UNIT 6 – Health Outcomes of Violence Against Women: Mind and Body

OVERVIEW

At first glance the parts of the unit mental health, addictions and eating disorders may not appear to be connected. In fact, the stresses that result from women's lived experiences often result in poor health outcomes. Depression itself can lead to substance abuse and to eating disorders. In a similar way eating disorders can lead to depression and abuse of alcohol, drugs and tobacco. This unit will provide a statistical overview of the extent of each of these health problems and then proceed to look at each one individually. Mental health concerns, substance abuse and eating disorders are health problems that many women face. There is a growing body of literature that links these three health issues with various forms of abuse in women's lives including child sexual abuse, and physical and emotional abuse of women in domestic settings. Regardless of when acts of violence occur in women's lives the health outcomes that can follow such acts often create health problems for women for the rest of their lives.

The five parts of this unit are:

PART I	Violence Against Women: An Overview
PART II	Mental Health
PART III	Eating Disorders
PART IV	Substance Abuse
PART V	The Healing Process: Feminist Interventions

LEARNING OUTCOMES

In Unit 6 you will:

1. begin to make connections between violence in women's lives and the ensuing health outcomes;
2. examine the extent of depression in women's lives and how it impacts their health;
3. understand the dimension of eating disorder and some of its underlying causes;
4. consider the reasons for substance abuse among women;
5. learn about feminist interventions and how they differs from standard forms of psychotherapy.

Unit Six

All readings are available online from the J.N. Desmarais Library or the internet and are linked from the course website (see the Study Guide for details).

ASSIGNED READING

Mason, "Hospital-Based Responses to Woman Abuse: How Well are We Doing?" pages 117-121.

Moussa, "Violence against Refugee Women: Gender Oppression, Canadian Policy, and the International Struggle for Human Rights."

Lemieux, "The Sexual Well-Being of Women Who Have Experienced Child Sexual Abuse."

OPTIONAL READING

Schreiber, "Wandering in the Dark: Women's Experiences with Depression."

Morris, CRIAW Fact Sheet: Violence against Women.

INTRODUCTION

Violence against women is an integral part of Canadian society. Many women would argue that they have not experienced violence in their lives. The pervasiveness of the problem, however, is evident by the fact that many women feel that it is necessary to lock their doors or they are fearful of walking the streets alone at night. Using the data collected in the Violence against Women Survey done in 1993 Holly Johnson reports that half of all women in Canada said that they had experienced at least one violent incident in their lives before they had reached the age of 16 (92). The problem is that locking the doors at night does not keep out the violence; most women experience violence at the hands of someone they know and often in their own homes. Only seven per cent of the violence against women in Canada is committed by strangers (McKenna and Larkin 10).

Even though violence by a stranger is not the most common form of violence women face, the fear of random acts of violence shape women's lives. Katherine McKenna and June Larkin, in *Violence against Women: New Canadian Perspectives* (2002), argue that women are subject to "a gender-based and generalized fear that controls and shapes women's lives in multiple ways" (10). Fear of violence is a factor that consciously or unconsciously informs their choices such as when to go for a run, whether or not it is wise to go to the late show, whether they should take the night shift, and so on. Thus, McKenna and Larkin argue that violence against women must be viewed as "a form of social control that operates to regulate female behaviour" (10).

Violence against women has health outcomes. Some of these are obvious such as the bruising that occurs following domestic violence. Others are not so obvious. The health problems experience by women that are increasingly being linked to violence against women are issues such as depression, eating disorders and substance abuse, particularly the abuse of alcohol and tobacco. The emphasis in this unit is on these conditions because they impact on many areas of a woman's well-being, and can lead to chronic health conditions and thus threaten women's ability to live a healthy life.

Ending violence against women will not be easy. This unit provides some insight into the extent of the task that lies before Canadians if they are to see an end to child sexual abuse, domestic violence, and workplace harassment. Ending violence against women would mean fundamentally changing the way that Canadian society is structured. As McKenna and Larkin state, it would mean ending all forms of power abuse, as well as structural inequalities including unfairness and discrimination in Canadian society, not just against women but it would mean ending racism, heterosexism and classism (17).

KEY CONCEPTS

- health outcomes of violence against women
- steps to end violence against women
- eating disorders
- differences between various eating disorders
- understanding eating disorders
- major vs. minor episodes of depression
- why do women smoke?
- explaining the causes of women's depression
- feminist interventions

PART I -Violence against Women – An Overview

Please read, Moussa, "Violence Against Refugee Women: Gender Oppression, Canadian Policy, and the International Struggle for Human Rights."

A good place to begin is with the available statistics. The Canadian Research Institute for the Advancement of Women (CRIAW) provides us with the following data drawn from The Violence against Women Survey (1993) and statistics compiled by Statistics Canada (2005):

- Half of all women have survived at least one incident of sexual or physical violence.
- 29% of women have been assaulted by a spouse. Nearly half of these suffered physical injury including bruising, cuts, scratches, burns, broken bones, fractures, internal injuries and miscarriages.
- Four out of five people murdered by their spouses are women. Every week at least one woman is murdered by a current or ex-spouse, boyfriend or ex-boyfriend. In most instances police were aware that the relationship was violent.
- Eighty percent of family-related sexual assaults are committed against girls; over half of family related physical assaults against children by family members are committed against girls. In 1997 fathers were the aggressors in 97% of all sexual assaults and 71% of physical assaults of children committed by a parent.
- Only 10% of sexual assaults on women are reported to the police. If we were to extend this data to the entire female population we would find that there are 509,860 reported and unreported sexual assaults every year in this country or 1,397 each day. Every minute of every day a female person in Canada is sexually assaulted. Very often sexual assaults are repeated on the same woman or child by the same offender.
- Ninety-eight per cent of sex offenders are men and 82% of the survivors of these assaults are girls and women.
- Data from the Women's Safety Project (Toronto 1993) reveals that forty-three per cent of women reported at least one act of sexual violence before the age of 16.
- Wife battering carries into old age. Spousal homicide accounts for 30% of the murders of women over the age of 65.
- About one million Canadian children have been a witness to violence against their mothers by their fathers or father figures. In more than half of these cases, the mother feared for her life and in 61% of the cases the mother sustained physical injuries. These children often exhibit signs of post-traumatic stress disorder, and their social skills and school achievement are adversely affected (http://criaw-icref.ca/indexFrame_e.htm).

Violence against women is not just a Canadian or North American issue, its dimensions are global and the statistics above could be extrapolated to reflect that. However, the numbers alone do not tell the whole story; some women are more vulnerable to violence than others. Young female children are highly susceptible to sexual assault. While boys are also subjected to an unacceptable level of sexual abuse, it appears in terms of children under 12 who are sexually abused, girls outnumber boys two to one.

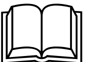
What is more surprising is the number of disabled women who are sexually abused. A survey done by the DisAbled Women's Network found that 40% of women with disabilities have been raped, abused or assaulted. More than half of those who had been abused were disabled from birth or early childhood. Aboriginal women are also a vulnerable group as are all women who belong to visible minority groups (Canadian Women's Health Network 2002).

✍ IDEAS TO REFLECT ON

As you read the article by Moussa, respond to the following:

1. Briefly outline the current global refugee situation (as outlined in the article by Moussa) and some of the reason given in the article for the displacement of women, children and men.
2. "Sexual torture of women is designed to destroy their identify as women" (189). Why is this done and why do women have so little recourse against the violence they experience?
3. Why are many women at a disadvantage under Canadian immigration policies?
4. On what basis can the author claim that "an abused refugee woman claimant may be in a particularly precarious position…." (192/202)?
5. In her conclusion the author states that "there are two key processes that particularly need to be assessed" to determine the effectiveness of the Immigration and Refugee Board (IRB) Guidelines on "Women Refugee Claimants Fearing Gender-Related Persecution" (191). What are they?

HEALTH OUTCOMES OF VIOLENCE AGAINST WOMEN



Please read, Lemieux and Byers, "The Sexual Well-Being of Women Who Have Experienced Child Sexual Abuse."

Knowing the health impact of violence against women is difficult. One problem is that there are different kinds of violence against women. They include physical, psychological and what McKenna and Larkin refer to as "structural forms of abuse" that include "systems that produce inadequate health care, economic vulnerability, cultural racism and other discriminatory processes" (10). As was explained in the first unit, violence against women is one of the critical determinants of health. Violence can function as a way to maintain inequalities in gender relations (McKenna and Larkin 10). A battered woman who turns up at the hospital with cuts and bruises can have those treated and, in the short term, it may appear that she has few visible marks; however, in the long term the trauma is not easy to diagnose and the implications for her overall health and well being are impossible to gage.

Health practitioners and professionals such as psychologists and psychiatrists are beginning to realize that there are long-term health implications associated with the violence and fear of violence that many women deal with daily. A recent study completed by the British Columbia Centre for Excellence for Women's Health suggests that the impact of violence against women who suffer from serious mental illness has been routinely overlooked in health planning, clinical practice and in educational manuals (Violence and Trauma 2000). In fact, the author of the study, Marina Morrow, claims that even today many mental health professionals

are reluctant to acknowledge the role of violence in women's lives by dismissing it outright, downplay its significance or viewing it as a separate issue rather than a mental health issue.

Making the connection between violence and women's health issues is anything but straightforward. However, there is a growing body of literature that is beginning to show that violence in women's lives can have health implications particularly in terms of women's mental health, eating disorders, and substance abuse. For example, we have known for some time now that the prevalence of child sexual abuse appears to be higher among female psychiatric inpatients (Violence and Trauma 2000). The study conducted in British Columbia Centre for Excellence in Women's Health, cited above, surveyed women at Riverview Psychiatric Hospital and found that 58% had been sexually abused as children (Violence and Trauma 2000). Another study that factored in both physical and sexual abuse found that 83% of women in an inpatient setting had these experiences (Violence and Trauma 2000). American studies reveal similar findings. For example, Sarah Ullman and Leanne Brecklin writing in the *Psychology of Women Quarterly* (2003), found that women who had been sexually assaulted as children were more likely to be diagnosed with post-traumatic stress disorder and other chronic medical conditions (47).

To show the extent of problems experienced by children who have experienced violence in Canadian society the organization, Champions for Children Foundation (http://www.championsforchildren.ca/mandate.htm), reports the following:

- Eighty- to eighty-five percent of women prisoners were victims of sexual abuse;
- Children with a history of sexual abuse are seven times more likely than other children to abuse alcohol or drugs;
- Individuals who have suffered abuse are more likely to be unemployed than those who have not suffered abuse;
- Young people who leave the child welfare system are twelve times more likely to be homeless within a year than other young people leaving home.

In her article "Exploring the Continuum: Sexualized Violence by Men and Male Youth against Women and Girls," Aysan Sev'er provides two theories that attempt to explain violence against women: social learning theory and feminist orientations (75). Social learning theory suggests that individuals learn to be violent through "observation, modelling, reward systems, or lack of punishment, and thus highlight the inter- or intra-generational transmission of violence" (75). Sev'er points out that children who live in situations where violence against their mothers is taken for granted will sometimes perpetuate that violence in their own relationships.

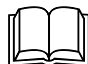
Social learning theories help to explain the extent of violence against women in our society, but Sev'er also provides some feminists explanations. She argues that feminist theory focuses on the inequality that exists between women and men and particularly the way in which men hold more power and have greater control over the resources in our society than do women (76). "Feminists," she argues, "underscore the fact that even men who do not directly harass, abuse or otherwise subjugate women benefit from the status quo where women's chances and choices are compromised" (76). In other words, patriarchal society in which men hold the balance of power in terms of status and the control of resources, reinforces the fact that the way our society is structured is natural. Therefore, men continue in positions of power and authority and women remain vulnerable particularly to poverty and violence.

✍ IDEAS TO REFLECT ON

After reading the article by Lemieux and Byers, consider the following points:

1. What are some of the methodological problems facing researchers on the sexual functioning of women with a history of child sexual abuse?
2. According to the authors what is the impact of child sexual abuse on women's sexual functioning?
3. What are some of the limitation to the Lemieux and Beyers research?

HEALTH RISKS RESULTING FROM VIOLENCE AGAINST WOMEN



Please read, Mason, "Hospital Responses to Woman Abuse: How Well are We Doing?"

Obviously the most serious health risk that violence poses for women is death. Canadian Statistics for the year 2000 show that between 1979 and 1998 1,468 women were killed by either current or previous male partners or husbands. A host of other physical health problems have been linked to women's experiences of violent behaviour at the hands of men. Damage to the central nervous system, sleep disorders, migraines, respiratory-related problems, heart problems, and reproductive problems, and many other health problems, have been identified as being connected to violence in women's lives (Violence and Trauma 2000). In Unit 4 you will recall that Sarwer and Durlack the authors of "Childhood Sexual Abuse as a Predictor of Adult Female Sexual Dysfunction: A Study of Couples Seeking Sex Therapy" concluded that their research showed that "sexual abuse may predispose individuals to greater likelihood of adult sexual problems" (Sarwer, et al. 969).

Eating disorders are increasingly connected to abuse in women's lives, particularly in young adolescent women. This is a new area of research and there are few statistics available to enlighten us to the extent of the problem. Research by Diann Ackard and Dianne Neumark-Sztainer, in their article "Date Violence and Date Rape Among Adolescents: Associations with Disordered Eating Behaviors and Psychological Health," found that date violence and rape are significantly associated with disordered eating behaviours and psychological health (468). In her article "Gender, Race, Childhood Abuse, and Body Image among Adolescents" Kim Logio's research uncovered similar findings. Logio examined the influences of race, gender and sexual or physical abuse on unhealthy eating and dieting practices among black and white adolescents. She found that the impact of past sexual or physical abuse emerged as a significant predictor of unhealthy dieting and eating behaviour for women (931). A study reported in *Healthy Weight Journal* (2002) by Jay G. Silverman used data from the Youth Risk Behaviour Survey in Massachusetts that found that one in five girls have experienced physical or sexual abuse by a dating partner (50). The authors found that a reported history of physical or sexual dating violence predicted unhealthy weight control practices, including the use of diet pills, laxatives, or vomiting to lose weight. They also found that other health risks were associated with a history of dating violence including abuse of alcohol, cigarettes, cocaine, high-risk sexual behaviours and suicide (50).

It has been pointed out that many victims of abuse repress their memories or have disassociated themselves from the abuse. Because of this they are unable to face the fact that abuse may be the root cause of their eating disorder. Some women who have either anorexia nervosa or bulimia nervosa (or both) use their illness as a way to protect themselves against the memories of abuse. “Facing issues of abuse can be very painful, so most people feel they need to forget about it or make the memories disappear (www.mirror-mirror.org/abuse.htm). Coleen Thompson writing for Eating Disorders Mirror-Mirror, an eating disorders website, argues that some women suppress their memories of abuse because they either blame the abuse on themselves or they do not believe that anyone will believe them. That being said, it must be made clear that depression and other mental health problems that women face, including eating disorders and substance abuse, are not always caused by violence in their lives. Health problems are caused by many factors, some of which overlap and are complex and difficult to solve.

✍ IDEAS TO REFLECT ON

After reading the article by Mason, consider the following questions:

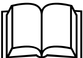
1. According to the author, how extensive is wife abuse in Ontario?

2. How many of these women require medical attention?

3. According to the author what is the state of the policies/protocols, the training and education and the quality assurance and accountability in place in hospitals regarding the treatment of abused women?

4. What are some of the influencing factors that prevented those who participated in the survey from acting when they discovered that a woman they were treating was an abused woman.

PART II - Mental Health



Optional reading Schreiber, “Wandering in the Dark: Women’s Experiences with Depression.”

Depression has been called the “common cold of women’s health” (Semler 333). This is not an attempt to trivialize what is a very serious health issues for women, but rather to suggest the severity of the problem. Janet Stoppard in *Understanding Depression* gives evidence that one-third of the women interviewed for her study had experienced depression. Women also reported stress, anxiety, tiredness and disturbed sleep (6).

Generally Canadian women experience depression at twice the rate of Canadian men. Young women tend to have more depressive episodes than older women. According to Statistics Canada in the 2003 8% of women 15-17, 9% of women aged 18-19, 7% of women 20-44 and 6% of women 45-54, 3% of women 55-64 and only 2% of women 65-74 and 1% of women 75 and over exhibited symptoms of a mood disorder (Women in Canada 2005 67). That being said it appears that young women recover from depression faster than older women (5 week vs. 10 weeks) (Women in Canada 2005 67).

Exactly what depression is and how it should be defined has caused debate among mental health professionals (Stoppard 6). Depression is a strictly defined illness that is believed to be caused by a network of biomedical and social issues (Semler 334). Depression is not just a matter of feeling "blue" or "down." As a mental disorder "depression is diagnosed when a recognizable constellation of symptoms is present and the symptoms are reported by the person experiencing them to have been present for a period of time, usually two weeks" (Stoppard 7). Some of these symptoms can include feeling sad, dejected, and hopeless, coupled with being pessimistic about themselves and their future prospects. As well, lack of interest in normal activities, social withdrawal, having physical complaints such as aches and pains, difficulty sleeping, loss of appetite (or overeating) and in severe cases thoughts of suicide (Stoppard 7).

The characteristics that define depressive disorders are those listed by the American Psychiatric Association in their *Diagnostic and Statistical Manual of Mental Disorders-4th edition,* commonly referred to as the *DSM-IV.* The DSM is a guide prepared by mental health professionals to assist them in diagnosing depression and other mental health disorders.

Thus far in this section the focus has been on what is referred to as major or clinical depression. However, minor depression is also common among women. The label minor depression does not suggest that the depression is less important than a major depression. Rather it is a term used to compare less debilitating emotional episodes of depression to more severe or longer lasting episodes. Sometimes chronic physical problems, aches and pains, may be at the root of an emotional problem. This is not to say that chronic pain is "all in your head" but rather to recognize that unexplained pain could be indicative of depression. Often proper treatment of the mental disturbance will result in a "cure" of the physical symptoms. Too often individuals do not want to admit to a mental health problem because of the stigma attached to a diagnosis of depression and they continue to go untreated.

EXPLAINING THE CAUSES OF WOMEN'S DEPRESSION

The American Psychological Association undertook research specifically aimed at uncovering the causes of women's depression. They reviewed hundreds of studies and determined that most often the underlying cause of depression arises from the social context of women's lives (Semler 338). The authors of *Our Bodies, Ourselves* claim that women have known for centuries that you cannot separate women's emotional well being from their physical selves (122). In *Understanding Depression* Janet Stoppard argues that "at the core of social models of depression is the idea that people become depressed because of the things that happen to them" (74).

The notion that women become depressed because of what is taking place in their lives is not new. In the early part of the twentieth century Freud drew a connection between mourning and depression and health professionals have for some time noted the connection between events of loss in the lives of women and depression (Stoppard 75). Researchers have found a number of other causes that contribute to the high rate of depression in women some of which are discussed below:

Abuse/violence against women: The most important explanation for depression from the American Psychological Association's study was abuse, already noted above. In fact Semler states that "abuse – physical, sexual and emotional – was at the top of the list of almost every mental health care expert that participated in the study undertaken by the American Psychological Association (338). Almost half of all women suffered some type of abuse and half of it originated within their families (Semler 339).

Woman's role as wife and mother: High rates of depression have been found among women who are full-time moms with many children to care for. Certainly, being home with children can be a satisfying experience. It can also be a source of stress. Caring for a family and children can be burdensome and the nature of the work is undervalued. As well many women must now combine their homemaking and childcare responsibility with low-status, low-paying jobs outside the home. As seen in Unit 3 on reproductive health, new mothers are sometimes prone to depression associated with the demands of motherhood.

Relationship problems: Women derive a great deal of self-esteem from healthy relationships. These may be romantic relationships or relationships with children, grandchildren or friends. When relationships sour, depression is often close behind. Semler argues that women who are in an unhappy relationship, such as marriage, are twenty-five times more likely to be depressed than women in a happy relationship. Depression arising out of failed relationships occurs in a number of ways. For example, depression can occur by association. That is, a woman's own relationships may be fine but she may be shouldering the burden of someone close to her who is having relationship problems, i.e., the breakdown of a child's marriage. Having a child that is chronically ill can lead a woman into depression. As the traditional care providers of others, women feel that they are expected to be the one to hold things together. The task is sometimes overwhelming and can lead to depression (Semler 343).

Low-control jobs: Most women who are employed outside the home for pay are in low status, low-paying, and often part-time jobs. The jobs offer them little opportunity for creativity or for initiative. The work is strictly regulated in terms of when they start, when they take a break, and when they can leave. The work itself can be repetitive and is often stressful and demanding. The value of the work they do is seldom recognized as being of any value to the workplace. Many of the women are underemployed, that is, they have educational qualifications that surpass what the work demands, but they have taken the job because it provides some income without putting a strain on family life.

Poverty: Women are the poorest people in Canada. One in every five women in Canada is living in poverty. Among the poorest women in Canada are women who are heading families and raising children on their own. Half of senior women are poor. The poorest of the poor, however, are disabled women and Aboriginal women who had an average income of only $13,300 (CRIAW 2002). Thirty-seven percent of visible minority women are poor. In every category mentioned, men have higher incomes than women. In fact, even after years of lobbying and legislation for equal pay for work of equal value, women will make only 73 cents for every $1 earned by a man in full-time jobs (CRIAW 2002). Education doesn't always make a difference. In 1997 a man employed full-year, full time with less than a Grade 9 education earned on average $30,731; a women with a post-secondary certificate or diploma earned less for full-time, full-year work $29,539 (CRIAW 2002). It's depressing!

Growing older: While menopause itself does not necessarily lead to depression in women, the onset of old age in our youth-oriented society does lead to depression in some women. Older women are more likely to live alone, to experience the death of a lifelong partner and to see their friends die before them. They are subject to poverty, poor housing, sleep problems and other health factors that can lead to depression.

HEALTH CONSEQUENCES OF DEPRESSION

Depression and substance abuse often go hand in hand. They appear to be circular problems for women. In other words it is often difficult to know what came first – depression that led to substance abuse or substance abuse that led to depression. The abuse and depression are often compounded by the fact that women who are substance abusers are often ostracized by society further exacerbating both the substance abuse and the depression. Depression can also lead to eating disorders as discussed above. However, the most severe health outcome of depression in women is suicide. Although men are successful at suicide four times more than women, women actually attempt suicide three to four times more than men. Women are hospitalized for attempted suicide one and a half times more than men. According to the Canadian Mental Health Association, people with mental disorders are a high risk for suicide. Suicide is the second leading cause of death for Canadians between the ages of 10 and 24 and it is the eleventh leading cause of death in Canada. Studies indicate that more than 90% of suicide victims had a diagnosable mental illness. People with severe mood disorders account for 15 to 25% of all deaths by suicide (Canadian Mental Health Association 2003).

PART III - Eating Disorders

Most women in the western world are dissatisfied with their weight. A 1998 survey of 37,500 young women between twelve and fifteen at England's Exeter University found that over half listed appearance as the biggest concern in their lives. The same study found that 59% of the girls aged twelve and thirteen who were suffering from low self-esteem were also on a diet. Other studies have found that more than half of teen girls are, or think that they should be, on a diet. They are anxious about the forty pounds that girls normally gain when they are between eight and fourteen. Some of these young women will go too far in their desire to be thin and will become either anorexic or bulimic (ANRED 2003).

ANOREXIA NERVOSA

Anorexia is an eating disorder that is characterized by significant weight loss resulting from excessive dieting. Anorexics consider themselves to be fat, no matter what their actual weight is. Often they do not realize they are underweight even when their weight falls to 80 pounds and may still claim that they are too fat (Mirror, Mirror 2002). This is the rarest form of eating disorder with approximately 1% of young women in North America suffering from anorexia (ANRED 2003). Although men too can be anorexic, nine out of ten people suffering from anorexia are female. Most anorexics are young but there is a growing body of literature on eating disorders among older women.

BULIMIA NERVOSA

Bulimia is an eating disorder that is characterized by a cycle of binge eating followed by purging to try and rid the body of unwanted calories (Mirror, Mirror 2002). A binge will vary according to the individual. For some it may be consuming as little as a thousand calories, for other it could mean eating as much at ten thousand calories in a short period of time. While purging usually means vomiting the food consumed, it also includes the abuse of laxatives, diet pills, diuretics and enemas (Mirror, Mirror 2002). Some bulimics fast or exercise excessively to rid themselves of the binge. Research suggests that about four per cent of university-aged women are bulimic. Almost half of women with anorexia also are bulimic.

BINGE EATING DISORDERS

This eating disorder is similar in some ways to bulimia except that after binging on large quantities of food in a short space of time there is no attempt to purge (Mirror, Mirror 2002). Those who suffer from binge eating disorder are often obese, that is, twenty percent or more are above what would be their normal weight. They often suffer pain, guilt and embarrassment because of their eating habits and their weight (Semler 456).

There is often considerable overlap among these eating disorders and individuals can experience more than one type of eating disorder at the same time. It was once thought that eating disorders was a white, middle-class problem. However, it is now widely accepted that eating disorders span all classes and races. There are considerable health risks associated with eating disorders. The most severe outcome is death; one in five anorexics will die as a result of their illness, usually from cardiac arrest or suicide (Semler 457).

UNDERSTANDING EATING DISORDERS

The study of eating disorders is a relatively new area of research. Because of this there is still much that is unknown about the problem (ANRED 2002). This unit has already made a connection between violence in women's lives and eating disorders. It is an important connection and one that must not be overlooked. Not everyone who has an eating disorder is a victim of violence. Nor is it being suggested here that women who have experienced violence in their lives will have an eating disorder. Many theories have been used to explain women's eating disorders including the influence of the media and popular culture; a parent who is preoccupied with their weight; being teased, bullied or harassed because of a person's size, gender, colour, physical abilities or disabilities; physical changes in the body such as those that take place at puberty and pregnancy; participation in activities where extreme thinness is promoted such as dance, gymnastics and modelling and issues concerning a woman's personality. The following will discuss three theories: society's obsession with thinness and the stresses that occur around the time women go through puberty and personality issues.

Society's obsession with thinness One of the most popular explanations for eating disorders among women is society's obsession with thinness. In fact, gender difference in eating disorders may be due in part to the fact that our society has different expectations for women and men in terms of how they look. Men are expected to be strong and powerful and, on the one hand, will do at lot to maintain a thin physique, but on the other hand will build a strong, muscular body with exercise. As well as building their body, men will consume protein rich foods to "bulk up" their physical frame (ANRED 2003). For women the expectations are different. There is an old saying that claims that, "you can never be too thin or have too many silk blouses." A *Glamour Magazine* survey in 1984 asked readers to answer the question "What would make you happiest?" Forty-two per cent put weight loss at the top of their list (ANAB 2003). This will not surprise anyone. Every form of the media promises rewards to thin women – good jobs, handsome boyfriend, fashionable clothes – rewards that are unavailable even to those women whose weight is average by North American standards.

The media's image of women is far from accurate. It is true that about 60% of North Americans consume more food that is necessary, but many of the super thin models we see in magazines are, in fact, computer generated images that have been both edited and airbrushed. Even though the average woman in North America is 5' 4", weighs 145 pounds, and wears a size 14 dress, the Barbie doll that young girls love to play with is 6 foot tall, weights 101 pounds, has a 39" bust, a 19" waist and hips that are 40 - 42" and wears a size 4 dress. Store mannequins that

display the clothes that women are expected to purchase are more representative of Barbie than they are of the average women. The media image is totally out of line with reality of women's body size but the media image – the ever present runway model - is a constant reminder that there is something wrong with those women who do not look like them and that women who do not measure up to the model or the Barbie are inadequate and the pressure to conform to the media image is ingrained in our society (ANRED 2002).

Physical changes in the body such as those that take place at puberty. Ruth Striegel-Moore of the Wesleyan University Academy for Eating Disorders, points to the stresses that the onset of puberty and adolescence can have on young women. Some girls may fear maturation and if they begin puberty before they are emotionally ready for it the consequences can be severe. Their resistance to breast development, weight gain and menstruation may make them vulnerable to an eating disorder as they attempt to control the changes taking place in their body (Semler 458)

Personality The personalities of women with eating disorders are receiving attention. Some researchers have identified "eating disorder personalities" that include the inability of some women to cope with stress, feelings of inadequacy and ineffectiveness. These women may have more difficulty coping with personal relationships, and may have unrealistically high goals for themselves and may tend be perfectionists but with overlying low self esteem (Semler 458). Women with eating disorders are often overly concerned with what others think of them; they are often competitive and anxious to please. "Combine these qualities with a skewed body image, outside pressure to be skinny and beautiful, chronic dieting and hunger, a hypercritical parent and chronic depression, and you can see a highly vulnerable individual" (Semler 458).

Health Risks of Eating Disorders

Certainly the most severe health risk of eating disorders is death: 20% of people with eating disorders will die (ANRED 2002). However starvation and cycles of binge eating or purging can place an enormous strain on the body and mind. There is a host of physical conditions that arise out of disordered eating. These include lack of energy and general fatigue, cessation of the menstrual cycle, skin problems, dizziness and headaches, dehydration, shortness of breath, irregular heartbeats, cold hands and feet, bloating, constipation, hair loss, stomach pains, decreased metabolic rate, water retention, loss of bone mass and eventually osteoporosis, kidney and liver damage, insomnia, infertility, cathartic colon caused by laxative abuse and cardiac arrest (ANRED 2002). As well, women who suffer from eating disorders are likely to experience depression with its own set of health risk factors.

PART IV – Substance Abuse

Similar to the way in which research on depression has either ignored women or presented studies that have been gender blind, research in the field of addictions has followed a similar path. Elizabeth Ettorre in "What Can She Depend On? Substance Use and Women's Health," argues that a feminist perspective is needed to uncover the issues that help to understand women's substance abuse. Ettorre argues that until the 1980s the lack of research and thus the absence of a body of literature on women's use of addictive substances led addiction counsellors, psychiatrists and psychologists to assume that this was a male issue and had little relevance to the lives of women. We now know that women, like men, can also abuse alcohol and become addicted to cigarette smoking. These issues will be discussed in this section of the unit.

WOMEN AND ALCOHOL

Alcohol is a drug commonly used and misused by women for centuries. Eighteenth century working class women seemed to favour gin and bought cheap homemade versions of it purchased from street vendors (www.news.bbc.co.uk). It was mixed with warm water to "soothe the nerves" and was often known as Mother's Ruin. In the nineteenth century middle-class women used patent medicines prescribed by health practitioners (both conventional and traditional) the base of which was alcohol and opiates. In fact, alcohol was the primary component in many commercially available patent medicines. These preparations were used for a variety of women's complaints such as menstrual cramps and anxiety (www.ccsa.ca). The use of these substances was so widespread that many women came to depend on them. The use of laudanum, an opium derivative, grew tremendously in the late nineteenth century. The few studies that have been done on opiate use in the 1880s suggest that women users outnumbered men two to one. Although it was socially unacceptable for women to drink publicly, the medications they received from doctors assured a continuous supply of alcohol. In middle-class society the "ill" or "indisposed" woman was widely accepted.

WHY DO WOMEN USE ALCOHOL?

Today women are still seeking the help from medical professionals to deal with issues that cause distress in their lives. Too often the underlying causes are ignored; rather the reasons for women's distress are masked either by easily accessible drugs such as alcohol or by prescription drugs particularly psychotropic drugs such as Valium and Prozac. Jillian Fleming and her colleagues writing in "The Relationship between childhood Sexual Abuse and Alcohol Abuse in Women—A Case-control Study," admit that the underlying causes of women's drinking remain obscure (1787). However, their work attempts to make a connection between childhood sexual abuse and women's alcohol abuse. They found that women undergoing treatment for alcohol abuse reported higher rates of sexual abuse than did women in the community at large.

Women are drinking at a younger age than ever before and developing alcohol-related problems earlier. As well as the issue of violence against women that contributes to women's use of alcohol, it has been suggested that the advertising of alcohol is often aimed at young people. The ads often show people in their late teens and younger hanging out with friend and having a great time. The message is that the use of alcohol will bring companionship and add a social dimension to a person's life. It is very appealing. Then again, there are many contemporary alcohol-based beverages that make early drinking easier such as wine coolers and fruit-based drinks made with hard alcohol. Everything about these drinks suggests a harmless social time with friends. These light drinks, however, contain as much alcohol as the equivalent amount of beer or even a shot of hard liquor. Because these drinks often look and taste just like fruit juice instead of hard liquor, they are sometimes consumed faster and in larger quantities than hard liquor alone would be.

It has been argued that women aged 35 to 49 who are divorced or separated or in some other way are suffering from "role loss," are more likely to drink than women in a stable relationship (Semler 379). In fact, it appears that those women who are unmarried, unemployed or work only part time are at greater risk of alcohol abuse. These women tend to have difficulty concentrating and have problems with insomnia. A number of researchers have noted that

women who abuse alcohol also have a tendency to abuse other drugs. Others have made a connection with women's abuse of alcohol and their family background. If they come from a family where alcohol was abused, they are more likely to abuse alcohol themselves.

ALCOHOL: HEALTH CONSEQUENCES

Until the 1980s it was difficult to come to grips with the rate of substance abuse by women. It is now widely accepted that approximately one-third of alcoholics are women. Knowledge of gender differences in alcohol use has increased substantially over the past few years. We now know that the physical and psychological damage done by alcohol abuse occurs more quickly in women than in men. Semler argues that alcoholic women are four times more likely than alcoholic men to die prematurely (378). Women who abuse alcohol have an increased risk of breast cancer and the lessening of inhibitions that can come with the alcohol can lead to sexually transmitted diseases such as Hepatitis C and HIV (Semler 378). Alcohol is seen as a "disease of losses" because the abuse of alcohol can lead to the loss of self-esteem, hobbies, time, friends, jobs, access to an automobile, and families.

Semler points to the various ways in which the female alcoholic is different from the male alcoholic. For example, when given alcohol, women react more intensely to the same amount of alcohol than men do. For example, when women and men consume the same level of alcohol women will develop a high blood alcohol level sooner. After drinking a similar amount of alcohol, a woman who is the same size and weight as a man will absorb 30% more alcohol into her bloodstream. While the reason for this is still unclear, one suggestion is that women have less body water than men for the same amount of body mass. A theory that is receiving considerable attention of late is the one that suggests that women metabolize alcohol differently than men (Semler 379). The argument is that women have less of an enzyme called alcohol dehydrogenase in their gastric tracts. This enzyme can be viewed as an alcohol buster, that is, the enzyme has the ability to break down or dilute alcohol before it enters the blood stream. Since women have less of this enzyme, so the theory goes, the alcohol that they drink is more likely to enter their bloodstream as alcohol rather than in a more diluted form as it would for men who have more of the enzyme.

WOMEN AND SMOKING

For the past 500 years tobacco was the sacred plant of Aboriginal peoples. When it was first commercialized it was largely men who smoked. Phyllis Jensen in "A History of Women Smoking" tells us that some women did smoke, but it was rare for a woman to smoke in public. The corn pipe was used by some Appalachian mountain women, and small cigars were used by bohemian women but generally their numbers were few (Jensen 29). Women who did smoke were viewed as either vulgar or having lose morals. At a time when marriage was one of the few options open to women, smoking was seen as an activity that would reduce a woman's chance to find a husband (29).

The prevalence of cigarette smoking grew during the First World War. It was common during the war for women's groups to send what was known as "soldier's comforts" a small package that contained chocolate, gum, hand-knit socks, and cigarettes to the troops overseas. These commercially manufactured cigarettes were made using a curing method and a strain of tobacco that produced a milder smoke and one that was easily inhaled. The new additives that the cigarettes contained were able to deliver more smoke per ounce of tobacco and gave the smoker a bigger "hit of nicotine," an addictive drug (29). Needless to say, thousands of young

men returned from the war addicted to tobacco. However, women war workers also began to take up the smoking habit and by 1920 about 5% of women smoked (29).

In the early 1920s the tobacco companies eyed women as an untapped and lucrative market for their product. A psychologist discovered through his research that women who smoked viewed cigarettes as symbols of freedom and liberation from the restricted roles society placed on them. Thus advertising cigarettes to women was framed around the themes of freedom and liberation. Women who had been able to "escape" society's traditional roles such as aviator Amelia Earhart and singers, actors and even women doctors were used to endorse cigarettes in advertisements during the 1920s (29). Debutants were paid to smoke in public; tobacco companies sponsored social events where the elites of society liberally used cigarettes.

In the 1920s the time of the "flapper" and the Jazz Age when thin was increasingly a measure of a woman's social value, it was discovered that a cigarette before supper could suppress hunger. Women used smoking more and more to control their weight. Today weight control is the reason most often given by adolescent girls for starting to smoke. Jensen describes one advertisement where a slim young woman is sitting beside an obese woman and the slogan reads, "When tempted to overindulge reach for a Lucky" (Lucky Strike cigarettes was a popular brand of cigarettes used last century) (30). Another popular slogan stated: "Light a Lucky and you'll never miss sweets that make you fat" (30).

The campaigns launched by the tobacco companies to target women were very successful. It took only one generation until one third of women in Canada were regular smokers (30). Today male smokers outnumber women smokers by a slight margin (23% vs. 20%); men also smoke more cigarettes per day (18% vs. 15%) than women (Canadian Tobacco 2003). In Canada there are provincial differences and racial differences in smoking rates. For example, Quebec has the most smokers: 33%; British Columbia has the lowest number of smokers: 24%. Racial differences are also evident: while 39% of non-native women smoke 65% of Dene women and 77% of Inuit women smoke. In fact, the percentage of First Nations adolescents in Canada who smoke is among the highest rates for adolescent girls in the world (30).

WHY DO WOMEN SMOKE?

✍ Before beginning this section, list the reasons why you think women smoke:

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Certainly, we have known about the health hazards of smoking for decades but that knowledge has made little difference to the number of people smoking. In fact, young women are smoking in greater numbers than ever before. During the 1990s women in the age group 15-19 increased their rate of smoking by 10% to 31%. One of the problems is that a cigarette today does not mean you will die tomorrow. For example, lung cancer has a twenty-year development rate (Jensen 30). Few women realize the extent to which smoking is an addiction that is as difficult to overcome as the use of heroin. Jensen argues that the nicotine found in cigarettes is a paradoxical drug because it has the ability to produce opposite effects (Jensen 30). Jensen explains it this way. Unlike the way that most drugs are ingested, tobacco is smoked and is, therefore, controlled by the user. Small, shallow puffs provide the user with a small amount of nicotine that stimulates the user and allows the smoker to stay awake, alert and physically active long after she should be resting. This allows many women, Jensen argues, to carry the triple load of worker, mother and wife (30).

A heavy drag on a cigarette allows for a larger intake of nicotine. This can release B-endorphins, "a natural feel-good, made-in-the-body morphine-like hormone that calms and relaxes during period of stress and anxiety" (Jensen 30). The nicotine allows women to control their feelings, swallow their anger, dampen their rage, and handle greater amounts of stress (Jensen 30). The nicotine produces a "natural high" as it forces the body to release its own hormones. Unlike the use of amphetamines and illegal drugs such as heroin and cocaine, the control of thought and physical performance is not lost with the use of tobacco, and can even be improved (Jensen 30). When viewed in this light it is somewhat understandable that the more stress a woman is under, the more likely she will smoke, and the less likely she will be able to quit (Jensen 30).

In explaining why women smoke Jensen cites statistics on marginalized women who smoke to a greater degree than other women. For example, women who are victims of violence are unemployed and women living in poverty are much more likely to smoke than employed women, and women with a good income.

The Canadian Women's Health Network cites the following reasons as explanations for women's smoking:

- to suppress appetite and to avoid putting on weight
- to take a break from caring for others, such as children or elderly parents
- to take a break from work responsibilities
- to cope with relationship problems
- to cope with feelings of powerlessness
- to cope with the loneliness or boredom of social isolation – smoking can seem like an old friend
- to maintain society connections
- to create distance to cope with uncomfortable or dangerous social situations

SMOKING: HEALTH CONSEQUENCES

Regarding the health consequences of smoking Tracy Semler in *All About Eve* puts it succinctly--"smoking is suicide for women" (386). Semler claims that "it's hard to find any type of women's health problem that's not exacerbated or caused by smoking" (386). In Canada one woman dies every 35 minutes from a smoking-related disease (Jensen 30). Lorraine Greaves in "Filtered Policy: Women and Tobacco in Canada" (2002) points out that "smoking related diseases continues to be the number one killer of Canadian women." Where women are concerned, tobacco use is the number one preventable cause of death and disease (Canadian Cancer Institute 2001). For example, lung cancer, a key smoking-related disease, has now surpassed breast cancer as the leading cause of cancer death in women; 85% of lung cancer can be attributed to smoking. Smoking also doubles the risk of cardiovascular disease, the leading cause of death in women.

It also appears that like alcohol women may be more affected by tobacco than men. The reason for this is not fully understood due to the lack of research (Greaves 2002). Just the same there are some gender specific vulnerabilities that have been identified. Women who smoke have more problems with infertility than those who do not smoke, they are more likely to begin menopause earlier, and they are more susceptible to loss of bone mass (Sembler 386). Smoking is directly linked to a number of cancers from which women die such as oral cavity, esophagus, larynx, bladder, pancreas, ovary, and cervix (Jensen 30). Some recent research has suggested that girls who begin smoking when their breasts are still developing have a higher chance of contracting the disease that other women. This is of particular concern since girls in their early teens are the fastest growing group of new smokers in Canada.

Short-term health problems are also attributed to smoking. Problems; pregnant women are more likely to miscarry, have stillborn babies or low birth weight babies and babies who die from sudden infant death syndrome (Jensen 30). Women smokers also experience more frequent coughs, colds and minor illnesses than those who do not smoke (Canadian Women's Health Network 2003.

PART IV – THE HEALING PROCESS: FEMINIST INTERVENTIONS

For the health issues discussed in this unit the healing process is challenging. Mental health problems are treatable. In fact, 80-90 percent of people with major depression can be treated successfully. However, the stigma that plagues the label of being or having been "mentally ill" often prevents individuals from seeking treatment. Only about one-third of people with a mental illness seek help (Centre for Addiction 2003). Almost thirty percent of people with mood disorders reported that it took over ten years for them to receive a correct diagnosis.

Likewise recovering from an eating disorder can be a slow process. It can take as long as three to five years of "slow progress that includes starts, stops, backward slides and ultimately, movement in the direction of mental and physical help" (ANRED 2002). Without treatment, up to twenty percent of people with serious eating disorders die; with treatment that number falls to three percent. When treated, sixty percent of people with eating disorders recover and maintain a healthy weight. However, even people who have been treated can relapse, and in fact about 20% only partially recover from the disorder. About twenty percent of people with eating disorders do not recover. They are seen repeatedly in emergency rooms, eating disorder clinics and mental health programs. "Their quietly desperate lives revolve around food and weight concerns, spiralling down into depression, loneliness, and feelings of helplessness and homelessness" (ANRED 2002).

In terms of recovering from smoking addiction, large-scale smoking cessation trials show that women are less likely than men to initiate quitting and more likely to relapse if they do quit. Women who attempt to quit using the nicotine replacement method such as the patch or gum find that curbing their cravings for tobacco is more difficult for them than it is for men (Bjornson et al. 223). In "Health and Behavioural Predictors of Success and an Intensive Smoking Cessation Program for Women," Phyllis Jensen and Robert Coambs found that there were certain factors that worked in favour of women's smoking cessation and others that worked against them. For example, women with a history of asthma and women who get pregnant have a strong motivation to quit smoking. Others who had a difficult time quitting are women whose mother smoked and women at home with a number of children (Jensen and Coambs 66). Addiction to smoking is treatable but treatment is not always successful. It usually follows a pattern of quitting, starting and quitting again (Bjornson et al. 223).

This unit has argued that there is a connection between women's mental health, the rate of eating disorders among women such as anorexia nervosa and bulimia nervosa, and women's addiction to alcohol and tobacco and violence in women's lives. Thus of the first issues in the overall approach to healing from depression, substance abuse and eating disorders should be to end violence against women. As already noted in this unit, violence is not always the root cause of women's health issues but a growing body of literature affirms the connection between various forms of abuse in women's lives and negative health outcomes. This research cannot be ignored. The Canadian Women's Health Network and the Canadian Research Institute for the Advancement of Women are highly critical of the government's action on ending violence against women. Even though the health outcomes of violence against women cost the state $1.5 billion a year for short-term medical and dental treatment for injuries, long-term physical and psychological care, time lost at work and the support of transition homes and crisis centres, clinics for eating disorders and smoking cessation programs and detoxification programs, the government has done little to end violence against women. Studying the issue and publishing the findings, which the government does, is not enough. Definite steps must be taken, particularly with respect to child sexual abuse and domestic violence. These are not private family matters; violence against women is something the entire community must assume responsibility for. Jennifer Howard writing for The Canadian Women's Health Network suggests the following ten steps that can be taken to end violence against women:

1. **Listen to women and believe them.** It is extremely rare for a woman to make up a story about rape or abuse. You may be the first and only person she tells. Believe her and support her decisions about dealing with her history of violence, without being judgemental.
2. **Health and violence in their lives.** Most women are survivors of some type of violence. Take care of yourself and do what you can to help yourself heal both emotionally and physically. Get counselling; join a support group.
3. **Break the silence.** When you are ready, tell other people your own story of survival. Breaking the silence about our own experiences can reduce the shame that surrounds abuse and can empower other people to talk about their own experiences.
4. **Make violence your business.** Keeping violence against women private helps no one. If you believe that someone is being abused – ask them. They might not tell you right away, but it will send a signal that you can be trusted to believe them when they are ready to talk.

5. **Raise non-violent children.** Talk to children in your life about violence. Help them find non-violent ways to resolve conflict. Don't use violence (spanking) as punishment.
6. **Use your time, energy and money to promote women's equality.** Women make up the vast majority of victims of violence. Get involved in organizations working to end poverty and violence against women.
7. **Speak up against negative media images.** The media often uses images of violence against women to sell products. If you see an advertisement or commercial that you feel is offensive to women, write/fax/email the company (the information to do this can usually be found on the internet). If acts of violence against women on television are passed off as entertainment, file a complaint with the Broadcast Standards Council or the Canadian Radio and Telecommunications Commission (CRTC).
8. **Help girls protect themselves.** Help girls build confidence and self-esteem. Let them know they are important as individuals. Talk frankly to them about sex and dating, stressing respect and their right to choose. Provide them with the information they need to protect themselves against an unwanted pregnancy and sexually transmitted diseases.
9. **Encourage people who commit violence to get help.** Don't judge them. Let them know that their behaviour is unacceptable and that there are counsellors and support groups to help them change.
10. **Remember.** Participate in acts of remembrance of victims of violence like the annual December 6 Vigil in memory of the victims of the Montreal Massacre. Celebrate survival.

The authors of *Our Bodies, Ourselves* note "the world is not an easy place for women" (122). Many women carry with them the pain of past traumas that arise from the condition of their lived experiences. It is a challenge for them to find ways to move through the pain and to take charge of their lives in order to live a fulfilling and healthy existence. The challenge to find treatment for these disorders can be a daunting task especially in places such as Northern Ontario where the shortage of psychiatrists and psychologists is acute. For those women who experience eating disorders, addictions, and mental illness, finding a competent feminist therapist can be a lifesaver.

As women allow themselves to focus on their own health concerns, as they nurture friendships and join community activities and/or support groups, women will gain a greater control over their well-being. When they do this victims of violence will discover that they are not alone. When depression threatens women and when patterns of abuse repeat themselves, it may be time to look for someone knowledgeable to talk through the issues that are causing pain. The authors of *Our Bodies, Ourselves* explain how therapy, or what is increasingly referred to as feminist intervention, can assist women in dealing with the pain of violence in their lives. Feminist interventions, are designed to promote women's safety, health, positive life styles, personal strength, competence, and resilience (Worell 335). Feminist sought new intervention theories and practices because of dissatisfaction with the way that conventional therapy viewed women's experiences. They were particularly concerned with the lack of attention paid to cultural issues, sexual orientation and the stereotypical notions about how women should behave. An important aspect of feminist psychology is to promote the empowerment of women as well as to develop in them "personal strength and resilience in the face of past, current and future adversity" (Worell 336). Women can be empowered by learning how to develop the strength to change behaviours and beliefs, and to place their concerns in the appropriate context whether

that is personal, interpersonal, or societal. Women can also learn to develop the skills that will help them solve current life problems, to communicate more clearly and effectively, to learn about setting limits and to establish appropriate boundaries. Feminist interventions can teach women how to ask for help and what kind of help is needed in order to better understand themselves (123).

In "A Feminist Approach to Psychotherapy" authors Shirley Addison, Shelley Glazer and Eimear O'Neill argue that the issue of power lies at the core of the differences between standard forms of therapy where the therapist is the "expert" and feminist interventions where equality is established and trust is formed between women seeking help and the counsellor. Conventional therapy follows the medical model where the patient's emotional state is evaluated using a rigid disease model and often results in diagnosis and treatment, usually with drug therapy (69).

A FINAL NOTE

This unit has attempted to make connections between some of the health issues that women experience, namely, depression, eating disorders and substance abuse with the level of violence that many women face throughout their lives. There is a growing body of literature that substantiates the connection. Violence against women is a serious social problem that has health outcomes for women. Only by ending violence against women will we see improvements in women's overall health and wellness.