doctors' attitudes. It's a good idea to see a doctor when you either think or know you are pregnant. During the initial visit he will examine you after (hopefully) taking a careful medical history. Be sure he knows your blood type. After the first visit, you will see him once a month until the 28th week. Then twice a month until the 36th week, and from then till the birth, once every week. During these exams you will have your blood pressure taken, your urine and weight checked. The doctor will measure the growth of the fetus both internally and externally. After the heartbeat becomes audible to him, he will listen to it each time

During pregnancy we can become emotionally vulnerable and, as a result of all we're experiencing and the often impersonal efficiency of the examination, we may be rendered almost speechless. Often both private and clinic doctors treat us as children who know very little and are capable of learning less. It's a good idea to prepare lists of questions and persist in asking them until the answers are clear and satisfactory. It's much easier to do this and to establish some kind of reasonably good relationship with a private doctor than with clinic doctors who rotate so that we don't see the same doctor twice during a pregnancy. In either case we should demand to be treated as the intelligent and capable human beings that we are. This involves a lot of fighting and persistence, for we'll come up against stereotypical situations (paternalistic, punitive, condescending attitudes) and find ourselves forced into taking roles and playing games we don't want to play.

Demands. When we are pregnant we should be able to meet with other pregnant women to discuss our common anxieties and apprehensions. Doctors and clinics should make addresses and phone numbers of pregnant women available to each other. In each office or clinic we should demand information about pregnancy classes for couples and women alone. We cannot depend on hospital one-time classes or even prepared childbirth classes as they exist today to meet all our needs for information, support and encouragement. We must help each other as much as possible and as women we must demand that society provide us with the rooms, printed materials and group leaders of our choice to make our pregnancies times of learning and growth, and not full of fears.

APPENDIX

Growth of the embryo-fetus from week to week

The word embryo comes from the Greeks and means to swell or to teem within. Fetus comes from Latin and means young one or offspring.

Fertilization and growth of the embryo: The female ovum can be fertilized 12 to 24 hours after leaving the ovary, and the male sperm is effective for about 48 hours. A few dozen reach the vicinity of the egg. There are approximately 400 million sperm to 3.9 cc. of an ejaculation. (Another estimate: 20 to 500 million sperm to an ejaculation.) While many sperm manage to detach the outer layer of the ovum (zona pellucida), only one sperm can fertilize the egg. It must reach the egg's nucleus. The sperm loses its tail: its head - a nucleus containing chromosomes - swells. The 23 chromosomes of one cell meet the 23 of the other to form a single cell. At that precise moment the sex is determined, as well as certain dominant characteristics of the (from the) parents. About 10 hours after the first cells unite, there are four cells. Within the next 30 or so hours, it becomes multicelled, called the morula or mulberry, and is the size of a pinpoint. At about the end of the fourth to fifth day, it has reached the uterus, propelled forward by the movements and the cilia (hairs) of the fallopian tubes. It is now about 150 cells with a kind of hollow space inside (blastocyst). Implantation (attachment to the uterus wall) occurs between 5½ to 7 days. This process is called nesting or nidation. Tiny blood vessels in the wall of the uterus are broken and the growing cells absorb the nutrients from them, grow roots called villi, gather nourishment and the blastocyst implants itself in the uterus.

During the second week, the embryo is plate-shaped, with hundreds of cells, some of which form the embryo itself, the embryonic shield which contains preliminary tissues for a whole body; some form the umbilical cord, the placenta and the amnion (a membrane, a cluster of cells into which fluid flows).

By the third week, the embryo is one-tenth of an inch long, its neural tube formed, a swelling which runs from head to tail; from this tube grows the spinal column, nervous tissue and brain. By the 18th day, the eyes and ears begin to develop. The placenta takes up one-fifth of the uterine surface. By this time the first period will have been missed.

Fourth week: The embryo is ¼ inch long. The heart, looking like a U-shaped tube, starts beating on the 25th day. Proportionate to the fetus it is nine times as large as the human heart. There's a beginning circulatory system. There are simple kidneys, liver and digestive tract. The tongue has begun to form. On the 26th day, limb buds appear. (By now you can be given a birth day about 238 days in the future.) "Relative size increase is never again so great as in this first month. The embryo is now 10,000 times larger than the egg. Also the extent of physical change is never again to be equaled." (Smith, p. 142) By now the embryo has a closed system of circulation independent of the mother's.

Fifth week: The heart is pumping frequently, 65 times a minute. External ears are starting to take shape. About the 31st day, arm buds become hands and shoulders, and a few days later, finger outlines appear. The nose, upper jaw and stomach start to form. The embryo is ½ inch long. On the 33rd day, the eyes are dark for the first time; black pigment has just formed in the retina. The brain is ¼ larger than three days earlier.

During this time the fetus is unnoticed but vulnerable. The mother's diseases can be communicated to the embryo; the part growing most rapidly is most susceptible.

Sixth week: About the 37th day the tip of the nose is visible and eyelids begin to form. Five separate fingers and toe outlines begin to appear. The skeleton is complete and growing, but it is still cartilage rather than bone. Stomach, intestines, reproductive organs, kidneys, bladder, liver, lungs, brain, nerves and circulatory system are developing rapidly. The embryo is ¾ inch long.

Seventh week: Embryo one inch long, weighs 1/30 of an ounce. The stomach produces digestive juices, the liver makes blood cells, and the kidneys have started to extract uric acid from the blood. The ears develop in unison, timing, and form, as do the arms and legs. The upper and lower jaws are clear, the mouth has lips, a sort of tongue and first teeth (buds). The arms are as long as printed exclamation marks!! The thumb is different from the fingers. The first true bone cells develop; there's a working brain and a working circulatory system. There are active muscular reflexes. The body is padded with muscles and covered with thin skin.

Eighth week: Neck visible, head very large. Uterus four inches long. Placental area 1/3 of the uterus.

Embryologists can tell precisely how old an embryo is by seeing the stage of formation of its body during the first 48 days. After the eighth week, the embryo changes mainly in dimension and in refinement of the working parts (perfection of funcion follows perfection of structure).

Ninth week: Its sex can be seen externally. Its footprints and palmprints are indelibly engraved for life. Spontaneous movements occur, eyelids and palms are sensitive to touch (reflex squinting and gripping). Nails begin to grow. Eyelids close for the first time. Amount of HCG reaches maximum level. (The 8th and 9th weeks considered the best time for abortions.)

Tenth week: The quarter stage reached at 66th day, but the fetus will have to multiply its weight over 600 times in the remaining three quarters. The uterus weighs about seven ounces, contains one to three ounces of amniotic fluid. A common time for miscarriages.

Eleventh to fourteenth weeks: Fetus can frown, move thumb to fingers, swallow. Vocal cords completed. Urination begun and urine is removed with renewal of amniotic fluid. Can digest swallowed fluid. Sperm or egg cells exist. The mother's uterus moves up out of the pelvis and can be felt from the outside if the woman is thin. By the 12th week the fetus is about 2¼ inches crown to rump or 2¾ inches crown to heel and weighs ¾ ounce.

This is roughly the end of the development period. The fetus and placenta are about equal in size. The fetus's movements are fluid and graceful. Every baby by now shows distinct individuality in his or her behavior. The amnion tissue surrounding the fetus is transparent, paper-thin, tough, slightly elastic, shimmering; it's an enclosing watertight protective bubble growing with the baby. The fluid within is never stagnant; one-third of its volume is removed and replaced every hour. The baby's lungs and kidneys are thought to be one source of the fluid; and so is the amnion itself. The fetus fills the uterus. Its heart pumps fifty pints a day. The uterus is halfway between the pubic bone and the navel. The placenta produces the hormone progesterone in sufficient amount to maintain pregnancy (formerly done by the defunct corpus luteum).

In its second stage of growth, during the 15th-18th weeks, hair starts to grow on its head. Eyelashes and eyebrows begin, nipples appear, nails become hard. At birth they will be so long they will need to be cut. The heartbeat can be heard externally and you can feel its movements as it moves and hiccups. The skeleton hardens, it sleeps and wakes like a newborn, buds for permanent teeth come in.

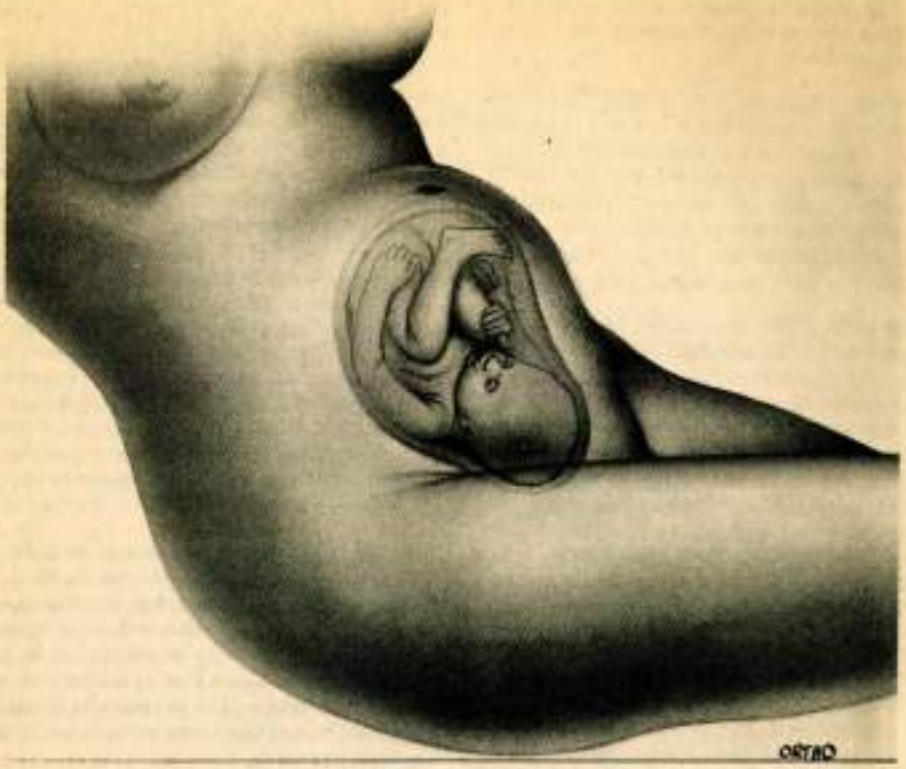
19th-22nd weeks: Premature life is possible. It can grip firmly with hands. A hairy growth called lanugo appears on arms, legs, and back. Now approximately 12 inches crown to heel. Uterus is up to navel.

23rd-26th weeks: Many prematures at this age are able to live. Amniotic fluid perhaps 1½ pints, but after 30th-36th week may not increase or might even decrease to allow fetal growth. Head hair grows long, lanugo disappears. Fetus can and does suck thumb. Umbilical cord reaches maximum length. Uterus a few inches above the navel, fetus about 14 inches long.

The third stage: 27th-30th weeks: by about the 28th week the fetus is "legally viable"; that is, it has organs sufficiently formed to enable it to live if born early. It settles into a head down position, is fatter, with smoother skin. About 16 inches long.

31st-34th weeks: Still growing, about 17 inches long. Premature babies look more like babies as they have more fat on them, and less like little old people.

35th-38th weeks: The fetus's heart pumps 600



pints a day. Growth stops shortly before birth. One cell has become 200 million cells. The weight of the original fertilized egg has been increased five billion times. The uterus is 14 inches long, maximum size, and it weighs 2¼ pounds. The placenta weighs 1½ pounds at term and is seven to nine inches in diameter. The baby is ready to be born.

From the mother's blood, from the placenta and perhaps from the amniotic fluid the baby has been receiving substances which make him immune to a large variety of diseases. It receives disease-combating proteins called antibodies which have been built up from the diseases she has had. These immunities will gradually wear off after the first six months of life. In the last month before birth, the baby will have a level of antibodies and gamma globulin equal to that of its mother.

Infertility

Many woman have difficulty becoming pregnant. Usually if a man and a woman have been trying to conceive over a long period of time, many tensions are built up. Trying to conceive on the mathematically right day, during ovulation, can become a self-conscious mechanical process, eventually destroying good sex. Both the man and the woman might begin to resent each other, to hold unfounded grudges and suspicions, and above all, to feel inadequate.

How long should a woman or a couple wait before seeing a doctor? If you can't conceive a child after trying for two years, or for one year if you can't wait or if you are past thirty (your fertility declines with increasing age), then you should see a doctor interested in infertility who has had obstetric and gynecologic experience, and knows about the physiology of reproduction. He should also definitely know about semen analysis. If he is a good doctor he will be aware of your tensions and hang-ups and he will try to deal with the emotional and psychological conflicts you might have toward each other and maybe towards having a child. A doctor who runs through a series of tests without talking with you will be helping you less than he could.

Often you, the woman, will feel more guilty and responsible for not being able to have children than the man will. Studies show that 10-15% of the couples in the U.S. are infertile, and in more than 40% of these cases the man is responsible. It's possible that some men will resist (1) the idea there's something amiss with them and (2) going

to the doctor with you. It's threatening for him as well as you to think himself on some level impotent, and even more upsetting to find out definitely that his sperm are not "powerful" or numerous enough. But if he's really interested in having a child, he'll consent to be examined first. It's usual to examine a man first because it's a much simpler process. But now it's possible within the span of two menstrual cycles for a woman to get a series of diagnostic studies done if the sequence is treated logically; or she can, in two days in the hospital, have many tests done. Of course these tests cost money, and we should demand that they be made available to all women who need to have them, who want to have a child.

If you decide to see a doctor systematically, then prepare for a first meeting by trying to go over your medical histories. The doctor should take your histories in detail. He'll probably ask you as a woman if you are married. He'll ask about your gynecological history: when did menstruation begin, regularity of periods, discharges, periodic bleeding, spotting, former infections, abortions, possible rape. It's hard to speak factually about difficult events like abortions and rape; but they are facts, possibly medically important, and it can be part of our strength that we speak of them clearly. The doctor will review your circulatory, digestive and excretory systems to find out if you have been or still are ill, and to find out how you have been treated for these illnesses in the past. He'll probably ask about your sexual relations.

The next step for a man will be a physical exam and a sperm analysis, and for the woman a physical exam and a pelvic exam. It might be that just going to see a doctor will relax you enough to conceive, if nothing else is wrong. It might be that the man's sperm might be defective in some way, and you can work with the doctor from that evidence to try and conceive.

Before going into the specific kinds of things the doctor will be looking for, it makes sense to mention the conditions on which fertility in women depends: (1) good general health, (2) desire to give birth to and rear a child, (3) no infection or inflammation in the reproductive tract, (4) good functioning of the reproductive tract – vagina, cervix, uterus, fallopian tubes, ovaries, the anterior pituitary gland and parts of the hypothalmus and cerebral cortex.

For an egg to be fertilized there are roughly twelve conditions: (1) At a time properly related to the developmental stage of the endometrium (lining of the uterus), an egg must be discharged from the ovary. That presupposes that at least one ovary be intact, that it have "responsive" follicles, that its activities be governed by a functioning hormonal-endrocrine apparatus. (2) Near the exact time of ovulation, the hairs (fimbriae) of the fallopian tube must surround the lower half of the ovary and catch the ovum. (3) In the tube the egg must progress at a rate of no more, no less than 5-6 days; otherwise, the fertilized egg will not implant successfully. (4) Healthy sperm must be deposited in a healthy intact vagina. (5) Once in the vagina a sufficient number of sperm must go into the endocervical canal as a result of their efforts or because of "in-sucking" organic contractions of the uterus. (6) Once in the canal there must be a good biochemical environment. The cervix must be in all ways intact. Its secretions must interact well (nontoxically) with the sperm. (7) From the canal the sperm must climb to the uterus. (8) Then into the fallopian tubes. (9) They must be able to swim against the push of the hairs to the farther third of the tube and there meet the egg during its time of viability. This depends on the vigor of the sperm, maybe on the chemical secretion of the tubal secretions. (10) Large numbers of sperm must affect the shell of the egg so that it can be penetrated. (11) As it is swept along the tube toward the uterus the fertilized egg must undergo a series of maturational changes that make it into a blastocyst as it arrives in the uterus. It must be genetically and embryologically normal. (12) The endometrium must be ready to receive it, the secretory changes of the menstrual cycle must be adequately advanced.

Thus, if any of these things are prevented from coming about, the end result can be infertility.

During the second step of the exam, the doctor will then give you a pelvic. He'll look at the distributions of pubic hair, the development of the labia, he'll look for evidence of infection. Next the entrance to the vagina is inspected. Sometimes it's found that the hymen isn't sufficiently open. Two glands (Bartholin's and Skene's) are examined to see if they're closed up, infected or tender. There might be some obstruction in the vagina. The amount, color and odor of vaginal secretions are noted. The doctor inserts a speculum to hold open the vaginal walls, and observes the position, size and shape of the cervix. Then he'll palpate the cervix and uterus with one finger inside and one hand outside to determine the size of the uterus in relation to the cervix, its position, consistency and freedom to be moved. In the same way he'll also check the position, size and consistency of the ovaries.

If he hasn't found anything wrong anatomically and if the man's semen is normal, then you return for the third step of the investigation, which con-

sists of complete blood tests to check your normal endocrine functioning and basic body health. You will have a complete blood count to check the number of red and white cells that you have; a hematocrit, a count of the percentage of red cells in a specimen of blood to determine anemia; a test to determine by checking white blood cell count if there's any infection and a differential: a check of the kinds of cells involved in the white blood cell count. Your blood will be typed, for it's possible that incompatible blood types may be reflected in the sperm and in the egg. And as abnormal thyroid function affects fertility, you'll have two or three tests to determine how efficiently the thyroid is working. You should have a two-hour post-prandial blood glucose test to determine that there's proper functioning of glucose control mechanisms, a test for diabetes. And finally you will have a urine analysis to determine kidney function, hormones in the urine, infections.

If everything described above gives no clues to what is wrong, the doctor will do a systematic investigation of the bodily systems of reproduction.

First he'll want to find out whether your ovaries produce graafian follicles which upon ripening emit eggs. Two days before menstruation he'll do an endometrial biopsy which consists of taking a small sample of the uterine wall tissue to give information about whether ovulation takes place and how the endometrium develops. He will do a fern test twice, once during mid-cycle, once at the end of the cycle: when estrogen is present and highly concentrated, during ovulation (mid-cycle), the cervical mucus under the microscope shows fern-like designs. At the end of the cycle the fern pattern will no longer be there, for the progesterone of a normally ovulating woman inhibits fern formation. Another way of determining ovulation is to record your basal body temperature rectally on a special thermometer. Your temperature is supposed to rise 1° F at ovulation and stay high during the life span of the corpus luteum. If there's no significant rise, progesterone isn't being provided in effective amounts. The basal body temperature is of greatest value with women who have regular menstrual cycles. All these tests of egg formation shouldn't be counted as conclusive. It might be that they'll have to be done a few times, for you might have an atypical cycle the first time. Any diagnosis of ovulation to be fairly complete should cover at least three cycles.

There are several kinds of menstrual disorders which indicate that something has gone wrong either with ovulation, hormonal levels or some other facet of the menstrual cycle. There are different kinds of bleeding: disfunctional uterine bleeding, possibly caused by persistent corpus luteum cysts, pelvic inflammations or infections, anemia; dysmenorrhea (abnormal menstruation); amenorrhea (no menstruation); anovulatory bleeding (bleeding without ovulation). The doctor needs to follow here a logical sequence of studies. A common cause of lack of menstruation is the Stein-Leventhal syndrome: enlarged ovaries or ovaries with cysts. The cysts can be removed by a simple operation.

If he has to continue the search, the doctor will check the transportation of the cells, by looking for tubal disorders. The fallopian tubes might be blocked, so that he will blow CO_2 through them (the Rubin test, CO_2 insufflation test). This test in itself might correct the blockage.

A hysterosappingram may be taken of the uterus and tubes. A water-soluble opaque medium is injected into the uterine cavity and outlines the uterus so that any obstruction or malformation shows up clearly in an X-ray.

Tubal disorders may be grouped under two categories: (1) mechanical obstruction by organic lesions, caused by pelvic inflammatory disease, ruptured appendix, peritonitis, abdominal or pelvic operations or (2) disturbances of the physiologic function of the tubes – failure of the ovum pick-up mechanism, delayed or too rapid ovum transport, endocrine disturbances and/or psychic stimuli; that is, if you are psychically disturbed, what goes on in your brain might inhibit certain necessary hormones from being released.

If nothing yet has been found to be wrong, the doctor will then look into how sperm are placed on or near the cervix and how they pass through the cervical canal. The most well-known test is the Sims-Huhner or Postcoital test. Often it is the first test to find out how the sperm enters the woman. It should be done six hours after a couple has had intercourse, though there's disagreement about that timing. When cervical mucus is taken from the woman and looked at under the microscope, the number of actively moving sperm is counted. There's also the semen penetration (Miller-Kurzrock) test in which a specimen of the man's semen is placed near a sample of cervical mucus. If the sperm can penetrate the mucus and live, then they are viable, they interact well. Sometimes the semen and cervical mucus are simply hostile, the male immune in some way to the female, or vice versa.

Position of a couple during intercourse becomes important, another kind of test.

Finally there's something called psychogenic

infertility. This means simply that because of conscious or unconscious anxieties or fears a woman will try in all kinds of ways not to have a baby. There's infertility due to no identifiable cause, the cause has not been found. And there is absolute sterility, for instance where both tubes have been seriously damaged.

The whole process of finding causes for infertility can be incredibly wearing and depressing. It takes a lot of strength for a woman to go through some or all of the above tests. But it's helpful to know some of the causes, some of the tests; it's essential to demand of the doctor that he tell you what the procedures he uses consist of, that he describe the tools he will be using if you want him to, that he give you some idea of how the different processes will feel and be responsive to your reactions.

Miscarriage (natural abortion)

Miscarriage is always an emotional event. There are different kinds of miscarriages at different times during pregnancy. If it happens early and the fetus is barely formed, you might be less affected than if it happens after the fourth or fifth month, after you have felt the fetus move within you and felt it to be real to you. But if you want a baby, even if it happens early and especially if it has occurred once or several times before, it can be occasion for increased anguish and despair and add to the tension involved in trying to conceive again. Many fears are increased, and you become more and more vulnerable and must work on building up defenses. If a miscarriage occurs in the fifth month or later, some women feel incredibly incomplete, and find themselves waiting for something to happen – their time sense gets shaken up. This can happen even earlier. All of this is not to alarm but to make women aware that miscarriage is a possibility during pregnancy (one in ten women miscarry) and can be very difficult to cope with. But anxieties can be lessened by your persistence in both learning reasons for your miscarriage and by being as much as possible aware and constantly in touch with your feelings and fears. It is also vitally helpful that you talk out these feelings, and very important that your friends not gloss over the event, feeling so uncomfortable with it - and it can be hard to deal with - that you are frustrated when you try to communicate your feelings. Often through talking both to the man involved and empathetic friends you can sort out your own strong feelings and begin to know your anxieties.

If a woman is not fertile, the reasons for her infertility might be the reasons for miscarriage. (The man is less responsible for miscarriage than for infertility.) So many of the tests performed for infertility are useful in determining why a woman will habitually abort.

There are four general classes of causes of miscarriage: (1) defective egg or sperm, (2) faulty production of estrogen or progesterone, (3) anatomical illness or functional abnormalities, or general illness or infection, (4) psychological. 30% of women abort and around 50% of the fetuses are found to be abnormal. Some more percentages: after a first miscarriage it's 85-90% sure that the next pregnancy will be all right. After a second, there's a 50% chance, and after a third, a 25% chance. A woman who has miscarried three times or more is called a habitual aborter. She should definitely have preventative (preconceptual) therapy and treatment.

Miscarriages are classified into stages or types. One abortion can pass through many stages.

Threatened abortion. There's a difference between bleeding and abortion bleeding. Some women when pregnant about the time they are supposed to have their periods bleed slightly for a few months. Sometimes as the blastocyst implants into the uterine lining there's slight bleeding. Sometimes the bleeding might be bright red – if it continues for several days, go to the doctor; he'll examine you for lesions. Early bleeding has no effect on fetal development. If bleeding does begin (slight brown staining with little or no abdominal cramps), there is always uncertainty. The pregnancy might or might not continue. You will be advised to go to bed until the bleeding has turned brown and then stopped for 24 hours. Afterwards you should not douche, be too active or make love until the 14th week of the pregnancy. Many women find the fact that there is no treatment hard to accept; and find it so hard to accept the fact that if the bleeding continues for several days, it means almost definite miscarriage.

Inevitable. Severe cramps, cervical effacement and dilation occur with strong bleeding and clots. No way to stop it.

Complete. The uterus empties itself completely of the fetus, membranes and the decidual lining of the uterus. During the first three weeks, spontaneous abortion is almost always complete. Sometimes then and even later it might feel like a really heavy period; sometimes you might not notice it at all as it takes place around the time you expect your period. If the pregnancy is more advanced than three weeks, the doctor would very likely give you a D&C to be sure that every bit of membrane is out of the uterus, for unless it is completely emptied, the uterine muscles won't contract to

compress the bleeding vessels and control the hemorrage.

Incomplete. Varying amounts of tissue remain in the uterus, either attached or free. Mild to severe cramps, perhaps pain in a specific place. Must get a D & C.

Missed. When the fetus has died but remains in the uterus. Symptoms of pregnancy disappear, breasts get smaller, the uterus stops growing and gets smaller. Spontaneous abortion almost always occurs. There's a brown spotting. Doctors usually wait until it begins by itself, and then give a D & C.

For the record there's something called a **septic** abortion. What that means is that a woman has tried to abort herself and has caused either infection or an incomplete abortion. If abortions were free and legal and easily available this "medical" category would completely disappear.

Sometimes a woman's cervix has been injured and can't hold in the fetus. A simple operation can be performed to prevent her from losing her baby.

In general, if you have a history of miscarriage, you should get fully examined along the lines of the infertility investigation. If you have miscarried only once, that usually means that the egg or sperm is defective, and it's paradoxically a healthy thing for your body to get rid of an embryo or fetus which isn't growing well.

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Prepared Childbirth

The purpose of this chapter is to explain to women the experience of childbirth and the ideas and techniques of prepared childbirth from a women's liberation viewpoint. It is important that prepared childbirth be discussed in the context of a course on women and their bodies that includes sections on sexuality, anatomy, medical institutions, etc. My larger aim is to re-unite women's minds and bodies, not just for the brief period of childbirth, but in an overall program of overcoming our mental and physical oppression as woman.

There are two basic assumptions which I think are important to state clearly at the beginning: (1) Every baby born should be wanted (there should be free, legal and safe abortions to any woman upon her request alone). (2) Every woman (married or unmarried, rich or poor, black, brown, yellow, red or white) has the right to childbirth preparation.

Childbirth preparation does not begin or end with childbirth; a more accurate description is preparation for children, which begins with the decision to have a child (hopefully not a casual one), goes through the defined stages of pregnancy, labor, delivery and birth of a child, a short postpartum period (length varied) and a longer (endless?) period of childcare. I will focus on labor, delivery and the birth of the child and will call that preparation for childbirth. This discrete period (average of 14 hours from beginning of true labor to birth of the child for a primipara or first-time woman) compared to the time it may have taken to conceive, the nine months of pregnancy and the 21 years of legal responsibility (years of emotional responsibility are unnumbered) is short and intense. Childbirth is a period of crisis for all women, a time of great physical, emotional and social changes. Childbirth preparation must help the pregnant woman and those close to her understand the changes and her feelings about them; it must identify the range of physical, emotional and social changes, their inter-connections and ramifications and offer support, experience, explanations, partial solutions. This sharing may start at conception of a child but it does not stop at childbirth.

My primary focus is on us as women, on us as people and we neither begin nor end with the birth of a child. The child is a new dimension and can be an exciting dimension as long as it isn't the only dimension. With this introduction we can focus on preparation for childbirth.

WHAT'S IN A NAME: SOME COMMENTS ABOUT HISTORY

Prepared childbirth is often misnamed "natural childbirth". The only thing that is natural is that a woman's body is biologically equipped to bear and give birth to a child. (We have been taught to want children and to expect to raise them ourselves.) Although considered normal by most women (reared on the usual myths), it is not natural for us to have our babies in helpless, degrading, ignorant pain and fear. Dr. Grantley Dick-Read, an English obstetrician, believed fear caused tension that inhibited the process of childbirth. If women were educated to understand what was happening to their bodies, he felt pain would be minimized. He certainly was a pioneer (book published in 1942) in preparing women for childbirth; however, his method appealed to religious conviction and mystical beliefs about a woman's role in society.

A French obstetrician, Fernand Lamaze, visited the Soviet Union and saw Pavlovian reflex theories applied to childbirth. All kinds of women gave birth in joy rather than in pain. Excited by what he observed, he returned to France and in 1951 introduced a method called the psycho-prophylactic technique in clinics for working women (psychoprophylaxis of pain in labor means prevention by psychic means).

"Although the goal was the same - childbirth with minimal discomfort and with medication, enabling the mother to see her child coming into the world - the Lamaze method differed from the Read method chiefly in advocating that the mother be very active during a contraction instead of concentrating on relaxing.

"The Lamaze method was introduced to the United States in 1959 with the publication of Thank You, Dr. Lamaze, a book written by Marjorie Karmel, an American whose first child had been delivered by the French physician in Paris.

"The following year, Mrs. Karmel and Elisabeth Bing, a Berlin-born physical therapist, founded the American Society for Psychoprophylaxis in Obstetrics [ASPO], a nonprofit teaching organization of doctors, teachers and parents.

"'We don't call it natural childbirth but educated childbirth,' says Mrs. Bing. . . 'Read says it's a normal physiological process, which shouldn't hurt if you think right. He's very mystical. We say labor is a situation of stress and we try to cope with that situation.'"[1]

As we examine the history of childbirth practices (see Awake and Aware by Dr. Irvin Chabon), we realize that when anesthesia began to be used and children began to be born in hospitals, less of us died in childbirth. However, we paid a price. As we moved from home to the hospital, we became "patients" ("objects", "victims"), were seen as "sick", and thus lost control over the experience. Now that we are taking control of our bodies and evaluating the use of drugs (not only during childbirth!), we are also questioning the hospital as the only place to have a baby. We are going forward, not backward. We are not saying no drugs, no hospital. We are learning the reasons for both and feel that they are an advance for some of us; but for others of us they are not necessary. It comes down to us understanding our own bodies, the risks we take, and demanding the right to shape our experiences, whether in the hospital or at home.

Preparation then takes on a new meaning beyond that envisioned by Lamaze and his followers. It is a process of exploring our own feelings and trying to figure out what we need and want during the short period of childbirth (and how that relates to the larger period of preparation for children); of learning what happens during labor and delivery and acquiring skills for coping with our bodies; of understanding the medical situation in America (particularly the hospital and the doctor) and finally of integrating the parts of the process for each of us in a way that enables us to approach childbirth with confidence in our ability to handle all parts of the experience so the experience as a whole is positive and one of growth for us.

HOW YOU GET PREPARED: CLASSES FOR PREPARATION, DETAILS AND DIFFERENCES IN APPROACH

There are two different groups that offer preparation classes in the Boston area. One is a group of trained nurses (RNs) who teach the Lamaze method (they have some LPNs too). The group is called The Lamaze Childbirth Education, Inc. Although not affiliated currently with ASPO, they are known as the official Lamaze group in the area. The other classes are sponsored by the Boston Association for Childbirth Education (BACE). You don't have to be a trained nurse to teach (often the teacher is a nurse and her assistant is not); BACE has its own training course and apprenticeship program for its instructors. The method they teach is eclectic, combining techniques of Dick-Read, Lamaze and Shiela Kitzinger (see bibliography).

The biggest difference between the two groups is their general organization. The Lamaze group is a medical, professional organization, and the BACE group has a parent, para-professional organization. As I mentioned above, this means that only trained nurses teach the Lamaze classes, while parents may teach the BACE classes. The Lamaze group has talked of non-nurses teaching, but has not changed since they feel it's important that the teachers also be **monitrices** (monitor or coach) during labor and delivery (to be a monitrice your credentials have to be approved by the hospitals). I don't know whether BACE has a system of monitrices, but parents do teach courses.

The orientation of the Lamaze classes is on childbirth and that of the BACE classes on parenthood. Both groups give similar physical training for the actual period of childbirth. BACE goes beyond the birth of the child and talks about breast feeding, child development and other topics of relevance to new parents. BACE also talks about family centered maternity care in the beginning, a concept which is a challenge to all medical facilities in the Boston area. The BACE classes will more likely teach you to be properly critical of hospital procedure and the medical profession than the Lamaze classes. The Lamaze classes teach the women (couple) how to cope with the doctors and hospital (responsibility is on the woman), while the BACE classes teach the woman (couple) that she will not be well received and will need a lot of support from her man (hospital's problem which couple has to be aware of). Even though the BACE group is not about to break with the medical profession, the governing body of the BACE organization is a parent board which shapes the classes and changes as the parents change.

From a woman's liberation point of view, both sets of classes fall short. Nevertheless, it is essential to have some kind of training and coaching in exercises and breathing, and they are the only ones doing it now. Both Lamaze and BACE are excellent in physical preparation of a woman for that short period of time called childbirth. BACE goes a little further in recognizing the emotional changes and social changes of becoming parents. However, neither group has adequate preparation for children. The classes do not begin early enough; they should start before conception. People should have an opportunity to talk through a decision to conceive a child before the child is actually conceived (e.g. if you want a child to care for, why not adopt?). From the period of conception to the start of classes in the seventh or eighth month is a long one; unless you happen to have other pregnant friends you are not likely to have a chance to talk out the many feelings and fears you have about having a child. (Even then there is pressure not to talk about negative feelings.) In other countries where midwifery is practiced, women have

contact with the midwife who will deliver her baby from very early in her pregnancy. The midwife is a woman with whom you can share feelings; she is also a source of contacts with other pregnant women (often in the neighborhood since the midwife is assigned to one or two neighborhoods). Clearly one of our demands must be to make the practice of midwifery legal and popular.

The classes never discuss the nuclear family as an institution of oppression (for both children and parents) and means of childcare (playgroups, day care, communal child care, etc.). This could be a time for women and men to split and talk alone and then come back together as a group.

The classes are too large (15 to 20 couples) to have the kind of discussion I'm talking about, too expensive ($30 a couple) and too exclusive (they attract primarily middle class, married couples, highly educated intellectual types). BACE has started one class in a local community center for low income women. But all women must have preparation – in their neighborhoods, in clinics, in churches, in schools.

PREPARATION BEFORE LABOR: LEARNING ABOUT YOUR BODY AND HOW TO USE IT – MUSCLES, EXERCISES AND NEUROMUSCULAR CONTROL

The work of labor centers on the pelvis and uterus. In order to approach labor, we have to understand the construction and functions of these parts of our body. Then through physical exercise we will prepare our bodies for the hard work of labor.

Pelvis. The pelvic girdle is formed by the hip bones which create a shape something like a lobster-pot sloping downwards and forwards, through which the baby passes when it is being born. The pelvic outlet is limited by the **sub-pubic area** in front, the **ischial tuberosities** at the sides, and the sacrum behind. The **coccyx**, the little bone at the bottom of the spine, although curved forward, is attached to the sacrum by a joint which moves back when the baby is being born, so that it does not get in the way.

Uterus. The internal reproductive organs of a woman are composed of a hollow, thick-walled mus-

cular **uterus** or womb, shaped like a pear with the stalk end pointing downwards and usually slightly backwards. In front and behind are the bladder and the rectum, and the mouth of the uterus, or **cervix**, connects up with the vagina from below.

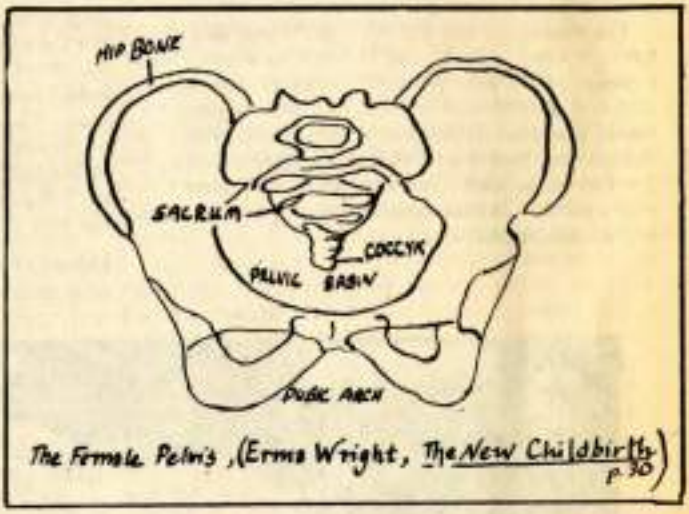
"By the end of pregnancy, the uterus has moved up and out of the pelvis into the abdomen, is narrow-shaped and about 12 inches long. Its **fundus** (top) reaches nearly as high as the **diaphragm**, which is the sheet of muscle which separates the abdomen from the **thorax** (chest). The baby is protected within the walls of the uterus which are about half an inch thick, and is also inside a bag of membranes, where [she] floats in (**amniotic fluid**, or bag of waters), attached by the umbilical cord to [her] placenta through which [she] is nourished.[2]

The open space created by the bony pelvis and which supports the growing muscular uterus is called the **pelvic basin**. Across the bottom of this basin stretch the **pelvic floor muscles**. In their normally firm state, these muscles keep the intestines and other soft organs from falling through the lower opening of the pelvis. During delivery these muscles should be relaxed to permit the baby to pass through.

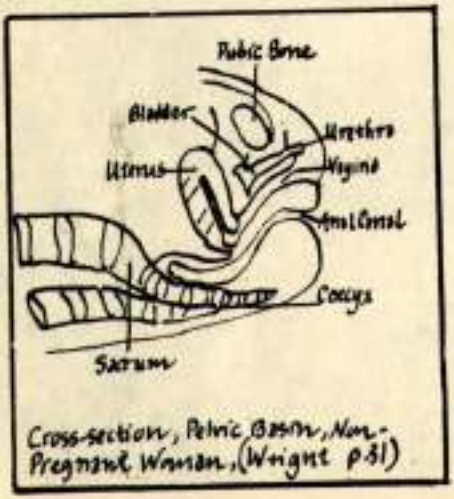
Here are three exercises from Erna Wright that will get your pelvic muscles in shape for labor. As you do them, you will understand your body better and take control of parts of it so it works for you during labor.

"Exercise 1. Sit on the floor 'tailor fashion'. If it feels hard sit on a cushion; but don't lean against anything. Make your back muscles support your body in an upright position. The exercise you are about to learn will help increase the suppleness of the muscles of the pelvic floor. . .

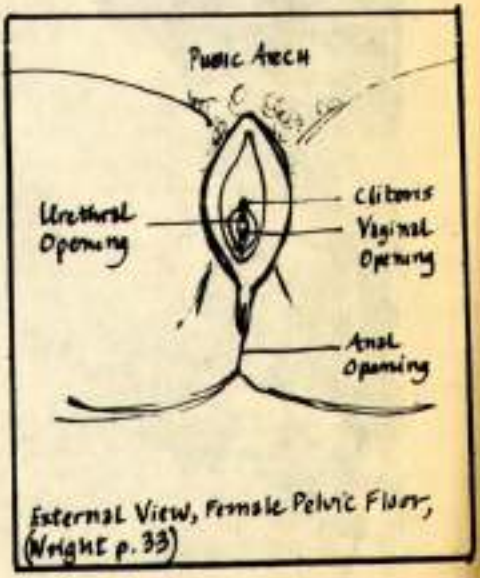
"Put the soles of your feet together with heels as close to your body as possible without losing your balance. Grasp your feet together with one hand and put the other hand **under** one knee. Now push your hand toward the floor with your leg; then bring the leg back to its previous position with your hand. Notice that the muscles on the



The Female Pelvis, (Erma Wright, The New Childbirth p. 30)



Cross-section, Pelvic Basin, Non-Pregnant Woman, (Wright p. 31)



External View, Female Pelvic Floor, (Wright p. 33)

outer side of the thigh are pulling against the muscles on the inner side, called the **adductors**. Repeat, pushing toward the floor in one smooth movement, and bring the knee back once more. After six repeats, change hands and do the exercise six times with the other leg. Then keep your feet together without holding them, and use both hands under both knees simultaneously. Again repeat six times. Don't jerk your knees downward – just push as smoothly as possible each time.

"After a few weeks of doing this whole pattern once daily, you will find that you can bring your heels closer to the body without losing balance – proof that your adductor muscles have lengthened (postnatal exercises will reverse this again).

"Exercise 2: This has become a boon to many expectant mothers who suffer from backache. The exercise is intended to make the muscles covering the back of the pelvis more supple.

"Kneel on the floor, sitting back on your heels. Rest your hands on the floor in front of you, with the elbows turned outward and slightly bent. Put your head down and hump your back. Now, using your thigh muscles like pistons, push your buttocks out backward – like a duck lifting its tail. Feel your thigh muscles doing the work. Then make them pull your buttocks back again, as though you were trying to hide them. Repeat six times. Alternatively you can do this exercise sitting on a hard chair about halfway along the seat. Plant your feet firmly on the floor in front of you. In this position hold your thighs with your hands to feel the muscles at work.

"If you ever find that you back suddenly goes into a spasm, especially after bending down, don't stay in a bent position. Sink onto your knees instead, and do this exercise. After a few minutes the cramplike sensation in your back will ease. This exercise is also often beneficial in early labor if backache is experienced.

"Exercise 3: Kneel on the floor with your knees slightly apart. Put your hands flat on the floor with your arms held straight. Your back should be arched slightly upward so that your body forms a square between knees and hands.

"Do the exercise as follows: Contract the muscles surrounding the back passage [anus]. Decontract. Repeat with muscles surrounding the front passage [urethra, vagina] and then the whole pelvic floor. Repeat the whole pattern three times, once a day.

"A word of comfort: It is almost impossible to do this the first few times. Just get the idea, and then persevere. After a few weeks you will achieve control over the different parts of the pelvic floor."[3]

You will want to do some exercises to strengthen the upper and lower muscles of your abdomen. These muscles are used during delivery when you help push the baby out. It's important that you begin to get these muscles in shape because the better each push is, the fewer pushes will be needed, and the baby will stay in the birth canal for a shorter period of time.

These exercises are very simple. Lie down flat on your back on the floor. With arms at your sides, relax (i.e. decontract) all muscles. Try to think that if the floor was not supporting you, you would float free in space.

Upper abdominal muscles: Slowly lift just your head from the floor (shoulders should come up as little as possible) until your chin touches your chest. Do this to the count of three and lower to count of three with pause in between raising and lowering. Do this three times the first time and work up to ten within a few weeks. Do this exercise once a day.

Lower abdominal muscles: Now lift your feet off the floor, keeping the rest of your body still. You should raise them just high enough so you feel a pulling sensation in your lower abdomen. Do this in the same pattern as for the exercise above.

You may also want to do exercises to strengthen the muscles under your growing breasts. Both of these exercises should be done sitting up straight. For the first, grasp both wrists with the opposite hands and push hard towards the elbows. Hold three counts. Relax. Repeat four times. For the second, place both palms at temples, fingers pointing upwards. Push palms against head while slowly raising elbows as high as possible. Repeat four times. These can be done after the baby is born too.

Not only these specific exercises, but exercise in general is important throughout pregnancy. The better physical shape you are in, the easier it will be for you to cope with the physical demands of labor. That doesn't mean you should start to do physically heavy work if you've never done it before. It's more that you should keep working and living as you had before. Dancing and sex included! (See section in Brecher summary of Masters and Johnson for sex during pregnancy.) For psychological reasons as well it's important that you remain active and not let the pregnancy dominate your life for nine months. Certainly think and talk about fears and feelings, about changes in your body, your head and your life. They are all real and legitimate and essential to talk out with women, with your man. But keep thinking about yourself and who you are/want to be in addition

to the reality of being a pregnant woman. You neither begin nor end with that baby; you are a person apart from the child and need continually to think on that – for your sake and for the child's.

Be as sensible about resting as about exercising. Rest when you need to. It's most important during the last month so you will be ready for the hard work of labor. It's also hardest then; you feel most heavy and it's difficult to find a comfortable position. Relaxation exercises, which I'll get to in a moment, can help.

To make the transition from those exercises which get our bodies in good shape before labor to those breathing exercises we need to learn to manage our labor, we need to talk about the functions of oxygen and of neuromuscular control.

"Before doing exercises, we must know how to do them properly. Whenever we make our body do any work that is more than the usual amount - and this is what exercise really means - the muscles use more body fuel, stored from our food. To do this efficiently, they need more **oxygen**. Oxygen is a gas present in the air, more so in fresh than in stale air, so always do your exercises in a room with an open window. The amount of oxygen we take in by ordinary automatic breathing is not quite sufficient for doing extra work, and under such circumstances we feel our body demanding more. Think back to the last time you ran after a bus. You will recall that when you reached it and collapsed into the nearest seat you were probably puffing a bit – the body's way of saying, 'More oxygen, and faster please.'

"This is not the best way of doing it. It is far better to recognize the need in advance and provide the extra oxygen by adapting one's breathing to the work the body is doing. We do this by using **consciously controlled breathing**.

"During [childbirth] the group of muscles called the uterus works very hard over several hours to deliver the baby from the mother's body into the outside world . . . The muscles are working far more than usual. And **as we cannot tell the uterus to rest when we choose to, we must prepare for constant work**. This is why it is important for all other physical activity to be reduced as much as possible. If other muscles go into action when the uterus does, they are wasting energy and oxygen that should be in reserve for the uterus. Then the body will tire quickly and prevent the uterus from functioning as efficiently as it should."[4]

We must learn certain skills so we can help the uterus work hard and constantly during labor with minimum diversion of energy to other muscles. If you have the image that you will lie and passively relax during labor you are wrong. Rather you will be very active, you will be working very hard; but **with** your uterus, not against it! Now how do we do that? First we learn how to breath in a conscious and controlled way. Today you may be unaware that you are breathing. During labor you will be aware of each and every breath. In a similar way you may be unaware when you move muscles to lift an arm or extend a leg today; but during labor you must become aware that each contraction of a muscle other than that of the uterus may be a waste of energy which must be conserved for the constant work of the uterus. In other words, you want to use other muscles efficiently, as you want to breath appropriately and efficiently.

Since we have learned to use muscles not singularly, but in combination with one another (we use many more muscles than those in our legs to walk, for instance), we have to learn to dissociate the muscles from one another if we are going to be able to allow the activity of the uterus to be as unhampered as possible.

"When any muscles work, they do so because of a message sent by your brain and prompted by your will. The brain sends the message to the muscles concerned via the nerves; this is called **neuromuscular skill**. The simple ability to reach out and grab something, which you acquire at about five months, is a complex neuromuscular skill.

"There is no harm in the fact that these skills become mechanical. It is perfectly all right for ordinary purposes. But it does mean the brain acquires habits in the way it works. . . We therefore have muscles with a strong habit of working together, regardless of whether or not they are needed for a particular activity.

"But in labor the situation is very different. In labor you have one group of muscles contracting as it wants to, to a particular pattern of its own. And when these muscles begin to contract strongly, then other muscles, quite unconnected with this function, do so too: the muscles of the arms, legs, back, and even face, all try to join in. And this is the typical picture painted so luridly by Victorian fiction writers when they described women in childbirth. 'A terrible groan escaped from her pale lips. Then her hands clutched the bedpost as her whole body was contorted by unendurable agony.' – something like that. But all they are **really** describing is neuromuscular association. Even so, it is rather an uncomfortable endeavor because it consumes so much energy and oxygen. And it's hardly a picture of relaxation, is it?

"Instead we will teach your brain a new neuromuscular skill – the skill of deliberately keeping

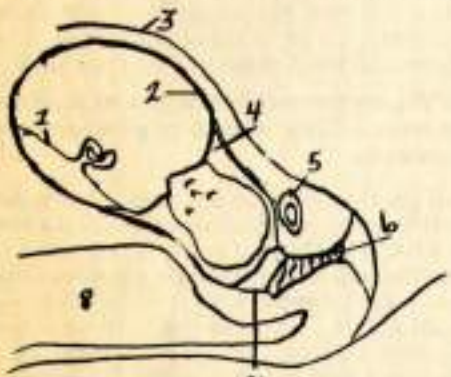
apart muscular activity. This is called **neuromuscular disassociation.**"[5]

LABOR AND DELIVERY

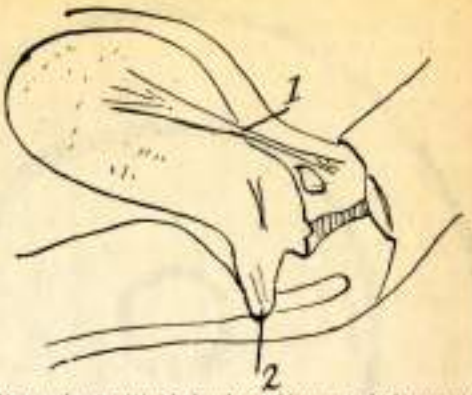
When I talk about labor and delivery, I am assuming a normal, uncomplicated one. It's all important to remember your experience will be similar but also unique.

You've gone through a lot from the time you decided to have a baby until now. You are well prepared, both physically and emotionally, and pretty psyched up to have the kid. And then you freak as the prospect of labor gets more real as you get closer to your "due date". You begin to feel scared and lose the confidence that has been building up over the months; you'll never be able to manage. You must have been crazy to want a kid in the first place; you worry about loss of your own independence, the dependence of another person on you. . . And will you be able to tell a true labor contraction from a false one? And what does a contraction feel like anyway??

A contraction during labor feels something like menstrual cramps. You may feel it in the lower abdomen, groin, back depending on your own body construction and on the baby's position. Unlike uterine cramping during menstruation, uterine contractions during labor are not a constant level sensation, but a sensation that rises to a peak and then falls. As seen in the sketch at the top of the page, the uterus is composed of opposing sets of muscles. "The opposing sets of muscles interlace down its upper two-thirds and more circularly around the bottom third. In pregnancy, the lower set keeps the baby from falling out, but during labor they must relax progressively against the pull



Full term baby before labor begins; mother on her back with head out of picture, left. (1) placenta and cord. (2) uterus. (3) mother's navel. (4) bag of waters (amniotic fluid) surrounding baby. (5) pubic bone. (6) birth canal. (7) cervix, thick and closed with mucus plug. *(8) bony structure of spine, tailbone, and back of pelvis.*



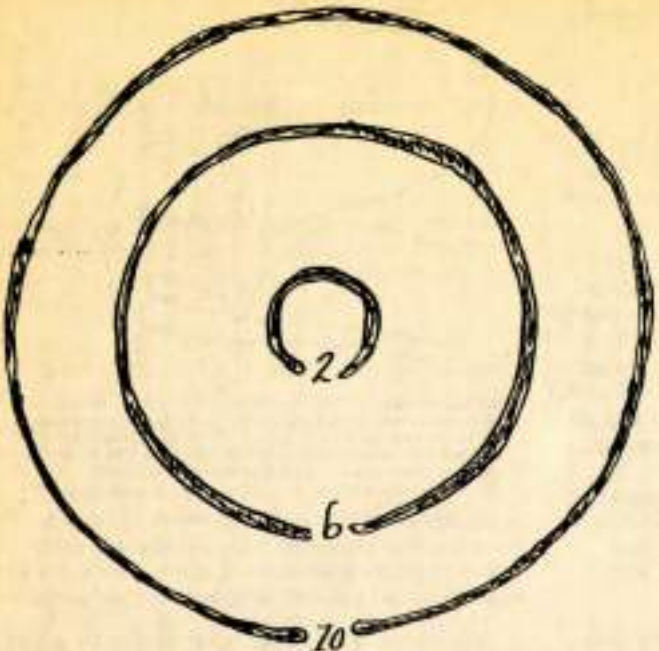
Uterus, showing (1) right-hand round ligament which moves it at the vulva and (2) right hand uterosacral ligament which attaches it to the back of the pelvis. There are also left round and left uterosacral ligaments on the far side not shown in the picture. (from Lester Hazell, Commonsense Childbirth, *p. 83)*

of the upper ones to allow the cervix to open up."[6] So as you feel a contraction beginning you may sort out a pushing sensation at the highest point of your bulge and a pulling sensation in your groin.

"During the three weeks or so prior to the onset of labor, certain changes take place which are useful for determining the approach of labor. These are (1) lightening (engagement of the baby's head); (2) frequency of urination; (3) beginning effacement (thinning) of the cervix; and (4) false labor.

"Lightening is the lowering of the uterus which takes place in first-time mothers (primiparae) several weeks before their due dates. This locks the baby's head down tight in the pelvis so that he can't do much gross moving around. Because the top of the uterus no longer crowds the lungs, breathing is easier, the heart and stomach function more smoothly, and the relief of pressure is the reason for calling this process lightening; though she doesn't look it, the woman feels lighter. In women who have had more than one baby (multiparae), the lightening often does not occur until early in labor itself, perhaps because the abdominal muscles may not be as firm, and the uterus tends to bulge out rather than being pushed down by them. After lightening has occurred, walking becomes more difficult from increased pressure on the hip joints. Frequency of urination may be due to the pressure of the baby's head on the bladder, limiting its capacity and requiring it to be emptied more often.

"Beginning effacement of the cervix and false labor should be discussed together because they will blend from precursors of labor into labor itself. Although there may have been false labor (Braxton Hicks contractions) since the beginning of pregnancy, it may make itself felt more and more in the last weeks before birth. False labor contractions are erratic and irregular; the uterus contracts and



Cervical dilation in centimeters, shown actual size: 2 centimeters in very early labor; 6 centimeters at beginning of transition; and 10 centimeters full dilation at end of first stage. (from Harell, op. cit., p. 274)

relaxes, whereas in true labor it contracts and **retracts**. (By retract we mean that each muscle fiber instead of contracting and relaxing, as is true of most other forms of exercise, contracts and then remains in a shortened state while it rests, thus pushing the baby farther down within the abdominal cavity and closer to [her] birth.) Early effacement of the cervix is probably the result of some of these false labor contractions which do more and more retracting as the due date approaches. . ."[7]

I want to mention the three stages of labor and include pictures before I go on to woman in actual labor. **Stage one** (which is further divided into **three parts**) is concerned with completing the **effacement** (thinning out of cervix or neck of uterus, measured in percentage from 0% to 100%) and **dilation** (opening of cervix measured in centimeters or fingers from 0 cm to 10 cm or 1 finger to 5 fingers; 1 finger equals 2 centimeters) of the cervix so it is wide enough for the baby's head to move into the birth canal. It begins with the onset of regular contractions and ends with the **crowning** of the baby's head (whole of top of baby's head is visible when lips of vagina are opened). Average time is 12 hours. **Stage two** begins with crowning and ends with delivery of the baby through the birth canal and out of the mother's body. Average time from one-half to two hours. **Stage three** is the separation and delivery of the placenta and attached membranes. Average time is from a few minutes to half an hour.

So when are you going to be in true labor? Enough with the preliminaries, you say! There are three signs that the first stage is beginning: (1) bloody show is visible; (2) premature rupture of membranes (from trickle to one cup); and (3) regular uterine contractions. The show is blood-tinged mucous (pinkish, thick vaginal discharge rather than bloody red) that has up until now been a plug in the cervix (like a cork on a bottle) which has served to protect the growing baby from germs that might enter through the vagina. The "cork" falling out shows that the cervix is beginning to open up.

For most women the bag of waters doesn't break until the beginning of the second stage of labor, though it can break before or any time during the first stage. The membranes can also be ruptured by piercing them with a needle (doesn't hurt; sensation like a balloon filled with water bursting). "The intact bag of water has an important function in labor that makes a superb dilator of the cervix by maintaining equal pressure according to the laws of hydrodynamics. If you apply force upon an enclosed liquid, this force will be transmitted equally everywhere throughout the liquid. In the case of the bag of water the part of it known as the forewaters protrudes down through the dilating cervix. As the uterus contracts, the total force of the contraction is transmitted right into that little finger of forewaters, causing it to spread and act as an opening wedge through the cervix. Hence the intact bag of waters makes a better dilator than the contours of the baby's head. . .

"The membranes often rupture when enough of the cervix is dilated so it no longer supports the membranes."[8]

If your bag of waters is leaking or has broken, call the doctor immediately and get to the hospital or settle in one place at home. The reason is that once the waters are gone, there is a chance that the cord can get wrapped around the baby's head, especially if the head is still high up in the uterus, but more important, there is a real possibility that the baby's head will press against the cord and cut off his own blood supply. If the contractions of your uterus stay regular, get longer, stronger and closer together, you know you are in true labor. If you have questions about whether you're really in labor or not, change position or activity. For

I Before Labor Begins
This baby has reached full term and is awaiting the start of childbirth

II Early Labor
The pressure of the baby's head has thinned the cervix of the uterus but has not yet started to dilate it.

III The cervix is fully dilated and the head is at the entrance to the birth canal. The amniotic sac is still unbroken here in some cases, it has already broken.

IV The Baby's Head Begins to Show

V The "Crowning". This is the point at which the crown of the head is fully visible outside the mother's body. On the next contraction the baby's head should slide out as far as the chin.

VI Turning. As the head emerges, it turns sideways, making the emergence of the shoulders and the rest of the body easier.

VII Third Stage of Labor
The baby is born. In the next 10-15 minutes the uterus starts to contract, expelling the placenta. With the expulsion of the placenta, labor is over.

VIII Pelvis After Delivery
The various organs in the pelvis now begin to go back to their pre-pregnancy size, shape, & position. After birth the uterus is now as hard as a rock.

example, if you are lying down, get up and walk around; if you're standing, sit down; or take a shower. I was told that when contractions were five minutes apart with my first baby (ten with my second – time depends on distance from the hospital and what's happening inside your particular body), I was to leave for the hospital. In the reading I've done since then, I discovered it wasn't the time intervals between contractions that were important, but the length and strength of the contractions, for they, rather than the time between, indicate how well your uterus is working (which made me think that doctors don't tell us that possibly because they don't think we can understand/judge that but assume we can tell time!).

Anyway, you're in labor and off to the hospital!

In addition to your suitcase with stuff for the hospital stay, take the following for labor (don't laugh; I'll explain uses as I go along): stop watch or watch; lollypops; small brown paper bag; tennis balls; powder or cornstarch; hot tea with sugar in thermos; playing cards; books; favorite pictures; posters; camera; tape recorder; candy bars; sandwiches (for your man, coach – they can eat while you labor even though you can't); and anything else that will make you happy in the foreign environment of the hospital.

To eat or not to eat. . . I'll present both viewpoints and you choose. You'll have to take into account when you last ate and when you expect to deliver. Not to eat: If you've just finished a big meal, too much oxygen will have to go to the digestive muscles and less to the uterus, which needs all the oxygen for contractions. You can take lollypops and sips of tea between contractions to give you quick energy. Some doctors say no to even that but I don't know any good reason why not. Even if you do feel nauseous during transition (end of first stage of labor), these foods won't remain in your system that long. To eat: "You must stock up on food before the digestive processes are cut down. Otherwise you will go into labor, the available sugar in your blood will exhaust itself, and you will get very tired, needlessly. In fact you will be starving. But you won't feel hungry, simply weak. So this meal is therapeutic."

As your contractions are about to begin, you want to think about the shape of them – there is a beginning, a middle and an end. They gradually rise to a peak and then descend. It's fascinating to observe the rise and fall of your own contractions, to see the pattern of your body emerge. Also, it keeps your mind active and prepared to respond with appropriate breathing techniques which also have a beginning, a middle and an end. Otherwise, you might be laboring all the time and not relaxing at all. The ability to relax becomes more important as labor gets harder.

The first regular contractions you may have are about **30 seconds** long and 15 minutes apart. These feel like premenstrual cramping only at regular intervals. Usually they are not uncomfortable and don't interfere with whatever you are doing at the time (these gentle contractions are sometimes called effacement contractions since that is their function). By the time the contractions are **45 seconds** long and five minutes apart, you'll probably need to begin breathing consciously (you may have started sooner). What you need is a gentle and relaxed kind of breathing, thus you do **Candle Blowing** (see Appendix, Chart A for instructions). (Also, this kind of breathing because it is so relaxing is helpful in getting to sleep during the last month of pregnancy and also may be useful toward the end of the first stage of labor if the more active breathing tires you out. With all kinds of breathing you can switch back and forth; the only guideline is **your comfort**.)

Three centimeters is an important guidepost: you are about one-third of the way through labor and also your contractions are at their strongest. They will get longer and closer together, but not stronger. This is very encouraging because you are totally on top of the situation at that point and it makes you feel that you really might be able to manage your labor! (I can't document this. The nurse who taught the Lamaze class I went to before the birth of my first child told us this. I can't remember if during either of my two labors I felt this to be true since the contractions of 9 centimeters are clearer in my memory than those of three centimeters. I do remember that it was a morale booster, especially at first birth. Whether you take it as fact or fancy, it's a good thing to remember.) At this point, when you're feeling very confident, I want to stress the importance of taking one contraction at a time – repeat – one contraction at a time. Just think about what you need to do for the one contraction that is upon you, not how many more there will be. I stress this because if you have a difficult contraction and start feeling tense and out of control, you tend to think about the endless numbers of contractions to come (they are finite) and assume that they will be as bad or worse than the one you just went through. Remember you got through it. A success! One at a time. **Count each success**, don't anticipate failure.

If you are not already in the hospital, you have called your doctor and are on your way by 3 centimeters dilation. You can lie down in the car if you're more comfortable that way. At the hospital,

if they are sure you're in labor you will probably be taken to a labor room; if they are not sure, to an examination room. If you are sure and they are not sure (nurse says, "you are so young, how could you know you're in labor"; or, grabbing you by the arm, says, "listen, girl, you think having a baby is fun; well, it's the worst pain you'll have known!" –help like this we can do without!), you and your man/coach can make demands to be taken directly to the labor room. You may still have to deal with a bitchy nurse or an inhuman resident who makes you feel dumb and worthless. It's lousy, but remember it's their problem, not yours. Insist long and hard enough. Don't forget you are paying a lot of money, whether you are a clinic or a private patient.

A note about hospital labor rooms: your social class is revealed by whether you're assigned to a private labor room or not. White, middle class patients go to private rooms, black, poor patients to ward rooms. For example, Boston Hospital for Women, Lying-In Division (BLI) will only give private labor rooms to private patients. Even if there are free single labor rooms, clinic patients go to the wards. When I questioned this policy, the woman who was taking us on the hospital tour told me "you get what you pay for". Other hospitals which have only a few private labor rooms follow the same class based policy only it's described in different terms. At Mt. Auburn Hospital in Cambridge, Lamaze patients get the private rooms, because they are too "noisy" and disturb the other women (a friend was told this by her doctor who is head of obstetrics there). I wanted to be alone with my husband when I had my two children. I can see a time, though, when all women have preparation for childbirth, that we might want to be together with our sisters during labor. But then group labor rooms would be our wishes and not hospital rules.

When you get to the labor room, you are what they call "preped" – you're put in a hospital gown and have your pubic hair shaved. There is a real question about the necessity of this shaving procedure; there are so many antiseptic solutions poured, wiped, etc. over your pubic area that it certainly is not for the sake of cleanliness. Rather, it's custom that most doctors subscribe to. Of course, they're men and don't have to deal with itchiness as pubic hair grows back. If you can avoid being shaved, you should. "The only valid reason for removing the hair that I can see is that it might becloud the doctor's view of the perineum in case he needs to make an incision. No hair grows where the incision should be. Some doctors have solved the problem by having the hair clipped with scissors right around the outlet of the birth canal. While this may be unnecessary, still it avoids the problem of shaving, not the least of which is itching and soreness as the hair grows back."[10] If you are shaved, you can ask the nurse to stop during contractions if the shaving bothers you. Remember about making demands. Think positive, assume success.

Next you will probably get a vaginal exam (maybe rectal too since the rectum is close to the cervix and therefore you can feel the amount of dilation from that point too – refer to pictures of anatomy earlier in this chapter) by a resident. (Doctor may not appear until middle to end of first stage of labor.) Ask any questions you have of anyone. You have to let people know you are a human being and not a piece of meat. The resident or nurse may listen to fetal heart tones (you can ask to hear it too) and check vital signs – temperature, blood pressure, pulse.

Another preparation is the enema. A bag's worth of soapy water is put into your rectum and within minutes you start eliminating everything – water and fecal matter. "As for the enema, it is supposed to insure that no fecal matter will be expelled with the second-stage contractions and contaminate the doctor's sterile field. But does this work? Sometimes, but so frequently does the last of the enema arrive along with the pushing of second stage that a friend of mine who is an obstetrical nurse remarks, 'I don't really believe the baby is coming until I smell feces.' [Does the American idea that childbirth is dirty come from this?]

"The other theoretical purpose of the enema is to make sure that there is no hard fecal matter in the rectum which would compress the adjacent birth canal, making the passage smaller for the baby. Left to her own devices, nature usually takes care of this. The same hormones that start up the contractions of the uterus in early labor often cause the intestines. Many women have a sort of painless diarrhea that persists until first stage is well advanced and the intestines are clear. The laxative action of labor may be lost, however, in the inhibiting atmosphere of the hospital. I have never seen a home delivery that was contaminated by involuntary bowel movements; many hospital labors are."[11]

If you can get to the toilet, it's more comfortable there than on a bedpan. Again, ask to wait until your contraction is over. You will have to do breathing for contractions while you are on the toilet. Contractions will get stronger right after the enema (because of it) and may persist at the strength for several contractions. The enema as well as the breakage of the bag of waters will speed up several contractions. Expect it; don't settle back into a pattern or rhythm which you will be

able to anticipate. But by this point you are ready for another kind of breathing. It is a **slow, shallow panting** where you close the pant by saying either **hut** or **out** (whichever you prefer). You can also do just a regular shallow pant (only your chest should move and ever so slightly), but the closing off of the pant with a sound seems to give you an added crispness and something more on which to concentrate. (See Appendix, Chart B for instructions.)

You know to start this kind of breathing because the candle blowing is no longer working, i.e. it no longer is enough to keep you comfortable. You feel a stronger pulling sensation at this point, pressure and tension building up during a contraction. You are dilated about 4-5 centimeters (2 to 2½ fingers); contractions are lasting about **one minute** and are four minutes apart. You may still be able to read, sing, play cards, talk to people around you if that is relaxing to you between contractions. Medical people need to check dilation, vital signs, fetal heart tones, but if they are just standing around and bothersome ask them to leave. You are having the baby and have the right to shape the kind of experience you have. If someone is annoying you and you lose control in the middle of a contraction, do the following: (1) relax, (2) pant rapidly (let your man/coach know and they should know how to command you to relax and should pant with you), (3) use rest time to relax completely. This is something you can do at any time during your labor. Remember, if you feel tired try candle blowing for a contraction or two. If you feel sleepy, change positions; if you've been lying down, sit up (prop pillows under legs and behind your back to make you comfortable). You need to be alert at all times. Whatever position - whether sitting, on your knees as for pelvic rock exercise, lying - is comfortable for you is the one you should use; disregard comments of nurse, etc. Sometimes a change in position is very helpful. Your coach might suggest it from time to time since you are so busy with breathing and relaxing. Coach should also be aware, because of what you're going through, that you may resent the suggestion (that resentment is normal too). Again, it's you that is having the baby. The Lamaze chart at the end lists feelings for this part of labor under mid-phase, first stage. Some comments on what you can do: if you start feeling tired, suck a lollypop; if you are thirsty - panting does that to you - ask for ice chips to suck or take little sips of water, not big gulps (you will still feel like taking big gulps). Sucking a cold, wet washcloth is also very satisfying.

This **mid-phase** (from 3 or 4 centimeters to 7 or 9 centimeters) can be a low point of labor. You've gotten over the initial excitement of realizing that you are really in labor and are really going to have a baby; you've been able to handle each contraction easily; you've gotten into a pattern. Then the pattern changes. Maybe the bag of waters breaks or is punctured by the doctor and the contractions are longer and closer together (remember they don't get stronger) and you have to concentrate harder. In addition, after working very hard for an hour, two hours or more, the doctor comes and examines you and says you haven't dilated any more. Discouragement sets in, you feel restless and your back begins to hurt since the baby's head has changed position and is pushing against the sacral vertebrae. Erna Wright lists several rules for handling backache labor: (1) all pressure must be taken off the back; (2) the uterus must be tipped forward during contractions; (3) the uterus must be supported during contractions; (4) back massage of back effleurage can be applied during contractions; (5) position should be changed every half hour to keep up the morale; and (6) between contractions a cold compress over the sacrum is a wonderful boon.[12] Don't let yourself be weepy. Remember you've managed each and every contraction so far and here comes another. You take a deep cleansing breath, let it out and start shallow panting in rhythm with your contraction. After the contraction is over is the time for some changes. Change your position and adjust your pillows. Have a lollypop and some water. While you are relaxing let your man/coach give you a gentle back rub which can be continued with greater force during the next contraction. While someone else is putting pressure on your back, you can give yourself an **effleurage**, the light caressing stroking of your abdomen, a very pleasant sensation after the hard work of the uterus (the powder of cornstarch is used when your abdomen gets hot and sweaty). The effleurage can be a circular motion with the fingertips of one or both hands which is slow and gentle; it can be a fairly rapid and heavier back and forth motion with the fingertips or with one hand; you can do it or someone else can do it if you are busy concentrating on your breathing (at one point during my second labor, I was breathing, my husband was putting pressure on my thighs and my monatrice was giving me an effleurage fast, furiously, but lightly). If the back or leg pressure is getting you down after a few contractions (even with all the changes), you can ask for an **analgesic**, a mild medication which relaxes your muscles. Doctors tend to have favorites. You should talk with him during your pregnancy about what kinds he uses and why; you should get the names because you may know that one of the several he uses really makes you dopey and you can request another (remember you want to relax, not go to sleep; you have to keep on top of your contractions, not be driven under by them).

"There are several categories of drugs used in labor. First are the tranquilizers, which have the well-known effect plus that of increasing the effects of other drugs given with them. I feel that tranquilizers have their greatest use in the hospital **after** the baby is born to ease the impact of a strange environment upon a mother who needs rest, and that they are still too new to be evaluated for side effects they may have while the baby is in utero.

"Next there are the sleep-producing drugs, of which seconal and nembutal are the classic examples. These have the effect of reducing the amount of oxygen available to the baby and are rarely used any more during labor if the baby is expected to be born during the time when the drug is having its effect and could interfere with the beginning of breathing. . .

"Next come the analgesics, the pain killers. Demerol is the one most often used in labor. It is like morphine in many ways and can also have a depressant effect on the baby's respiratory center if it is given within a few hours before the baby's birth. You can never be sure how soon the baby will be born. As with other drugs, different women respond in different ways to Demerol. A common side effect is vomiting and some women find that it is not particularly helpful for relieving discomfort. Doctors who regularly conduct minimum drug labors have found that if Demerol is going to be effective, the smallest dose, recommended by drug companies, 50 milligrams intramuscularly, will usually work just as well as the higher dosages with probably less risk to the baby. (It is an interesting aside that an 8-pound baby needing Demerol **after** he/she is born would be given 5 milligrams.)

"Probably the safest analgesic if used correctly is Trilene. This is a volatile liquid that is placed in a special inhaler. The mother holds the inhaler herself and breathes in the vapors as she needs to. If she gets enough of the vapor to make her drowsy her hand falls away, and she will soon have her head clear from breathing fresh air. Trilene used in this manner is an analgesic rather than a general anesthetic. The only problem comes in the mother's learning to time her breathing of the Trilene so that its maximum effect coincides with the height of the contraction. In most women it takes about thirty seconds for the Trilene to take effect. Therefore in order for it to work, they must labor breathe the Trilene from the first inkling of the contraction's coming. Trilene has the definite advantage to the baby that its effects are apparently not residual as they are with any substance that is injected into the mother."[13]

You are working hard and long and your spirits are rising as you handle each new contraction. Doctor comes in and says he has to examine you during a contraction to find out most accurately the extent of the dilation. You pant for all you are worth, but it hurts. Doctor says you've made progress; you've gone from 3 or 4 to 7 or 8 centimeters. Wow, you feel great! But no time, a new contraction, and you have to start the more **rapid panting**, third kind of breathing (see Appendix, Chart C). You've moved very quickly into the third and final phase and hardest phase of the first stage of labor. It's called **transition**. It goes from 7 or 8 centimeters to 10 centimeters and complete dilation. Contractions are **60 seconds** (sometimes as much as 90 seconds) and 3 to 1½ minutes apart. Basically contractions are long and very close together. Be encouraged, baby is almost out! If the labor has been normal up to now and the baby's head is in the normal posterior position (head down, face toward backbone), it should last for only one hour and about 20 contractions if it is a first baby. If you can, try to remember time is short, the end is in sight. You'll have a hard time concentrating and need someone to be **very** directive and to do the panting with you. Because you are panting so fast, you may get **hyperventilated**. This means that you are taking in too much oxygen and not giving off enough carbon dioxide. As a result you may feel tingling in hands and feet and feel dizzy. Counteract this by breathing into the brown bag you've brought (or into your hands if you forgot the bag). At this point the doctor may become very concerned about fetal heart tones. If your oxygen-carbon dioxide balance is off, so will be the baby's. The doctor has to watch that the baby's breathing rate stays above a certain point; if it goes below that point, the doctor knows he has a definite time period in which the baby must be born and if he doesn't think the baby will naturally be born in that time span he'll have to speed up the delivery himself.

You may have to cope with feelings of nausea (remember you have nothing in your stomach to throw up). You may feel very hot (you don't have time for ice chips but a wet washcloth over your face is great and you can suck it too). You may feel irritable and then will need direction and encouragement, strong and clear, loud and repetitive. You are almost there! You may have to deal with the urge to push. You will feel this urge because of the position of the baby's head. The urge may be weak or so very strong that you're sure you're just about ready to shit the baby out! It feels like you have to have the biggest bowel movement you've ever had and you can't hold it in one second more. But you can't push because you are not completely dilated and will tear yourself and hurt baby's head if you do. So there are three breathing techniques you can use to control the urge to push until you're completely dilated and the doc-

tor gives you the signal:

Whoo-Ha. A rapid, shallow pant done saying the words Whoo-Ha and moving your head side to side (another thing to keep your mind active) at the same time. This can be used earlier in labor during difficult contractions or just for variety. With any of these techniques where words and motions are incorporated into the breathing, they should be done clearly and loudly. It takes lots of concentration and your mind off your uterus which is working for all it's worth at this point.

Pant–Pant–Blow. A couple of shallow rapid pants followed by a huge, loud blowing out of air. You can't blow out and push at the same time, which is true of the other techniques too. You need to pant as well as blow or you'll get hyperventilated (even practicing the technique when not in labor makes you feel a little dizzy).

Slump and rapid shallow panting technique accompanied by saying "one-two-one-two" as you slap your leg and expel air. Sound complicated? It does in fact take a lot of practice to do it on command, but you avoid the problem of hyperventilation if you can do it well. However, you can't use this technique if you are lying down (impossible to slump in that position) and have to use one of the others. Whoo-Ha will work if your urge to push is not too strong. But if it's strong you'll need to use the Pant-Pant-Blow and keep a brown bag handy in case of hyperventilation.

Now we can think about medication. Only now, when the baby's head is crowning and the hardest work of the uterus is done, can we be given **anesthesia** (as opposed to analgesia, tranquilizers). Why not until this point? Medication which deadens the nerves so you don't feel the contractions also slows down the uterus and until this point it's essential that the uterus be working at full force to get the baby's head into place to be delivered and to get the cervix dilated. Remember **you are not a failure** if you take medication. If you've handled each contraction up to this point **and** the baby's head is in a position so the delivery will be normal **and** you are not so tired that you can't go on (fatigue slows down labor), then don't worry about medication now and refuse the **caudal** that the doctor offers. The caudal must be started no later than 7 centimeters because it takes a while to work (don't expect immediate relief; the aim is to get it working best during delivery when you may or may not need it), in contrast to the **spinal** or **saddle block**, which is given later and takes effect immediately.

"Conduction anesthetics is a very popular category today. This consists of saddle blocks, caudals, epidurals and other local anesthetic agents injected somewhere into the back, depending on where the doctor wishes the anesthesia to extend. The caudal and saddle block are the most popular for obstetrics. In a caudal, a large-gauge needle is put up into the low back where the tailbone connects. Through the needle is run a catheter tube which remains in place throughout labor and through which the local anesthetic agent can be injected from time to time. Doctors who use this method usually start at about 4 centimeters dilation and keep injecting the agent as necessary to maintain numbness. The effect is to numb and paralyze everything from that level down. This is a tricky procedure from the standpoint of getting the anesthetic agent in the caudal canal where it belongs, and there are dangers which require a very experienced doctor to handle. For this reason caudal is not the choice of most doctors unless they work in a large well-equipped medical center. There is some dnager of inadvertently putting the needle into the baby's head, but more likely is a misplacing of some of the anesthetic agent with a subsequent drop in blood pressure to the mother and less oxygen to the baby. When the mother's blood pressure drops, so of course does the blood pressure in the placental bed. By far the worst disadvantage to caudal is that the bearing-down reflex is obliterated, and the baby usually must be tugged out by forceps on his head instead of pushed from behind by the gentle force of the contractions.

"Saddle block is a low spinal anesthetic which is a one shot affair. It gets the name from the fact that it blocks the area of the mother that would touch a saddle if she were riding a horse. The effects last about an hour and a half, and it has the blood pressure and forceps disadvantages of the caudal. In addition, about 20% of mothers receiving a saddle block have a spinal headache afterward for days that is far worse than the pain of labor it was supposed to obliterate. Since there are more local, less dangerous ways of blocking nerves, and since the saddle block is given after transition, which is the hardest part of labor, it seems to me to be the poor choice of too much too late.

"Local anesthetics, pudental blocks, and paracervical infiltrations are injections made from below directly into the nerves of the perineum or around the birth canal or the cervix. They don't carry the general risks of caudals and spinals, nor do they stop a mother from bearing down. The main reason locals and pudentals are given is to numb the perineum when an episiotomy will be made and must be repaired. However, the descending head of the baby creates its own anesthesia of the perineum, which lasts about ten or fifteen minutes after the baby is born. I can testify from personal experience and observation that when an

episiotomy is made at a time when the perineum is bulging and the baby's head is clearly visible, there is no pain from it. The sensation is rather like having the sleeve of your coat cut: you are aware that someone is using scissors near you, but there is no pain. However, the episiotomy must be repaired right away or this natural anesthesia wears off. If the doctor is by himself and must see to the baby immediately, often he cannot put the stitches in before the numbness is gone. If he has a helper, he can do the necessary needlework before the placenta comes out and can leave threads loose to allow him extra room to deliver the placenta.

"Paracervical infiltration can be done repeatedly (it wears off in about an hour and a half) from about 3 or 4 centimeters of dilation. It numbs the area around the cervix and is a help in relieving backache. However, in a certain number of cases it causes the babies' heart rates to slow temporarily. Although these babies seem all right at birth, the possible long-term effects have not been evaluated.

"Another class of drugs. . . is the type used to stimulate the uterus to contract. These drugs are called oxytocics. Posterior pituitary extract (Pitocin) is a common one, and it is sometimes used in induced labors to start the contractions as well as in slow labors to speed things along. It is usually given along with intravenous fluids in an arm vein. It can be lifesaving but must be used with care. Because of the unpredictability of the amounts of labor hormones secreted by the mother, Pitocin carries the danger of a possible violent labor with ruptured uterus, or oxygen deprivation in the baby from having the uterus contracted long enough and hard enough to cut placental circulation. As a hangover from the days when mothers were so drugged that their uteri were completely flaccid after birth, a similar drug is given routinely on the delivery table after the baby is born. Sometimes with an awake mother who is producing her own abundant supply of posterior pituitary hormones, this causes the placenta to be trapped, which is an annoyance requiring either patience until the effects of the drug wear off or a strong sedative or general anesthetic to relax the uterus. Oxytocics also duplicate the natural hormones which are secreted and contract the uterus as soon as the baby is put to the breast. The result usually is painful uterine cramps. Also for the purpose of contracting the uterus, Ergotrate, another oxytocic, is often given in pill form for a day or so after the baby is born. I suspect this is necessary for women who don't breast-feed, but for those who do, it may give rise to painful "after pains'."[14]

You want to take as little anesthesia as necessary. Remember, it's given according to your body weight, which is a large dose for the average 7-pound baby. Unless there are problems involving the life of your baby, I see no good reason for a general anesthesia which knocks you out completely (and even in the case of deformity or death it may be more difficult to deal with the pain involved if we're put out and awake to discover the horror). In any case, we should be involved in the decision about whether or not we get general anesthesia.

After that low note let's go on to a high one. It's absolutely fantastic to watch your baby be born and important in your feelings about yourself and your baby in the hours and days that follow the birth. So on to delivery!

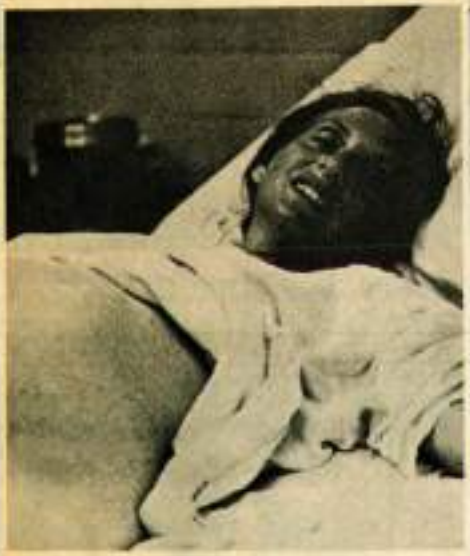
The **second stage of labor** is the delivery. You have been wheeled from the labor room (where you've been for approximately 12 hours if it's been a typical first delivery, shorter time for subsequent deliveries). You are moved to a new table (it's uncomfortable in the middle of a contraction, so ask nurse, etc., to wait). Your legs are put in stirrups; they are like the ones on the examining tables in the doctor's office though wider apart. (There is question whether stirrups are necessary - home deliveries are done without them - or for the doctor's convenience. There is a special chair designed for childbirth that supports our bodies in a sitting, slightly reclined position which certainly seems a more "natural" position for birth (body is in line with the forces of gravity and thus facilitates the delivery) than lying down on a bed. Of course, these chairs are not in use in American hospitals, as I know!) Then they may try to strap your hands down. **Don't let them** – they have no right and you need to use your hands for pushing. Someone (the anesthetist) may try to give you a spinal. Be sure there is a reason for it. In some hospitals it's so routine they don't stop to ask the doctor, let alone you (this happened to me last year at Cambridge City Hospital). (Like the doctor, the anesthetist is concerned about getting his money for his time and he may be required to be on duty whether or not his skills are needed.) Next you'll have sterile solutions poured all over your crotch and your legs and body draped with sterile cloths. If you're lucky, there will be a mirror so you can see what it looks like from below as your baby is born. Mirror or not, be sure your man/coach supports you under your shoulders so you can get as close to the action and see as much as possible. If your membranes haven't ruptured naturally or been broken by the doctor, he will do it now. It's been a long day of probably the most concentrated physical exertion for you, but you're almost at the end; the prize is almost in view!

Lamaze and his followers have falsely given women "the idea of birth as an athletic achievement. . . Under this system the obstetrician may keep up a running commentary on the progress of a woman's labor and although some women like this constant encouragement, some are distressed by the continual flow of words, the reiterated 'Alors! Madame, attention! Poussez! Poussez . . . Poussez . . . Poussez . . . Encore. Encore! Continuez! Continuez! Tres bien. Tres bien. Reposez-vous. Respirez bien.' etc. . . .The better the coordination of uterine contractions, voluntary muscular activity and breathing rhythm, the less effort is required from the woman and a relaxed and natural second stage results."[15]

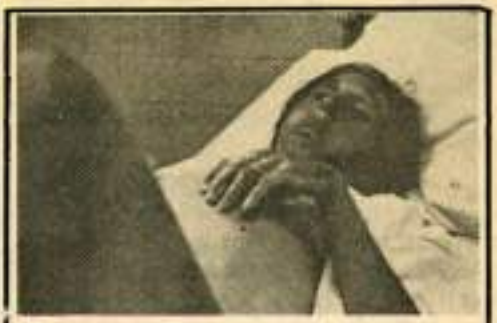
Contractions are **one minute** long, 4-5 minutes apart, and of decreasing intensity after transition. This part usually takes about an hour. Now if you get the urge to push, you can push (you may have been pushing in the labor room or on the way to the delivery room). It feels great, you feel exhilerated! It's also a hard time since very probably you're tired and you may feel uncomfortable as the baby's head is pushing on the perineum, causing a burning sensation. Keep your perineum relaxed by pushing it out and the burning will be less. The tiredness and burning continue but in contrast to what many male doctors think, this stage is not as painful as transition might have been. They may gauge pain by the effort you are exerting as you push and the redness of your face, but you may feel tremendous excitement at that time as you know that the baby's coming within minutes! A contraction is about to begin and the doctor signals you to push. You'll use the following technique: Take a cleansing breath and let it out. Then take a deep breath to fill your lungs as completely as you can with air and hold it. As you are taking the breath, get into position to push by putting your hands on the stirrups and by lifting your shoulders and tucking your head on your chest. (The exercises for the various muscles of your abdomen prepared you for this.) And now you push hard with all the muscles of the abdomen against your vagina (in contrast to against your rectum as for a bowel movement). When you run out of air, drop your head back quickly, take another breath and push again. You may need two or three new breaths or three pushes for each contraction. You only push during contractions. In between them you should rest. Probably after a few pushes the doctor will give you a local anesthesia (if you haven't had anesthesia already) into the perineal area (the perineum is the skin that stretches from anus to vagina which you have strengthened by exercise and learned to relax for labor and which you will learn to tighten after delivery so that internal organs won't fall out in later years). Next comes the **episiotomy**, or cut into the perineum. I question the need for an episiotomy for all women. They are now done routinely but should be done on an individual basis. Some babies need more room to get out (for instance those in breech position with bottom rather than head first), and then it makes sense for the doctor to make a cut than for the woman to be torn. If it's done so that the woman's pelvic floor doesn't get stretched excessively, that has to be weighed against how long it will take stitches to heal and problems in sexual intercourse from too tight stitching or from stitches not dissolving as they are supposed to. Remember the doctor is a man and has his own and other men's interest in mind more than that of woman. To illustrate with a comment from my doctor at my six week checkup after the birth of my last child: Full of male pride he tells me - while doing a pelvic exam - "I did a beautiful job sewing you up. You're tight like a virgin. Your husband should thank me." These same lines were repeated to other women friends who use the same chauvinistic doctor! We must share in making the decision about whether or not we get an episiotomy.

The doctor may need to use certain instruments at this time. "Instruments used in labor include forceps and the newer vacuum extractor. Basically forceps are tongs with two blades that can be separated. The doctor inserts each blade individually before joining them at the hinge and pulling the baby out. Forceps can be lifesaving to the mother and baby, but their use is often abused. While many of the babies who would have been delivered by dangerous 'high' forceps (used before the baby's head is engaged) are delivered by Cesarean section, it is still routine in many parts of the United States to give knock-out amounts of gas or paralyzing conduction anesthetics and deliver babies by 'low' forceps (when the head is visible during contractions). The newest tool, which is still being evaluated, is the vacuum extractor. It is a suction cup which is placed on the baby's head and pulls him out of the birth canal. The method seems to be less damaging to both mother and baby than forceps, but more experience is needed before the best use can be made of this tool."[16]

At delivery the baby needs to tuck her head onto her chest to decrease its diameter to get under mother's pubic bone. The doctor will then turn or rotate the baby internally to get her head through. Rotation usually takes place at the first contraction and pressure is then decreased on sacral vertebrae (this is the cause of low back pain). When the baby's head is coming out, **pant**, don't push; you don't want to hurt her head. Contractions are pushing the baby's head out with help of your pushing.



1 Mother in first stages of labor relaxes between contractions.



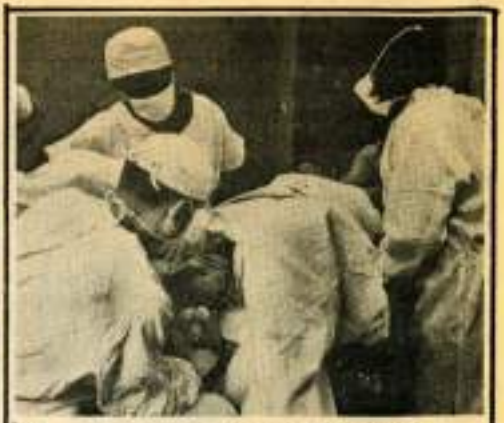
2 Transitional stage: She uses the transitional breathing and effleurage (abdominal massage).

3 Moved into the delivery room, she pushes with 2nd stage contractions.

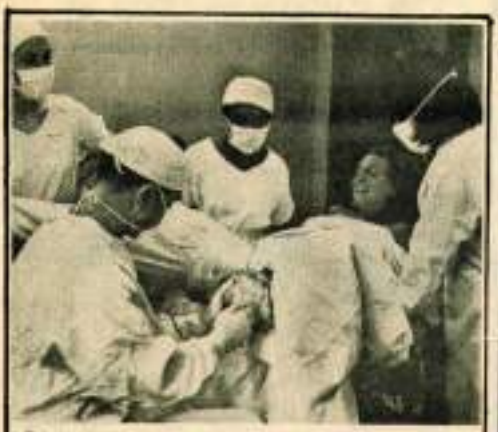
4 Hard labor

5 Infant's head is born.

6 Mother sits up to meet her child. Downward pressure applied to effect delivery of upper shoulder.



7 Upward pressure now applied to deliver lower shoulder.



9 Infant has begun to cry

8 With infant's head down to drain mucus from respiratory passages, umbilical cord is cut.

10 The cord has been cut, and mother meets her child.

11 Minutes after birth.

there is a rocking back and forth motion; a little more progress with each contraction and then your baby's head is born! (Each time I've typed this sentence I've remembered just how excited I felt when my daughter's head was born!) You can't believe it! The baby may begin to cry when only her head is visible and the rest of her body is still inside you. It feels amazing! She is bluish and purple; if she cries before completely born she will look fairly pink by the time her body is out. She is wet looking, her head is shaped or molded from the birth canal, openings full of mucous, very little blood. You may want very much to grab her and deliver her from your body yourself. But you'll be stopped; your hands are not sterile, and of course, it's the doctor's job, his achievement to deliver the baby (while in actuality you've done all the hard work). Lousy but true. I've seen marvelous pictures of women taking their own babies from their bodies (some books on bibliography include such "dirty" pictures), but it will never happen in American hospitals! Your baby will cry now if she hasn't already; rarely are babies spanked or need help in starting to breathe when the mother has not had medication (doctor himself or a machine can force oxygen into the baby's lungs if there are problems in getting the baby to breathe on her own and avoid danger or retardation which comes from a lack of oxygen to the baby's brain). "If the cord is long enough, the mother can hold and nurse [her] even before it is cut. As soon as the blood is emptied from the cord, the doctor will clamp it a few inches from the baby's navel and cut it. After several days the remnant of the cord will drop off, and the baby's navel will look like any other navel. Contrary to some misinformation, the contours of the baby's navel are determined by heredity and not by the doctor's skill in cutting the cord."[17]

The cord struck me as exceedingly strong and beautiful – translucent, blue and in the shape of a telephone cord but thicker. The doctor gave my baby to the nurse to suck out more mucous, wipe and wrap and only then did I get her. I was shaky, chilly, exhausted and happy. I wanted to hold and nurse my baby but had no energy left. So my husband held her close to me. I felt so close to him at that moment and also to the woman who was my monatrice. She had been great, especially during the pushes, and very supportive. I realized later it was very important for me to have a woman there who had been through the same experience as I. I only wish now it had been at home and with my other child and friends around. (See Lester Hazell and Shiela Kitzinger for details about home delivery.)

The placenta is delivered during the **third stage**. Watch for it. I was amazed at how it looked – beef hearts on one side and an intricate series of veins and arteries on the other. Part of the transparent bag was attached. It was so amazing because it was this placenta that kept my baby living in utero for nine months! Several contractions expel the placenta and it slides out; the doctor can push on your abdomen (ouch) and reach in and grab it. If he does, pant to keep comfortable. You can do pushes as you did to help the baby come out for the placenta. When the placenta is taken off the wall of the uterus, the circular muscles close off the blood vessels so massive internal bleeding does not occur. You may be given a drug (shot or drip into your arm) to keep the uterus contracted. Take pain relieving medication (like Darvon) for constant crampiness. Learn to feel if your uterus is hard; if it softens, massage it briskly. Better for you to do the massage than nurse.

After the placenta is out and examined, the doctor will sew you up. That was the only thing that hurt me. (It could have been less painful if he had put in the stitches loosely before the numbness of the area wore off and therefore before the placenta was taken out.) It was a sensation of pin pricks. It was bothersome because by that time I did not want anyone to touch my body. "You will notice that first of all you get a series of small injections around the area to be repaired. Those will numb the area, although they will not take all the sensation out. You should breathe [do what kind makes you comfortable] and decontract the pelvic floor. In fact the trick is to push the pelvic floor forward a little [as you did when the baby's head was born] so that there is no tendency to tighten the muscles. Keep the pelvic floor forward, and don't contract your stomach muscles. . ."[18] (By the way, the stitches don't have to be taken out. They will dissolve by themselves.)

In addition to the possible afterpains or crampiness you'll have a blood loss like a heavy menstrual period that will last for several weeks. It's called **lochia**. Lochia reminds me about sexual relations, because the most liberal of the "experts" say you should wait until lochia ends (discharge of lochia goes from bright red to brown to a yellowish discharge) to have intercourse. Doctors say wait until the six week checkup. Masters and Johnson say six weeks may not be necessary. I say let your mind and body decide for you – see how you feel emotionally and physically.

YOUR FEELINGS RIGHT AFTER CHILDBIRTH

You are wheeled from the delivery room into a room which is your room in the hospital. (You

may be with another, with one, two or many other women. The more privacy, the more you pay. The first time I really enjoyed being with another woman. It was her third child and she was very helpful to me. The second time, since I couldn't be with close friends, I wanted to be alone.) You'll be starved, tired, exhausted to the bone, but probably not ready to sleep (if you haven't been drugged, that is). You'll be happy with yourself and your man/coach, but also feel strange and not at home in the hospital. You'll want to share your excitement with family and friends, but you'll be limited to telephone. (If you don't have a telephone in your room then that is not even a choice right after birth.) You may feel some loss when you look down at your abdomen and also realize they have taken your baby - whom you have just barely seen - to the nursery for a minimum of 12 hours. You may feel sad about that and also guilty that you haven't felt some "gush" of motherhood. Don't feel guilty; it doesn't happen like that! It takes time for you and for the beautiful little creature that has just emerged from your body - amazing, you feel, as you recall what's just happened! - to get to know each other. You may also just want to be alone for a while. You may feel very scared, you may get depressed when you think of what responsibility for another person means. You may need to talk with your man, your coach or someone else. You may have other feelings that I haven't mentioned. Remember those feelings are yours and you have the right to feel whatever you do; don't let anyone tell you otherwise. You also have the right to make demands for your needs to be met. I'll make no promises about what response you'll get, but you never know until you've tried. If you are feeling miserable and being treated like a non-person, make demands to get out of the hospital as soon as you can. (They usually make you stay five days, but I have known women who have left the hospital as little as one day after the birth of their child.)

I'm thinking two sets of thoughts as I'm writing: (1) negative ones about the hospital and (2) positive ones about the experience of childbirth.

More and more I feel that if we want our babies to be born at home it should be possible for every woman – unless there are strong medical or personal reasons against it. We should know all the facts and be the ones that make the final decision. (What if our homes are crawling with rats and roaches and are not fit to live in, let alone give birth in? That means we must demand that every woman have a home where she can give birth and can then actually make the choice of home or hospital. That means our struggle for ourselves must be a struggle for all women (all people) which won't end until we have power over all aspects of our lives, until we take power from those who keep the system running for ourselves. It means a revolution, sister!)

At this time our demands should include: (1) availability of life supporting mobile units to all homes; (2) doctors deliver babies at home until (3) there are enough trained midwives to take the place of doctors. We women want to have our babies in safety and in comfort. And we will not be satisfied until this is a right of all women.

The experience of childbirth is an important one – and should be a positive one as well – for those of us who decide to have children. For some of us it is the first time in our lives we are in touch with all parts of our body. And when we are prepared, it is an experience which demands that our minds and bodies work together and therefore an experience that helps us break out of the mind-body separation that keeps women "in their place". Also the whole range of feelings of giving birth to another being - especially as you see with your own eyes that being emerge from your own body - is so very powerful (thrilling) and other women talk of feeling much more able to allow themselves to experience sexual pleasure (and to demand it once they have felt it) after going through the physical upheaval of labor and childbirth. "Nothing more massive could happen to my body," one women said to a group of women, "so I could let myself get into and enjoy sex more."

And you have a child, a child who will change your life and whose life you will help to shape. With the help of your man, your friends and good childcare arrangements (which you'll have to struggle to get; it seems to me that deciding to have a child today is also a decision to get into that struggle, a struggle of survival for women and for their children), the activity of raising a child, like that of giving birth, is rewarding, unalienated work!

I tried to write this paper so that other women who have not had children and not thought about childbirth could learn enough about childbirth preparation to teach it to others. However, everything can't be included in a paper of this length, nor could I, as one person, even think of all the information and feelings that are relevant. So I caution all who use the paper to talk to other women about their feelings and experiences and ideas and to refer to books on the booklist. Finally, there are several movies of actual births that might be helpful (refer to organizations mentioned on booklist).

Childbirth preparation for all!
Power to women!

APPENDIX

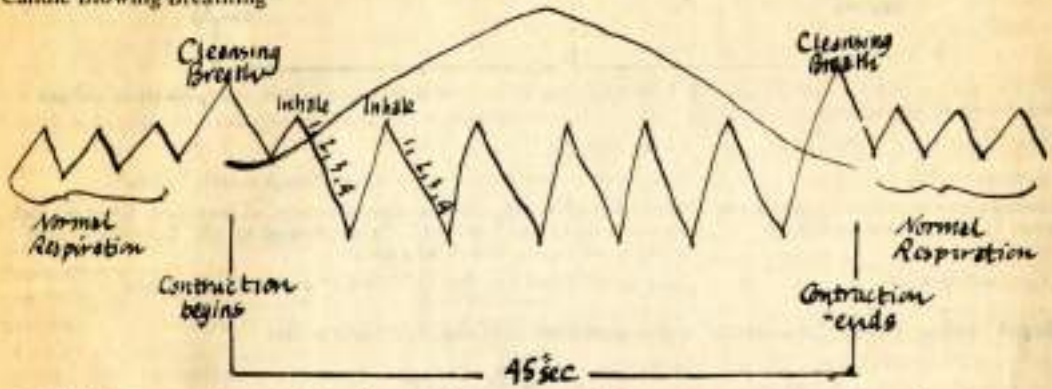
Breathing Techniques – Practice Outline

The instructions that follow are from two different Lamaze classes I took.

Practice for brief periods, frequently during the day. Make use of Braxton-Hicks contractions, for they will give you some sense of what early labor contractions feel like.

During practice, stop if you get dizzy. You do not need the extra oxygen now, as you will in labor. Also, don't get discouraged if it seems hard to master these breathing techniques at first; they are easier to do during actual labor than during practice sessions.

Candle Blowing Breathing



Candle blowing is used most in the early part of the first stage of labor (it may be used in the last months of pregnancy to help you relax and also later in labor for variety for a contraction or two). Use this technique as long as it keeps you comfortable. It usually stops being helpful about three centimeters dilation, but trust your own feelings and don't worry about numbers.

At the start of a contraction take a deep cleansing breath and let it out, making a sound like "whew" loudly and clearly and crisply. It's important that you be clear and noisy and definite in this and all breathing – both in practice and during labor; the patterned nature of the breathing is as crucial for a comfortable labor as is the technique of breathing itself.

Inhale a normal amount of air and breathe out evenly through pursed lips, counting 1, 2, 3, 4 to yourself as you exhale. You should imagine that there is a lit candle a foot from your mouth and with each count you are exhaling to bend the flame of the candle evenly and constantly without blowing it out. You can practice with an actual candle or with just a match at first to get the feel of it. The breathing should be very smooth and the transition from one to the next breath should feel easy. This kind of breathing should make you feel relaxed. (Keep your eyes open; you don't want to go to sleep!)

Begin practicing with 10 second pretend contractions. Gradually increase to 30-45 seconds, perhaps five seconds a day until you reach 45.

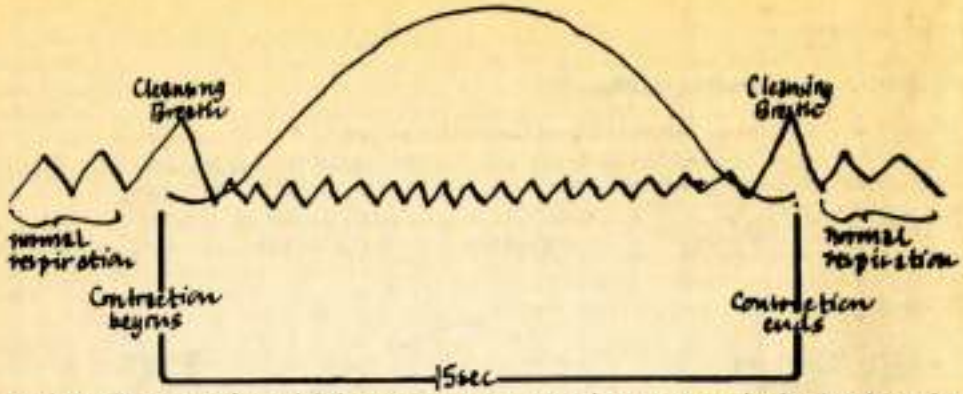
Add neuromuscular release technique when the breathing has been mastered. When you can relax (decontract all muscles) and do the candle blowing, add the effleurage. (Both are described in the body of this chapter.)

COACH OR SELF COMMANDS	*WHAT YOU DO*
"Contraction begins"	Cleansing breath in through nose, out through mouth with "whew"
"Inhale"	Inhale through nose at normal depth
"One-two-three-four"	Exhale steadily through pursed lips to the count of four
Repeat count of four as you time the pretend contractions	Continue through pretend contractions (rate of 8-12 a minute)
"Contraction is over"	Deep breath in through nose, out through mouth with "whew". End contraction just as you began it.
"Rest"	Resume normal respiration, stop conscious control

Slow, shallow panting, closed off by "Hut" or "Out" (chart next page)

This "hut" or "out" panting is used when the candle blowing no longer keeps you comfortable.

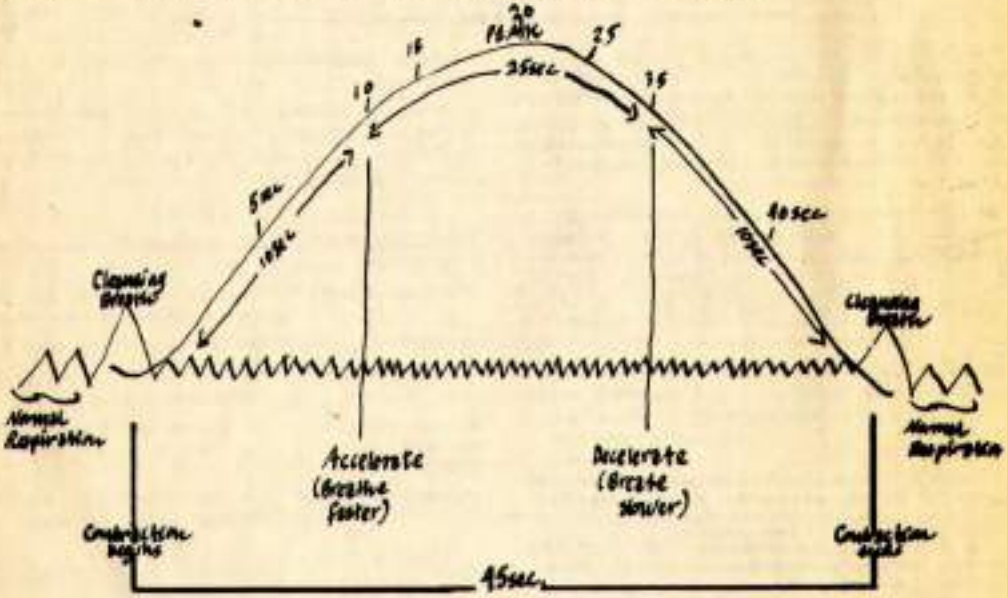
Start with a deep breath in and out. Then begin slow shallow breathing with most of the air exchanged in the upper chest, just below the throat. Use either nose or mouth, not both. Mouth is easier for most people. Abdomen and shoulders should remain as motionless as possible. Say the words either "hut" or "out" to close off each breath with a sound. Keep the depth regular and even. Think light and bouncy. Keep your tongue behind upper teeth to minimize drying of



your mouth (ice chips or sips of water help between contractions). Finish contraction with a deep breath in and out. Rest between contractions.

COACH OR SELF COMMANDS	*WHAT YOU DO*
"Contraction begins"	Take a deep breath through nose, exhale through mouth, "whew".
Coach paces contraction by calling out when 15, 30 and 45 seconds have elapsed.	Inhale through mouth, less than normal amount, at faster rate. Close off each pant with either "hut" or "out". Exhale through mouth. Continue through pretend contraction (rate of 60 a minute).
"Contraction is over"	Deep breath in and out, "whew". Rest, resume normal respirations.

Rapid Shallow Panting, accelerated and decelerated with shape of contraction



This kind of breathing feels much like the previous kind, only it must be quicker to respond to contractions which are longer, closer together and feel stronger. The more active the uterus, the more active must be the breathing to keep our attention on the breathing, to keep us from tensing muscles and thus interfering with the work of the uterus. The panting is so rapid that we don't have time to close off each pant with a sound as before. We must be sure to exhale as much as we inhale or else get hyperventilated from an imbalance of oxygen-carbon dioxide.

Start with a deep cleansing breath and then begin shallow panting with acceleration of speed as the contraction builds up; fast superficial breathing at the crest of contraction; deceleration of speed as contraction subsides. Finish with deep cleansing breath. Both in practice and during labor you will need to concentrate fully to make the change in rhythm very smooth, and keep the breathing even within each rhythm.

Practice for 2-3 contractions each of 60 second duration a couple of times a day. Don't start this kind until you have mastered the other two kinds of breathing. So you will build up to what is suggested above slowly, at your

own pace. It's important not to become discouraged during practice because you think there is some pre-set endurance test you have to meet. Make your own schedule. Just be sure you do practice regularly according to that schedule.

When you practice, use a watch with a second hand. 15 seconds to go up to the wave of the contraction with the breathing gradually getting quicker; 30 seconds of rapid-shallow breathing at peak (rate may be as high as 140-160 a minute at peak; don't try to practice that amount, for you'll get too dizzy – remember it's much easier to do this breathing during labor than in practice); and 15 seconds for the gradual return of normal breathing as the contraction ends. Vary length of practice contraction occasionally. Add neuromuscular release technique and effleurage when breathing is mastered. It helps if your coach calls out passage of time (i.e. 10 seconds, 15, 20, etc.); gives you a sense that there is movement and the hard work will end and there will be a brief rest period before you start again.

This breathing is used when the slow "hut" or "out" panting no longer works for you. We may use it before then, when there is a change in the pattern of our contractions and we need more active breathing to cope, after enema or breakage of bag of waters.

COACH OR SELF COMMANDS	*WHAT TO DO*
"Contraction begins"	Cleansing breath in through nose, out through mouth with "whew"
Coach paces contraction by calling out passage of seconds and by signalling when to accelerate, decelerate breathing	Inhale through mouth, less than normal amount, at fast pace which gets faster as contraction peaks and becomes slower with decrease in intensity of contraction. Exhale through mouth. Continue through pretend contraction.
"Contraction is over"	Deep breath in and out, "whew". Rest, resume normal respiration.

LABOR SUMMARY (Lamaze)

PHASE OF LABOR	WHAT YOU MIGHT FEEL	WHAT YOU CAN DO
Stage One		
Early Phase 0-2 fingers 0-4 cm.	Backache Diarrhea or constipation Abdominal cramps Show Ruptured membranes Excitement, anticipation Regular contractions	No food Time contractions Call nurse and doctor Pelvic rock for backache Candle-blowing breathing Get accustomed to contractions Conscious relaxation
Mid-Phase 2-4 fingers 4-8 cm.	Stronger, more frequent contractions More serious concentration Dependent on companionship Discouragement, doubts Restlessness Back and/or leg pain Weepy	Slow "hut" or "out" panting or rapid panting Effleurage Ice chips, water sips Relax Vary position bed/pillows Mild medication (analgesic) Back rub Concentrate on one contraction at a time Encouragement from man/coach
Transition 4-5 fingers 8-10 cm.	Leg cramps and shaking Nausea and vomiting Heavy show Hot and perspiring "Sleeping" between contractions Total involvement, detachment Apprehension Inability to concentrate Increased pressure Desire to push Dizziness	Rapid panting mostly but vary with other kinds Techniques for resisting urge to push Remember time is short Wet cloth on face, neck Man/coach tell woman to concentrate Specific commands Lots of encouragement Use brown bag, hand over mouth for tingling from hyperventilation **Don't panic!**
Stage Two		
Expulsion of Baby	Contractions may slow down Urge to push Pressure to rectum, perineum Total involvement May feel exhausted and have difficulty concentrating Excitement with actual birth of head, shoulders, etc.	Specific instructions for each contraction Relax, push out perineal muscles Three pushes/contraction (don't be afraid to push hard) Be ready to stop pushing and pant Man/coach support shoulders, give encouragement
Stage Three		
Expulsion of Placenta	May feel slight contraction	Relax, pant, push out perineal muscles. May ask to stitch loosely before removes placenta.
Nursing (Hazell, p. 232)	Suckling at the breast helps contract the womb to prevent bleeding and satisfies the baby	The baby is offered both breasts right after birth and whenever [she] is hungry.

FOOTNOTES

1. "We Don't Call It Natural Childbirth, but Educated Childbirth", Marilyn Bender, *New York Times*, 16 May 1967, p. 380.
2. Kitzinger, pp. 29-31. 3. Wright, pp. 53-56. 4. Ibid, pp. 33-34, 85. 5. Ibid., pp. 81, 82, 83-84. 6. Hazell, p. 92. 7. Ibid, p. 84,91.
8. Ibid., p. 95. 9. Wright, p. 109. 10. Hazell, p. 9. 11. Ibid., pp. 9-10. 12. Wright, p. 162. 13. Hazell, pp. 132-33.
14. Ibid., pp. 134-36. 15. Kitzinger, p. 143-44. 16. Hazell, p. 136. 17. Ibid., p. 98. 18. Wright, p. 142. (See booklist for references.)

BOOKLIST

Childbirth Without Fear. Dr. Grantley Dick-Read (1942).
Written by English doctor who was one originator of prepared childbirth. Method more mystical than Lamaze method, with more stress on relaxation and less on activity.

Thank You, Dr. Lamaze. Marjorie Karmel (1959), pb.
Lively, personal account of two experiences with prepared childbirth. First child delivered in France by Dr. Lamaze, second in America. (Comparisons of practices in two countries!) Fun to read. Little outdated.

Childbirth Without Pain. Dr. Pierre Velley (1961).
Series of lectures, exercises by associate of Lamaze. Good, thorough in Lamaze method though hard to read. Shouldn't be the first book you read. Be sure to look at the pictures of a delivery – very exciting! Velley is practicing in France.

Awake and Aware. Dr. Irvin Chabon (1967), pb.
Book written by American doctor. Good history of childbirth practices (part I liked best was explanation of change from home to hospital deliveries), Lamaze method, short birth records of women, exercises and good pictures. Current, easy to read, recommended.

The New Childbirth. Ezra Wright (1966), pb.
Manual to prepare woman for childbirth written by midwife. Excellent preparation in Lamaze method. Written by woman who has children. Pictures! Less critical of medical profession than book by Hazell. Could do all physical preparation necessary with this handbook alone.

The Experience of Childbirth. Sheila Kitzinger (1962).
English woman. Method described combines Read and Lamaze. Strong psychological orientation (I felt it made woman look too much in on herself and not look enough beyond herself, at the society, for origin of some problems). Has chapter on home delivery which is more specific than the one in Hazell.

Commonsense Childbirth. Lester Hazell (1969).
Written by woman. Best overall book for many reasons: good to read, complete and sensible approach to childbirth. She has had kids of her own and conveys what it feels like to give birth. Even more important, she has an understanding of the source of lots of women's problems during childbirth – the medical profession (and is very critical of it). (This is more important since no other books I've seen on the subject of childbirth preparation seem to have that understanding.) Information in book fits right into women's liberation. Excellent section on why to have a baby at home; also good one on breast feeding. If you buy one hardback book, get this one.

A Practical Training Course for the Psychoprophylactic Method of Childbirth. Elisabeth Bing, Marjorie Karmel, Alfred Tanz, M.D. (1961).
Lamaze techniques. Manual officially approved by A.S.P.O.

Pregnancy and Birth. Dr. Allan Gutmacher (1965), pb.
Gutmacher is head of International Planned Parenthood; he practiced obstetrics and gynecology for many years in New York. He has written many books for the general public. This book is okay when you don't expect to understand topics in too great depth.

The First Nine Months of Life. Geraldine Lux Flanagan (1962), pb.
Story of conception and week by week progress of baby in utero. Exciting to follow when pregnant. Terrific pictures, for example of baby sucking thumb in utero!

Life Before Birth. Ashley Montagu (1964), pb.
I haven't read this book. Title covers the content though I can't make any comments on author's point of view.

Husband-Coached Childbirth. Dr. Robert A. Bradley.
I haven't read the book. It's often referred to in childbirth preparation courses, I guess because it's directed toward the man. However, I'm skeptical about a man writing about how men can help women in childbirth; without having read the book, I'd be happier if the author were a woman.

A Child Is Born. Lennart Nilsson and Axel Ingelman-Sundberg and Claes Wirsen (1965), pb.
Beautiful color photographs.

Conception, Pregnancy and Contraception. (1969).
New book with excellent drawings and photographs. I was especially impressed with drawings of female anatomy which gave a sense of the relation of one part of our bodies to another (which is rare in most books I've seen).

The Womanly Art of Breastfeeding. La Leche League (1963), pb.
Some helpful information if you can get past the sickening stuff about a woman's role is to bear and raise kids. Little outdated in comparisons between breast and bottle milk! Does give woman lots of support for breast feeding.

Nursing Your Baby. Karen Pryor.
I haven't read it completely, but I felt it had the same information as *The Womanly Art...* and was less objectionable to read.

Baby and Child Care. Dr. Benjamin Spock (1946; rev. 1968), pb.
Well, what does one say about Spock, anyway? He was reassuring to me at times, but mostly was too general to be of real help (have to always call your own doctor). Revised edition not much different than original. He may be good about Vietnam war, but he's terrible on women (don't expect father to play with the child after a long hard day at the office, let him read his paper, bring him his slippers), sex, and religion. He has a new book out called *Decent and Indecent*, which is more chauvinistic and more rigid than the first. Spock is on his way out as far as I'm concerned. We'll have to write our own book to replace his "classic".

Textbook of Pediatrics. Nelson.
This was recommended by a woman medical student friend. I haven't gotten it since it's expensive ($20.). Several of us have talked about buying it collectively. It's the book pediatricians use to check on illnesses. With a medical dictionary to decipher the jargon, we should be able to check before we call the doctor and have some check on his diagnosis.

Prenatal Care, Infant and Child Care, Your Child from 6 to 17, Adolescence. U.S. Department of Health, Education and Welfare, Children's Bureau Pamphlets.
Have about the same information as Spock, but are free from the government.

The Magic Years. Selma Fraiberg, pb.
Covers years from birth to six. Freudian but not too offensive. (I haven't read it thoroughly since women's liberation and now might find it worse.) Helpful hints and some good stories if you don't take everything too literally.

Gesell Institute's Child Behavior. Ilg and Ames (1956), pb.
Can give some information of what to expect from a child of a given age. Don't take age norms too seriously. Remember it's a statement about what children **have done** in this society over ten years ago. Things are changing and need to be pushed more. (For instance, children can begin to relate to each other from the time they are only weeks old. Yet this and other books say not until three, an assumption that the child is in the nuclear family until that age and then goes to nursery school as a first encounter with the outside.)

Love Is Not Enough. Bruno Bettelheim, pb.
Written about children in his special Orthogenic School in Chicago. Although the book is not about "normal" children and Bettelheim is a very authoritarian man, he has some important things to say about all kids. I especially liked his chapter on food, on in-between times and space.

Infants and Mothers and Their Development. Dr. T. Berry Brazelton (1969).
The book is a study of three different children. I haven't read the book but he is the pediatrician I use. He has done work with Jerome Bruner and the book reflects these studies on learning, I'm sure. It probably has some good observations about effect of children on their environment (as well as the environment on them). Beware of his chauvinism (I understand it has a terrible part on working mothers) and tendency to Freudian interpretations.

Analysis of Human Sexual Response. Ruth and Edward Brecher.
Excellent summary of revolutionary (?) studies of sex by Masters and Johnson. Talks about sex during pregnancy and after childbirth and that's why it's on this list.

I did not do a survey of literature to make up this booklist; the list is based on the books I like and was familiar with. I'm sure there are things I have left out. Please feel free to add others (and pass the word on to me).

If you can't get the books from the library or from the bookstores, check with (1) Boston Association for Childbirth Education, (2) Lamaze Education, Inc., (3) La Leche League

Outside the Boston area, you can check with these groups: International Childbirth Education Association, Box 5852, Milwaukee, Wis. 53220; American Society for Psychoprophylaxis in Obstetrics, 36 W. 96 St., New York, N.Y. 10025; La Leche League International, 9616 Minneapolis Ave., Franklin Park, Ill. 60131

Post Partum

INTRODUCTION

Postpartum emotional disturbances, like most (possibly all) mental disorders, are defined by the social context in which they occur. (Marcuse writes, "Health is a state defined by an elite.") For example, on an Israeli kibbutz the mother who feels that she cannot leave her newborn between nursing times to contribute to the community work is regarded as in need of special counseling for anxiety. In the U.S., the woman who returns promptly to work after childbirth is regarded as cold, neurotic and unresponsive to the needs of her baby.

In fact, a baby's need for stable responsible adults can be met by a group or community of people. We believe it is a myth that the mother must be omnipresent to prevent psychological damage to the infant. The myth is perpetrated to keep us isolated and privatized in keeping with the competitive capitalist ethic.

What little research has been done on postpartum is heavy with male bias and conventional attitudes about motherhood. It shows that over half of all women who bear children have some emotional upsets following childbirth. If we look at the minority of women who cope well during this difficult time, we may find the seeds of the social conditions needed to make both motherhood and childhood a time of satisfaction and growth. Some of these

are: (1) complete choice in becoming pregnant (physically, psychologically, and socially); (2) economic security; (3) child care that can meet the needs of infants and toddlers so that we need not give up our work in order to be mothers.

The psychological postpartum period, the months following childbirth (for some the feeling of helpless lethargy lingers on for years), is for many of us a time of emotional changes. Some of us are high, some mellow, some lethargic and depressed, some have mood swings. We are confused and a little scared because our moods do not resemble the way we are accustomed to feel; we never expected this overwhelming need to sleep, even in the early morning, the inability to concentrate on a book or other activity, the suicidal fantasies (anger turned inward) or the fantasies of leaving the baby and its father (anger turned outward). We are frightened by anger at the baby who is so terribly vulnerable and dependent on us. If you never have had the experience of being responsible for another's care - if you have never cared for small children - it is an awesome responsibility to find yourself totally responsible for the life of another human being. The newborn human infant cannot meet its own needs except by crying to signal discomfort. It depends on us for nourishment, removal of fecal matter, clean clothes and occasionally even a change of position (let alone affection).

For us as first time mothers it begins to seem as though life henceforth will be merely a struggle to meet the personal needs of the baby and ourselves (in that order), with little or no time left for anything meaningful or fun.

It is very important to remember that the time the baby needs so much care is short. In the first year, babies learn to hold their own bottles or cups, sit up, crawl, stand, sometimes walk and begin to say words. Every few months brings a new stage of development (don't worry if your baby is a bit slower than your friends') and some lightening of your load (more messes at first, though).

Example: At a recent meeting a woman speaks suddenly about herself: "I have one child and I'm pregnant again. Immediately after the birth of my first baby, I felt high and exhilerated. But that night I got sad. I cried all night long. During the next few days I lay in my bed thinking of how I would kill myself. I looked at how the windows opened and I concentrated on figuring out times when no nurses were on duty. I couldn't sleep at all. I tried to tell them I was depressed, and all they gave me were sleeping pills. I felt like I'd never feel anything again but this incredible despair, that it would never end. I had nightmares. The one I remember best is where I would be feeding the baby. I would fall asleep and the baby would fall off the bed and be killed. I don't know why I had these dreams and impulses. I have had a happy marriage and it was a wanted pregnancy." She talked about meeting another woman and finding that she had gone through the same kind of experience, including a dream that she had slit her new baby's throat with a knife.

The postpartum period, the first few months after childbirth, is treated by most doctors from a purely physiological point of view. They dismiss most of the psychological and emotional feelings as "natural". Postpartum depression in its mild forms is considered so common as to be unworthy of mention, so little research has gone on in this field. However, some 10% of the psychosis in women develops from the reproductive experience (Piker, '38). Women are offered verbal bromicides rather than realistic treatment. After all, society tells us, women should find Motherhood totally fulfilling and should instinctively know how to respond to and care for their babies. Because of the societal pressures surrounding Motherhood - the mystique of the maternal instinct, joys of child care, fulfillment through others - many women are unable to pinpoint their feelings of confusion and inadequacy or are unable to feel legitimate in verbalizing their hesitations and problems. This

chapter will cover the emotional, social, and physical stresses on the postpartum woman, and put forth some proposals for action by women so that pregnancy, birth and the initial phase of motherhood can be a positive experience, perhaps even a time of real psychological growth.

The problems that develop in this period are accentuated by the fact that the obstetrician is often the only supportive professional the woman sees during pregnancy. And he is very rarely supportive of her emotional needs. When a woman becomes pregnant, she is put on an assembly line, whether she goes to a clinic or sees a private doctor. She goes to the doctor and finds that her body is regarded as a machine to be serviced periodically. Pregnant women are always referred to as the patients (the same category as sick people). She is shunted through at predetermined intervals during pregnancy, and then not until six weeks after delivery. If she sees a private doctor, she should object to paying a fee for the cursory treatment she is given. If she goes to a clinic she will see a number of doctors and possibly even be delivered by one she has never met.

Nowhere are the woman's many fears touched upon: her difficulty in coping with her self image and the changes it must undergo when she becomes a mother. The doctor does not usually make a real attempt to deal with her feelings. Even fears of childbirth are rarely dealt with. Concerns about parenthood are almost certain to be dismissed with bland assurances that women simply know these things when they need to. The myths about the unbounding joys of pregnancy, delivery, birth, and motherhood felt by "normal" women are only enhanced. Even most childbirth preparation classes are oriented toward physical control during the birth process and do nothing to prepare the mother for motherhood and babycare. Furthermore, in this society the positive self-esteem gained by motherhood is undercut by the difficulty in continuing one's career because of the extra domestic activities she now has. Although the occupation of motherhood is highly touted, that of housewife (=drudge) is generally considered pretty undesirable. But for most people they are inseparable, with motherhood held out as the reward for cheap household labor.

Yet pregnancy, a life crisis with tremendous growth possibilities, is treated merely as an initiation period to be gotten through, with birth as a climax, while the birth of a child can be a traumatic experience for any couple, or person, and for us to build an entirely new web of relationships. This emphasis on the delivery is useful for the image of the doctor as a specialist, and a performer; a sop to his ego. He is the magician, the "deliverer". Paid up until birth, he sees the woman afterwards only in extreme cases except for the perfunctory six week checkup at the end of the puerperium (Latin; puer – a child, parere – to bring forth). During this time the generative tract usually returns to normal.

After the birth, if the woman should be upset and call her doctor he might refer to the baby blues, a catchall term, used to describe the common symptoms of irritability, crying, and hypersensitivity. Her legitimate complaints might be brushed aside as emotionalism. One woman here in Boston, soon after childbirth complained that fecal matter was coming out of her vagina. The doctor refused to examine her and dismissed this as fantasy. Was he unwilling to acknowledge the possibility that his episiotomy was not done perfectly? In desperation, the woman went to another doctor, who treated her successfully for a ripped vagina. Thus the woman is left mostly on her own. Specialization provides her with one physician up to the birth, another for her newborn child, and a psychiatrist if needed for severe emotional problems. The English midwife system (explained later) eliminates this fragmentation.

Most women go home after a five day enforced rest in the hospital, which is now about five days for paying patients and two days for non-paying. There they have no help and often have other children to care for. For the next few months, they are unable to get more than four hours of sleep at a stretch. In casual conversation, many women report such things as falling asleep in company, no time to fix their hair or take care of their own personal needs, inability to cope with daily household routines, or inability to maintain involvement in outside interests. They often feel that they have lost control of their lives, and a dread that life will always be this way. They often feel guilty because they think their own inadequacies are the cause of their unhappiness. **They do not ask if their roles are realizable.** The casual observations are confirmed by a survey of 137 obstetrical patients postpartum. They showed "subjective evidence of anxiety and/or depressed and cognitive dysfunction in 64%. Symptoms included inability to sustain attention, distractibility, poor recent memory and labile moods resembling clinical signs seen in acute brain syndromes but much milder in degree."

Many household routines can be minimized or streamlined during this period in the interests of efficiency and getting rest but even those activities that are beneficial to the woman's morale are often too much of an effort after a day of crying babies, feeding every three hours, and washing clothes. In earlier times, women had fewer appliances, but more people helped with housework, especially when a new baby arrived. Even the visiting nurse seems to have gone out of style as women become "better educated". That our education rarely touches on baby or child care is taken into account by no existing public or private institution. Although there are many classes which help us to deal better with the physical side of pregnancy and childbirth, there is little readily available instruction for childcare, which is also a **learned** skill, not instinctual. A study of maternal role-taking responses showed consistently higher scores for multiparas (those who have been mothers before) (Reva Rubin, Nursing Research). Another study (Gordon and Gordon) shows that women who attended child care classes during pregnancy had significantly fewer emotional upsets postpartum. All the classes emphasized that the responsibilities of mothers are **learned**, not inborn. This confirms our belief that knowing what to do with a newborn does not necessarily get into our heads by "maternal instinct".

There frequently is a mild depression on or about the second and fourth days, corresponding to engorgement and the beginning of lactation. It is not really known why this connection exists. Some people feel that the separation of the mother and child in the hospital increases the depression. This is true for nursing mothers as well since there is usually an initial mandatory twelve hour separation. Mild postpartum depression is not an item high on the research priority list although nearly half the adult population in the United States (i.e. most of the women) experience this syndrome (probably because mothers are not as important to the efficient functioning of the industrial machine as other members of society). These "blues" in themselves are not indicative of longer term depression. During this time it is a good idea to talk to someone about your feelings. If your doctor has no time for you or is unsympathetic, try to have someone close to you be there to talk to.

Our attempt to research the professional journals produced only a handful of articles over the last two years. Most of these deal with aspects of the postpartum depression. Of course, everyone should not expect to have a depression, but it is common enough to suggest that contributing factors exist in most of our lives. One study done in 1968 by Rita Stein shows the lack of integrated research of the emotional side of pregnancy and postpartum period. (Her study contains a valuable bibliography, showing the gap from Hippocrates to 1928. It provides a good historical overview with a sociological approach.)

The "traditional" and first serious theory (30

years old) was that women suffering from severe postpartum depression had deep-seated mental illness and that the birth of the baby was merely the trigger that brought the pre-existing psychic disturbance to the surface. Women suffering from psychotic postpartum disturbances were diagnosed as schizophrenic, manic depressive, or whatever clinical syndrome their behavior was thought to resemble. Often they were hospitalized for years; in some cases, for life.

Today this attitude is being rejected in favor of stress triggering theories. These can be broken down into two streams of thought: (1) The depression is caused by physical stress, i.e. hormonal imbalance and the bodily shock of labor. (2) The depression is caused by social stress, including one's background and one's current environment. A study in 1962 found postpartum depression analogous to combat fatigue (Hamilton). Women who exhibited severe symptoms were sometimes found to have thyroid difficulties and made dramatic recoveries when treated with thyroid compounds. It is known that there is normally a change in the amounts of 17-hydroxyclorticoids, steroids related to the sex hormones, in the blood level whenever there is a general emotional arousal. Perhaps the hormonal imbalance caused by the end of pregnancy can help to trigger the depressed feelings so often encountered. Those who favor the physical stress theories emphasize hormonal treatments, drugs, such as tranquilizers, anti-depressants, and sometimes hospitalization in severe cases. A study currently being done in Boston attempts to prevent recurrences by controlling the hormonal balance, tapering the drug dosage off over a period of two months. Other reports show that the social factors including one's background and one's current environment are larger contributors to depression for most people. This is borne out by reports of depression in fathers (Lunenberg, 1967) and adoptive mothers (Rheingold). Rita Stine's study lists four major role changes for the mother of a newborn: (1) Becoming maternal yet not experienced in coping with the demands of an infant. This dichotomy between expectations and experience is definitely perpetuated by the nuclear family, where there is usually no other adult to help with child care during the day. (2) A change in personal status in the occupational and social scheme. She must choose between **doing** something and **being** a mother, since child care is not available in many cases. (3) A change in ego-ideal. The mother must put the child's needs before her own. A woman is taught to obliterate her personality and live through her children and husband. (4) A change in marriage and family patterns. Her role becomes more rigid and confined. Rita Stein recommends taking life histories emphasizing early childhood and marital adjustment to determine which women are likely to require special help in changing into their new roles. She does not discuss the validity of the role. Another recommendation of the study is to use pre-natal groups to discuss problems.

A questionnaire developed by Richard and Katherine Gordon was successfully used to spot potential problem areas and predict the statistical likelihood of having postpartum difficulties. The findings of this study showed that 78% of the women who showed 7-10 stress factors (explained below) developed postpartum problems. Those with the most stress factors were likely to have the most severe and long-lasting illnesses. Of first-time mothers interviewed, nearly one in three developed difficulties! For one out of ten, the problem persisted for at least six months.

Stress factors for this study are divided into two main categories: (1) "Personal insecurity" or background factors, such as loss of a parent in early childhood, inexperience with babies, first pregnancy, etc., and (2) Current environmental factors, especially role conflict, but including such things as isolation, financial problems, husband working late, and upward social mobility. The Gordons believe that though a woman's history plays some part in her ability to "adjust to motherhood", it is the current factors of isolation, **lack of stimulation** and **role conflict** that deepen the problems and cause them to continue. In The Wretched of the Earth, Franz Fanon similarly finds that mental disorders of childbirth among Algerian refugees were deepened by their living conditions despite appropriate treatment. This has application for all women who must bear their children under traumatic conditions and raise them in poverty.

In making use of information gathered by social scientists we should be careful to distinguish between scientific findings and the underlying assumptions, biases, of the researcher. We should beware of such phrases as "a good adjustment to motherhood" or "female-passive vs. male-aggressive role conflict". In the Gordon study, the stress factors were separated into two categories, personal insecurity and role conflict. As we read the items which make up the personal insecurity factors, we find they refer to such things as early death of the mother or lack of experience with babies. In other words, these are factors of insufficient experience and knowledge in the maternal role. If a man feels insecure the first day of a new job, his masculinity and whole self image are not called into question. Unfortunately, our society encourages a woman to fuse and confuse her role as a person with her role as a mother. She is taught to believe only she

can best mold her children. This is reinforced by a society that does not provide her with adequate alternative child care. Role conflict exists because the society makes it so difficult for a woman to pursue other goals while providing good care for her children.

PHYSICAL ASPECTS

The physical changes occurring in the postpartum period are enormous. Although they are considered "natural" they closely resemble the pathological. Nicholson J. Eastman, M.D., who is the author of a textbook for medical students on obstetrics as well as a book for pregnant women called Expectant Motherhood, says that "under no other circumstances does such marked and rapid tissue catabolism (tissue break-down) take place without a departure from a condition of health." A woman should be aware that such changes are taking place and that they will probably affect her physically as well as emotionally. It is important to note here that feelings, particularly of depression, are intensified and are of longer duration if the woman permits herself to get run down physically. Some women have stubborn virus infections which may lead to depressions, or substitute for them (in women who cannot acknowledge depression).

As with pregnancy, some women will experience a number of discomforts while others will have hardly any at all. Some discomforts of this period are sweating, especially at night, loss of appetite, thirst due to loss of fluids and constipation partly due to inactivity but principally due to relaxation of the abdominal walls and their consequent inability to aid in evacuating the intestinal contents. Getting up and walking as soon as possible is thought to prevent severe constipation. A woman may feel that her genitals are looser. As far as sexual relations are concerned, the Masters and Johnson study indicates that if a woman's vaginal area feels okay, there is no reason to avoid intercourse if you desire it. However, proceed slowly at first because if your episiotomy is still tender and starts to hurt under pressure of the penis, the side position is probably best for intercourse. The taboo varies from one country to another, even in the Western world. Many women in the U.S. begin in their third week postpartum. Most women find that their vaginas do not lubricate easily at this time and fear they've become frigid. (If you have this trouble, just use a plain, unscented lubricant, as K-Y Jelly.) Doctors make the six week rule for their convenience so they do not have to be bothered taking each case individually. This rule originated in the days before antibiotics. Remember, too, that if you sleep with someone regularly you probably already share the same germs and have developed a tolerance for them. (See appendix for more on postpartum sex.)

After a normal delivery the patient is out of bed 24 to 72 hours postpartum. Those who get up soon after delivery state that they feel better and stronger sooner and have fewer bladder and bowel difficulties. By getting patients up earlier it has been possible to reduce the recommended hospital stay to four or five days as compared to the customary ten days in the recent past. You might also consider whether the high costs of hospital stays, shortage of beds and the depersonalized treatment the patient gets will affect how healthy you feel. It would be better if women had the choice of delivering at home. (It's safely done now in England.)

However, it should be emphasized that because the woman is able to get up out of bed and move around does not mean she is ready to re-assume her usual responsibilities at home. It is important to get enough sleep and to set aside some time in the afternoon to make up sleep lost due to night feedings. For the entire six weeks, time should be set aside for exercise and rest. Paternity leave, time a father gets off from work when a child is born to help care for it, or daycare for other children would help with this immensely. Housework should be shared by other family members or simply kept to an absolute minimum. If there is no help, the first week home plan on take-outs, frozen dinners, paper plates, etc. No more stair climbing and other exercise should be done than you can do comfortably. You may feel you want to limit stair climbing to once a day for even the first week. Be careful of heavy lifting, which should not be done before you are able. Try to tune in to signs your body gives to tell you it is tired; don't ignore them.

Thanks to prepared childbirth, women feel better after giving birth and are able to resume their customary activities sooner. However, we feel that the common discomforts of this period have been so de-emphasized that "prepared" mothers are often quite distressed when they find themselves not feeling as well or as strong as they had expected. Do not get taken in by the modern equivalent of dropping the baby in the fields – the cliche ending of the natural childbirth films in which the motner hops off the delivery table with the baby at her breast and walks off unsupported into the sunset. You may feel great, you may have few or no discomforts, you may have many; you will not know until the time comes. But when you are aware of the range of possibilities you probably can handle them better if they occur. For a more detailed physical account of the body changes and their effects on you during this time, please turn to the appendix.

WHAT CAN BE DONE

We as a women's liberation group can begin to organize ourselves to fight those aspects of our society which make childrearing a stressful rather than a fulfilling experience. We should recognize the fragmentation of education into subjects not integrated with real experience so that most of us learn nothing about babies until we have them. We should be aware of the isolation of the nuclear family. We need to be aware of the lack of maternity and paternity leave, lack of good child-care facilities forcing women to choose between family and career. We must recognize the mystique of the full-time mother that causes women to feel that they are depriving their children if they have careers or other pursuits and fight the male supremacy which requires the women to come home from a job and take care of the backlog of home and child care.

1. As an immediate step, the Gordon questionnaire could be widely distributed to obs and clinics with follow up provided for women who showed six or more social stress factors. Since it doesn't look as though this is being done, a women's group could leaflet these questionnaires at medical buildings, clinics, childbirth classes and maternity shops inviting women to come to meetings to talk about infant care, women and social stress. Group counseling could be organized for pregnant and postpartum women who are already experiencing difficulties. Crash counseling can help women deal with their problems effectively (Kniebel).

2. Develop pregnant-couples groups to explore feelings, fears, hopes about pregnancy, childbirth, and parenthood. Use the crisis of pregnancy to bring about individual psychological growth and help move the marital relationships (where they exist) to a new stage of development.

3. Make more use of group processes in already existing groups. Humanize childbirth classes so that feelings are dealt with along with the physical facts of pregnancy. Psychologically trained people should train lay people and nurses to deal with feelings in these groups. Psychiatrists should be available to consult with individuals or couples who feel they need it.

4. Set up a pre- and post-natal telephone service. Any woman with a problem could call. Serious problems would be referred to qualified people.

5. New organizations of visiting laywomen to help with post-natal problems.

6. Work on developing, with sympathetic medical people, a nurse-midwife approach like that existing in England. The midwife sees the woman during pregnancy, stays with her during all of the delivery, and helps with child care for the first few months of the child's life. She can handle all routine procedures competently and can recognize complications. Then the obstetricians could be on call for all difficult pregnancies and births, pediatricians could care for all serious infant illnesses, not just for those who could afford to have them.

7. Develop mobile emergency units (again, as in England) to enable women who want to deliver at home to do so as safely as in a hospital. This would remove the implications of emergency, trauma, and disease associated with hospitals from the birth process. With these unnecessary stresses removed, the return to normal activities could be speeded up.

8. Place realistic information in every clinic and doctor's office. (The doctors should pay a little for the printing.)

9. Demand maternity leave for mothers and fathers as provided in Sweden. Then both parents can cement the "love affair with the baby" (Baher) and learn together to meet its needs.

10. Daycare should be provided by all places of employment so both parents can return to productive work with mothers able to nurse the child on the job. This will have the added benefit of breaking down puritanical prejudices against breast feeding, a natural function of a woman's body. It should not have to be done surreptitiously.

We must free ourselves from the equations woman = passive, man = active, woman = child rearer, man = provider. We are all human beings, all one species. Our reproductive organs determine complementary roles in reproduction. They need not and should not determine our roles in society.

APPENDIX

The appendix describes the physical aspects of postpartum in more detail than the chapter.

After Labor

For at least one hour after the completion of labor, the physician or midwife should remain in attendance in case of complications. If at the end of that period the uterus has satisfactorily contracted, the woman may be left alone. If not, contractions should be stimulated and progress carefully watched until all danger of hemorrhage

has passed.

The genitals must be kept clean to prevent infection. The cervix is large after pregnancy, admitting two fingers. It is very important not to introduce anything into the vagina because of the danger of infection. The cervix returns to nearly normal condition in **one week** by proliferation of new cells (unlike the uterus, which first autodigests part of itself and then makes a new lining). The genitals are washed with an antiseptic solution each time after elimination and the sterile pad changed. Dr. H. J. Eastman, the author of our medical text, states that the pad is useful not only to absorb the lochia but because "it makes it difficult for the patient to touch her genitalia, a practice very common among the uneducated classes. . ." The good doctor does not mention whether he has ever tried **telling** these "uneducated" women about the dangers of infection.

An abdominal binder is not necessary, but many women feel more comfortable wearing one (usually a girdle that won't roll up).

Afterpains caused by contractions of the uterus are more common in women who have had more than one child. They are often accentuated while the baby is nursing. When they are severe, codeine or aspirin is prescribed.

The **uterus**, by a process called involution, becomes reduced to 1/20 to 1/25 of its size at delivery. Involution is effected by autolytic (self-breakdown of cells) processes by which the protein material of the uterine wall is broken down, absorbed and cast off through the urine. The endometrium (lining of the uterus) is excreted as lochia (a blood stained vaginal discharge). The discharge is bright red for the first few days; after three or four days it becomes paler and usually after ten days there is merely a whitish or yellowish discharge. Unusually heave or long term bleeding suggests need for more rest. Though the lochia consists of waste material (not longer needed in the body), it is clean and should not have a bad odor. If it does, it may indicate imperfect involution or retention of parts of the afterbirth. By the end of the third week, the entire endometrium has been cast off, including the placental site, so that women who bear many children do not have scar tissue in the uterus.

There is usually a weight loss of about five pounds in addition to the weight loss representing the baby and the contents of the uterus. This represents water loss and other factors.

The **vagina** requires some time to recover from the distention and rarely returns to its pre-pregnant size. If you have used a diaphragm, most likely it won't fit now, so use another method of birth control. If you are nursing and can't take the pill, use your old diaphragm with lots of cream or jelly until you can be fitted with a new size. It is not known if any of the commonly prescribed exercises for the vagina are effective. The vaginal outlet is markedly distended and shows signs of laceration. The labia majora and minora become flabby and atrophic as compared with their condition before childbirth. You can probably see some of the changes of your genitals if you look at yourself with a mirror.

Masters and Johnson examined a limited number of postpartum women during **intercourse** and found marked changes from the normal. The physiologic reactions of most parts of the genitals were reduced in rapidity and intensity. The vaginal walls were quite thin and failed to lubricate as soon or as much as before. "Normal rugal patterns (folds) were flattened or absent and the vagina was light pink in color [usually vivid] and appeared almost senile to direct observation. Particularly was this steroid-starvation true for the three nursing mothers." Orgasm was not as strong or as intense. Interestingly enough, the feelings of sexual tension did not correspond to the physical appearance, as they usually do. "Sexual tensions frequently were described at non-pregnant levels, particularly among the nursing mothers." This may be in part due to pelvic congestion, which can be experienced as sexual arousal. But even more important, the women could not **subjectively** feel the difference between orgasms during this time (3-4 weeks) and those three months later when their orgasms looked physiologically like those of a nonpregnant woman.

The process of involution of the peritoneum (abdominal cavity) and the abdominal wall, requires at least six weeks. Except for the presence of silvery striaie, they gradually return to their original condition provided the abdominal muscles have retained their tonicity. This is why it may be important to exercise during pregnancy and to do the exercises prescribed for the postpartum period.

Between the second and fifth day there is a condition called diureses or lots of **urination**. During pregnancy the body tends to retain water and this diureses of the puerperium is simply a reversal of the process and a return to normal of the water metabolism. Urination may amount to over a gallon a day. Occasionally **sugar** is found in the urine. This is due to the presence of lactose or milk sugar and has no connection

with diabetes. If the patient does not urinate within six hours after delivery, she must be catheterized because the bladder may become distended to the point of bursting. Patients who have had analgesics in labor may not be aware that their bladder is full.

Bowels. A mild cathartic may be given on the second or third day to relieve constipation. It is desirable to get the bowels moving during the hospital stay but this is not always possible.

Most of the **blood and metabolic alterations** of pregnancy disappear within the first two weeks of the puerperium. In a study of 1000 deliveries, 20% of patients had anemia on the fourth day postpartum. In 15% it was mild, but in 5% it was severe. If you feel unusually weak or tired during the first two weeks, anemia may be the cause.

Diet. The postpartum woman may eat a normal diet. La Leche League lists foods for nursing mothers which may help to avoid colic. If she is nursing, her diet should be the same as during pregnancy with the addition of a pint of milk, bringing the milk total to a quart and a half a day.

Temperature. The temperature should be carefully watched during the first two weeks because fever is usually the first sign of infection.

Care of the Nipples. Little attention is required beyond simple cleanliness. If the nipples become sore, a nipple shield may be used temporarily.

If your doctor is not helpful with nursing problems, call La Leche League.

Menstruation usually returns in eight weeks in women who do not nurse. In nursing mothers there is ordinarily no menstruation as long as the child is completely fed by nursing, but there is great variation with menstruation occurring sometimes as early as two months but most commonly at four months. Most women do not ovulate while nursing, but a substantial number do, so it is wise to employ reliable birth control precautions.

APPENDIX ON CHILDCARE

An entire paper should be devoted to childcare. But that hasn't been written and your child has arrived and so we're adding a few notes on children, mothers, and childcare.

The full impact of having a child often doesn't hit us until we're home from the hospital and faced with the responsibility for another human being. Many feelings, thoughts, and fears come to mind: I am supposed to be fulfilled because now I am a mother, but this seven pound being that just emerged from my body is not a person – she just sleeps, eats, and shits at first. But I still have to be around most of the time to care for the baby and give up my other interests, my independence. And I feel scared: what if I do something wrong – I'm afraid to even bathe the baby for fear I might drop and kill her.

All these things are common problems. Just because we're women, we don't instinctually know how to care for children – experience is essential. Also, once your child is born, she is a separate being, one that you have to get to know, and who has to get to know you. We have learned from talking with each other that a child has a very strong will to live; there is not much we can do to hurt the child physically. We have also learned that our

independence and emotional well being is as important for our children as for ourselves: we must remain people in spite of the fact that we're now mothers! Therefore, in thinking about childcare we have to talk about our own needs as well as the needs of our child.

And we must talk about our own needs first, because in no other place are they given the consideration we know they warrant.

Even though we have physically borne the children, we know that we cannot for ourselves and must not for our children rear them alone. Depending upon our own living situations, we have to find the easiest way to share the care of our children **from the very first day home**. Sharing means to us joint responsibility, not just a division of tasks. We expect the other constant adults in our children's lives to know how to take care of the child without having to turn to us as "the experts" ("I didn't know how to change a diaper any more than my husband did. In fact, I may have been more nervous about it, since as a woman I was 'expected' to know how. I learned to do it and so can he and others.") Our children need intimate, consistent care from adults, and that care can come from the father of the child, friends with whom we may be living collectively, in childcare centers, and from us as mothers. The important thing to remember is that we must not forget about ourselves as people just because we're now mothers. And if that means we want to be away for a day, a week, or even a month, our children shouldn't suffer. If primary relationships exist between our children and other adults **from the start**, then everyone will be happier. If, on the other hand, we allow ourselves to think that we are the only adults able to care for and love our children, then we will almost always come to think of our children as our possessions.

We don't want to push women out of the home, but we want to leave the door wide open - for both ourselves and our children - to grow and develop as independent people.

Clearly we can't cover all the things we've learned about children. We have learned from talking with the other adults who share the care of our children and from our sisters who have been mothers before us. We have learned that there are no final rules to follow; our children are as different from each other as we are from our friends. The key thing is to try to relax and enjoy your children - they can be great fun - as long as you don't have exclusive responsibility for them twenty-four hours a day.

Here are some random pointers that come to mind:

1. No books are adequate (especially Dr. Spock, even though he can be reassuring at times). None take into account the mother as a person. Talking to friends is more helpful.

2. Time for ourselves alone is essential – awake and asleep. You'd be surprised how much getting enough sleep determines your ability to cope. When you're away from you baby, enjoy being yourself; motherhood is only one part of you.

3. For details about the physical care of yourself and your baby:

– Check Lester Hazell's Commonsense Childbirth (not yet in paperback) and Sheila Kitzinger's The Experience of Childbirth.

– If you're planning to breast feed your baby, read some good, supportive books about it first (Commonsense Childbirth has an excellent section on breastfeeding, as does the Kitzinger book, and Karen Pryor's). Don't let people discourage you, and remember that sleep and lots of liquids are necessary.

– Don't let up on your doctor/clinic until all your questions are answered. If you have a question, it's valid even though the doctor may not think so!

– Check with your friends – their experiences will give you support as well as information.

4. Finally, we're including a list of some products we have found helpful (you may or may not). If you get your baby used to these things from the start, you'll probably have less hassle.

– Disposable diapers (Pampers); diaper service; or if you do your own, use diaper antiseptic in the wash.

– Pacifiers (some babies won't ever take them, and probably don't need them, but it's useful to introduce them during the first week to get your baby accustomed to them).

– Baby carriers, infant seats, portable beds, etc. –anything that increases your mobility. A baby can sleep anywhere and under most circumstances if you teach her early enough. Security shouldn't come from a bed or a place but from adult reassurance, and your expectation that the child can do it.

– Other equipment that gives the child mobility and variety: jump seats, swings, jumpers, Mobiles, etc.

– A food grinder (which you can buy for about $1.00) or a blender (a lot more expensive) will allow you to grind all adult food into baby food. It saves money on canned baby food, and it's also almost invariably better for the baby.

We can't emphasize enough that caring for a baby is a learned skill, and one that we are continually learning. Through experience - the everyday variety of trial and error - you and your

housemates will come to know the baby's needs and learn to meet them in the most direct and uncomplicated way.

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Medical Institutions

In the previous sections to this course, we have discussed the problems women face in their encounter with our medical system. We have been given inadequate and often incorrect information on how our bodies function. We can't get birth control, so thousands of us die each year from illegal abortions. Childbirth is often a terrifying and inhumane experience. These problems are not mistakes, they are results of a system which is designed to make profits, maintain a professional elite, and treat certain sick people, rather than deal with the problems of human beings and their illnesses. The purpose of this paper is to show how our medical institutions work so we can better understand how to restructure them for our own use and health.

Doctors, clinics, hospitals, and medical schools do not take responsibility for the health of the people. Health care in America is not a unified system dedicated to keeping people healthy, measuring the results of treatment, or dealing with health problems in the society. It is a system designed to profit certain groups of individuals or corporations. In one study it was revealed that 60% of therapy reviewed was below acceptable standards (Fortune, January 1970). There are practically no preventitive public health programs in the country. Most of the existing programs study epidemiology and innoculate against communicable diseases. When Federal money is allocated to "more important" expenditures, such as the war in Vietnam, even these programs suffer. The Federal government recently decreased funds for a mass innoculation campaign against a German Measles epidemic predicted for the year of 1970. In contrast, it has reported that communicable diseases have been practically eliminated in North Vietnam.

It is well known that German Measles can be serious for children and devastating to the fetus in early pregnancy. It can be very damaging even when the mother has such a light case that she is unaware of it and before she has discovered that she is pregnant. If you are contemplating getting pregnant, it takes two or three months in Massachusetts to have a simple antibody titer test done on your blood. If you don't have antibodies and want an immunization, you have to wait three months after the shot to be safe, and then have another blood test. You can go out of state and pay $10 (in Massachusetts, it is a free state test only) to have the results in a few days.

The factors in our society which produce a great amount of sickness are not dealt with by the medical establishment. In fact, bad housing, poor nutrition, poor sanitation, pollution, and dangerous working conditions are not dealt with by any establishment. The diseases resulting from these factors are obviously suffered mainly by poor people who have no control over them. Unfortunately for the poor, building low income housing, as has been stated many times by builders, landlords, bankers, and city planners, is not profitable. All of the previously-mentioned disease-producing factors could be eradicated if the effort were made and the money were allocated. Recently, the Mass. Dept. of Health refused to set up stricter levels for pollution in our air, although it was reported that the yearly average of sulfur dioxide in Boston, for example, was double the amount at which adverse health effects have been noted. Boston Edison was the voice they listened to when making their standards. The FDA is supposed to screen drugs before their release, but in a recent study in 19 out of 27 drugs, dangerous contraindications were not reported to or checked by the FDA. The FDA, a regulatory agency, is well regulated by the pharmaceutical ("ethical drugs") industry (see The Therapeutic Nightmare). It commonly approves drugs known by the drug companies, and often by the FDA itself, to be unnecessary and lethal.

Children put things in their mouths. In slum

apartments in every city in the country, they are eating lead-based paint which is flaking off the walls. Lead poisoning is also an industrial disease where lead or compounds of lead are used. The human body has no way of eliminating lead. As it accumulates, the initial signs are intestinal pain, muscular weakness, and anemia; later signs, produced by relatively tiny concentrations, are mental retardation and death. The lead lobby, people who profit by the use of lead, are strong enough to prevent other substances being substituted for lead in certain products, such as gasoline.

In the rural South, hookworms live in the soil and enter the body through bare feet. The multiply, are very debilitating, and can cause death. Hookworm infestation is more prevalent among poor people because of the lack of shoes and because malnutrition increases the likelihood of being sick with hookworm. Malnutrition makes the body more susceptible to any infections and many other diseases. Dr. Jack Geiger of Tufts has said: "If I could do just one thing to improve the health of the people, I would double their per capita income."

In coal mines, the coal dust in the air causes black lung disease (Reader's Digest, from the Washingtonian, April 1969), which shortens life drastically. 125,000 Americans have black lung disease. The coal companies have successfully blocked black lung compensation bills in West Virginia. Because the coal companies have refused to install a $50 device which has cut the incidence of black lung in European mines, some miners die and others have to retire at forty with no compensation, so the companies won't have to dig into their profits. Recently a compensation bill was passed, with the money coming out of tax money instead of company profits.

In Boston, workers who dig tunnels for our gas mains, water mains, and transportation systems suffer 20-30% casualties on every job because of dangerous working conditions. In nearly every industrial shop, workers can tell you about unnecessary conditions that endanger life and limb. In 1968, 2,200,000 industrial injuries were reported, 900,000 leading to permanent disability and 14,500 leading to death (HRN 5-69). The only way for these accidents to be decreased is for management to be more concerned with the health of the workers and less concerned with profit.

The U.S. spent $62 billion for medical care in 1969 –

- $35B to "proprietary" hospitals and nursing homes
- $12B to doctor's services
- $10B to supply companies
- $ 6B to drug companies
- $ 6B to commercial health insurance
- $ 2B on medical research
- $ 2B on construction costs for hospital building

America spends more money per person on health than any other country in the world. It is estimated that by 1975, health care will be the nation's largest "industry" in terms of money spent and people employed: our national health bill is expected to be $94 billion. In the last nine years it has gone from $27 billion to $62 billion. This figure includes everything connected with health: drugs, doctor's bills, hospital bills, private health insurance premiums and so on. Someone is making money off sickness, the money is going to profit, not good medical care. Of the $62 billion spent on health in 1969, at least $3 billion are profits, $600 million going to drug companies, $400 million to supply companies, and $1,400 million to physicians and surgeons. In one supply company, 93% of its income comes from disposable items, thus increasing unemployment (no laundering) and pollution (burning the items).

Stock brokers are recommending the health industry for good investments. Some of the companies expanding into health issues are: Motorola, IBM, Monsanto, Litton, Lockheed, and Philip Morris. In its second year, Healthcare Corp., a Boston-based nursing home and medical supply company, made a net profit of $1 million. (In its third year,

Healthcare Corp. has had an antitrust suit filed against it.) The state of New York has banned for-profit corporations from owning hospitals. Has someone realized that profit making is not compatible with high health standards?

America has the most highly developed medical technology, the most equipment, the most drugs, and just about the worst health record of any industrialized country. We rank 18th in infant mortality and 12th in maternal mortality in the world. Of course, as Fortune magazine points out, if you exclude the poor, the figures go up. The non-poor Americans as a group rank 10th in infant mortality, indicating the poor quality of medical care given even to people who pay for what they think is the best care available. Millions of America's children are born disabled or become disabled through medical and nutritional neglect during their early years. We rank 22nd (World Health Organization) in life expectancy for males. If we figure the statistics separately for blacks and whites, we find that black life expectancy is seven years less than that of whites, and that black maternal mortality rate is four times that of whites; a pathetic example of the unequal distribution of medical care. Harris polls show that over one-third of the nation feels ill-cared for in its medical needs. One-third of this nation also lives in poverty or severe deprivation. For all our technology, we discover hunger in 1968.

Medicine, like other fields, has traditionally discriminated against women. Hysteria comes from the Greek word for uterus and was thought to be caused by the wandering of the uterus to various parts of the body because of its longing for children. Hippocrates recommended marriage as the remedy. Dorland's Medical Dictionary defines hysteria as a psychoneurosis with certain symptoms and does not mention any sex incidence. Medical students, however, learn from their teachers (often by snide remarks) that hysteriacs are bound to be women. It is obvious then that a man presenting identical symptoms is defined differently. The difference isn't in behavior, but in the word used.

Doctors' attitudes toward patients are terribly condescending, especially toward women. You aren't supposed to read the record of your own body, and you are scolded like a child if you do. Doctors withhold information that you are dying. They withhold information that you might have a difficult pregnancy or childbirth. In playing God, their attitude is that you must have complete confidence in them to make all of your decisions for you. Why should they make your decisions?

Doctors see women as patients more frequently, women average 25% more visits to the doctor per year than men, not counting the many times they accompany their children. A standard complaint of doctors is that they are tired of neurotic women with nothing wrong with them who come in because they are lonely or dissatisfied with life. Psychiatrists get more women patients. A study showed recently that conceptions of behavior of normal men and normal adults coincided, but behavior stereotypically feminine was not thought by psychoanalysts to be normal adult behavior. No wonder more women end up on the couch, where they are supposed to learn to adjust.* It is also true that many women have a more difficult time adapting to "their roles" in society.

The system fails to provide basic preventive medicine for people. For example, cancer of the cervix or the uterus can be totally cured by early detection by the Pap smear and early treatment. The Pap smear was developed about thirty years ago, and yet today (1970) only 12% of American women regularly get Pap smears. It would be simple (but boring) to have a mass screening campaign. A great proportion of the 14,000 deaths per year from uterine cancer could have been prevented. A young internist recently remarked that he rarely did pelvic examinations of his women patients because it embarrassed him. How many women die because doctors have hang-ups about their genitals?

On the other hand, unnecessary and cruel surgery is often performed. In a study at Columbia, one-third of the hysterectomies reviewed were judged as having been done without medical justification. The study covered 6,248 operations. 30% of the patients aged 20-29 who had hysterectomies had no disease whatsoever. In individual hospitals, the percentage of unnecessary hysterectomies has been as high as 66%. (Carter, The Doctor Business) In Appalachia, doctors have removed healthy reproductive organs from 11 and 12 year old girls to get the $250 fee. Unnecessary surgery is common in America. We have twice as much surgery, per capita, as England. The unnecessary operations are called "remunerectomies" (done for monetary remuneration). How many remunerative testectomies do you think are done?

The medical system is not responsle to the community. It is controlled by the doctors. Fortune magazine says,

> The doctors created the system. They run it. And they are the most formidable obstacle to

* "The country's number one problem", occupying half of the hospital beds, has been designated to be abnormal behavior, people who can't adjust to life situations. Maybe the "sick" person is the one who can adjust to life situations and the society around him or her. It is often not us, but our society, which is sick.

its improvement. It is the doctor who decides which patients will be treated, where, under what conditions, and for what fee; who will enter the hospital, for what therapy, and for how long; what drugs will be purchased and in what quantities.

We also know they decide how we will have our babies and whether anyone can be with us. A private doctor is responsible only for the patients who walk into his office. He (note sex assumption) has no means of knowing what's going on out there in the community, whether the people are healthy, what the medical problems are, what the causes are. Not many doctors will refuse to see a patient who can't pay them, but most will make all possible efforts to direct people without money to clinics. Few patients are willing to press the point that they should get reduced rates or free care from the doctor. It's good to know that if you ask for a reduction of fees, you can get it. Faced with the reality of your income versus his, the doctor does sometimes give in. Recently, however, Robert K. Funkhouse, M.D., of Cambridge, answered a young couple whose income was $5500/year before taxes and who requested to pay $10 instead of $20 for a 20 minute examination:

> Unfortunately it is completely impossible for me to make a living wage at the rate you have calculated. As it is, from a full-time medical practice I am only able to earn something in the neighborhood of $20,000 a year which is not enough to enable me to put my children through college.
>
> While the system of financing medical care in the United States may leave much to be desired, it is the one that existed at the time you made an appointment to come to see me, and I would very much appreciate it if you would pay my fee.

The fee-for-service system sets the tone of private medical care in the country. The doctor sells a commodity to those who want to buy it and can afford it, and he sells it on his terms. All the private doctors in Charlestown take Wednesday off. Patients complained, and they asked the doctors to rotate days off so there would always be someone there. All the doctors in Charlestown still take Wednesday off. For obvious reasons, most doctors prefer the fee-for-service system. This is the system by which the doctor bills the patient himself, the amount based on what the service was and what he thinks the patient can pay. For example, a family without insurance was charged $150 for an appendectomy. A few months later, another child in the family had the same operation and the family was relieved that in the meantime they had gotten insurance. This time the doctor charged $300, $150 for the family to pay and $150 for the insurance. He argued if they paid it before, they can pay it now. This attitude reflects the attitude that 'if it doesn't hurt, it isn't doing any good'. The doctors feel if it doesn't hurt the pocketbook, you won't appreciate the medical care; also, you might lose respect of the doctor if he loses control of the billing process.

There are two alternate systems of remuneration: one is prepaid group practice where the doctors are salaried. The AMA state and local societies have fought this system by using their power to deny hospital admitting privileges to the physicians in group practice. Group practices have difficulties attracting doctors. One western group has been trying to recruit an orthopedic surgeon at $40,000 per year in vain because they can make $80,000. Another drawback in this system is that it may be set up so that salaried doctors may be exploited by senior partners (often doctors) in the business and keep the profits for themselves. The other system is payment per patient treated (i.e. by the government); this is called capitation.

The AMA (American Medical Association) has been an extremely powerful force in insuring that

CLENCHED FIST SALUTE is given by some of demonstrators leaving Hot Americana ballroom after interrupting opening of American Medical Ass meeting. They protested AMA stand on health care measures. (AP)

medicine is practiced for the doctors, not the patients. Although it does not speak for every doctor as an individual, it does write the rules that all doctors must follow. Milford O. Rouse, M.D., last year's AMA president, has asserted that there is a threat to medicine in the concept of health care as a right rather than a privilege. The AMA has the richest lobby in Washington, spending $1.1 million in 1965 (HRN, 8-69). In 1968, AMPAC, the AMA's front for political contributions, gave $680,000 to candidates for national office who think our resources should be allocated to death: wars and guns and ABMs and MIRVs, rather than to clinics and more doctors. It is estimated that five times this amount is spent at the local level.

The N.Y. State Journal of Medicine, the organ of the state medical society, has an interesting definition of illness, although it doesn't look as if the patient would benefit by it (Carter, The Doctor Business).

> . . What does illness mean? Cowardice, malingering, laziness, maladaptation, cussedness, pure worthlessness. . . It is time that someone - everyone - should hoist Mr. Charles Darwin from his grave and blow life into his ashes so that they could proclaim again to the world his tough but practical doctrine of the survival of the fittest. . . The Declaration of Independence said that man was entitled to the "pursuit of happiness". Any man who wishes to pursue happiness had better be able to stand on his own two feet. He will not be successful if he feels that he can afford to be ill.

It has been stated that physicians have a low opinion of humanity.

The AMA has opposed free innoculations against diphtheria and polio, free vaccinations against smallpox, the establishment of Red Cross blood-banks, federal grants for medical school construction and medical student loans, national health insurance and Medicare. In 1938, federal public health authorities made it known that they were ready to spend millions on polio research. The AMA opposed it: "Until we learn more about it, any program which contemplates prevention of infantile paralysis is a bogus campaign." (Carter, The Doctor Business) In 1955, after Salk developed his vaccine, the AMA House of Delegates passed a resolution demanding "immediate termination" of free distribution of the vaccine. The Federal Government's program to innoculate people was called "a violation of the principles of free enterprise". In New Jersey, the state medical society forbade physicians to participate in the free programs except when the patients were paupers. Half of the vaccine purchased by the Federal Government went unused in the first year of the program, due to doctors' unwillingness to participate in free programs. The doctors charged $5 a shot. They get most vaccines free.

The AMA has fought any form of practice of medicine that promotes preventive measures rather than curative treatment. The AMA's positions on pollution, smoking, car safety, and working conditions all show that they put the freedom of the corporations above the concern of keeping people healthy. 45% (HRN 8-69) of the AMA's operating budget comes from the drug and medical supply industries, so the AMA is interested in laws which bolster the exorbitant profits of these industries. An example of such a law is the ability of the drug companies to obtain a patent on a new drug, thus inhibiting competitive pricing. Dr. Milton Rouse has stated the purpose of the AMA by saying that the AMA should "concentrate [its] attention on the single obligation to protect the American Way of Life. That way can be described in one word: capitalism."

The "usual and customary" fee-for-service clause in Medicare was inserted by the AMA, ensuring that the traditional system of the doctors billing the patients be preserved. Subsequently, in 1966, doctors raised their fees 8%, costing the U.S. public $500 million (HRN 8-69). The AMA has also had a hand in setting up hospital practices.

Instead of having health teams to give continuous care necessary for the protection of health, the system in this country is that patients are treated only after they become sick enough for admission to a hospital. (When was the last time a doctor came to your house?) Hospitals are centers for dealing with crisis medical problems. Yet only a few hospitals can do this well. The others do not have enough personnel, equipment, experience, or desire. There are several kinds of hospitals. Proprietary hospitals are owned by private investors, usually doctors, and make a profit for their owners. Their annual reports are often confidential. There are mainly small ones in Boston. Most of the big hospitals around here are voluntary hospitals, originally set up by charitable organizations and partially supported by private contributions although now most of their financing comes from governmental and other quasi-public funds. The other kind of hospital is public and is supported by the city or other government. The source of the financing of the public and voluntary hospitals does not differ greatly (eventually, tax money), but they are benefitting different people. Most of the people who can't pay for their care and who don't have insurance

are supposed to go to the publicly-financed public hospitals while private patients go to the publicly-financed "private" hospitals. But there are many more private and voluntary hospitals than public. The city of Somerville has 88,000 people and no public hospital, one proprietary and one voluntary. Government grants and other monies go mainly to the voluntary hospitals thus insuring that more money is spent on "welfare" to rich and middle class people, rather than poor people.

Most of the hospitals' policies are set up by the doctors who are involved in them. The doctors are in an extremely hierarchical and autocratic pecking order. This pecking order also extends down through nurses, nurses' aides, technicians, orderlies, maintenance, and housekeeping. The decisions are made by the chiefs of each medical department and passed down to each lower person as in the military. This insures that the high people won't be bothered by the low people. There was actually a conference titled "Developing Subordinates" at the New England Hospital Assembly, Spring 1970.

Fortune, January 1970, says that payroll represents 60-70% of hospital costs (which are reaching $100 a day). Fortune cites Mass General statistics of salary increases for blue-collar workers, nurses, interns, and residents which have gone up to $84 and $150 a week, $7,000 and $11,000 a year respectively. These figures fail to mention that senior physicians get around $40,000 in addition to their private patients, and hospital administrators get over $40,000, to one of $75,000 (New York City). 35% of hospital employees are in this upper category and here is where most of the payroll money is going. If a hospital had 100 employees, 35 of them getting $40,000 and 65 averaging $6,000 (which is probably high), then the annual payroll would be $1,400,000 to the doctors and administrators and $390,000 for everyone else. And in their public statements, hospital administrators blame the wage increases of the workers for the increase in cost.

A teaching hospital is any hospital which takes medical students for teaching purposes. The teaching hospitals are run mainly by the medical schools. All of the major hospitals in Boston have relationships with one or more of the three medical schools. Here is one place to look for medical empires. Although the trend is allegedly changing, the medical students practice mainly on "charity" patients, that is, poor people who come in without a private doctor. The hospital is dependent upon the medical school for personnel to do the routine scut work. Taking advantage of medical students and treating them roughly insures they will continue the tradition when they have the power to do so. The medical schools could not teach without patients to work with.

Hospitals are concerned with having the equipment and supplies that allow doctors to practice modern medicine. As it is, they are spending most of their money on equipment and specialists that can meet the most exciting type of medical difficulty. Boston City Hospital recently announced its first open heart surgery case. There are three other places within a ten minute drive (assuming no traffic congestion) where the same operation could have been performed. The hospitals are competing among themselves for prestige. This is why they build another open heart surgery team which costs $500,000 a year to maintain, rather than spend the money on ambulances, community doctors, or local clinics. The Public Health Service reports that in 1967, 776 hospitals had open heart units, but 31% hadn't been used for a year. Not using the equipment and people's skill regularly is very dangerous for the patient. In the Soviet Union, they have centers for such a specialized operation, and the government flies patients thousands of miles to them. Would the community the hospital was supposed to be serving pick open heart surgery over something like 15,000 out-patient visits a year? Prestige is also measured by the "quality" of interns and residents the hospitals get, and they need fancy equipment to get them. Harvard in particular has a number of superlaboratories at hospitals to train people who will be leaders in medical schools all over the country. This helps to maintain Harvard's elitist and highly academic, research-oriented influence on the training of doctors all over the country.

The medical schools are becoming an increasingly dominant force in the way medicine is coming down to people. Doctors are doctor chauvinists as well as male chauvinists. Most women doctors are no exception to this, having taken a role of "honorary men". Although 70% of hospital employees are women, 7-10% of the doctors are women. Two percent of doctors are black (Parade, 11-30-69). Medical schools teach their students very carefully. You learn that you are being trained to occupy an exalted position in the medical world (and society in general), but in the process you must take a lot of shit. Dr. Lewis of Harvard has said: "Doctors go through a greater socializing process than even the priesthood." For at least seven years they spend most of their waking hours not only absorbing medical information, but "learning how to act and think as well". Thus the order in which the doctors dump all over anyone below them is established.

Medical schools are maintained as elitist institutions by their high tuition and the almost total lack of federal aid for scholarships to medical schools (unlike graduate schools). The students are mainly from well-off families. The top 12% of the socio-economic structure in this country provides 50% of the medical students (HRN 8-69). The AMA has fought hard to maintain this status quo. The AMA has also contributed by blocking federal funds to build medical schools, keeping the number of doctors for an expanding population criminally low. In 1900, before medicine was so "advanced", there were 157 doctors per 100,000 population in the U.S. In 1959, there were 132.7. In Massachusetts, the figures were 174, in Mississippi, 69 (EAM, Harris). Somerville has 35 doctors for 88,000 people and their average age is 60.

Medical schools are disease-oriented rather than people-oriented. This leads to the dehumanizing experience of a person being referred to as "a pneumonia in room 222". The medical schools have recently been pushed, largely by students, to reform. A committee of deans and faculty and a few students try to decide what's to be done without asking the people in the community they are supposed to be serving. The community does not represent the same interests as the trustees do: real estate, banking, construction, insurance, drugs, and hospital supply companies. These reports are usually shelved.

The purpose of clinics is to provide care for the patient who can't afford a private doctor. They are run with this in mind. Most of the poor people in Boston go to the clinics at Boston City Hospital, where facilities are so understaffed and undersupplied that a doctor was heard complaining about his inability to find a clean tongue depressor. This concentration of patients is changing a little with the other big hospitals expanding their clinic facilities. BCH serves over 1000 people a day in assembly line fashion. You may see as many as six doctors in the course of your pregnancy. In no case is any effort made that you see the same doctor for any longer than the duration of one particular illness. Disease is regarded as a purely technical matter, the malfunctioning of a machine (the heart is a pump. . .). Work is arranged so that the students, interns, and residents of the teaching hospital can see the maximum number of "cases" in a short period of time. They fail to take the whole person into account, to see that he/she follows as good a diet as possible, to recognize his/her fears and anxieties which may be exaggerating his/her sickness, to see that her/his life is making her/him sick.

In the out-patient department at Boston City, most patients wait two or more hours to see a doctor. Much of the human contact comes in the form of "Alright, numbers one through ten line up and get weighed". There are only two nurses and two aides for sixty patients each morning in the Ob-Gyn clinic. Some new liberal administrators at BCH are concerned that the service is inhuman. They think that the solution is an appointment system, which the Ob-Gyn clinic has had for a long time. Only about half the patients keep their appointment, which messes up the system. The liberal administrator interprets the unkept appointment as a lack of the middle class value of the importance of time, so they plan to give lectures to the waiting patients on the value of keeping their appointments. A few conversations with patients would reveal that when you wake up in the morning, two or three bus trips from the clinic, a household to care for, children to find a babysitter for or lug on the bus with you, not feeling well, and anticipating the bureaucracy and coldness of the clinic, you think twice about going. It takes a lot of will power to go. The appointment system doesn't necessarily decrease the amount of waiting anyway, because patients always come in without appointments.

The Boston hospital system is dimly aware of the fact that they are too far from where the patients live. It is reasonable to have to travel several bus trips to get specialty treatment, involving complicated machinery or specially trained personnel. But basic family services should be available around the corner. The city provides some very fragmented services out in the communities. Mayor Kevin White and hospital administrators give lip service to the need to establish comprehensive care units in neighborhoods. They have vague plans to establish nine such centers in Boston. One has been built in Charlestown, but they have put off any work on the rest of the centers for two years and have given their planning grant to an organization called Hospital Planning for Greater Boston, now Health Planning for Greater Boston. Instead, they announced the construction of a new out-patient facility in an empty lot right across the street from BCH. Again the city and hospital administrators have decided against neighborhood facilities. Perhaps this is because in some places where neighborhood health centers have been established, the community has begun efforts to try to take over their administration and make it serve their needs.

It may be that the city decided to locate the outpatient facility where they did because of the problem of staffing community clinics. Medical personnal clearly prefer the centralized system since it allows efficient concentration of teachers,

students, and teaching material (patients). Out of 1000 people who get sick, 100 go to the doctor, ten go to a hospital, and one goes to a teaching hospital. Our doctors are trained almost exclusively on that one case in 1000. When (and if) they get out and set up a practice and find out that nearly every patient has something minor and/or is neurotic, they are bored. They were trained for more complicated things. The big money is in specialties. The big prestige is an appointment at a teaching hospital.

The need for neighborhood clinics is still desperate. There are only 17 doctors practising in Roxbury, for a community of 70,000 people. Roxbury used to have a hospital called the New England Hospital, which was originally set up as a hospital for women doctors to practice, since they were not allowed into the other hospitals. After the exodus of doctors from Roxbury, the hospital wasn't getting enough patients. A planning firm studied the problem, and concluded that the problem must be an antiquated physical plant, and that they should build a new one (a standard answer). Then some experts from Harvard came along and said the hospital should get federal funds to support certain community services. The hospital's board of directors voted to include the Harvard men on the board. The new board shut down the hospital. They are making plans to put in a maternal and infant care program and a youth program. These programs are extentions of the work of community medicine departments at Harvard teaching hospitals, thus contributing to the increasing fragmentation of medical services and their control by distant institutions who know very little about, and have little concern for, the community.

The Columbia Point Health Center sounded good on the drawing board. It was the first center funded by OEO, the organization consisting mainly of public relations programs to demonstrate to Americans that there really is a Great Society. The grant proposal submitted by Tufts said that the purpose of Columbia Point Center was "to intervene . . . in the cycle of extreme poverty, ill health, unemployment and illiteracy by providing comprehensive health services, based on multi-disciplinary community health centers, oriented toward maximum community participation." Nice language, but it hasn't worked out that way. At Columbia Point, the community has gotten together to fight for its interests and the clinic tries to hold on to its decision-making power. The theory is that it is only the professionals, with all their training, who know

how to run a health center. The reality is that the professionals are isolated, by their backgrounds, their training in elitist institutions, and their positions of authority over the people they treat.

So far, the existing medical institutions have been unable to give proper medical care to all the people. Because of this inability, small groups in a few places have gotten together to form clinics of their own. In the spirit of the idea that health care is a human right, most of these clinics have been free. Our society and the medical world do not take kindly to these clinics, they are not the American Way. The Black Panther Party of Boston has set up a free clinic in Roxbury on the pattern of the Judson Mobile Health unit in New York in which the patients are encouraged to ask questions, and are invited to look through microscopes at their own blood samples, and participate in the decision making. Watch out for harassment. The Free Clinic in Berkeley was attacked by the Berkeley police with cannisters of CS gas during a fight over People's Park. One of the cannisters was shot through the window of the clinic during regular clinic hours. CS is a dangerous substance, especially when used against already sick people. Many medical and scientific personnel in this country spend all their time on research, development, and testing of chemical-bacteriological weapons, yet the Hippocratic Oath says, "I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing."

The drug companies and equipment manufacturers have a clearer position on health care. They admit that they're in the business for the money. Drug companies made over 15% profits on their sales in 1960, it is said to be up over 20% now. This compares with around 9% for the average of the top 500 corporations in the country (EAM). The rise in stockholders' investment in leading drug companies has gone from $287 million in 1947 to $896 million in 1959 and has risen greatly since. In this country there are over 7000 drugs on the market; Sweden, which has a better health record, has only 2000 drugs on the market. The government there limits drugs to the ones it considers useful and safe. Of every dollar we spend on drugs, 6% goes to research and 25% goes to advertising; the cost of the materials was 32%. In tetracycline, a drug known for price fixing, the production cost of a certain amount was $5.03, the sale to wholesalers $24.22, sales to druggists $30.60, the sales to the consumer $51.00 (EAM). Drug companies' expenditures on trying to get doctors to buy their products by means of pamphlets, ads, engraved golf balls, and steak or lobster dinners (at Jimmy's Harborside) amount to $4000 per doctor per year (HRN 8-69). With over 300,000 doctors in the country, think what this money could do if it were spent on medical care. Doctors and hospital administrators also benefit from the high profits of the drug and medical supply companies; often they own stock in these companies and sit on their boards of directors. They are in an excellent position to have their company develop and market what the hospital needs, and to have the hospital buy from the company. The result is higher costs to the sick and a higher standard living for the elite. The major catalog of drugs is Physician's Desk Reference, which is published by drug company interests and distributed free. Needless to say, it lists no price for drugs, so the doctor often has no idea of the costs of drugs (he gets his free).

The medical institutions we have do just exactly what they are intended to do. The drug and supply companies make money, the AMA protects capitalism. The medical schools train a small number of people to fit into the system. The hospitals treat some sick people. The clinics see some people and offer study material to students. None of them is responsible for the health of the people.

Blue Cross was set up during the depression by the hospitals, to insure they would have their bills paid. Blue Cross is non-profit, tax exempt and receives all its funds from its subscribers (and interest from investments). Financial information of Blue Cross is not available, although it accumulates large reserves ($4-5 million in Connecticut alone) which it invests. They have a policy called "experience rating" which evaluates group policies. Those groups who have a higher rate of sickness pay more. Since poorer groups of people are sicker, the poor again pay more. The Board of Trustees of Blue Cross does not have the consumer interest represented unless you count leading businessmen from Con Ed, International Nickel, and Federated Mortgage Investors. Ten out of 23 board members are doctors, hospital administrators, trustees or other medical establishment (HPB, 9-69). When hospitals negotiate reimbursement contracts with Blue Cross, they are often negotiating with themselves.

Medicare and Medicaid were supposed to allow poor people the means to have a private doctor, but the Mass. General still has the White building for poor people, Baker for middle-class, and Phillips for the rich. And the difference is phenominal. The Reader's Digest (8-69) alleges that "the Medicaid program is in deep trouble because a disgracefully large minority of medical professionals have been permitted to cheat both the government and the needy." It is estimated that double-billing,

kickbacks, and overcharging, by our respected medical profession (doctors, nursing homes, druggists and dentists) have amounted to half a billion dollars in the last year alone. Is this what the AMA means when it talks about the American Way of Life? No significant changes can or will be made until an entirely new system of medical care is installed. The present programs like Medicaid and Medicare are designed to protest capitalism and the fee-for-service system and to prevent the coming of the bogeyman, Socialized Medicine. Socialized medicine merely means that medicine is practiced for the people rather than the profession. Many people have advocated a national health insurance. There are three major plans on the drawing boards now: the AMA plan, the Rockefeller plan, and the Reuther plan (HPB, 1-70). These are insurance plans, not socialized medicine. A few people may benefit from them in terms of medical care, but the major beneficiaries as usual will be the doctors, drug companies, the usual. The Reuther plan is the most liberal, but still shares the shortcomings of the others:

– National health insurance (NHI) will reinforce the fee-for-service system.
– NHI will make the health system dependent on private insurance companies.
– NHI has no aggressive cost control mechanisms built in.
– Most of the proposals for NHI are based on regressive taxing methods.
– NHI makes no provision for consumer/community participation in program planning or budgeting.

The medical establishment is being challenged on all sides. It is changing and being changed. There is some federal money available for local neighborhood clinics run by the community, although the AMA and medical societies have traditionally opposed these clinics because they would take some power out of doctors' hands. Doctors are losing some of their power but unfortunately it is not to the people but to the corporations. January 1970's Fortune shows the trend clearly.

The first of four articles on American Medicine is called "Better Care at Less Cost Without Miracles" and extolls the Kaiser Foundation program of prepaid corporate medicine. The Kaiser plan is an improvement at the moment to Blue Cross, but it is still set up to profit the doctors and hospitals. "Any reduction in operating costs below management's projections swells a bonus fund that is shared by doctors and hospitals." In 1968, the Kaiser doctors in Northern California each collected a bonus of $7,900, on top of their $20,000-$53,000.

The third article is "The Medical Industrial Complex". Johnson and Johnson's earnings went from $15 million in 1959 to $59 million in 1968. General Electric "dominates" the medical X-ray machine market. (Past anti-trust suits have shown how GE "dominates"). "According to Arthur D. Little Inc., the total market for medical technology, including electronic devices, probably exceeds $450 million a year." They are talking big business. A headline to this article is "Costly Machines to Save Lives". This is corporate propaganda: if you are against a hospital's purchase of a costly machine, you are against saving human lives. These articles clearly show the shift that is taking place in medicine. Medicine is converting (or being converted) from entrepreneurial capitalism to corporate capitalism. Before we cheer the loss of power of the medical societies, we'd better take a look at what is replacing them.

We will have a National Health Insurance. It will be run either by insurance companies who will obviously run it in the interests of big business (themselves) or it will be run by the Federal Government. In the latter case it will still be run in the interests of big business, much like the Department of Defense. We will have to spend millions in the War against Death as we do in the War against Communism. And it will be in the form of Costly Machines to Save Lives. The situation, like the Defense Department, will be that the suppliers will create the need for goods, will be assured that the goods will be bought for a long time, plan the obsolescence, and fix the prices. Fortune reports that "a single X-ray unit can cost $100,000 and is subject to rapid obsolescence." Like defense, the government, universities, and medical schools have collaborated to serve industry. Much more money is given in National Institute of Health grants for equipment than personnel. The schools are competing with each other and the measure of success has become the amount of equipment possessed.

The construction industry is also benefitting from the surge in medical spending. Their answer has been to solve human problems by building new buildings such as hospitals. This is known as the "Ediface Complex". Fortune's last chapter in the medical series is "Hospitals Need Management Even More than Money". They advised that new managerial approaches and scientific planning methods which hospitals need, demand computers and perhaps going into sideline business ventures (such as hospital supply?) to boost their incomes.

We believe that health care is a human right and that a society should provide free health care for itself. Health care cannot be adequate as long as it is conceived of as insurance, which is the

business of taking in $100 from 100 people to guarantee them against loss by a contingent event and then paying out $40 to the people the event happened to and pocketing the rest. The profit system guarantees that certain people will benefit and the rest will be exploited. We will gain nothing by pumping more money into our present system. Health care for everyone is possible only outside of the profit system. Elitist attitudes and patients being regarded as "consumers" would not be supported if society and its institutions were run by and for all of the people.

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Women, Medicine, and Capitalism

Marcuse says that "health is a state defined by an elite." A year ago, few of us understood that statement. What does he mean? We believed that all people want to be healthy and that some of us are more fortunate than others because we have more competent doctors. "Now you should go to Dr. A. Man. He's my doctor and he's just great!"

Today we understand the stark truth of Marcuse's statement. We have not only started to look at health differently, but have found that health is one more example of the many problems we as people, especially as women, face in this society. We have not had power to determine medical priorities; they are determined by the corporate medical industry (including drug companies, Blue Cross, the AMA and other profit-making groups) and academic research. We have learned that we are not to blame for choosing a bad doctor or not having the money to even choose. Certainly, some doctors have learned medical skills better than others, but how good are technical skills if they are not practiced in a human way?

We as women are redefining competence: a doctor who behaves in a male chauvinist way is not competent, even if he has medical skills. We have decided that health can no longer be defined by an elite group of white, upper middle class men. It must be defined by us, the women who need the most health care, in a way that meets the needs of all our sisters and brothers – poor, black, brown, red, yellow and pink.

THE IDEOLOGY OF CONTROL AND SUBMISSION

Perhaps the most obvious indication of this ideology is the way that doctors treat us as women patients. We are considered stupid, mindless creatures, unable to follow instructions (known as orders). While men patients may also be treated this way, we fare worse because women are thought to be incapable of understanding or dealing with our own situation. Health is not something which belongs to a person, but is rather a precious item that the doctor doles out from his stores. Thus, the doctor preserves his expertise and powers for himself. He controls the knowledge and thereby controls the patient. He maintains his status in a number of ways: First, he and his colleagues make it very difficult for more people to become doctors. (For instance, for thirty years the AMA opposed the expansion of the existing medical schools, primarily to protect their entrepreneurial economic privilege.) Second, he sets himself off from other people in a number of ways, including dressing in whites. (In fact, in most hospitals there is a rigid hierarchy which is demarcated according to dress: doctors wear whites, nurses wear white with a cap denoting what school they attended, nurses' aides wear another color uniform, and housekeeping women still another color. The implication being, of course, that it is very important not to confuse one group with another.) Another much more important way doctors set themselves off from other people is through their language. Pseudoscientific jargon is the immense wall around that body of information, experience, etc., which they consider as medical knowledge. (epistaxis = nosebleed, thrombosis = blood clot, scleral icterus = yellow eyeballs, etc.)

Thirdly, doctors insulate themselves from the rest of society by making the education process (indoctrination) so long, tedious, and grueling that the public has come to believe that one must be superhuman to survive it. (Actually, it is like one long fraternity "rush" after which you've made it and can do what you like. Only members of the club get to learn the secret, which is that doctors don't know much to begin with and are bluffing a good deal of time.) Thus, a small medical elite preserves its own position through **mystification**, butressed by symbolic dress, language, and education.

It is important for us to understand that mysti-

fication is the primary process here. It is mystification that makes us postpone going to the doctor for "that little pain", since he's such a "busy man" It is mystification that prevents us from demanding a precise explanation of what is the matter and how exactly he is going to treat it. It is mystification that causes us to become passive objects who submit to his control and supposed expertise.

OBJECTIFICATION

We know that we as women are objectified as sex objects in our society. Any woman who has walked alone at night knows the feeling of vulnerability and helplessness that accompanies our awareness that we are being perceived as pure sex objects. The medical setting further objectifies a person. The patient is assumed to be an object on which one can "objectively" and "scientifically" perform certain operations. The patient is merely the vehicle which brings the disease to the interventionist (instrumentalist). The outgrowth of these assumptions is that the best place for a doctor to act on a patient is in the hospital, i.e. when the patient is horizontal, passive, most like an object. Finally, that part of a person which is considered sick is further separated and removed. ("The ulcer in 417." or "We did a gall bladder today.") For us as women, the treatment of any gynecological or obstetrical problem thereby results in the alienation of us from our own body, from our own genitals.

ALIENATION

Naomi Weisstein, in her essay on women, 'Psychology Constructs the Female", has outlined very well how the society has caused the alienation of a woman from her body. Freud's impact cannot be overestimated; we have internalized the notion that woman is incomplete, that something is missing. This alienation leads to a condition which is epitomized by the middle class woman, who, whenever she feels ill, goes to see her gynecologist. The implication: whatever is the matter with her has to do with her sexuality.

Alienation is also what makes it hard for us to talk about sex. Our sexual experience is so privatized that we never find out that other women have the same problems we do. We come to accept not having orgasm as our natural condition. We remain ignorant about our own sexuality and chalk it up to our own inadequacies. And if we should be so bold as to go to a doctor - and if we should summon up the courage to ask him about our common problem - chances are he will know nothing about it, although he will never or rarely admit this and will probably laughingly dismiss our questions. Doctors in general are as ignorant about sexuality as the rest of the men in society.

Doctors' blatant ignorance about sex stands in stark contradiction to the fact that they are considered the only legitimate person to consult about any sexual problem. Thus, we bring all our awkwardness and ignorance about sex to a doctor who cannot understand that his own ignorance and arrogance are the epitome of male chauvinism. (Add any man's standard portion of male chauvinism to the whole mind set and life style of the man who controls knowledge and thereby people

"for their benefit" and we come up with the doctor of our society.)

Which brings us to preventative medicine. We as women are made to feel uncomfortable about going to a doctor in the first place. If we cannot feel comfortable going to our doctors normally, then to go for preventive reasons will be all the more difficult. Thus, while the medical profession has come out in favor of massive screening of women for cancer of the breast and cervix (the cervix is the neck of the uterus, or womb), their practice, their approach, their manner - that is to say, their ideology - all works in the opposite direction. First, our complaints aren't important enough, since we think that we aren't important. (A man is made to feel uncomfortable in a different way; he is made to feel that it isn't masculine to admit to a minor ailment, since he should be tough and not feel it.) The net result is that both men and women postpone seeing a doctor, whom they regard as too important to be bothered. And when the visit involves a pelvic examination, it is even less likely a woman will go through with it. Small wonder that only 12% of the women in this country who ought to have "Pap" tests (short for Papinicolaou, the guy who invented it) for cervical cancer get them. This is one of the very concrete ways that male chauvinist medicine means poorer health care and health protection for us.

We cannot begin to write here about capitalist forms of medicine per se; that is to say, the prohibitive cost of medical care, the racist and inferior treatment of poor people and black people, the profit and prestige-making institutions of the "health industry" (hospitals, medical schools, drug companies, etc.), the total neglect of the public or preventive protection, or the fee-for-service, pay-as-you-die economic base upon which most medical practice is based. This is an important and extensive issue which must be dealt with elsewhere. Suffice it to say that capitalism is incapable of providing good health care, both curative and preventive, for all the people. Cost-benefit analysis trades off the benefit to the people of collective public health in favor of the cost to the people of private, patch-up medical care. The capitalist medical care system can be no more dedicated to improving the people's health than can General Motors become dedicated to improving the people's public transportation. Our difficulty in perceiving the similarity between the health care system and any other corporate capitalist enterprise in the society results from our acceptance of the rhetoric that medicine helps people.

FROM THE AUTHORS . . .

Beginning September 1972 we plan to publish a revised expanded "Our Bodies, Ourselves" with Simon and Schuster.

We've struggled for a long time over this decision. Our decision is based on one main consideration: We want the book to get out more quickly to more women in more places.

We feel a tremendous sense of urgency: We all quickly need good information about ourselves and the system which oppresses us. As we rewrite the book, we realize how little we knew about ourselves to begin with, how much we've learned over the past three years, how much we still need to learn, how much effort it takes to go through the complicated process of changing ourselves and of challenging and changing existing institutions.

We want the book to reach women who don't ordinarily come in contact with movement publications. We have a sense of the **womens' movement** becoming larger and more unified than it is now.

We feel that the movement doesn't yet have an adequate distribution network to get the book into places like chain markets and drugstores. Our collective doesn't have the time and energy right now to work on building this network.

So we want to take advantage of the extensive complex distribution channels already set up by the large publishing companies. In this way we are making use of Simon and Schuster. Yes they will make money. Yes they will charge you more for the book.

Yet we have written up a strong contract. Two of its provisions are most important. First, clinics and health counseling services will be able to buy **at cost** (70% off the retail price) as many books as they'll need. Simon and Schuster has agreed to see to the distribution of these books. Second, our collective is wholly committed to trying to get the books free or at low cost to individuals and to all groups which don't qualify as clinics, etc., such as womens' groups. We'll buy these books with our royalties. We'll also receive a substantial sum from the sale of the book to a mass market company. So all money made by the book goes back into making the book widely available.

As for control, we retain the copyright to the book; we have only sold distribution rights. We have made provision for a Spanish edition. We retain control over cover design, blurb, and advertising. We expect hassles—we've already had some notable ones—but we count on having the strength to keep as much control as we need to. We feel we can use the "establishment" to our advantage.

Maybe you regret the choice we've made. Maybe you would have made a different choice. But we plan to stick by our decision.

And the Free Press will continue printing and distributing the book up until S & S publishes it again in the fall. Continue to order through the Free Press.

Your letters have been crucial to us. They are moving and exciting and have given us a lot of energy to continue working on the book. They give us a good sense of who the book is reaching so that we're not just talking among ourselves. By adding your knowledge and experience to ours you've improved the content scope and power of the book. We've realized too that many books of this kind need to be written.

So we welcome your letters and communication. We read them all but we can't answer them all. We know that the book will continue to grow and change. It will be continually revised and continually alive.

You can write to us at our new address: Boston Womens' Health Book Collective, Box 192, West Somerville, Mass. 02144.

Judy - Ruth - Norma - Wilma - Mary - Jane - Nancy - Pam - Wendy - Esther - Paula - Joan

. . . AND A REPLY FROM THE NEW ENGLAND FREE PRESS (distributors and co-publishers)

We disagree with the Boston Women's Health Collective's decision to publish with Simon and Schuster.

The book is reaching many, many women. "Our Bodies, Our Selves" has sold itself, it needs no capitalist distributor. By May 1972, after more than a year with New England Free Press as sole distributor, 90,000 copies of the book have been distributed. Lately they've been going at the rate of 15,000 a month, and the rate is accelerating.

At Simon and Schuster's selling price of $2.00, white and third world poor and working women will be less able and likely to get the book. Presently, most women receive the book from women's centers, health and abortion services and other women's organizations. Many of these groups will find themselves too poor to buy the book **in quantity**.

There is a provision in the contract that certain groups will be able to buy the book at 60¢ a book. The groups that qualify for this discount are: health clinics **licensed** by the state or federal government and/or organizations that do health counselling service in whole or in part and whose incorporation papers are filed with the federal government. Many of the groups that do good political work through use of the book are neither licensed nor incorporated and will not qualify to buy the book at 60¢. Simon & Shuster is not in business to get tens of thousands of copies of OBOS **at cost** to movement organizations. It is our opinion that S & S will be able to get around the Health Collective's commitment to getting the book to these groups cheaply. **No** contract, no group can control the complex bureaucracy of a capitalist publishing house. S & S has the actual power to make daily decisions about executing the contract terms.

The Health Collective plans to get the book to all groups that are distributing the book free or at its present low cost. They will be using their royalties (on a sliding scale starting at 12¢ per $2.00 copy sold) to subsidize purchases by groups who could not otherwise afford the book. But we seriously doubt that this will work out as the Collective hopes.

The method of subsidizing will be for the Collective to buy books from S & S at 60¢ each and send them to groups they wish to subsidize. Taking into account the 15¢ per book that postage will cost the Collective, the first 50,000 copies of the book sold at $2.00 will result in the Collective's being able to subsidize 8500 copies. The first 100,000 copies of the book sold at $2.00 will lead to the Collective's being able to subsidize 20,000 copies. This doesn't compare too well to the 10,000+ copies being sold to women's organizations and health groups **every month** now. And we foresee further difficulties for the Health Collective in setting up a distribution system to handle the requests for subsidized books.

We at the Free Press feel strongly that "Our Bodies, Our Selves" should continue to be distributed through the Movement where it will help build a socialist women's consciousness. Women are now getting the book from political people and organizations they trust. This makes the book part of a personal process of political education. Selling the book through capitalist distributors in bookstores or even supermarkets will only impede that process.

The genuine widespread need for "Our Bodies, Our Selves" has also helped to expand Movement distribution channels. More people have had contact with the Free Press, more have been introduced to radical literature. The movement becomes more self-sufficient and people have more faith in anti-capitalist alternatives. Indeed, the book itself was written to relieve women's dependence on medical institutions and authorities in caring for our bodies. Why then turn the book over to the publishing institutions and authorities, thus forfeiting the control over its distribution.

As the Health Collective has signed the contract with S & S, it looks like we will have to stop distribution in September. Please plan to stock up before time runs out on us. But you should be aware that the S & S edition will have 50% new material, since the capitalists have demanded this in their contract.

People who use OBOS should know that the Health Collective can still break their contract with S & S. Groups which will not be able to use the book at its inflated price should immediately protest the Collective's decision.