General Editor’s Introduction

In the month of March, the world again had an opportunity to celebrate the twin international events. The first was on March 8th (International Women’s Day) and the second on March 21st (The International Day for the Elimination of Racial Discrimination). Naturally, the magnitude of such celebrations vary from geographic region to geographic region and from country to country. Yet, with much disappointment, one can hardly avoid noticing that the infectious energy of the 1970s and 80s is lacking from the recent celebrations of the Women’s Day events. Likewise, the outrage against racial segregation, apartheid and state-violence which formed the basis of the United Nations Declaration of the Elimination of Racial Discrimination (1966) is muted at best.

What happened since the 1970s and 80s to erode some of the positive energy to demand and initiate social change? The optimists can argue that in the majority of the countries, including some remote and tradition-bound patches of the globe, the most severe limitations against women have been mostly addressed if not completely resolved. Indeed, observations and statistical information abound to support such up-beat assertions. For example, who can forget the images of some Afghani women shedding their claustrophobic burkas and who can forget the victoriously raised purple-ink-stained fingers of the Iraqi women who were allowed to vote after a long period of oppression?

Optimists can also make numerous positive claims in terms of race and ethnic relations. For example, even the ultra-conservative US Republicans recently chose a black woman to serve as the Secretary of the State. The cold war is long over and legalized apartheid has been abolished in South Africa. Moreover, the malevolence of ethnic cleansing in Rwanda, Bosnia, Chechia etc., is no longer making the daily headlines and evening-news nightmares.

Regardless of the degree of one’s optimism, however, the darker side of the coin also requires some acknowledgement. Just to give an example, there is a worrisome resignation in the masses about women’s issues. This resignation is visible in the developed as well as the less developed worlds, although its causes may be quite different. In the west, there is a heightened sense, albeit mostly erroneous, that gender equality has been reached. Ironically, this belief is equally shared by young men and women. In contrast, in the less developed world, the existing problems of poverty, ethnic or racial strife, political instability and even natural disasters are so overwhelming that an in-depth focus on women’s issues may not be palatable for most.

For race and culture-based issues and problems, even a misguided level of resignation is not possible. The ‘we versus them’ and the ‘good versus evil’ rhetoric of most western political and economic decision-makers are trickling down to dangerous polarizations. France and
Germany are in the throes of rapturous ethnic and racial unrest; US is struggling with the problems of its own disenfranchised minorities. Even amongst people whose backgrounds and belief systems are mostly alike, for instance, different paths of Islam, the ‘othering’ is becoming rampant. These loaded group tensions are further fuelled by the carefully crafted preemption of a super-power which declares wars with impunity. In the resulting mayhem and the many-sided bloodshed, one almost wonders whether the bone-chilling cold-war era was any worse than what we now have!

In Canada, we generally experience the boiling tensions and the increasing skirmishes of the world in a mercifully diluted way. Although far from perfect, it is indeed the case that Canadian women have more rights and protections than most other women in the world and race and culture clashes in Canada are much less pronounced and much less destructive than those which increasingly fill the schools, streets, workplaces and homes of other countries—developed and less-well-developed alike. As Canadian women and as people from myriad of backgrounds, we are privileged indeed. Yet, even Canada has a long way to go before we can start talking about true and uncontested equalities. For example, just a few days before the Women’s Day, a man brutally killed his estranged wife and their two children (Globe & Mail, April 04, 2006, A8). and a woman killed two of her children and tried to commit suicide. Both families were from minority groups and relatively recent immigrants. We will never know how their adjustment efforts may have contributed to their gendered, interpersonal problems. In Canada, we are so caught up in the ‘rhetoric of diversity’ that we will rather overlook the additional challenges members of diverse groups (i.e., women and children from strictly patriarchal cultures of origin) experience and the special services they may need.

These recent murders made only a ripple in the media. There are so many examples of intimate partner murders and so much violence against children that there is a growing emotional immunity, a form of satiation, towards these kinds of events. On March the 6th, just two days before the Women’s Day, I was interviewed on television in relation to the recent murders. The allotted time for the _entire_ interview was two minutes. The question I was asked was ‘why is there no longer an outrage about these events?’ I hardly controlled myself from saying something like ‘why do you expect an outrage from others when the media reduces the murder of a woman and her two children into a two-minute sound-bite?’ To be fair, the problem is with the class/race/gender triangulation. The media sometimes ignores and at other times, amplifies the issues. For example, if the victim is particularly interesting for media coverage and if the murder is particularly gruesome in its method, the coverage will eventually engender a task-force or some commission to get assigned to the study of the problem and come up with recommendations. In Canada, the last media-frenzied femicide was Gillian Hadley’s murder (Toronto Star, 23-24 October, 2001, B1 & A1). Gillian was ambushed by her
estranged husband while taking a shower. She ran to the street, completely naked, carrying her infant daughter and crying for help. Gillian’s ultimate motherly act was to pass her baby into the safe arms of a horrified neighbour, before her estranged husband shot and killed her. What was also recognized by everyone, including the media, but not necessarily openly discussed was the fact that Gillian was very attractive and white. The Kafkaesque nature of the crime coupled with the characteristics of the victim not only made the news, but also stayed on the headlines for a long time. It also resulted in a 58-item, well-thought out and absolutely necessary recommendations of a task force (National Post, February 9, 2002, 1).

Many years passed since Gillian’s death and only a few of the recommendations the inquiry produced have been implemented. Many other victims of partner abuse died since then, many other children lost their lives at the hands of their violent fathers or desperate mothers. Many other sincere, but muted celebrations of the Women’s Day and the Elimination of Racial Discrimination Days have provided some assurance that major issues regarding gender and/or race are on the mend. Yet, western women’s vulnerabilities within interpersonal relationships and at work continue to lurk just beneath the surface. These problems may be compounded for women of colour and immigrant women because of multiple structural barriers they face.

In the developing world, the vulnerabilities of women are many fold and the protections women and children have are much weaker. Women and girl children, especially from overtly ‘othered’ groups, different cultural backgrounds and belief systems, continue to live their lives in constant fear and apprehension. Some of them survive against many odds, others die under unjustifiable and unimaginable circumstances. Some are not even allowed to be born, just because they are females. Especially in the economically developing but patriarchally ossified regions of the world, women’s health and women’s lives hang from a thin thread.

In the current issue, Preet Rustagi explores the plight of the ‘discriminated and damned’ girl children. She explores the underlying factors behind the declining sex ratios. In order to eliminate the confounding factor of adult (male) migrations, she analyzes the much more robust child sex ratios. Her analyses starts from the distant gaze of a demographer in the analyses of census data to the keen concern of an advocate as she unfolds the cruel and unusual means to eliminate the female unborn or the female infants. What is extremely interesting in Rustagi’s analysis is the dispelling of the myth that poverty is the cause of infanticide or foeticide. Ironically, the slum-dwellers, those from the lowest casts and/or from the poorest of the state regions seem to have more balanced sex ratios. It is true that these regions of despair have higher death rates overall and higher infant mortality rates, but not necessarily a fanatical bias against their girl children. According to Rustagi, the girl children are the most vulnerable in the burgeoning
middle classes and amongst the propertied classes. It is within the greed for larger dowries (for families of boys) and the fear of providing such dowries for the girls that male-child-craze continues. One of the many dilemmas ingrained in this gendered conundrum relates to abortion rights. On the one hand, the right to discontinue unwanted pregnancies is one of the fundamental rights of women. On the other hand, through the misuse and abuse of the sex identification technologies, the right to abortion has been turned on its head to mean the elimination of girl children. The ‘story’ Rustagi tells us shows that when women bow to the patriarchal demands, they increasingly lose status; when women have low status, their female children are at risk of losing their lives.

Sev’er and Ba¤li also address a serious problem which is related to women’s low status and economic dependency in a different part of the world (southeastern Turkey). The issue they address is levirat/sororat marriages. In either case, a woman marries (or is forced to marry) her brother-in-law, either when her own sister dies or when her husband dies. This tradition often is defended under the rubric of protecting the orphaned children. Defenders also suggest that women and men are mutually bound within such resolutions. The authors of the paper disagree with the purely altruistic explanations. Instead, they argue that levirat and sororat marriages are a way of keeping the land/belongings of the tribal families intact. By forcing women to stay within the family, patriarchal households deprive women from their lawful inheritance and the choice and freedom their inheritance may bring. Moreover, the interviews with 45 respondents disclose a more sinister gendered aspect of these arrangements: Men, although having some pressure on them to follow the traditions, still exercise a veto power. Moreover, very few men report traumatic experiences related to these contrived couplings. Women, on the other hand, are rarely asked, but end up in conjugal intimacies with men who have been their ‘brothers-in-law.’ Women are deeply hurt because of the unnatural and illegal marriages they find themselves in. These are arrangements that treat women as possessions that are handed down, regardless of their choice or consent. Despite the illegality of such practices in Turkey since 1926 and despite the egalitarian inheritance laws, women in the southeast often find themselves in the grip of patriarchal practices that overrule their economic rights and violate their bodies.

Shelley Reuter’s article is not about life or death decisions that haunt women in the developing world, but about the genderization of health issues across time. The topic is agoraphobia and the process is the social/medical transformation of the disorder from an almost exclusively male to an almost exclusively female ailment. Through her historical analysis, Reuter teases out three main threads of this transformation: The first is linked to the acknowledgement and a major reconceptualization of the psychological horror and panic of men returning from World War I. In other words, although the ‘panic’ might have been similar or the same as those experienced by the earlier, mostly male agoraphobics, the ailment of
the war veterans has required a new and a loftier social construction—one that is particularly masculine in nature (shell shock). The second thread Reuter untangles is the ‘legitimate’ fears emerging from fast and not necessarily well-thought-out forms of urbanization. Rather than acknowledging women’s legitimate fears, the urbanizing and industrializing capitalism has found a psychological twist to send women to their homes, as their labour got displaced by the labour of men returning from the war. The third thread Reuter follows is the gendered remedial interventions. Here, capitalism and patriarchy again join hands. Women’s regaining their health is sought in sending them to ‘shopping malls’ whereas, men’s efforts to get well are directed at their return to work. The game is to assure the gendered production and consumption cycles, as capitalism dictates, not necessarily a genuine concern about psychological states.

After touching upon India, Turkey and the European and US efforts in genderizing and re-genderizing women’s health, Ellen Sweeney’s article on breast cancer brings our gaze back to Canada. In her work, the culprit is not patriarchy per se, but the capitalist system (although how men benefit from the workings of the capitalistic system remains obvious). Sweeney’s paper identifies a disjuncture between what information is made available to women versus the environmental as the most probable etiology of breast cancer. Reuter’s work implies that this disjuncture may not be benign (pun intended), but may be closely tied to the multibillion dollar research interests and drug profits biomedical industries spin-off. Women are led to believe that the danger that awaits them (breast cancer) is cellular, hormonal and genetic in nature. They are urged to engage in routine breast examinations, visit their doctors, subject themselves to mammograms etc. The odds that they are advised to beat is 1/8. If and when they get the bad news, their choices are limited to the slash/burn/chemical annihilation techniques. Although so far these are indeed the best tools that may be available to the patients who have cancer, these tools do nothing about preventative measures and environmental vigilance. As a physician on a CBC show on breast cancer ‘honestly’ argued, there are no profits to be made in prevention (aired on April 8, 2006; Host Wendy Mesley). If the latter were the emphasis (and Reuter’s work suggests it is crucial), the gaze will shift from individual forms of responsibility to social and political forms of responsibility. In industrialized nations where the environmental factors are at a premium, women’s health risks may be substantially reduced through cleaner work environments, cleaner water, air, soil, reduced use of pesticides, herbicides and by reduction of a whole host of other carcinogens. Ironically, some of the biomedical industries that produce and sell the medicines and pills for cancer are the same industries that spew carcinogens into the air we breathe and the water we drink.

Aysan Sev’er
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The Deprived, Discriminated & Damned Girl Child:
Story of Declining Child Sex Ratios in India

Preet Rustagi
Institute for Human Development, New Delhi, India

KEY WORDS: SEX RATIOS, FEMALE CHILDREN, INDIA, FOETICIDE, WOMEN

This article traces the different elements that explain and help understand the phenomena of declining child sex ratios in India along with the debates on the subject, with specific focus on urban locations. The gender discriminatory practices prevalent in India stem from the influence of patriarchy and the lower status of women which result in higher female child mortality rates as compared to males, intra household inequalities in consumption, heinous practice of demanding exorbitant dowries for marrying girls, abandonment of girls and so on. The misuse of medical technologies—evolved to identify abnormalities in foetal stages—as tools for identification of the sex of the foetus instead and resort to sex-selective abortion of female fetuses have come to light since the eighties. This female foeticide is in many ways more horrific, as it is also practiced by the educated, better off sections of the population and is more rampant among urban locales.

Over the years, the disinterest and unwantedness of girl children in India has become more glaring and prominent. This is reflected poignantly in the continuously declining child sex ratios (defined here as number of females per 1000 males among 0-6 years population), the higher female infant and child mortality rates as compared to the male counterparts and from the information regarding the incidence of female foeticide and infanticide. The discriminatory treatment meted out in nutrition and health to boys and girls are further substantiated by the intra-household inequalities in consumption across gender which depicts the elements of deprivation faced by the girl child. In addition to these biases, girl children also face abandonment and exposure. The undervaluation of women stemming from the lower status ascribed to them is passed on to the girl child, adding on to their unwantedness. Practices of exorbitant dowry payments to get daughters married and the overwhelming fear of sexual exploitation and abuse in a socio-environmental milieu where women are treated with disdain serve as other prominent deterrents to the girl child’s arrival in Indian homes.

Patrilineal property transfers, religious and ritualistic practices and other patriarchal social structures together lay emphasis on the need for a male offspring. This forms the base for a family which should have at

1 For Inquiries, please contact Preet Rustagi at Institute for Human Development, NIDM Building, IIPA Campus, M.G. Marg, New Delhi, India, 110002. This is a revised version of a paper presented at the writer’s workshop on ‘The Wellbeing of India’s Population: A Compendium of Selected Perspectives’ held in New Delhi, January 2006. The author would like to thank the anonymous reviewers and editor of the journal for their useful comments and suggestions (preet.r@rediffmail.com).
least one or more boys. The lower status ascribed to women stemming from societal beliefs and practices that view them as burdens, costs and dangers to family honour and dignity further intensifies this male preference. While these factors have a strong influence among the propertied, well-to-do, upper castes, their spread over to other castes and communities over time is noted. The tribal populations who remain out of the caste system follow a relatively more egalitarian system and are noted as being less gender discriminatory as compared to other social groups. However, changes over time with increasing monetization and individual oriented socio-economic development have disturbed the values of tribal populations in some regions as well. The sex ratios are most strikingly imbalanced and declining over the years among the younger cohorts of most regions and among different social groups.

Evil, greed-driven practices such as dowry demands have a significant role in enhancing the non-desirability of girls, given the near universality of marriages in India. The centrality of the reproductive role of women remains more or less constant, dwarfing all other dimensions of their lives (Baru, 2003; Datta, 2003). Hence, marriage plays a significant role in determining even the need for women. The campaign against female foeticide (unnatural termination of female pregnancies) therefore uses the plea that there will be ‘no girls for your son’ argument for allowing girls their right to be born. Ironically, it is the social pressure of getting girls married off and the demands of dowry from the boy groom-to-be and his family that have so heightened the unwantedness of girls.

The increasing male skew in sex ratios highlights the son preference attitudes among most patriarchal societies. Early explanations focused on undercounting and non-enumeration of females (Visaria, 1971; Kanitkar, 1991). Socio-cultural and religious factors together with patrilineal property transfers were other factors proffered for the male fetishism. With modernization and smaller family norms, the emphasis on sons heightens (Dasgupta & Bhat, 1998). The technological innovations and their misuses facilitate the exercise of such preferences by elimination of the girl child prior to birth or even pre-conception (Lingam, 1998; Patel, 1997).

The medico-technological advancement and innovations to detect and avert genetic disorders have been put to misutilisation for sex identification of fetuses and even as measures of pre-conception choice of gender. The legal provisions banning such misuse prove inadequate due to the mutual benefits for demanders and suppliers of such services (Bose, 2002). The exercise of right to abortion, measures for population control and fertility checks as making available pro-woman choices by ensuring to women control over their own bodies and reproductive decisions to some extent are put to contestation amidst the abuse of these provisions, thereby making them anti-women.
Patriarchal biases are prevalent in different spheres—all adding up to the discrimination against the girl child and her future. These resilient forces of patriarchal institutions operate directly as well as through women’s own agency, making it extremely difficult to put in place corrective measures without hurting the women involved. Women’s own interests may be reverted as regressive forces set in to purportedly correct anti-women biases. The employ of religious groups for advocacy against female foeticide, without questioning their approach to women’s equality per se; or unleashing of scope for anti-abortion groups to stress upon reversion of the right to abortion on the plea of its misuse are lurking dangers.

Medical professionals consider themselves as service providers by serving the demand for not facilitating the birth of girl children who are unwanted (Bose, 2002). Further, some of them even feel that they are promoting the cause of family planning by helping families choosing sex composition (Hoskins & Holmes, 1984; Lingam, 1998). However, some of the concerned medical professionals have joined the campaign against misuse of technologies and in the interest of safeguarding their image from maligning due to their involvement in such sex detection based selective female foeticide.

The falling supply of women, using standard economic logic was considered to serve in favour of women as they become scarce, thereby enhancing their value in the marriage market. Such a consideration does not account for the multilayered nuances which help form the notions of value and status ascription within extremely complex socio-economic and cultural contexts. The locations where women are relatively scarce like in the state of Haryana for instance, have witnessed women being brought in from other states for marriage (Kaur, 2004). Sexual trafficking is often dangerous interwoven in parallel with the channels employed to procure the women. Poverty and false information regarding a bright future and a happily married life propels women into traps laid out for them. The utter lack of information on their legal rights, the low levels of education among the women and their desperation for matrimony, which the socialization process highlights as the sole objective of their lives, make women, especially poor women, extremely vulnerable.

The diversity of the vast Indian population of more than 1.1 billion persons spread across 3.3 million square kilometers, which is divided into 28 administrative states and seven Union Territories, stems from multiple and crosscutting identities derived from religion, language, caste, region and myriad cultural customs and practices, many of which are dynamic in as much as they are constantly evolving. Nevertheless, the hold of patriarchy and subordination of women is one of the overarching elements of these diverse peoples. Even increasing literacy levels among
urban women from 64% in 1991 to 73% in 2001 as well as many of them joining the labourforce does not entirely make them free from this oppression. The double burden of managing paid work along with household responsibility which continues to remain entirely theirs, keeps women tied up and tangled in the power hierarchies that subjugate them to male authority.

The economically poor, with nearly 26 per cent of the population being calculated as living below the poverty line (based on Planning Commission, India estimates for 1999-2000 as reported in Central Statistical Organization, 2001), consist of proportionately larger numbers of the scheduled castes and tribes among the asset-less and deprived. Ironically, neither education nor affluence seems to have brought about any significant change in attitudes towards and value of women (Patel, 2004). The pointers for major culprits resorting to heinous criminal acts of killing girls seem to be in the direction of the prosperous as reflected in the data analysis of child sex ratio across regions of India. The economically developed states with a higher state domestic product and lower levels of households living below the poverty line such as Punjab, Haryana, Gujarat, Maharashtra, Himachal Pradesh, Delhi (most of which are northern states with some western ones) display very low child sex ratios, which are declining further. The poorer states and among them, the scheduled castes and tribes as well as the slum dwellers who clearly are among the economically less endowed populations, record relatively better sex ratios among children of 0-6 years.

After this introduction, the broader contours of the issues concerning sex ratios in India are presented in the following section. The third section will provide a regional analysis of the child sex ratio in India based on Census data on the states and Union Territories for 2001. The gender inequalities and class dimensions pertaining to the child sex ratios are elucidated in the fourth section. The concluding section discusses some of the debates and conflicts arising from the misuses of various rights and developments that have occurred over time to reflect upon the social changes that are essential to ameliorate the situation whereby women are treated as equals in their own right and not undervalued for being women.

Child Sex Ratios—Beyond a Demographic Indicator

The sex ratio is a demographic indicator which depicts the balance of males and females in the population. The decline in sex ratios for India has been noted by demographers since 1970s (Mitra, 1979; Visaria, 1971). The linking of this demographic parameter with the concern over women’s lower status and the unequal treatment meted out to them, led to the emergence of sex ratios as a composite indicator of women’s status (CSWI, 1975). Search for explanations as to why the sex ratios have been declining began over the last quarter of the twentieth century (Kanitkar,
The resurgence of women’s groups (often associated with the ‘third’ wave of feminism), establishment of the women’s studies centers in India and gaining interest in research on gender issues provided the appropriate environment for this phenomena to take firm roots in domains of enquiry—be it research, policy, advocacy or law.

The sex ratios in India defined as numbers of females per 1000 males have been noted for their deficit in female population from the beginning of the twentieth century. Early explanations on this shortfall dwelt upon the hypothesis of undercounting of females during the Census enumeration. Given the low significance of women and the operation of patriarchal values, it was felt that non-reportage of female members may be common which was attributed as the cause for their deficit. This debate was contested especially with improvements in Census enumeration and better coverage of females (Kundu & Sahu, 1991). The research on mortality rates over a long period convincingly highlighted the impact of unusually high mortality of females as compared to males, being the cause for deficit of females as reflected in the sex ratios (Clark, 1987; Visaria, 1985).

The anti-girl child sentiments have always been prominent in Indian society. The more landed, propertied and well-to-do the families are, the greater the emphasis on male off-springs—at least, one or two per family. The larger family size offered a certain buffer to the anti-girl stance not becoming an overt and active one. However, with declining fertility rates and the stress on smaller family sizes, the male-craze attitudes have become more prominent (Dasgupta & Bhat, 1998). The scenario of declining sex ratios with fewer girls as an impact of governmental policy of ‘one child norm’ is noted prominently in the context of China (Porras, 1996, cited in Gendercide Watch).

The one element, which directly distorts sex ratios across regions/states in India, is that of migration. The shift of rural persons to urban areas for better livelihood opportunities is quite common and this is one of the causes for increasing urbanization in India. In cases where male migration occurs into cities, leaving behind women and children, the shift in the skew of adult sex ratios can reflect this factor. This can negate or question the analysis, which considers masculinisation of sex ratios as an indicator of gender biases and discrimination against women in a given society (CSWI, 1975). Looking at the children alone, that is, population within 0-6 years of age overcomes this problem to a large extent. The child sex ratio is a very robust indicator since it is not affected by any noise factor such as migration in case of the adult sex ratios (Agnihotri, 2000). However, researchers working on sex ratios over time and across states have accounted for the migration factor, by adjusting the figures of sex ratios. Even after accounting for the shifting population, the decline in sex ratios is observable (Banerjee & Jain, 2001).
One of the most prominent explanatory elements of declining child sex ratios is that of mortality among infants and children. The extent of mortality noted for India and among most states is quite high as compared to many of the developing countries of the world. Nevertheless, it is noteworthy that the mortality rates are in fact declining over time with the improvements in the health sphere.

The reduction of male mortality at younger ages due to the improvements in health services and the existence of gender bias in availing health care facilities may indeed account for a share of the imbalance (Bardhan, 1982; Khan et al., 1988). Nevertheless, demographers claim that this is inadequate in explaining the extent of the imbalance. Especially since mortality rates have been declining with improvements in health conditions and fertility rates have also been steadily falling, the smaller number of women in the population has posed a challenge to demographers, social scientists and women’s studies researchers (Bhat, 2002).

The decline in mortality rates seen in conjunction with the declining child sex ratios raises a quandary, as to what is causing the fall? Is it a matter of genetics, whereby the sex ratio at birth itself is declining and fewer girls than boys are being conceived? Or is it a reflection of the inaccuracies in the calculated mortality rates, given the large segments of Indian population who are outside the coverage of institutional health services and even civil registration systems functional in the country? The abortion of female fetuses after sex determination tests is highlighted as one of the explanations. Can the magnitude of decline in sex ratios be accounted for by this factor alone? If the latter is the case, it will hint at high rates of female foeticide.

A number of reasons are provided by researchers which link up to the son preference, gender bias against girls in health care, differential nutrition, food allocation and so on. The desired family size and gender composition of children under the prevalent regime of male preference work towards elimination of girls, in the foetal stages through intervention of advanced scientific technologies, in the infancy stages through (killing infants adopting a number of methods) or neglect and discrimination (Lingam, 1998).

If a family is to have one or two children, then at least one of them ought to be a boy! To ensure a family unit of one or two children, selection of the sex of the child so as to include at least one boy becomes a critical parameter (Jejeebhoy, 1993). Therefore, analysis based on birth order of children clearly shows that while the first girl child may survive, the next order girls face tremendous risk of abortion, or neglect. The association of parents and families with the first born child and the novelty element may also be a factor. However, the importance of having a male offspring among certain households, regions and communities seem to overrule any such sentimentality.

The social pressures of marriage for girls and the practice of increasing greed-driven dowry demands have become extremely unreasonable over time. These practices have spread into communities and regions where these were lesser known as being mandatory. The rising probability of such returns on
male children is gaining attractiveness, just as the mounting social compulsion of having to provide for dowry is serving as a factor to avoid girls being born into families (Patel, 2004). The use of available techniques to determine the sex of the child and doing away with the birth of girls is implicitly considered as a safeguard against future calamity and hardships that is bound to befall upon the household when it is time to get them married. Hence, the early advertisements in the eighties and nineties suggesting ‘spend Rs. 500 [one Indian rupee is equal to about 2.3¢ US] now in order to save Rs. five lakhs in future [100,000 Rs equal to one lakh]’ (Lingam, 1998; Mazumdar, 1994). The social menace of dowry has indeed become a major factor against girl children, especially among the relatively better off sections of the population, since they are the ones who have to safeguard and in some cases even enhance their social status by investing heavily for their daughters’ dowries. Ironically, most of this expenditure goes into pomp and show, the glitter of external celebrations that are most of the times wasteful and hence, hardly an investment!

While these are India specific factors of explanations sought from the socio-cultural spheres, it is also pertinent to note that the declining sex ratios phenomenon is not unique to India or the Asian countries. What is interesting and of additional concern is that the sex ratios are declining world over. This strong male preference is witnessed not only in India but also in other societies such as Japan, China, North Korea and so on (Krishnaji, 2000; Filmer, King & Pritchett, 1998). This is especially so in societies where a cultural tradition of son preference is strong. Even in areas where there are fewer signs of overt gender discrimination and anti-female biases, a decline in child sex ratios is noted. The literature on the subject is linking the phenomena to the lowering family size and fertility decline. The probability of attaining a better balance probably increases with more numbers of children per family.

Perceptions affect behaviour and often influence research as well. The poor were expected to harbour anti-girl sentiments, since they would be looking for more working hands, which necessarily are to be male since women’s work is unrecognized and undervalued, if not completely unpaid. The poorer economic position was viewed as another element that propels anti-girl child stance since socio-culturally, substantial resources are needed for girls’ marriage alliances, dowry etc. However, research of sex ratios across socio-economic groups highlight the reverse picture: The worse sex ratios are noted among the better-off, economically, relatively prosperous regions. This reflects the practiced gender bias among the economically better off, often noted as the ‘prosperity effect’ of sex ratios (Miller, 1981; Agnihotri, 2000).

Similarly, the socio-economically weaker sections of Scheduled castes (SCs) and Scheduled tribes (STs) have a better/more balanced sex ratio than the total population. This holds true even among the children from 0-6 years. The STs, off course, have the better sex ratios. States of the south, where gender equality indicators reveal more positive scenario as compared to the North, have a more balanced sex ratio (Rustagi, 2003). However, the decline in the child sex ratios even in the hitherto relatively lesser gender biased states is a
matter of concern. The phenomena are a reflection of the operation of strong patriarchal values across the length and breadth of the country. Androcentric patriarchal mindsets strive and aim for male offspring’s – even if this implies resort to murder and crime!

Female infanticide and killing of girl children as soon as they were born has been associated with conservative, pre-modern practices derived from male fetishism. Such practices were also resorted to in locations of difficult geophysical areas, such as on the Arctic Coast among the Eskimo groups, with extremely limited resources as a mechanism to cope with the specific circumstances (Balikci, 1967; Freeman, 1971). Even under such a scenario, these practices led to much inhuman and uncivilized adult behaviour due to shortage of female members. It may be shocking—but is true—that many households resort to such practices in this day and age! Media reports on abandoned dead bodies of newborn girls, trashing of aborted female fetuses and the dreadful practices of cold blooded murder of girls by midwives or older women who assist in the delivery of the child, reveal the heartrending tails of how patriarchy operates in preventing girls even of their right to be born (Dogra, 2006; Muthulakshmi, 1997; Sudha & Rajan, 1999; Sunanda, 1995).

The most conservative and crude methods are adopted to eliminate and do away with the girl child. Families enter into the agreement with the midwives prior to the delivery that if the child turns out to be a girl, she need not show her to them. Rather, she may resort to employing any of the means available with her to kill the girl infant, either by using a wet towel to smother her breath and suffocate her to death, or to sniff calatropis to her nostrils or feed her on it—that will definitely kill her. It is futile to deliberate on whether the use of this crude method is worse or using the sophisticated modern technique and aborting the foetus is bad, for both of these are done with the same objective and serve a similar end: eliminating the girl child! (Lingam, 1998; Menon-Sen & Kumar, 2001; George, Rajaratnham & Miller, 1992).

Since both the demanders and service providers are perceptibly benefitting from such methods, it is extremely difficult to check on these practices. Also, the deed is done in substantial privacy—even when it happens in hospitals—and therefore remains hidden to public enquiry (Bose, 2002). The absence of legal sanctions against socially camouflaged practices tends to perpetuate the unlawful acts of elimination of females. The law against infanticide not only proved inadequate to prevent the cases as they were privately executed, but also failed to address the newer practices of technological sex-detection-based female foeticide.

The legal provisions as they existed began being questioned in the 1980s and 1990s, when instances of female foeticide came into light. The practice of elimination of female foetuses prior to their birth itself was facilitated by the onset of technological medical aids such as sonography, amniocentesis and so on (Hoskins & Holmes, 1984; Patel, 1997; Lingam, 1998). The introduction of medical technological innovations to facilitate identification of abnormalities in foetal stages within the womb was being misused in a number of instances to
determine the sex of the foetus. These unlawful uses of technology called for legal reforms and introduction of fresh legislation to make such usage illegal and punishable.

The co-operation of medical professionals for monetary benefits and that of clients for their son-craze and anti-female biases made it extremely difficult to create measures to check on or prevent such practices. Clearly, mere imposition of legal provisions against such misuse of sonography techniques was inadequate to control these practices (Bose, 2002). Due to the hand-in-glove relation among the suppliers and demanders of these services, alternative mechanisms had to be thought of in order to impose restrictions and control these malpractices.

Spread of the misutilisation of these medical techniques for sex-determination by various means took place. The medical practitioners did not have to indulge in very active publicity since the service demanders seemed to have the necessary information in most cases. In any case, there were little restrictions on public advertisement of such facilities as occurred when the Gen-select advertisement appeared in national dailies touted as new from the United States (‘gender selection is now a reality!’). It was only subsequently that some women’s groups objected to this and filed a court case against the newspaper.

The irony is that even media-based social messages have the potential to serve as advertisement of the sex-selection option being available for the masses hitherto unaware of it. Ironically, even the legal imposition of placing a placard stating that sex detection is not undertaken in the clinic/centre often served as an advertisement that such a thing is possible. A complete failure of generating of legal sanction or fear of punishment by the use of publicity materials questioned the mode of using media as well as highlighted the resistance of the social mindsets against girls.

**Trends & Patterns of Child Sex Ratios in India**

Any analyses of indicators are subject to the availability of data. In order to provide a flavour of the trends across the states of India, child sex ratios have been calculated for two decadal time periods of 1991 and 2001. Although there are 28 states as per the 2001 Census, only 24 have been included here. This is because of the following reasons: first, three new states were bifurcated from Bihar, Madhya Pradesh and Uttar Pradesh, namely Jharkhand, Chattisgarh and Uttaranchal; second, the state of Jammu and Kashmir was not surveyed for the 1991 Census due to disturbances in the state; and lastly this comparison leaves out the Union Territories of India. For the pattern of sex ratios, however, all the 35 states and Union Territories for the year of 2001 (that is, the latest Census of India) have been included in the analysis to provide a complete picture of how child sex ratios fare in the country.

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2 It is heartening to note that as the paper was being finalized for publication, the first ever conviction of a doctor and his assistant under the Pre-natal Diagnostic Techniques (Regulation & Prevention of Misuse) Act occurred by adopting a decoy patient method to expose the medical misuses practiced in a clinic in Faridabad, a town bordering the capital city of Delhi.
The actual scenario over the last decade 1991-2001 regarding child sex ratios for all the states of India is presented in Table 1. This reveals the low proportion of girls in the states of Punjab, Haryana, Gujarat, Himachal Pradesh, Rajasthan, Uttar Pradesh and Maharashtra. The declining trend is almost universal, except for the states of Sikkim, Tripura, Kerala and Mizoram. Although not conclusive, historical prevalence of matriliny, women’s control over property and resources, greater economic participation and a more significant role in decision-making may be some of the likely factors that explain the better demographic sex balance and the improvements in the sex ratios in these states.

On the other extreme, lower proportion of women in the north-western regions of the country has also been witnessed since the beginning of the twentieth century (Dreze & Sen, 1995). However, the rate of decline in that share has been rapid over the decades. Research studies through fieldwork have highlighted the lower status of women in these societies as explanations for the adverse sex ratios (Dasgupta, 1987). Explanations for women’s plight have ranged from invasion, kidnapping, sexual assault to son preference. Subsequent decline, as is continuing even today, draws upon prevalent factors of dowry, foeticide, increasing financial burden, smaller family size, wherein one or more boys are considered desirable and even mandatory.

Table 1: Child Sex Ratio over the Decade 1991-2001 among States
(Number of female per 1000 males for 0-6 year-old population)

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Punjab</td>
<td>793</td>
<td>875</td>
<td>-82</td>
</tr>
<tr>
<td>2</td>
<td>Haryana</td>
<td>820</td>
<td>879</td>
<td>-59</td>
</tr>
<tr>
<td>3</td>
<td>Gujarat</td>
<td>879</td>
<td>928</td>
<td>-49</td>
</tr>
<tr>
<td>4</td>
<td>Himachal Pradesh</td>
<td>897</td>
<td>951</td>
<td>-54</td>
</tr>
<tr>
<td>5</td>
<td>Rajasthan</td>
<td>909</td>
<td>916</td>
<td>-7</td>
</tr>
<tr>
<td>6</td>
<td>Uttar Pradesh</td>
<td>915</td>
<td>928</td>
<td>-13</td>
</tr>
<tr>
<td>7</td>
<td>Maharashtra</td>
<td>917</td>
<td>946</td>
<td>-29</td>
</tr>
<tr>
<td>8</td>
<td>INDIA</td>
<td>927</td>
<td>945</td>
<td>-18</td>
</tr>
<tr>
<td>9</td>
<td>Goa</td>
<td>933</td>
<td>964</td>
<td>-31</td>
</tr>
<tr>
<td>10</td>
<td>Madhya Pradesh</td>
<td>933</td>
<td>952</td>
<td>-19</td>
</tr>
<tr>
<td>11</td>
<td>Bihar</td>
<td>938</td>
<td>959</td>
<td>-21</td>
</tr>
<tr>
<td>12</td>
<td>Tamilnadu</td>
<td>939</td>
<td>948</td>
<td>-9</td>
</tr>
<tr>
<td>13</td>
<td>Karnatak</td>
<td>949</td>
<td>960</td>
<td>-11</td>
</tr>
<tr>
<td>14</td>
<td>Orissa</td>
<td>950</td>
<td>967</td>
<td>-17</td>
</tr>
<tr>
<td>15</td>
<td>Manipur</td>
<td>961</td>
<td>974</td>
<td>-13</td>
</tr>
<tr>
<td>16</td>
<td>Arunachal Pradesh</td>
<td>961</td>
<td>982</td>
<td>-21</td>
</tr>
<tr>
<td>17</td>
<td>Kerala</td>
<td>963</td>
<td>958</td>
<td>5</td>
</tr>
<tr>
<td>18</td>
<td>West Bengal</td>
<td>963</td>
<td>967</td>
<td>-4</td>
</tr>
<tr>
<td>19</td>
<td>Andhra Pradesh</td>
<td>964</td>
<td>975</td>
<td>-11</td>
</tr>
<tr>
<td>20</td>
<td>Assam</td>
<td>964</td>
<td>975</td>
<td>-11</td>
</tr>
<tr>
<td>21</td>
<td>Mizoram</td>
<td>971</td>
<td>969</td>
<td>2</td>
</tr>
<tr>
<td>22</td>
<td>Tripura</td>
<td>975</td>
<td>967</td>
<td>8</td>
</tr>
<tr>
<td>23</td>
<td>Nagaland</td>
<td>975</td>
<td>993</td>
<td>-18</td>
</tr>
<tr>
<td>24</td>
<td>Meghalaya</td>
<td>975</td>
<td>986</td>
<td>-11</td>
</tr>
</tbody>
</table>

Source: Calculated from Census of India, 1991 and 2001; see Rustagi, 2003, p.12.
Notes: 1. All Union Territories have been excluded. 2. Three states of India—Bihar, Madhya Pradesh and Uttar Pradesh—were bifurcated to create the new states of Jharkhand, Chattisgarh and Uttarakhand respectively in 1997. In order to compare across the two decadal censuses—1991 & 2001—the erstwhile states prior to bifurcation have been used for analysis. 3. The state of Jammu and Kashmir is excluded since no Census could be undertaken in the state for 1991.
Contrary to the expectation that the economic burden of bringing up a daughter would compel the poor to resort to various measures against the girl child’s survival, it is those who have the means to exercise such choice by using their economic prosperity, who pose a threat to girls being born and their survival. This is exemplified in the states of Punjab, Haryana, Gujarat and Maharashtra (all of which are prosperous states within the country), sliding down on the child sex ratios indicator. The role of advanced scientific technologies in facilitating the elimination of female foetuses has been highlighted by many researchers and groups in the various states where its adoption is attaining severe limits. This is facilitated by the connivance of greedy medical professionals. Such access is more easy and prominent in urban locations and among the relatively well-to-do prosperous states. The urban areas display consistently worse sex ratios and child sex ratios with very few exceptions (see table 2).

Table 2: Ranks Based on Child Sex Ratios Across Locations among States & Union Territories (UTs) of India

<table>
<thead>
<tr>
<th>State/Union Territories</th>
<th>Child Sex Ratio for 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>India</td>
<td>927</td>
</tr>
<tr>
<td>Jammu &amp; Kashmir</td>
<td>941</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>896</td>
</tr>
<tr>
<td>Punjab</td>
<td>798</td>
</tr>
<tr>
<td>Chandigarh*</td>
<td>845</td>
</tr>
<tr>
<td>Uttarakhand</td>
<td>908</td>
</tr>
<tr>
<td>Haryana</td>
<td>819</td>
</tr>
<tr>
<td>Delhi*</td>
<td>868</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>909</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>916</td>
</tr>
<tr>
<td>Bihar</td>
<td>942</td>
</tr>
<tr>
<td>Sikkim</td>
<td>963</td>
</tr>
<tr>
<td>Arunachal Pradesh</td>
<td>964</td>
</tr>
<tr>
<td>Nagaland</td>
<td>964</td>
</tr>
<tr>
<td>Manipur</td>
<td>957</td>
</tr>
<tr>
<td>Mizoram</td>
<td>964</td>
</tr>
<tr>
<td>Tripura</td>
<td>966</td>
</tr>
<tr>
<td>Meghalaya</td>
<td>973</td>
</tr>
<tr>
<td>Assam</td>
<td>965</td>
</tr>
<tr>
<td>West Bengal</td>
<td>960</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>965</td>
</tr>
<tr>
<td>Orissa</td>
<td>953</td>
</tr>
<tr>
<td>Chhattisgarh</td>
<td>975</td>
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<tr>
<td>Madhya Pradesh</td>
<td>932</td>
</tr>
<tr>
<td>Gujarat</td>
<td>883</td>
</tr>
<tr>
<td>Daman &amp; Diu*</td>
<td>926</td>
</tr>
<tr>
<td>Dadra &amp; Nagar Haveli*</td>
<td>979</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>913</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>961</td>
</tr>
<tr>
<td>Karnataka</td>
<td>946</td>
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<tr>
<td>Goa</td>
<td>938</td>
</tr>
<tr>
<td>Lakshadweep*</td>
<td>959</td>
</tr>
<tr>
<td>Kerala</td>
<td>960</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>942</td>
</tr>
<tr>
<td>Puducherry*</td>
<td>967</td>
</tr>
<tr>
<td>Andaman &amp; Nicobar Islands*</td>
<td>957</td>
</tr>
</tbody>
</table>

Note 1: Rank T refers to CSR rank for total areas and Rank U pertains to Urban areas.
Note 2: * refers to Union Territories Source: Calculated from Census of India, 2001.
As the legal provisions make efforts to tighten their grip on the problem, the cost to be incurred by the demanders escalates. Having to pay higher sums to abort female fetuses ensures that these illegal services are more accessible to the prosperous and better off sections of Indian population who can afford such costs.

**Gender Inequalities & Class Dimensions**

There can be no denying of the fact that the declining child sex ratio is a reflection of the prevalence of the gender biases in society, given the nature of the manifestation of the phenomenon in certain parts of India, among some sections more prominently than in others. The impact of patriarchal influences is discrimination against girls in various spheres which in turn affects the sex ratios as well. The son preference attitudes together with the unwantedness of girls manifest themselves in different forms. Discriminatory treatment in the spheres of health and nutrition adversely affect girls, increasing their mortality during infancy and childhood (Bardhan, 1982; Basu & Basu, 1991). While the poor witness higher mortality among children, in most cases both the boys and girls face similar nutritional deprivation. In other words, such deprivation is not necessarily and overtly discriminatory against the girl child.

However, the female infant mortality rates in most parts of India are higher than that of the male infant mortality rates. This hints at the relatively higher levels of gender discrimination being practiced among the non-poor. An examination of data provided by the Census 2001 on slum populations serves as a good proxy for the practices of the poor. The sex ratios among slum and non-slum populations are very revealing in this respect. They highlight that the poor are relatively less overtly gender discriminatory when it comes to the unwantedness of the female child or elimination of female fetuses.

The abandoned children and the children reaching adoption centres in different parts of the country are disproportionately girls (Fruzzetti, 2006; Lilani, 1995). The demand for male children among prospective adoptive parents puts a premium upon the boys, while girls are available in larger numbers and therefore promoted by the adoption agencies and their counselors. However, systematic data from these centres and agencies are lacking for undertaking a more comprehensive analysis on dimensions of patriarchal mindsets in the country.

**Health & Nutrition Related Concerns**

At the all India level, in opposition to the biological and medically known robustness of girl children, a higher infant mortality rate (IMR) among females is noted when compared with that for males. The various factors that affect the gender differentials in mortality rates of infants and children, beyond the health-nutrition-physical elements, overbearingly dwell upon the patriarchal mindsets which result in
gender discriminating behaviour against girl children. Even among children beyond the infancy years (above one and up to 5 years), girls often face higher mortality rates in comparison to boys. This is the case in India for both rural and urban areas, although IMRs for urban areas are generally lower than that of villages in India (Rustagi, 2003).

The incidence of deaths among children is reported every year by the Sample Registration System (2001) data generated by the Registrar General’s Office. Infant mortality rate among females is the probability of infant deaths among every 1000 infants before reaching age one. Mortality rate among infants take up a high proportion in the overall mortality rates since mortality rates are the highest in the infancy stages as compared to all other ages. Male infants are known to be more susceptible to early demise than female infants due to biological and genetic reasons. However, in India, the female infant mortality rate surpasses that of males which is reflective of the socio-cultural influences on mortality (Kishor, 1993; Visaria, 1985).

Table 3: Infant Mortality Rates – India 2001

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>66</td>
<td>64</td>
<td>68</td>
</tr>
<tr>
<td>Rural</td>
<td>72</td>
<td>70</td>
<td>74</td>
</tr>
<tr>
<td>Urban</td>
<td>42</td>
<td>41</td>
<td>44</td>
</tr>
</tbody>
</table>

Source: Sample Registration System, 2001, Registrar General, India.

When viewed over time, the mortality rates for the country have been improving as they have continuously moved downwards. Nevertheless, the decline in mortality rates has not bridged or tampered the gender disparities. The female infant mortality rate (IMR) defined as number of female infant deaths per 1000 live births has remained higher than that for male infants. The scenario across states, however, differs—with a number of states reporting higher male IMRs as well.

The intra-household disparities in consumption behaviour have highlighted the gender discrimination against females (Haddad & Kanbur, 1990; Tinker, 1990). These practices of discrimination start very early in age for children, right from the time of birth through infancy and beyond. The prevalence of such discriminatory behaviour over time can impact upon the mortality rate differentials across sex (Basu, 1989).

As discussed extensively, the girl child being the undesired one is often neglected and deficient in the levels of nutrition required at any age (Levinson, 1974; Khan, et al., 1988). The general scenario of males being the primary earning member and the perception that supports gender discriminatory behaviour is that earning members should be taken care of in terms of food and nutrition to ensure steady flow of income. Illness or weakness among earners can debilitating the poor
households doubly by loss of earning for periods resulting in indebtedness and further poverty.

Among poorer households, the likelihood of both boys and girls among infants suffering due to malnutrition or being prone to mortality is almost equally high. The gender biases become starker among those with the wherewithal to provide nutrition for infants. It is among these households where a choice in favour of males—while withdrawing from or depriving girls—is made. The practices of the male-craving households to kill an infant girl so that early conception is made feasible opening up another chance of having a male child is often noted. Similarly, the stopping of breastfeeding for girls in a shorter span of time is another mechanism, since it is often believed that further conception is prevented during periods of breastfeeding. Many studies have noted the shorter period of breastfeeding of girls, thereby depriving them of healthy and immunization-building opportunities from an infancy stage!

Natural Chances for Girl Child Among the Poor

The prosperity-poverty connection to lower sex ratios has been drawn effectively in the literature to show the urban, better-off locations having worse sex ratios as compared to the rural, poorer masses (Miller, 1981; Rustagi, 2000). The Census of India 2001 provides detailed slum population data. This reveals very stark patterns of lower levels of gender discrimination in terms of girl child elimination or female unwantedness. The sex ratios among slum populations are far higher that the non-slum populations in most of the states.

Metropolitan cities and some of the newer million-plus cities also reflect the same situation with slum populations having better sex ratios, in comparison to the non-slum inhabitants. As many as 17 of the 26 States and Union Territories (for which slum population data is provided) reported higher sex ratios among slum dwellers compared to the non-slum residents (Chakravertti, 2005).

The child sex ratio (CSR) defined as the number of girls per 1000 boys in the age group of 0-6 years for slum population is 919, which is significantly higher than the 904 recorded for non-slum urban areas. The CSR—an indicator which accounts for the noise factor of migration into urban cities and their seeking residence in slums—reflects an even clearer picture of the lower incidence of such gender-biased elimination or pre-birth selection being practiced among the poor urbanites.

Of the 26 States/UTs, 21 show the slum CSR to be higher than their non-slum counterparts. Chandigarh, an UT known for its poor CSRs, records a very stark difference across slum and non-slum populations. While the CSR among slums of Chandigarh is 917, the non-slum inhabitants record a low 825 girls per 1000 boys. Moreover, amongst the 27 million-plus Indian cities, 22 show higher CSR among slum dwellers as compared to the rest of the population, with an additional two cities recording the same CSRs among both slum and non-slum areas (Chakravertti, 2005).

The discussed comparisons provide a clear picture about who the ‘guilty’ are and point to the erroneousness of associating the practices of sex discrimination as the outcome of poverty. Poverty in itself debilitates in various
ways, but does not turn the poor populations into being anti-female and into becoming girl-child murderers. What is horrifyingly surprising is that the middle class—lower-middle, middle-middle or upper-middle—have all been caught up in the stronghold of patriarchal gender ideologies. These attitudinal and behavioural norms are intensified through socio-cultural mores which pressurizes people to follow costly and unaffordable practices. Such consumptive expectations, in turn, make the middle-classes materialistic. For some, this materialism goes so far as resorting to barbaric practices, such as the decision to throttle their newborn girl children!

Technology seems to provide a sophisticated cover-up for the historical animistic and inhuman female infanticide through pre-birth sex-determination-based abortion of female foetuses. The fees for the services of these medical facilities are out-of-reach of the really poor; it is the non-poor who use these new techniques. Also, the poor view any additional member as another working hand and therefore a productive economic investment that will fetch returns in the long-run. For the poor, the cost of investment into any child is relatively lower than that of the non-poor. Additionally, since the mortality rate of infants and children is already higher due to lower levels of nutrition and lack of access to health care facilities, slum dwellers have a different approach to children and their protection. Survival of children—irrespective of gender—is already a major struggle for slum dwellers; hence the reverse practice of killing any child would go against the grain of their existential and survival philosophies.

Crimes Against Children

Crime data procured from police records are subject to inherent lacunae stemming from non-reportage. The under-reporting is especially applicable in cases of violence such as infanticide, foeticide and so on. Thus, it is expected that relatively larger number of cases will be registered under the heading of ‘exposure and abandonment’. In 2003, the NCRB data on crimes against children recorded an incidence of 722 cases under exposure and abandonment. Maximum cases are recorded in Maharashtra, Rajasthan, Madhya Pradesh, Gujarat, Andhra Pradesh and Haryana.

| Table 4: Incidence of Selected Crimes Against Children by Selected Years |
|----------------|--------|--------|--------|
| Cases            | 2001   | 2002   | 2003   |
| Foeticide        | 55     | 84     | 57     |
| Infanticide      | 133    | 115    | 103    |
| Exposure and Abandonment | 678 | 644 | 722 |


As Table 4 depicts, a total of 57 cases have been registered under foeticide for 2003, while more than 100 cases are listed under infanticide. The states prominent for incidence of infanticide are Madhya Pradesh, Uttar Pradesh, Tamil Nadu, Maharashtra, Rajasthan and Punjab. There is little doubt that these figures are gross under-estimates due to the non-
reportage and poor recognition of these acts as being criminal. Estimated numbers from one of the controversial studies reported in the *Lancet* suggest what is considered a conservative number of nearly 10 million female fetuses being aborted in the last two decades in the country (reported in Dogra, 2006, p.67). This is based on the estimation of the missing girls calculated from sex ratios. However, what is distressing about this and similar studies is what they show about the higher chances of pregnancy termination if the first child is already a girl and the following pregnancy is tested to be a female foetus. The incidence of such behaviour being higher in case of the educated mothers is brought out by the *Lancet* study (reported in Raaj, 2006) and another Delhi based selected hospita-focused study by the Christian Medical Association of India (Bagga, 2005).

**Abandonment & Adoption**

The disinterest for girls is reflected in certain other ways, where parents abandon them or give them up for adoption to organizations involved in these tasks. While the NCRB (2001, 2002, 2003) provides information on exposure and abandonment of children, unfortunately it does not give the gender disaggregated data. Therefore, even if we know the numbers of children abandoned, it is difficult to ascertain how many of these actually are girls. However, the media news and other sets of information from common sources of knowledge make it obvious that girl children are most often the unwanted ones. Another set of information that hints at this is the presence of larger numbers of girls in adoption centers (Fruzzetti, 2006). Visits to most of the adoption homes show that girls are plentiful among children available for adoption.

The relative undervaluation of girls even in adoption centres is an additional matter of concern. While the average fee to adopt a girl child may be around Rs. 10,000 (approximately US $ 222), adoption of a boy will require at least twice as much. Since boys are desirable and much more in demand, there are clandestine deals through which boys are procured at times and the cost for adopting male children is pitched at exorbitant rates. Thus, even among children within adoption centres, the girl child tends to be undervalued.

The lower cost of adopting girls, their availability in larger numbers and the added advantage of choice among the available girl children are probably the reasons behind the higher adoption rates for girls. It needs to be emphasised that it is not as much a favoured preference for girls among adopting parents/adults which is the cause for their adoption, but the conditions that make it more difficult to adopt male children: longer waiting periods, non-availability of male infants and the high, demand-based spiraling of costs for procuring males. While it may be a positive policy to create demand for adoption of girls by willing parents, especially from among middle-class circles, this may in fact result in a
politically correct behavioural response. Nevertheless, the reality that results in the adoption of girl children seems to hint at other practical, logistical reasons rather than a sensitivity to girls’ plight.

What will further the gender analysis is the regular generation of data and statistical information from adoption centres. For example, availability of children by sex in these institutions and the rate of their being sought for adoption will be a very useful. Other details that are relevant are the age of the children along with the reasons why they have ended-up at the adoption agencies.

Processing of application forms handed over to adoption centres with the specifications regarding the child preferred for adoption and other details can be another useful source of data. Do prospective adoptive parents state their preferences regarding the gender of the child? In the absence of such information being available on a systematic basis, only input from interviews with adoption centres and informal sources form the basis for emphasizing the significance and utility of such information. What such information provides may be the expected gender-bias. However, it will further assist in drawing strong conclusions and making the arguments based on the resilience of gender ideologies. What is today seen as more of an argument being pushed by some activists and agenda setters will be more convincingly acceptable to all—lay persons, the middle class, educated persons, who are part of the society which is practicing this gender discriminatory behaviour.

**CONCLUDING REMARKS**

The debates around declining child sex ratios are juxtaposed to the population policy and its emphasis on reduction of the high population growth rate in the country. This, in turn facilitated the otherwise controversial right to abortion in early seventies; the advancement of medical technologies oriented to identify abnormalities and disorders during foetal stages of pregnancy. The latter, almost from its introduction, became associated with the sex detection and came to be misused for sex selective female foeticide. The identification of social group/s which indulge in these discriminatory practices since earlier methods to do away with girl children through infanticide were linked to specific communities and regions, associated with poverty and inability to bear the economic and social burden of nurturing girls.

Among specific geographical locations, the scarce resources and harsh conditions were sought to be balanced through resorting to female infanticide. This was even lauded as an innovative mechanism to keep

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3 Based on personal interviews with foster parents in Delhi.
4 The term of ‘female foeticide’ is more in vogue in India and chosen against the more neutral terminology of gendercide constructed to mean large scale selective elimination of any particular sex be it male or female.
population growth under check. Reducing the numbers of women not only took care of these generations provisions but also served as a check of increasing population in the next generation. Thus, infanticide or selective elimination of girls was one effective population control mechanism! However, shortage of women meant otherwise unmarriageable females to marry and affected the need and desire to create one’s own progeny as well. Violence in terms of killing for women, wife snatching and other socially unpardonable behaviour in a global civilized society was noted in the context.

The need to control population growth facilitated introduction of measures which encouraged use of techniques so as to prevent unwanted pregnancies, conceptions and deliveries. The fight for the right to abortion (not granted in most countries of the world) arose as a means to liberate women and not compel them to bear children when they do not intend to do so. It received support from the advocates of population control. Abortion was also viewed as a much needed option in circumstances where the population control measures were inadequate or where these failed.

The granting of the right to abortion became legal with the enacting of the Medical Termination of Pregnancy (MTP) Act in 1971. This was viewed as a progressive measure, since the earlier stringent approach towards abortion resulted in a large number of ‘illegal’, ‘underground’ abortions in extremely unhealthy and unsafe conditions, affecting women’s lives. Although the law was enacted seemingly with the purpose of safeguarding the rights of pregnant women, the underlying pressure to grant the green signal received impetus from the need felt for controlling the growth in India’s population. The implementation also followed the principles of population control despite the law stipulating various caveats under which the right to abortion is to be granted, such as health reasons, on humanitarian grounds and eugenic grounds.

In light of the choices being made available to society for planning their families some of the socio cultural considerations, predominantly those emanating from patriarchal structures also came into operation. One of the prominent ones is the sex determination techniques to plan the sex of one’s offsprings. Some of the other preferences relate to racism, the yearning for ‘white’ or ‘fair-skinned’ children, or children with pre-specified physical traits and so on.

If restricting the number of children that is strongly advocated by the planners and policymakers is not a problematic issue, then why should choice of sex of the children per family matter? Infanticide was practiced on the sly, in secrecy among certain communities much more than among others. Specific historical and community factors were linked to the adoption of such practices to eliminate females as in the case of Kallars in Tamil Nadu, or war-faring communities of Rajputs. The operation of such practices in rural areas, among illiterate and often poor masses seemed to be the obvious connections drawn.

The spread and identification of elimination of females being practiced
among literate, urban and prosperous households has thrown up a paradox defying easy explanations. The son preference and extreme unwantedness of daughters witnessed are signs of the stronghold of patriarchal values and unequal, discriminatory treatment of girls.

Women’s rights over their own bodies and having the right to make decisions regarding their reproductive roles must be granted legally and become socially acceptable. At the same time, the misuse of abortion to eliminate girl children while still in their foetal stages subsequent to sex determination tests needs to be prevented. The responsibility of medical professionals in prevention of such misuse is tremendous. Campaigns against female foeticide in the country are therefore shifting focus in a more concerted fashion upon this community, employing all methods available to expose the crime committed within private spaces of hospitals or clinics.

In addition to these advocacy campaigns, research studies on the subject are essential for awareness generation on these aspects of societal deviancy, which have spread roots very widely and seem to be expanding their outreach for all the wrong reasons. A continued emphasis on generation of systematic data from different sources on diverse dimensions are required in order to shed clearer light on this complex phenomenon of declining numbers of girl children. The issue of ‘missing’ girl children is an outcome of patriarchal undervaluation of women in Indian society, which needs to be anchored as a human rights subject that aims for gender equality. The need to recognize equal sex ratios as a public necessity has also been argued by Miller (1981). The right to equality for women and elimination of discrimination against women ratified with the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW in Menon-Sen & Kumar, 2001) form the background within which the efforts to improve the status of women are located. The Millenium Development Goals (MDGs) includes gender equality as an overarching objective of the United Nations compact towards human development.

The constraints towards women’s empowerment, such as education, health care, access to institutions and political participation, income generation, dignity of work and protection from violence need to be addressed to improve women’s status. On the legal front, the existing gaps in provisions have to be bridged and amendments need to be made to increase the efficacy of the execution of laws against misuse of medical facilities. This, along with constant efforts to create effective mechanisms to operationalise legislative provisions by building bridges and involving more partners will be essential (local, international, governmental, non-governmental advocacy groups, etc.), to safeguard the future of the girl child. Efforts oriented to address the problem of declining sex ratios and improving the gender balances necessarily need to work towards changing the prevalent mindsets in order to enhance women’s status. This requires a multi-dimensional approach to tackle the deep-rooted patriarchal ideologies that perpetually undervalue women and lower their status.
REFERENCES


LEVIRAT & SORORAT MARRIAGES IN SOUTHEASTERN TURKEY: INTACT FAMILY OR SANCTIFIED INCEST?1

Aysan Sev’er, University of Toronto
Mazhar Bağli, Dicle University

KEYWORDS: LEVIRAT, SORORAT, TURKEY, WOMEN, PATRIARCHY, FORCED MARRIAGE, INTACT MARRIAGE

Forty-five people who were either currently living, or have recently lived in levirat and sororat marriages were interviewed. Sororat refers to a man’s marriage to his deceased wife’s sister and levirat refers to a woman’s marriage to her brother-in-law after the death of her husband. The current paper explores the gendered reactions to tensions and role confusion in these marriages. We observed that both men and women shared the general expectations about women’s traditional roles within marriage. We also observed that family and kin seem to be equally persistent on formulating levirat or sororat types of marriages for widows and widowers. However, men had a ultimate veto power over these arrangements and women did not. Moreover, tensions on women, especially in terms of establishing sexual intimacy with their new partners were traumatic. We argue that material considerations play a primary importance on the continuation of these marriages, despite the problems these marriages entail, especially for women.

In the west, definitions of the family vary. Functionalist orientations define the family in terms of its structures and its functions. Within the structural aspects, what is often emphasized is the presence of a heterosexual union, often with or expecting to have children and sharing the same residence. Blood or marriage ties amongst the family members is assumed and the intactness of the families and their permanence are openly preferred to all other configurations (Eschleman & Wilson, 2001; Kilbride, 1994; Parsons & Bales, 1995; Ramu, 1993; Zelditch, 1955). In the west, the ‘intactness of the family’ almost exclusively, refers to the nuclear family form which consists of the marital pair and their dependent children. In the developing world, ‘intactness of the family’ may subsume larger family units that are considered indivisible, such as patriarchal family households with more than two generation of families that live within them. Some of these families may be polygynous or consist of close-kin marriages (Elmaci, 1996). Functional arguments about the family are based upon assumptions about the desirability of division of labour, socialization of children and sharing sexual, affective and economic resources. Division of labour implies that women will specialize in affective tasks such as nurturing, solving emotional problems, kin-

1 This research is supported by funds provided by the Social Sciences and Humanities Research Council of Canada (SSHRC) and by The Research Coordinator of Dicle University, Diyarbakir, Turkey. We thank the 45 respondents who candidly talked to us about their Levirat and Sororat marriages.
keeping, etc., while men concentrate on representing the family in the public sphere, assuring the families’ economic well-being and taking care of tasks that require physical power or expert knowledge (Parsons & Bales, 1955; Zelditch, 1995).

Feminists have always quarrelled with such rigid definitions of the family. Instead, they claim that the functionalist views about the structures and the functions of families give legitimacy to only a small portion of the variation in families (Eichler, 1997; Luxton, 2001). In reality, people who consider themselves and who are considered by others as a family may not live in the husband/wife/children form (divorced, widowed, childless are some variations). Moreover, they may not be heterosexual, they may not share the same residence, or they may have external sexual relations. Conversely, some intact families may pose problems and dangers for women and children despite their structural intactness (dysfunctional families, abusive husbands, violence against children are examples). In short, the structural aspect (intactness) does not necessarily guarantee equity or happiness.

Another point of departure for feminists from the functionalist arguments is the assumptions about the division of labour. Increased paid labour force participation of women in the west, feminists claim, has made the traditional arguments obsolete. In fact, the merit attributed to traditional roles, hide the deep unrest among men and women about the extraordinary work women shoulder as paid workers/mothers/wives and kin-keepers (Armstrong & Armstrong, 1984; Hartman, 1976; Hochschild, 2001; Fox & Luxton, 2001). In patriarchal portions of the developing world, the division of labour arguments have been used to keep women out of the paid labour force, engendering a life-long dependence on men. Indeed, the structural functional arguments about the family, feminists claim, are nothing more than what androcentric societies have prescribed and reinforced through policies and procedures. Feminists charge functionalists for failing to address the different needs arising from the existing variations, locally or globally.

Instead of utopic expectations about affective and instrumental divisions and smooth parent-child interactions, at the macro level, feminist theories analyze family life within the material conditions that surrounds it (Hartman, 1979). For example, how do laws, policies, economic conditions impact family life? In addition, the availability of adequate housing, accessibility of health and child-care services also are taken into account, along with the status of women in a given society (Eichler, 1997). Feminists are also cognizant about cultural variations which may put additional pressures on women from patriarchal societies. In essence, families are not seen as occurring or dissipating in a vacuum but are analyzed as firmly embedded in the material and cultural conditions that either promote or hamper their growth.

Feminist theories also attempt to understand families as a dynamic
entity, rather than a typology with predetermined attributes (Fox & Luxton, 2001). For example, how do autonomy and agency of women factor into the day-to-day life and whether or not members of the family have relatively equal/equatable access to resources. In other words, whether power is distributed amongst family members or whether it is concentrated in the hands of one (usually a man) becomes issues of inquiry. What is crucial to understand is the position of women and girl children, vis-a-vis men and boys (Kagitcibasi, 1993; Kandiyoti, 1988). In patriarchal societies, family relations are far from egalitarian and women/female children have much less access to resources such as adequate food, clothing or schooling. In difficult times, their share of the resources may further dwindle (Chopra, 2002; Wolf, 2000). Another aspect feminists emphasize is whether women have decision-making power or whether decisions are made for them.

This paper adds to the above summarized traditional debates about the family. What is pursued here is how some patriarchal societies manipulate the ‘intact family’ expectations to an extreme and in doing so, subjugate women and children. Under the auspices of paternalist protectionism, what in fact transpires is that women’s choices and their children’s access to opportunities are circumvented to fit male priorities and privilege.

What is explored in this paper is sororat (S) and levirat (L) types of marriages. The first refers to the patriarchal practice of a man marrying his wife’s sister in case of the death of his wife. The second refers to the practice of a brother of a man who has died, marrying his sister-in-law. Levirat or S types of marriages are perhaps the least well-known type amongst many family forms, be it traditional or modern. This lack of knowledge is partially due to the fact that they are uncommon and they often take place amongst remote, rural domains of extremely patriarchal regions of developing societies. Moreover, people who engage in L or S types of marriages may also engage in other unions that may be prohibited by the laws of the state that governs them. For example, they may practice bigamous or polygynous marriages, child-betrothal, dowry or bride-price. The state may also prohibit close-relative marriages like in-law marriages. The above mentioned reasons combine to make L and S marriages one of the most elusive and one of the most understudied forms of marriage. In our view, L or S marriages are one of many examples of traditional societies’ condemnation of women to what Chopra calls a ‘subterranean’ existence in kin-dominated households (Chopra, 2002).

This paper attempts to fill the existing void by reporting on 45 participants of L or S marriages. The current examples are selected from very remote and mostly poverty stricken pockets of southeastern Turkey. Although they are becoming very rare through Amodernization@ that is sweeping the globe, L and S marriages are family forms that personify all
that is problematic in functionalist arguments about keeping families intact. Our results will make it clear that L and S exemplify the patriarchal grip on women’s lives under the guise of family obligations. Although the families remain ‘intact,’ and the land base they live on remains undivided, this intactness is achieved at the cost of the freedom of women to establish independent lives for themselves and for their children. What is sad is that women do see these traditions as a necessary evil to take care of their children since the same societies give no other alternative for them to be independent social or economic agents.

In the following pages, we will first review some general information about southeastern Turkey where L and S marriages are still practiced. Then, we will introduce the methods of our study and our findings from our in-depth, face-to-face interviews with 45 L or S marriage participants. Indeed, it is our intention to show how the economic dependence of women (and their children) and cultural expectations about women’s rigidly defined familial roles turn them into pawns in marital decisions and exchanges. As our findings will demonstrate, women rarely have a say in what happens to them in their marriages. We are going to argue that the general functionalist arguments about keeping the families intact may indeed be dysfunctional since, in some cases, they confuse rather than clarify roles and statuses. In the particular cases that we will address, nieces and nephews of one may become one’s step children with the passing on of a sister or a brother and one’s sister or brother-in-law may one day become a wife or a husband, all under the grip of paternalistic traditions. We will argue that under the guise of ‘protecting women,’ L or S types of marriages represent nothing more than depriving women of choice over their bodies or inheritance. Given a death of a previous spouse, L or S marriages make women sexually available for men who are already related to them through marriage.

SOME FACTS ABOUT TURKEY & SOUTHEASTERN TURKEY

Turkey fought a costly war of independence against the remnants of the corrupt Ottoman forces as well as the expansionist aspirations of the triumphant allies of the First World War. In 1923, Turkey became a democratic, secular republic. From its inception to the current day, Turkey has aspired to establish a true westernized state with a constitution which gives equal rights to all its citizens, regardless of gender, race or religion (since 1924). Starting from the mid 1920s, Turkish civil and criminal laws closely mimicked their westernized counterparts (Arat, 1996; Marcotte, 2003; Orucu, 1996; Tekeli, 1995). Turkish women became entitled to a vote.

In Turkey, L or S marriages occur in regions where the Kurdish minority constitute a local majority, although the practice is not exclusive to the Kurdish Turks.

After Prime Minister Brian Mulroney’s resignation, Kim Campbell served as the Prime Minister of Canada for a few months, but she was never elected or re-elected to this position.
in 1930 and has been elected to the Turkish Parliament since 1934 (Kidog, 1997; 1998; Kislali, 1996; Kocturk, 1992; Tokgoz, 1996). Turkey is one of the few democracies that has ever elected a female Prime Minister (Tansu Ciller), a feat that still escapes both Canada and the U.S. However, as both Marcotte (2003) and Nasir (1994) argue, states with a vast proportion of Islamic populations have not been able to resolve family based issues just through the modernization of their laws. States with large Moslem constituents have always experienced tensions between laws versus traditions and practices (Marcotte, 2003).

In more recent years, Turkey has accelerated its westernization due to its aspiration to join the European Union. Bold initiatives in its penal and legal systems, improvements in its human and political rights stance, becoming signatory to various United Nations conventions and declarations (albeit with some reservations) are unquestionable affirmations of this modernization. Some of the most noteworthy commitments Turkey made are the signing of the CEDAW (United Nations Convention on Elimination of All Forms of Discrimination Against Women, 1979), DEVAW (Declaration on the Elimination of Violence Against Women, 1993) and CRC (Convention on the Rights of the Child, see UNICEF, 2000). In articles 5, 10 and 11, CEDAW requires the signatory states to eliminate discrimination against women in education, work or any other culturally prescribed roles. Moreover, in articles 16 and 19, CEDAW expands its requirements to the elimination of discrimination against women in family relations. Another United Nations declaration has placed protection of women from early marriages or child-betrothals, family or husband violence and unequal treatment in cases of divorce, widowhood or inheritance at its core (DEVAW, 1993). The declaration makes it clear that these are not some disjointed legal issues for individual states to deal with at their will, but form serious and integral human rights issues with global significance (Bond & Phillips, 2001; UNIFEM, 2001).

Despite all these positive developments, Turkey continues to experience economic, social and structural challenges. For example, a large population, a modest land-base, high birth rates, high infant and maternal mortality rates, low life expectancy and extreme regional variations in wealth and standard of living persist (Akyildirim, 2001). What also needs to be emphasized is that parts of southeastern Turkey is caught in a time warp (see Table 1 for some sociodemographic comparisons) and ethnic conflict. In Collins’s (2004: 4) words: “Turkey is a country of contradictions. Its major cities are modern and sophisticated, but rural Turkey is a long way from the country’s cultural capital of Istanbul. The village is where the old ways live on.” Especially in the patriarchal southeastern Anatolia, women’s and young girls’ lives basically remain at the mercy of their male relatives and kin (Sev’er & Yurdakul, 2001). Despite the modernized Turkish civil laws, girls can be
betrothed, married to much older men to settle family disputes, or can be bartered in marriage by families who want to avoid paying bride-price. Both the bartering and the bride-price systems are against the Turkish laws, but this fact does not prevent their frequent occurrence in the region. In Kurdish, barter is referred to as ‘berdel’ which means that a sister/brother are wed to a brother/sister pair (Ilkkaracan, 2000). Yet, if either one of these marriages fail (even by death), the other marriage is also considered obsolete, leaving women and children always anxious about their future.

Additional problems pertain to women’s work. Although most women in the southeast work very hard in either paid labour force (as farm labourers or as factory workers in the cotton or rug-making/pottery industries) or within kin-owned farms, they rarely have access to the money they make. Women who are locked up in traditional roles are more vulnerable, since they have no say in family decisions or management of family property. Their legal right to inherit from fathers and husbands may also be circumvented through manipulation of marriage systems. The fact that girl children are much less likely to be sent to school and much more likely to be illiterate compounds the matters. Bound by cultural practices, women are rarely in a position to demand their legal rights in work, education, inheritance or marriages (Kidog, 1997; 1998). Many marriages in southeastern Turkey are polygynous (Elmaci, 1996).

In their provocative discussion about the culturally constructed reasons behind polygyny, Kanazawa & Still (1999) argue that women prefer polygynous marriages when inequalities of wealth amongst men are substantial. According to the authors, for the safety of their children and for their own safety, women prefer to be the 2nd or 3rd wife of a rich man rather than being the only wife of a poor one. In contrast, when resource inequalities in a given society are not that differentiated, it is argued that women will opt for monogamy. Sanderson (2001) strongly challenges Kanazawa and Still for ignoring the power and ability of men to manipulate marriages. He argues that all men want polygyny, but they curb their desire to reduce competition and possible hostility amongst themselves. After all, if many men had multiple wives, some men will have no access to marriage, a condition Sanderson sees as explosive (2001). Kilbride (1994) also underscores the decision making power of men, but highlights the importance of land and property ownership rather than simple sexual access to women. For Kilbride (1994), men retain the possession of lands and property, first by denying women a fair share of the inheritance and also, by arranging their marriages. Thus, according to Kilbride (1994, pp. 38-39, 43), different forms of marriage arise to regulate the ownership and inheritance of land and material goods that women are disallowed to own.

In southeastern Turkey, especially amongst the Kurdish minority, a cultural pattern that disadvantages women is the regionally felt revulsion
against property splits. A region which is blistered by plus 40°C temperatures, that lack adequate water supplies and is devoid of fertile soil or other natural resources makes the rationale for this revulsion obvious. Large families cannot survive on minute parcels of land. In contrast, the Turkish inheritance laws are egalitarian and demand equal treatment of men/women or boys/girls in cases of death within legal marriages. To keep the land intact, rural people use numerous loopholes to circumvent the egalitarian laws and effectively deprive women and girl children from their legal inheritance. One way is to perform marriages as a "religious" ceremony, which carries cultural importance but no legal protection for women. Legally, their children are considered to be born out of wedlock and deprived of inheritance. Moreover, contrary to the monogamous legal marriages, religious marriages can be polygynous. Another way is to shift widows onto another male member of the patriarchal clan. Usually the shift takes place from a deceased to a surviving brother (L). Some men are encouraged to marry their sisters-in-law when their own wives die (S), especially in cases when there are young children. Given the high mortality rates in the region (see Table 1), these L or S marriages can be a frequent occurrence. The sister of the deceased wife is seen as the de facto surrogate mother, regardless of her own desires, aspirations or age. Despite this functional convenience, we believe that male dominance over land "family resources spills over to the treatment of women as 'family property.' In turn, these reasons are used to justify L or S marriages.

Table 1: Selected Demographic Indicators from Three Regions in Southeastern Turkey (Diyarbakir, Mardin & Sanli Urfa)

<table>
<thead>
<tr>
<th>Population (x 1000)</th>
<th>TURKEY</th>
<th>THREE REGIONS OF OUR STUDY IN SOUTHEASTERN TURKEY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65,293</td>
<td>DIYARBAKIR</td>
</tr>
<tr>
<td>Population increase (%)</td>
<td>1.5</td>
<td>2.2</td>
</tr>
<tr>
<td>Gross birth rate (per 1000)</td>
<td>21.5</td>
<td>37.6</td>
</tr>
<tr>
<td>Gross death rate (per 1000)</td>
<td>6.7</td>
<td>6.5</td>
</tr>
<tr>
<td>Average # of children (per adult women)</td>
<td>2.5</td>
<td>4.3</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live births)</td>
<td>35.3</td>
<td>55.0</td>
</tr>
<tr>
<td>Life expectancy (overall)</td>
<td>69.1</td>
<td>63.0</td>
</tr>
<tr>
<td>For men</td>
<td>66.9</td>
<td>61.0</td>
</tr>
<tr>
<td>For women</td>
<td>71.5</td>
<td>65.2</td>
</tr>
<tr>
<td>% of women in population available</td>
<td>Not available</td>
<td>47.4</td>
</tr>
</tbody>
</table>

Source: Akyildirim, 2001
**Fundamentalist Justifications**

Although Turkey is a secular democracy which meticulously segregates religion from governmental affairs, the fact remains that close to 99% of its population is Moslem. In stringently patriarchal pockets such as the southeast, Islamic teachings and practices still form a strong basis for how people organize their lives (Collins, 2004). Islamic traditions are based on the Koran (the holy book), the hadiths (prophet Mohammad’s behaviour and sayings) and the Shariah (Islamic code of law). Although centuries behind the secular Turkish modernism, some justification for L or S types of marriages are resurrected from the Koran and the hadiths by religious fundamentalists. This is not very hard to do, given the fact that ‘some 80% of Koranic rulings are devoted to regulating marital relations and the conduct of women’ (Goodwin, 2003: 36). What is unfortunate in these fundamentalist resurrections is that practices which were devised solely for the well-being of women and their children in the 7th century AD are now twisted to deprive women of choice and freedom (Goodwin, 2003; Kandiyoti, 1997; Kocturk, 1992; Marcotte, 2003).

The Koran allows up to four wives for men, especially if the death of their wives has left them with young orphans. However, this permission comes with very stringent expectations: ‘If you fear that you cannot treat orphan [girls] with fairness, then you may marry other women who seem good to you: two, three or four of them. But, if you fear that you cannot maintain equality among them, marry one only... (The Koran, 1976 translation, p. 366; elaboration of orphans as [girls] in original translation). The Koran also clearly states that ‘it is unlawful for you to inherit the women of your deceased kinsmen against their will, or bar them from re-marrying...’ (The Koran, 1976, p. 368). The prophet Mohammed, after a monogamous and egalitarian relationship with his first wife (Khadija), has married numerous women upon her death. All but one of Mohammed’s wives were war widows (Goodwin, 2003) and the hadiths show his painstaking effort to treat them equally.

Thus, although the free choice of women in marital decisions is entrenched in Turkish laws as well as in The Koran, the current practice of L or S marriages in southeastern Turkey deviates from both aspirations that uphold women’s choice.

**METHODS**

The current study is based on a convenience sample of 45. We used a snow-balling technique to recruit our participants who were either living or have recently lived in a L or S marriage. Interviews were conducted in a face-to-face setting, at the convenience of the participants. The majority of interviews took place at remote village homes. Participants were informed of the nature of our study and no deception was used. They were clearly told that they would never be identified, the results of the study will only be used in teaching and academic publications and they
were free to withdraw from the study or refrain from answering a particular question any time they wished. Since most of our participants were illiterate or barely literate, we required only a verbal consent. Moreover, since numerous participants were monolingual (Kurdish), some interviews were conducted in their native tongue by Kurdish/Turkish speaking interviewers. Other interviews were conducted in Turkish. All responses were recorded in Turkish.

The study was conducted during the summer of 2003. Interviews lasted between one to two hours. The length of the interview was determined by the willingness of the participants to elaborate on the open-ended questions. Although gentle probes were used in pre-determined portions of the interviews, participants were free to elaborate or not to elaborate. Most were eager to talk about issues which, they told us, have never been asked of them before. It is also our experience that our interviews with women participants took longer than our interviews with male respondents (average of one hour versus one-and-a-half hours).

Questions

Our questionnaire can be summed up under four categories. The first part was the usual sociodemographic variables about gender, age, education, income, rural/urban location, marriage type, number of marriages and number of children (if applicable, from different marriages). A second set of questions explored the general perceptions of marriage and general attitudes towards L or S types of marriages. In the latter, we were particularly interested in finding out how the participants justified this type of marriage (within personal, parental, familial, kin or religious terms). We were also interested in seeing whether men and women differed on their attitudes and perceptions about forming L or S unions.

Our third set of questions explored the decision making process. If the consent of the woman/man was sought, who made the final decision and whether the woman/man had any veto power over the decision were asked.

The last set of questions were about roles and role confusion and the emotional responses to the shifting roles in L or S marriages. In this portion, we asked our respondents about their emotions that accompanied the consummation of their L or S marriages. More specifically, we asked our respondents about how they felt during the first night of their marriage. Given our knowledge of the culture, we had no doubt that men would be quite forthcoming, but we were not sure about the reactions from our female participants. To our pleasant surprise, our fears about women being too shy to answer this question did not materialize. Instead, almost all female respondents were eager to talk about their emotional turmoil. Most male respondents expressed joy rather than turmoil (see Table 2).
Table 2. How Male & Female Respondents (MR/FR) Felt During the ‘First Night’ of their L or S Marriages*

| MR (08): | It was like incest. |
| MR (09): | I was devastated. |
| MR (11): | I felt exactly the same way as anyone feels on a “normal” marriage. |
| MR (13): | I was elated to think that my children were gaining a new mother. |
| MR (18): | I tried not to think about it. |
| MR (29): | For me, there was no difference! (meaning no different from a regular marriage). |
| MR (32): | I was extremely happy because I found a woman who would serve as a mother to my children. |
| MR (33): | It was my choice to marry my sister-in-law. I was very happy. |
| FR (01): | It was very difficult. I was embarrassed. I spent hours about dreading the intimacy [sexual intimacy] of the night. |
| FR (04): | I was unconsolable! I felt like a criminal. As a result, I was not able to sleep with my [new] husband for three months. |
| FR (10): | I had many mixed feelings, because my mother demanded this marriage [to the brother-in-law]. |
| FR (14): | The situation [first night] that I found myself in deeply embarrassed me! |
| FR (15): | It was awful! |
| FR (19): | Although I strongly opposed the idea, I was forced to marry my sister’s husband. This was very traumatic for me. It was a despicable night. Continuously, I thought about my sister [the deceased wife]. I thought about the nauseating situation I was forced into! |
| FR (22): | It was awful! May God protect everyone from experiencing such a disaster. It was like death.... but, you get used to it. |
| FR (25): | There are no words to express what happened that night! I hope, I will never ever have to live through such a night! |
| FR (26): | We couldn’t communicate with one another. We were very embarrassed. |
| FR (28): | I was disgusted with myself! |
| FR (30): | I had a lot of difficulty to accept any kind of intimacy with my brother-in-law.... but, over time, I got used to it. |
| FR (35): | I was embarrassed. |
| FR (36): | It felt like I was living a nightmare! |
| FR (38): | I was embarrassed and horrified! |
| FR (39): | I thought about committing suicide! |
| FR (41): | I felt that I had to go through this since I had no other economic solution to my problems [widowhood and two small children]. |
| FR (42): | It was a horrible night. I endured it because of necessity and because of my children [widowhood and three small children]. |

* Verbatim translations are provided by the first author.

In this portion, we also inquired about how children responded to the changing roles, whether they were negatively affected by the switch (from uncle to father and from aunt to mother) and whether there were tensions and mixed loyalties amongst children and parents from different sets of unions.

The final question we asked explored whether our male and female respondents were happy with their gender, or would have liked to be born as a member of the opposite sex. Not surprisingly, no men wanted to switch to being a woman, but all but five women wished they were born as a man (see Table 3).
Table 3. Reasons Given by the Male Respondents (MR) about Satisfaction to be a Man & Reasons Given by the Female Respondents (FR) about Why They Would Have Rather be a Man than a Woman*

<table>
<thead>
<tr>
<th>MR (03):</th>
<th>Men are more valuable!</th>
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<tr>
<td>MR (08):</td>
<td>Women are helpless.</td>
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<td>MR (09):</td>
<td>Men are more independent.</td>
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<td>MR (13):</td>
<td>In our society, men have many more rights.</td>
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<td>MR (16):</td>
<td>In the society I live in, I would always want to be a man.</td>
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<td>MR (17):</td>
<td>Men are more free.</td>
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<td>MR (18):</td>
<td>Women have low status.</td>
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<td>MR (20):</td>
<td>Women are oppressed in our society.</td>
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<td>MR (29):</td>
<td>In our society, men dominate.</td>
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<td>MR (32):</td>
<td>It is hard to be a woman.</td>
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<td>MR (33):</td>
<td>I think, women are oppressed.</td>
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<td>MR (34):</td>
<td>Women are 2nd class citizens.</td>
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<tr>
<td>FR (01):</td>
<td>Women are like slaves. If I were a man, I would be free.</td>
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<td>FR (02):</td>
<td>To have many more rights.</td>
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<td>FR (04):</td>
<td>If I were a man, I would have a job. I would be able to choose my husband.</td>
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<td>FR (06):</td>
<td>There is a lot of pressure on women.</td>
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<td>FR (10):</td>
<td>Although I was the only daughter of my family, I never felt valued.</td>
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<td>FR (15):</td>
<td>Men are free and can do whatever they like.</td>
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<td>FR (19):</td>
<td>Men have a say in our society. I would have liked to be born as a man.</td>
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<td>FR (21):</td>
<td>Women have no freedom or agency. I want to be born as a man to be free.</td>
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<td>FR (25):</td>
<td>They [men] can say `no.'</td>
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<td>FR (26):</td>
<td>Men can do whatever they want.</td>
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<td>FR (30):</td>
<td>Men are stronger and have more rights.</td>
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<td>FR (35):</td>
<td>Most of the time, men are capable of arriving at their own decisions.</td>
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<tr>
<td>FR (36):</td>
<td>I could be free to decide for myself.</td>
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<td>FR (39):</td>
<td>Men are more important!</td>
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<td>FR (42):</td>
<td>Women are oppressed.</td>
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<td>FR (43):</td>
<td>Men dominate the society I live in.</td>
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<td>FR (44):</td>
<td>Men can do whatever they like.</td>
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</table>

* Verbatim translations are provided by the first author.

FINDINGS

Sociodemographic Characteristics
Sex: 26 women and 19 men (total= 45) who were currently living or have lived in a L or S marriage participated in our study.
Age: 8 participants were between 26-30, 18 participants were between 31-40 and 19 participants were over 40 years of age.
Education: 32 (71%) of our participants were illiterate or semi-literate and 11 (24%) had an elementary school education. Only 2 (4%) had attended or completed high school, which in Turkey, goes up to grade 8.
Income: Our respondents were from the poorest segment of the poorest region of the Turkish society. Indeed, 41 (91%) came from families which made less than $600 per year. The family income of the remaining 3 (7%) was between $ 601-1000. Only one of our respondents (2%) reported an annual family income of over $1,000. It should be underscored that these are annual `family' incomes.
Occupation: 22 respondents were housewives. The remaining occupations reported were mostly in farming (7 or 16%), small merchant (4 or 9%) and labourer (2 or 4.5%) categories. Eight (18%) were not employed or semi employed in transient jobs.
Regions & rural/urban residence: Our respondents came from three regions
of southeastern Turkey. Fifteen (33%) were from Diyarbakir, 13 (29%) from Mardin and 17 (38%) from Sanliurfa regions and their villages. Thirty-one (69%) of our 45 respondents lived in small or very small villages. Fourteen (31%) lived in impoverished zones of a town or a city. These zones are generally referred to as ‘varos’ and resemble the destitute North American ghettoes. However, residents of varos areas are often docile and much more resigned to their fate than their North American counterparts. Gang violence is unheard of despite the poverty in varoses.

Marriage type & previous marriages: At the time of the interviews, 29 (64.5%) respondents were ‘legally’ married. Sixteen (35.5%) were married through a religious ceremony alone, which the Turkish family law does not recognize as a legal marriage. Over 62% of our respondents (28) reported living in a L marriage. An additional 29% (13) lived in S marriages. Four respondents (10%) lived in more complex family forms (i.e., L or S combined with multiple wives). Moreover, 27 (60%) of our respondents were previously married. For 16 (35.5%), the L or S marriage was their only marriage (2 had more complex configurations).

Number of children: Forty-one (91%) respondents had a total of 228 children. Of the 228, 75 were from earlier marriages and the remaining 153 were from L or S marriages. Only four (9%) respondents had no children.

Duration of L or S marriages: The duration of L or S marriages of our respondents ranged from two to 42 years (mean=15).

House composition: 31 respondents (69%) lived in nuclear types of families at the time of the interviews. Six (13%) lived in an extended family context (with parents or with in-laws). The remaining eight had more complex arrangements (multiple wives, concubines or living with brothers and uncles).

General Attitudes

Table 4 shows the correlation matrix amongst some of our demographic and attitudinal variables. Most significantly, sex is significantly correlated with education, type of marriage, veto power of men, L/S opinion, L/S effect, L/S disadvantage and feelings about the first night. Age is also correlated with feelings about the first night, comparison of first and L or S marriage and presence of children from both the original and the subsequent marriages. The following discussions will expand on some of our most interesting findings. Education correlated with perceived L/S effect as well as comparisons between the past and the current marriages. Not surprisingly, income did not show any significant correlations, possibly because almost all of our respondents were poor and there was no real variation in income (dropped from Table 4).
Table 4: Correlations Between Selected Variables (p<.05; 01; 001)

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Educ. = education; Type = marriage type; Press. = pressure; Who = who pressured; Opin. = whether opinion was sought; Marr Opin. = opinion about marriages; L/s opin. = opinion about L/S marriages; L/S affect = effects of L/S marriages; L/S disad. = who is negatively disadvantaged by L/S marriages; Comp. = comparisons between old and new marriage; Ch#1 = number of children from first marriage; Ch#2 = number of children from L/S marriage.
We asked our participants what they thought about marriage as an institution (marriage opinion variable in Table 4). Twenty-five (55.5%) said that partners should be able to freely talk to each other and communicate with each other. The remaining responses we received were varied: Four (9%) each said marriage should be seen as a religious or as a family obligation. Three (7%) each said that marriages should make men the dominant person of the house, or should be organized to please family and kin. An additional two (4.5%) claimed that marriage was a must for the continuation of their traditions. We classified the responses under egalitarian or traditional or very traditional views about what marriage was seen as. A Chi² analysis showed the gendered differences in opinions about marriage. Women thought that marriages were constructed for much less egalitarian values than men did (df=2, Chi²=10.0, p<.01).

When we asked our respondents about what they thought about L or S marriages, the range of responses we got were quite varied (L/S opinion variable in Table 4). Twenty-two (49%) said such marriages were Anormal@ for either cultural, traditional or religious reasons. Nine (20%) said they were necessary for the sake of women and children and an additional 3(6.5%) said they were necessary for men and their children. Ten respondents (22%) expressed strong objections to the lack of choice in such arrangements. We again classified the responses under egalitarian or traditional or very traditional views. Our analysis clearly showed that our male and female respondents differed in their attitudes toward L or S marriages. Women were much less likely to find these arrangements acceptable than men did (df=2, Chi² =6.5, p=.03).

We also inquired about who is most likely to be affected by L or S marriages (L/S effect variable in Table 4). Twenty-one respondents said it was women, 12 said it was children, 4 said it was men and 7 claimed it was the family in general. An analysis of the gendering of these responses produced significant differences (df=3, Chi² =27.3, p<.001). Interestingly, more women thought that L or S types of marriages would effect women and children. When we asked if these effects would be negative (L/S disadvantage variable in Table 4), again we observed a highly significant gender difference (df=3, Chi² =35.8, p<.001). Apparently, men are under the illusion of thinking that L or S types of marriages benefit women, whereas women perceive these arrangements as adverse, but unavoidable intrusions.

When we followed up with the question about who benefits from L or S types of marriage (not in Table 4), 16 (35.5%) stated that children do. An additional 10 (22%) stated that family, 9 (20%) claimed that women were the beneficiaries. Three (7%) thought that the tribe and an additional 3 (7%) thought that men benefited the most. Four respondents (9%) gave other answers. What is interesting in these responses is that children’s and family’s benefit is assumed to outweigh women’s and men’s benefit from the L or S marriages. There is no gender difference in this variable.
Decision Making Process

Twenty-three (53%) respondents admitted to being pressured to making the L or S type of marriage (pressure variable in Table 4). This variable is highly correlated with where the pressure came from (who pressured variable in Table 4), male and female veto power, first night and children from the original marriage (male/female veto, first night and ch#1 variables in Table 4). Twenty-one (46%) did not mention pressure and one person chose not to respond to this question. What is more interesting is the “source of pressure’ respondents identified in the following question (who pressured variable in Table 4). Fifteen (33%) respondents said they were pressured by their families, 4 (9%) by their fathers and one each (7%) by their mothers or father/mother-in-laws (note the high correlation between pressure and who pressured variables in Table 4). An additional two (4.5%) blamed traditions. When we asked who was ultimately responsible for the L or S marriage decision, only 6 (13%) said that it was up to them. Nineteen (42%) claimed that the decision belonged to their families, 8 (18%) attributed the decision to their parents and an additional 7 (15.5%) to their relatives. Thus the decision can be easily interpreted as belonging to the family/kin, not to the individuals.

To further understand the decision making process, we asked our male and female participants if men had some kind of a veto power over the family decision about L or S marriages (veto male variable in Table 4). Thirty-two respondents (71%) said that men had the power to block an unwanted marriage. When we asked the same question about women’s veto power (veto female variable in Table 4), only 16 (35.5%) of our respondents mentioned that women could object. The difference between type of marriage (L or S or complex), gender (M or F) and perceived male veto (yes or no) power is a statistically significant difference (df=2, \( \chi^2 = 32.9 \), \( p<.001 \)). Conversely, the relationship amongst the type and gender variables with female veto power is not statistically significant (df=2 \( \chi^2 = 3.75 \), \( p>.05 \)). These analyses show the relative power of men to have their say but the perceived powerlessness of women (as acknowledged by both men and women) in L or S marriages.

Roles & Role-shifts

Before we asked our respondents about roles and role shifts, we asked them about the role of women in marriages. Nineteen (42%) claimed that women’s role was to serve their family, another 19 (42.5%) stated that women’s role was to assure the happiness of their families. Only 7 (15%) said that married women can pursue their individual wants. There were no significant gender differences on these perceptions (marriage opinion variable in Table 4).

Our last set of questions probed the tensions in the roles and role shifts due to L or S marriages. We first inquired about how our
respondents dealt with children from their own or their partner’s previous marriage or their mutual children from the current marriage. Twenty-eight (62%) respondents said that their treatment of the different sets of children were the same. However, 3 (6.5%) claimed that they liked the current, 7 (15.5%) said they liked their own children from the previous marriage and 2 (4.4%) claimed that they liked their step-children more. The rest had no children.

We also asked how they felt the different sets of children treated the new set of parents. Twenty-six (58%) of our respondents reported no difference. However, 6 (13%) claimed that their previous children loved them more and 3 (6.5%) felt that their current children loved them more. Five (11%) of our respondents expressed dissatisfaction.

We asked our respondents whether they made comparisons between their old versus L or S marriages to a problematic degree (compare variable in Table 4). As Table 4 depicts, this variable is correlated with age, education and female veto variables. Five (11%) respondents said they made comparisons very often and 18 (40%) said they made comparisons some of the time. Almost fifty percent of our respondents did not identify past/current marriage comparisons as a problem in their lives.

For a few women, there was the burden of becoming an extra wife in a polygynous marriage. For example, FR (01) stated that her husband spends one week with her and one week with his other wife. FR (39) has to live with two other wives and their children of her L husband. Four other women reported currently living with their children, husbands, in-laws, as well as brothers-in-law and their families. Our research cannot bring illumination on how our respondents may have been affected by these complex and often undesirable living arrangements. However, these complexities is congruent with our position that women’s wishes and perceptions are rarely taken into account in marriage formulations.

We believe that one of the questions that produced the most insightful response is the question about how our respondents felt during the first night of their marriage. As Table 4 shows, the first night variable is highly correlated with gender, age, marriage type, pressure, opinion about marriage and the existence of children from the first marriage. Qualitative responses about the first night are revealing, both in and of themselves and in terms of the gender differences (see Table 2). Overall, 17 respondents said the first night was extremely difficult. An additional 17 said it was difficult. Only 6 respondents (five of whom were men) claimed that the first night of the L or S marriage was normal or pleasant, while another five did not elaborate. When we analysed these opinions on the basis of gender, the emotional turmoil women experienced became clearer (df=2, Chi²=19.6, p<.001). As Table 2 clearly shows, women talked about feeling awful (FR 15, 22), feeling like a criminal (FR 04), being
unconsolable (FR 04), feeling disgusted (FR 28), being nauseated (FR 19) and even thinking about suicide (FR 39). Others used terms like a nightmare (FR 36), horrified (FR 38) and horrible (FR 42). One woman (FR 25) claimed that there are no words to express how she felt. One woman (FR 22) compared the experience to ‘death’.

In contrast, most male respondents either did not bother to elaborate on their answer or expressed pleasure with the experience (see Table 2). Although our question was specifically about the first night, a few men chose to cloak their elation as being pleased for the sake of their children (MR 13, 32). To be fair, two male respondents (MR 08, 09) were also traumatized by the role shift, but they were the exception than the rule. The real trauma showed in the experiences of almost all women (see Table 2).

Another revealing question pertains to whether our respondents were content with their own gender or wished to be a member of the opposite sex. Not surprisingly, all men felt content as men. In explaining their satisfaction, male participants either emphasized the value of men or the helplessness and oppression of women (see MR responses in Table 3). In contrast, all but five women wished they were born as a man. Their justifications highlighted the pressure, control, workload and lack of freedom and lack of choice for women (see FR responses in Table 3). As one woman (FR 25) put it, ‘they can say no!’ What is interesting to note is the congruence between how both men and women see the ‘value’ their culture places on men. This mutual recognition explains why men are happy as they are, but women wish they were men.

SUMMARY & DISCUSSION

In the present study, we tried to understand the structural determinants as well as the dynamic of L or S marriages which are still practiced in remote, patriarchal regions of the developing world. Our respondents live in or around Diyarbakir, Mardin and Sanliurfa regions in southeastern Turkey. We interviewed 45 men/women who were currently living or have recently lived in one of these types of marriages. Other than their marginally higher poverty and lack of education, our respondents are similar to the people of the region.

What we found is that L or S types of marriages are difficult, even for people who are socialized to think of these marriages as unavoidable. The difficulty arises from women’s lack of input into the decision making process as well as the confusion of roles these types of marriages engender. Although the family and kin pressures on men seem to be almost as pronounced as they are on women, men at least seem to enjoy a veto power over the issue (Table 4). Women do not seem to have this veto power, which adds to their anguish. What is interesting is that both men and women equally agree on the relative powerlessness of women (Table 3).
Approximately 58% of our respondents did not find raising children from different but closely related family formations to be a problem. However, tensions were apparent in the others. Numerous respondents expressed displeasure about how their different sets of children treated them. Some also confessed that they, themselves had positive or negative preferences towards their own or their L or S partner’s previous children.

Our results also indicated that although these marriages are difficult for a few men and for almost all women, men seem to be under the illusion that these marriages are doing a favour to women and their children. Women recognized the adverse effects of such marriages, but at the same time, realized that they did not have alternatives (Table 4). After telling us how ‘awful’ and ‘like death’ the first night was, respondent 22 went on to elaborate on her helpless resignation: ‘if the [economic] circumstances were different and if I were a man, my life would have been completely different. I would have had a career, a job and economic independence. I wish, I had economic independence.... but, there is none! When you don’t have [economic] safety, the worst things happen to you’ [in her case, L type marriage]. Respondent 04 (Table 3) also noted: ‘if I were a man, I would have a job. I would have been able to choose my partner.’

A society which deprives women of economic independence is a society that condemns them to live their lives as appendages of men, whether they like it or not. It is our contention that if these women had the economic ability to sustain themselves and their children, most would actively resist L or S types of marriages. In their own words, the role shift, especially the part that involved sexual intimacy with their brothers-in-law, was traumatic for them (Table 2). Although men and women were only slightly differentiated on their views about the traditional roles of women within the family (i.e., as sacrificing for the extended family and family happiness), these traditional attitudes did not make the role shift any easier for women. Most wished they were born as men in order to escape their gendered predicament (Table 3).

In our opening comments, we highlighted the fact that Turkey is a signatory to CEDAW (1979) and DEVAW (1993). Both hold the states responsible for directly protecting women from all types of discrimination and violence. DEVAW also holds the states responsible for changing the conditions which lead to or exasperate discrimination against women. Under pressure from women’s groups, some other signatory states (such as India, Bangladesh and Sri Lanka) have started to recognize, at least to a limited extent, that inflicting mental anguish on women should become offences under their criminal laws (Goonesekere, 2004). So far, Turkish civil laws are not very effective in preventing L or S marriages and Turkish criminal laws do not recognize the pressure on or the anguish women experience in L or S marriages as an offence. Thus, rural women who lack education and personal means for economic independence
continue to find themselves dependent on husbands. In case of the demise of a husband, they become the possessions of brothers-in-law or other surviving male kin. Poor women also find themselves as replacement for their deceased sisters, regardless of their reservations about the role confusion L or S marriages engender. Their economic dependence translates into their being traded as possessions after the death of their husbands or their sisters. Although a few touched upon these types of families as a ‘religious obligation,’ such attributions were the exception rather than the rule. What really pushed these women into L or S marriages was their economic binds and possibly, their lack of knowledge about their inheritance rights. Through L or S types of marriages, patriarchal families bypass the egalitarian inheritance laws and keep the farming lands intact in the hands of tribes.

Although the ‘intactness’ of families are favoured by all traditional societies (and traditional theories of family), sometimes ‘intactness’ is attained by sacrificing free will and choice. As our findings clearly show, in cases of L or S marriages, this process is gendered. In traditional societies (and to a lesser degree, in non-traditional ones), women are the keepers of the family hearth and socializers of the next generation. Moreover, traditional societies put additional burdens on the marital institution, for example, the pressure to keep the property intact. The end result is arranging women’s marriages, or exchanging or bartering them as commodities. As we have shown in L or S marriages, women can even be made part of the inheritance package, rather than being allowed to inherit their fair share and pursue independent lives. As we tried to make clear, this is despite the modernized laws and it is also in spite of some protection of women embedded in The Koran. Under the guise of ‘traditions,’ the real engine of marital forms is economics. What patriarchal societies proclaim to be ‘functional’ to family or kin group is nothing but a traumatic intrusion on women who are made to survive in such unnatural arrangements. Despite the overt acceptance in patriarchal pockets of developing societies, L or S type of marriages can be seen as an incestuous commodification of women.
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(Re)Gendering Panic: Towards a Critical Sociology of Agoraphobia

Shelley Z. Reuter
Concordia University

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Since 1871, when the first psychiatric article on agoraphobia was published, this disease—known variously as panic, panic disorder, agoraphobia with or without panic, and so forth—has had a curious trajectory: beginning with a marked prevalence in men that lasted roughly five decades, the disease was 're-gendered' after the First World War and has persisted as a predominantly female problem ever since. Using the method of discourse analysis and working from the premise that psychiatry is shaped by factors beyond medicine, this paper examines psychiatric reports of agoraphobia since the late nineteenth century to argue that the history of this disease represents more than simply that of an individual psychological/biological disease phenomenon. Rather, it is important to understand agoraphobia in the context of the complex normative social and historical process of its re-gendering.

In the industrialised West, a surprisingly high proportion of the population suffers from agoraphobia, the fear of public or open spaces. Mostly urban dwelling (George, Hughes & Blazer, 1986), some agoraphobics are too fearful of public spaces even to step just a few feet beyond their front door to collect their mail or newspaper. With prevalence rates estimated as high as 5% (Rosenbaum et al., 1995) or over 12 million sufferers in the United States, agoraphobia has emerged as a significant social problem. To date the vast majority of people who are reported to suffer from agoraphobia are women. In fact, women are between two to four times more likely than men to develop agoraphobia/panic disorder (Sheikh, Leskin & Klein, 2002; Weissman, 1990; also Joyce et al., 1989). Moreover, being female increases the likelihood of developing one of a number of anxiety disorders by as much as 85% (Cloitre et al., 2004). But these rates are particularly striking when considered in historical context: prior to the First World War over 80% of reported agoraphobia sufferers were men (Reuter, 2001, p. 73).

Using the method of discourse analysis and working from the premise that psychiatry is shaped by factors beyond medicine, this paper will interrogate the gendering, and subsequent re-gendering, of this disorder following the war. Following Arthur Kleinman who argues that ‘[p]sychiatric concepts, research methodologies, and even data are embedded in ,’ and further, that ‘psychiatric diagnostic categories are constrained by history and culture as much as by biology’ (1988, pp. 3-4),

1 For inquiries, Shelley Reuter can be reached at Department of Sociology & Anthropology, Concordia University, 1455 de Maisonneuve Blvd. West, Montreal, Canada, H3G 1M8 (sreuter@alcor.concordia.ca)
the paper aims to demonstrate that from the outset of its recorded history, the discourse of agoraphobia has been more than simply descriptive of an individual biological or psychological disease phenomenon. Rather, it is important to understand the (re)gendering of agoraphobia as a complex normative social and historical process—one that is distinct from other medicalised conditions over-ascribed to women. For example, previous feminist studies of hysteria, another ‘female disease’ with origins in the nineteenth century, have forcefully illustrated the politics and subordinating implications of medicalising femininity (see Reuter, 2006 for an overview of this literature). However the present discussion goes beyond these accounts of hysteria—written mainly by historians and literary theorists—to offer a distinctly sociological perspective.

First, on the face of it, agoraphobia seems to be a problem for individuals and more suited to psychological study, which may account for why only a few social scientists have taken interest in this apparently anti-social, disorder (see Brown, 1986; de Swaan, 1990; Seidenberg & DeCrow, 1983; Reeves & Austin, 1986). Yet even the isolation typical of agoraphobic behaviour could be seen as essentially social. Durkheim certainly demonstrated the sociality of individual behaviour when he argued that suicide—an act that seems to encapsulate individual distress par excellence—is in fact a social phenomenon (Durkheim, 1951 [1897]). Furthermore, as Simmel has argued: the ‘mere fact that an individual does not interact with others... does [not] express the whole idea of isolation. For, isolation... refers by no means to the absence of society.’ Isolation represents a very specific relation to society and ‘a given quantity and quality of social life creates a certain number of temporarily or chronically lonely existences’ (1950 [1903], pp. 118-9).

Second, central to the psychiatric accounts of agoraphobia is the fundamental and normative question of what it means to have social order, which, as we shall see, includes ideologies of gender, culture and political economy. As such, psychiatric discourse emerges as an important site for sociological analysis since, as Rose has argued, the psychosciences are profoundly social (1998, p. 67).

Third, existing critical accounts of this disease accept rather uncritically the disease category of agoraphobia as uniform and stable, yet a close reading of the psychiatric literature reveals that in fact, practitioners and researchers deploy this disease concept quite inconsistently, suggesting that agoraphobia has been a disease with many ontologies. Not only has agoraphobia been a disease prevalent in men and in women, but it has also been referred to by several different names and descriptions, including panic, panic disorder, agoraphobia with or without panic, space phobia, claustrophobia, neurosis, anxiety, a symptom, a syndrome, a disease, a disorder and so forth. This variability has persisted despite the American Psychiatric Association’s efforts to
contain it within their ‘scientific’ system of classification, the Diagnostic & Statistical Manual of Mental Disorders.

Fourth, the study of apparently individual problems such as agoraphobia in sociological terms is critical to the sociological imagination itself. As C. Wright Mills famously stated, an accumulation of ‘personal troubles... must be understood as public issues.’ Sociologists must explore ‘the human meaning of public issues’ and relate them ‘to personal troubles—and to the problems of the individual life’ (1959, p. 226).

And finally, the current reductionist feminising of agoraphobia must be understood in terms of its substantive and distinct early history as a disease prevalent in men. As demonstrated elsewhere, psychiatric representations of agoraphobia have served as a key conduit to its production as a meaningful and powerful psychiatric category because within these representations is contained what may be referred to as the ‘psychiatric narrative’ (Reuter, 2006). Specifically, while the disease embodies very real physiological and emotional experiences of suffering, implicit in this medical narrative is a normative and gendered (and ‘raced’ and classed) socio-cultural account of patriarchal capitalist social order. That is, the disease must be understood in terms of the intersection of gender, class, race and culture. Thus building on Foucault’s genealogical work, this paper seeks to understand the role of psychiatric discourse in producing gendered agoraphobic subjects in this context. As Foucault argues (in a discussion of genealogical method): ‘It’s a matter of shaking this false self-evidence, of demonstrating its precariousness, of making visible not its arbitrariness, but its complex interconnection with a multiplicity of historical processes’ (1991, p. 75).

The paper begins by outlining its methodology, to be followed by a brief discussion of agoraphobia’s modern urban origins in order to provide a context for understanding the early prevalence of agoraphobia in men, and its subsequent re-gendering after the First World War.

**METHODOLOGY**

In assessing critically the role of psychiatric discursive practices in the production of agoraphobia as first a male and then later a female disorder, the present discussion takes a genealogical approach. It emphasizes the processes by which social-psychiatric categories are naturalised and aims to trace and problematise these extant categories as historical formations. Such an approach can reveal how dominant rationalities—such as psychiatry—are deployed as technologies of power: ‘how forms of rationality inscribe themselves in practices or systems of practices and what role they play within them’ (Foucault, 1991, pp. 79; see also 1982, p. 210).

As part of a larger historical-sociological study of agoraphobia, psychiatry and psychoanalysis (see Reuter, 2001; 2002; 2006), the main
source of data for this paper is primary-source psychiatric reports of agoraphobia since the first cases were documented in 1871. The mobilisation of this disease category in and through these medical texts is of particular interest because these texts are a key means for doctors to discuss with one another such things as causation and treatment. Therefore, they constitute an essential site for exploring the discursive processes that Foucault observes. Reading these materials enables us to explore the cultural assumptions that inform psychiatric writing and in the case of this paper, dichotomous (that is, bifurcated, ideological) ideas about gender. These materials especially enable us to see how these ideas intersect with and are inextricable from the question of what it means, both medically and culturally, to be ‘normal’ and ‘pathological.’ In other words, how do these texts perform critical ideological work (Poovey, 1988, p. 2)? A close reading of these texts reveals not only the gendering and re-gendering of panic but also a gendered and medicalised response to first men and then women who step(ped) outside the prevailing social order.

The materials to be examined here are primarily comprised of individual psychiatric case reports by individual physicians because this style of medical reporting of agoraphobia has, until relatively recently, been most common. Over time the discourse has also come to include larger multi-authored scientific studies and entries in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1952; 1968; 1980; 1987; 1994; 2000). In collecting these data, the search was restricted to English-language reports only, which has largely meant a focus on British and American psychiatry. However, whenever possible, translated materials are also included. In the last two to three decades especially, the discourse of agoraphobia has become more international, yet the influence of the American Psychiatric Association and its DSM categories is evident. The discourse of agoraphobia continues to be oriented particularly to American concerns and experiences; moreover, most of the literature published today is in English.

The reports published between 1871 and 1965 were compiled using the Index Medicus, a paper index to current published medical literature of the world. Approximately 130 relevant reports between the years 1871 and 1965 were found, with twenty written prior to the First World War. An electronic index to medical literature, was used to locate reports published between 1966 and the present. A broad search, i.e., simply using the term ‘agoraphobia’ with no limits other than language, turned up over 2400 reports with most having publications dates after 1980 (i.e., the release of DSM-III). Given the high volume, these reports were sorted

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2 Berrios & Link (1995) offer an account of the history of anxiety disorders from the perspective of French and German physicians that is largely consistent with the present account.

3 The diagnosis of agoraphobia/panic disorder remains most common in North America and Western Europe.
according to emergent themes (see Reuter, 2006), relevance and the law of diminishing returns. Reports informing the present discussion were selected on the basis of explicit or implicit references to gender.

**URBAN INDUSTRIAL MODERNITY & AGORAPHOBIA**

In the late nineteenth century amid growing secularism, medicine moved into a position of great social importance. Physicians’ abilities were considered to be both ‘powerful and seductive,’ and sickness was increasingly seen as best left in‘credentialed hands’ (Rosenberg, 1992, pp. 267-268). Combined with an increasing propensity among the laity to seek self-improvement, doctors working within such a potentially lucrative medical market developed an unprecedented degree of authority (Hansen, 1992, p. 119; also Porter, 1997, p. 305).

As the role of medicine in society expanded, so too did the division of medical labour. As a result, many doctors tended towards specialisation in psychological medicine, for which demand was on the rise. Indeed, professional psychotherapy provided a ‘vocabulary of troubles… shaping lay definitions of everyday difficulties [and] moulding the presentation of individual complaints [into] problems suitable for professional treatment’ (de Swaan, 1990, p. 139). In other words, psychiatry gave lay individuals a language and a framework for speaking about themselves, their everyday experiences and, most importantly, their problems.

Among the problems that individuals were experiencing was that of the agoraphobic—a ‘new’ category to label people who were fearful of public or open spaces. This new social type emerged at least partly as a result of the professionalisation of psychological medicine (Clark, 1995, p. 567) and the medical publications that emerged following doctors’ encounters with agoraphobic patients (Reuter, 2002). But as Clark has demonstrated, the delineation of anxiety and panic disorders ‘required more than just the existence of an organized medical profession and psychiatric specialty and the presence of free-floating symptomatologies waiting to be appropriated and classified.’ What was also required was enough of a change in society so that ‘anxiety and panic no longer appeared as more or less continuous or recurrent features of common life, but rather as exceptional and to some extent avoidable disturbances to individual mental health and well-being’ (Clark, 1995, p. 567).

Dr. Charles Atwood of New York, for example, wrote a paper on ‘our present ways of living,’ that in the city ‘our rapid and over strenuous life,’ unaccompanied by sufficient rest, is the cause of the ‘increase in nervous and mental derangement.’ He saw mental strain as the result of the ‘increased demands upon us, the increased number of sensory impressions and variety of ideas forced upon us by our increasing interests.’ Atwood argued that ‘[t]he emotions are intensified by our present rapid methods of living and drawn upon continually’ (1903, pp. 1070-1072).
The ‘rapid methods of living’ that Dr. Atwood describes were particular to the modern urban context (of that time), where abnormal anxiety was on the rise and acquiring a higher profile among neurologists, psychiatrists and surgeons throughout the industrialised world. Therefore it can be argued that agoraphobia emerged also partly in response to the changes in society due to the growth of industrial capitalism and the associated challenges of urban existence. Building on Clark’s arguments and combined with those of Atwood, it was only with the changes brought about by urban industrial modernity that the anxiety and stress that Atwood describes could be perceived as extraordinary: [w]hereas it was ‘normal’ in pre-modern and modern times to be anxious about things such as crop failure and famine, epidemic diseases, personal security, war and so forth,’ only with ‘the rise of urban industrial capitalism,’ as well as modern medicine and psychiatry, did anxiety and panic become ‘more exceptional’ and ‘individualised’ (see Clark, 1995, p. 568).

Atwood’s remarks also reflect an emerging and expanding fear of the modern city evident in many physicians’ reports of agoraphobia. Dr. Henry Sutherland, for example, maintained that some patients only experienced agoraphobic feelings in cities, as demonstrated by their ability ‘to bear the sight of a wide green plain’ (1877, p. 266). Though he wrote very little on agoraphobia per se, the psychoanalyst Sigmund Freud also expressed some concerns about city living, arguing that ‘modern nervousness’ was spreading rapidly. The tension between individual constitution in the nervous patient and the demands of modern civilisation—between ‘living in simple, healthy, country conditions’ as the ‘forefathers’ did, and living in ‘the great cities’—was causing ‘‘increasing nervousness’ of the present day and modern civilized life’ (1963 [1908], p. 21).4

As discussed elsewhere (Reuter, 2001; 2006), these concerns about the city were also echoed by architects and urban planners (see for example Sitte, 1965 [1889], p. 45), for whom agoraphobia was ‘not simply… an affliction of the modern city dweller’ but ‘proof that contemporary cities were in their very form bad for health’ (Vidler, 1991, p. 35). A parallel discourse emerged among social theorists such as Karl Marx (1964 [1884]), Emile Durkheim (1933 [1893]), Max Weber (1958 [1904-5]), Ferdinand Tönnies (1957 [1887]) and Georg Simmel (1950 [1903]; 1978 [1900]), all of whom perceived a growth in social problems and turmoil brought about by the changes of modernity. Among their concerns were the rise of mass production, the increasing division of labour and the growing estrangement and the progressively more impersonal nature of social relationships. Indeed, by century’s end, anxiety came to be seen as reflective and symptomatic of problems in society at large (Clark, 1995, p. 564).

Simmel especially focused on mental life and the metropolis or ‘the

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4 Freud also blamed the ‘undue suppression of the sexual life in civilized peoples (or classes) as a result of the ‘civilized’ sexual morality which prevails among them’ (1963 [1908], p. 24).
seat of the money economy' where exchange value and consumption were the basis for impersonal social relations. Like others, Simmel perceived that modernity had brought with it a host of social problems. He observed that life in the modern city, with all its 'nervous stimulation'—the crowds, the intensity and the rampant individualism—produced the ideal conditions for the development of mental and emotional difficulties. The 'psychological conditions which the metropolis create[d]' were constituted, in Simmel's words, by the 'rapid crowding of changing images, the sharp discontinuity in the grasp of a single glance, and the unexpectedness of onrushing impressions.' Simmel argued that, '[t]he metropolis exacts from man [sic] as a discriminating creature a different amount of consciousness than does rural life' (Simmel, 1950 [1903], pp. 410). Life was so fragmented in this 'asphalt and stone wilderness' (Vidler, 1993, p. 34) that people had to create an 'inner barrier' in order to protect their fragile psyches—a 'blasé attitude' as Simmel put it. This blasé attitude was a response to the 'rapidly changing and closely compressed contrasting stimulations of the nerves.' In the modern urban context, one's nerves were agitated 'to their strongest reactivity for such a long time that they finally cease to react at all.' Moreover, 'harmless impressions force such violent responses, tearing the nerves so brutally hither and thither that their last reserves of strength are spent.' Eventually, one would become unable to 'react to new sensations with the appropriate energy' (Simmel, 1950[1903], pp. 413-414), driving one to take social distance by developing 'an inner barrier.' This inner barrier was 'indispensable for the modern form of life.' Without such psychological distance, the metropolis, with all its 'jostling crowdedness,' would 'simply be unbearable' for the 'sensitive and modern individual' (in Frisby, 1986, p. 73).

Thus, as Simmel's remarks demonstrate, a self-preserving response of emotional withdrawal was a way of coping with progress and the exigencies of modern existence. As he wrote, 'Since contemporary urban culture, with its commercial, professional and social intercourse, forces us to be physically close to an enormous number of people, sensitive and nervous modern people would sink completely into despair if the objectification of social relationships did not bring with it an inner boundary and reserve' (in Frisby, 1986, p. 73). And the condition that best captured this 'emotional trait' of anxious reserve was, as Simmel wrote, 'the so-called 'agoraphobia': the fear of coming into too close a contact with objects, a consequence of hyperaesthesia, for which every direct and energetic disturbance causes pain' (1978 [1900], pp. 474).

In sum, physicians, architects, planners and even social theorists helped give social estrangement 'all the dimensions of a psychological complex' constructed from a range of new mental diseases, which seemed tied to the urban context. Agoraphobia was thus at once both diagnosis and metaphor: the pathology described symptoms of urban anxiety at the
same time as it captured the alienation that individuals felt and experienced in modern society (Vidler, 1994, p. 12). More importantly, the diagnosis gave agoraphobic individuals a medical framework through which to make sense of their experiences in the city and of themselves as different from ‘normal’ others (Hansen, 1992). It was in this context that physicians diagnosed the first patients—all men—and it is to them that we turn next.

**Gendered Panic**

First among the early reports of agoraphobia was that of the German physician, Carl Otto Westphal (1833-1890), whose ‘Die Agoraphobie’ appeared in the *Archiv für Psychiatrie und Nervenkrankheiten* in 1871 just as the discourse of urban anxiety was beginning to escalate. Already well known for his monographs on diseases of the brain and spinal cord and for publishing the first-ever case report of ‘sexual inversion’ (1869), Westphal would also become known for having given the fear of public or open spaces its permanent name (his colleague M. Benedikt previously described the problem as *platzschwindel* in 1870.)

In addition to being the first case report to deal with this disease, also noteworthy about ‘Die Agoraphobie’ was that all of the patients Westphal described were men. They included a 32-year-old commercial traveller, a 24-year-old merchant and a 26-year-old engineer (as well as a fourth man, a hypochondriac, who suffered only occasional bouts of agoraphobia), all of whom resided in the city (Berlin) and complained of symptoms such as difficulty walking through open areas, crossing streets and squares, and being in crowds and enclosed spaces. When the men found themselves in these situations they felt unsafe and were overcome with overwhelming fear, confusion and even trembling. But the presence of an ‘escort,’ a ‘vehicle going [in] the same direction,’ or ‘seeing an open door in one of the houses located on abandoned streets’ seemed to alleviate the anxiety, enabling the men to go where they needed (1988 [1871], p. 74).

Westphal was not unusual in his reporting only on men. The evidence, gleaned from the psychiatric reports of the period between ‘Die Agoraphobie’ and the First World War, suggests that affluent ‘adult men of education’ (Van Horn, 1886, p. 601) were generally the most prone to developing agoraphobia (though it must be acknowledged that as individuals of means, these men may have been the most likely to seek medical help). Dr. J. Headley noted that agoraphobia ‘seldom attack[ed] poor people,’ and in his ‘experience professional men suffer most, clergymen in particular.’ Headley Neale noted that he had known ‘merchant princes, commercial travellers, middle-aged spinsters, and even young married women caught in its toils,’ but opted to use ‘the male pronoun for brevity’ since ‘the disorder [was] more common in males’ (1898, pp. 1322-3). However this was only true until the war, after which time the (reported) incidence of agoraphobia in males dropped, while the
incidence in women increased significantly.

So the question becomes why? Why did the gendered prevalence of agoraphobia shift to women? How did this shift come to pass? If the thesis put forth by Simmel, physicians and architects and urban planners was correct that the anxiety people experienced in the city led some individuals to develop agoraphobia, then why were men apparently—yet only initially—more vulnerable to urban stress? The next section will explore possible explanations.

(Re)Gendering Panic

Together with the view that agoraphobia was connected with the perils of modern social change and over-stimulation in cities, the individual characters of patients figured prominently in the perceived etiology of agoraphobia. Mental disorders were often equated with moral depravity and personal weakness and were seen as threatening to bring about a ‘moral epidemic or even... change the structure of society and unity of the household’ (Atwood, 1903, p. 1072). We might recall, for example, Dr. Sutherland; he was certain that the agoraphobia in his patients (all male) was the result of their excess and debauchery (1877). His theory was consistent with a widespread belief among doctors of that period that diseases ‘followed in the wake of excesses of all kinds’ (Agar, 1886, p. 3) and ‘deficiencies in the way a patient lived’ (Warner, 1986, p. 86). As one physician, F.W. van Dyke (from Oregon) observed, ‘with the majority of men who begin [drinking alcohol] in moderation, the immoderate use becomes the rule, and with this a decline of mental and physical power’ (1908, p. 178).

But these moralistic interpretations of agoraphobia’s etiology cannot be fully understood in isolation from some very strong turn-of-the-century bourgeois ideas about gender roles (i.e., how proper women and men should behave) that were in force at that time. In particular, we might consider the restrictions on women’s movement in public space (still occurring in some contexts) aimed at excluding them from public life—albeit restrictions that were bound up with highly contradictory messages. As Wilson writes, ‘[j]ust as nineteenth-century society was trying to deepen and secure the boundary between public and private, industrial capitalism was erasing it’ (Wilson, 1995, p. 149). This was because women’s social status hinged in part on her and her husband’s material possessions and ability to consume (Wolff, 1989), resulting in an increasing and seductive market consumerism that included exhibitions, department stores, refreshment rooms, rest rooms and reading rooms—all places where bourgeois women could go unchaperoned. But of course alongside this tendency to encourage (bourgeois) women to consume and move about in public space, was a perhaps stronger desire to control them.

This desire—the ideology of ‘separate spheres’—was evident in
ladies’ nineteenth century deportment manuals, for example, where women’s role was declared to be primarily that of wife and mother. As Barbara Welter has shown, prescriptive guides to True Womanhood (such as the aptly titled *The Young Lady’s Book: A Manual of Elegant Recreations, Exercises & Pursuits & Woman as She Was, Is & Should Be* (Welter, 1966, p. 152), promoted a clear and definite boundary (still evident today) between women of refinement and those of the lower classes. Premised on the middle-class notion that a ‘lady’s’ place was in the home and consistent with reformers’ unease about women’s sexual and intellectual independence, women unaccompanied in city streets were seen as a moral problem (see Wilson, 1992; also Strange, 1995). Thus in this context, staying home for a bourgeois woman—agoraphobic or not—may well have signified *normality* in so far as it consisted with what was deemed proper and moral middle-class feminine behaviour.

However, the early historiography on separate spheres, which included Welter’s work, was based on two contested assumptions that must also be taken into account. The first was that nervous diseases such as this were ‘a kind of pathological by-product of middle-class Victorian and Wilhelminian society’ (Micale, 1995, p. 156). Yet historians have established convincingly that these problems have manifested in lower-class populations since well before the nineteenth century. That such problems were evident among the lower classes suggests not that they were rare, but rather, that they were ‘simply unrecognized, untreated, and unreported.’ Citing Charles Rosenberg, Micale observes that in the latter decades of the nineteenth century health care services administering to and increasingly used by the working classes were created. But until the early twentieth century the bourgeoisie and aristocracy were much more able and likely than people of the lower classes to go to doctors and to be treated and studied by the professionals doing the sort of medical writing under examination here (Micale, 1995; Rosenberg, 1974).

This early historiography also assumed congruence between the prescriptions of deportment literature and bourgeois women’s real experiences. Although there were restrictions on women’s presence in the streets alone, scholars have questioned the extent to which women occupied a truly *separate* sphere (Davidoff & Hall, 1987; Kerber, 1988; Vickery, 1993). Evidence suggests that the metaphor of separate spheres oversimplified the ‘real’ situation of women in the latter half of the nineteenth century, that the rhetoric—the ideology—was a departure from the reality. While there was *something* to the metaphor, women’s lives were more complex than straightforward confinement in the home. Indeed, their experiences varied by class, region, degree and type of industrialisation and numerous other factors (Wolff, 1989), including the imperative of consumption as well as the greater participation of men in domestic life than the notion of separate spheres would suggest (Davidoff & Hall, 1987). Certainly working-class women would have been more
concerned about subsistence than the ideological requirement of domesticity; as August (1994) has demonstrated in his study of lower-class and poor women’s employment in the late nineteenth-century (London), contrary to the middle-class notion that married women only worked when the household was in financial crisis, in fact it was common for single, married and widowed poor women to work hard throughout their lives.

While clearly the symptoms of agoraphobia mapped directly onto what was expected of bourgeois women, then, it can be argued that prior to the shift in prevalence after the First World War, their staying home had gone unrecognised as pathological. Perhaps this ‘passed’ as appropriate feminine behaviour rather than making women candidates for psychiatric diagnosis like their male counterparts, precisely because the symptoms of agoraphobia corresponded with the ideological criteria for ‘normal’ and class-based femininity. However what was previously considered normal bourgeois feminine behaviour—domesticity—did eventually become seen as pathological—as agoraphobic—and there are several possible explanations for this change in perception.

First, affluent (white) women’s experiences of public space were changing, pointing to a possible relationship between the increasing tendency to diagnose women with agoraphobia after World War I and their increasing participation in the public sphere. During the war and in the absence of their male relatives, women achieved some measure of independence but this independence came with increased public responsibilities that some but not all women necessarily wanted to assume. As Kohler Riessman has demonstrated in her study of the medicalisation of childbirth and reproductive control, ‘women have simultaneously gained and lost with the medicalization of their life problems.’ In fact, women have ‘actively participated in the construction of the new medical definitions…. Women were not simply passive victims of medical ascendancy [and to] cast them solely in a passive role is to perpetuate the very kinds of assumptions about women that feminists have been trying to challenge’ (Riessman, 1998, p. 47). Extrapolating from this, it is conceivable that with modern urban life apparently so difficult for many people, not all women could face their own emancipation and/or were deterred from doing so by other social forces and relationships. Therefore, in some instances, post-war agoraphobia may have provided a legitimate means to avoid gender politics. In other words, following Rosenberg’s (1972) influential argument that hysteria served as ‘an alternate role option for particular women incapable of accepting their life situation’ (p. 655), the agoraphobic ‘sick role’ may have similarly provided a means for some women to circumvent the gap between the ideal and the reality of wartime and post-war independence.

Second, and conversely, although the doctrine of separate spheres was on some level rhetorical, the ‘invention’ of agoraphobia provided the
added advantage of social control. With the social authority medicine had secured for itself by this time, perhaps reinforcing the imperative of ‘True Womanhood’ in the language of disease was a way of thwarting the expansion of (bourgeois) women’s rights. As the American psychiatrist Abraham Myerson put it (in 1929) in one of the several essays he wrote on the tyranny of domesticity, ‘the neurotic woman, a chronic invalid for housework, may do a dragon’s work for Woman Suffrage’ (pp. 71-72). Myerson’s support of feminism was exceptional for its social-historical time, though, and despite a substantial number of women practitioners, early twentieth-century psychiatry, in its ‘aggressive masculinism’ was unmistakably a man’s field (Lunbeck, 1994, pp. 35-36). Accordingly, it was predominantly men who wrote the scholarship on agoraphobia and by the war’s end little space was left for the possibility of this disease being anything other than a peculiarly feminine problem whose subtext was a narrative about proper (normal) gender and class-specific behaviour. As Lunbeck observes, in the early twentieth-century American psychiatry shifted its focus from insanity to the normal; that is, to the ‘realm of everyday concerns—sex, marriage, womanhood and manhood’ and so forth, thereby ‘weaving a psychiatric point of view into its many aspects’ (1994, p. 47). The shift in prevalence of agoraphobia from men to women may well reflect psychiatry’s overall shift to an emphasis on normative gender roles.

Third, ‘war neurosis’ or shell shock had also emerged on the psychiatric landscape by this time (and notably, here too the labels were classed and gendered). Allan Young documents that in total the Royal Army Medical Corps, for example, had treated 80,000 cases of the disorder and 30,000 troops diagnosed with nervous trauma had been evacuated to British hospitals (1995, p. 42). In fact, this diagnosis—rather than the diagnosis of agoraphobia—was frequently invoked in doctors’ reports of men’s anxieties—whether or not they had been anywhere near an exploding shell (Shephard, 2001). With 200,000 ex-servicemen in receipt of pensions for nervous disorders (Stone, 1988, p. 249), the war produced ‘large numbers of men who acted like women,’ that is, ‘strangely hysterical.’ Psychiatrists had no choice but to reconceptualise hysteria as a strictly female problem (Lunbeck, 1994, p. 252). Because the conceptual separation of hysteria and agoraphobia did not ‘take’ until Freud’s ideas did, (that is not until well into the 1920s), arguably agoraphobia was included in (American & British) psychiatrists’ rethinking what they meant exactly by hysteria, especially in relation to men, before and after the war.

Fourth, given its resonance with the ideals of True Womanhood and the perceived essential femininity of nervous disease, a diagnosis of agoraphobia would have called into question male patients’ masculinity, unlike the comparatively more heroic war neurosis. Of course, diagnosing men with shell shock would not necessarily have saved them from stigma
or disgrace, but the point is that agoraphobia served the important purpose of demarcating feminine gender identity. As one agoraphobic writer (Vincent, 1919) lamented ‘Can I ever take my place in the world unhandicapped as other men are, and enjoy a single day undepressed by dark dread? If I could be as other men, it seems to me that my usefulness should be increased a hundredfold’ (p. 299). The following passage taken from Regeneration, Pat Barker’s fictionalised account of the (real) British medical psychologist William Rivers’ efforts to treat soldiers with shell shock, vividly captures the pressure to be masculine that ‘Vincent’ describes. Rivers observes:

in leading his patients to understand that breakdown was nothing to be ashamed of, that horror and fear were inevitable responses to the trauma of war and were better acknowledged than suppressed, that feelings of tenderness for other men were natural and right, that tears were an acceptable and helpful part of grieving, he was setting himself against the whole tenor of their upbringing. They’d been trained to identify emotional repression, as the essence of manliness. Men who broke down, or cried, or admitted to feeling fear, were sissies, weaklings, failures. Not men.

(Barker, 1991, p. 48)

Rivers’ words echo those of one male pre-war agoraphobic who told his physician, Dr. John D. Jackson of Kentucky, that he ‘tried manfully to brave off the spells’, but as he said, ‘at each time I permitted myself to be alone, I suffered terrible agony’ (Jackson, 1872, p. 61).

These passages are juxtaposed in order to demonstrate that men measured themselves against a historically located (and class-based) cultural ideal of manliness; the man ‘who did not measure up as a man’ was thus perceived as mentally unhinged (Lunbeck, 1994, p. 238). Agoraphobia diagnosed in men, who especially during and after the war were expected as to keep a ‘stiff upper lip,’ may even suggest resistance on their part to an imperative of masculinity imposed upon them that they could not fulfil—resistance that was subsequently pathologised (as it may have been for women diagnosed with hysteria and its accompanying signs and symptoms; see Rosenberg, 1972). This could be difficult to prove, however the real point here is that physicians’ concerns were not strictly ‘medical’ insofar as they both reinforced were clearly embedded in ideas about class, gender and gender roles.

5 These words resonate with an article on the military that recently appeared in The Globe & Mail. The writer describes how a ‘major with decades of experience in the... toughest, most battle-hardened regiments, found himself in a circle with 30 of his military comrades, crying, confessing and searching for his inner soldier.’ This outpouring opened ‘emotional channels that had been blocked by years in the military, where the expression of feelings has long been discouraged.’ In his words, ‘[y]ou were taught to hide your feelings. To show your feelings was to show weakness.... Boys don’t cry. They fight.’ (Cheney, 2001, p. A3).
And finally, we must also consider the possibility that regardless of who was being diagnosed with the disease, it was, essentially, seen as a feminine disorder (allowing heterosexism and homophobia to also play out in the process). Even when it was primarily men being diagnosed with the disease, agoraphobia was ‘assigned a definite place in the gendering of metropolitan psychopathology… and thought of as fundamentally “female” in character’ (Vidler, 1993, p. 35). Consider that on the few occasions prior to World War I that a diagnosis of agoraphobia in women did occur, the origin of the disease was attributed to the woman’s reproductive system. In one case, for example, agoraphobia was thought to have resulted from excessive lactation and frequent childbearing. With symptoms that were suggestive of post-partum depression, this woman’s physician, Dr. C.W. Suckling (of the Queen’s Hospital in Birmingham), was actually ‘struck by the marked potency of childbearing as a cause of agoraphobia and allied morbid fears’ (Suckling, 1890, p. 478). Along similar lines, another woman’s agoraphobia was thought to be the result of—or at least exacerbated by—a ‘laceration on the cervix’ since her fear was always much worse in the week prior to her menstrual period. After Dr. L.T. Potter ‘made local applications,’ this Chicago patient was still unable to travel without trepidation, however, and so she took matters into her own hands. As the doctor observed, a ‘bottle of valerianate of ammonia, and a flask well filled with brandy, were always her constant companions when undertaking a journey by rail.’ Whenever this patient travelled, ‘invariably’ she sat ‘with a brandy flask in the right hand and her Bible in the left; presumably the one counteracting the influence of the other’ (Potter, 1882, p. 474).

In contrast, diagnoses of agoraphobia in men were usually made in the context of problems with their nervous systems. As Dr. White wrote in 1884, for example, agoraphobia represented a ‘curious phase of nervous phenomenon.’ He then went on to describe the symptoms in a 30-year-old professional gentleman with no family history of nervous disorders but who ‘suffered from a nervous kind of light-headedness… brought on by the ideas of space’ (1884, p.1140). Dr. Webber wrote that at ‘the foundation of these sensations of anxiety lies one common… corporeal cause’ occurring ‘in a certain pathological group, including what may be expressed by the name nervous irritability, crethism, irritable weakness.’ He maintained that in this ‘pathological group the entire nervous system… may be thrown into extreme commotion.’ Yet, as Nancy Theriot observes, in the nineteenth century ‘nerves’ were themselves perceived as feminine. Medical illustrations depicted the nervous system as female (as opposed to the muscular system normally represented as male) and rendered women ‘inherently prone to nervousness and to manic, depressive, or hysterical responses to life’s difficulties’ (1997, p. 165). The diagnosis of agoraphobia in men thus failed to mitigate against its being seen as
a feminine disorder given that all things nervous were seen as feminine by definition.

Gendered Expectations

The focus of the discussion thus far has been agoraphobia in the late nineteenth and early twentieth centuries. However, the tendency towards gendered (and re-gendered) psychiatric thinking was not limited to these early cases. For example, gendered expectations informed a 1964 report on five female patients who, as Dr. Roberts reports, were all ‘coping adequately with routine home duties’ (1964, p. 195). Dr. B.C. Bignold described ten women he saw at the Mental Hospital of Claremont in Western Australia as opportunists for whom ‘the symptom was personally useful’ as a way of avoiding scrubbing the kitchen floor, controlling family outings, and in one of these cases, ‘bring[ing] pressure to bear on [a] husband’ (who refused to capitulate to his wife’s wish to move to Holland). ‘When the symptom served a useful purpose, it was refractory to treatment. The possessive mother features in several histories. Dominant dames have diffident daughters’ (1960, p. 333). The description of two patients in another report published as recently as 1996 is also provocative: the first patient was a ‘33 year old woman living with her husband and three children, who were aged between 2 and 12 years’ and who came to the authors’ clinic in 1986 complaining of panic attacks after the birth of her third child; ‘[n]o other stress was evident.’ The second patient was a 23-year-old single male who ‘worked for the sales department of a company in a technologically advanced industry for 1 year following his graduation from college. He worked hard but reported that his working conditions were stressful.’ His agoraphobic avoidance began after a panic attack while out on business with the company car (Sakai & Takeichi, 1996, p. 335). Interestingly, this male patient is defined by his education and paid work, while the female patient is defined by her role as wife and mother—problematic because neither aspect of her life is perceived by these writers as a source of stress, nor for that matter as work.

These contrasting descriptions reflect the seemingly benign criteria listed in the American Psychological Association’s (APA, DSM-IV, 1994), when it was already clear that most diagnosed agoraphobics were women. As listed there: ‘Individuals’ avoidance of situations may impair their ability to travel to work or carry out homemaking responsibilities (e.g., grocery shopping, taking children to the doctor)’ (APA, 1994, p. 396; emphasis added). Jarring for its having been added to the 1994 edition, this wording is reminiscent of sociologist Talcott Parsons’ assertion that a wife’s ‘primary function’ was housekeeping and the care of children (1954). But as an extension of gender ideology more generally, the APA’s message to women is double-edged: Being in the stereotypic feminine role—staying at home, being anxious and (apparently) non-functional,
depending on a significant other—is an increasingly unacceptable way for modern women to behave. Yet, family responsibilities must remain their priority or they risk being pathologised. Women ‘are expected to be “out there” in the world and still put their families first’ (Fodor, 1992, p. 201).

Behaviourist therapy programmes which flow out of DSM criteria and have been increasingly common in the treatment of agoraphobia since the 1970s (Reuter, 2006), also tend to build upon this very important-because-gendered conception of agoraphobia. Specifically, in the few case reports of agoraphobic men, there is a tendency in their treatment to gear the programme towards getting them back to paid work. In contrast, women’s treatment tends to emphasise getting them back into stores, the implication being that not shopping (and by extension not being good, feminine homemakers) is abnormal. This observation is by no means intended to disparage homemaking, nor should it be taken to suggest that agoraphobia is not really a disabling condition because, clearly it is. But it is meaningful that, for example, one clinical drug trial included a ‘test walk’ through a shopping mall (Roth et al., 1988), while another study examined whether agoraphobics interpret the environment in large shops and supermarkets differently from ‘general’ (read: ‘normal’) shoppers (Jones, Humphris & Lewis, 1996). As Kupers observes, since ‘the explosive growth of consumerism in the 1920s, newer, milder, diagnoses are needed for those who are capable of working, who buy into the promise of ad[vertising] campaigns that the purchase of one commodity after another will lead to happiness, and yet are unable to attain the kind of happiness portrayed in advertisements and films.’ They must be ‘neurotic; perhaps they need psychoanalysis, psychotherapy, a tranquilizer or an antidepressant’ (1995, p. 70).

Following Kupers, what could be more problematic than a disease that prevents some individuals from even entering stores? For example, for a ‘Mrs Griffiths’ the ‘furthest she could venture alone was to the two shops about 50 yards from her house’ (Stantworth, 1982, p. 400). Although resentful for having been ‘tied to the house for 14 years’ and forced into ‘the role of wife and mother’ (p. 403), she depended almost completely on her husband ‘who had to carry out for or with her many of the normal day to day tasks of a housewife’ (p. 400). She did, however, manage eventually to achieve her goal of entering the local shops on her own, a challenge Mrs. Griffith’s therapist planned for the day that she normally bought meat ‘so that she had a good incentive to succeed or the family would be hungry’ (p. 402). For ‘Holly,’ a ‘pleasant, tubby 46-year-old woman,’ problems arose on the first day of her programme when she started to walk with her nurse therapist to the shops (Wondrak, 1980, p. 43). On the way she became very anxious, sweaty and faint, but with encouragement, she was able to walk a bit further until the shops were in sight, at which point she and her therapist returned to the hospital. The
next day Holly’s success was even greater—Holly made it all the way to the shops this time. A ‘Mrs. A’ similarly wanted to make it to a dress shop in the mall near her house. She ‘was able to imagine herself going through the process of getting to the store, entering it, looking at dresses, going into the changing rooms, standing at a sales counter, paying for her selection, leaving the store and going home (Pyke & Longdon, 1985, p. 21). But ‘Mrs. A’ had not ventured beyond a three-block radius of her home in years, and increasingly avoided certain anxiety-producing situations and places, including shopping malls, movie theatres, banks, hairdressers, and dentists. Another woman (described as ‘extremely obese’), ‘Mrs. Manton’, also had difficulty shopping and was unable to use public transport or visit friends and relatives (Brooker, 1980). For another patient, shopping and other domestic errands had to be fulfilled by her teenage daughter who frequently missed school in order to accomplish everything her mother wanted done (Liffiton, 1992, p. 33). Also suffering from an inability to shop for groceries, one therapist’s treatment of a patient named ‘Helen’ had her visiting the supermarket two times per week, including busy Saturday mornings and remaining there for at least one hour (Garland, 1992, p. 26).

In contrast is a patient named ‘Mr. Prince’ who had difficulty walking certain distances and riding on the bus, making it impossible for him to get to his work place. As part of his therapy, Mr. Prince was ‘encouraged to go on short walks by himself and to increase the distances gradually.’ By the end of the third week of his treatment from home, he was to come on his own for an appointment at the clinic and to the nurse therapist’s great surprise and delight Mr. Prince was successful. From this the patient graduated to public transportation: ‘His next step would be to... take the bus to the city where he worked... and find his way to his [place of employment].’ With his career at a large international bank on the line, Mr. Prince was determined to return to his job after five months away and achieving this goal was a major accomplishment. He was ‘very pleased with himself [and] grateful ... that we had helped him retain his work and with it his dignity and self-respect... [If he had lost his job he would have been utterly demoralised’ (Lim, 1985, p. 19).

The extent to which Mr. Prince’s ‘dignity and self-respect’—his identity—were tied to his (in)ability to get to his place of employment contrasts sharply with the other reports about women for whom the central goal of their treatment was to overcome their inability to shop. While it is possible that the gendered nature of these behaviourist treatment programmes may simply reflect a gendering in the types of agoraphobic situations reported by the male and female patients (that is, a gendered social reality), and while it is also true that in cities one must shop for (as opposed to grow) one’s food, it is meaningful that in these reports this particular activity—shopping—is associated only with women and unpaid work. Again, Mr. Prince’s anxiety was associated
with going to paid work yet surely he also required groceries and the occasional item of new clothing? Moreover, production and consumption are being cited by these reports (and eventually the DSM-IV) as criteria for ‘normal’ behaviour. That is, when doctors incorporate shopping into treatment, they transmit an ideological cultural imperative to their patients, one that reflects a dominant ideal linking normal femininity with consumption and unpaid work while in Mr. Prince’s case, defining normal masculinity by his employment. Edlund (1990) has demonstrated convincingly that agoraphobia is bad for the economy, so while some may consider not working (for pay) ideal feminine behaviour, the implication is that political economic assumptions colour the lens through which psychiatrists gaze at their patients (as do class issues if we consider who can and cannot afford to shop). The possibility of living outside the framework of patriarchal capitalism is thereby pathologised.

Gendered economic questions also extend into the role of pharmaceuticals in treating agoraphobia. In the last two to three decades, the pharmacological approach to treating this disorder has involved mainly anti-depressants and benzodiazepines (minor tranquillisers), making the disproportionate diagnosis of agoraphobia in women alarming. Among the most widely prescribed and possibly overprescribed anti-anxiety medications (Botts, 1997; Swinson, Cox & Woszczyina, 1992), if not among the most widely prescribed of medications (Salzman, 1993; Evans, Oei & Hoey, 1988; Freeman et al., 1993), certain benzodiazepines (alprazolam and others) are known to be addictive and stopping them too soon or abruptly can lead to a relapse of symptoms (Hallfors & Saxe, 1993; Medical Letter, 1981, 1982, 1988; Pecknold & Swinson, 1986; Salzman, 1993; and Verster & Volkerts, 2004). These addictive properties may help explain why one patient named ‘Anna’ (as described in a case report from 1979), for example, was – for 10 years – only able to ‘carry out normal daily activities’ with ‘out-patient support supplemented by diazepam (Valium) and Chlordiazepoxide (Librium)’ (King, 1981; also Stantworth, 1982).

It is undeniable that pharmaceuticals have, among other social and political forces, helped reduce the number of patients in psychiatric hospitals (Silverman & Lee, 1974, p. 12). It is also true that they have had positive effects for some patients in enabling them to carry out their ‘normal’ responsibilities in their day-to-day lives. But given their addictiveness – an attractive feature from a drug manufacturer’s point of view – we must question the gendered pharmacoepidemiology of agoraphobia/panic. These drugs have served not only as a tool in the management of agoraphobia and panic experiences, but arguably also in the management (through their medicalisation) of women themselves. For example, as Kupers has pointedly remarked in a discussion of gender bias and the psychiatric diagnosis of PMS, ‘is it merely coincidental that
just when middle-class women are entering the workplace in record numbers, premenstrual syndrome is declared a form of mental disorder’ (1995, p. 69)? Similarly, is it merely a coincidence that both the prevalence of agoraphobia and the prescription of these particular drugs to agoraphobics who were mostly women increased at a time in history when their participation in the paid labour force increased as well?

The Normative ‘Whiteness’ of Agoraphobia

Before concluding, it is important to note that racialism also is, albeit implicitly, an important factor in this story insofar as the ‘white’ medical subject has persisted as normative throughout the discourse of agoraphobia, a tendency that is evident even in the earliest literature on the disease when medical racialism and a discourse of ‘race’ (and immigration) were already in motion (Reuter, nd). Yet the fact is that although racialism was a dominant theme in other medical contexts, the agoraphobic patients in these reports are rarely described in ‘racial’ terms at all, even though historically many mental diseases have been racialised and the use of racial categories by psychiatrists has not been uncommon (Grob, 1985, p. 269; Lunbeck, 1994, p. 125). That the discourse of agoraphobia has been ‘race-less’ suggests that the typical agoraphobic patient has historically been ‘white’, since in Western discourse—medical and otherwise—whiteness tends not to require qualification or even articulation. Whiteness is taken for granted and tacitly normalised in its position as the privileged signifier (Dyer, 2002; also McIntosh 2003).

The findings of two American epidemiological studies on agoraphobia (Boyd et al., 1990; Weissman, 1990) are especially striking. In this community study of five major US cities, the researchers discovered that the prevalence of agoraphobia (and other phobias) was higher among African American women with the lowest socioeconomic status (Boyd et al., 1990).7 That this finding was new can be explained in part by the fact that most of the psychiatric literature on agoraphobia is based on clinical populations comprised of the most severely disabled phobics (as opposed to community populations comprised of individuals who tend not to seek treatment). For historical and economic (class-based) reasons these clinical populations are over-represented by middle-class ‘whites’. Historical reasons for the overrepresentation of middle-class ‘whites’ in the agoraphobia literature include a longstanding legacy of distrust among African Americans that prevents them from going to see doctors with their problems (see Gamble, 1993; 1997). Economic reasons point in large part to gross economic disparity; in 1984 (approximately when the epidemiological data was collected), median annual family income for

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6 Orr observes, the ‘story of panic disorder’ is one ‘told by a medical/corporate model of biological illness’ that reproduces ‘women-bodies as a secure, because we’re panicked, site for pharmaceutical profits’ (1990, p. 483).
‘whites’ was significantly higher at $27,686 (US) as compared with that of African Americans, which averaged only $15,432 (US). This inequality corresponds with inequality in health insurance coverage and state and county mental hospital admissions (see U.S. Department of Health & Human Services, 1986, pp. 14 and 74.) as well as a greater opportunity to avail themselves of private therapy by ‘whites’ (US Census Bureau, 2000; US Department of Health & Human Services, 1986; 1987), which means they appear more often in the clinical literature on agoraphobia. It is also well established that not only do African Americans visit physicians less frequently than Whites, but they also do not receive the same quality of care (U.S. Census Bureau 1999; 2000; U.S. Department of Health & Human Services, 1986; 1987; Geiger, 1997, p. 1766). In light of these data, it is not especially surprising that poor, urban, African American women do not present for treatment, which is why they are generally not reflected in clinical articles (reinforcing the perception of agoraphobia as a white middle-class disease) and why they would only emerge in a community study.

However the findings of this epidemiological study also reflect the possibility that agoraphobia may have gone undetected in poor, African American women because the official criteria for this diagnosis—derived from the DSM-III—are based on a normative, white, middle-class urban experience that excludes racism as a possible (and legitimate) reason for not going out into public spaces. The interviews conducted for the epidemiological study were based on a schedule (the ‘DIS’) defined by the criteria of DSM-III. If the questions included in the revised DSM-III-R schedule (the ‘SCID’) are any indication, it is likely that the DIS was also based on normative white experiences and did not address issues of racism. Indeed, as Knowles has insightfully demonstrated, ‘[p]sychiatry contains a series of powerful, racialized narratives which dictate the terms on which certain lives will be lived and judged’ (1996, p. 56).

Moreover, though not explicitly about ‘race,’ two cases reported from the volatile social-political context of Northern Ireland (during the latter part of the twentieth century) are instructive here: As the therapist of one patient, Mrs. James, described, she ‘had never been in the city for any length of time since the outbreak of violence, [so] she had to be prepared for the security arrangements and what to do during a bomb scare, all of which were new to her’ (Bradley, 1975, p. 967). Another therapist, also Irish, described a similar situation with an agoraphobic-claustrophobic woman patient. ‘Cynthia,’ decided to pursue treatment even though ‘[e]veryday somewhere in Belfast buses were being hi-jacked. Everyday there was the possibility of being injured in bomb blasts. People were

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7 1.28 for African Americans versus 1.00 for ‘whites’, with p< 0.01; 1.00 for highest quartile of SES versus 1.80 for lowest quartile, with p<0.001 (Boyd et al., 1990, p. 318).
8 US Census data reveal that in 1998 African Americans made 89.8 million office visits to physicians (259 visits per 100 patients); ‘whites’ made 702.2 million visits (317 visits per 100).
being shot. There were security checks to pass through which meant waiting to be searched. And not long ago, a shopping centre, similar to the one she [wanted] to go to, had been wrecked in a car bomb which had resulted in three deaths and many injuries’ (Williamson, 1974, pp. 1843-1844). As noted with reference to C. Wright Mills in the introduction to this paper, these passages illustrate how the social historical context can be a factor in what has primarily been an individualised phenomenon.

Poor, African American women living in inner city America would have their own parallel concerns. In fact, contrary to the usual way in which agoraphobia is characterised in the literature, these examples underscore the possibility that agoraphobic fear could be a completely rational response to the pressures of public urban space. This does not mean that African American women do not really experience the distress of agoraphobia, but rather, this may account in part for why their agoraphobia had gone previously unnoticed. Thus, similar to affluent white women’s ‘passing’ as ‘True Women’ rather than agoraphobic at the turn of the nineteenth century, contemporary African American women’s legitimate anxieties about being out in possibly racist and dangerous public spaces may have also ‘passed’ as something other than agoraphobic. In other words, the epidemiological findings point to the possibility that conditions of ‘racial’ inequality shapes the fear these women have of going out into public urban spaces. Moreover, racism in psychiatric narratives has important psychological (and political) consequences and can feature in both its silences and explicit statements. This is very significant: the African American women ‘discovered’ through community (as opposed to clinical) research may have ‘qualified’ as agoraphobics simply because researchers did not avail themselves of a theoretical framework drawing attention to interacting social factors and thus did not ask the right questions—that is, questions that might have illustrated the possibility that racism and fear of crime and violence, rather than irrational fear, discouraged these women from public places.

**CONCLUSION**

This paper has argued that psychiatric categories are socially shaped. The discussion has attempted to show how the discourse of agoraphobia both informs and is informed by our culture and social relations. More than an individual disease phenomenon, contained within the discourse of this disease is an exclusionary and normative imperative of social order. Reading the psychiatric literature on agoraphobia with this in mind enables us to see this and other psychiatric narratives in terms of cultural processes and assumptions—assumptions that include, but are not limited to, ideological notions of gender and especially the deep sociality inherent in the question of what it means, both medically and culturally, to be ‘normal’ and ‘pathological’. In so far as psychiatric categories bear a
certain amount of social content, then, it has been argued that psychiatric thought would be strengthened by a more critical and sociologically informed understanding not only of the pathologies with which it is concerned, but also of the social-historical context in which these pathologies exist.
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Breast Cancer:  
The Importance of Prevention in Public Education

Ellen Sweeney  
Dalhousie University

KEY WORDS: WOMEN, BREAST CANCER, PUBLIC EDUCATION, ENVIRONMENT, PREVENTION

It is a well cited statistic that one out of every eight North American women will develop breast cancer during their lifetimes. Approximately, seventy percent of women who develop breast cancer have no known risk factors, other than advancing age (Breast Cancer Society of Canada, 2006). In order to understand what information is readily available for women on the issues surrounding breast cancer, an examination of public education literature distributed by different health care organizations in Halifax, Nova Scotia was conducted in 2003. It is vital that women have access to information which not only offers the traditional biomedical model treatment options, but promotes prevention awareness, recognizing the role played by social, economic and environmental factors.

One of the most prominent areas of scientific research during the 1990s was the identification of genetic links to diseases, including the discovery of the breast cancer susceptibility genes, BRCA1 and BRCA2 (Sherman, 2000). It is important to remember, however, that genes do not work in isolation; their effect is a product of DNA programming operating within a particular set of environmental conditions (Sherwin, 1994). It is a well cited statistic that one out of every eight North American women will develop breast cancer during their lifetime. Breast cancer deaths comprise the second highest cancer death rate, after lung cancer, among Canadian women and seventy percent of women who develop breast cancer have no known risk factors, other than advancing age (Sherman, 2000; Breast Cancer Society of Canada, 2006). In order to understand what information is readily available for women on the issues surrounding breast cancer, an examination the public education literature distributed by health care organizations in Halifax, Nova Scotia was conducted. This research is based in qualitative content analysis and utilizes pamphlets and brochures from the Halifax Breast Cancer Screening Clinic, the Canadian Breast Cancer Foundation, the Canadian Cancer Society and Cancer Care Nova Scotia. It is vital that women have access to information which not only offers the traditional biomedical model treatment options, but promotes prevention awareness, recognizing the role played by social, economic and environmental factors.

1 For inquiries, Ellen Sweeney can be reached at 1271 Church Street, Apt #401, Halifax, NS, Canada, B3J 3L3 (ecsweene@dal.ca)
LITERATURE REVIEW

Sociology of Health & Illness

Society and social institutions shape the occurrence of disease, the forces called upon to respond to disease and the experience of illness. Kasper and Ferguson (2000) contend that ‘[s]ocieties in part create the disease they experience, and further, they materially shape the ways in which diseases are to be experienced… [T]he varieties of human affliction owe as much to the inventiveness of culture as they do to the vagaries of nature’ (Kasper & Ferguson, 2000, p. 3). Physicians are in a highly authoritative position to shape a society’s thinking about the character of illness and how it should be treated. Over fifty years ago, medical historian Erwin H. Ackernecht argued that disease is not strictly a physical phenomenon (Karp, 1996). Most researchers in the behavioural, biomedical and physical sciences are trained in the scientific method and believe in its power. It is argued, however, that few are aware of its historical and philosophical roots in logical positivism and objectivity (Rosser, 2000). The methods of positivist science suggest explicitly that the tasks of identifying, diagnosing and treating any disease entity are independent of and unaffected by the social, cultural, political, or economic contexts within which both physicians and patients may live their lives (Frankel, Speechly & Wade, 1996).

It is important to examine the ways in which medical and scientific knowledge are determined, created and constructed by, or at least influenced by social conditions. The literature within the sociology of health and illness allows us to look at breast cancer with a social lens rather than a medical one, raising significant new questions. For example, instead of wanting to know the results of the latest clinical trial, we want to know why some forms of research are being undertaken while others are not, which scientists get funded and why, who is paying for breast cancer research and who benefits from the findings. The vast public and private research enterprise can be viewed as a social institution. The goals of the research establishment should include finding answers to perplexing and pressing questions about disease, but its goals are also economic and political and these dimensions influence research priorities and resources (Kasper & Ferguson, 2000).

In the past two decades, social scientists have studied the bias and absence of value neutrality to science, specifically in the discipline of biology. Scientists have introduced flaws into their experimental results in several areas of biology by excluding females as experimental subjects (Rosser, 2000). Exclusion of women from clinical drug trials was so pervasive that a meta-analysis, published in 1992 in the Journal of the American Medical Association, surveying the literature from 1960 to 1991 on clinical trials of medications used to treat heart attacks, found that women were included in less than twenty percent and the elderly in less
than forty percent of those studies. Thus, the individuals most likely to benefit from these medications were excluded from most of the clinical trials (Rosser, 2000).

Although difficulties with breast cancer research reflect the general problems facing women’s health research in North America at this time, breast cancer research faces some unique problems. Through the 1980s less than five percent of American women with breast cancer participated in clinical trials; those most at risk of dying from breast cancer, older women and African American women, had even lower participation rates in clinical trial research, often due to lack of knowledge about clinical trial research and access to participation (Rosser, 2000). Biomedical researchers used biology as a justification for their male focus, citing estrus cycles in nonhuman females, menstrual cycles in women and life changes correlated with changes in the reproductive cycle, such as pregnancy and menopause. For breast cancer research, this missing information is critical in order to understand causes and treatments of a disease where hormone levels and reproductive history have documented, critical roles. Differing estrogen levels among women and changing levels associated with pregnancy, breast-feeding and menopause have been correlated with different risks, treatment successes and mortality outcomes in breast cancer. A long history of understanding changes in hormone levels over the life cycle of women from diverse races, ages and social classes, with differing reproductive backgrounds, appears crucial for breast cancer research (Rosser, 2000). Einstein argues that political, social, cultural, sexist and racist factors intersect in the field of breast cancer and this should be recognized and incorporated into the epidemiological work surrounding breast cancer (Einstein, 2001, p. 86).

**Breast Cancer, Society & the Environment**

The main emphasis in almost all references to breast cancer are treatment, reconstruction and genetic factors. *Adweek* describes breast cancer as a ‘dream cause... it’s the feminist issue without the politics... without controversy’ (Zones, 2000). Politicians may have adopted breast cancer issues to straddle the gender divide, but breast cancer is an illness that is surrounded with controversy. Breast cancers visibility, accompanied by a wealth of economic and political possibilities, has made the illness a province of entrepreneurs (Zones, 2000). Boehmer contends that research on both women’s health and cancer prevention is underfunded and that cancer is dominated by the economic interests of the cancer industry and its gender dynamics (Boehmer cited in Potts, 2004a).

The tradition of researching a disease and how to cure it rather than studying health with the goal of preventing illness places responsibility on the individual rather than the society as a whole. Focusing basic
research at the level of the cell and below also has consequences for treatments developed to treat disease. Susan Love’s (2006) characterization of ‘slash, burn and poison’ as the treatment methods for breast cancer highlights the cellular approach (Love, 2006). The theory of cancer as cells growing out of control leads to treatments that attempt to limit cell growth by surgically removing the cells (slash), killing the cancer cells which divide more rapidly than nonmalignant cells (burn through radiation therapy) or changing the cellular environment to one that is less favourable for the growth of cancer cells (poisoning through chemotherapy). These treatments encourage resources to be directed towards treatment in individuals and away from societal prevention of cancer. They center on the individual and her body while diverting attention from surrounding social, economic and political factors that may contribute to the disease and its progress (Rosser, 2000).

Breast cancer incidence rates are highest in North America, Europe, Australia and New Zealand; however rates are rising among recently industrialized countries (Klawiter, 2000; Evans, 2006). Migrant studies by epidemiologists address whether breast cancer risk can increase or decrease when women move to a location with different rates. For example, Japanese women who have immigrated to the United States or Canada tend to have higher breast cancer incidence rates than women who remain in Japan. This suggests that factors other than genetics are significant in relation to the cause of the disease and has led researchers to believe that environmental factors, such as diet and exposure to carcinogens, play a significant role in the development of breast cancer (Nagata & Shimizu, 1996; Hirshaut & Pressman, 2000; Evans, 2006).

The popular and scientific presses emphasize a woman’s risk for developing breast cancer. The traditionally mentioned risks are individualistic (Potts, 2004b) and include a family history of breast cancer; early onset of menarche; late onset of menopause; never pregnant or first full-term pregnancy after age 30; not breast feeding; obesity and/or a high fat diet; oral contraceptive use; personal history of fibrocytic disease, ovarian or endometrial cancer and excessive alcohol consumption (Sherman, 2000, p. 11). However, these factors account for less than 30% of breast cancers (Sherman, 2000).

Less than one out of every 10 cases of breast cancer occurs in women born with a genetic predisposition for the disease. Recent research reveals that breast cancer arises from multiple factors, which may include genetic mutations, as well as exposures to external agents that affect genes or the production of estrogen. More than one exposure is usually required before breast cancer will develop and it is important to note that the same set of genetic and environmental circumstances will not produce cancer in every individual (Evans, 2006). It is also important to note that scientific research now shows that low-dose exposure to environmental chemicals, parts per billion or per trillion, can cause permanent damage to living
organisms (Evans, 2006).

As the origin of most breast cancers remains unexplained and because there is an apparent connection between breast cancer and naturally occurring estrogen, scientific attention has begun to turn to the possible role of xenoestrogens—chemicals foreign to the body that, directly or indirectly, act like estrogens (Steingraber, 2000). Like the naturally occurring estrogen estradiol, xenoestrogens such as organochlorines and other endocrine disrupters, slip from blood serum into the interior of cells, attach themselves to estrogen receptors, and elicit growth-promoting changes within target tissues. The ability of certain synthetic chemicals to mimic estrogen in this way has been known for some time, but until recently, many researchers assumed that any breast cancer risk created paled in comparison to the power of a woman’s own hormones. This assumption was based on several observations. First, few synthetic chemicals closely resemble the estrogen molecule and estrogen is the key that must fit into the receptor’s lock in order for the process to begin. Second, foreign estrogens are much less potent than naturally occurring estradiol. Third, xenoestrogens exist in much lower concentrations in the body than naturally occurring estrogens, which surge to impressive levels during the first half of a woman’s menstrual cycle (Steingraber, 2000).

Recent findings have cast severe doubt on the reasoning outlined above. It has been discovered that close physical resemblance is not required for successful estrogen impersonation. As a lock, the estrogen receptor accepts many keys, some widely divergent in shape and size. Organic compounds that look nothing like estradiol, from pesticides to plastics to detergents, all possess estrogenic properties and they are far more common than anyone had imagined (Steingraber, 2000). Xenoestrogens have significant biological impacts even at very low levels (Environment Canada, 2006) and they also act in combination with one another exerting estrogenic effects many time higher than one working alone (Steingraber, 2002). One of the greatest concerns about xenoestrogens is that unlike natural estrogens found in the body and in foods such as soy, they are not easily broken down, accumulating and being stored in the body’s fat cells, including breast fat (Women’s Network on Health, 1997).

Dr. Sherman argues that ‘it is... impossible to ignore the carnage of endocrine-disrupting chemicals, nuclear radiation and chemical carcinogens, alone and in combination, invading nearly every family with cancer’ (Sherman, 2000, p. 4). Environmental racism literature recognizes that in addition to a lack of universal health care, waste sites, incinerators and nuclear reactors are most frequently located near poor and marginalized communities, leaving specific groups of people at a much higher risk for developing life-threatening illnesses (White, 1998). In general, women with a low socioeconomic status have a ten to fifteen percent lower cancer survival rate regardless of race (Rosser, 2000). Those...
who live below the poverty line often live in substandard housing, experience underemployment and a disproportionate exposure to industrial pollution. Evans argues that underserved and overexposed individuals are at a high risk for breast cancer (Evans, 2006, p. 45). Research that relies on biology alone and ignores socioeconomic factors will be unlikely to uncover the best way to remove this survival differential. An interdisciplinary approach that utilizes methods from social sciences in conjunction with those from biomedicine may be able to clearly explain the relative effects that increased levels of exposure to workplace and environmental carcinogens and a lack of access to high-quality health care have upon the higher incidence and lower survival rates experienced by African American women with breast cancer (Rosser, 2000).

Barriers to production of environmental knowledge are political and economic (Fosket, 2004). Potts (2004a) contends that the breast cancer and environment movement is differentiated from other breast cancer social movements because it focuses on the environmental rather than individual causes of disease and thus recognizes the importance of prevention. It focuses on the effects of pesticides, cosmetics, toxic waste, and radiation; as well as recognizing socio-economic status, the precautionary principle and lay knowledge of the disease (Potts, 2004a, p. 555).

ANALYSIS OF PUBLIC EDUCATION LITERATURE

An examination of the breast cancer public education literature was conducted in Halifax, Nova Scotia. The literature being distributed from health care organizations focuses on emphasizing awareness with breast cancer statistics, early detection, the doctor-patient relationship, methods of treatment (surgery, chemotherapy and radiation), and raising funds to research new treatment methods.

The Breast Cancer Screening Clinic’s pamphlet called ‘Facts on Breast Cancer’ is one of the most in-depth pieces available. It was published by the Canadian Cancer Society and revised, reviewed and reprinted in July 2000. The pamphlet begins by outlining basic facts on breast cancer in Canada; what the breasts are; what cancer is; and what breast cancer is. They state that studies of large numbers of women with the disease have identified a number of risk factors which increase the chances of developing breast cancer; they include age; previous breast cancer; strong family history of premenopausal breast cancer; a precancerous finding of ‘atypical epithelial hyperplasia’ on biopsy; age at first pregnancy; menstruation; and diet (Canadian Cancer Society, Facts on Breast Cancer, 2000, p. 5-6). Underneath these bulleted key points, they touch on subjects including the use of female sex hormones, birth control pills and hormone replacement therapy; as well as the effects of abortions and
pesticide exposure in relation to breast cancer (Canadian Cancer Society, 
Facts on Breast Cancer; 2000, p. 6-7). Unlike the numbered risk factors 
which are clearly outlined and explained, this gives the reader very little 
information on a variety of complex subjects. In a pamphlet entitled 
Cancer Facts for Women, the Canadian Cancer Society reminds us that ‘the 
old truism, prevention is better than cure, holds good for cancer.’ 
However, the next sentence is contradictory and encourages women to 
remember that the earlier a disease is discovered, the better the chances 
for a cure. This is a recurring theme in a pamphlet from the Halifax Breast 
Screening Clinic (published by the Canadian Cancer Society), as 
demonstrated by a section entitled ‘How Can You Protect Yourself From 
Breast Cancer?’ Their recommendations include mammography, physical 
examination, breast self-examination and a healthy diet.

The majority of the pamphlets and brochures promote 
mammography and breast self-examination. However, it is important to 
clarify that these are tools of detection and not prevention. Detecting a 
tumor, however early in its development, precludes prevention 
(Steingraber, 2000). If prevention is mentioned within the literature from 
the local health care organizations the trend is strictly toward diet and 
exercise. This emphasis on lifestyle factors places the responsibility on the 
individual, with success or failure dependent upon how one chooses to 
live one’s life. Brown et al. (2001) had similar findings in their 
examination of the print media coverage of environmental causation of 
breast cancer. They found little coverage of possible environmental 
causation, instead articles focused on individual responsibility for diet 
and other personal behaviours. Thus, these factors place personal 
responsibility on women for preventing breast cancer (Brown et al., 2001).

A sociological analysis demonstrates the long-term perspective of 
health and illness, examining disease within societies and different 
environments, focusing on how these affect our health. It moves from 
considering individuals to considering groups of individuals, 
communities and larger social units, and in doing so, shifts the 
responsibility for health from the individual to the social, economic, 
political, and environmental realms (Simpson, 2000).

Dr. Sandra Steingraber provides an interesting example of the 
medical establishment’s history of ‘blaming the victim.’ In 1832, at the 
height of a cholera epidemic, the New York City medical council 
announced that cholera’s victims were imprudent, intemperate or prone 
to injury by the consumption of improper medicines. Lists of cholera 
prevention tips were posted publicly with advice ranging from avoiding 
drafts and crude vegetables to abstaining from alcohol. Decades later, 
improvements in public sanitation finally brought cholera under control 
and the pathogen responsible for the disease was finally isolated by 
Robert Koch in 1883. The behavioural changes urged by the 1832 flyers 
were not entirely without merit, uncooked produce was an important
route of exposure, but it was fecal-borne bacteria, not a healthy-eating lifestyle, that was the cause (Steingraber, 2000).

The emphasis on lifestyle is evident in the public educational literature on breast cancer. Women are encouraged to exercise, lower the fat in their diets, be aware of their family history, perform breast self-examinations and receive regular mammograms. Public education on the topic of breast cancer emphasizes personal habits rather than the possibility of chemical carcinogens as the underlying cause of the disease. Breast cancer like cholera before it, has been framed as a problem of behaviour rather than as a problem of exposure to disease-causing agents (Steingraber, 2000).

The ‘Seven Steps to Health’ appear in five of the public education pamphlets (Breast-Self Examination: How to Check Your Breasts, 1997; Facts on Breast Cancer, 2000; Cancer Facts for Women, 2000; Breast Health: What You Can Do, 2002; and Breast Self-Examination: What You Can Do, 2002). All of this material was published by the Canadian Cancer Society and the ‘Seven Steps for Health’ are found in key focal points in the pamphlets, either on the back or the first page when it is opened. The ‘Seven Steps to Health’ states:

Research continues to show that some cancers can be prevented. Take these steps now to reduce your risk of developing [breast] cancer:

1. Be a non-smoker and avoid second-hand smoke.
2. Eat 5 to 10 servings of vegetables and fruit a day. Choose high fibre, lower fat foods. If you drink alcohol, limit your intake to 1 or 2 drinks a day.
3. Be physically active on a regular basis: this will also help you maintain a healthy body weight.
4. Protect yourself and your family from the sun. Reduce sun exposure between 11 a.m. and 4 p.m. Check your skin regularly and report any changes to your doctor.
5. Follow cancer screening guidelines. For women, discuss mammography, Pap tests and breast exams with a health professional. For men, discuss testicular exams and prostate screening with a health professional. Both men and women should also discuss screening for colon and rectal cancers.
6. Visit your doctor or dentists if you notice a change in your normal state of health.
7. Follow health and safety instructions both at home and at work when using, storing and disposing of hazardous materials.

While there is some mention of toxins or contaminants, this still places the onus of responsibility on the individual and ignores environmental toxins and contaminants that one cannot control. Scientists and activists recognize that we are exposed to thousands of chemicals every day. Synergistic effects of exposures often occur over long periods of time and cause-and-effect relationships are difficult to establish. Thus, focusing on how chemicals alter breast cancer risk in the context of multiple contributing causes will be vital for future breast cancer research (Evans, 2006).
On the surface it is difficult to understand why an industrialized society does not focus on the prevention of exposures to carcinogens. A primary prevention approach could save thousands of lives, as well as reducing the need for costly diagnostic techniques, treatment and care, which cost $14.5 billion in 1998 in Canada (Murphy, 2002). In 2000-2001, the Canadian Cancer Society devoted $633,217 to research on contaminants other than tobacco, which accounts for only 1.4% of their research budget. The Canadian Institute of Health Research’s cancer research division spends just $3 million per year on environmental agents and the Canadian Breast Cancer Research Initiative spent less than $2 million on environmental and toxic-chemical research between 1993 and 2001, approximately 2.5% of their total funding (Murphy, 2002).

Clinical trials are extremely costly and time-consuming because cancer has such a long latency period (Murphy, 2002), but environmental research presents unique challenges of its own. It is difficult to determine the exact impact of one pollutant when we are surrounded by thousands of untested chemicals; we are exposed to these chemicals over a lifetime and pinpointing the time between exposure and developing cancer may be several decades; and assuming you could find a group of unexposed individuals, is it ethical to create a control group given the potential deadly effects of organochlorines and other toxic substances?

When it comes to hazards in the workplace and environment, the safe response, which has come to be accepted as scientifically responsible, is to say nothing and do nothing until we have clear proof that the hazard actually makes people sick. When we cannot produce definitive statistical proof of a toxin’s specific harmful effect, supported by a clear theory of the mechanism of that effect, it has become standard to say that we simply do not know whether the toxin is harmful or not. The apparent absence of harm becomes grounds for inaction (Davis, 2002). It seems reasonable that scientists want high-quality, evidence-based research, however it sometimes acts as a stalling mechanism for suspected, probable and even proven carcinogens. For example, thousands of North Americans died while industry and regulators debated over the carcinogenicity of benzene. We now know that benzene causes cancer (it is still a by-product expelled from tailpipes all over Canada), but many more might have died if the cancer establishment had not undertaken a precautionary campaign against tobacco in the 1960s. Tobacco’s main carcinogen, benzo(a)pyrene, was not determined until 1996 (Murphy, 2002).

The limitations of science and the time required to obtain absolute proof has led many North American physicians and scientists to prescribe the ‘precautionary principle’ as a guide for the prevention of illness. The precautionary principle states that ‘when there is reasonable suspicion of harm, lack of scientific certainty or consensus must not be used to postpone preventative action’ (Institute of Science, 2000). The precautionary principle puts the burden of proof onto the innovator or perpetrator, they must
demonstrate beyond reasonable doubt that a given product is safe, so society does not have to prove a product harmful, in what may be years of a potentially deadly struggle against government and industry (Institute of Science, 2000).

Many survivors and environmentalists are underwhelmed by the primary-prevention plans developed by cancer agencies because they leave little to no precautionary advocacy in the short term (Murphy, 2002). A new study, ‘Breast Cancer: An Environmental Disease: The Case for Primary Prevention’ argues that there are specific barriers against a primary prevention focus. These barriers include:

- Acceptance—Our society has been conditioned to think of breast cancer as a fact of life and as unpreventable;
- Confusion—Women are taught that early detection and treatment are the answers to breast cancer;
- Fear—The fear linked to all forms of cancer leads to resistance;
- Fixation—Our society is fixated on treatment and control of disease, rather than primary prevention;
- Ignorance—The narrow focus on lifestyle factors as the key to prevention;
- Invisibility—The lack of visibility in many carcinogenic chemicals (no odour or colour) creates an “out of sight, out of mind” mentality;
- Procrastination—Policy makers often call for more research when prevention is concerned;

The most damning criticism against Canadian cancer agencies surrounding primary prevention stems from their past reluctance to inform the public about known and suspected carcinogens and to lobby for their elimination or replacement (Murphy, 2002).

It is interesting to examine the evolution of the Canadian Cancer Society’s Seven Steps to Health over the years. The Breast Self-Examination pamphlet from the Breast Screening Clinic was published in 1997 and Step 7 states: ‘At home and at work, follow health and safety instructions when using hazardous materials.’ In 2000, Step 7 was slightly altered to say: ‘Follow health and safety instructions at home and at work when using, storing and disposing of hazardous materials.’ When asked why Step 7 offers advice on handling hazardous materials and does not urge people to avoid known carcinogens altogether, Julie White, the Canadian Cancer Society’s CEO, replied that ‘[i]t’s sort of wussy,’ and said that all materials should be up to date within the year (Murphy, 2002, p. 32). This interview was published in the March/April 2002 issue of This Magazine,
but two of the pamphlets that were revised and printed in July 2002 (Breast Health: What You Can Do and Breast Self-Examination: What You Can Do) still have Step 7 stating ‘Follow health and safety instructions both at home and at work when using, storing and disposing of hazardous materials,’ nearly identical to the advice from seven years prior. This research was completed in April 2003 and at this time the Canadian Cancer Society’s website had the same advice as the pamphlets (Canadian Cancer Society, 2003). After revisiting the Canadian Cancer Society’s website, Step 7 remains the same as of October 2005. However, they have added a separate link entitled ‘Environmental Contaminants’ (Canadian Cancer Society, 2005).

Critics point out that the cancer ‘establishment’ (mainstream cancer hospitals, National Cancer Institutes, cancer societies, etc.) has been reluctant to fund research on pollution prevention because of its close ties to the pharmaceutical industry. Ironically, there are companies who both pollute and benefit directly from the effects of pollution. General Electric and Dupont have the most toxic Superfund sites in the United States, which are uncontrolled or abandoned places where hazardous waste is located (US Environmental Protection, 2003) and they also sell more than $100 million in mammogram machinery and x-ray film every year (Epstein et al., 1998). AstraZeneca, a transnational biosciences corporation manufactures the cancer drug, Novaldex, with profits of $470 million per year, as well as the world’s best selling breast cancer drug, tamoxifen. AstraZeneca is the founding sponsor of Breast Cancer Awareness Month observed annually in North America during October and controls the promotional materials published for this campaign. Until recently, in addition to selling drugs to battle cancer, AstraZeneca had a $300 million per year business selling the carcinogenic herbicide acetochlor, as well as pesticides and chlorine- and petroleum-based products; all of which are harmful chemicals linked to breast cancer (Epstein et al., 1998; Potts, 2004b).

The article in This Magazine does say that the society has pulled old brochures on healthy eating that dismissed pesticide concerns, stating ‘[d]on’t let yourself get sidetracked by worries that are unproven or exist as remote possibilities’ (Murphy, 2002, p. 32); but most cancer agencies maintain that advocacy on environmental carcinogens is simply not in their mandate (Murphy, 2002). While cancer charities undoubtedly contribute to the community in positive ways, we must continue to examine such organizations critically, as many cancer activists and survivors already do. The fact that cancer charities continue to take sponsorships and corporate donations from notable Canadian polluters sends the public a conflicting message. The Canadian Cancer Society lists
donors such as Noranda, Inco and Falconbridge; all in the top-10 list of Canadian companies releasing known carcinogens (Murphy, 2002). The Canadian Cancer Society does not accept funds from companies linked to tobacco and have recently put their policy on pharmaceutical and biotech companies under review, but they have not devised a restriction on corporate polluters (Murphy, 2002).

**CONCLUSIONS**

*The Importance of Prevention in Public Education*

In ‘Controversies in Breast Cancer Prevention,’ Christy Simpson outlines three ideological positions which can be identified in discussions of health and illness. The ‘technology ideology’ is concerned with the belief in technological and pharmacological solutions to problems of health and illness and points to the success of new technologies in curing individuals with disease. In many cases the use of a new technology or drug will help a number of people, however these options will not be successful for many and may even do harm to some. The large degree of positive attention given to new medical breakthroughs within contemporary culture makes it difficult to question or resist this technological push and to pursue other options for dealing with problems of health and disease, such as reducing the number of carcinogens in our environment. The dominant belief in the value and worthiness of the biomedical model and in science helps to reinforce this ideology (Simpson, 2000). It is important to remember, however, that commercial interests may conflict with the best interests of women because breast cancer has become a source of economic gain (Zones, 2000). Simpson argues that the interests of ‘big business’ in promoting the technology ideology cannot be ignored because the profit to be made from new drugs and technologies is staggering (Simpson, 2000). For example, Taxol, the largest selling cancer drug in the world with estimated sales of $1.2 billion in 1998, has been used for years as a treatment for metastatic breast cancer. Although Taxol was discovered and developed by the American federal government at the taxpayers’ expense, it is now produced and sold by Bristol-Myers Squibb. Bristol-Myers Squibb charges a wholesale price of nearly five dollars per milligram, although it costs less than forty cents per milligram to manufacture. This makes the drug out of reach for many patients who may require several hundred milligrams per month over a period of many months (Zones, 2000).

The second ideological perspective is the ‘personal responsibility ideology’ which emphasizes the promotion of personal or individual responsibility for health. The assumption is that if this is done properly and with commitment, most diseases or health problems will be avoided. While it is true that certain provisions, such as a healthy diet and exercise,
can decrease one’s chances of getting a number of diseases, following these provisions should not be taken to mean that one will never become ill. The emphasis on lifestyle factors promotes a short-term perspective on health and illness, placing the responsibility on the individual, with success or failure dependent upon how one chooses to live one’s life. Individual women are and should be concerned about breast cancer and will want to do everything possible to avoid getting this disease, but the focus on personal responsibility for avoiding breast cancer should not obscure the risks created by living in a polluted environment and the need for social responsibility with respect to health and disease (Simpson, 2000).

The third dominant ideological discourse, the ‘social ideology,’ addresses health and illness from a broader perspective. A sociological analysis demonstrates the long-term perspective on health and disease, examining disease within societies and different environments, focusing on how these affect our health. The social ideology moves from considering individuals to considering groups of individuals, communities and larger social units, and in doing so, shifts responsibility for health from the individual to social, economic, political, and environmental realms. When discussing the importance of cancer prevention, Robert Proctor suggests that, ‘the value of the social perspective... is that it allows us to broaden our understanding of where one might intervene in the process of carcinogenesis’ (Simpson, 2000, p. 137). If the personal responsibility ideology is shaping how we, as individuals and as a society, think of carcinogenesis, we will be focused on an individual person, what predisposes them to get cancer and what each of these individuals can do to prevent their getting cancer. In contrast, if the social ideology is shaping how we think of carcinogenesis, the focus will expand from individuals to looking at groups of individuals in relation to the environments in which they live and work. New options for the prevention cancer, and specifically breast cancer, will present themselves. These options may include creating safer, healthier workplaces and enforcing stricter controls on the disposal of hazardous wastes (Simpson, 2000).

The public education literature being distributed from the Halifax Breast Cancer Screening Clinic, the Canadian Breast Cancer Foundation, the Canadian Cancer Society, and Cancer Care Nova Scotia is all important, clear and easy to understand, making them accessible to a wide audience. The pamphlets and brochures focus on emphasizing awareness with breast cancer statistics, early detection, the doctor-patient relationship, methods of treatment (surgery, chemotherapy and radiation), and raising funds to research new treatment methods. This literature is likely influenced by the biomedical model which focuses on anatomy and physiology and causes of disease at the cellular, hormonal, and genetic levels rather than behavioural, social and environmental
contributions to disease (Rosser, 2000). The social ideology, however, recognizes the accumulated knowledge linking toxic chemicals found in the environment with the increasing breast cancer rates and means we must focus our energies and efforts on prevention (Sherman, 2000).

The biomedical model of disease currently provides the best options for curing patients with breast cancer, but as scientists announce new fields of research in breast cancer studies, behavioural, social and environmental factors must become a part of the climate for this research. Continuing to focus solely on the cellular, hormonal and genetic causes represent a reductionist approach to the problem (Rosser, 2000). The old adage “an ounce of prevention is worth a pound of cure” is more than applicable to this situation, therefore it is of the utmost importance that information on prevention is available to women; recognizing the role played by social, economic and environmental factors.
REFERENCES


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- Forced marriages and women’s health
- Female circumcision and genital mutilation
- Wife beating, kitchen fires, honour killings
- Rape and war and women’s health
- Cultural differences in women’s health
- Traditional healing, and women’s health circle
WOMEN’S HEALTH & URBAN LIFE:
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SUBMISSION GUIDELINES
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Four copies of the manuscript should be submitted to (electronic submissions are not accepted):
Dr. Aysan Sev’er, Editor
Department of Sociology, University of Toronto at Scarborough
1265 Military Trail, Scarborough, Ontario, Canada, M1C 1A4

2. SUBMISSION:
Submission to the Women’s Health & Urban Life Journal (WH & UL) is a representation that the
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References should conform to the American Psychological Association’s (APA, 4th edition)
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University of Minnesota Press.
Government publications:
Statistics Canada. (1994). Processing of sexual assault cases (Cat. 85-538E). Ottawa, Canada:
Canadian Centre for Justice.