The Public i, a project of the Urbana-Champaign Independent Media Center, is an independent, collectively-run, community-oriented publication that provides a forum for articles on issues of local impact written by authors with local ties.

The opinions are those of the authors and do not reflect the views of the IMC as a whole.

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You don’t need a degree in journalism to be a citizen journalist. We are all experts in something, and we have the ability to share our information and viewpoints with others. Contact one of the editors to find out how you can help with the Public i. Our editors meet on the second Saturday of the month at 5:30pm at the UCIMC, to post a story to the website (http://www.ucimc.org), or to contact one of the editors.

If you or your organization would like to become a sustaining contributor to the Public i, or would like more information, please call 344-7265, or email imc-print@ucimc.org.

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Meetings every Sunday at 5pm at the IMC

Jul-Aug 2006•V6 #6

Anarchy & Christ
Eric Anglada

Postpartum Blues
Marcia Zumbahlen

Homeopathy & You
Barbara Raska Antisdel

Health

Habari Connection Awards Dinner

Habari Connection Inc. is hosting an Awards Dinner SUMMER CAREER SUCCESS TRAINING PROGRAM
Tuesday, July 18th from 6-8pm at the Park Inn Free Dinner. Donations Appreciated. Open to the public.

Contact us to RSVP By July 10 Contact Tanya Parker, Habari Connection Inc. 217-766-6374, or habariconnection@gmail.com

Join us in honoring the youth that have successfully completed the Career Success Training Program, and learn more about Habari Connection Inc. and its vision for our community. Through our work with Independent Media Center, to help create an even more dynamic impact. We have several awesome events coming soon!

From June 19 through July 15, Habari Connection Inc. sponsored a 4-week Career Success Training Program. They experienced career exploration, learned sales presentation skills, entrepreneurial skills, and how to set up a business. The program was focused on helping youth to achieve their personal success. Our program was featured in the News Gazette on June 23, 2006, by Amy Reiter.

We are looking forward to seeing you at the dinner. If you cannot make it to our dinner, but would still like to be informed of our activities or make a contribution to Habari Connection, feel free to contact us.

Mail donations to:
Habari Connection
P.O. Box 6684
Champaign, IL 61826

Please make checks payable to Independent Media Center, Memo Habari Connection. A percentage of donations support the IMC.

Thanks for helping us to strengthen the Champaign-Urbana community.

Invited Guest Speaker:
Gloria Thompson-Brown, Civil Rights Activist

Please call today, SPACE IS LIMITED: 766-6374 for more information.

WE CREATE LEADERS FOR LIFE.

Get Involved with the Public i!
HPV: Prevention of Cervical Cancer Through Vaccination

By Suzanne Trupin, M.D.

A HPV vaccine has been hailed by gynecologists as the most significant breakthrough in Women’s Health of the century. The first HPV Vaccine has been approved by the FDA. HPV is a DNA virus that infects skin and mucosal tissues and causes cell changes that lead to what is known as cell proliferation (overgrowth) and formation of neoplastic changes (premalignant and malignant). These vaccines have the ability to prevent the majority of cervical cancers, a cancer thought to be virtually 100% preventable. Two vaccine are one: the newly approved Merck quadrivalent vaccine Gardasil®, targets four types of the HPV virus 16, 18, 6, 11. It is a vaccine that gives the individual a fairly rapid immunity to one of four types of the HPV virus. Merck has targeted the HPV 16 and 18 viruses because they together are the responsible for 70-80% of cervical cancer cases. They included 6, 11 because they cause genital warts and abnormal pap smears, and the vaccine has the ability to prevent 90% of those. There are over 100 identified types of the HPV virus. A second vaccine was developed to target only HPV 16 and 18, called Cervarix®. FDA approval is still being sought.

The quadrivalent vaccine that has been approved is a series of three shots, with the second shot administered two months after the first, followed by a final shot four months later. The injection is not that of a live virus, but that of the proteins of the outer shell that are called VLPs or virus like particles, that are perceived as the virus by the body, and robust antibodies are formed to that particle. With this antibody formation, for at least the few years that the vaccine has been studied, there is virtually complete immunity formed against HPV. The immunity means that persistent infections are absent. There is almost complete protection against the virus acquisition in those not infected, even in those that didn’t adhere completely to the study protocol.

Cervical cancer has been a world wide epidemic for generations. Over 500,000 cases are diagnosed world-wide; over 250,000 women die. They die in the midst of their reproductive lives, but the numbers pale, and fewer than 4,000 American women die each year here of this disease. This is due to the wide availability of pap smears, accurate tests to diagnose the primary causative agent, referral to gynecological treatment and effective elimination of most pre-invasive cervical disease. We in the United States also do fairly well at preventing the diseases of anal cancer, vaginal cancer, vulvar cancers, the rare penile cancer and laryngeal papillomatous growths as well. Yet, even with our medical system of track and triage the burden of genital warts has continued to grow: 20 million infected Americans, and most unknowingly. Since only 4,000 die and 20M are infected, it’s not cancer that is the real American Tragedy of the disease here. It is the ever increasing numbers of young women who have contracted the virus and have to deal with the consequences: financial, emotional, physical and mental. Take the medical scenario of the only treatments of pre-invasive disease being surgical excision. There are legions of young women who have had large areas of the cervix permanently removed in an attempt to ward off the cancer. Genital warts are treated in much the same way, using the affected tissue. Since elimination of the wart is not always accompanied by elimination of the viral infection causing the wart, recurrences are extremely common and resistance to treatment common as well. Other consequences of infection are depression, lower sex drive, lower self esteem, anxiety, and the issues of “pre-existing” i.e. “not-covered” conditions on your next insurance policy, which causes economic burdens for those in treatment.

A focus group of girls and women with the HPV disease might have a 17 year-old who’s had abnormal pap smears for many years, has had two procedures to remove the dysplastic tissue, and is at risk for consequences such as cervical incompetence in pregnancy resulting in miscarriage; a 40 year-old with multiple excisional procedures of the vulva to remove abnormal tissue who is at risk for sexual dysfunction; a 52 year-old with cervical cancer; a 26 year-old with multiple genital warts, who will likely require at least 3-4 visits just to remove this round of the infection, and a 28 year-old pregnant woman with an abnormal pap smear. In addition to the numbers of young women with the infection, we now estimate 80-90% of us will acquire the HPV infection by age 50, and 20% of women who have contracted the disease have had only one partner. This group will ask where they got the infection: unable to say, as tests for HPV are so newly available we can’t say how long an individual has harbored her infection; how likely they will resolve the infection. About 70% will clear sometime after 6 months, closer to 90% of infections clear by 2 years, and by 5 years if it’s going to clear at all. Questions remain: when is sex safe again and what should I tell my partner? Disclosure issues are troublesome since there’s no real test for the men. Who will need the vaccine? We know that about 50% of adolescent women will contract HPV within three years of becoming sexually active, so the vaccine is most likely to help those women prior to their debut into sexuality. Administering an STD vaccine to a child, in a sheltered life, with monogamous parents who married when they were virgins, is looking to be a very hard sell politically. No one has an emotional problem preventing small pox, or mumps, or whooping cough, or polio, but when it comes to the S word topic, apparently that is a NIMBY discussion. Abstinence has been called 100% effective 100% of the time, and for the sexual virus-to-genital contact disease that is probably true, but for variations in sexuality, not so good. So young people of both sexes probably need vaccinations. The Merck vaccine has been tested in girls and women from 9-26.

Condoms don’t work effectively to protect against HPV disease. They aren’t used consistently, aren’t used with appropriate microbical concentrations of spermicide, and plain and simply do not cover the potential odd wart or two that sits on the male body instead of the shaft, or the rectum, or the skin of the scrotum, or the rectal areas, or the female perineal areas. Latex condoms do help to block transmission, but if any skin-to-skin contact occurs in an affected area transmission will occur. Suffice it to say, even a body bag wouldn’t do it. Because slippage, breakage, and plain old holes let alone the lax application of said bag would not work, does not work. Now those of us in the business do need to add they don’t drastically reduce the rates of other infections: gonorrhea, Chlamydia (a cofactor in the cervical cancer cases), herpes (another cofactor in cervical cancer) and the rates of HIV infection, and by the way, are very effective at preventing unwanted pregnancy. Yet in the midst of an STD epidemic the Congress has been set on legislation designed to highlight condom’s failures rather than on strategies that would increase their use.

Vaccines, if effective, are the only way to go when预防ing a case of a sexually transmitted disease, or an outbreak, or an epidemic, or a pandemic. Years ago our CDC decided that it’s only logical, that if gonorrhea is spread through sex, and you find an individual with said case, treat the partner who gave it to him or her and you’ll stop the chain of events. With rules, regulations, laws, troops of more or less informed public health workers, and a patchwork of policies and procedures, where has it gotten us? We see pretty stable rates of most of the common sexually transmitted diseases within the US. In the year 2000 we had over 19 million new infections reported. We have done a good job of decreasing syphilis by the way, but still HPV itself is responsible for about 50% of new STDs. And we forge ahead with these policies, as it still ‘seems prudent’, but there’s not a single well done prospective study to say this is effective.

The HPV vaccines have the ability to prevent disease, save money, and save lives. This is not debatable. Many of the available vaccines we do take are for diseases that are frankly rare; this one is not. What is debatable is how to overcome the significant political and social obstacles to accepting the vaccine. Is getting vaccinated a ticket to lose or so-called unsafe sexual behavior? Moral extremists have been heard to say that STDs are just payment for out-of-wedlock sexuality. Both sexes will need to be vaccinated, but will public distrust of vaccine safety allow boys to be vaccinated at all? The vaccine is not a panacea, and will vaccinated women stop getting pap smears when we know this will not prevent every HPV infection or every cervical cancer? Will the vaccine reduce condom use and inadvertently increase unwanted pregnancies? We’ll need to be administering more of those morning after pills if condoms decline and that will be another topic for future discussion.

It is unlikely that legislation is going to rubberstamp HPV vaccination policies or protocols. It is most likely that the vaccine’s acceptance will rest largely with individual providers, patient education and discussion and maximal understanding of the disease, its serious consequences, the consequences of avoidance of vaccination.
On Saturday: July 22 at 9pm a vigil will be held for Quentin Larry, Terrell Layfield, and others who have died while in police custody at the Champaign County Jail. Bring a candle and meet us at 204 E. Main, downtown Urbana, in front of the Champaign County Sheriff’s office. From the beginning, the Sheriff could not start his investigation until the Champaign County State’s Attorney determined that no criminal charges were to be filed. If the Sher if was to be sued, State’s Attorney Julia Reitz would be his lawyer. In this scenario, as Sandra Ahten writes, “the State’s Attorney would be both prosecution and defense” (ucimc.org 2/11/2005).

An independent investigation into the five deaths is the final piece in the puzzle to find out what is going on in the Champaign County Jail. The repeated incidents suggest that these deaths are not “accidental” but systemic and procedural. In the words of Mrs. Layfield, “In my opinion, suicides are not only the fault of the jail system, but also the fault of our government”. To police officers, jail guards, lawyers, and judges, inmates are not people who have loved ones, wives and children. Terrell Layfield was charged with cocaine possession. He took it to trial and was found innocent. Yet he was found guilty on the trivial charge of obstruction of justice for lying to the police about his name. The heavy sentence of more than five years given by Judge Heidi Ladd should be seen as retribution for his beating the drug charges and lying to an officer. Layfield was obviously distraught about the long sentence. When he was denied a routine phone call to his wife, he became upset and began to make noise in his cell. He was not responded to for several hours. Committing suicide was his final act of protest against an unfair justice system. According to the Department of Justice, drug offenders were found to have the lowest suicide and homicide rates of all inmates. Terrell Layfield was not suicidal before he entered the Champaign County Jail. The inhumane condition in our jails and prisons do not correct, but only create more death and destruction. Those who administer justice become jaded and themselves become desensitized. In the courtroom, Judge Heidi Ladd said Layfield received several years because he was “living like a bum.” On the ucimc.org web site, Mrs. Layfield responded to these comments saying Terrell was a father, husband and son. She blamed the authorities who failed to take the first suicides seriously. “What did they change to prevent this from happening again to me – it killed me and my family.” While steps have been taken by Sheriff Walsh, not enough has been done to prevent two more deaths in the jail. How many more before we have a restoration of the public trust?

The individuals and their families are the real victims in this country’s War on Drugs. Quentin Larry, who died of a heart attack the Sheriff is calling drug-related, is the latest victim. Larry died over Memorial Day weekend and his case is still under investigation. The City of Champaign police have been assigned to investigate this incident, another inside job.

The families of Quentin Larry and Terrell Layfield are supporting this vigil and asking for a full explanation of all of their loved ones. Join us on July 22 at 9 pm in front of the Sheriff’s office, 204 E. Main Street, downtown Urbana. The vigil is being sponsored by the Urban League, Champaign, Urbana Citizens for Peace and Justice, Visionaries Educating Youth and Adults (Veya), and Anti-War, Anti-Racism Effort (Aware). For more information see the June issue of the Public i.

Local: You Were Told What?

A Short History on the Refusal of Insurance Plans and Pharmacists to Fill Prescriptions for Birth Control and Emergency Contraception

By Kathy Spegal

Throughout the US, women have been at the mercy of insurance carriers and employers who have refused to include contraceptive options as part of their health care plans. Women who have been prescribed birth control for medical purposes other than contraception have had to petition their providers to make an exception. Prempro was given grudgingly by many pharmacies after many phone calls and documentation. In 2001, a University of Illinois employee, whom we will call Sandra, got fed up with her insurance provider’s refusal of coverage of birth control for endometriosis. Sandra called the Champaign County Health Care Consumers to see what she could do. The director and the insurance provider dickered it out, a call went out to other health care agencies to meet and discuss what could be done to address the issue.
The Women’s Health Task Force (WHTF) was formed and this issue was the first one to be tackled. It is ironic to note that of 11 students had easy access to birth control during their college years. The EEOC ruled in the favor of women and employers began to take notice. WHTF requested an audience with the Chancellor to discuss broadening coverage to faculty and staff for birth control. After several meetings, the Chancellor announced that faculty and staff could pick up birth control at McKinley, a first step. Meanwhile, efforts were being spearheaded by Planned Parenthood at the University of Illinois which was concerned about employment and insurance companies to include birth control in plans that included pharmacy coverage. This provision was passed into law in Illinois. Preparations were made for pharmacists who would dispense Plan B. This is often a Wal-Mart which meant that communities only have one pharmacy and it is often a Wal-Mart which meant that women had to drive many miles to a provider who would dispense Plan B. In Illinois, several pharmacists have been terminated as a result of their refusal to fill the prescription. The excuse is their moral objection to birth control and they would like to invoke the conscience clause used by medical providers. Planned Parenthood and many physicians do not consider pharmacists health care providers. Several Right Wing groups have taken this issue as their “cause célèbre” and are suing the State of Illinois for not allowing pharmacists to pursue their career with their own moral interpretations. The governor has only submitted a rule that would make a posting of information on access to birth control and emergency contraception mandatory.

The WHTF spent many hours at rallies, protests, educational events such as “Living in Community 101,” Urban-Rural Environmental Sustainability: An Alternative to the Mass Consumerism System where practitioners and professionals can begin to use their own moral compass to spark ideas on practices that may apply to the various situations we find ourselves in.

CoMmuniTy FoRum

Vigil for Quentin Larry and Terrell Layfield

by Brian Dolinar
In my first child’s birth, I was led to believe this was the prenatal period that my O.B. and the hospital staff would be supportive of a natural birth. When it came time to actually labor and deliver, the midwives really wanted to have “supporting” a natural birth was not to physically force you to have (most) interventions. (I say “most” because of the use of the vacuum extractor WAS physically forced on me.) There was no alternative offered to any of the interventions, no actual “support”. The two options for dealing with the pain and difficulty of labor seemed to be 1) drugs, or 2) nothing whatsoever. I think it’s dishonest to allow a woman to think you’re going to support her in natural birth, when the entire system is set up against it.

I was sent to the hospital by my OB after about 24 hours of unproductive labor and asked to be pitocinized. Because of my reproductive history, an artificial version of the hormone that gets labor going and keeps it moving along. I had indicated that I didn’t want pitocin, and had researched ways of getting labor moving, but none of these measures were encouraged. Because of the pitocin, continuous fetal monitoring was required. After several hours strapped down to the bed with the fetal monitor on one side and the IV on the other, I finally gave in and started Nubain (a narcotic). The nurse came in to turn up the pitocin periodically, despite my protests. After several more hours, when I was fully dilated but had stopped feeling contractions for some reason, I was told I had to push. The baby was still very high up, and it was really too early to push. He went into fetal distress and was then pulled out by vacuum extractor without any explanation or giving me even 10 seconds to get mentally prepared for the insertion of the vacuum extractor. Traumatic birth has been compared to rape, incidentally, and I suffered flashbacks and nightmares about the birth for weeks. I later read in a medical journal that having the mother push when the baby is up too high can cause fetal distress. So basically, my OB actually created a medical emergency. The term for this type of situation is “iatrogenic”, meaning that the physician’s actions actually do more harm than doing nothing at all would have done.

In the whole “emergency vacuum extraction” fiasco, part of my vaginal wall was caught in the thing, causing damage to the muscle and put pressure on my perineum, making me push without even realizing it. I felt like I was on a runaway train. My body was just doing it on its own. The mind-body connection was allowed to happen. Very, very different from the over-medicalized first birth.

Here are the interventions I had during my first birth and the consequences they can have (off the top of my head):

- IV fluids: Can cause labor to slow because the mother’s hormone levels drop. Can also cause swelling in the birth canal, making it harder for the baby to work its way out. Can cause baby to be overhydrated at birth, making for a larger weight loss in the early days before nursing.
- Episiotomy: They are done to avoid tearing or to get the baby out faster, but many tears end up being WORSE because of the episiotomy. They cut through muscle, which takes longer to heal.
- Vacuum extractor delivery: Can be a wonderful tool if used sparingly, but damage can be done to the mother. I think it is also painful to the baby’s head.

There were no interventions like these in the homebirth. I had good perineal support and only had a 2nd degree tear, despite the baby being born very, very quickly, not allowing things to stretch.

Birth Doulas (Professional Labor Support) by Suelia the Doula

The Birth of your Baby will be a lifelong memory and yours will be changed forever. Inviting a doula into your birth space will help you have the most positive birth experience possible.

- Recognizes birth as a key life experience and as a fundamental right of passage.
- Understands the basic physiology and the emotional needs of a woman in labor.
- Complements and works with the woman’s partner and care provider.
- Allows the partner to participate at his or her own comfort level rather than as the “labor authority.”
- Stays with you throughout your entire labor.
- Provides emotional, physical, and spiritual support.

A doula is not:

- Your voice, she can however help you find your voice, helping you to form your thoughts and questions.
- A medical professional. A doula stays within her code of practice and will not perform any medical procedures such as vaginal exams, blood pressure, etc.
- Someone who tells you how to give birth.

A doula will work to educate you in simple ways:

- Trust your body first.
- Ask questions. Know what your provider’s standard procedures are and if they don’t agree with your thoughts and desires for birth, shop around and find someone who does.
- She will support you at home and/or in the hospital.
- If you choose to use medication, know and remember that all women can give birth without it as long as there is not a medical reason to use it. Know the facts about medication before you choose to use.
- Trust is the key.

Studies done by Marshall H. Klaus, M.D., John H. Kennell, M.D., and Phyllis H. Klaus, C.S.W., M.F.T. indicate that doulas help:

- Decrease overall cesarean rates.
- Decrease length of labor.
- Decrease the need for epidurals.
- Decrease the use of oxytocin.
- Increase the confidence of the partner’s participation.
- Decrease postpartum depression and levels of anxiety.
- It breaks my heart to hear a woman say that her birth was the most horrible and painful experience in her life. That legacy was passed to me by my mother and I swore I would not pass it to my daughter. I wish I could help just one woman understand that birth is the hardest work she will ever do in her life and, although it hurts, it will teach her how powerful and strong she is! We as doulas cannot change what has happened in your birth but we can stand with you and hold your spirit in our heart as you go through this part of your life. Birth is not something to fear; it is something to respect and honor. And you can do it!

If you would like to know more about doulas and my alternative birth sessions, Birth with Courage and Power, visit smecdoula.com.

Of the US births in 2002:

- 34-38% of the mothers had little or no understanding of their rights to refuse procedures or ask for more information
- 44% were induced
- 17-53% of the mothers were aware of various epidural side effects
- 6.8% of the mothers used water therapy (the most helpful non-medical intervention)
Reducing Postpartum Depression the Village Way

by Marcia Zumbahlen

In June 2001 the country was shocked to learn how Andrea Yates killed her children during an episode of post partum psychosis. The “eye for an eye” folks wanted her electrocuted. The “spare the rod, spoil the child” folks wanted her punished with a harsh sentence that would deter future killings. The “there but by the grace of God go I” folks wanted the world to wake up to the reality of how postpartum mood disorders (PPMD) can change a woman’s life.

In the aftermath the New York Times began shedding light on the tragedy. Allegedly, Andrea’s “controlling” husband limited her free time to two hours per week (despite the fact that she was isolated and also caring for and later grieving for her Alzheimer’s-ridden father). Her church didn’t encourage baby-making, her psychiatrist minimized her condition and failed to prescribe an anti-psychotic medication, and Andrea was progressively deprived of clinical care prematurely because insurance wouldn’t pay for extended services (i.e., “coverage maxed out”). Knowing that these were things we could change, everybody wanted to fix the system so such tragedies would never happen again.

How are attitudes toward PPMD changing since Andrea Yates’ case?

Five years later people are still downplaying the gravity of PPMD and its impact on children (see Julia’s vignette this issue). Just three months ago a woman told me, “My husband doesn’t believe post partum depression is real. He thinks I should just get over it. You know, ‘Just do it!’” How unfortunate because PPMD generally responds to treatment (see sidebar on PPMD). When family members or professionals minimize a mother’s concerns, this lack of social support increases the costs. Hence, PPMD is less likely to be alleviated with the baby’s development solid grounding. Most infants are not socially responsive until three to four months of age, and many parents need longer to feel the rewards of parenting. Most infants do not have the capacity to sleep through the night until four months of age, and many parents need time to make up lost sleep.

Early return to work can disrupt the adjustments that families must make after the birth of a child. When a mother is at risk for depression, early return to work, especially when caring for a child with special needs, could push her into depression. Developmental research shows that shorter leaves are associated with increased depressive symptoms in mothers and with more negative affect and behavior toward infants at 4 months. When a family has a significant stressor (e.g., depression, poor physical health, infant with special needs or difficult temperament), longer leaves are associated with increased affect, sensitivity, and responsiveness and decreased negative interactions toward infants at four months of age (Clark, Hyde, Essex, & Klein, 1997; also see Julia’s vignette this issue).

It is unacceptable that employees feel lucky if they have a few weeks of paid leave after a baby’s birth. Ask your state representatives to support flexible equal-opportunity family-work policies that recognize individual differences and vulnerabilities in families’ needs and values. Consider pushing for HB 3470, the Illinois Family Leave Insurance Program (FLIP), which has been sitting in the House Rules Committee since March 2005 (see sidebar), or the socialist models used in Scandinavia (see sidebar on page 6).

Push for Family Support Programs

In several places around the world women are pampered for 40 days after they give birth. Usually the grandmother comes to make special meals that will replenish the mother’s blood supply and tend to household tasks so the mother can sleep and bond with her baby. In the US, many women give birth in a community-supported home or hospital where the staff encroaches minimally and the mother’s blood supply and to tend to household tasks so the mother can sleep and bond with her baby. In the US, many women give birth at home alone with her children (not counting night-time feedings while her husband sleeps), because, as she said, “Most of the people around me work during the day and my husband takes our car so it’s hard to get out.”

In a 2002 survey, 35% of women reported feeling isolated in the months following birth (childbirthconnection.org). Isolation prevents early detection and deprives women of the support they need to combat stress. Our current solution: wait for depression to happen and train pediatricians to screen women for PPMD during well-baby visits. There are more proactive approaches.

Individuals could mobilize their neighbors to take care of their families with new babies (checking on them, helping them laugh, offering respite, connecting them with other families, telling them to, and referring to this topic in the local service, Healthy Families, or http://helpbook.prairie.net.org? temporary). Early Childhood Care and Education programs could join the community! Illinois network (strengtheningfamiliesillinois.org) to learn how to care for families...

Three Common Types of Postpartum Depression

<table>
<thead>
<tr>
<th>TYPE</th>
<th>RATE</th>
<th>SYMPTOMS</th>
<th>ONSET</th>
<th>TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby Blues</td>
<td>80%</td>
<td>tearfulness, worry, lack of concentration</td>
<td>Within first week after birth</td>
<td>Time (lasts a few hours to several days)</td>
</tr>
<tr>
<td>Post Partum</td>
<td>10–20%</td>
<td>baby blues for 1 month, difficulty coping, early return to work</td>
<td>Gradual within first year</td>
<td>Exercise, social support, cognitive-behavioral therapy, anti-psychotic medication</td>
</tr>
<tr>
<td>Depression</td>
<td>.1–.2%</td>
<td>hallucinations, delusions (about infant's death, denial of birth), delirium or mania</td>
<td>Within 2 weeks after birth</td>
<td>Anti-psychotic medication given at onset</td>
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In short, millions cannot afford to take an unpaid leave when they need it the most. Current family leave policies don’t offer families ample time to recover and support each other following a birth. A leave gives the mother the time to physically recover and adapt to her infant. It gives parents time to adjust their relationship, balance family chores, recover from sleep loss, integrate the baby into the family, learn their baby’s cues and patterns, and feel effective in soothing their baby and organizing her day. Three months is too short for many families to accomplish these tasks let alone give their babies’ development solid grounding. Most infants are not socially responsive until three to four months of age, and many parents need longer to feel the rewards of parenting. Most infants do not have the capacity to sleep through the night until four months of age, and many parents need time to make up lost sleep.

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Push for Family Support Programs

In several places around the world women are pampered for 40 days after they give birth. Usually the grandmother comes to make special meals that will replenish the mother’s blood supply and tend to household tasks so the mother can sleep and bond with her baby. In the US, many women give birth at home alone with her children (not counting night-time feedings while her husband sleeps), because, as she said, “Most of the people around me work during the day and my husband takes our car so it’s hard to get out.”

In a 2002 survey, 35% of women reported feeling isolated in the months following birth (childbirthconnection.org). Isolation prevents early detection and deprives women of the support they need to combat stress. Our current solution: wait for depression to happen and train pediatricians to screen women for PPMD during well-baby visits. There are more proactive approaches.

Individuals could mobilize their neighbors to take care of their families with new babies (checking on them, helping them laugh, offering respite, connecting them with other families, telling them to, and referring to this topic in the local service, Healthy Families, or http://helpbook.prairie.net.org? temporary). Early Childhood Care and Education programs could join the community! Illinois network (strengtheningfamiliesillinois.org) to learn how to care for families...

Continued on next page
not just children. Hospitals and public health officials could add programs like the Nurse-Family Partnership (www.nursefamilypartnership.org) that send highly educated nurse home visitors or infant mental health specialists to visit families bi-weekly during pregnancy and the first two years after birth. These programs can save 4 times the money spent on them by improving the lives of mothers and their children up to 15 years down the line (including reduced arrests and negative adjudications).

**PUSH FOR UNIVERSAL ACCESS TO QUALITY HEALTH CARE**

In my recent search for health insurance I discovered that many health care packages do not offer maternity care, let alone coverage for pregnancy-related conditions like PPMD. Policies with maternity care come at a very high premium and/or are difficult or impossible to add after a woman becomes pregnant. Texas, where Andrea Yates lives, ranks near the bottom in the U.S. for mental health care (healthbyplace.com). A doctor referenced on this site said that even though “improved drug therapy and outpatient care have reduced the need for long hospital stays… the time authorized by most managed care plans, often just 10 days… still isn’t nearly enough” (also see Julia’s vignette this issue). “Managed care selectively and deliberately cut the funding and the benefits for people with mental illnesses and addictive disorders in this country,” says Dr. Peel. “It’s deliberate corporate practice… resulting in drive-by hospitalizations.”

To bolster these programs let your representatives know that you want to invest your tax dollars in wrap-around programs for families with infants instead of funding things like war. Shared responsibility for family care cycles back so that children, families, tax dollars in wrap-around programs for families with infants instead of funding things like drive-by hospitalizations.

**Life in Scandinavia**

“There is just a completely different level of acceptance among employers here. It is not uncommon to put a telephone conference on hold, because you can hear a baby crying in the background.” (Norwegian female executive, http://news.bbc.co.uk, 28 March 2006).

- Mothers or fathers can choose childbirth-related leaves (including adoption) up to a year and a half with full or part-time employment replacement
- Fathers are required to take 1 month of leave following the birth of a child or forfeit 1 month of leave for the entire family
- Families can extend leave until a child is 3 years old with a lesser allowance or part-time employment during the entire leave
- Universal home visiting after childbirth is a routine, widely accepted component of these moments. I tried my best to get help.

**STOP 1: BREASTFEEDING CLINIC**

I said, “My baby’s tongue is always in the way.” They said, “Don’t worry, he is gaining weight.”

**STOP 2: PEDIATRIC WELL-BABY VISIT**

I said, “My baby sleeps only 45 minutes at a time and I can’t soothe him. My husband and I have tried forcing a pacifier into his mouth, rocking him, driving him in the car, running the vacuum, water, and hairdryers, playing static on the radio, ocean wave CDs, and saying “shh” close to his ears. We’re exhausted.” They said, “Don’t worry, he just has colic.”

I’m sure my baby felt it then and at the times I thought more about myself. Fortunately, my doula attended.

**STOP 3: MY EMPLOYER**

I said, “I have a problem.” She said, “You meet the criteria for depression. But I can only give you two more weeks of additional leave.”

With the diagnosis I was able to pay for these two extra weeks through short-term disability. I returned to work when my son was 3-1/2 months old.

By the time my baby was four months old he started sleeping better. This gave me room to think more about myself. Fortunately, my doula found a support group for depressed moms that had just begun in the area and I was able to attend.

**Julia’s Story**

MY NAME IS JULIA. I moved to C-U 10 years ago after finishing my post-baccalaureate education. I’m now 33-years old and live with my husband and son in a comfortable, upper-class neighborhood. I’ve always known that I had a genetic risk for anxiety and depression. But when I had my son I didn’t think it would affect me. Soon after the birth I began worrying about how I was nursing him and complained about his piercing cries. I’m sure my baby felt it then and at the times I lugged him off to another house for care during the day because he started crying more during the night at that time. One night I was so frustrated by my baby’s cries that I “threw” him onto the bed. Out of desperation I finally sought a doctor for myself.

**STOP 4: HMO PRIMARY CARE PHYSICIAN**

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Within weeks I noticed my baby and I started to play, but traces of our rocky start lingered in his screams for attention and his clinginess beyond the norm. I wondered if he might have still been a bit mad for being ignored or remembered how it felt to wonder if I would ever come back. Six months later the facilitator for the support group moved to Seattle. My search began again. I found some playgroups but things didn’t really change until Illinois’ Early Intervention system diagnosed my son with Sensory Processing Disorder (explaining the piercing cries and difficulty with sleeping and calming) and our family began to receive SOME of the services we should have received in the beginning. By my son’s second birthday I was playing lots of spinning and tummy-time games to help him and I was being properly treated for depression and anxiety. We were finally happy.

(from childpolicyintl.org)
HOMEOPATHIC MEDICINE

by Barbara Raska Antisdale

In order to find the correct remedy, the homeopath must understand the patient as a whole, taking into account all of the symptoms that are present. The homeopath will observe the patient and ask questions to get a comprehensive picture of their health. The remedy is then chosen based on the patient's unique symptoms and how they interact with each other.

The remedies used in homeopathy are derived from natural substances, such as plants, minerals, and animals. These remedies are diluted and potentized to create a form of energy or vibrational medicine. The correct remedy for a patient is individualized for each person, taking into consideration all of their symptoms, rather than just treating the patient's main complaint.

The homeopath will work with the patient to help them achieve their full potential. This may involve dietary changes, exercise, stress management, and other lifestyle modifications. The homeopath will also work to help the patient regain their balance, including mental, emotional, and physical aspects.

Homeopathy is truly holistic with a general improvement in health. Long suppressed shifts in significant relationships occur. Everything is related and connected in the holistic homeopathic perspective. In order to find the correct remedy, the homeopath must understand the patient as a whole, taking into account all of the symptoms that are present. The homeopath will observe the patient and ask questions to get a comprehensive picture of their health. The remedy is then chosen based on the patient's unique symptoms and how they interact with each other.

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LISTENERS WERE OFTEN SCANDALIZED when Dorothy Day—devout Catholic, co-founder of the Catholic Worker Movement, and, notably, a U of I dropout—described herself as an anarchist. Indeed, the terms anarchist and anarchy conjure of disorder, chaos, and throwers. This perception however is for the most part a distorted notion of anar- chist thought, and has nothing to do with the anarchist of Dorothy Day.

Surely, to talk about a likeness between Christianity and anarchism is to risk being thought absurd and oxymoronic. Some would argue that to use the label “anarchist” is to encourage misapprehension, even hostility. But the same case could just as cogently be made in accepting the label “Christi- an.” For, after all, to be a Christian is to be a right-wing con- servative, right? So, while acknowledging the dangerous- ness of both labels, I wish to show the essential com- parity between these two lines of thought—if we properly understand them, of course. Hence this essay.

Anarchism is a term notoriously hard to pin down, as, by definition, it resists a concrete definition. In its most basic sense it means no rulers or no domination. Anarchists tend to be suspicious of any clear blueprint for exactly what anarchy would look like. There is certainly some value in pointing to actions that look like a desirable way to live, but anarchism is not static—it is dynamic, an orientation, acknowledging cer- tain principles, freedom being foremost, that must be main- tained at all times.

Currently, the most interesting group moving along this line is the Zapatista movement in Chiapas, Mexico. Although they have not identified themselves with anarchism explicit- ly—I don’t think it would be unfair to describe them as at least anarchistic. They are anti-political, in that they are not seek- ing to run for office. Unlike their Latin American revolution- ary counterparts, they are not attempting to take over state power. Instead, they are engaging in a social revolution, desiring to simply live autonomously as they see fit, outside of the pernicious confines of the “new world order” of free market globalization. Marcos, who the media tend to identify as their leader, negating his title Subcomandante, describes the Zapataista worldview in his typically lyrical way: “I am as I am and you are as you are; we are building a world where I can be, without having to cease being me, where you can be, without having to stop being you, and where neither I nor you have to become another to be like me or you,” when Zapatistas say, “a world where many worlds fit,” we are saying, more or less, “everyone does his own thing.” (October 26, 1999)

Inevitably the question arises: if everyone does their own thing, won’t everyone just kill each other? This is a serious concern, that “everyone does his own thing.” (October 26, 1999)

But there have been, before the invention of the modern nation- state, societies that have lived quite happily, peaceful lives without a central coercive apparatus. Some of these are elucidated in Harold Barclay’s interesting study People Without Government: An Anthropology of Anarchism. With the 20th century perhaps the most notable experiment in anarchism was in Spain during the thirties. Although the movement was ulti- mately quashed by France and the fascists, it remains in many ways the ultimate anarchist accomplishment to date. While I have serious reservations about that accom- plishment—going too far into politics as well as their use of violence—it does remain a sign of hope for those of us today working towards an alternative practice of social life.

Part and parcel of any movement towards the kingdom of God I am describing is the acknowledgment and development of a spiritual life. Even a thinker such as Noam Chomsky, not noted for his religious faith, has discussed this in an appeal towards a libertarian socialist (i.e. anarchist) society, in saying that he believes not only will a spiritual change help bring about this new order, but that this new order would actually contribute to such a revolution. We live in such an alienated, narcissistic culture that this is no easy task. But I do think the central urgency of the day is, as Dorothy Day put it, how to bring about a revolution of the heart.

Enter Christianity. Anarchists have not only resisted the nation-state; they have, more broadly, stood in opposition to anything that dominates: patriarchy, capitalism, consumerism, technology and, of course, Christianity. The Spanish anarchists, noted above, for example, were steadfastly anti- Christian. How then, can I, as a Christian, legitimately call myself an anarchist? This will take some unpacking, though

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As noted above, most anarchists are as equally opposed to the state as they are to the church. But I do think there is a point out a path that is important to highlight, however. They too resist Bar- cley’s notion of God as tyrant in the sky. Instead, they view God as, above all, love. Being inherently non-coercive, love is willing to suffer, to persevere until we turn towards God. The cross is that sign par excellence for Christians. If God then won’t trespass on our gift of free- dom, how could we possibly justify doing what God refuses to do to one another?

It has been my goal in this essay to show that Christians should take seriously what anarchists have complained about in our religion, and that the both of us, perhaps rather surpris- ingly, share a similar orientation. Given the political options of our era, the Christian should choose anarchism, for it’s the only one that rejects the state and its coercion altogether, unlike the socialists, greens, democrats, etc. If we realize this, there’s a chance that we can truly “build a new society within the shell of the old.”

I would invite anyone intrigued by this line of thinking to come to the 4th annual Anarchism and Christianity confer- ence that will be taking place at the Illinois Disciples Founda- tion on August 4-5th. We will have a chance to explore more deeply what it means to bring Christianity and anarchism together to not only engage a critique of the state, but more practically—How do we live in community? What is our relationship to the police? Technology? Education? For more information, go to www.jesusradicals.com

I would also invite folks interested in a practical outlet to consider coming over to the Catholic Worker House where many of us are intentionally asking these questions and trying to live out the answers.