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# ENGENDERING SPIRITS: ALCOHOLIC SELF-HELP AND EMPHASIZED FEMININITY

by

ABBY JACKSON

Under the Direction of Dawn Baunach

## ABSTRACT

Gender theorists have long posited that the social construction of gender encourages women to embody specific ideals of femininity. Any circumstance or situation, then, that threatens a woman's ability or capacity to fulfill these ideals is regarded as abnormal and often receives large amount of interest. This thesis provides a critical analysis of the gendered practices used in conjunction with the ideas, messages, and advice given to women with alcohol dependence. By doing a qualitative content analysis, I explored how the concepts of emphasized femininity are presented in self-help literature for alcohol dependent women. My findings show that gendered ideas about alcoholic recovery are mainly constructed through white, heterosexual, middle-class lenses that perpetuate feminine subordination.

INDEX WORDS: Alcohol, Femininity, Sociology, Feminism, Gender, Self-help, Medicalization

ENGENDERING SPIRITS: ALCOHOLIC SELF-HELP AND EMPHASIZED FEMININITY

by

ABBY JACKSON

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2012

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2012

ENGENDERING SPIRITS: ALCOHOLIC SELF-HELP AND EMPHASIZED FEMININITY

by

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August 2012

**DEDICATION**

This thesis is dedicated to my grandfather Tuck Jackson who taught me the values of patience and persistence.

## ACKNOWLEDGMENTS

I must extend my sincere gratitude to my thesis committee members and their dedication to the field of sociology. First, special thanks to my chair, Dr. Dawn Baunach, for your guidance, optimism and support throughout the entire process. Second, to Dr. Anthony Hatch for offering input, providing critiques and instilling in me a lasting proficiency to question the absences. And to Dr. Wendy Simonds, for inspiring me as a feminist writer and for encouraging the critical analysis of the self-help genre in the first place.

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## 1 INTRODUCTION

Alcoholism, or more specifically “alcohol dependence,” was added to the list of diseases in The Diagnostic and Statistical Manual (DSM I) in 1953. The DSM I’s definition of dependence emphasized tolerance to drugs and saw any physical withdrawal symptoms from them as being the key components to diagnostic procedures. At this time, an estimated one out of every seven alcoholics was a woman. As of 2010 reports, the estimated proportion of women to men alcoholics has risen to almost half (Barnes 2011).

As the percentage of diagnosed cases of alcohol dependence in women continues to rise, treatment options for the disorder diversify. Varying styles and methods for treatments are largely reflective of the time-based, cultural conceptions concerning dependence. For example, during the Puritan Era the church was regarded by the general populace as the only institution effective at treating alcoholism, as alcoholism was considered a moral failing (Elias 1978). In the late 19th century as a disease model gained ground (Levine 1985), doctors and physicians were solicited as the facilitators for overcoming addiction. Today, a considerable number of remedial options are available that reflect the current multiplicity of cultural and sociological ideas about alcohol consumption. A number of persons with alcohol dependence continue to use religious or spiritual support for controlling their ailment; others take a wholly chemo-biological approach by utilizing medically assisted detoxification therapies (Grucza 2008); and still others focus exclusively on psychological management and seek remedies through cognitive and/or behavioral therapies.

Common to all treatment options though, is the role that the individual is expected to assume in their own healing process. Because of the “personal responsibility” mantra (Johnson et. al 1996), a glut of self-management literature is marketed towards alcoholics in their personal quest for health. This genre of literature is large and expansive enough to offer individualized plans targeted toward topics like

the patient's religion, age, and, for the purposes of this study, the patient's gender. Yet unlike religious identity and age, self-help books that use gender as a thematic frame must work in tandem with gender, as gender does not allow for other identities to assert themselves without getting entangled in and modifying themselves to it. Gender is a significant and pervasive social construction, yet conceptions about the proper constitutions of gender are reiterated, maintained, and perpetuated through numerous institutional and cultural conditions (Stets and Burke 1996), including the genre of self-help.

For the structure of this thesis, I will first review the literature on the culture of self-help. The section that follows is a summary of the framework for analysis of study: emphasized femininity, in which I will introduce Connell's theory of emphasized femininity and the recent contributing theories that expand it. The hypotheses follow. Then I justify my process for selection of texts and defend the methodological approach I utilized. I examine and then discuss the results. Lastly, I re-visit my hypotheses, discuss the strengths and weakness of my thesis, and highlight the significance of this study in terms of the political implications of gender within self-help books.

## 2 LITERATURE REVIEW

### 2.1 The Self-help Genre

Self-help books represent an ever-increasing and profitable genre of literature with close to \$8 billion annually in profits (Salerno 2005). Beyond basic print media are the growing number of websites, TV shows, and at-home tool kits offering psychological services that are intended to help individuals solve their problems. While best-selling books such as *The Road Less Traveled*<sup>1</sup> and *Who Moved My Cheese*<sup>2</sup> are not gender-specific, studies have shown that the self-help industry specifically targets women consumers and that women are the primary purchasers (Wilson and Cash 2000). Research has failed to show why women are more compelled to solicit advice from books than men, but women's participation in a self-help culture is clear.

Many consumers select and peruse self-help products on their own accord; others have been referred to the texts by their doctors or psychotherapists. Presently, self-help literature represents the mass commodification of therapeutic assistance. Self-help books provide counseling, advice, and guidance to the large quantities of women who choose to read them. They are relatively cheap (compared to traditional therapy) and allow for flexibility in terms of both time commitment and emotional involvement. By providing a constant source of encouragement and tone of authority, they set up a relationship of communication and therapy that is essential to all rehabilitation. But unlike the prototypical client/therapist dialog (where the relationship grows mutually and the inequalities of the therapist are often clearly acknowledged), self-help is one-sided.

The proposals and recommendations in these books are allegedly used for personal development and self-awareness, but it has been suggested that sometimes the advice given is

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<sup>1</sup> *The Road Less Traveled* by Scott Peck was published in 1978 sold more than ten million copies. It documents Peck's ideas about spiritual development through delayed gratification.

<sup>2</sup> *Who Moved My Cheese?* remained on the New York Times business bestseller list for almost five years and is a business fable designed to motivate readers to "move on" when laid off or fired from their employment.

antagonistic to the agency or the empowerment of the reader. In the 1970s, the American Psychological Association (APA) cautioned therapists against assigning reading materials to patients. The APA was concerned about the efficacy of using literature in therapy and went so far as to claim that it could often be harmful. The APA viewed these materials as problematic, as they can cause fallacious self-diagnoses, can mislead patients with quick and easy promises concerning future results, or they can fail to influence changes in personality in a lasting or impactful way (Forest 1991). Schilling (1993) suggested that self-help readers exhibit an unquestioning acceptance of their own pathology and will blindly adhere to the solutions offered by the author, however ineffective or illogical they may be.

Despite these concerns, the self-help genre has become so prolific that it has jumped into the medical realm of addiction therapy. This “recovery” literature may contain tones of pathology and medically-orientated notions throughout, but it still functions as to “promulgat[e] the notion that psychological phenomena fit into the same frameworks as physiological disease” (Simonds 1992, p. 208). Like in most self-help books, societal or collective forces (e.g. poverty, lack of education) that contribute to substance abuse are largely ignored in preference for the individualized solutions of pop psychology; the sufferer is left solely responsible for orchestrating their own cure. Identity re-formation is often the “medicine” prescribed to individuals to help them overcome their afflictions. The identity-as-growth message that is continuously reiterated by self-help authors (Simonds 1992: 191) is especially troubling when we stop to examine *which identities* are being espoused.

Sociologists and psychologists have long investigated the ways in which the self is an active and creative agent in the formation and the confirmation of identity. People select specific identities that legitimize their interactions and imbue their lives with functionality and meaningfulness. Yet identities are not created in a vacuum but are negotiated in conjunction with others and the perceived judgment they provide, for example Cooley’s (1902) “looking-glass self” and Bandura’s (1991) self-regulation. Self-

help is a cultural instrument that provides its readers with the language, meanings, and stories used toward the construction of identity.<sup>3</sup>

Self-help has been shown to offer comforting stereotypes, deflecting readers' apprehensions toward the stories of deviance, and away from their own, possible pathologies. Yet the social comparisons available to readers of self-help have been shown to have a final effect of reader self-awareness and introspection. The reader's attention ultimately moves from the generalized other and toward either the condemnation or acclamation of the self. Identities are formed and re-formed as actors objectify themselves by employing linguistic labels of their objectifications (Perinbanayagam 2000). Self-help can therefore be seen as a potential agent of influence, as successful fashioning of the "healthy" body relies ultimately on internalization of standards, rules, and norms.

Self-help could be providing more than just the construction and internalization of a deviant identity, but could be functioning as an instrument of acculturation. Like all literature, self-help is a product of cultural and historical circumstances and reinforces their ideological power. Although self-help has put mental health in the public eye and urged people to address and recover from ailments, it is far from being an apolitical entity. Self-help constructs and details how readers should understand their relationship with their pathologized bodies and make choices about behaviors and attitudes. These constructions, under the guise of legitimacy, are neither wholly objective nor scientific, but are closely related to dominant social constructions and perspectives of the time. Self-help alcohol dependence discourse may be not only what produces women's identifications and stories with alcoholism, but may also function to situate and reconstitute their associations with femininity.

### **2.3 Theoretical Framework: Emphasized Femininity**

Gender is a strong, salient identity that it is often considered a master identity (Hughes 1940) because it not only defines a person's background but is evoked across a large number of settings and

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<sup>3</sup> Step one in AA is the admittance of dependence and the identification with alcoholic pathology.

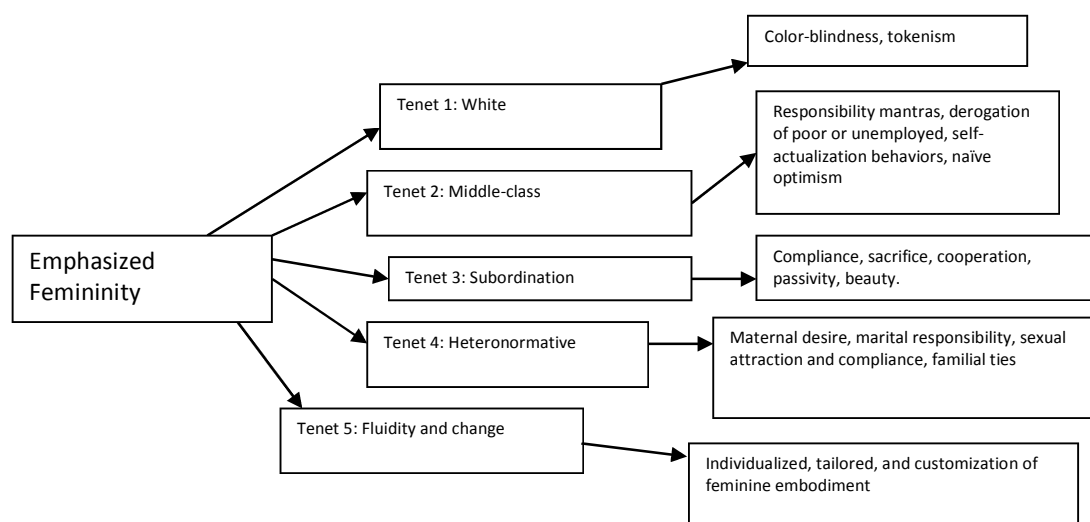
situations. Even when additional categorizations occur, such as occupational status or sexuality, the fundamental understanding of a person as male or female becomes cognitively nested within those categories (Brewer and Lui 1989, Stangor et al. 1992). Studies have shown how feminine identities are “othered,” and subsequently marginalized (Luke 1994; Proweller 1998). The dichotomy of male and female has broader implications as these binary constructs imply not only difference but inequality.

In 1987, R. W. Connell wrote on gender hierarchy in society and the global dominance of men over women. She created the concept of hegemonic masculinity, defining it as “the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women” (77). Hegemonic masculinity is not what men who are powerful *are* but what sustains their power. The hierarchy of patriarchal domination is embedded within many social networks. Hegemonic masculinity is the cultural endorsement of the normative ideals of male behavior (aggression, strength, self-reliance) that contribute to the subordinate position of women. Many women willingly submit to patriarchal domination without being threatened, coerced, or brutalized by men, either collectively or individually.

Later, Connell began theorizing about power structures for women and she reasoned that the social construction of femininity lacks the organizational hegemonic dominance over the other gender that is inherent to hegemonic masculinity; therefore a concept of hegemonic femininity is fallacious. In response to this, she coined the term *emphasized femininity* (Connell 1987) to describe the ideologies and behaviors that are oriented to accommodating the interests and needs of men. Emphasized femininity theory posits that the symbolic construction of gender encourages women to embody certain kinds of cultural ideals such as beauty, passivity, sacrifice, and maternal responsibility. Beyond these ideals are specific social attributes implicit in the emphasized femininity discourse: all-white, middle-class, heterosexual, child-bearing, and nuclear-family based.



It is important to acknowledge that Connell's theory allows for women's agency in creating alternative feminine paradigms such as lesbianism, promiscuity, "bad ass" girls, and authoritative women. Although actual femininities may be diverse, she claimed that all forms of femininity are constructed within the context of the subordination of women to men. Women who exhibit a deviant form of femininity are still expected to maintain and assert superior, positively evaluated, or emphasized behaviors, and identities. These identities are institutionalized and relegated to both private roles (e.g., mother, wife) and public roles (e.g., secretary, nurse, waitress).



**Figure 1: Emphasized Femininity**

Connell's gender theories were initially criticized as being inchoate, reductionist and two-dimensional (Demetriou 2001). In order to conquer these weaknesses without jettisoning the theory completely, gender theorists extrapolated on Connell's original emphasized femininity theory, extending and developing it into other realms of social oppression. They reason that the "feminine" is not simply a construct of patriarchal subjugation, but is created in tandem with other social assemblages such as race, class, and sexuality. The inclusion of these social variables adds complexity and color to the theory of emphasized femininity and elucidates the ways in which the narrowed conception of "proper" womanhood is comprehensive of further tenets beyond just the gender dichotomy.

Tenet 1 of emphasized femininity is its association with white exclusivity (Chapkis 1984; Collins 2004, 2005; Crenshaw 1989; Espiritu 1997). Emphasized femininity essentializes femaleness and womanhood by assuming women's experiences are defined—or most accurately reflected—by white women's experiences. In a culture that privileges their race, white women's production of femininity is superior to the forms displayed by racially and/or ethnically subordinated women. White women are monolithically constructed as independent, self-confident, assertive and successful (the same characteristics as white men albeit in a less aggressive form).

The standardized yet pervasive imagery of the white, Western woman has created a representational mandate for many women that is not only impossible to obtain but serves to denigrate and objectify women of color (Chapkis 1984; Collins 2005). For example, Patricia Hill Collins (2004) explains how the elevated images of white womanhood need devalued, stereotypical images of black womanhood (i.e., the mammy, the matriarch, and the whore) in order to maintain credibility. The “abnormality” of black femininities is analogous to the “controlling images” that Espirtu (1997) showed surrounding Asian women: hyperfeminized, dutiful, passively weak, quiet, and sexually exotic. The “white is right” adage informing the discourse surrounding femininity fails to provide a place for mutually distinct or diverse perspectives of race-based identities.<sup>4</sup>

Tenet 2 of emphasized femininity is the various ways it serves to buttress the necessary characteristics of achieving a middle-class existence (Bartky 1988; hooks 1984; Morantz 1977; Pyke 1996). Gender is experienced differently based on socioeconomic status, yet middle-class virtues such as acquisition of money, industry, and a stellar work ethic are habitually enforced in discourse about proper femininity (Bartky 1988). The middle-class prescription for femininity is unattainable for most

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<sup>4</sup> The white centrism is particularly troubling considering the increasing number of ethnic minorities with alcohol dependence and the alcohol industry's effective advertising schemes marketed towards marginalized segments of the population (Alaniz and Wilkes 1998).

women, as the determinants of a person's class status are often out of their direct control. Therefore, the assumption that all women can embody a middle-class subjectivity is fallacious.

Tenet 3 of emphasized femininity is the prominence of female subordination (Chapkis 1984; Lips 2000; Schippers 2007). Schippers (2007) expands on Connell's concept of hegemonic masculinity by explaining how the masculine characteristics of physical strength, the ability to use interpersonal violence in the face of conflict, and authority are symbolically paired with the complementary and inferior qualities attached to femininity including physical vulnerability, an inability to use violence effectively, and compliance. This subordination is defined not only in reference to relationships with others but with women's embodied relations with themselves and, mainly, their quest for beauty. Chapkis (1984) describes how women's power is stripped from them by a culture that implies "the body beautiful is woman's responsibility and authority" (14). This beauty standard is an elemental part of self-help ideology, as Simonds (1992) explains how the "makeover" has come to represent the central story of feminine metamorphosis: "If you don't like it, change it; dress up your assets and hide the ugly parts" (224).

Self-help's emphasis on self-blame may be encouraging female subordination. Simonds (1992) reveals the way self-help authors weave an ironic story of how women are omnipotent, and yet powerless, over their problems. By illustrating harsh, smothering mothers or archetypal illustrations of overcommitted lovers, authors hold women responsible for creating and maintaining problems for themselves and others. Self-help books are filled with common labels that work against women in an attempt to codify certain behaviors. Women are encouraged to reflect on and amend their behaviors in accordance with the author's idea of rightful relationships, which often include women's sensitivity to solely the man or the family needs, sacrifice, and the perpetuation of gender inequality. Women's self-improvement efforts must be balanced on a thin tightrope of "healthy" self-introspection and individual advancement but never tip over into overt narcissism nor complete liberation.

Tenet 4 of emphasized femininity is heterosexuality (Butler 1990; Collins 2005; Lorde 1984). In Black Feminist Thought (2005) Collins explained how heterosexism is a system of power that serves the interests and ascendancy of ruling classes and legitimates their dominance. Prior to Collins, Judith Butler (1990) described how relationships of heterosexual difference are central to the conceptualization of gender. Heterosexual, erotic desire is a defining feature for both women and men and is what binds their binary, hierarchical relationship. The idealized sexual features of masculinity and femininity are complementary and serve as a rationale for social relations at many levels of social organization, including the family unit. Women's compulsory heterosexuality (Rich 1986) is institutionalized through embodied interactions and practices like marriage, conception, and child rearing.

Intrinsic in the narrative of heterosexuality is the glorification of the home and the triumph of domesticity. Ehrenreich and English (1989) in *For Her Own Good: Two Centuries of the Experts' Advice to Women* outline what occurred when industry and science gained ground and the home/work dichotomy was created during the Industrial Revolution: "Nothing could be more abhorrent from a romantic standpoint than the feminist program [to dissolve the home]" (p. 27). Thus the patriarchal ideology within the public imagination relied on not only nostalgia for the past but archaic imagery where women are pure yet morally inferior, beautiful yet weak, powerful yet in need of protection. These attitudes continue today to justify the persistence of gender inequality while legitimizing poor treatment against domestic workers (paid or unpaid). Ehrenreich and English (1989: 361) conclude that as even feminism hedges itself with the broad personal freedom philosophy of the self-help marketplace, the idealization of home life gains ground and the options for women become more and more contracted.

The last tenet of emphasized femininity is its fluidity (Connell and Messerschmidt 2005; West and Zimmerman 1989). Scholars have long noted that the content of masculinity and femininity are not static or inherent but are produced in on-going, dynamic, everyday social processes. Strategies to

contest the power dynamics of the hierarchical gender relationship are particularly effective at transforming specific, idealized feminine characteristics. Novel configurations of feminine characteristics are redefined as deviant and stigmatized in order to guarantee men's exclusive access to hegemonic gender characteristics.

The self-help genre is conveying to women constantly fluctuating descriptions of femininity. The descriptions are usually based upon whatever theory the author happens to be advocating. Some authors advocate for change, some for acceptance, some for development, some for anger, some for passivity. The long list of divergent approaches and unique behavioral cures may be expansive and exhaustive, but common ideological currents are running beneath the surfaces that point back to patriarchal oppression within femininity mandates.

I hypothesize that self-help literature for women who are alcoholics uses the current dominant cultural constructions about *emphasized femininity*. The gendering of alcoholism is associated with the proscriptions for being a woman, which are narrow, limited, and restricted to those characteristics aligned with emphasized femininity. Self-help books illuminate images of women prevalent in our society and explicate how directives towards feminine embodiment are decreed. Self-help literature could be recommending courses of action based on normative components of a gendered society, specifically gender suppositions and andocentric biases.

### **3 METHODS**

#### **3.1 Sampling**

Twenty self-help texts were selected for this analysis. Examining these books allowed me to explore how alcohol dependence is explained to women by the voices of the self-help movement. I aimed to gather books targeted toward women readers. I employed three separate search techniques to allow for a broad array of categorical views. Twenty books are by no means exhaustive of the literature available to women, but my search methods generated a list of popular books that are inclusive of a number of perspectives. The selection displays diverse authorships from unique experiences and backgrounds: doctors, psychologists, recovering alcoholics and literature from alcoholic support groups.

The first selection of books was chosen based on the top three-recommended reading materials for women according to Alcoholics Anonymous (AA) website catalog. AA is a mutual aid social group whose primary mission is to help people with alcohol dependence achieve sobriety. AA claims to have over 2 million members who receive some form of treatment or guidance annually. Rudy and Greil (1989) describe AA as a quasi-religious organization where spiritual transcendence is key to recovery. The inclusion of only three AA books out of a total of twenty in this study lies in the endemic selectivity of literature within the AA organization itself. AA's "twelve step" philosophy remains the core component of their recovery literature any subsequent books originating from the initial twelve steps, merely reinforce this philosophy.

The second category of books was chosen using the search engine Google.com by employing the query words: "self-help," "women" and "alcohol dependence." Eysenbach and Kohler (2002) appraised the methods used by consumers when they search for health information on the internet and discovered that users often explore only the first two or three links provided, with little to no regard for the credibility of a site. Using this information I picked the first ten books Google provides given that

there were no repeated books from category one. As one book were duplicated from category one, additional links were explored until ten unique books were identified. Google is the number one internet search engine, and its wide availability in public institutions such as schools and libraries, places of business, and private homes with internet access means the likelihood that an individual will use it to search for information is high. For these reasons, half of my selected books came from the Google search.

Lastly, to choose the final seven books I selected randomly from Amazon.com's website. The key words "self-help," "women" and "alcohol dependence" were used again as search terms. The total list was imported into a randomizer software and seven books were selected. Amazon is a widely used internet bookstore specifically tailored towards internet shoppers.

### **3.2 Procedure and Coding**

I used directed content analysis methodology for the purpose of this study. Content analysis systematically examines messages contained in the units of analysis, in this case self-help books, and allowed me to explore the fundamental questions of my research. Directed content analysis is often used to extend and validate prior theories. Due to the substantial prior research in gender theory and emphasized femininity, I could reasonably predict and predetermine the variables and themes of interest. The structured approach in directed content analysis allowed me to identify and operationalize initial categorizations and coding schemes, as the aforementioned theory of emphasized femininity indicated specific tenets and concepts. See Appendix B for the coding sheet.

I examined the texts for their content and structure in regard to the themes of my research questions: What are the ways that femininity is (re)defined in self-help for women with alcohol dependence? How are the tenets of emphasized femininity expressed in these books? My framework for approaching the texts rested in looking for particular personality characteristics and identities surrounding the concept of "being a woman" espoused in the text and how they conflate, engage,

legitimate, reproduce, and encourage emphasized femininity. Specific examples of emphasized femininity characteristics and their subsequent manifestations are as follows:

*White centrism.* A white-centered discourse lacks cultural or racial traditions or stories. It has a “colorblind” bias or simply ignores race altogether, insinuating that alcoholism is a disease experienced by all races/ethnicities equally. It tells “token” stories of minority women’s experiences with alcoholism reasoning that those specific stories are representative of the entire minority culture. Additionally, the discourse outlines for women characteristics they should display (assertiveness, sexuality or confidence), not recognizing these behaviors are experienced differently for different races.

*Middle-class.* Self-help has previously been shown to be directed towards the middle-class culture (Ehrenreich and English 1989; Starker 1989). A middle-class discourse is devoid of sensitivity to issues of poverty or lack of resources. For example, the author urges their readers to see a doctor and, if needed, take drugs or seek hospitalization as a part of the detoxification process with little regard given to the cost of these measures. Themes such as unbridled optimism, self-actualization and the personal-responsibility mantra contribute to the middle-class demand for self-help products, especially as the financial insecurity of the middle-class grows. Crass materialism is cloaked in a vague sort of spirituality, and the “religion” of self-help places blame on individuals for being poor or unemployed.

A middle-class discourse also assumes that luxury support networks exist for the readers where they simply may not, such as travel or vacation options, gym memberships, babysitters, employee healthcare, personal shopping services, or housecleaning. Additionally, because middle-class women may have a choice to stay at home where lower class women are dependent on earning incomes at places of business, self-help authors take this choice for granted, presuming that employment is simply a decision to be selected or not.

*Heteronormativity.* A heteronormative discourse is rife with assumptions about the readers’ supposed heterosexuality. It treats all women as if they have male partners and emphasizes the role



that their partners should be taking in response to the disease. It also assumes that women's primary responsibilities are familial ones: mothering, sexual and emotional obligations to spouses, caregiving to parents and the sick. It may persuade women to abandon alcohol because of the sexual and reproductive health risks involved, such as low sex drive or diminished chances for pregnancy. The discourse outright ignores the issues that same-sex couples face with alcohol dependence such as social alienation, lack of legal marital status, adoption difficulties or the fact that homosexuals are more likely than heterosexuals to become alcoholics in the first place.

*Subordination.* As explained in the first section of this thesis, a large part of self-help literature revolves around re-structuring the reader's identity to match their disease narrative. An alcoholic identity must, therefore, complement emphasized femininity's subordination criterion. Subordination discourses urge readers to submit themselves and their will over to their new identities and the "community" of recovery. New members must admit they are powerless and discuss their problems with older members who are always willing to offer advice. Lack of cooperation with authorities (including doctors, treatment programs, God and the self-help book itself) is deemed destructive to the healing process and readers are told to avoid it. Subordination also implies sacrifice, or the ability to put others before oneself. Women may be told to think of those who "love them" when they desire a drink instead of thinking about the ways this may be benefitting themselves. Or they may be told to remember a particularly guilt-inducing intoxication in order to shame them into sobriety.

A subordination discourse perpetuates emphasized femininity by narrowing the standards of feminine beauty and the means to obtain it. By treating alcohol dependence as a disease that will ruin the (flawless) body, self-help culture regards the destruction of the body as a major failing of women alcoholics. Insistence on beautifying behaviors are deemed as the means to which a woman alcoholic may "overcome" the compulsion to drink: shopping, exercising, eating healthy or dressing up.

*Fluidity.* While the above tenets of emphasized femininity are likely to be present in self-help, self-help may be challenging/modifying them at the same time. Yet because gender is culturally and historically contingent, any new definitions or manifestation that might originate are only likely to rearticulate feminine and masculine dichotomies. For example, a fluid dynamic encourages the expression of typically “masculine characteristics” in women like anger, strong yearnings for sex, or putting oneself first. Yet, this normalization of aberrant behaviors/feelings in women functions only in conjunction with the disease and the recovery process specifically. A fluid discourse likely encourages women to then abandon these behaviors and find their own form of womanhood, perhaps encouraging women to lose themselves in narcissistic pursuits like art classes or cooking lessons. The quest for feminine authenticity, even when posed as a self-reliant or individually directed path, is an elite value of the American, white, middle-class.

#### 4 WHITE CENTRISM

Critical race scholars have explored the ways in which race is both dichotomously and hierarchically constructed (Glenn 2002; Ferree, Lorber and Hess 1999). They theorize that the dominance of one race imposes a normalization of it, and yet renders it invisible at the same time. The same way that Man is genderless in gender hegemony, White is raceless in race hegemony (Dyer 1988). Meanwhile, the power of this one, dominant race renders its “opposites” variant and deviant. The data obtained in this study concurs with these previous studies, as numerous instances were found wherein the authors outright ignore race or ignore how gender is racialized, therefore problematizing versions of femininity that are not within a “white” conception of womanhood. When race was discussed, the authors either provided token stories of race or they negated the repressive aspects of racial oppression that can affect health and wellness outcomes. This chapter discusses how the data, through tokenism, the false democratization of health and healthcare, or the modeling womanhood as a raceless construct, adheres to fixed and dominate dichotomies of racial meaning.

Feminist sociologists value the individual, experiential knowledge. Yet the perspectives and experiences of many women— most notably, women of color— are lacking in the self-help literature selected for this thesis. When race was rarely acknowledged, “token” stories were provided. The story of “Louise” (Cary 1993: 217) represents one of these token stories. The author introduces her readers to Louise as an angry woman who allowed her out-of-control emotions to lead her to addiction. Unsurprisingly, her anger was attributed to the social conditions of Louise’s childhood, “A lot of it had to do with growing up in Atlanta under segregated conditions” (217). But, according to the author, Louise’s history in race-based oppression was no excuse for her drinking. Self-help posits that no amount of unfair external circumstances extenuate women from failing to take responsibility for their over-consumption.

Another token story was Iliff's (2008) "Fannie Mae." Fannie Mae likens her recovery experience to her experience with blackness as a child. During her addiction she would feel shameful and try to shower like "when I was little, I used to use a razor blade to try to scrape off my skin. I'd used bleaching cream to try to take off my color" (Iliff 2008: 45). Like Louise, though, excuses such as race or social shame are not sufficient for the continuance of alcoholic behaviors.

I had to stop using my race, my gender, and my history as excuses for either not doing something I really wanted to do, or as an excuse for my bad behavior (Iliff 2008: 48).

So, the author's inclusion of the token subject is dependent on their adherence to the submissive aspects of recovery.

The authors' intention with token stories may be representative of an attempt to diversify the book or as an attempt to be inclusive, but with the rare insidencies of tokenism comes the "othering" and "problemitizing" of minority races (Kanter 1977). The token stories exaggerate the boundaries of race and likely encapsulate the given subject into a stereotype, at best, or a negative racial trope, at worst. Token stories conceptualize Black or minority women based on dominant ideologies that maintain racism, such as the hypersexualization of Louise in the example above. Also, the heightened attention to race in the instances of tokenism may cause readers to believe racism and structural inequality were properly addressed by the author, when in fact they were not.

Another way race was managed in the books was through the negation of the environmental factors that affect recovery success rates for minorities. Self-help books have been shown to generalize and oversimplify complex social and/or physical phenomena and the ways in which these aspects of reality affect people differently. In this data, some of the authors express thoughts or opinions that indicate towards a "democratization" of alcohol dependence, both in its epidemiology and in its approach to treatment. For example, most of the self-help books introduce the subject matter of alcoholism by calling it the "great leveler." Christina (Wandzilak and Curry 2006) pronounces that in rehabilitation "[t]he housewife, the business owner, and the homeless girl were all there for the same

reason. Each of us had the same disease” (164). With the contention that alcohol dependence is democratically or egalitarian produced and experienced by individuals, exogenous factors that in reality affect health outcomes, including race, become invisible.

The color-blind discourse used throughout the data is likely a reflection of the morality-based determinism surrounding alcoholism, which has been constructing cultural ideas about alcoholism for decades (Ketcham and Asbury 2000). Moral determinism fails to recognize how racial oppression can create a culture of people with different vulnerabilities to illness. The authors’ insistence that alcoholism is not determined by environment factors is not only dangerous but completely erroneous, as occurrences of alcoholism have been shown to be correlated with poverty (Khan, Murray and Barnes 2002), minority status (Jones-Webb, Hsiao and Hannan 1995), prior stigmatizations (Room 2005) and mental illness (Menezes et al. 1996). Each of these factors alone increases the probability that addiction could occur, and we do not yet understand their combined effects. And while some self-help books may concede the social dimensions of alcoholism, they still emphasize the individual in the healing process:

Influences in our environment such as our living situation and socioeconomic and cultural issues. While none of these alone causes addiction, a mixture of them can be a recipe for addiction. . . .REASONS DON’T MATTER (Iliff 2008: 7).

Lastly, self-help authors use constructions of gender to erect a monolithic and color-blind idea of femininity, funneling “womanhood” down into narrow images that ignore how gender is racialized. White women authors often construct themselves as independent, self-confident, assertive (sometimes sexually) and successful, expecting their readers to do the same.

I care what people think of me more than I want to admit. Drinking swanky martinis and expensive wine was part of a party diva image I tried to manufacture for myself. I like people who stood out and spoke their minds (Wilhelmson 2011: 55).

I want to be the kind of mother who never talks about diapers or potty training. . .who makes husbands deeply uncomfortable (Brownell 2009: 62).

In public I am the rebellious swearing mama who is lively, saucy and driven (Brownell 2009: 61).

Swearing is my Higher Power (Brownell 2009: 93).

These stories fail to recognize that these behaviors would be experienced differently for women of different races, and these behaviors might serve to further denigrate or objectify women of color (Chapkis 1984; Collins 2005). Even in the subtext of self-help writing, the authors suggest that the “woman” gender is static, standardized and sometimes completely implicitly, as if there is some kind of universal law governing the behavior of all women, across all time, and in all settings. Because of these generalizations, the formations and the conceptualizations of “woman” can be seen to be isolated to whiteness. The dominant grouping becomes the unquestioned norm of femininity: it represents the unmarked model that describes and illustrates the lives of recovering women.

By privileging the experiences of white women, self-help both generalizes the understanding of addiction recovery and sets up a paradigm of white superiority. Individual empowerment, through the directives outlined in self-help, require black women to reject their experiences with race. It excludes the forces within the “matrix” of domination (Collins 2000) that affect black women and other non-whites that may be diminishing their capacity for health. Racism is re-produced by privileging Euro-American subjectivities over nonwhite subjectivities. Furthermore, because these dominate constructions go unquestioned, they hide the privilege that white women receive. Western ideologies are propagated, and gender and racial inequalities are fortified.

Tokenism, the perpetuation of the fallacious belief that alcoholism is an “equal opportunity illness,” and the “white-washing” of gender assemblages in recovery literature contribute the white-biasing of emphasized femininity. The danger of a white-centered form of femininity as it pertains to recovery literature is that alcoholism is not a disease experienced by all races/ethnicities equally. The statistics show that barely 10% of those who try for lifelong sobriety achieve it (Cary 1993). With this dire success rate, the social dimensions of addiction need to be acknowledged and scrutinized, with race and inequality being important aspects of that conversation. Racism and race should be acknowledged

as a variable and as a social configuration that affect and individual's access to health. Without an honest conversation about systems of racial and gender power, the quest for health and equality will continue to elude not only women but other, marginalized groups.

## 5 CLASS

Class position is an important part of the hegemony of gender, as middle-class women's socio-economic position better serves to accommodate the interests of men. Normative middle-class existence relies on a public/private dichotomy in order to shape gender roles in the workspace and within the private sphere of the family. This dichotomy, even when women work outside the home, bestows more power to the man both because of his earning power and the dependency his wife and children have on him. But middle-class women, while subservient to men in a number of ways, still have a relative degree of economic security, allowing them the flexibility and the safety to search for subjective forms of personal and professional autonomy, if desired. Beyond white-centered biases, the self-help books were shown to have a middle-classed partiality and status-based preconceptions.

Before concentrating on the advantages afforded to middle-class women in recovery, it is important to note how class privilege is abundant in the self-help recovery literature for women. Often the enjoyment of alcohol *began* in privileged atmospheres and continued re-initiating itself in situations of prosperity. Women speak of how they came to love the intoxicating elements of classy parties, preparing food and entertaining guests, and travelling (Kirkpatrick 1977: 17). Jill Kelly (2007) talked of her addiction days: "We cooked gourmet meals, drank bourbon cocktails like our parents and good wine like our friends, and entertained lavishly" (49). Women speak of how alcohol was often symbolic to them of elegance, refinement, and exclusivity.

New Englanders, or at least people from upper-crust Connecticut as I imagine it, have a preference for martinis as they reinforce an already ingrained social code of the body. . . . Martinis can femme up the butchest girl and make the most macho guy appear a tad fey. . . . The martini is a disciplinary apparatus, dictating not only the body's movements, but inescapably one's sense of self before the first sip it taken (Barreca 2011: 33).

[Bruce] was a connoisseur of whiskies; I was knowledgeable about wines from my years with Tom (Kelly 2007: 78).



I take myself to lunch on the town square amid elegant middle-class French people, white tablecloths, and solicitous waiters. . . .pretend I'm writing about important things, serious reflections on life and love (Kelly 2007: 73).

Many authors present the creative and glamorous associations that go with alcoholism: Dylan Thomas, Dorothy Parker, F. Scott Fitzgerald, Ernest Hemingway. Some admit that consuming alcohol can display an air of authority as many leaders, artists, and intellectuals are big drinkers (Fanning and O'Neill 1996: 13). But even glamour in drinking only goes so far, as Maggie states about F. Scott Fitzgerald's women: "Lushes all-- like luscious, but less flattering. . . .What is lush is often lovely. Unless it's a noun, and then it's a drinker. A female drunk, and decidedly unlovely" (Barreca 2011: 23).

Recovering women often lament over the loss of hobbies and lifestyles that confirm their wealthy status. For example, Fanning and O'Neill (1996) define the loss of a wine-making hobby as a negative of recovery (23). Yet recovery brings advantages too, that reveal a lifestyle of affluence as well.

I'd taken up drinking Pellegrino with a slice of lemon in a wineglass at home because I liked my stemware almost as much as I liked my wine (Wilhelmson 2011: 43).

You'll have more time for hobbies. . . .home improvement (Fanning and O'Neill 1996: 21).

[I'd] take myself to buy coffee . . . and sit in the café for a well-deserved break from the stresses of motherhood (Wandzilak and Curry 2006: 63).

Although recovery can, on the surface, look cheap (self-help is relatively inexpensive to buy and recovery programs are almost always free), the building of an alcohol free lifestyle can cause financial difficulties. The very notion of recovery is privileged in its commodification. Many authors recommend women shop around, "try on," and buy different means for health. As Fanning and O'Neill (1996) phrase it: "It's a buyer's market" (42). Most books employ women to go to therapists, enter detoxification treatment centers, take up acupuncture, get massages, and manage stress by hiring babysitters, cleaners, and yard maintenance crews. Even if these recommendations are state-subsidized or covered by healthcare, it still takes time and energy to perform the tasks regularly. The commodification of

health is unfair and wearisome, as Brownell (2009) admits when she realizes she inhabits a world where “happy endings can be purchased if one has correct change” (60).

Some books illustrate what a recovered woman’s life looks like compared to her days in addiction. These graphics include certain lifestyle elements that can be quite expensive. Examples include urging women to take up a daily yoga or workout regime, go back to school, mediate in a quiet place for at least thirty minutes a day, or begin soliciting alternative health like quoi dong or hypnosis.

Travel, dine out, go to concerts, plays (Fanning and O’Neill 1996: 141).

Grocery shop online and have it delivered to the house (Hatvana 2011: 60).

Get enough rest each night (Covington 2000: 74).

Note that in the last recommendation, sociologists have shown that even getting a full night’s sleep is a privileged advantage (Adams 2006).

Affluent lifestyle measures can even recommend that women change living locations. Although “geographics” (escaping locations with the hope of change, only to run into the same addiction patterns in the new location) are to be avoided, the authors admit that housing relocation can be beneficial to recovering women.

If you are surrounded by addicted people or live in a drug-infested community, moving away can help (Najavits 2002: 124).

If our home is a trigger, we may consider living somewhere else for period of time (Iliff 2008: 62).

When I left the South at the end of that year, I left behind all those triggers. It was a relief to live in an apartment where I had never had a drink (Kelly 2007: 105).

Authors also suggest traveling as a behavior to combat the stresses of recovery.

I’d go away on spiritual weekend retreats to commune with nature and animals. This led to my getting in touch with myself the first time in my life (Cary 1993: 167).

[M]ost of the first year of recovery I was raw and restless. I escaped my apartment on weekends, travelling long distances to stay with friends. . . just so my old routines, my old angst wouldn’t resurface (Kelly 2007: 114).

The medical attention women receive during their recovery also reveals the class privileged climate. Most went to detoxification clinics for weeks or months, expenses covered by others.

My almost year in the hospital with daily psychiatric treatment and the months afterward as an outpatient in a city apartment, my father's nest egg had slowly but irreversibly dwindled (Kirkpatrick 1977: 125).

The obliviousness to the financial realities and difficulties of most people makes this self-help literature, purposefully or not, targeted to middle- to higher-class women.

In addition to the affluent tone of self-help stories, women's adherence to the role of employee is surmised to be an essential part of the recovery lifestyle. Self-help authors often emphasize that women obtain steady employment, have a steady income, and be stellar employees within their career field. These manifestations are seen as signs that a woman is progressing correctly in her recovery. Virtues such as acquisition of money, industry, and a stellar work ethic are habitually enforced in the discourse about proper recovery.

AA knows that if the recovering person is ever going to succeed in life, he or she is simply going to have to learn how to be a good worker (Cary 1993: 53).

To help recovering alcoholics learn to be good workers, AA offers some handy little slogans to hang onto when the going gets rough: "Suit up and show up" reminds AA members that responsibility, reliability and persistence pay off. "Be a worker among workers" reminds them not to hang onto childlike expectations of being "special" at work, and not to demand unearned privileges (Cary 1993: 55).

Employment is mostly deemed to be essential because it keeps women busy. Whether through employment outside of the home, or through housework, busy-ness is thought to be a foundation of sobriety. As Hatvany (2011) says, "standing still puts me in too much danger of my drinking catching up to me. I'm terrified it might suck me back in" (192). Kirkpatrick's (1977) advice to readers is also to stay engaged: "On this first day of your new life, keep yourself very busy. The object is to try to overcome the obsessive thoughts about drinking that will plague you" (146).

Employment, coupled with sobriety, can also bring prosperity. Women are told their drinking has hurt them financially. Self-help gives optimistic examples of women who “made their fortune” when they stopped drinking. Cary (1993) describes a woman who went “from state aid to \$60,000 a year” (62) when she quit drinking. Alcoholism is portrayed as a chief hindrance to occupational achievement.

You may be an otherwise brilliant businesswoman with the exception of your attitude and actions in regard to your drinking (Kirkpatrick 1977: 146).

Advice is also given to women about how to manage their alcoholism in combination with their career. For example, how to stay sober during a business-related holiday party (Fanning and O’Neill 1996: 38), how to discuss alcoholism with bosses and co-workers, and how to increase job skills through training (Najavits 2002: 125). A woman’s dedication to career advancement allegedly illustrates how well they are recovering (or will recover) fully from alcohol addiction. Women are lead to believe that if they are industrious, financially successful and productive in their occupational spheres they will reap rewards in their addiction recuperation as well.

Although women are urged to be respectable employees, they still must walk a very fine line between career ambition and familial responsibility. Women are often caught in an unfair bargain where they must sacrifice their career for their family, or their family for their career. Self-help books emphasize the maternal role as the priority, and certain books even go so far as to demonize over-ambition. Brown (2004) warns her readers against over-confidence when she describes the case of “Carole,” a woman on the way up the executive ladder. Carole’s climb was cut short by her false façade of independence and control: “She felt full of herself, so sure that she knew everything. She didn’t even try to hide her attitude. . . .This led to a false self of Carole” (134). Career and financial success should be avoided by women if it means they will end up arrogant, haughty, or willing to reject society’s maternal mandates.

Certain books’ descriptions of employment reflect class privilege, in that employment is viewed as optional and/or flexible. Amy Hatvany flippantly states during her recovery period: “I’ve decided to

ask for my job back. . . .I need a routine” (240). She then begins “easily” waitressing for money and states that “while I don’t think waiting tables is something I’ll do forever, it’s enough for me while I figure out what exactly it is I really want to do with my life” (252). Her job compliments her recovery in that “serving others is a great lesson in humility” (235). Middle and high-class women often have a *choice* to stay-at-home, where lower class women are dependent on earning incomes at places of business. Self-help authors take this choice for granted, presuming that employment is simply a decision to be selected or not.

When my son was two or three, I had a shift in priorities. I realized that there was no amount of money, prestige, or success that was as important as having time with my son. . . . I started leaving work at two or three in the afternoon. . . .I take vacations (Cary 1993: 73).

In early recovery, we may get what we call “recovery jobs” even when we don’t need to work. A job provides the needed schedule and structure (Iliff 2008: 192).

Recovery literature’s insistence on responsibility and labor subsequently frames unemployment as a personal failing. The farthest one can fall in addiction is into abject poverty. Some of the “I hit rock bottom” stories are when an alcoholic is confronted with poverty or homelessness.

I know I had to hit bottom, and I did. I was living in a dirty little house in the ghetto, scrounging on welfare and food stamps (Cary 1993: 220).

The poor and homeless are degraded in this manner, as their life situations are established as moral failings.

Dignity is the glue that holds the mind, body, and spirit together, and once that is gone, the person breaks apart, held together only by skin. Street life corrodes the decency that lines the soul of every wakeful human (Wandzilak and Curry 2006: 130).

Gabrielle, lived on state disability during her first few years of sobriety. Gut in order to stay emotionally comfortable enough to stay sober, she knew she had to grow up, get a job, and support herself (Cary 1993: 52).

This mandate for women to work represents the merging of the first and second shift that Arlie Hochschild examined in her work The Second Shift (1989). She explained the overburden women have faced as a result in employment gains in the latter half of the 20th century. At the same time women

were (and are) making progress in the marketplace, the job of being a mother still lurks at home, which is not a part-time nor a paid job. Hochschild reasons that men have not paralleled women's entry in the marketplace with an entry into the world of domestic responsibilities. This has led to a different kind of tension and conflict in modern marriage. With the added burden of recovery in consideration, self-help authors persuade women to embrace their first and second shift responsibilities as integral components of their recovery.

The mandate to work as a process of self-development in recovery also leaves out the focal purpose of jobs for most workers: to earn money to then consume goods and services. Rising capital wealth, even in relatively small amounts, has been shown to increase the likelihood a person will increase their consumption of goods and services. Consumption is often done in gendered and racialized ways that maintain social hierarchies. The social and cultural dimensions of consumerism were outlined by Thorstein Veblen in "The Theory of the Leisure Class: An Economic Study of Institutions" (1899). In response to the gendered dynamics of consumption, he argued that women may not be slaves or servants of their husbands, but their status as wife and primary consumer of household goods still bears traces of their former servitude. Although men and families are not necessarily always present in the lives of modern women, the various social obligations of women still point to the need for them to define their class and gender status through domestic consumption. Home living magazines, fashion articles, parental books, even health books tell women how to properly adorn their homes and bodies to adequately represent themselves as women. Women's desires are almost always channeled down into domestic outlets.

A recovering woman, who is likely experiencing some form of stigmatization from her disease, may have a strong desire to "normalize" her life by conspicuously consuming for status verification and/or upward mobility, as Kirpatrick (1977) describes in her experience after AA: "I spent money like it was going out of style" (38). Yet a woman's consumption of goods, much like her consumption of

alcohol, must be done in limited and confined ways. Women who choose to consume too liberally beyond the confines of domesticity or women whose consumption is either too much or too little beyond the margins of social norms will likely experience pathologizing. Women who become unruly or threatening in their expenditures are labeled as shop-a-holics, kleptomaniacs, materialistic, or self-indulgent. Self-help warns women of these “unruly” expenditures: “people who struggle with cash [should] let someone they trust handle their finances for a while” (Iliff 2008: 60). Women occupy a large part of their time, energy, and salary on finding the fine balance between consumer and consumed. This delicate line is something they must smoothly traverse in order to appropriately demonstrate their class and gender status in society.

A woman’s middle-class existence, both as she works and when she consumes, integrates her to the center of power: white men. Through classed interactions either at home or in the workplace, middle-class women are socialized into forms of femininity that oblige men and confer them their power. Even when class structure obligates women to forms of feminine subordination, middle-class women have more freedom and privilege to indulge in behaviors that are not available to those outside their class structure. This benefit comes from their familial and financial attachments to men in power.

Self-help’s emphasis on women’s career attainment, affluent lifestyle, and directives for proper consumption expose its middle-class bias. But other perceptions about femininity are present in this middle-class discourse that bring to light another tenet in Connell’s theory of emphasized femininity: subordination. Middle-class women at home, as either wives or mothers are told to be allegiant, loyal and accommodating. In the workplace, if they are required to work at all, middle-class women are told to be passive, docile and obedient. These dutiful obligations move us appropriately towards the next chapter of analysis, where we shift away from class and race structures and towards the theme of subordination.

## 6 SUBORDINATION

Women's subordination is a fundamental part of emphasized femininity. As Epstein (2007) states: "women's subordination is basic to maintaining the social cohesion and stratification systems of ruling and governing groups—male groups—on national and local levels, in the family, and in all other major institutions"(4). Women position themselves into conventional notions of the feminine gender subjectivities and into gender role divisions that enforce their reproductive and supportive activities and often limit their autonomy. Cultural and psychological mechanisms are required to support the process of subordination. The subordination mechanisms, in the books, were shown to be integral parts of bodily conformity, emotional compliance, and adherence to medicalized standards and practices required in alcoholic recovery.

### 6.1 Physical Subordination

Disembodiment, or the disengagement of the mind from the body, seems to be a common occurrence for alcoholic women. Women's biographical accounts explain that their addictions were primarily and repeatedly fueled by a desire to leave the body. In The Lost Years, Kristina Wandzilak (2006) explains how getting drunk for her became just a way get to "out of my body" (145). Eleanor R. (2011) said being drunk gave her "that feeling of being transported out of my insecure body" (15). One author explained that even as a kid she felt the desire to displace her mind from herself, "I'd look at myself in the mirror and feel like I was looking at myself from outside my body" (Wilhelmson 2011: 177). Women's disembodiment is sometimes so acute that others notice it too. Hatvany's (2011) husband speaks of her disaffected appearance while drinking: "There was this . . . I don't know, vacancy in you. Like you stepped away from your body" (229). The relief granted from being repeatedly disembodied reinforces the desire to numb oneself through over-consuming alcohol.



The texts propose a number of theories as to why women use alcohol to alienate themselves from their body.

Women who have been traumatized by others often report that they survived a terrible experience by withdrawing into themselves and by “going out of their bodies.” They describe removing themselves perceptually and emotionally from the horrific “now” by disassociation (Brown 2004:140).

Male-dominated culture has worked for thousands of years to strip women of our awareness of the holy, of the Goddess inside of us, to suppress our sexuality and to divorce our spirituality from our bodies...In order to truly connect with the Divine we are told we must deny our physical selves (Porterfield 1994:3).

Although various manifestations of feminine oppression are exposed, the texts quickly move onto why drinking is not the proper response. Any political or social analyses are avoided. Social institutions and general cultural ideas about women’s inferiority that perpetuate the disparaging treatment of women (including sexual and child abuse) are ignored. Recovery is about re-discovering the lost body, not challenging the things that may cause the initial desire for disembodiment or sustain substance abuse. Brown (2004) individualizes alcoholic treatment by hypothesizing that addiction is when women turn the hurt they have experienced back on themselves: “she became the perpetrator and the victim. A woman in this position might have other victims too, which is a horrible reality to face” (105).

Women disclosed that their disembodiment was so intense that they rarely even *saw* themselves. It was not until they were forced to look at themselves objectively that they noticed the change in their appearances. Often women would inadvertently catch a glimpse of themselves in a mirror and be shocked at what they saw. Hatvany (2011) described her first night in hospitalization: “I didn’t recognize the person in the mirror. My hair was a rat’s nest. I was swollen and disheveled. My eyes were empty” (138). Other women recount their “mirror” stories:

The following morning, as I drag myself out of bed, hungover and looking like something the cat dragged in yet again, the terrible truth is reflected in the bathroom mirror (Rogers 2010: 59).

I stopped for a moment to stare at myself in the bathroom mirror--- I had not seen myself in a long time. My long shiny hair was dull. In fact, it was falling out and

splitting from the roots. My skin, once tanned and smooth, was now yellowish, marked with sores and scars. . . . I looked sick (Wandzilak and Curry 2006: 72).

Self-help manuals will sometimes goad women into this shocking objective observation: “take a hand mirror and go to a window where sunlight is shining in...look closely at your face. Notice the tiny broken blood vessels around the nose and in your cheeks, observe the deadness of your eyes, look at the dry and slaky quality of your skin” (Kirkpatrick 1977: 67). It was not always the woman who was the first to note that alcoholism was modifying her looks. Sometimes others pointed out that her body or looks were beginning to change. Nevertheless, the idea that alcohol was hurting their beauty (not how horrible they felt or how they were hurting their lives) often pushed women into recovery mode.

What finally did it was when he told me, “Monika, it’s beginning to show. You don’t look so good anymore.” (Cary 1993: 198).

Once entering recovery and reviving the mind/body connection, some women express relief at uncovering their lost self.

The 12 Steps. . . brought me back to myself. . . .I was a stranger in my own body. My body was foreign and I was not even aware of it. (Eleanor R. 2011: 119).

They can talk all they want in here about losing their children, their jobs, but what I missed most of all was my own body. It didn’t belong to me anymore (Porterfield 1994: 133).

But not all recovering women are relieved when they find themselves thrust back into their previously estranged bodies. Rogers (2010) turned to frigid water to numb her body when she went into early menopause as a result of her addiction: “I slip on a bathing suit, go out to the lake, and walk into the frigid water up to my neck. It’s heaven. Numbness begins to set in” (134). Women express frustration over dealing with the emotions that accompany embodiment. Kirkpatrick (1977) expresses her relief at being able, in her detoxification center, to lie on her bed each afternoon for about an hour “thinking about space and permitting myself to be divorced from my body” (117).

Despite the irritations that accompany embodiment, self-help authors emphasize the role bodiliness plays in the recuperation of health, and they stress the importance of corporeal awareness to

re-engage bodiliness. “Wholesome” behaviors that promote health and wellness are prescribed; how to restore and maintain health becomes a topic commonly discussed in the books. As Fanning and O’Neill (1996) put it, “developing a sense of stewardship for [the body]” is mandatory for revitalizing the sick body (57). Physical exercise, diet, and beautifying behaviors are the therapies most self-help authors advocate.

The books almost always regard exercise as a vehicle to facilitate women’s progressions back to their bodies. “Jessie” (Cary 1993) says that she likes exercise because “[m]y intellect and my intuition were entirely separate when I got sober. . . . I discovered that if I exercise regularly. . . my intellect and my intuition get integrated. But any time I stop exercising, they get separated again” (174). Reintegrating a woman with her body is almost always deemed as the primary purpose for physical exercise.

Adequate and healthy eating are also judged as a reintegration techniques. Self-help authors justify proper nutrition by speculating that any hunger or thirst cravings could lead to relapse. Kirkpatrick (1986) says that “good nutrition and heavy drinking are totally antagonistic to each other. When drinking ends, the alcoholic must begin a program of good nutrition and care of the physical body” (124). Kirkpatrick believes that the physical damage caused by years of drinking leave the alcoholic “nutritionally deprived, [with] major cell damage, and [they] must devote sober time to providing care for and repair of this severe metabolic crisis” (122).

Despite the truth or fiction behind the role nutrition plays physiologically in recovery, food occupies an interesting position in the literature, bearing in mind that 80% of women with one addiction find it bleeding into other addictions, most commonly food addictions (Nolen-Hoeksema 2006). Because of this fact, most authors spend time discussing dual-addiction and how it may be affecting their readers. The authors explain that women may be using food, like alcohol, as a coping strategy in a society that values them mainly on their physical attractiveness. Women internalize this gaze and, as

Nolen-Hoeksema (2006) points out, “evaluat[e] their self-worth based on the ability to control what goes into their mouth” (17). Women will either over-eat or under-eat as “eating temporarily takes your mind off your troubles and makes you feel good again” (Nolen-Hoeksema 2006: 23).

Yet while the societal pressures that propagate women’s negative relationships with food are sometimes exposed, strict dietary management and exercise are still regarded as essential components to alcoholic treatment. Self-help tells readers they over-consume food in response to the lack of human relationships in their lives, similar to the way they began drinking in order to quench their desire to be loved and/or wanted. Women’s own personal stories show they frame their addictions to food under the same umbrella as they do their alcohol addictions: something that developed early in life, something that is out of their control, and something that prevents them from having full relationships with others.

I can also see that I started using substances very early-- sugar in this case-- to keep me occupied and content, rather than connect with loving human beings (Eleanor R. 2011: 9).

I don’t remember when I made the connection between the restlessness that I felt all the time and the sweet relief of the candy. I know I was unhappy (Kelly 2007: 18).

I was fifteen years clean and sober when I hit my bottom with food. Many times over the years, I had surrendered certain foods, only to un-surrender them over and over again. I had come a long way, but I didn’t really begin this second stage of healing until I faced my food addiction (Eleanor R. 2011: 47).

Maintaining a proper diet requires time, money, and vigilance, but is seen as a foundation for recovery.

In your new life you will: eat differently. You will have to fill the vacuum left from not drinking (Kirkpatrick 1977: 75).

Improve your self-care. . . have at least one hour a day just for you. . . .Eat healthier food. . . .Take a day-trip or weekend trip (Najavits 2002: 148).

Sometimes women will develop other addictive behaviors during recovery--they turn to food suddenly after many years of recovery (Brown 2004: 94).

Note that the last quote cautions all women, even those who may have never had problems with food before, to be alert to the possibility that food will become an addiction too.

With the focus on “correct” eating, thinness becomes an added goal to be acquired through eliminating alcohol. Some books pepper their dietary discourse with quotes from sober women expressing joy at their slimmer bodies they have obtained through sobriety.

All I can tell you is that everything is better now that I am in a right-sized body (Eleanor R. 2011: 91).

At one year sober, I am perfect. Dazzlingly beautiful and healthy, with a taut stomach and thighs, a tantric master, a person adored and cherished by all (Brownell 2009: 156).

I’m careful about what I put in my mouth. I take vitamins. I’m in a weight-loss program, and I just took off twenty-six pounds (Iliff 2008: 47).

Fatness, subsequently, is labeled as a harmful symptom of addiction. Eleanor R. describes in her addiction “The more I tried to control things, the unhappier and fatter I got” (43). She was “exhausted all the time and [she] was fat” (44). In the dietary management texts, avoidance foods are regularly listed by self-help authors. The foods that are cataloged reveal a bias as these foods are, interestingly, foods that lead to weight gain. Fat, sugar, candy, caffeine and salt are particularly shunned foods.

Reduce your intake of fat. . . .Read labels on everything (Fanning and O’Neill 1996: 63).

Nutritional Rule 1: No matter what anyone tells you about eating candy, avoid it like the plague. Eat no candy, no sugar, no ice cream, no honey. (Kirkpatrick 1986: 123).

I have surrendered alcohol, sugar, flour, quantities of food, chewing gum, other people, fantasizing, flirting, gossiping, diet soda, artificial sweeteners, true crime novels, worry and salt! (Eleanor R. 2011: 59).

Along with thinness, beauty is an added “bonus” of sobriety. Alcoholism is frequently connected with deteriorating looks as Kirkpatrick (1986) recounts about herself and her peers on their first day of rehabilitation: “our faces bore the physical deterioration for all to see: blotchy complexions and many small broken blood vessels around the nose. We looked hard. And old” (xvi). Beautifying behaviors, and the desire to revamp ones looks, are regarded as positive actions of a recovering woman, and sometimes even required actions for women who want to recover. Fanning and O’Neill (1996) list the “Good things about quitting: weight reduction, more attractive appearance, you’ll be able to get back in

shape” (20). Readers are convinced that the display and ornamentation of the feminine body are positive actions for recovery.

My other daughters tried to help her become more feminine and comfortable with her beauty, but it would take time for Kristina to accept a new image of herself and years to soften her hard edge (Wandzilak and Curry 2006: 230).

Overconsumption is associated with old age as a segment of unattractiveness (not merely the elapsing of time); and recovery offers the promise of youth.

This journey has led me to the buried treasures and the secret maps to the everlasting life and even the fountain of youth (Eleanor R. 2011: 121).

Surprisingly, I’ve been feeling happy about turning forty. I look young, I’m in good shape, and I’m grateful to have lived this long. Life is good (Wilhelmson 2011: 328).

The “healthy” tone of self-help instructions encourages women to engage in certain bodily practices. These bodily practices, often under the guise of medical authority, nevertheless endorse emphasized femininity mandates, particularly the alignment of the aesthetic physical body with current ideals of beauty. Fitness and diet discourse encourages readers to normalize their appearance with the most current beauty standards, not simply as ways to maximize health. This is particularly troubling considering the conformity to emphasized femininity may actually increase the possibility of health risks for women. For example, a woman who conforms to the edicts of thinness and youth may find herself establishing excessive exercise routines, denying symptoms of injury, or eating a lower calorie diet than her body may need.

Not all books encourage physical subordination within emphasized femininity precepts, like of thinness, beauty and youth. Some authors admit that beauty standards are unfair and that “the ‘beauty’ demanded of a woman’s personality requires that her self conforms to a shape that is not hers” (Brown 2004: 5). Other authors admit the commitment to sobriety should not always be coupled with achieving an idealized version of bodily perfection. Nevertheless, all books encourage “health” as an ideology. Successful fashioning of the “healthy” body through alcoholic treatment relies ultimately on an

internalization of standards, rules, and norms that enforce and disseminate ideas on not only emphasized femininity, but also a medicalized discourse of alcoholism. The next section will focus on the subordination of the “healthy” body to the medicalized standards of recovery.

## 6.2 Medicalization

Medicalization is the process where problems are (re)defined in medical terms and medical frames are used in the attempts to manage the problem (Conrad 2000). The diagnosis begins the process of medicalization in alcoholism. It is fair to say that many women may turn to self-help with a fair amount of uncertainty about their alcoholism and the course of their recovery. Self-help books impose order on the disorderly effects of the alcoholic’s life, beginning with the clinical. Step 1 in AA is “admitting powerlessness” and the “study of Step One will be largely devoted to the physical illness of alcoholism” (Little Red Book 1946: 13). The uncertainties of alcohol dependence become organized through the diagnosis itself-- the codification of the illness. Most books do a fair amount of “convincing” readers they are true alcoholics, reiterating to women that any denial on their part is dangerous.

When drinkers decide that they do not meet the normative categories of a casual drinker, they begin the categorical identification with alcoholism. Katovich (1986) has argued that individuals often embrace previously defined categories so that the stability of social life can persist. Diagnosis then becomes part of the woman’s identity, legitimizing her life situation and the behaviors needed to overcome their illness.

As the authors’ dichotomize alcoholics from “normal” people, the medicalization tone grows. Many authors spend time telling the reader they differ from other people, and some even speak of this difference as genetic or biologically predetermined. The authors tend to biologize the problem of alcoholism, which reiterates the medicalized discourse.

I am pretty sure that Mom knew I was an alcoholic long before I took my first drink because I had all the early symptoms: sugar cravings, irritability, extreme self-centeredness, genetics and a chaotic home life (Eleanor R. 2011: 5).

Because the books have a tendency to marginalize and stigmatize alcoholics as “different” from the general population, riskiness frames the “outside” world. The borders of space become demarcated by danger, and controlling and managing that risk becomes essential. Some books define alcoholics as being susceptible to other, auxiliary traits of non-normativity. Included in this “non-normativity” are other psychological diseases to be cautious about: Generalized Anxiety Disorder (Najavits 2002: 89) Obsessive Compulsive Disorder (Najavits 2002: 91), personality disorders, phobias, depression, TV addiction, sex addiction, panic disorder, eating disorders, overthinking, worrying, drug addiction, etc. Nolen-Hoeksema (2006) informs her readers that alcoholics sometimes ignore their increased risks of other “illnesses” because they like to think linearly about addiction (6). She cautions readers to scrutinize their behaviors, bodies, and emotions, as they are prone at any time to develop further health complications. Najavits (2002) warns that being a woman itself is risky and should be regarded cautiously, as mental illnesses are much more “common in women than in men” (93).

With an increasing medicalized discourse surrounding alcoholic self-help, the doctor becomes the main authoritative and qualified individual to recommend treatment to alcoholics. Authors advise women to augment their regular doctors visits with heightened medical surveillance, not only in the beginning phase of their recovery (when the risk of delirium tremens and seizures are at their highest), but throughout their recovery as precautionary measures against the risk of relapse and other physical and psychological risks. Most books advise women to seek professional medical opinions and utilize services such as rehabilitation clinics, psychotherapists, and medical doctors that specialize in addiction.

Some books propose that prescription drugs can play a chief role in recovery. Fanning and O’Neill (1996) explain that drugs “normalize” behavior (100), particularly behaviors like depression, rage, and disorientation that can cause a susceptibility to abusing alcohol again. But the authors disagree over medications and the assistance they can provide to recovering people. Some authors believe medication is coercive, dangerous, and can trap women into yet another addictive habit. Rogers (2010)



talks of how she was manipulated into prescription remedies by her rehabilitation clinic: “I had to agree to stay on my medications and go to therapy, for at least two years” (30). She relapsed and later went off these medications when she came to believe that her addiction was simply a consequence of her lack of appreciation of her life (146). Cary (1993) also had a bad experience with doctors and explains that her addiction to substances started as a child when she “was pudgy and unhappy about it, so my mother took me to a diet doctor” (188) who gave out pills. The pills started her lifelong connection to substances.

The medicalized discourse in self-help serves to bolster or justify almost all of the medical modes of self-care women may solicit. Medicine occupies the primary position in the hierarchy of expertise, which justify the medical creation of a roadmap to recovery. Self-help prods women to take care of the body first; the heart and soul will then follow. The authors use medicine as the first form of social control, justifying their later use of emotional, moral and spiritual fields to direct their readers (more on this later).

Self-help authors do little to challenge modern standards of beauty, body, or the medicalization of alcoholism. Similar to what Foucault outlined in Discipline and Punish (1977), self-help’s disciplinary practices use instrumental reason, self-surveillance, and heightened self-consciousness to control the body. The body, which to so many alcoholic women is either alien or enemy, is to be re-discovered through recovery, and then further disciplined through diet, exercise, and medicalized practices.

This disciplinary transformation involves a measure of shame, as the deficiencies of the body can never be completely overcome by women, no matter how hard they try. They may quit drinking, but they can never fully achieve perfect health, beauty, or size. It is burdensome for all women to try to achieve the current standards of beauty and health, but particularly poor women because they do not have the financial means to attempt to manifest them. The medicalization of alcoholism has lessened the moral stigma that was once attached to the disease. Nevertheless, self-help books explain that

medicine, medical rehabilitation, and physical modifications are not definite cures. Other modifications, specifically spirituality and therapeutic emotional work, are the measures that will keep alcoholism at bay. In the next section, the analysis moves toward the emotional work that creates the “practiced and subjected” body.

### **6.3 Emotional Subordination**

While the focus on the body and medical treatment of alcoholism are notable, emotional work is also deemed an important component of recovery. Self-help authors also acknowledge the intense and often vitriolic emotions women might feel as they continue their recovery. Addiction is viewed as having an emotional cavity that is being filled with harmful substances.

Being addicted is the repetitive process of acting on impulse to satisfy or quiet and internal experience that usually an emotional threat to the security of self (Brown 2004: 25).

Many addicted people also have an emotional problem such as depression, eating disorder, or anxiety disorder. Co-occurring means “happening at the same time” as the addiction. It’s also call dual diagnosis or double trouble, for two disorders. Most substance abusers have a co-occurring disorder (Najavits 2002: 80).

Self-help books support women’s desire to relinquish themselves of these extreme emotions. Cary (1993) states that in AA “members are encouraged to attend lots of meetings, and by listening to other talk about their feelings, they’ll be better able to identify their own” (19). The expression of emotion is considered to be an imperative part of the treatment, hence the confessional self-story required in most recovery groups.

Emotions, though, are thought to be “healthy” only when they are expressed in specific ways. Not all emotions are to be treated the same, as Kirkpatrick (1977) puts it when she states: “As drinking women, we know that negative emotions destroy us” (146). Self-help authors spend ample amounts of time defining, constructing and labeling for women the emotions they may be experiencing, and then outlining the proper management of these emotions.

Some authors focus on loneliness as a major emotion and how it can fuel addiction. Authors consider seclusion, and particularly isolation, to be dangerous situations for woman alcoholics. Florence Ridlon's (1988) work showed how women's status insularity makes it less likely they will be labeled as alcoholics, even when their drinking is out of control. Yet the books generalize the emotional isolation of the women as a product of alcoholism, not as product of women's insularity in general.

Years of drinking narrow the personality without the drinker's awareness. We become subjective, egocentric, demanding, self-pitying, resentful. We are wrapped in a cocoon (Kirkpatrick 1977: 69).

I became a housewife drunk. I stayed in the house, drank in the house, and went mad in the house (Cary 1993: 99).

The detrimental effects of this insularity, despite the cause, may be why many of the books insist women "come out" as alcoholics, to themselves and to others, as quickly and as loudly as possible. Cary (1993) expresses the dignity in her illness: "I absolutely refuse to be ashamed of being an alcoholic" (7).

Powerlessness is another emotion that is heavily discussed throughout the books. Step One of AA is admitting powerlessness, but the books repeatedly affirm that this powerlessness can be a strength. Brown (2004) states that powerlessness "is hard for women who have a long history of being victimized or repressed by people who have power"(106), but she assures women that there is "strength in your powerlessness" (80). Covington (2000) contends that "surrender is different than submission" (24). The books broach the subjects of power and weakness carefully, without ever completely acknowledging whether women are totally in control or completely out of control of themselves and their environments.

Anger and rage are also emotions the authors choose to discuss. These are expected to be expressed in limited ways and in limited places. Uncontrolled anger led Rachel (Brownell 2009) to AA meetings when her husband flatly told her "you're becoming mean" (67). Recovery promises to lead women into kinder, gentler, and more loving versions of themselves.

I have become transformed from the self-centered, know-it-all to a kind, loving and tenderhearted woman (Eleanor R. 2011: 121).

Problems can only bother me to the extent that I let them to...in learning that we can control our reactions, that we needn't react at all (Kirkpatrick 1977: 169).

In order to have contented abstinence and recovery, I must endeavor to be agreeable, look my best, be polite and respectful and only speak well of others. . . . I am not to control or criticize my children or my husband (Eleanor R. 2011: 89).

Shame and guilt are two other emotions discussed in the books. Guilt is described differently than shame: "Guilt can be healthy in recovery. It shows we have a conscience. Shame is not healthy" (Iliff 2008: 147). Shame is the emotion where "healthy" guilt becomes incessant and takes its toll on the woman.

Dealing with shame. . . . I found myself standing in the shower, trying to take off what I thought was surface dirt. . . . I kept thinking if I cleaned my body, I would clean who I am on the inside. And I couldn't. No amount of soap and water, no amount of pretty clothes, no amount of perfume would ever take away the stench of who I had become as a woman alcoholic (Iliff 2008: 45).

Self-help authors unwaveringly convey to their readers that they understand how personal traumas and role stress can contribute to their unstable emotional life and their dissension into alcoholism. They advise that women may drink for a number of understandable reasons: to fit in, to remain youthful, to maintain a sense of freedom.

I felt depressed and went to a meeting. The guy who spoke said he drank because he didn't want to grow up. I can completely relate. Drinking allowed me to cut loose, feel free, forget my responsibilities (Wilhelmson 2011: 347).

I wanted to be popular. I wanted to be noticed. I wanted to be the "life of the party." And when I first had a few drinks, it seemed as if I had found the nectar of the gods. Just a few drinks, and I began to believe I was all those things I wanted to be. I felt as if I were oozing charisma (Kirkpatrick 1986: 51).

[Women] start using to lose weight, reduce sexual inhibition, relieve stress, improve their mood, increase their self-confidence, belong to their group, or even avoid hurting someone else's feelings (Iliff 2008: 8).

Authors rationalize these emotions can be dealt with in other, less deleterious ways and so should not justify an excuse to drink.

The texts advise women that the emotional work in recovery should be done with others. Sharing the isolation of alcoholism helps to build a community of support, and procuring supportive relationships is a vital requisite for recovering women.

Four relationship skills: tell a secret, share responsibility, become friends with women, seek support (Najavits 2002: 114).

Women express relief at being a part of a healing community or beneficial friendship.

A huge part of healing in recovery is hearing the so-familiar secrets of others and realizing, I am not a bad woman. . . .Hearing other women's stories starts to normalize what we have done as an addict (Iloff 2008: 24).

Knowing Cindy was there for me, no matter what, soothed a lonely place in me that alcohol had never been able to fill (Kelly 2007: 121).

Many books call for women to mobilize themselves separately from men in women's treatment communities. They treat female separatism as a means for emotional support and as a space where women can express their solidarity. Kirkpatrick's (1986) devotes her entire book Goodbye Hangovers, Hello Life to creating her alternative to AA, Women For Sobriety. She claims to have founded this organization when she discovered, during her own recovery, that AA "so is male-dominated that it did not really speak to my particular needs as a woman. Women must have certain elements in recovery because they are different from men" (xv). For her, women must face elements of recovery that do not necessarily affect men alcoholics, like depression, loneliness, and stigma.

[Women] have almost no feelings that can be translated into self-value and respect. In recovery, as women, we have much longer roads to travel than men do" (Kirkpatrick 1986: 53).

Kirkpatrick advocates for women-only recovery groups and she was not the only author to do so. Many authors believe gender segregation would be beneficial to women. Gender differentiation is

always the rationale that precipitates the creation of these groups. Some authors locate the gender difference in childhood socialization techniques.

Girls don't learn as many strategies [as boys] for moving from being upset to doing something about it. They don't learn how to soothe their own negative feelings. . . . They take control over the only thing they can control—their body—and try to change how they feel with food or drink (Nolen-Hoeksema 2006: 63).

One popular theory holds that women's primary motivation in life is relationships (much more so than for men). Thus it's no surprise that addiction and relationships so often go together for women (Najavits 2002:69).

Others have more biologically essentialist approaches.

[I]ncreases in oxytocin activity in girls during puberty lead them to become more affiliate-- to care more about relationships with others, to become more caring towards others, and to desire to be with and be liked by others (Nolen-Hoeksema 2006: 105).

Women's specific emotional needs, women's meanings concerning failure, or their particular coping mechanisms also justify gender segregation.

Women's recovery is different because of the amount of shame women have, and because of trying to juggle everything (Najavits 2002: 26).

Men and women tend to differ in the meanings they attribute to being alcoholic (Brown 2004: 27).

Women alcoholics need something more (than AA), because alcoholic women feel that they have failed...as wives, as mothers, as daughters, as women (Kirkpatrick 1977: 160).

[M]en tend to externalize stress-- blaming other people for their negative feelings and difficult circumstances—women tend to internalize it, holding it in their bodies and minds (Nolen-Hoeksema 2006: 7).

The mobilization along gender lines also serves as the basis for the organization of an emotion culture in women's self-help groups. Findings show that women's self-help movements form around informal leadership, personal relationships, and emotional support (Ferree, Marx, and Martin 1995; Taylor 1999). The books informally outline the organization of the support group, with female solidarity being a stable part of the assemblage.

As in a pomegranate, each woman is a seed, separate in herself, but held in a web of support that makes up a whole community (Brown 2004: 137).

Going through life alone is like being a ghost-- no one knows you. Support gives you a boost. It makes things easier, more stable. It gives you people to bounce ideas off of (Najavits 2002: 124).

Bibliotherapy, or self-help reading, can be seen as a way women mobilize themselves through communication technologies in our informational society. The books, then, can be seen as agents of preparation for the structural form of self-help groups which necessitate open displays of emotion. The books tell women they must be wholly involved in their recovery communities, extending vast amount of effort if needed. This begins with opening the self to new ways of thinking and doing what they are told.

[O]ld defenses get in the way of growth in ongoing recovery if they are the first place you go. They're typically slow to recede, but you are more open and flexible now and you can begin to let them go (Brown 2004: 83).

At the age of 38, I learned for the first time to do what I was told. That and only that empowered me to conquer my own cravings and desires (Eleanor R. 2011: 105).

The language of the gender wars is aggressive. It's striving for "power over." It's a win "against." In contrast, the language of recovery is accepting (Brown 2004: 104).

The books define recovery as a spiritual awakening that leads to contentment. All books contain the "higher power" doctrine, promising substantial and lasting change. The "higher power" belief accepts that human beings are united as expressions or emanations of a central energy or principle-- Spirit. This belief compels a certain amount of optimism as an extensive part of recovery.

Enthusiasm is my daily exercise (Kirkpatrick 1977: 157).

Happiness never came to me until I learned the secret of making it for myself, of finding an inner glow that somehow made all other things right. (Kirkpatrick 1977: 168).

It's commonplace to hear people express gratitude for having been alcoholic, because it led them to sobriety and to a much better life (Cary 1993: 126).

While contentment, optimism and belief in a Higher Power are not inherently bad, the language of hopefulness contradicts the social and political contexts of addiction. The Serenity Prayer ("God, grant me the serenity to accept the things I cannot change") illustrates how optimism and a "live and let live"

attitude can become an injunction against action. Women may be more at peace with their life situation when they stop drinking, but their political complacency is apparent.

I had become deeply convinced that our lives reflect our thoughts and we mold and shape our lives from our thoughts (Kirkpatrick 1977: 142).

After five years of sobriety, I was beginning to trust that material things would all work out, that I could trust in the Universe to help me take care of myself (Kelly 2007: 137)

“One day at a time,” she’d say, “you’ll have the life you dream of as long as you stay sober” (Wandzilak and Curry 2006: 212).

The stipulated emotional performances for women in recovery fall under the umbrella of emphasized femininity. The books judge feminine emotional attributes such as sociability, nurturance and hospitality as valuable emotions for recovery within the self and in helping others recover as well. The added requirement that women congregate in gender specific support groups is likely to exacerbate the potential that feminine emotions will be the only ones present. While support groups are customary in all addiction circles, segregated circles essentialize and biologize these constructed gendered emotions. This specific organizational atmosphere not only shapes feminine interactions but reproduces the emotional interactions between members, further legitimizing the emotional imperatives outlined by self-help (whether they effectively cure addiction or not is moot).

Women’s new emotional lives (and the need for its expression) are substantial topics throughout self-help. This standard of recovery can be seen as a resistance toward masculinity, as women are overcoming the emotional detachment and inexpressiveness of middle-class masculinity (Hickman 1991). However, the ways in which emotions are constructed and how their meanings are clarified sustains the theory of emphasized femininity. Moreover, the insistence that women are emotional beings upholds gender difference, as it justifies women’s separation with biological essentialism.

Bodily restriction, medicalization and emotional control are aspects of recovery that fall under the umbrella of emphasized femininity’s subordination tenet. These facets establish for women ways



to define and reconstruct their bodies and their emotional performances to better align themselves with the recovery lifestyle. The authors give advice that is not only remarkably persistent, but transcends the boundaries of both the body and the mind to (re)define and (re)introduce women to the regulation of themselves.

## 7 HETERONORMATIVITY

Susan Bordo (1992), pulling from Foucault's prior theories, explains how, with modernization and industrialization, new forms of gender domination arise and spread. She explains how normative femininity is becoming more and more centered on the body-- mainly its presumed heterosexuality and its appearance. Previous discussion elucidated the narrowed beauty standards and medicalized practices recovery literature places on women's bodies. This chapter will focus on the roles of mother and wife, and how these roles not only work in tandem with masculine hegemonic power, but also become implicated in perpetuating cultural norms of (hetero)sexuality.

Motherhood was by far one of the largest and most persistently discussed themes in the books. Self-help authors repeatedly conceptualize motherhood as a normal yet stressful element of the woman experience. They address the fact that motherhood is often an overwhelming and burdensome responsibility, sometimes complicated by the lack of support mothers receive. Women's own personal expectations concerning motherhood can further lead to frustration as Brownell (2009) admits: "Motherhood gets too big to manage, and I want to be perfect. I want to be everything good and loving and patient and kind" (64). A dominant scene throughout the books is one where a woman is struggling with her ideas and emotions concerning maternal satisfaction.

I'm completely underprepared for how utterly lonely new motherhood is for me. I resent how dependent I am on Jon. I resent him his freedom from breastfeeding, and from the neurotic overconcern that plagues me at every turn (Brownell 2009: 42).

I worked at home, took Max to parks and museums, and felt guilty about whatever I was doing. When I was writing, I felt guilty about not playing with Max. When I was playing with Max, I felt guilty about not writing (Wilhelmson 2011: 7).

I'm exhausted and crazy. I'm in Crazy Mommy World (Brownell 2009: 48).

The strains of motherhood become increasingly complicated as women battle to maintain their youthful sense of self with their new status as a mom. Recovering women's biographical accounts

describe how motherhood is often the catalyst for a descent into drinking, and often describe how the role of mother enabled them to drink more.

When I became a stay-at-home mom and housebound freelance writer, I started hitting the wine and vodka pretty hard. Charlie got to leave the house, go out for drinks after work, travel, play tennis. I was at home and angry about the mind-numbing tasks that filled my day. Much of my day was spent in the kitchen making food, feeding people, and cleaning up the food. I would stew and tell myself I was meant for greater things (Wilhelmson 2011: 83).

Soon I saw a trend in all these mommy events-- they were our respectable, socially acceptable alibis for drinking (Barreca 2011: 166).

I want to be the anti-June Cleaver, the un-wife, the un-mother. . . .Drinking does begin as a bulwark against the onslaught of mama drones (Brownell 2009: 58).

Though motherhood can sometimes lend itself to over-consumption, drinking as a mother is tolerated only to a specific degree. Women account how their motherly duties were so imperative, yet simultaneously overlooked, that no one ever noticed their addictions, including themselves, as long as they were fulfilling their familial obligations. Fanning and O'Neill (1996) explain to readers that a woman "excusing" herself in the early years of addiction sounds something like, "I must be doing things Okay—I always get to work on time (manage to cook dinner, finish assignments, pick up kids)" (12). Other women use their maternal accomplishments to convince themselves that their addiction is not that bad.

I couldn't possibly be an alcoholic. I'm a well-educated, reasonably well-adjusted, thirty-nine-year-old woman with a home and a family, children, good job and ambition. I drink sometimes to unwind and to give myself a treat after a long day of shuttling kids, working, making dinner, folding laundry, and sweeping floors, but I keep it under control. (Brownell 2009: 8).

I don't drink during the day. . . .and my drinking doesn't interfere with my work or being a good mother (Wilhelmson 2011: 12).

Apparently, women (or others around them) only begin to realize they may have a drinking problem when they start "slipping" in their maternal obligations. Louise, in Women Celebrate Long-Term Sobriety (1993), describes her shock when she discovers she was not doing the things she believed

other mothers do: "I looked out the window, and I saw families walking together to church. I can remember suddenly feeling so ashamed, because I had never done any of those family things with my children" (219). She exposes her guilt further as she continues: "I was unpleasant and testy with my kids" (Cary 1993: 93). Even when mothers are there for their children, they blame their alcoholism for the reactionary responses they have to their children's behavior or for lack of "quality" time they give their kids.

Women use motherhood as both a way to define themselves and to compare themselves to others, often with dire consequences, as there is always more work to be done as a mother. Brownell (2009) expresses her pain at feeling unqualified as a mom, "Mother Guilt takes root in my soul. I know that all the other (better) mothers are happily at home making cookies or cleaning things or disciplining children patiently" (43).

While women acknowledge that being a mother is difficult work, actual mothers frequently come under attack for their transgressions. In the autobiographical accounts, women's judgments frequently go back into their own personal histories and their own mothers. This is not surprising, considering the prevailing culture of egocentricity and a contemporary tendency to constantly re-examine the past. Yet failed mother-daughter alliances emerge as a gateway to addiction vulnerabilities. Nolen-Hoeksema states that a mother "is especially likely to draw her daughters into. . . her sense of incompetence" (64), which will contribute to an addictive personality in the child. The books list a variety of maternal failures that can damage a child, most of which have contradicting categorizations: intrusive or excessive, force-feeding or denial, smothering or neglect.

One book focuses on the damaging mother-daughter story of Mai Lee and her mother. The story explains that Mai Lee's uncle had been sexually abusive to her throughout her childhood; Mai Lee told her mother of the abuse yet her mother remained in denial. The author states that "this part of the conflict--Mai Lee's hurt and anger at her mother-- was largely unconscious for many years" (121). The

author argues that the psychological injury caused by the defective mother-daughter relationship, not by the sexual abuse, led Mai Lee to her addiction. Mai Lee's therapy, which uncovered buried feelings, allowed Mai Lee to work toward forgiving her mother (Brown 2004: 121). Other authors also suggest that a flawed mother-daughter relationship may lead to alcohol dependence.

Many [alcoholics] had rejecting mothers and/or domineering mothers; most were brought up in families lacking in understanding or not displaying warmth or affection (Kirkpatrick 1977: 164).

Especially in alcoholic families, there is plenty of abuse, neglect, abandonment, and betrayal to go around (Fanning and O'Neill 1996: 127).

I found it difficult to come to a clear understanding of God. One difficulty lay in reconciling the gentle Jesus and the wrathful Father, who too closely resembled my two mothers (Kelly 2007: 207).

A mother's failures may pilot her daughter's addiction even if she is not a drinker; but if she is a drinker, it is a double hit against the mother. The idea that a mother's drinking behaviors often result in children mimicking those destructive behaviors leads to the "family sin" theory of alcoholism. As Brown (2004) says "family's alcoholism, a legacy and a birthright" (xiv). Najavits' (2002) book even recommends women re-reading certain chapters to determine whether their children have any of the problems outlined (82).

While alcoholism is framed as being caused by failures of the maternal role, the books inform women that, through their own health, they can break "the chain of addiction" for their children and their children's future (Cary 1993: 256). Barreca (2001) tells a chronicle of what could possibly happen if the chain of addiction is not broken: "Your daughter, twelve, will be sipping what you recognize as Zima. . . .You shudder. . . .and marvel at the secrets we bottle up in our hearts, how early they start, how long they survive" (31).

The books do not romanticize or idealize the incredible responsibilities faced by mothers, but even when the strains and disadvantages of motherhood are recognized, the underlying assumption remains: having children is beneficial for a number of reasons. First, motherhood is framed as a

biological desire that will also complete a woman spiritually and emotionally. As Amy Hatvany (2011) succinctly puts “there is something in me too hollow to be filled by anything other than having my child in my arms” (276). Also in her memoir, Hatvany explained that it often felt like not having her child with her was like not having a leg (218). Women’s desire to be mothers is portrayed as absolute, instinctual and essential. Women who are either unable to conceive or have any experience losing a child, often blame themselves morally and in conjunction with their addiction, not the biological or social factors that may have impacted their fertility.

[W]hen I lost a child before he was born, I simply shut down, knowing that for some reason I wasn’t fit to be a mother (Rogers 2010: 28).

Women who simply do not want children express this sentiment to their readers guiltily.

I don’t remember wanting to be a mother, even to a doll . . . I thought suddenly of how relieved I would be if I learned I was sterile (Kelly 2007: 188).

I remember wondering if I would be better off if Charlie never existed. This is a shadow of a thought (Hatvany 2011: 117).

Motherhood is also beneficial in that it can be used as the driving force and the sustaining motivation for overcoming addiction. Women speak of how their alcoholism harmed their relationship with their children. “You just can’t be a loving parent if you are a practicing alcoholic. You’re too self-centered. Alcohol creates distance, like a wall of ice between people” (Cary 1993: 142). Fanning and O’Neill outline two of the social implications for alcohol use as “setting the worst possible example of your kids” and “undermining family unity” (28). Copious amounts of horror stories occur concerning the effect of alcoholism on children, as Cary (1993) says about his subject “Her drinking had a negative impact on all five of her children” (138). The authors promise though, that the harm to children from alcoholic mothers is only temporary. Sobriety offers a new chance to fulfill motherly duties:

When I got sober, I unfroze and became pleasant again, and my love for my kids came roaring back (Cary 1993: 98).

In addiction recovery, the ideal is to reunite family members in order to improve marriages, heal breaches between partners and children (Cary 1993: 116).

Try to imagine a new life with your family...Think about the time to come when your family will no longer have to say "mother isn't feeling well today" or any of the other countless excuses made by husbands, children, mother, fathers (Kirkpatrick 1977: 68).

Women in recovery can comfort themselves by the fact their children are well; "whatever else happens, I've saved my children from being motherless, orphans of alcohol and oblivion and distraction.

(Brownell 2009: 115).

Some authors use pregnancy as a facet of motherhood to demonstrate the destructiveness of addiction. Women's reproductive health and, more considerably, the health of the fetus, are used to alarm women that alcoholism can be damaging to their fertility and to the health of their hypothetical child. Najavits (2002) explains the associations between women's addiction and reproductive problems including "increased risk of spontaneous abortion, early menopause, difficulty becoming pregnant, and changes to the period and ovulation" (12). Women's reproductive health is a subject in all but four of the books.

[W]omen with addiction have a greater risk than other women of having breast cancer (due to increased estrogen production), osteoporosis, ob-gyn problems, pregnancy problems, negative effects on newborn children (Iliff 2008: 9).

Armstrong (1998), while researching Fetal Alcohol Syndrome, showed how the relatively new strands of medical knowledge centered on the fetus in the early 20th century resulted from the shifting boundaries of gender. One wonders whether the focus on fetal health in self-help is merely corollary of the continuing moral panic surrounding women's gender roles.

Recovering women relate to one another through the condition of motherhood. The various stresses of motherhood serve as a common ground in women's recovery circles. Many women express relief simply by hearing that other women, who are mothers, drink. Hatvany (2011) speaks of her first AA meeting and the reprieve she felt the "first time I have heard another woman speak of drinking in front of her kids" (157). Hatvany (2011) describes the "silver line of connection" pulling her towards

other mothers who can admit to their wrongdoings (158). Mothers find common ground in addiction recovery simply by admitting they cannot exhibit the “superwoman” image demanded of them.

Being a good mother does not mean being perfect every moment. We screw up. We get mad, we drink too much, eat too much, yell too much (Hatvany, 2011: 168).

Because motherhood is constituted as one of the core functions of American women, self-help authors are obliged to discuss how the responsibilities of motherhood can get in the way of recovery and what women can do to prevent that. Wilhelmson (2011) admits in her discussion with her sponsor: “I thought I was a regular. . .I don’t hit that meeting every week. I have a husband and children and things come up” (280). Recovery literature is replete with advice for women like Wilhelmson, as it explains how a woman can properly balance her “needs” and “desires” as an individual in recovery with her obligations as a mother. The guidance admits that recovery is often regarded as a selfish process, but reassures women that the focus on their self is beneficial, in that it is for the sake of her family.

[A] focus on the self for each person offers the best possibility for healthy couples growth and healthy family growth (Brown 2004: 49).

Use your family’s health as a motivator [to be healthy] (Nolen-Hoeksema 2006: 175).

You make sure your children are safe, and you encourage your family to get the help they, too, need in the recovery process. But you keep your focus on yourself (Brown 2004: 53).

The authors’ advice encourages women to embrace the roles of motherhood *and* housekeeping, and outlines how housewifery duties can support a proper recovery. Rogers (2010) explains how she kept her addiction in line by setting “reasonable goals to keep the house clean and organized” (148), when not accompanying her husband into town to help him with his work. In self-help manuals, women are urged to “straighten up house” as a keeping busy activity for sobriety (Fanning and O’Neill 1996: 52). Nolen-Hoeksema (2006) implores her readers to “clean your house” to stay sober (172). And Cary (1993) says her sponsor told “me to see my everyday household chores as self-esteem or growth exercise. These little actions, such as waxing the kitchen floor or straightening out the shoes in the closet, turned out to be important first steps in getting some order back into my life” (43).



Housekeeping advice assumes that women's role as mother is inclusive of not only childbirth and childrearing, but of the majority of unpaid labor in the home.

Motherhood is such a major theme that it is even used outside of purely parent/child contexts. The books employ maternal metaphors to illustrate the community of support women receive from their peers. Brown (2004) infantilizes the recovery process by stating "a woman is 'cradled' and rocked through the early days" of sobriety and that she can never be fed too much AA (148). Familial metaphors, involving parents and babies, describe the varying styles of attachment behaviors needed for recovery (Brown 2004: 41). Brownell's (2009) "Mommy no longer has wine as her security blanket" (91) statement depicts the pettiness that often frames the genuine dilemmas of motherhood.

The prominence that motherhood plays in recovery literature for women carries with it the notion that women are, and should be, primary caretakers. The assumption that motherhood is a universal norm for all women contributes to feminine gender role expectations. The inclusion of stories concerning the burdens of motherhood may be of help for women in those situations, but this also implies that these situations are normal. Only two books featured single women with no children, but even in these books, the women had to justify their no-child status.

She has no regrets about not having had children. "It's taken me this long to raise me!" (Cary 1993: 169).

I am thirty-seven. I'm single, and I have no children. Sometimes I drink a Jolly Rancher martini to show that I'm too much of a free spirit to settle down just yet. I refuse to act my age-- life's too short (Barreca 2011: 51).

In addition to motherhood, romantic relationships play a key theme in the texts. Some books clarify that relationships, whether they are beneficial or injurious to the woman, should be seen as vehicles of growth and channels towards recovery. But not all the self-help authors bother to justify the presence of love stories or explain why they necessarily correlate with the subject of recovery. Love stories in these texts were so prolific that they predicate the cultural assumption that romantic attraction always exists and that people are prone to act on these attractions. This belief, termed as

“the relational imperative” by Holland and Eisenhart (1990), typifies the notion that women always want love, romance, relationships, and marriage.

Most self-help books presume that women’s addictions are by-products of certain deficiencies they may be having in their love lives. Self-help tells women they may have started drinking as a replacement for the affection their lives were lacking, or that they drink because their vulnerable emotional states provoke them into unhealthy coping behaviors.

A woman drinks from a feeling of inadequacy and from a need for love (Kirkpatrick 1977: 21).

Many women’s emotional problems and disturbances are all tied up in the male-female relationship (Kirkpatrick 1977: 163).

Najavits (2002) believes women’s addictions are often the result of bad relationships as “women tend to take on the addiction patterns of their partners” (12). But the authors also reason that safe and “healthy” romantic relationships can play key roles in the recovery process.

Intimacy is a core of healthy sobriety. It is not an intimacy you need to make you whole. You are already whole, and it is your whole self that you now bring to relationships with others (Brown 2004: 91).

Addiction is about constriction; recovery is about expansion. This includes expansion in relationships (Iliff 2008: 228).

Even as authors regard relationships as essential to recovery, they critique women who jump into them too fast or women that may fall into relationships who do not benefit their recovery. Women are told to evaluate men on the basis of their ability to conform to monogamy, and they are told to evaluate their own relational availability based on their recovery status. Hatvany’s (2011) describes a conversation she had with her young son about her new boyfriend. Her son says “you can marry him if you want,” but she explains that she is “not quite ready to marry again. Not yet” (327). Her ability to forestall a relationship in favor of her recovery mission is positioned as mature and responsible.

Women who have been previously treated negatively in a romantic relationship blame the treatment on their addiction. In Sleeping with Dionysus, Porterfield (1994 Julie Novak-McSweeney)

explains her addictive timeline, “I drifted through a series of relationships with emotionally abusive/neglectful men” (122). Additional descriptions are given by women who merged their relationship with addiction with their relationships with men.

Maybe I had thought so much of [Ben] because I thought so little of myself. . . .I needed to figure out how to be true to myself (Wandzilak and Curry 2006: 176).

“Let me get you another drink” he said, even though I’d barely touched the one already in front of me. I could see that what he was really saying was “Let me Take Care of You” (Porterfield 1994:60).

Some authors give readers tips on how their new sobriety, and the concepts they are learning from addiction therapy, can help them win over (and keep) mates.

I applied the same concept to my marriage. In a nutshell, I have been extremely happy and content in my marriage ever since. My husband has not changed (Eleanor R. 2011: 84).

This experience. . .enabled me to let go of the person I used to be and to become the person I always wanted to be; which was an authentic self, a mindful self, a caring, giving and compassionate self. My marriage deepened (Iliff 2008: 103).

The books frame marriage as the final and ultimate stage in the sequence of romance. They give women rules as to how to negotiate the various stages in their relationships, with the eventual destination of marriage as the objective.

Don’t let a bad or dead-end relationship keep you off the market. For a woman especially, time is of the essence (Cary 1993: 112).

Most women get scared and back off when a boyfriend won’t commit. But sobriety eventually gives women courage (Cary 1993: 96).

A large part of the requisite lifestyle for recovering women is the transformation from singleness into a relationship status. In every story where women were succeeding in continuing their sobriety, there was almost always an accompanying story of romantic love. Wandzilak (2006), describing a relationship she began in rehabilitation, was delighted to tell her readers: “Nick told me that one day he was going to make me his wife” (217).

Women recount how their love life is “richer” and “fuller” now that they are sober.

I had no idea recovery was also learning how to be in intimate relationships, learning how to have close, wonderful friends. Then there's my marriage. My husband and I have developed a rich life together (Brown 2004: 3).

Every night as I lie next to my husband, my rest is sound and warm. When I play on the floor with my beautiful son and now my baby daughter, I know I am in the grace of God (Wandzilak and Curry 2006: 270).

Even when women are not taking part in a romantic relationship, the books view the mere desire for romance as a sign of recovery.

Leah has been feeling more open to meeting a man, and more prepared to do the necessary work (Cary 1993: 74).

In my third year of sobriety, I felt ready to start looking for a partner (Kelly 2007: 122).

Because of the pervasive expectation that women should want love, many women in the biographical accounts who were not in a romantic relationship felt they had to justify their single status.

Jill has chosen not to marry again. "I didn't feel the need to. I have my AA friends and my non-AA friends." (Cary 1993: 141).

I've had some nice love relationships in sobriety, but I'd rather be alone than with the wrong person (Porterfield 1994: 169).

Various language metaphors used the prominent theme of romantic love, like motherhood, to describe the concept of addiction. Alcohol was personified as friend or lover, a buddy who was there for the woman when no one else was present. Knapp's (1996) memoirs is named, appropriately, A Love Story; she explains in the prologue "It happened this way: I fell in love and then, because the love was ruining everything I cared about, I had to fall out" (xv). In Make Mine a Double (Barreca 2011), Fay sexualizes her love for alcohol when she states, "I lost my virginity to Cointreau" (57). And Hatvany (2011) says that "my craving speaks to me in a hypnotic lover's voice" (160).

While romantic relationships are deemed as beneficial to recovery, sex was not viewed in necessarily the same light. The authors carefully emphasize that love differs dramatically from "hooking up" or having casual sexual encounters with others. The author Brenda Iliff (2008) explains in the

“Relationships” chapter of her book that “Intimacy is not the same thing as sex. Intimacy is about getting to know someone deeply through sharing feelings, thoughts, and beliefs” (226).

Women’s accounts of their sexual behavior expose that they situate sexuality within a moral sphere, and sex while using addictive substances is particularly taboo. Women often speak negatively of their sexual behavior while they were abusing alcohol.

Putting out had become second nature. It was my lifeline to survival. And wine was the life raft (Porterfield 1994: 31).

[I was] like a dog that had marked every place with pee (Eleanor R. 2011: 22).

I hate to say it, but I was very sexually active when I was out there in the throes of my addiction, and I’m no longer like that. Today I have morals (18: 226).

Note that the language in these sexual accounts reveals that women view wanton sex as basic, animalistic, and immoral. They also reason that their addiction brought out these sexual behaviors, further reiterating their need for recovery. Self-help explains that women’s sexual behaviors become “civilized” and “conscious” during the recovery process. As Eleanor R. (2011) points out, recovery is seen as a time to learn how to “properly” exhibit sexuality: “I still ran around like a wild woman staying out late with no boundaries or discernment over boyfriends. It took a while but, for the first time, I learned how to act right” (62).

While women are continuously guiltily revealing past transgressions in sexual behavior, one wonders whether men in recovery are doing the same. The ways in which women are told to “properly” demonstrate their sexuality represents the sexual double standard women must manage. Moreover, recovery literature often stigmatizes men as unquestionably sexually driven. Kirkpatrick (1977) notes that in her quest for a relationship she “became always aware that men are, in the first place, sexual” (37). Wilhelmson (2011) discloses her anger toward her husband while she dealt with her and her father’s illness, “Charlie never asks about father. He doesn’t seem to give a shit. Charlie works, gets a paycheck, and wants to get laid. That’s it” (289). And Cary (1993) reasons that men are so emotionally

incompetent she suspects that “if men told the truth about how they really feel, they’d never get laid” (96). This essentialist view of men’s sexuality leads to the expectations that men will be sexually competent yet aggressive, and thus women should be careful, scrutinizing and discriminating. Women are told to expect men to be the sexual initiators, and yet it is the woman who is forced to carefully calculate their pursuits and the likelihood that those encounters could lead to a relationship.

Self-help treats sexuality for women who are “coupled” with a partner differently than sexuality for single women. It treats sex in monogamous relationships as not only beneficial, but as a constructive part of personal growth. A major tenet of recovery is the promotion sexual health. Monogamous relationships, and particularly marriages, are deemed the primary context for safe and healthy sexual behavior, and sex becomes obligatory in these situations. Women in committed relationships must reckon with their obligations to please their partner, whether or not they feel up to the task. Recovering women express their frustration at their new, sober sex-life. Wilhelmson (2011) verbalizes her disappointment with her sex life when she says, “sex isn’t the same sober. It’s not as uninhibited and naughty” (59). Some women even express fear over the act of sex without the help of alcohol. “I am terrified of having sober sex” (Brownell 2009: 106), and Kelly (2007) admits: “I’ve always been astounded when people write about the oblivion of desire, of losing themselves in the act of making love, of taking leave of their senses. That only happened to me when I was drunk” (58). Nevertheless, the authors make it clear that women are sexually obligated to their partners and that a goal of recovery should be to do just that. This obligatory concept entitles men who are in committed relationships, privileging their pleasure over their partners, and confirming their higher status.

Many authors frame overconsumption as prohibiting women from properly demonstrating their sexuality. Brown (2004) says that “[t]he person who becomes addicted gets sidetracked and even derailed from a normal development path. . . .Addiction can also interfere with a young woman’s

developing capacity for intimacy and sexuality” (15). The emotional and physical impairments that prohibit recovering women from exhibiting their sexuality are revealed.

One study found that sexual dysfunction was the single best predictor of women’s alcohol problems over a five-year period (Najavits 2002: 59).

Alcohol actually decreases sexual functioning in women (Najavits 2002: 59).

Armstrong and Hamilton (2009) speak of how “sexual interaction is a critical location for the production of gender difference and inequality” (593), so it is not surprising that sex plays a major role in the construction of emphasized femininity. Self-help clearly displays hegemonic cultural beliefs about sex. Sexual desire drives men, and women should expect to be judged if they do not confine their sexual behavior to committed relationships. Self-help also ignores the fact that women’s desirability is often based on the presentation of their sexiness, yet by taking part in actual sex they risk being seen as immoral. Recovery literature, in effect, perpetuates the madonna-whore dichotomy.

The discussions about motherhood, sex, and love reveal the heteronormativity of the books. Love and sex are almost always in heterosexual contexts. Only one instance of homosexuality was given by Iliff (2008). Iliff’s subject Amy came “to terms with who I am as a lesbian. . . . I finally found a lesbian meeting” (171). Yet even Amy has maternal desire and, in agreement with the earlier motherhood discussion, recovery brought Amy new goals for her life: “I like who I am. I have a good job that pays the bills. I can become a mom. I can fulfill that dream” (172). The role of mother was constructed in the books as biologically deterministic, leaving little room for of adoptive parents or families that exist outside the typical nuclear family arrangement. The biologically essentialist approach that authors use to describe motherhood protects the institution of reproductive heterosexuality from critique, as it assumes all women can be, should be or want to be mothers.

Self-help portrays the role wife as another main strain faced by women. By outlining various ways women should endeavor to handle this conventional, heterosexual role-based arrangement, self-help authors unintentionally consign their readers to these responsibilities and situate *only* women as

the rightful “owner” of this role. The authors encourage women to play out the role of wife “appropriately”, revealing the ways in which they conceive the proper manifestations of femininity. They not only perpetuate the ideals of emphasized femininity, but they encourage heterosexuality in these creations.



## 8 FLUIDITY

The various manifestations and expressions of gender were described in the data in many different ways. The books, through the repetition of emphasized feminine tenets, encourage and disseminate cultural meanings about femininity. Nevertheless, they also acquiesce that women have the freedom and the choice to construe an identity outside of this cultural milieu. Most books describe for women ways in which to adjust their gender performances or their individualized notions of “womanhood” in order to recovery fully and functionally from alcohol dependence. In fact, these adjustments are considered to be imperative to the recovery process, whether they occur in isolation or in relation to the supportiveness of their environments. Although an essential sense of femininity clearly exists, there are other social factors at play too.

Although tenets femininity are recognizable, the authors also concede these are not universal or timeless but must be approached with historical, individualized, and contextual considerations. They challenge the reader to seek an eternal notion of who they are and what they want, despite what anyone else says. As the books encourage women to embrace the aspects of gender presentation they feel comfortable with, they offer opportunity for resistance. This creates a discontinuity, a displacement, and a destabilization of emphasized femininity theory.

The books also teach their readers how to (sometimes forcefully) communicate their needs to those around them. They tell women that the new powers they have discovered in recovery will change the dynamics of their relationships, but reassure them it is for the best. They portray relationships that disintegrate through the course of recovery as fruitless associations anyway.

Many women are overly apologetic and take too much of the blame in relationship conflicts (Najavits 2002: 117).

You will discover the power of boundaries. . . .It is what allows you to say yes and no (Brown 2004: 108).

Divorces occur with sobriety because their marriage partners do not know how to respond to sober spouses. Sobriety strains the relationship, and the couple breaks up. Too often a man is unable to deal with a new, strong, and resilient wife (Kirkpatrick 1986: 102).

The books reason with the reader and her desire to develop insights and perspective out of her experiences with marginalization. They explain ways for women to consciously approach gender formation with a sense of self-exploration and creativity.

Compose alternative core beliefs about self: I can make a safe world for myself and my child (O'Neill 1996: 147).

Explore your own identity. . . .Tomorrow can be different (Najavits 2002: 23).

Their new-found recovery identity and the notion that their lives would be completely transformed within a recovery lifestyle likely heighten the sense of possibility.

The authors admit that there is a sort of "foundationlessness" that fragments our ideas about identity and gender. So even though general patterns run under the surface, they become irrelevant when women's own agency is taken into account. Women are told to increase their awareness of their power within the construction of their new identities as alcoholics. So women, with increased personal reflexivity, could enhance their ability to "be themselves," rather than as a guide that prescribed how they should be.

The authors legitimize the situation of alcoholism and vindicate most choices their readers choose to make. One significant theme in alcoholic self-help books is compassion and support for the reader. Self-help authors spend large amounts of text, particularly at the beginning of their works, acknowledging and elucidating the inequitable gender roles women may be facing in their lives. From micro-level issues such as physical abuse, to macro-level issues like low paying jobs, self-help outlines the various reasons why women may begin drinking as a coping mechanism. Self-help authors allow women to embrace broader understandings of their problems, and often link alcoholism to the inferior

ways that women are treated by society. They may alert women to the collective nature of their problem and, at times, serve as opportunities to counter assumptions of femininity.

The self-help genre itself seems to offer women both a place of safety and a place of potential creativity in gender performance. As women begin to explore a world where alcohol cannot facilitate their interactions with others, they may “practice” their new situations through reading self-help. Self-help stories allow women to vicariously explore new forms of “performing” their both gender and their abstinence, thinking about how they will represent themselves and their transformation to others. They can read how others have previously navigated the world of sobriety successfully, and then possibly model their behaviors after these examples.

The books describe a process where in an addict should open up dialogues about her disease and her place as a woman. A quest for authenticity is at the heart of most of the books. The search for authenticity plays on people’s need to feel self-determining, agentic, and freely motivated. Nevertheless, this idea of a “self” challenges the notion that gender is an artificiality. Self-help books assume women have an internal sense of self, outside of their gendered experiences, that they experience as essential.

Knowledge is power-- and perhaps the most important knowledge of all is who you really are inside (Najavits 2002: 75).

I want to know who I am (Wilhelmson 2011: 56).

Developing a real self is the core work of recovery (Brown 2004: 121).

The whole purpose of the sobriety journey is to go back to get yourself, to reclaim that person you intended to be (Cary 1993: 37).

Butler (1990), in *Gender Trouble*, argues that the idea of an interior and organized core is an illusion, a “fantasy instituted and inscribed on the surface of bodies through performance” (136). She argues that the “core” self is not authentic, but is an effect of our performances. With this in mind, I would not say that the texts go so far as to unsettle or challenge gender in any grand way (at least not in

any radical fashion), but they do pronounce that versions of femininity are unclear, and potential tenets are still left to be charted by gender theorists. The books do not illustrate an outright subversion of gender hegemony; I am hesitant to view the fluidity of gender in the books in any celebratory fashion, especially as the prior chapters of this thesis focus on examining the still present and powerful images of normative femininity. What the books do illustrate is that the prevailing system of gender hegemony is in no way seamless. We may be witnessing the spawning of new forms of subjectivity that will transform the existing systems of relations into simply another form of gender hegemony.

## 9 CONCLUSION

### 9.1 Strengths and Weaknesses of Study

Sociological studies of alcoholism focus mainly on the practices and the problems of drinking behaviors. Some go so far as to examine the institutions (religion, medicine, family) that may shape and control drinking behaviors and recovery management. I chose self-help books as the medium for analysis because they offer the ability to examine the both cultural assumptions concerning alcoholism and the social interpretations of the “woman” gender. I employed a sampling technique to obtain books that were recommended by both the recovery community and individuals, books that were widely and easily accessible, and books well selling enough to be present on internet search engines.

My subjectivity was an ever-present concern throughout the coding and analysis processes. I have no experience with addiction recovery (either personally or professionally). This may have situated me in a less than ideal location, as my emotional and experiential understandings of the realities of addiction are limited. Yet my perspective may have also provided a certain form of objective distance from the emotional aspects of the books. To increase reliability and validity, I coded all of the books before I proceeded to look for key themes or patterns. Although I had prior feminist theories directing the research, I tried to read from a place of objectivity.

In my sample, the vast majority of books were written by women and most of these books were an autobiographical account where the woman described her own experiences with alcohol dependence. It has been said that the biography says more about the biographer than it does about the subject. Because of the mostly autobiographical nature of my sample, the individualized aspects of the writers were more than apparent. Therefore, it came as no surprise that books written by white, middle-class and heterosexual women did not contain advice or aspects that may appeal to those outside their privileged statuses. However, what did surprise me was that the manuals, guides and

handbooks I examined (that were not biographical accounts) had very limited occurrences of stories, discussions or recommendations for oppressed groups.

The biographical genre also brings its own uncertainties. I began to wonder how much detachment is present in biographies. How honest can a woman be about the humiliating aspects of her addiction and how accurate are her memories? Despite my hesitations, autobiographies offer unique perspectives because the authors have integrated the multitude of addiction experiences (medical, personal, emotional) into a concise material for their readers. They have filtered the magnitude of experiences about what it means to be or become a “good” alcoholic woman, bringing the often blurred aspects of gender socialization into focus.

Out of the twenty books selected for this research, twelve of them were autobiographical. Through their own confessions, autobiographical authors offer advice for other women who desire to modify their own behavior. The production of knowledge through biographical accounts, by privileging individual self-knowledge over patriarchal authority, can be seen as an attempt to resist female subjection. Similar to Collins’ (1986) idea of the “outsider within,” women’s biographies may be agents of self-definition and self-evaluations that challenge the political knowledge-validation process. Nevertheless, recovering women’s compulsion to put into language the stories of addiction still imposes standard forms of knowledge upon the reader. Women authors must interact between their own inner world of addiction and the outer, social world with its norms, laws, and expectations. These creations of meaning reveal how women remain enclosed in power relationships, particularly through the influence of emphasized femininity.

A weakness of my research was the material itself. Investigating only the object of a book disregards the living interpretations of literature. Books are not deterministic devices, reading them does not bind one to do what they propose. The books are static objects yet the possibilities for women’s unique interpretations of them are infinite. Additional research needs to be done on how

recovering women read these books, improvising and rebelling against them, altering and redefining within them, and relating and connecting to them.

## 9.2 Intersections of Race, Class, and Sexuality

In my analysis, I generalized and totalized the tenets of femininity that were present in the data. Methodologically, this was justified as I needed to treat gender as *the* major strand of analysis congruent with my fundamental theory. The sexist bifurcation of gender was my targeted topic, and it was my intention to search for patterns that would point to a universality of feminine directives. I did not want to be too relentlessly focused on heterogeneity while attempting to deconstruct the simple duality of the male/female formations. I find that the breadth and depth of gender is significant enough to warrant its own investigation, before other axes of oppression are brought into the theory.

Nevertheless, gender and emphasized feminine directives are not exhibited in a pure form, they are shaped by a multitude of influences. They work in conjunction with not only one another but with other axes of identity than the ones I outlined such as age, ethnicity, and race. These further axes of identity converge, interpenetrate and reconfigure our understandings of gender and oppression. Through them we can re-examine the cultural constructions of gender and how they are experienced. A deeper look into these variables reveals that the same gendering process used to define the “proper” manifestation of femininity also exists in relation to devalued races, devalued classes, and devalued sexualities.

Earlier I described how self-help illustrates narrow standards “appropriate” of femininity, perpetuating the “white”-ning of womanhood. By normalizing racially-biased, cultural forms of femininity, self-help marginalizes subgroups of women that do not conform to these norms and even goes so far as to demonize the demonstrations of atypical femininities as destructive to addiction treatment. Women of color are forced to conform to white notions of family, sexuality and beauty.

In regard to the role of worker, the self-help books compose a discourse that assumes traditional constructions of work: that it is outside the home and for pay. Kirkpatrick reasons that because women are housewives their “lives tend to be narrower and smaller than men’s” (115). Other authors give advice about how to achieve a work/home balance.

Even if the recovering alcoholic is married, she will probably have to go to work or continue to work, whichever the case may be (Cary 1993: 52).

Maybe you should look for a job. . . .Get out of your apartment and start feeling productive (Wilhelmson 2011: 277).

These hidden assumptions about women’s work ignore the reality (particularly for women of color) that work often occurs at multiple sites for women: in the home and often not for pay. The sharp distinction between market/home workplace is evident and unquestioned, and discounts the cultural promotion and communal need for woman to be the primary caretakers, with or without an “outside” job at their disposal.

Consumption for women also is not only about gender and class presentation, but is a racialized experience as well. In a 2001 study, Michele Lamont and Virag Molnar in their article “How Blacks Use Consumption to Shape their Collective Identity” (2001), through qualitative interviews, affirmed that consumption is “uniquely important for blacks in gaining social membership. Their experience with racism makes the issue of group and community membership particularly salient, and consuming is a democratically available way of affirming insertion in mainstream society” (42). Blacks, whose bodies have been stigmatized, actively feel the need to refute that stigma. The desire to gain status, therefore, is not just about individual re-framing but constitutes a collective act to transform visible racial stereotypes of the group. So although upper mobility for whites is individualistic, for minorities it becomes an act of positive envisionment of their cultural distinctiveness. That self-help books individualize consumption behavior and personalize the individualistic agency that money can provide only further demonstrates their white bias.



The physical and emotional subordination elements of recovery literature are socioeconomically and racially biased too. For example, physical activity is determined to be an imperative part of a recovering lifestyle. Yet the insistence on physical exercise in gyms, yoga studios or around one's home overlooks the observed racial differences in preferred types of physical activities (Crespo et. al., 2000). Additionally, the physical activity mandate does not account for the substantial physical exertion done in blue-collar jobs or as elements of the functions of a homemaker. Physical activity is also contingent on financial resources, safe communities and the ability to have the "leisure" time to exercise, all representing social capital that not all people possess.

The emotional subordination and the construction of "good" emotions for women is racially prejudiced. Women are told they should be willing to emotionally and physically surrender to the philosophies of recovery and the principles that go with it (Higher Power Doctrine, medicalized treatment). Black women have traditionally been loaded with an image of emotional strength and stoicism, making it difficult for them to surrender to the emotional subordination needed in therapy. The color-blind assumptions of most recovery programs (where race is not regarded as an operational component of addiction) ignores the double bind that black women must accept, where they have an identity as both a woman and a racial minority.

The medicalized construction of addiction also perpetuates the institutionalization of race and class control mechanisms. Acquiring medical help often depends on financial and social resources not available to all. Specialized medical knowledge is deemed essential in overcoming alcoholism which give the professional (yet public) white space of the hospital, rehabilitation clinic, or psychiatrist office their symbolic power. With the sanctification of the medicalized space, race and racism remain taboo topics and color-blind racism continues (Porter and Barbee 2004). Also, white, middle-class values construct the etiquette of medical service (Page and Thomas 1994), dismissing the ethnic particularities and reinforcing black victimization tendencies. Self-help locates the individual as the locus of health and

permits the writers to transcend any racial or social biases and the specific health needs of race and/or poor communities are ignored. In this way, self-help can also be seen as an ally of and an aid to modern medical establishments which seek to minimize (often racial) differences in heterogeneous populations in their attempts to increase the calculability of treatments and efficiently organize the sick.

The role of wife and mother were outlined and both were shown to buttress the emphasized femininity tenet of compulsory heterosexuality. While assuming that all women are or want to be mothers, the books also offer readers a narrow view on motherhood, racially and socio-economically. Self-help's attention to women's struggle balancing work and family reflects a white, married, and middle-class bias, as women of color, single women, and working-class women have been struggling with this for years (Hochschild 1989). Continually, one of the primary reasons to overcome disease is for the preservation of the self for reproduction, but the family is not regarded as a key location for class, race, or heterosexual replication in the books.

Heteronormativity is always present in the accounts of motherhood. In the depictions of parenting, a father or male partner is present; there are no accounts of the adoption issues, struggles with a homophobic society, or other parenting issues same-sex couples may face. The assumption of a biological pregnancy and the postulation of biologically deterministic emotions are also heteronormative and racially distinctive conceptions. Black women's experiences as "othermothers" and adoption mother's experiences with the biological hardships of motherhood (for example post-partum depression) challenge the biologically deterministic and masculinistic norms of motherhood.

Motherhood is conceived of as both a facilitator and as a motivator for women to use towards recovery. As Eleanor R. states, "when I was in my disease, I just didn't have time or energy for the children" (63). Yet motherhood may be the very thing preventing some minority women from admitting their addiction and/or seeking recovery. Powerful and varying racial icons (crack Mother, welfare queen) that stereotype African American mothers influence the legislation and policies that target poor

women of color for punishment. The cultural prevalence of the loose sexuality stereotype exposes minority women to prejudiced assumptions about them and their children. Women of color may be all too aware of the cultural misrepresentations that devalue them as mothers and may avoid seeking help from Twelve Step Anonymous groups and books in order to protect their children. Because women of color's formations of motherhood are often labeled as deviant, they may be influenced to avoid recovery groups altogether.

The books' presentations of romantic relationships have a classed dynamic. The relationship discourse is structured by what sociologists (Arnett 2004; Rosenfeld 2007) call the self-development imperative. The self-development imperative suggests that in certain stages of life (mainly the 20's and early 30's) women should avoid committed relationships if it would derail them from investing in their own human capital (education and career). In these books, the self-development imperative centers on addiction, and women are expected to defer romance for their main task of recovery. Nevertheless, less privileged women, characterized by a faster transition to adulthood, have their own orientation to sex and romance beyond the "common" relational imperative (Armstrong and Hamilton 2009). These women have less exposure to notions of self-development occurring separately from romantic development. Most books do not converse with women who want to "settle" for men who may not completely support their recovery. Therefore, the relational imperative is, whether intended to or not, for more privileged groups: women who can be flexible whenever relationships are deemed a distraction from their recovery.

I outlined how heterosexuality and particularly marriage is considered a fundamental component of a recovery lifestyle. Self-help authors tell women their romantic lives are directly correlated with their progression in recovery and that true commitment to health means finding marriage and/or monogamy with a man. Cary (1993) states "in recovery, the ideal is to reunite family member in order to improve marriages, heal breaches between partners and children" (116). But the

various ways in which the books conceive of these roles reveals an ignorance concerning the lives and the views of marginalized people. The “wife” role for recovering women is class, sexuality and racially biased, as becoming a wife is not a desirable or even viable option for all women. Ingraham (1999), in her book “White Weddings,” argues that marriage is not financially or socially beneficial to marginalized groups as it “disqualifies many for the complex array of benefits they need to survive....For those living below the federally established poverty threshold, they are eligible for food stamps, Temporary Assistance to Needy Families, child tax credits, and Earned Income Tax Credit...marital status actually disqualifies some of them for assistance” (51). While marriage increases the earning potential of the middle- and upper-class, it reduces the relative wealth of lower classes. This disadvantageous outcome is often harnessed by the privileged and used to legitimize decreased funding of social programs to the poor. Often political pundits will point to low marriage rates in poor communities as a marker of moral ineptitude and lack of family values, justifying already inequitable policies and social structures.

Ingraham’s book also outlines the ways in which the marriage/wedding industrial complex and the marital industry itself perpetuate the heterosexual imaginary. She explores marriage as an American institution that goes under-studied, ignored or dismissed as just tradition. Her analysis summarizes the various ways in which companies market their wedding and marriage “products” (wedding dresses, honeymoons, destination weddings) along class and racial lines, using biologically deterministic discourse to advertise a life and a social reality that “should be.” Women’s experiences in self-help books seem to reflect the desire to have a fairy tale wedding and to obtain a kind of idealized married life with children.

Mike and I had a beautiful wedding, I felt like a princess. . . .For that moment, with five years of sobriety, I was healed. . . .I felt like Cinderella in her horse drawn carriage with my Prince Charming (Eleanor R 2011: 41).

I wanted to be taken care of. I was ready to settle down, have a home and family (Wandzilak and Curry 2006: 23).

The culture of this “white wedding” industry buttresses privileged racial and class interests not only through state and legal structures but through popular culture itself. For example, the white wedding dress has been transformed from an aesthetic fashion item to the symbol of purity, chastity, cleanliness. The weddings of Princess Diana and Kate Middleton are highlighted by popular magazines, TV, and newscasters as demonstrations of superior lifestyle distinction. These spectacles allow the public to fetishize the women; and have since allowed the wedding industry to capitalize on what is seen as the ultimate fantasy: a fairy-tale wedding with a happily-ever-after ending. Media conglomerates, such as The Disney Corporation, disseminate wedding culture to their audiences with repeated intensity. The dream becomes naturalized, and women who do not desire it often are pathologized as witches, bitter, or lesbians. The images impart in the collective conscious a distorted view of reality and play into the unification of ideas about heterosexuality, class, race, and gender. They also constitute what a “real” family should be (wife, husband, son, daughter). The genre of self-help is another cultural promoter of the heterosexual, affluent, white paradigm that is often unattainable to all but a few.

Race, sexuality, and socio-economic status are all social locations that can impinge on an individual’s capacity for wellness. Color-blind, class-blind and sexuality-blind perspectives in self-help decontextualize the realities of oppression. This decontextualization has multiple implications. On a macro-level, the health consequences of social disparities remain shielded with self-help’s denial or outright negation of the patterns of morbidity and mortality in oppressed groups. The powers of Whiteness, economic abundance, and heterosexuality remain obscure. On a micro-level, any efforts to design or deliver acceptable health services from a multicultural perspective are denied because alcoholic identity is not considered to be a part racial identity. Considerable revisions are needed in self-help to direct assistance towards heterogeneous populations and the inclusion of racial, classed, and sexual identities. And 12-step programs need to incorporate ideologies that prioritize any perspective that may challenge the dominant narratives of addiction.

### 9.3 Individualized Problems vs. Communal Problems

Sociologists and epidemiologists have shown how the American tendency is to locate explanation for disease at the individual level rather than see it as a consequence of social conditions like poverty or racial inequality (Diez-Roux 1998). Self-help literature is the epitomization of this propensity. The literature focuses mainly on direct servicing at an individual level. Although there is a partiality toward group work in AA and other recovery groups, the final goal is for the individual to change. The individual focus obscures the social structures that mutually reinforce the problems of health disparities.

Every social reality, including the reality of alcoholism, is constructed out of collective experiences, including the dynamics of gender, class, race, and sexuality. Despite this fact, the books do not advocate for politicizing the treatment of addiction. There is no focus on lobbying toward: demanding health insurance coverage for alcoholics, advocating for public funding towards prevention, cleaning up the damages in economic, sexist and racist systems, or pressuring medical and mental health professionals to recognize the special place women occupy in addiction circles. The relatively small amount of preventive education to populations at risk is ignored. Emphasized femininity is perpetuated by the tailoring of alcoholic treatment towards the individual.

Self-help, by commodifying certain ideologies of feminism (empowerment, choice), uses these strategic principles as tools for selling women ideas about suitable recovery. Women are convinced that through individual effort and personal agency they can change their lives for the better. For example, exercising or eating “healthily” will benefit them by giving them increased sexual attraction, more energy for taking care of children or a better self-image. However, the increased agency that physical attraction may provide one woman exists in a larger climate where beauty standards devalue and decrease women’s agency.

Of course, one could argue that this research represents a bias in that self-help literature was the only literature utilized. “Self” is, of course, individualized. Yet, because self-help encourages women to embrace simple psychological explanations to their illness, they are likely to never challenge feminine mandates beyond the pages of the book. Some books go so far as to demonize the feminist movement itself, as Brown (2004) does when she states: “The feminist movement in the late twentieth century, which influenced so many women in one way or another, often left women feeling they had to prove they were equal to men by having power and self-control and by vigorously denying any signs of need” (132). One could argue that not because of the feminist movement, but because feminist goals were never completely realized, is why alcoholism persists.

#### **9.4 Re-examining Research Questions**

In this study, I investigated the following research questions: (1) What are the ways that femininity is (re)defined in self-help for women with alcohol dependence? (2) Is the gendering of alcoholism associated with the proscriptions for being a woman, which are narrow, limited, and restricted to those characteristics aligned with emphasized femininity? (3) If present, how are the tenets of emphasized femininity expressed in these books?

While researching these questions behind the theories of gender hegemony, I felt I must holistically approach the bodies of work from many different angles. While I am primarily a feminist social researcher, I was compelled to increase my awareness in the fields of medicine, addiction, public health, psychology, and spirituality because self-help constructs alcoholism as a complex amalgamation of deficiencies in the body, the mind, the emotional center, and the soul. The approaches to recovery are complex, diverse, dense and often perplexing. This leaves the reader susceptible any number of dominate coercions in their redefinition of the self, including the influences of hegemonic masculinity and their sponsoring of emphasized feminine directives. The acceptable and unacceptable performances of womanhood outlined by self-help authors fall under the model of Connell’s

emphasized femininity. The tenets of emphasized femininity in self-help disseminate the abundant world of medical and psychological informational books into vehicles to perpetuate gender inequality. Overall I found that the books did reinforce systems of gender inequality and confirmed some aspects of the theory of emphasized femininity, but there were instances when these systems were resisted at the same time.

In the analysis, I outlined how self-help reinscribes women back into the traditionally mandated realms of femininity including domesticity, marriage, and family values. Women's participation in these roles requires the added emotional work prescribed by emphasized femininity such as sacrifice, reliability and compliance. The ideals of contemporary motherhood also impose women as moral guardians of the home requiring their adherence to standards of passivity and modesty not necessarily imposed on fathers in the same way. Household responsibilities, proper childrearing, and submission to the husband in order to honor the institution of marriage are framed as strategic exercises to aid in the recovery process.

The books demonstrate that women themselves can become the instruments of their own oppression. They reveal how authors have internalized the patriarchal gaze as they assign meaning to their lives by naming, critiquing, and offering strategies to overcome addiction. As autobiographers label their behavior and through therapeutic of the work, the author becomes obligated to explain herself. The therapies and techniques proposed (whether exercise, or emotion work, or medical help) rarely seriously question female victimhood. These books exhibit how hegemonic agencies of power have transferred from expert to patient, from man to woman, from oppressor to oppressed.

While all the tenets exposed in my hypothesis were supported, there were instances where resistance to emphasized femininity did occur. The process of bringing one's life back together after the experience of addiction has many facets and self-help authors are prone to bring up all aspects of a woman's reality, including the reality of gender subordination. That many books acknowledge the



societal gender disparities women face is a positive development. My analysis shows that self-help expects women to rebel and sometimes counteract feminine mandates if they require the woman to fall prey to the temptation to drink. Some authors position women as strong, capable and worthy of leading healthy lives, this is also a positive development. Alcoholic women may need this constant and sometimes exaggerated assurance to convince themselves they should overcome their addiction.

Yet even when women are told they should refuse to “play girl” if it means they will start drinking again, they are *not* told to do this as a political act or to permanently adopt this rebelliousness as part of their identity. The fluidity of gender identities may be representative the postmodern fragmentation of culture, or the beginnings of the toppling of Western Dichotomies of Gender Thinking, or maybe it is simply a modern form of nihilism. But the proliferation of abstract images and options allotted to the reader reflect on the ways in which we eschew the idea that there is an essentialist or authoritative construction of gender. Women can improvise against feminine mandates at the individual level (refusing to do the dishes in order to go to AA, gaining a few extra pounds in order to stop drinking entirely) yet womanhood itself is not challenged at the collective level. Individual, rebellious acts of resistance only push gender boundaries in microcosmic ways.

Additionally, the reassurance that women are strong and capable does not address the reasons many women begin drinking as a coping response to the inequitable pressures they feel within patriarchy. The books rarely conceptualize alcoholism particularly (and health inequality in general) as products of gender power differences. The books lack content on not only power relationships but particularly the ways in which dominant groups benefit from distributional differences in resources and social capital. Changes (quality child care, affordable education, living wage programs, universal healthcare) that might alleviate the stresses many women face are not discussed. By not directly addressing the processes and environmental inequalities that sustain and perpetuate oppression, self-help authors are blind to the political, economic, cultural, and social causes of health disparities.

Many people ask me if I would recommend any of the self-help books I read for this thesis to women alcoholics. This question forces me into a conundrum. First off, my goal was not to moralize or demonize self-help literature itself but to show how it constructs emphasized forms of femininity. Second, if the biographical stories from these books taught me anything, it is that alcoholism is a dangerous and tough disease. The advice in these books, if used accurately, may be powerful enough to bring transformation and development to an ailing person. Nevertheless, the discursive strategy that promotes personal reconstruction may be encouraging, through its imposition, a larger disempowerment for women. Women may occasionally introduce insurgent identities, but even within these identities, a wider social reality is represented that includes the coercive facets of racism, classism, and heteronormativity.

#### **9.5 Broader Implications and Advice for Continuing Research**

History shows that women's conditions, when culturally constructed as threatening, must be contained. Alcoholism represents a destructive manifestation of appetite. So do other destructive addictive behaviors women are prone to participating in: excess dieting, stealing, gambling and sex addiction. (It is fascinating to note how women lack total liberty in the areas of food consumption, capitalism, risk taking, and sexuality, respectively). Women's unbalanced participation in most social spheres must be fixed, as these external restrictions may be causing the rebellious of her consumption. Women's desire to numb themselves physically and emotionally will only be ameliorated when oppression (in all traditional, institutional and cultural arrangements) is dissolved.

The responsibilities that women are subtly yet powerfully provoked into need expansion. Motherhood and women's central place in the home was once the driving force for their addiction. Yet even today, when women have more access to employment outside the home, their rates of addiction are rising. Women's new financial independence and their changing economic roles put them in situations where alcohol is more readily available to them than previously- in bars, at happy hours and

at work place functions. The dangers and risks of addiction, then, can no longer be simply blamed on women's domestic role restrictions. As my thesis demonstrates, the interactions between ALL (at work and in public) feminine role expectations and alcohol may exacerbate the alcoholic problem and the emotions that accompany it.

Yet women's traditional role positions are still regarded as the forces that can alleviate their suffering. When the fundamental roles that women are told to play are either one of sacrificial mother, doting wife, or obedient employee, they may begin to believe they are only valued for their utilitarian capacities. It should come as no surprise then that modern women (who are most of the time highly educated and liberalized) are prone to having role crises in situations where their independence is thwarted. Our cultural understandings of the "natures" of women (that really only promote their oppression) need expansion.

The limited roles of wife, mother and worker cap a woman's abilities and bind her from becoming her own person. Women who define themselves solely by their roles with others in relationships are vulnerable to severe crisis if those others happen to leave. One role is not a lifetime post. If she either loses her husband or when her kids grow up and move away (or both) a woman will have no one there to confirm her status. She might reason that she amounts to nothing. Women who undergo changes in their lives often have no guidelines or rites of passage to help weather the change. The insistence on traditional feminine role structures leave women susceptible to the standard vicissitudes of life course change.

Medical ideas drive the discussion on addiction in women. This focus on the (medicalized) body is reflective of the pervasive biomedical model dominating health research and practice in modern society. The self-help genre does seem to be counteracting some of the over-encompassing aspects of medicine by enabling and encouraging women to talk about their addiction on a personal level. Unfortunately, the medicalized treatment of addiction seems to be dominating most of what they are

saying. The biomedical paradigm and medicalization discourses are troubling because, once again, they ignore any critical analysis concerning the dimensions of social inequality. The individual as the starting point of recovery theory decontextualizes the social conditions of health. Our national investments in solely biomedical research perpetuate this paradigm. The definitions of “health” need to be expanded beyond the individual bodies to incorporate the social relations that situate health in social sectors.

Public education to combat the stereotypes about alcoholic women and women in general are also needed. Prevailing social attitudes still regard alcoholics as weak, immoral and/or psychologically disturbed. This viewpoint, as well as the belief that women themselves are inherently less emotionally stable than men by virtue of their biology, are fallacious and damaging. These assumptions, encouraged by the powerful medical industry, are leading medical professionals to overprescribe medications to women who may only need cognitive/behavioral therapy and/or caring treatment. These stereotypes may also encourage the alcoholic herself to internalize the belief of her maladjustment, fueling the desire to request drugs from a doctor.

The desire for disembodiment as a fundamental component of a woman’s experience also needs to be addressed. Mainly the beauty and “health” principles that promote sexist beauty standards need dismantling. While overturning longstanding conceptions of beauty is a lofty goal, it is especially important for medical doctors, addiction researchers and recovery therapists to attempt to be as neutral as possible when it comes to judging women on the state of their beauty and health. To push unfair standards or norms on women (who are already exhausted physically, emotionally and possibly financially) is only likely to aggravate their internal conflict. At the corporate level, ads for alcohol that appeal to women’s desire to be beautiful, seductive and yet sexually passive should be censored from children. The alcohol industry preys on women by telling them to use their bodies for personal gain, but then only disadvantages them by dissociating them from themselves.

Disembodiment may also be a product of the medicalization of alcoholism itself, as medical care often distances a woman from her body. Technical language, specialized treatment, and the scientific estrangement from patients' subjectivity create disempowering experiences for many women. It is imperative that we begin to accept alternative means for treating addiction (like holistic healthcare, social and cognitive adaptation therapy, or psychological counseling) and to acknowledge the difficulties of addiction recovery might be more than just manifestations of a "sick" body.

Our cultural understandings of gendered drinking behaviors need questioning and may need alterations. Women have made immense gains in gender equality efforts over the past century and particularly over the past several decades. Nevertheless, widespread sex discrimination still exists in social institutions. Genuine efforts to change women's inferior status are often met with staunch resistance at the local and national level. Drinking has become a symbol of feminine liberation; it does not cost society much to allow women into the "man's world" of drinking. This form of consumption "achievement" may be distracting women from the real struggle of equality. Women are confusing the symbol with the substance. As they continue to drink to keep up with men, their "achievements" may be miring them into further disadvantage.

The social isolation for marginalized sectors of women needs to be remedied too, as it may increase the risk of addiction. For example, lesbians suffer the inequality of all women but even more so because of their sexual preference to other women. The gay bar was created out of the stigmatization that lesbians and gays suffer; it offers them a place of social unity. Bars often give alienated groups a nuclear, safe place where social lives can be formed without much fear. But as lesbians and gays come to rely on the bar as their social outlet many may notice an intensification in their need to drink. Bars should not be the only social spaces that offer unique opportunities to meet like-minded people. The bar scene can be viewed as a product of an environment that isolates gay men and lesbians. This

represents one of the many ways that marginalized individuals may be undermining their health in response to not being fully respected as people.

Our understandings of gender need modifications beyond feminine mandates. The potential for genderless ideas and ways of relation are already there; they just need embracing. New dimensions in gender neutrality need to be applied at micro levels. Sexual, reproductive and romantic discourses need re-balancing towards negating traditional gendered traits. Also, we need to continue examining how gender identity may be modified through participation in societal institutions, particularly authoritative institutions like medicine or the family. The process of reconstructing gender roles to be more multifaceted is, again, a lofty goal. Nevertheless, findings (Hooberman 1979; Woodhill and Samuals 2003) have shown that people who self identify as androgynous were more likely to maintain positive psychological health than those who identified with singularly femininity or masculinity. This finding alone should increase, if anything, our curiosity about the potentials of androgyny.

While recovery therapies that impose stereotypical feminine visions are likely to create in women the very feelings that triggered their consumption from the beginning, the disparaging of traditionally “masculine” behaviors like anger or aggressiveness for women will increase gendered struggles too. If a woman feels these behaviors are part of her personality but is told they are “unnatural,” it will only increase her shame. Both genders must feel permitted to explore all emotional aspects of themselves before they can straightforwardly label those behaviors as beneficial or destructive to their recovery. Real freedom for women does not come from being more like men, but from embracing and reintegrating repressed parts of themselves. Becoming “whole” means shedding the linear thought structures that comprise and imprison us in gender dichotomies.

Overcoming gender dichotomies does not mean that gender health disparities or addiction itself will go away completely. Even in a completely androgynous world substance abuse and addiction are still likely to arise. What would change would be the goals of recovery: women’s lives and bodies would

not be solely valued for their efficiency, beauty and procreative ability. Women would be assisted into discovering the parts of themselves where growth has been stunted.

The gradual dissolution of sex roles will be beneficial for men too. Studies show that men often admit they drink to give themselves a sense they have power over others (Capraro 2000). If men were permitted to express the “feminine” sides of themselves (emotionality, dependence, compassion), their desire for power may not disappear, but it would certainly be diminished.

Sociologists need to continue to tease out the ways gender shapes racial and socioeconomic disparities. New approaches are needed in order to hurdle the racial and socioeconomic disparities in health (Link and Phelan 1999). Public health specialists, medical sociologists, and addiction therapy groups need to continuously unravel race, class, gender, and sexuality from health to address the ways these positions change and modify it. Our increased understanding of the intersecting dynamics of these systems will lead us to better health care management policies.

The exploration of macro levels of subordination should not discount the micro interpersonal agency available to women. Any sustained social hierarchies within the aggregate do not negate a woman’s ability to act separately and in isolation. Women need to demand equality in the home. The sexual division of labor that keeps women bound to “second shift” responsibilities needs questioning. Yet to expose the various manifestations of oppression may cause dissent; and as we saw earlier, self-help is often about silencing the dissenting voices.

The ever-changing dynamics of production and perpetuation of gender means the analysis emphasized femininity is never complete. Our objective, as sociologists, should be to continually expand our critical knowledge of gender into new arenas of social life, particularly the intersections of medical knowledge, social problems, gender, the body, and the culture of self-help.

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## APPENDICES

### Appendix A: Reference of Self-help Books Used in Sample

Barreca, Gina (2011). *Make Mine a Double*.

Brown, Stephanie (2004). *A Place Called Self: Women, Sobriety, and Radical Transformation*.

Brownell, Rachel (2009). *Mommy Doesn't Drink Here Anymore*.

Cary, Sylvia (1993). *Women Celebrate Long-term Sobriety*.

Casey, Karen and W., Bill (2004). *The Little Red Book For Women*.

Covington, Stephanie (2000). *A Woman's Way Through the 12 steps*.

Fanning, Patrick and O'Neill, John T. (1996). *The Addiction Workbook*.

Hatvany, Amy (2011). *Best Kept Secret*.

Iloff, Brenda (2008). *A Woman's Guide to Recovery*.

Kelly, Jill (2007). *Sober Truths: The Making of an Honest Woman*.

Kirkpatrick, Jean (1986). *Goodbye Hangovers, Hello Life*.

Kirkpatrick, Jean (1977). *Turnabout: New Help for the Woman Alcoholic*.

Knapp, Caroline (1997). *Drinking: A Love Story*.

Najavits, Lisa (2002). *A Woman's Addiction Workbook*.

Nolen-Hoeksema, Susan (2006). *The toxic triangle: drinking, dieting and overthinking*.

Porterfield, Kay Marie (1994). *Sleeping with Dionysus*.

R., Eleanor (2011). *The Disease of More*.

Rogers, Barb (2010). *If I Die before I Wake: A Memoir of Drinking & Recovery*.

Wandzilak, Kristina and Curry, Constance (2006). *The Lost Years*.

Wilhelmson, Brenda (2011). *Diary of an Alcoholic Housewife*.

**Appendix B: Coding Sheet****Book Demographics**

Title: \_\_\_\_\_

Author: \_\_\_\_\_ Author's gender: \_\_\_\_\_

Source: \_\_\_\_AA \_\_\_\_Google \_\_\_\_Amazon

Length in pages: \_\_\_\_\_

Year published: \_\_\_\_\_

**Tenets of emphasized femininity:***White-Centrism*

\_\_\_\_\_ Colorblind assumptions about femininity:

\_\_\_\_\_ Aggressiveness

\_\_\_\_\_ Sexuality

\_\_\_\_\_ Confidence

\_\_\_\_\_ Other (name \_\_\_\_\_)

\_\_\_\_\_ Ignores Race

\_\_\_\_\_ Mentions Race (pos/neg)

\_\_\_\_\_ Token Stories

*Middle-class*

Recommendations:

\_\_\_\_\_ See doctor

\_\_\_\_\_ Take drugs

\_\_\_\_\_ Detox Programs

\_\_\_\_\_ Hospitalization

Support networks:

- \_\_\_\_\_ Travel/vacation
- \_\_\_\_\_ Babysitter/nanny
- \_\_\_\_\_ Healthcare
- \_\_\_\_\_ Flexible employment
- \_\_\_\_\_ Cleaning services/cooks/shopping
- \_\_\_\_\_ Church or community organization
- \_\_\_\_\_ Other (name \_\_\_\_\_)

Themes:

- \_\_\_\_\_ Optimism
- \_\_\_\_\_ Self-actualization
- \_\_\_\_\_ Acquisition of money
- \_\_\_\_\_ Industry
- \_\_\_\_\_ Work ethic
- \_\_\_\_\_ Employment illustrations of white-collar jobs
- \_\_\_\_\_ Homemaker
- \_\_\_\_\_ Stories of affluence
- \_\_\_\_\_ Derogation of poor or unemployed

*Subordination*

Bodily:

- \_\_\_\_\_ Thinness
- \_\_\_\_\_ Youth as ideal
- \_\_\_\_\_ Dietary management
- \_\_\_\_\_ Beauty
- \_\_\_\_\_ Transformation stories



\_\_\_\_\_ Health as morality

Emotional:

\_\_\_\_\_ Passivity

\_\_\_\_\_ Compliant/Cooperative

\_\_\_\_\_ Sensitive

\_\_\_\_\_ Restrictive use of anger

\_\_\_\_\_ Sacrifice

\_\_\_\_\_ Guilt

\_\_\_\_\_ Appeal to reason and not intuition

\_\_\_\_\_ Unintelligence

\_\_\_\_\_ Dependence on others financially

Incentives for health:

\_\_\_\_\_ Children

\_\_\_\_\_ Husband

\_\_\_\_\_ Self

\_\_\_\_\_ Society

\_\_\_\_\_ Other ( \_\_\_\_\_ )

*Heterosexuality*

\_\_\_\_\_ Marriage as norm

\_\_\_\_\_ Mentions husband or male partner

\_\_\_\_\_ Familial obligations (child-rearing)

\_\_\_\_\_ Erotic desire or sexual obligation to partner

\_\_\_\_\_ Emphasis on reproductive health

\_\_\_\_\_ Absence of social alienation stories resulting from homosexuality

\_\_\_\_\_Absence of adoption/legality of marriage issues

\_\_\_\_\_Nuclear household formations

\_\_\_\_\_Singleness viewed as abnormal

*Fluidity*

\_\_\_\_\_Individualization

\_\_\_\_\_encouragement of masculine characteristics to overcome alcoholism

\_\_\_\_\_encouragement of "finding" oneself

\_\_\_\_\_talk of authenticity