INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.
Safeguarding Hegemony: White Middle-Class Women and the Discourse of New Temperance

Dissertation

Presented in Partial Fulfillment of the Requirements for the

Degree Doctor of Philosophy in the Graduate School

Of The Ohio State University

By

Susan M. Yadlon
B.A., M.A.

The Ohio State University
1999

Dissertation Committee:
Dr. Debra Moddelmog, Adviser
Dr. Valerie Lee
Dr. Linda Mizejewski

Approved by

Dr. Debra Moddelmog
Adviser
Graduate English Department
This dissertation argues that several conditions have significantly challenged relations of power over the last thirty years. It identifies two strategies that have emerged to maintain the hegemonic equilibrium: granting white middle-class women access to positions of social authority, and the health discourse of new temperance. The project contends that the two strategies work in tandem, with new temperance both legitimating the entrance of white middle-class women into the public sphere, yet simultaneously managing their participation to ensure that hegemony will remain relatively unchanged. As such, the dissertation identifies the entrance of white middle-class women into the social as what Italian theorist Antonio Gramsci characterized as a hegemonic sacrifice — a compromise made by those in power to elicit consent from disenfranchised groups.

However, this dissertation defines hegemony not as an attainable state but rather, as an interactive process composed of responses and counter responses. Using the work of Foucault to theorize the inherent stability of discourse, the project examines the contradictions within the discourse of new temperance, as well as the several texts that act as counter discourses.
ACKNOWLEDGMENTS

I would like to thank my committee — Dr. Debra Moddelmog, Dr. Linda Miziojewski, and Dr. Valerie Lee for their insight and assistance. I am also grateful to Dr. Julian Markels, who has been such a thoughtful reader of my work, and to Kitty O'Brien, who helped me navigate the bureaucratic requirements and without whom I would never have been able to graduate long-distance.

I wish to thank my parents, Robert and Marie Yadlon, and my sister, Kathy Yadlon-Pappas for reminding me not to take myself too seriously.

Several friends have supported me in various ways throughout the life of this project: Elizabeth Taylor got me started thinking about this subject; Annette Van has been an all-around dear friend; and Thelma Ross and Olya Evanitsky were kind enough to act as my dissertation reading group in Manhattan.

Lastly, many thanks to Brendan Potter and Patrick Murphy, who offered me a job outside of academia, which ironically, is what enabled me to finish this dissertation.
VITA

May 1, 1964 Born – Denville, New Jersey

1986 B.A. The University of Notre Dame
  Major: English.

1992 M.A. Syracuse University
  20th Century American Literature, Feminist/Cultural Theory

1992 Syracuse University’s Women’s Studies Graduate Program Certificate

PUBLICATIONS


FIELDS OF STUDY

Major Field: English
TABLE OF CONTENTS

Abstract ......................................................................................................... ii
Acknowledgments ....................................................................................... iii
Vita................................................................................................................. iv

Chapters:

1. Safeguarding Hegemony: The New Woman and the Discourse of Temperance 1

2. Disrupting Hegemony?: New Temperance and the Women's Health Movement 37

3. Automimmunity and Diversity Management: Logics of the Body in Late 20th Century America 65

4. Skinny Women and Good Mothers: The Rhetoric of Risk, Control, and Culpability in the Production of Knowledge about Breast Cancer 97

5. Resistant Discourse: The Impossibility of Hegemony 142
CHAPTER 1
SAFEGUARDING HEGEMONY: THE NEW WOMAN AND THE DISCOURSE OF TEMPERANCE

Americans are exposed to staggering amounts of information about health. There are a plethora of magazines specifically devoted to the topic (Health, American Health, Eating Well, Self), and many popular magazines feature health columns: Newsweek, Time, Vogue, Ms., and Glamour. The major news stations, both national and local, have health reporters, and nightly newscasts regularly air health segments ranging from the most recent scientific developments to surveys on America's fat intake and exercise levels.¹ This dissemination of data is not limited to the traditional news media: in 1995, the FDA mandated that packaged foods must supply nutritional information that can be easily understood by the average consumer. Even the 99 cent spiral notebook I purchased to take reading notes for this dissertation contained a "Student Survival Guide," the first page of which lists the fat grams and calories in a variety of foods, including the menus from Taco Bell, McDonald's, and Pizza Hut.

¹ One local news station in Columbus, WSYX-6, advertises that "If it's important to your health, it's on Six on Your Side." Another's selling point is that its health reporter is a registered nurse with years of experience.
These examples underscore that health discourse is alive and thriving in contemporary American culture. While this might seem beneficial, perhaps even a democratization of access to vital information, the work of Michel Foucault cautions us to take a closer look at this proliferation of data. Foucault argues that the production of knowledge is never a neutral process, but is always infused with relations of power. Because knowledge is both an instrument and an effect of power, he advocates a careful analysis of the conditions that produce a particular discourse as well as the effects of its dissemination:

we must question them [discourses] on the two levels of their tactical productivity (what reciprocal effects of power and knowledge they ensure) and their strategical integration (what conjunction and what force relationship make their utilization necessary in a given episode of the various confrontations that occur). (1980, 102)

Building on Foucault's insight about the relationship between power and knowledge, this dissertation attempts to uncover the tactical productivity and strategic integration of the discourses of health in the contemporary American landscape. The project contends that health discourse is a mechanism through which the social order is negotiated and, as such, understands discussions of health as symptoms in and of themselves: markers of social antagonisms, contested meanings, and profound ideological labor.

Specifically, this dissertation investigates the role of health discourse in the challenge to and maintenance of hegemony. As Italian theorist Antonio Gramsci argues, hegemony is consolidated not solely through coercion, but through a process
of negotiation and compromise which manufactures consensus. This "organization of consent" is created on several fronts in civil society—the family, education, law, religion, etc. According to Michele Barrett, Gramsci "was interested in the ways in which 'popular' knowledge and culture developed in such a way as to secure the participation of the masses in the project of the ruling bloc" (54).

Ideology is a central component of the "organization of consent" because according to Gramsci it works at the level of the material, influencing one's behavior and understanding of the world: "Ideologies . . . 'organise' human masses, and create the terrain on which men [sic] move, acquire consciousness of their position, struggle" (377). This terrain includes but is not limited to economic relations; in fact, Gramsci argues that any group unable to achieve social, moral and intellectual prestige is "incapable of establishing its hegemony" (269). Hegemony, therefore, must be understood as the establishment of political, cultural and social authority, not just economic power.

Despite Gramsci's recognition of the importance of the superstructure and the materiality of ideology, Barrett contends that Gramsci and the Marxist tradition he hails from still privilege the necessary class character of ideology, i.e., that all ideologies are "really caused by, or functional to, the overriding dynamic of class and class conflict" (Barrett 57). According to Barrett, Gramsci and his contemporaries took it "for granted that—whatever your theory of ideology—it was organised around social class as the essential and formative category" (57). This dissertation will move away from understanding class as the essential, formative
foundation of health discourse, and instead, define it as one of several crucial elements that inform health ideology. In order to highlight the dynamic nature of social relations (for example, the way that one’s class identification is simultaneously influenced and transmogrified by a host of other elements—race, gender, sexuality, nationality, religion, etc.), this project adopts Ernesto LaClau and Chantal Mouffe’s modified version of the Gramscian model of hegemony.

LaClau and Mouffe do not disavow the importance of class in the formation of ideologies. Indeed, they argue that “There is practically no domain of individual or collective life which escapes capitalist relations” (161). Like Barrett, however, LaClau and Mouffe find that Gramsci’s theory ultimately remains loyal to economic determinism: “For Gramsci . . . there must always be a single unifying principle in every hegemonic formation, and this can only be a fundamental class . . . Class hegemony is not a wholly practical result of struggle, but has an ultimate ontological foundation” (69).

To avoid positioning class as the essential foundation, LaClau and Mouffe describe society as characterized by a radical openness or plurality that prevents total fixity (e.g., a society in which class relations primarily structure all social relations). However, this openness does not imply “either pluralism or the total diffusion of power within the social, as this would blind the analysis . . . to the particular concentrations of power existing in every concrete social formation” (142). According to LaClau and Mouffe, these concentrations of power are constructed through discourse, a mechanism which tries “to arrest the flow of differences, to
construct a centre” around privileged moments called “nodal points” (112). Any discourse can have multiple nodal points, and each nodal point may represent “points of condensation of a number of social relations and, thus, become the focal point of a multiplicity of totalizing effects” (139).

The emphasis on nodal points allows LaClau and Mouffe to construct a model of hegemony which recognizes the importance of social class, yet does not grant it sole dominion. Class may in fact be a powerful nodal point in any given discourse, yet other nodal points simultaneously may exist which ameliorate, modify, or even contradict the effect that the discourse has on class relations. LaClau and Mouffe’s model is extremely useful to this dissertation as it introduces a way to theorize the complexity of power relations that call forth our contemporary discourses of health (strategical integration) as well as the complexity of effects these discourses provoke across the various social registries of power (tactical productivity).

While there are fundamental differences between LaClau and Mouffe’s and Gramsci’s models of hegemony, both formulations recognize that hegemony is never permanently secured. Rather, hegemony is a tenuous state in constant need of shoring up, an interactive process of responses and counter responses through which social groups attempt to establish dominance and maintain that equilibrium. LaClau and Mouffe’s rejection of total fixity means that discourse can only temporarily construct a center and arrest the flow the differences. And Gramsci theorizes that establishing and maintaining hegemony requires constant compromise and sacrifice.
on the part of what he calls “the leading group” in order to elicit consent:

“Undoubtedly, the fact of hegemony presupposes that account be taken of the interests and the tendencies of the groups over which hegemony is exercised, and that a certain compromise equilibrium should be formed—in other words, that the leading group should make sacrifices” ( Forgacs 211). However, Gramsci is clear that “such sacrifices and such a compromise cannot touch the essential” ( Forgacs 211). In other words, sacrifice must not result in any significant alteration of power relations.

This dissertation focuses on the contemporary process of compromise and sacrifice employed in the effort to maintain hegemonic equilibrium. It contends that the delicate hegemonic balance in the United States has been challenged by a number of conditions that have emerged and intensified over the last three decades. These include but are not limited to:

1) a shift in the demographics of the American populace—U. S. Census Bureau estimates predict that in the next two decades, the European American majority will erode significantly;

2) various civil right movements that have fought economic and social hierarchies, winning increased access to educational and employment opportunities, legal reforms (Sexual Harassment, Affirmative Action, and Anti-discrimination laws), etc.; and

3) the transition from a Fordist-Keynesian economic structure to a model commonly referred to as multinational capitalism that has led to a widening
of the economic disparity between the wealthiest and the poorest Americans, as well as ushered in a period of economic instability for the middle-class.

This project argues that one strategy employed to maintain the hegemonic equilibrium has been to allow white middle-class women access to positions of social authority. In Gramscian terms, this strategy operates as a necessary hegemonic sacrifice—granting a measure of power to members of a disenfranchised group in order to elicit consent. The strategy’s brilliance lies in that it addresses all three conditions identified earlier as potential disrupters of the hegemonic balance: it sustains European American economic and cultural power by increasing the number of whites in positions of social authority; 2) by meeting some of the demands of feminist groups, it can be used as an argument that calls for diversity are being responded to seriously; and 3) it helps offset the recent economic losses sustained by the middle-class by providing increased employment opportunities for middle-class women.

Specifically, the project investigates the role of a particular ideology of health in this process of transitioning white middle-class women from the domestic to the public sphere. This ideology, which David Wagner calls “new temperance,” stresses the role of individual responsibility and personal culpability in the onset of disease. Although always available as a framework through which to theorize health and disease, “new temperance” emerged as the predominant framework for understanding disease in the early 1970s, roughly contemporaneous with the three conditions mentioned above. This dissertation extends Wagner’s work on new

---

2 It also decreases the likelihood that the various minority groups will form an effective coalition.
temperance by examining how the discourse operates to legitimate, if not necessitate, the entrance of white middle-class women into the social sphere.

However, granting power to members of a marginalized group is a potentially risky proposition as the possibility exists that they may use that power to disrupt hegemony. This is why Gramsci specified that any hegemonic sacrifice must not result in a significant realignment of power relations. Some reshuffling may occur, but the essence of hegemony, the core relations of power must remain untouched. To that end, this dissertation further extends Wagner’s work by examining how new temperance works to ensure that these “newly-public” white middle-class women produced via new temperance do nothing to alter relations of power significantly.

The project once again relies on the work of Foucault to understand how new temperance operates to both legitimate and contain white middle-class women’s participation in the public sphere. The dissertation defines new temperance as what Foucault calls a disciplinary technology. These technologies are “methods which ma[k]e possible the meticulous control of the operations of the body, which assure the constant subjection of its forces and impose upon them a relation of docility-utility” (1979, 137). This control is not achieved through physical force but through “bio-power,” a mechanism which induces the individual to be self-disciplining, to act in certain ways, perform certain behaviors, etc. The end result is the creation of a docile body, obedient and highly useful to the relations of power that produce it.
Foucault argues that disciplinary technologies can have as much impact on the social order as more traditional modes of domination like political discourse and the law. But because they work covertly, their effects are often masked. For example, Hubert Dreyfus and Paul Rabinow note:

the eighteenth-century humanist discourse of equality fired political movements of an unprecedented scale. But at the same time, in a quieter way, tighter discipline in manufacturing workshops, regimented corvees of vagabonds, and the increased police surveillance of every member of the society assured the growth of a set of relations which were not and could not be ones of equality, fraternity, and liberty. (135-6)

Similarly, this dissertation argues that new temperance permeates and shapes the public participation of these newly-public white middle-class women in ways that guarantee that hegemony will be reproduced. As such, they exemplify what Rosemary Hennessy calls “the conservative face of the new” (103). According to Hennessy, the discourse of the new can function as a mechanism whereby oppositional modes of thinking are sutured into the prevailing regimes of truth in order to maintain a particular symbolic order. The discourse of the new can serve to anchor emergent modes of thinking in traditional categories that help support rather than disrupt the prevailing social order. In this way, the discourse of the new operates conservatively to tame counterhegemonic ways of making sense which threaten the coherence of the social imaginary . . . the appeal to the new serves an instrument of hegemony. (104-105)

Lastly, this project uses Foucault’s work on power/knowledge to understand how a discourse like new temperance can emerge as the predominant framework for
theorizing health and disease. Foucault argues that the production of knowledge is shaped by what he calls “the will to truth.” The will to truth is a mechanism through which certain types of knowledge become validated as true and other competing knowledges disregarded and/or marginalized. The will to truth does not focus on whether information is factually true or not but rather, on how certain knowledges become embued with truth-value.

For Foucault, the process of transforming knowledge into truth is a communal one and requires support from various social arenas: the will to truth “relies on institutional support; it is both reinforced and accompanied by whole strata of practices such as pedagogy . . . the book-system, publishing, libraries . . . and laboratories. But it is probably even more profoundly accompanied by the manner in which knowledge is employed in a society” (1972, 219). By tracing the ways that the entrance of white middle-class women is justified and simultaneously managed by new temperance, this dissertation traces how the will to truth functions. For example, as these newly public white middle-class women produced via new temperance take up positions of social authority, they help spread and popularize the discourse, i.e., they participate and further the will to truth which keeps new temperance the dominant framework.

The will to truth, however, cannot prevent the creation of other types of knowledges that operate as competing discourses, nor does it ensure that a discourse will have a coherent and unified effect. In fact, Foucault argues that discourse is
characterized by an inherent slipperiness that can produce contradiction both within
and external to it:

We must make allowance for the complex and unstable process
whereby discourse can be both an instrument and an effect of power,
but also a hindrance, a stumbling-block, a point of resistance and a
starting point for an opposing strategy. Discourse transmits and
produces power; it reinforces it, but also undermines and exposes it,
renders it fragile and makes it possible to thwart it. (1980, 101)

The instability of discourse opens up the possibility that a discourse like new
temperance will work in multiple and contradictory ways. It simultaneously
guarantees the existence of opposing discourses and multiple sites of resistance.
This project will pay close attention to the contradictions within new temperance and
the contradictory effects of its deployment, as well as to several texts which contest
the reigning will to truth in the production of knowledge about what causes disease.

This dissertation is divided into five chapters. The remainder of this chapter
traces the dual functionality of new temperance (legitimating the entrance of white
middle-class women into the social/managing their participation to ensure
hegemony) in an earlier period in American history, 1880-1920. Chapter Two
examines how a similar process is occurring in our contemporary era, defined
roughly as 1970-present. Chapters Three and Four provide in-depth examples of
how new temperance plays out in the discourses of two diseases which primarily
strike women—breast cancer and autoimmune disease. The final chapter offers three
examples of counter discourses to the ideology of new temperance.
The period between 1880-1920 shares many characteristics with our contemporary era. The early part of these forty years witnessed a rapid transformation of the economic structure as the Industrial Revolution of the 1880s and 1890s replaced a rural agrarian economic system with an urban industrial one. This had a particularly devastating impact on the middle-class. Competition from monopolies and large corporations forced many small businesses to collapse in the 1880s and 1890s (Wiebe 46), and those small-town entrepreneurs who did survive struggled to find their place in an economy that was functioning more and more on a national level. Simultaneously, “the very economic and technological forces that demolished the composure and autonomy of small-town America . . . raised up a new generation of managers and professionals as its problem solvers . . . the new managerial bourgeoisie developed within the new corporate bureaucracies, or came from the professions that serviced those corporations” (Smith-Rosenberg 172). This recomposition of the middle-class’ occupational structure led to intra-class conflict. As the urban professionals “quickly replaced small-town businessmen and professionals as the formulators and spokespersons for the bourgeois way of life [t]he older bourgeoisie viewed this new bourgeoisie with open hostility” (173).

Second, the demographics of the American populace underwent a swift transformation as the country experienced the largest waves of immigration in its history. Although many immigrants lived in poverty in the new urban centers, there were some visible challenges to the political machinery, particularly in the larger
towns in the Northeast Industrial belt. As Robert Wiebe describes: “Against a backdrop of tension, Catholics of Irish descent had been elected mayors of Scranton in 1878, New York City in 1880, Lawrence in 1881, and Boston in 1884” (50).³

Third, the abolitionist movement helped birth a vital women’s movement which pressed for increased educational and employment opportunities for women, as well as for the vote. Additionally, various groups sprung up to defend the civil rights of African Americans in the post-Reconstruction era, mostly notably the Anti-Lynching Campaign.

Fourth, similar to our contemporary era, the period from 1880-1920 was characterized by an intense concern about health and sickness. A number of popular health reform movements emerged: Social Hygiene, Temperance, Anti-Smoking, Anti-Tuberculosis, and Hydrotherapy. Health reformers regularly lectured to large public audiences, and self-help manuals and journals enjoyed tremendous popularity. Additionally, magazines and journals that were not health specific often published articles that gave medical advice and explained the most recent scientific discoveries. As Anita and Michael Fellman assert, this was particularly true of magazines with middle-class readerships (10).

Although in many ways this attention to health was a continuation of the health reform movements of the 1830s, the Fellmans argue that the discourse of health that emerged in the 1880s differed from the early discourses of health, and that this reflected changing social conditions as much as scientific advances.

³ Wiebe notes that political challenges also occurred outside of the industrial Northeast -- the Democratic party, most often the home of these immigrants, upset the Republican strongholds in Wisconsin, Illinois,
Wagner calls this emergent ideology “temperance” (not to be confused with the actual Temperance Movement), and characterizes it as a focus on personal behavior as the primary cause of disease.

As the Fellmans note, this ideology appealed particularly to health reform movements that dealt primarily with behavior, for example, Temperance, which focused on alcohol use, and the Social Hygiene Movement, which preached sexual moderation. However, Paul Starr argues that this ideology also permeated health reform movements that focused on diseases like tuberculosis. Indeed, Starr asserts that scientific advances such as the development of bacteriology in the 1890s actually strengthened the emphasis on personal habits and individual responsibility. Prior to the 1890s, the anti-tuberculosis campaign had focused on environmental causes—clean water and air, and sanitary living/working conditions. But once bacteriologists located the source of transmission as individuals, public health authorities gradually began “Shifting attention from the environment to the individual, [and] they increasingly relied on the techniques of medicine and personal hygiene” (Starr 181). For example, Charles V. Chapin, health commissioner of Providence, Rhode Island, argued that “It will make no demonstrable difference in a city’s mortality whether its streets are clean or not, whether its garbage is removed promptly or allowed to accumulate, or whether it has a plumbing law” (qtd in Starr 190). Instead, Chapin stressed that people “Wash the hands well before eating and

Ohio, Kansas and the Dakotas (50).

4 Certain elements in the anti-tuberculosis campaign argued for higher wages in order to allow workers to improve their home environments.
always after the use of the toilet. Teach this to children by precept and especially by example" (qtd in Starr 190). Although Starr argues that Chapin’s viewpoint was “extreme,” he asserts that “it reflected a widespread shift in orientation that contemporaries referred to as the ‘new public health’ “ (190). The characteristics of the new public health—an emphasis on personal hygiene and on the supervisory role of professionals like social workers, physicians and public health officials—were applied to a variety of health reform movements during this era.

Starr argues that this two-pronged attack (a focus on personal hygiene and supervision by medical professionals) was not “in fact, always a logical response to bacteriological discoveries” (191). For example, the tuberculin test introduced in 1890 and refined in 1907 led to the discovery that latent tuberculosis infection was widespread among the populace. Starr contends that this could have led to the understanding that “strengthening resistance” through improving nutrition, and housing and working conditions might be as valuable as preventing infection. However, anti-tuberculosis campaigns continued their primary focus on personal hygiene; for example, a Christmas Seal campaign enrolled three million children as “modern health crusaders” and awarded them points for performing “hygienic chores” like brushing their teeth (191).

What might account for the popularity and widespread reliance on the health discourse of temperance, even after bacteriological discoveries opened up the possibility for new discourses of health to emerge? To restate this question in Foucauldian terms, what conditions and power relations propelled the will to truth to
operate in such a way as to make temperance the predominant ideology of health (strategic integration), and what were the effects of this process (tactical productivity)? This dissertation argues that temperance became the dominant discourse of health because it served the needs of several groups who had vested interests in maintaining the hegemonic balance.

First, temperance sheltered business and government interests by focusing on reforming individual habits rather than reforming structural problems like widespread poverty and inadequate government services. This was certainly beneficial to both business and government sectors; purifying water supplies, increasing wages and providing better working conditions were expensive solutions for alleviating disease. As Charles Chapin noted, “The introduction, or even the purification of a municipal water supply may require millions . . . To wash the hands before eating and after the toilet costs nothing” (qtd in Starr 190).

David Wagner’s work focuses on the ways that temperance benefited the middle-class. He contends that temperance allowed the white, Protestant, middle-class to shift the focus away from a variety of social conflicts that threatened their power—widening economic disparity, violent clashes between unions and capitalists, the increasing integration of African-Americans into the economic and social sphere—onto the behaviors of the groups that threatened them. As such, temperance was a political response to the perceived need to control the social unrest of the immigrants and native ‘dangerous classes’ of this period. Although the more liberal reformers of the Progressive period did seek social reforms such as child
labor laws, the eight-hour workday, and women's suffrage, their deep anxieties about the decay of white Protestant hegemony prevented them from condemning the social structural arrangement of American society. In particular, they feared that growing labor unrest, radical ideologies, and the diluting of the U.S. native Protestant population by millions of immigrants could lead to revolution or, at a minimum, major losses of status and power (33).

Additionally, temperance reaffirmed middle-class respectability by locating middle-class values and behaviors as necessary for the attainment of health. Wagner argues that the health reform movements were characterized by "a strong ethnocentric belief in the correctness of white, Protestant, middle-class social norms (called the 'white life' in some Women's Christian Temperance Union and Social Purity propaganda)" (19). For example, the movement against infant mortality established middle-class norms of motherhood (staying at home with the child and giving him/her unlimited attention) as necessary for infant survival. The goal of this health reform movement was to instruct working-class and immigrant mothers in this method of caregiving, and the absence of programs for white, middle-class women highlighted which groups were understood as already possessing proper values.

Regina Morantz claims that "By the end of the nineteenth century, reform ideas about personal cleanliness, public health, and family hygiene had become familiar axioms of middle-class American culture—a badge of distinction by which members set themselves off from 'illegitimate' groups" (353). In general, attitudes toward the behaviors targeted by health reform split along class and race lines; for

\footnote{The Jim Crow laws and the prevalent use of lynching were attempts to restrain this integration.}
example, the middle and upper-middle classes were "dry" (i.e., did not drink alcohol) while African Americans and immigrants (Irish, Italian, Eastern European and German) were "wet." The same pattern holds true for the Anti-Cigarette campaigns. Even the health reform movements that focused on diseases like tuberculosis served this differentiation—Catherine Ott's *Fevered Lives* argues that the emphasis on personal hygiene helped shift the understanding of tuberculosis from a disease that struck the general populace to a disease of immigrants and the lower classes. This distinction not only reaffirmed the privileged cultural status of the white middle-class, but also furthered the representation of immigrants, African-Americans, and the working poor as unhealthy, dangerous, and detrimental to national interest.

Four, temperance provided a measure of economic stability for the middle-class as a whole during a time when its occupational structure was undergoing dramatic recomposition. The ideology's reliance on medical professionals (doctors, public health officials, social workers, etc.) in the attainment of health helped establish these professions as a national necessity. This increasing reliance on professions was part of a much larger trend that encompassed other middle-class professions as well. As argued previously, threatened by an insurgent lower class and a powerful new capitalist class, a new type of middle-class professional emerged: "social workers, public-school teachers, educational reformers, public-health experts, architects and early city planners (Smith-Rosenberg 172). Barbara

---

6 Interestingly, this movement never targeted cigar smoking, which was generally a habit of "respectable" men.
Ehrenreich argues that “In every field, professionalization was presented as a reform, a bold new measure aimed at replacing guesswork and tradition with science and rationality. But it was also an economic strategy . . . Through professionalization the middle class sought to carve out an occupational niche that would be closed both to the poor and to those who were merely rich” (78).

The professionalization of medicine is a perfect example of how this process worked. Prior to professionalization, “the role of doctor did not confer a clear and unequivocal class status” (Starr 81). In fact, “Although a few eminent doctors made handsome fortunes, many before 1900 could hardly scrape together a respectable living” (Starr 7). The lack of licensing laws meant that anyone could “hang up a shingle” and practice medicine, and in many cases this resulted in an oversupply of “physicians” that kept salaries modest. Additionally, medical societies were relatively autonomous and the large number of such organizations kept their respective memberships low. For instance, in 1901, the AMA claimed only 8,000 members; other local, state and national societies in combination had 33,000 members and the overwhelming majority of doctors (77,000) did not belong to any society (Starr 109).

In 1901, however, the AMA reorganized itself as a confederation of state medical societies, which in turn became confederations of local and countywide organizations. This interlocking structure increased membership (and dues) across the board because membership in one society necessitated membership in others (i.e., to belong to the AMA a doctor also had to belong to the local and state
organizations). By 1910, 77,000 doctors were members of the AMA, nearly half the physicians in America (Starr 110).

Soon after its reorganization, the AMA began a campaign to institute licensing laws. Starr argues that as "large corporations dominated the economic landscape... licensing... became a part of the resistance of a threatened petite bourgeoisie" (103). The AMA also attempted to halt the overproduction of physicians by reforming medical education. In 1900, 160 medical schools could confer licenses. Gradually, the AMA introduced a number of changes—a pre-entrance requirement of 1-3 years of college, a lengthening of the number of years it took to graduate from medical school. Starr notes that "Under the emerging system, young doctors could scarcely hope to be making a living on their own before age thirty" (118). These requirements ensured that only the upper and middle-classes could attend medical schools for few from the working classes could afford the pre-entrance requirements, the increased tuition (from the lengthening of years-to-degree), or the number of years without earning a salary.

As a result of professionalization, physicians' incomes and status rose, and medicine became firmly established as a middle-, if not upper middle-class occupation. Importantly, professionalization was simultaneously occurring in other fields as well: law, engineering, and architecture. Across the board, the professions provided for the middle-class a measure of economic relief and assurance at a time of great upheaval. As Barbara Ehrenreich argues:

Through professionalization, the middle-class gained purchase in an increasingly uncertain world. Henceforth, it would be shielded, at least slightly, from the upheavals of the market economy. Its
‘capital’ would be knowledge or, more precisely, expertise. Its security would lie in the monopolization of that expertise through the device of professionalization. (80)

The emergence of the professions, however, also suited capitalists’ interests. As Ehrenreich argues, “one of the purposes of the modern professions was ‘to keep the workers in line’” (133). The period in which the professions developed, roughly 1880-1920, was a time of great labor unrest. The Industrial Workers of the World claimed one million members at the turn of the century; socialist candidate Eugene V. Debs garnered 900,000 votes in the presidential election of 1912. Strikes were commonplace from the mines of Tennessee to the mills of Massachusetts, and often responded to with violence. Ehrenreich suggests that the emergent professions offered a method of non-violent social control that in the long run would be more effective than bullets and billy clubs. Mines and mills did not have to be hotbeds of working-class sedition; they could be run more smoothly by trained, ‘scientific’ managers. Working-class families did not have to be perpetual antagonists to capitalist society; they could be ‘Americanized’ by teachers and social workers and eventually seduced by ad men and marketing experts. Almost every profession or would-be profession, from sociology to home economics, had something to offer in the great task of ‘taming’ the American working class. (134)7

Of critical import to this dissertation is the role that white middle-class women played in these emerging professions. Feminist historians have noted that during the 1890s-1920s, a large number of white middle-class women left the

7 Ehrenreich notes that in 1907, Edward A. Ross, one of America’s first sociologists, advocated “social engineering” as a method of managing class conflict (134).
domestic sphere and entered the public sphere via the new professions. Historians commonly refer to this collective group of females as the New Woman. This dissertation is interested in the ways that the emergent discourse of temperance worked in combination with the emergence of the New Woman to maintain hegemony. Specifically, it contends that the discourse of temperance justified the participation of the New Woman in the social and economic spheres while simultaneously ensuring that this participation would not alter relations of power significantly.

Generally, the New Woman was white, native-born, and highly educated. Linda Gordon's study of 76 national leaders of the major reform organizations in the Progressive era revealed that while less than one percent of all American women held college degrees, 86% of the reformers were college educated, 37% had attended the elite Northeastern women's colleges, and 66% had received graduate degrees. The New Woman was also economically autonomous, often finding work in the newly created middle-class professions that the new public health relied so heavily on—social work, health care, nursing, and program administration.

A visible number of New Women eschewed marriage, and instead formed women-centered lifestyles and/or lived in female communities like women's colleges and settlement houses. Perhaps the most famous settlement house, Hull House, became the long-term or permanent residence of a number middle-class reformers: Alice Hamilton, the first woman on the faculty of the Harvard Medical School, and

---

8 See Carol Smith-Rosenberg's Disorderly Conduct: Visions of Gender in Victorian America for a broader discussion of the New Woman.
Florence Kelley, Julia Lathrop and Grace Abbott, all of whom would assume at one time the directorship of the Children's Bureau. Several formed life-long partnerships with other women; for example, Jane Addams, founder of Hull House, lived with Mary Rozet Smith for over forty years.

Although these characteristics seem to contradict the dominant codes of late Victorian bourgeois femininity, New Women understood themselves to be following the tenets of femininity. The reigning ideology of the feminine stressed women's inherent purity and morality, and legitimated service to others (women would counterbalance the corrupting influence of civilization) as well as loving friendships among women. Linda Gordon argues, "Their own avoidance of marriage did not mean that they were . . . challenging gender itself. On the contrary, they were convinced that their notions of the feminine flowed in parallel with those of the majority of married women . . . Those who lived as couples with other women considered themselves to be living in respectable, womanly arrangements" (80). In fact, many saw their commitment to other women and children as proof of their "true" womanhood:

Women who sought to secure the health and happiness of working-class children through child-labor legislation, the public-health movement, visiting-nursing services, and educational reform, Jane Addams and other settlement-house women argued, had assumed the role of public mothers. Indeed, Addams . . . and other New Women reformers vigorously defended their 'womanly' natures. (Smith-Rosenberg 263)⁹

---

⁹ Charlotte Perkins Gilman advocated what she called "social motherliness" (Gordon 55).
Many of the activities the New Woman was involved with focused on health. For example, in a letter to the Children's Bureau, Sophonisba Breckinridge proposed an agenda that focused on "the prevention of infant mortality, the anti-tuberculosis movement, the various public health activities, the movement to do away with illiteracy on the part of children in the South... There are other items but these are the most significant" (qtd in Gordon 104). As the ordering of Breckinridge's agenda items indicates, decreasing America's infant mortality rates was a high priority for New Women. Richard Meckel argues that the infant mortality campaign increasingly became a "woman's campaign" as it began to include the prevention of maternal death in childbirth (209).

Prior to the 1890s, the campaign to prevent infant mortality had focused on environmental causes—dirt, "dirty" air that required fumigation, poor sanitation. Two events in the 1890s caused a dramatic shift in the philosophical orientation of that campaign—the emergence of bacteriology which proved the link between impure milk and infant diarrhea, one of the major causes of infant death, and 2) the emergence of the health discourse of temperance which linked individual behavior to the onset of disease, and stressed the supervisory role of medical professionals. The result was that the campaign to prevent infant mortality began focusing on the behavior of mothers, particularly, how and what they fed their children.

Bacteriology and temperance meshed in the creation of milk stations that dispensed pasteurized milk to tenement mothers. Although several municipal health

---

10 See Chapter 5, of Paul Starr's The Social Transformation of American Medicine for a broader discussion of the philosophical reorientation in public health policies.
departments established milk depots, the overwhelming majority was run by private philanthropies. For example, in 1893, New York merchant Nathan Straus opened several milk stations, distributing two to four million bottles of free or subsidized milk to poor mothers in the metropolitan New York area (Meckel 78). Many of these privately-run milk stations were organized by white middle-class women's clubs or settlement houses.

To keep costs down, most milk stations did not dispense prepared formula, but distributed whole milk and the additives separately. Nurses were then sent to the tenement homes where they instructed mothers on how to properly prepare the formula. Once there, nurses would also instruct the mothers on infant and domestic hygiene. As Richard Meckel explains, this practice met with criticism from rank-and-file physicians, particularly those who served the immigrant poor. “In the crowded medical marketplace of turn-of-the-century urban America, competition for patients was intense, and was especially so among those physicians without medical and social connections” (127). However, this criticism was offset by other doctors who used the milk stations to gain valuable experience in a specialized area—infant care (doctors were needed to examine and weigh babies to determine the proper formula prescription). These physicians were often new graduates of medical schools, and outweighed the rank-and-file physicians in both stature and number.

By 1915, there were over 900 visiting nurses. Meckel asserts that they were “the field troops in the campaign to educate urban mothers. They managed the everyday operations of the stations, canvassed neighborhoods for newborns, and
climbed innumerable filthy and dimly lit stairways to visit and instruct tenement mothers in their homes" (129). In part due to the influence of these nurse/educators, and in part due to the fact that infant mortality rates remained high despite the success of milk stations, especially among the urban poor, the infant mortality campaign began focusing less on nutrition, and more intensely on other behavioral aspects of mothering such as hygiene and general infant care.

This resulted in an increased reliance on medical and other professionals to provide supervision and instruction. According to Meckel, the new direction entailed a two-pronged attack: 1) "establishing programs of social and medical welfare for expectant and new mothers so that they might enjoy good health, medical attendance and supervision," and 2) "promoting maternal health, proper feeding, and hygienic infant care through instruction" (100). In practice, however, Meckel contends that the latter effort became predominant. "[E]ducating mothers seemed to hold promise as a panacea for infant mortality that could avoid the critical and problematic issue of poverty and make unnecessary more fundamental socioeconomic reform and the provision of social and medical welfare" (100).

Framing the problem of infant mortality in terms of the behavior of mothers served the interests of the many groups who had shaped the debate. Meckel suggests it deflected attention away from issues like fair wages and adequate government services. It simultaneously strengthened the emerging medical professions, particularly obstetrics and pediatrics. It also benefited New Women because social workers, health reform advocates and nurses were required to adequately supervise
and instruct mothers. Indeed, the careers of many New Women flourished through the expansion of supervisory services aimed at poor mothers. For example, in 1912 the United States government established its first social welfare agency, the Children's Bureau. Run by prominent women (Florence Kelley and Julia Lathrop) and almost entirely staffed by females, in practice the Bureau operated as both a Women's Bureau and an advocacy organization for children.

The emphasis on the behavior of mothers also gave rise to a number of mechanisms that allowed government and private agencies to intervene in the lives of the poor and/or immigrants. For example, the Children's Bureau instituted a process of birth registration in order to track child health. In 1908 New York's Bureau of Child Hygiene was established. Run by S. Josephine Baker, the bureau dispatched hundreds of nurses to tenement homes to inspect babies and instruct mothers in infant hygiene and maternal care practices. Other cities across the nation followed New York City's example.

Often instructions about proper maternal care contained a bias towards white middle-class assumptions about mothering and motherhood. Meckel asserts that "visiting nurses sought to acculturate immigrant mothers by introducing them to a scientific infant care, considered both more hygienic and more American. Certain essentials of that care, however, rested on a view of the maternal-infant relationship that was a product of industrial, middle-class culture and thus not shared by immigrants from preindustrial societies" (136). For example, nurses advocated "scientific" feeding schedules that could be adhered to only by stay-at-home mothers.
the idea of scheduling was extremely popular among white middle-class mothers) and that ran counter to the childrearing practices of many immigrant mothers. To ignore these schedules was often seen as a sign of improper mothering. As one nurse wrote:

[the baby] is fed irregularly. When the mother ‘goes out for the day,’ she nurses the baby at mealtimes and during the night. Irregular artificial feeding supplements her nursings. In the case of the non-wage earning mother, the nursings are equally irregular. The child is nursed when it cries or whenever the mother thinks it necessary. The clock is not consulted. (qtd in Meckel 137)

Other areas of contention included the use of solid food and pacifiers, swaddling, leaving the infant in the care of an older sibling, general cleanliness and the amount of room a baby should have to itself (Meckel 137).

Linda Gordon argues that welfarist programs like the visiting nurses emerged from a racialized system of thought. According to Gordon, “Progressive Era elite reformers usually considered the new European immigrants to be of a different race” (84), and therefore, reform programs were motivated by anxiety about the changing racial makeup of the country. “The early-twentieth century social work/welfare vision expressed a consciousness that the United States was in a social crisis created in large part by the new immigration. The survival of the democratic republic seemed to depend on turning the new immigrants into democratic citizens—educated, self-controlled, disciplined” (84-85). In this schema, motherhood became a function of citizenship, and health discourse a valuable mechanism for the production of an appropriate citizenry.
In light of the association between maternal education programs and social citizenship, it is crucial to recognize that not all women were the targets/beneficiaries of these services. Most notably, African-American women and children were virtually ignored in the infant mortality campaign. In part, this is due to the fact that maternal education programs were mostly instituted in urban areas, and large populations of African-Americans lived in the rural South. However, the geographic distribution of services cannot account for the fact that the needs of urban African-Americans were overlooked by these programs. For example, it was not until 1916, a full eight years after Baker's visiting nurses entered the tenements in New York City, that the first maternal education program was conducted in an urban black neighborhood. As Meckel points out, "This tendency to ignore, or pay only cursory attention to, black infant mortality was particularly tragic because black infants seem to have suffered the highest death rate of any group of American babies" (142).

The tendency to ignore African American infant mortality also points to a difference in the way health reformers viewed immigrants and blacks. Although immigrants were considered to be of a different race, Linda Gordon argues that they were viewed as "changeable, salvageable; indeed their presence created an urgent need for reculturation" (84). African Americans, as Evelyn Higginbotham asserts, were not considered assimilatable, and therefore they could not act as civilizing agents for the families and communities (265).

This distinction between those considered as trainable, and hence, potential citizens, and those understood as incapable of citizenship was continued with the
passage of the Sheppard-Towner Act in 1921. The first federal welfare measure in the United States, Sheppard-Towner funded state-run programs that provided medical services to women and children. The brainchild of the Children’s Bureau, which administered the Act’s implementation, Sheppard-Towner was passed in large part due to lobbying from women’s groups. A coalition of fourteen national women’s organizations (including The Women’s Christian Temperance Union, the YWCA, the National Consumer’s League, the General Federation of Business and Professional Women, and the National Organization of Public Health Nurses) spearheaded the lobbying effort. Additionally, a number of women’s magazines (Good Housekeeping, Woman’s Home Companion, McCall’s, and Ladies Home Journal) published numerous articles and editorials supporting Sheppard-Towner and urging their readers to write their representatives in support of the bill (Meckel 210). Meckel asserts, “Indeed, with the exception of suffrage, no other political issue seemed to galvanize American women in the postwar era as did Sheppard-Towner” (209).

Of course, not all American women supported Sheppard-Towner. Many politically conservative women argued that the Act would destroy the family by giving federal and state government control over family life. In the wake of the Red Scare brought on by the Russian Revolution of 1917, others argued that it was a form of socialized medicine. Additionally, members of the medical establishment contended that it would give lay persons control over establishing and administering medical services. However, there was considerable disagreement within the ranks of the Association; many specialty professions (like obstetricians and pediatricians) and
general practitioners who favored Sheppard-Towner’s emphasis on preventive care supported the Act. Indeed, on the day that the AMA voted to condemn Sheppard-Towner, a group of AMA pediatricians released a statement in favor of the Act to the press (Meckel 216).

Although the bill passed by a vote of 279-39, its opponents were able to exact certain compromises. Most notably, Sheppard-Towner programs were prevented from providing direct monetary compensation to individual mothers, and the bill was funded for a limited time and would need to be renewed periodically. Further, an oversight board including the Surgeon General and other medical professionals was established, giving these professionals direct control over the supervision of medical services. However, as Linda Gordon notes, this last compromise was not particularly bothersome to the Children’s Bureau because they stressed health education as the primary mechanism for preventing infant mortality, and they retained control over those services (94-95).

Specifically, the act concentrated on providing childbirth and early childhood health care services to poor, rural areas, particularly the Southern and Western states where prior to Sheppard-Towner, these services were virtually nonexistent. In these areas, the overwhelming majority of rural childbirths (among women of all races) were attended by midwives. The Act sought to discourage this

---

11 Meckel notes that one senator admitted to a reporter from the Ladies Home Journal that “if the members of Congress could have voted on the measure in their cloak rooms, it would have been killed as emphatically as it was finally passed in the open” (211).

12 Meckel points out that in 1925, 561 child health and prenatal centers were established, 21,935 child health and prenatal conferences held, 299,100 home visits were made by nurses, 2,195,000 instructional
practice by establishing clinics staffed by certified medical professionals. Bruce Bellingham and Mary Pugh Mathis assert that Sheppard-Towner “contributed to the rapid rise of a national standard of medical birth management” (158) and, as such “helped to democratize what had been an urban, middle-class cultural advantage” (157).

However, as Bellingham and Mathis also argue, the medicalization of childbirth was not extended to African-American women and children. Rather than discourage the use of midwives for black women, Bellingham and Mathis contend that Sheppard-Towner programs “set out to produce such midwives” (165):

The persistence of nonmedical birth attendance within the African American population was not merely accepted, but actively organized, by Children’s Bureau consultants who guided state staff in setting up and standardizing programs to qualify for Sheppard-Towner funding. Health officials began to count, register, organize, and instruct lay birth attendants in the first attempt to bring the reproductive capacities of southern African American mothers under some form of governmental purview. (165)

For example, the Children’s Bureau hired Dr. Iona Rollin Whipper, an African American female physician to run the training programs for black midwives. Whipper traveled throughout the South conducting classes and awarding certificates to those who passed. However, these classes focused on preparation for childbirth and the proper procedures for reporting births, but largely neglected to address the actual birth.13 While the content of the classes for black midwives paralleled the leaflets distributed. In Georgia alone 12,000 infants and young children were examined and 45,000 home visits were made (212).
content of the classes for white mothers, Bellingham and Mathis contend that “this omission made little sense” because the audiences differed. In other words, since the goal of Sheppard-Towner was to provide scientific, modern medical services (seen as preferable to the knowledge midwives possessed), then training for midwives should have included instruction in the latest birthing technologies and techniques. Bellingham and Mathis explain that, “In this case, reserving critical medical information for professionals not only prevented midwives from learning what they needed to practice knowledgeably, but also ultimately deprived their patients—African American mothers and children—of adequate care” (170-171).

Bellingham and Mathis do not argue against midwifery per se, nor do they assert that midwives were incapable of providing adequate medical care. Rather, their intent is to point out that Sheppard-Towner programs for black midwives “imposed only the symbols and ceremonies of medicine” (170) and therefore did little to improve the quality of care for African American women and children. Additionally, since Sheppard-Towner and the infant mortality programs that preceded it associated the medical management of childbirth with citizenship, the program’s support of midwifery for blacks highlights not only that African Americans were denied equal services, but were not considered as potential citizens.

In essence, the campaign against infant mortality forged a redefinition of citizenship. White, middle-class health reformers were the ideal, but white immigrants and poor, rural whites could be trained to adopt the behaviors that would

---

13 Bellingham and Mathis note that one component of the training was a slide show which contrasted an untrained "granny" with a new, supervised midwife, shown in white, receiving a certificate from a white public health nurse (170).
qualify them. African Americans, on the other hand, were left out of this equation while still subject to biopolitical mechanisms of control. As Bellingham and Mathis conclude, “Thus citizenly uplift for poor whites was inseparable from either the moral hegemony of middle-class reformers or the derogation of uncivilized races” (163).

The Sheppard-Towner Act exemplifies how a discourse like temperance can cause multiple and sometimes contradictory effects across various registries of social power. This is because, as LaClau and Mouffe argue, discourses contain several nodal points, and each nodal point can be a condensation of social relations. In the discourse of temperance, gender, class and race are three nodal points vital for understanding the way that the discourse functioned. On the one hand, temperance allowed white middle-class women to contest the codes of dominant bourgeois femininity and access positions of social authority, and the programs they created are some of the first examples of social welfare in America. Yet at the same time, these programs replicated and strengthened the racial and class hierarchies of the day. The mechanisms of surveillance inherent in the campaign to prevent infant mortality sought to acculturate the potentially dangerous immigrant classes and continued the exclusion of African-Americans from the body politic. Hegemonic relations were reshuffled slightly with the entrance of white middle-class women into the social, but temperance worked to manage that participation so that racial and class hierarchies would remain untouched.
WORKS CITED


The previous chapter argued that during an earlier period in American history when the hegemonic equilibrium was threatened by a multitude of conditions, two strategies emerged and worked hand in hand to ensure that hegemony would be maintained. The first strategy -- allowing white middle-class women access to positions of social authority -- is what Gramsci characterizes as a necessary hegemonic sacrifice. Gramsci, however, is clear that any sacrifice must not alter relations of power significantly, and to that end, the chapter examined the ways that the second strategy, the discourse of temperance, operated to ensure that relations of power did not undergo a radical transformation.

Chapter Two traces a parallel process in our contemporary era, roughly defined as the period from 1970-present. It contends that similar challenges to the social order have emerged over the course of the last 30 years, and further, that similar strategies have been adopted to contain those challenges. First, the demographics of the American populace are shifting; estimates predict that in the next three decades, the European American majority will erode significantly. According to U.S. Census Bureau statistics, whites accounted for 75.6% of the
population in 1990; by 1998 that number had dropped to 72.1%. The Bureau's estimates predict that by 2030, whites will constitute 60.5% of the American population. The recomposition of the American populace is already affecting the political landscape; political pundits are noting the need to capture the Hispanic vote in the 2000 Presidential elections, and George Bush, Jr. received considerable attention for his ability to do so in the most recent Texas gubernatorial race.

Second, various civil right movements over the last three decades have posed a considerable challenge to reigning social and economic hierarchies. Signs of anxiety about these challenges dot the American landscape -- reverse discrimination cases, attempts to scale back Affirmative Action (consider California's and Texas' recent decisions to no longer factor in race when evaluating candidates for admission to state universities), a spate of media coverage on the plight of the "angry white man." For example, a 1993 Newsweek poll reported that 48% of white men feel they are losing influence in American society, and 56% feel they are losing an advantage in terms of jobs and income (Gates 50). A 1994 article in Business Week called "White, Male, and Worried" begins with three personal narratives -- a white man laid off while two co-workers of color were retained, a white man who feels he isn't employable because he has the "wrong pigment, wrong plumbing" (Galen 50), and a 15-year-old white male who worries about his chances of getting into college. The article goes on to argue that diversity management programs have sparked "a white, male backlash" (52). Even the language implies a certain anxiety: the need

---

14 Between 1987 and 1994, 10,501 reverse discrimination charges were filed by white men to the Equal Opportunity Commission (Issues Quarterly 6).
to "manage" diversity suggests that diversity is potentially unruly and detrimental, and that only under precisely supervised conditions can it be "made to pay."

Third, during the 1970s the U.S. economy began its transition from a Fordist-Keynesian model to a structure commonly referred to as multinational capitalism. One effect of the emergence of multinational capitalism has been the widening of the gap between the richest and the poorest in America. According to Doug Henwood, the inflation adjusted annual income of the poorest 20% of American households decreased .8% from 1967-1997 while the richest 5% saw increases of nearly 78%.

The transition to multinational capitalism also resulted in a recomposition of the occupational structure of the middle class, similar to the one experienced from 1880-1920. The transition entailed a shift in emphasis from manufacturing and industry towards financial speculation, commonly referred to as "the deindustrialization of America." This had a severe impact on the middle class as professionals and managers lost their jobs to plant closings and the fiscal crises of the 1970s. However, the shift to multinational capitalism also created new middle-class occupations. "The shift in business emphasis from manufacturing and distribution to financial speculation created openings for whole armies of brokers, financial analysts, and bankers" (Ehrenreich 209). This recomposition has caused economic chaos for many in the middle class as they scramble to reorient themselves to the new economic order.

---

15 For a broader discussion of this transition, see David Harvey's *The Condition of Postmodernity*. 39
Not surprisingly, the number of middle-class families shrunk (defined as households with the middle range of income, $20,000 and $50,000) from 53 percent in 1973 to less than 48 percent in 1984 (Ehrenreich 205). Additionally, as inflation drove the cost of living up, "For the first time in postwar America, a middle-level income no longer guaranteed what we have come to think of as a middle-class lifestyle" (Ehrenreich 205). For example, a 1984 study by the National Association of Homebuilders reported that the median family income was $11,000 short of the amount needed to purchase a median-priced home. Housing costs had surged from 14% of a wage earners' gross monthly pay to 44% by the early 1980s (Ehrenreich 205).

Another significant potential disrupter of the social order were two discourses of health which were rapidly gaining popularity at the end of the 1960s. The first discourse focused on the social causes of disease, for example, occupational safety and environmental pollution. Writing in 1977, Robert Crawford asserts, "The American people have been inundated in just the last few years with a constant flow of environmental warnings and disasters: air pollution, contamination of drinking supplies, ozone watches . . . food additive carcinogens . . . vinyl chlorides, pesticides, the controversy over nuclear power plants, and more" (667). Wagner credits the various environmental and consumer movements of the late 1960s and early 1970s for bringing this discourse to the forefront of American politics, and reminds us that this discourse wielded considerable clout a mere three decades ago:

From Ralph Nader's campaigns for auto safety to demonstrations against the nuclear power plants, there was a time not so long ago when it looked like the 'margins' of society . . . might alter the shape
of the debate about risk, and attach the charge of 'defilement' and pollution to the corporate giants and governmental leaders (58).

The second discourse of health gaining in popularity framed health care as a civil rights issue. Starr contends that the various civil rights movements of the 1960s served as a template for a host of grass-roots, health rights causes -- the women's health movement, patients' rights, rights for the handicapped and the mentally ill: "Health care as a matter of right, not privilege. No other single idea so captures the spirit of the time. The law did not, in fact, recognize any general right to health care. . . But . . . the claim was for a time so widely acknowledged as almost to be uncontroversial" (389). This notion of health care as a right resulted in intensified demands for health care services from both the government (i.e., increased government services) and business (improved health insurance).

It was during this time of civil rights movements, discontent on the part of the middle and working classes, and the growing politicization of the social production of disease that the will to truth operated in such a way as to bring a third discourse of health to predominance. Like temperance, this discourse stressed the role of individual behavior and personal culpability in the production of disease; in fact Wagner calls it the "new temperance" in order to mark its similarities to the discourse that emerged in the 1890s.

Two of the first groups to adopt the discourse of new temperance were business and government leaders. Howard Leichter notes that the "prevailing wisdom among opinion leaders and policymakers . . . about the way people can best achieve healthy lives" underwent "a fundamental shift" (4) in the early 1970s.
According to Leichter, "The most basic assumption of the new perspective is that a good deal of disease is self-inflicted, a product of our daily habits, and that individuals, through negligence, self-indulgence, and irresponsibility, contribute significantly to their own ill health" (75-76). As such, the "new perspective" has meant shifting much of the responsibility for promoting health and the culpability for endangering it from the collective, both private and public, to the individual arena. This is not to suggest that environmental or occupational health problems have been ignored or that they are unimportant, but simply that the philosophical and political emphasis . . . has been on individual rather than corporate actors. (8-9)

At the policy level, this "new perspective" has involved a shift in focus from health care services to health "promotion." Health promotion stresses the role that education plays in preventing disease. For example, in 1976 Congress passed the National Consumer Health Information and Health Promotion Act. This legislation established the Office of Health Education and endowed it with the responsibility of educating the American public and encouraging health through lifestyle changes. Leichter states that with the passage of this act, "the federal government took cognizance of the relationship between life-style and ill health and committed itself, largely through health education, to improve individual health consciousness and habits" (93). Crawford argues that the bill simultaneously worked to curtail health care services by funding only those "programs which promote 'appropriate use' " of those services (1977, 676).

New temperance performs many of the same functions as the discourse of temperance did in the 1880s-1920s. First, it protects the interests of the government
and business sectors in two ways. One, the emphasis on personal risk factors (some would say failings) like improper diet, the inability to handle stress, or genetic susceptibility shifts responsibility from environmental causes (safe working conditions/pollution) to the individual. As Wagner argues, "'lifestyle' illnesses, which began to be trumpeted by government, medicine, and business in the 1970s, cast the moral blame back at the individual -- the smoker, the drinker, the overeater -- rather than attributing the potential defilement to corporate greed, government inefficiency, or the failure of our culture to satisfy human needs" (58).

Second, new temperance shifts responsibility for responding to illness away from business and government and on to the individual. As Crawford argues, "the victim blaming ideology will help justify shifting the burden of costs back to users. If you are responsible for your illness, you should be responsible for your bill as well" (1977, 670). It must not be underestimated that new temperance emerged during a time of intensified demands for more health services, both from the government and from business, and during a time of rising health care costs. For example, in 1975 General Motors claimed that it spent more money on employee health care benefits than on buying metal from its primary supplier, U. S. Steel; in 1976, Standard Oil announced that employee health care costs had tripled in the last seven years (Crawford, 1977, 666).

Crawford also contends that the focus on personal behavior as the primary risk "justifies a retreat from the language of rights and the policies of entitlements" (1977, 668). In part, this is achieved by recasting health not as a right, but as a duty. As Leon Kass argued in 1975, "It no more makes sense to claim a right to health
than a right to wisdom and courage. These excellences of soul and of body require natural gift, attention, effort and discipline on the part of each person who desires them . . . I would lean much more in the direction . . . of saying that health is a duty" (qtd in Crawford, 1977, 669). Further, this duty was often linked with the performance of responsible citizenship. Joseph Califano, Carter's Secretary of Health, wrote in the foreword to the Surgeon General's report Healthy People that "indulgence in 'private' excess has results that are far from private. Public expenditures for health care that consume eleven cents of every federal tax dollar are only one of those results" (qtd in Leichter 14).

However, it would be reductive to argue that new temperance held such popular appeal solely because it served the interests of political and corporate elites. Wagner asserts that new temperance served as a "reassertion of the ideology of middle-class respectability" (103). Ehrenreich suggests that new temperance, which she refers to as "voluntary simplicity," functioned as a tool through which the middle-class could differentiate itself at a time when its boundaries had been significantly blurred:

Voluntary simplicity . . . sought a way to express middle-class political aspirations in the form of personal behavior, or, in seventies terminology, 'lifestyle' . . . middle-class simplicity meant . . . lighter meals, 'health foods,' and a horror of strong drink and cigarette smoke . . . voluntary simplicity seemed to have become the very hallmark of middle-class existence -- not only an ethic but a set of behavioral cues that distinguished the middle class from those both above it and below it. (226)

Indeed, Leichter asserts that this period witnessed "a change in the health consciousness of people . . . Beginning in the late 1970s . . . particularly among the
younger, more affluent, and politically influential, the pursuit of good health through life-style change became a major personal preoccupation" (9). Crawford concurs that this rise in health consciousness "displays a distinctive -- although not exclusive -- middle-class stamp" (1980, 366). Writing in 1980, he contended:

A new popular health consciousness pervades our culture. The concern with personal health has become a national preoccupation . . . The past few years have witnessed an exercise and running explosion, the emergence of a vocal and often aggressive anti-smoking ethic, the proliferation of popular health magazines, and the appearance with amazing frequency of health themes in newspapers, magazines, and advertisements. (1980, 365)

Lastly, Crawford argues that because new temperance defines health as a result of personal behavior, it cements class relations by obscuring "the reality of class and the impact of social inequality on health. It is compatible with the conception that people are free agents" (1997, 672). Because new temperance "proposes solutions most likely to reproduce existing class relations, [it] represent[s] a class strategy" (1977, 664). In other words, the focus on personal behavior shuts down an examination of structural inequalities and, as such, leaves class relations in tact.

Wagner extends Crawford's critique, arguing that by redefining health as a function of merit, new temperance justifies punitive measures against those who do not adopt "proper" behaviors. Locating the contemporary campaigns against promiscuity, drug use and teen pregnancy as part of new temperance, Wagner notes that disenfranchised groups -- people of color, the poor, gay men and lesbians -- have been the primary targets of social intervention. Therefore, the discourse of new
temperance not only "hides major subtexts of anxieties about social class, race and ethnicity"\textsuperscript{16} (6) but simultaneously provides a mechanism for social control.\textsuperscript{17}

This dissertation extends Wagner's work by arguing that new temperance achieves social control not only by creating mechanisms of surveillance over the poor and/or people of color, but also by working hand in hand with another strategy employed to maintain hegemony -- granting white middle-class women access to positions of social authority. The project contends that new temperance operates in ways that tame the disruptive potential inherent in allowing a marginalized group a measure of social power.

One arena where this another strategy is highly visible is the U.S. labor force. In the early 1970s, white women began entering the workforce in record numbers. Statistics from the U. S. Department of Labor show that prior to the 1970s, minority women workers far outnumbered their white counterparts. By 1980, however, the numbers had reached relative parity, and in 1991, white women's labor participation rates surpassed that of women of color for the first time.

Importantly, the largest increase in white female employment since 1973 has occurred in middle-class occupations, managerial and professional jobs. While it is true that all groups of women have increased their presence in managerial occupations\textsuperscript{18} (in the last decade alone, the growth in this occupational category

\textsuperscript{16} And I would add gender and sexuality.

\textsuperscript{17} Please note that programs in the 1890s-1920s had similar results and visiting nurses and other professionals monitored the behavior of immigrants, African-Americans, and the urban poor.

\textsuperscript{18} Interestingly, the fifteen-year period prior to 1973 (1957-1972) witnessed a marked decrease of women in these occupations.
accounted for over half of the total increase in female employment\(^\text{19}\), white women have been the primary beneficiaries. For example, in 1966, white women, who account for 37% of population overall, held 13% of all managerial positions. This increased to 32% by 1979 and 42% in 1990. In contrast, black women, who constitute 6% of the population, held .6% of managerial posts in 1966, increasing to a mere 2.2% in 1979 (Sokoloff 18). This disparity has continued up until the present. Consider the following table of Executives, Managers, and Administrators by Industry from the Glass Ceiling Commission\(^\text{20}\) (19):

<table>
<thead>
<tr>
<th>Industry</th>
<th>% of Women</th>
<th>White</th>
<th>Hispanic</th>
<th>Asian</th>
<th>Afr.-Amer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Overall)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business</td>
<td>37.7</td>
<td>32.8</td>
<td>3.2</td>
<td>1.2</td>
<td>0.5</td>
</tr>
<tr>
<td>Finance</td>
<td>47.8</td>
<td>37.6</td>
<td>5.0</td>
<td>2.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Communications</td>
<td>30.3</td>
<td>25.6</td>
<td>3.4</td>
<td>0.3</td>
<td>1.0</td>
</tr>
<tr>
<td>Insurance</td>
<td>49.6</td>
<td>40.7</td>
<td>4.2</td>
<td>1.7</td>
<td>3.0</td>
</tr>
</tbody>
</table>

The statistics are even more grim for senior management positions: The Glass Ceiling Commission (1995) reports that in Fortune 1000 industries and Fortune 500 companies, 96% of female senior managers are white.

The increased presence of white women in managerial positions has ensured that the racial composition of this occupational category has changed very little

\(^{19}\) Although the largest increase has come in the middle-class professions, women are still over represented in low-paying jobs. In 1990, 78% of women workers made less than $25,000 a year (Women Workers: Trends & Issues, U.S. Department of Labor, 1993: iii).

\(^{20}\) Data come from the 1990 national census.
despite the diversification of the American workforce. In fact, as the number of white men in managerial and professional positions decreased (from 83.5% in 1960 [Sokoloff 18] to 47% in 1993 [Galen 52-53]) the number of white females increased proportionately. The increasing presence of white women has allowed whites managed to retain 89% of managerial and professional positions. In other words, as the number of white males in the workforce has declined, the presence of white middle-class women has ensured that whites remain predominant in this occupational category. This will become increasingly true in the next few decades. According to the Hudson Institute's data, whites will account for fifty-seven percent of new workers by the turn of the century, but forty-two of that fifty-seven percent will be white women. As Avery Gordon notes, "What these data suggest is . . . the role of white women will be increasingly significant to overall corporate race relations" (26).

The increase of white middle-class women in the workforce responds to the three conditions identified earlier as potential disrupters of hegemony. First, the increase of white women in positions of authority helps alleviate fear about the loss of white dominance due to the shifting demographics of the American populace. Second, by addressing liberal feminist demands for inclusion, it pacifies one of the largest civil rights groups and decreases the likelihood that an alliance will be formed among disenfranchised groups. Third, in a time of economic chaos for the middle-

---

21 This holds true for the overall workforce as well. In 1960 whites constituted 89.5% of the total workforce. By 1980, even with a 15% decrease among white males, whites still remained 89% of the overall workforce (Sokoloff 40). In 1990, they accounted for 85% of the workforce.
class, the white middle-class female professional helps to consolidate the economic power of her class. Ehrenreich argues that

the assimilation of women has almost doubled the economic resources of the middle class, helping save it from the decline experienced by the working class and lifting it, in fact, well out of the middle range of income. The $60,000-plus a year that a professional couple can expect to earn by pooling their incomes puts them financially well ahead of over 80 percent of American families. By assimilating women, what we have called the middle class became, in strictly economic terms, upper middle class. (223)

One of the most visible groups of new professional women is medical professionals. In the last twenty-five years, the number of women in medical schools has quadrupled. In 1969, women constituted only 9% of those in medical schools; by 1987, they accounted for 37%. Not surprisingly, white, middle-class women have been the primary beneficiaries of this "diversification" (Ehrenreich 443, Rodriguez-Trias 443). In fact, Helen Rodriguez-Trias argues that gains made by white women in the medical profession have come at the expense of all other minority groups.

Another arena where the entrance of white middle-class women into the public sphere was highly visible was the women's health movement, a coalition of individual groups focusing on women's health-related issues. Although women from a wide range of races/classes/sexualities participated in the multiple facets of the movement, the overwhelming majority of participants were white, well-educated, heterosexual, middle-class women (Rodriguez-Trias 439, Ruzek 188). Many of the white middle-class women involved in the movement were not professionals but, as one women remarked "ordinary housewife looking types" (qtd in Ruzek 174). For
example, Carol Downer, who founded one of the first self-help clinics, was a full-time mother with six children. As one mother noted, "The Self-Help Clinic was originated by, thought of, created, developed, organized, carried out to the world . . . collated, annotated by US, US BREEDERS" (qtd in Ruzek 195). Sheryl Ruzek argues that the self-help philosophy of the movement appealed to non-professional women because it offered them a space within the larger feminist movement where "their experience . . . was regarded positively rather than as evidence of their having been duped into cultural compliance" (195).

Overall, the women's health care movement worked to achieve two goals: to reform the existing health care system, and to simultaneously create an alternative, women-controlled system that could provide an array of health-care services. Ehrenreich claims, "Feminists wanted women to be doctors, but they also wanted to abolish medicine as an elite profession and encourage the skills and participation of more humble health workers, lay practitioners (such as the self-trained midwives who began practicing illegally in the seventies), and the 'consumers' of health care" (215). This dual-pronged strategy can be seen in the women's health movement's originary rallying cause, the struggle for reproductive rights. As Helen Marieskind wrote in 1975:

women in the Women's Health Movement have concluded that their reproductive potential is a central cause of their oppression. Women recognize that the means to control their reproductive potential is determined not only by the government, but by the preponderance of males in the top ranks of the health care industry. Medical knowledge and therefore 'scientific' definitions of women are known

---

22 While researching this project, I had numerous conversations with women who participated in the women's health movement. In these conversations, it became apparent that lesbians were a strong and vital force in the movement. However, I could find no research that addressed this issue.
To achieve their first goal, reform of the existing health care system, the women's health movement concentrated on two arenas -- government and the for-profit medical profession. In terms of the first arena, a variety of tactics were adopted to bring about change in governmental policies. In 1973, the movement succeeded in legalizing abortion. An investigation into the safety of the birth control pill was launched with the publication of Barbara Seaman's *The Doctor's Case Against the Pill*. This resulted in an FDA mandate to provide warning labels on estrogen products as well as increased research on the long-term effects of the birth control pill. Women's health activists argued that profit propelled corporations to market products before adequate testing had been done, and often long after health problems surfaced. These activists pressured the FDA to protect women from corporate greed, and government investigations on the safety of IUDs, Depo-Provera, and DES followed. Certain groups within the movement also pressed for the inclusion of women in scientific studies and an increase in the number of women in medical schools. For example, in 1975, these groups helped pass the Public Health Service Act that outlawed gender discrimination in medical school admissions.

Other strategies were adopted in order to push for change within the medical profession. Women's health activists provided patient advocacy services, especially for women of color, immigrants, teenagers seeking abortion, and poor women. Monitoring physicians was another popular tactic. Many groups had patients
evaluate individual physicians or group practices. If the evaluations were negative, women's health groups blacklisted the physicians and at times registered formal complaints with state agencies. Sheryl Ruzek notes that one New York boycott was so successful that the obstetricians/gynecologists asked to be reevaluated, claiming they had changed their behavior. 23 Further, women's health groups picketed hospitals that refused to provide abortion services, or monitored hospitals with high infant mortality rates.

The second goal of the women's health movement, creating an alternative, women-centered and controlled health-care delivery system, was achieved by establishing a number of clinics that provided reproductive and other health services. In order to challenge what activists saw as the unnecessary medicalization of women's bodies, these clinics utilized what Sandra Morgen calls a "well woman model" (1986, 201). This model asserted that many events in women's lives that had been defined as requiring medical intervention were in fact natural occurrences that could be attended to by lay persons with adequate knowledge of bodily processes. The first of these clinics, The Feminist Women's Health Center in Los Angeles, was established by Carol Downer in 1971. The FWHC ran consciousness-raising groups, offered educational classes that trained women in the use of the speculum, provided treatment for common gynecological problems like vaginal infections, and fitted diaphragms.

---

23 This example points to how effective surveillance is as a strategy. Although women, people of color, and the poor have been the ones traditionally monitored, once the tables were turned, so to speak, the same result occurred -- the monitored group conformed to the wishes of the monitoring group.
The self-help philosophy that underwrote the FWHC caused concern among many in the medical establishment and the government. After six months of undercover surveillance, on September 20, 1972, eight plainclothesman and two uniformed Los Angeles policeman entered the center with a search warrant. They confiscated books, health records, specula, birth control devices, even the refrigerated yogurt used to treat yeast infections (Ruzek 58). Downer and Coleen Wilson were arrested and charged with practicing medicine without a license. The case received national attention and a huge outpouring of support from women's groups and individual feminists. In order to avoid a trial, Wilson plead guilty to fitting a diaphragm and was fined $250 and placed on two-year's probation. Downer chose to go to trial, and was acquitted.

Downer's acquittal encouraged the creation of thousands of similar clinics across the nation (Rodriguez-Trias 440) -- the Feminist Women's Health Center in Salt Lake City, the Fremont Women's Clinic in Seattle, the Somerville Women's Health Project in Massachusetts. Self-help in their orientation, they stressed "preventive health concepts, self-awareness, and comprehension through a basic knowledge of bodily processes" (Marieskind 217). Through this basic knowledge, they sought "to demystify medicine" (Marieskind 217). Medical professionals were used minimally in the clinics, mostly to provide those services that would be illegal for lay persons to perform. Non-professionals provided the majority of services. As Marieskind explains:

All groups have questioned the hierarchical structure of our present health delivery system and stress the use of paramedics, lay health workers, the sharing of skills and information, and the active involvement of the patient in her health care process. The
Movement as a whole rejects the power considerations that place the physician at the apex of the health care pyramid. (221)

Throughout the 1970s, the women's health movement flourished. In 1974, the Women's Health Forum estimated that there were 1,200 groups which were part of the women's health movement and "tens of thousands of women who consider themselves to be part of this movement" (Ehrenreich and Marieskind 38). Two national journals were created, The Monthly Extract: An Irregular Periodical in 1972 and HealthRight in 1974. The movement also produced a body of literature, probably the best known being Our Bodies, Ourselves by the Boston Women's Health Collective.

The women's health movement was a vital counterdiscourse that contested the power that government, the medical profession, and business at large had over women's lives. Yet on many levels it did not challenge hegemonic relations of power. Because its focus reflected the needs of its primary constituency, white middle-class women, "Often the thrust was individualistic and at best reformist, as if being in the 'know' and shopping for better care were the goals" (Rodriguez-Trias 447). Considerable emphasis was placed on a woman's personal responsibility for her own health care -- the need to educate oneself and learn how to choose wisely among the various options. Rodriguez-Trias argues that this emphasis was at times at odds with the needs of working-class women and women of color: "When [white middle-class] women in the movement posed utopian solutions such as filling health needs through self-help, they alienated women who struggled to bring medical care into their communities" (447).
In fact, the deployment of the self-help model that infused the mainstream women's health movement was so divergent from minority women's needs that Rodriguez-Trias suggests there were two parallel women's health movements:

While predominantly white middle-class women organized a health movement around their concerns, putting emphasis on changing their relationship to doctors and controlling their bodies, working-class and Third World women were clamoring for day care, welfare rights, entry-level jobs in the health care system, and the establishment of community health care centers. White women concentrated on health care, women of color and of the working class on health status with a gut understanding of its socioeconomic determinants. (441)

The struggle for reproductive freedom is a perfect example of this. Once the movement had secured an individual's right to choose, it neglected to examine and contest the mechanisms of control that emerged to manage the reproductive capacity of poor women and women of color. For example, shortly after abortion was legalized, minority women charged that they were being pressured into abortions at welfare clinics, or offered free abortions if they would agree to sterilization as well. A few years later, the Hyde Amendment prohibited the use of Medicaid funds to pay for abortions, effectively negating poor and working-class women's right to choose. The Hyde Amendment has yet to be overturned.

Rodriguez-Trias' critique of the women's health movement parallels Crawford's argument that new temperance's emphasis on personal behavior can act as a class strategy because it obscures the impact of class on health. Rodriguez-Trias shows the limitations of Crawford's argument, highlighting the way that race, gender, and class inform one another in extremely complicated ways. In terms of the
women’s health movement, the discourse of new temperance informed the self-help model in a way that contested certain elements of patriarchy, yet kept the women’s health movement from challenging many of the relations of power that subtend hegemony.

Additionally, racialized and class relations of power were often replicated within the clinics themselves. Ruzek notes that there were "marked differences between clinic users and women who run health groups and participate in self-help activities. Women who operate the clinics and attend self-help activities tend to be middle class and white -- even in areas serving predominantly ethnic minorities and working-class communities" (188). Sandra Morgen's ethnographic study of a feminist health collective, fictitiously named the Women's Health Center, provides an in-depth look at how this process worked. It also highlights another way that the discourse of new temperance infused the women's health movement. Morgen shows that a reliance of state funding worked to decrease the politicization of health and increase the emphasis on personal behavior and individual responsibility for health.

Located in a mid-sized, industrial city in the northeast (which Morgen calls "Fleetport") the WHC was founded by a consciousness-raising group in 1972. The WHC functioned like many other women's health clinics -- it was staffed by nonprofessionals who trained themselves to provide family planning counseling, pregnancy testing, abortion counseling and routine gynecological services. Understanding itself as part of the larger women's health movement, it emphasized self-help, women's autonomy and collective action.
For two years the WHC operated as a women-run collective, stressing "equality in all phases of its operation: decision-making, division of labor, and access to knowledge, wages and rewards" (1986, 201). Staff rotated the provision of services, all doing clerical, outreach, and educational programs. However, when the group later turned to the State to secure funds earmarked for an expansion of services, the result was the increasing exclusion of outreach, advocacy, and political activism, as well as such hallmark feminist practices as cervical self-examination. The collective features of organization were undermined as a more traditional bureaucratic structure emerged. (1986, 201)

As Morgen explains, the WHC collectively decided to attract state money in order to fulfill its feminist goals -- to expand outreach services and to enable itself to diversify its membership by paying salaries to working-class women who could not afford to donate time without compensation. One of the first grants the WHC applied for was a CETA grant (Comprehensive Employment and Training Act) from the Department of Labor that allocated money for training low-income women. The director of CETA told the WHC that their chances for obtaining funding would increase if their proposal included a survey component, and the WHC proposed a year-long health education and service project that would survey the attitudes and needs of low-income women in Fleetport.

The WHC received the CETA funding. This doubled their annual budget and tripled their staff, allowing them to hire 15 new workers, primarily low-income women and/or women of color. The money also allowed them to expand services. However, the funding eventually compromised the WHC's ability to act as a collective. First, CETA funding required detailed documentation of services, and
gradually, a specialized clerical staff emerged to manage the paperwork. Second, as new grants were needed to continue the services originated through the CETA funding, certain staff assumed responsibility for grant writing. This was in part a matter of practicality and time constraints -- grant applications are notoriously complicated, require the mastery of certain expository skills and familiarity with budgeting and other statistics, and have brief "turn-around" times (i.e., they are due relatively quickly after they are announced), which encourage specialization in this area.

Third, the contract required that the WHC designate a "director." Although contrary to the collective model, the WHC agreed to name a staff person "on paper only," intending to proceed as usual despite this bureaucratic detail. Over time, however, as the "on paper" director came to know more than other staff about the Center's fiscal, legal and service responsibilities to external agencies, she assumed the role of an actual director. Two years later, when the "on paper" director resigned, the WHC formally hired a director.

Fourth, the rapid expansion of staff made the collective process unwieldy. This resulted in the creation of two "collectives": CETA staff (primarily low-income women and/or women of color) who dealt with the year-long survey, and "regular" staff (primarily middle-class white women) who oversaw the operation and direction of the WHC. In combination, these factors led to a hierarchy in the WHC along race and class lines. As Morgen notes, "the division of labor and resulting unequal distribution of knowledge led to a process of decision-making which reflected the very real hierarchies solidifying within the staff -- between the director and the rest
of the staff, the full time and part time staff, the paid staff and the volunteers, and the 'regular' staff and the 'CETA staff' (1986, 205).

The reliance on state funding also impacted the WHC's willingness to politicize women's health issues. For one, because grant applications required positive recommendations from external, often non-feminist agencies, the WHC's ability to advocate for their clients with other agencies or to critique other agencies' sexist policies became compromised. As Morgen notes, the second director characterized "politically motivated opposition towards agencies with sexist policies and services . . . as 'abrasive' behavior which detracted from the ability of the WHC to provide necessary services for women" (206). Additionally, funding often necessitated establishing formal cooperative relationships with other health care agencies. For example, to obtain the important privilege of billing Medicaid, the WHC was required to negotiate a contract with the local hospital. When the hospital later discontinued its prenatal and gynecology clinics, the only source of affordable care in the area, the WHC originally protested but eventually withdrew its protest for fear it would jeopardize its ability to receive Medicaid funds.

Second, since payment from the state was retroactively reimbursed (after services had been provided) the WHC took out bank loans to meet their immediate needs. With a perpetual loan in balance, the staff became more and more hesitant to contest other state policies. For example, when another feminist group asked the WHC to join in fighting a controversial new welfare regulation, many staff feared that such a protest might provoke the state to delay payment past the term of the bank loan. Another instance occurred when the Hyde Amendment (which restricted
the use of Medicaid funds for abortions) was passed. Certain staff members felt it was "too political" to protest the amendment. Morgen contends:

That such a position would be taken by an organization which emerged out of the women's health movement -- whose initial and primary raison d'être had been women's right to autonomy over their reproductive lives . . . points to the erosion of the feminist political vision . . . advocacy and political activism, two of the seeds from which the WHC had germinated had become transformed into 'risks.' The dependency on external funding had decreased the ability of the Center to function autonomously and had so enmeshed the Center in service provision that the larger political goals underlying the Center's activities had been obscured. (1986, 206)

The reliance on state funding also dampened the politicization of women's health within the clinic itself. Because state funding allocated resources for one-to-one services, and not group-oriented services, "the provider-client model was increasingly pervasive both in practice and in theory as the Center described their work in grant applications . . . The earliest brochure described Center volunteers as 'women helping women.' Brochures for programs in the late 1970s described the staff as 'paraprofessionals serving clients'" (1986, 204.) This reorientation of services was more than just rhetorical; Morgen notes that the "staff rap group" where counselors talked about their work and about particular women they had counseled was renamed "counseling supervision" and became a forum run by a psychologist where staff discussed "difficult cases." The one-to-one casework model tended to individualize and depoliticize health care issues. As Morgen contends, "'Self-help' took on a clinical rather than a political meaning, as counselors stood mid-way between health professionals and ordinary women" (1986, 204).
Few would deny that the women's health movement was not a valuable endeavor. It politicized the production of knowledge about women's bodies, and contested governmental and business control over women's lives. At the same time, however, it must be noted that the movement followed a trajectory similar to that of the Children's Bureau and the campaign against infant mortality: the discourse of new temperance, in this case, the self-help model, justified the entrance of white middle-class into the public sphere and into positions of social authority. While this model empowered white middle-class women, it deflected attention away from the ways that race and class impact health. This neglect ensured that hegemonic relations of power remained relatively unchanged, with the exception (I would argue, the sacrifice) that white middle-class women had been granted a measure of social power. The clinics themselves replicated class and racial hierarchies, and the discourse of new temperance worked to create new mechanisms of surveillance as rap groups turned into monitoring sessions focusing on “difficult cases” and overseen by psychologists. As Morgen notes, this process is not coercive, but rather "the State elicits the 'consent' of those it rules; it does not force actions as much as it shapes actions and beliefs through control of political and economic resources, institutions and ideas" (1986, 207).

Although the type of clinic originally founded by the women's health movement is no longer the predominant model, activism around women's health issues continues. There are several groups that focus on women's health: for example, The National Women's Health Network, the National Breast Cancer Coalition, and the Congressional Congress for Women's Issues. Pressure from these groups resulted in the establishment of the Office of Research on Women's Health in 1991 (located in the National Institutes of Health) which ensures the inclusion of
women in medical research funded by the federal government. In 1990, the National Institutes of Health appointed its first female director, Dr. Bernadine Healy. And in 1992, the Women's Health Initiative was launched, a $625 million, long-term study which investigates various facets of women's health. In fact The Harvard Women's Health Watch contends:

the 1990s may go down as the decade of women's health. Within that 10-year span, the gender inequities in medical research have been acknowledged, addressed, and, in many cases, set aright . . . the number of research projects involving women has grown exponentially. Not only are there more observational studies and clinical trials, there are now more channels for disseminating the resulting information, including several scientific journals devoted exclusively to women's health issues. (5)

The next two chapters will examine two diseases that primarily strike women and that have been given a great deal of attention in the last decade – autoimmunity and breast cancer. Specifically, these chapters track the cultural conversations about causation and responsibility for these two diseases, and trace the ways that the discourse of new temperance continues to operate to legitimate the entrance of white middle-class women into the social while at the same time managing their participation to ensure that hegemony will not be significantly altered.
WORKS CITED


---. "Two Faces of the State: Women, Social Control, and Empowerment." *Uncertain Terms: Negotiating Gender in American Culture*. Ed. Faye


The previous chapters have examined how two strategies, granting white middle-class women access to positions of social authority and the discourse of new temperance, worked together to establish the hegemonic equilibrium. This chapter traces a similar process, but on a slightly different terrain -- it investigates the will to truth operates to provide a predominant logic of the body. Beginning in the late 1960s/early 1970s, a new understanding of how the human body functions emerged. This chapter explores our contemporary understanding of the body, and further, how that understanding combines with the strategies mentioned above to maintain hegemony.

Emily Martin's sociological study, *Flexible Bodies*, chronicles the transition over the last three decades in the way we conceptualize the body and health. Martin asserts that in the first half of the twentieth century, the body was envisioned as a "seamless whole" with clearly defined borders. Depicted as a castle or fortress, the body was imagined as a self-contained entity constantly embattled by a dangerous environment. Theories of disease prevention focused on the necessity of maintaining borders and preventing invasion -- emphasis was placed on keeping the
places where bacteria could enter (the mouth, wounds) clean and in keeping one's immediate environment hygienic.

The body was also often represented as a machine. However, little attention was paid to the internal workings of the mechanism, but rather, to the external personal habits (diet, sleep, hygiene) that the body needed in order to function efficiently. Martin notes that this image of the body as castle/machine paralleled the economic logic of the Fordist era (Fordism emphasized the efficiency of the machine/assembly line) and the political logic of the Cold War.

In the late 1960s, "the delicate outlines of an emerging new common sense" (Martin 13) about the body and health came into being. This common sense understands the body as a communications network, a complex system of internal mechanisms highly interconnected with its environment and with far less-definable borders between self and world. No longer a castle, Martin points to a 1993 cover of Science magazine that depicts the body without skin and foregrounds a complicated web of tissue, muscle, and lymph nodes. Disease prevention models for this body concentrate on individual, internal responses: the role of antibodies, the adaptability of T-cells, etc.

A key component of this contemporary body is the immune system, a network of cells that individually tailor themselves to greet and disarm harmful elements. Unlike the castle, the immune system body is flexibly responsive; it "actively relates to the world . . . selects from a cornucopia of continually produced new antibodies that keep the body healthy and enable it to meet every new challenge. Possessed of agile responses, and flexible specificity, our adroit, innovative bodies
are poised to anticipate any conceivable challenge" (37). Yet, this highly effective control and response mechanism is difficult to locate. As Donna Haraway notes, "the immune system is sited in several relatively amorphous tissues and organs . . . but a large fraction of its cells are in the blood and lymph circulatory systems and in body fluids and spaces . . . The immune system is everywhere and nowhere" (217-218). Again, as with the castle/machine model of the body, this new model parallels current economic and political logics: a fluid, mobile system of multinational capitalism which is both everywhere and nowhere, in which individual countries function as part of a larger global network and national borders are transcendentable.24

What might account for this general compatibility between the logic of the body and the logic of other sites of social organization? Haraway argues that the answer lies in the fact that bodies "are not born; they are made" (208). Historically and culturally specific entities, "Late twentieth-century bodies do not grow from internal harmonic principles theorized within Romanticism. Neither are they discovered in the domains of realism and modernism" (208). Rather, the contemporary body is produced on "the political-epistemological terrain of postmodernism" (208), emerging from "the intersection of biological research, writing, and publishing; medical and other business practices; cultural productions of all kinds, including available metaphors and narratives; and technology" (208).

24 Of course, multinational capitalism's reliance on countries that provide cheap labor, relaxed environmental controls, and tax inducements evidence that national borders remain a crucial element in the operation of this economic system, but I speak here of the representation of multinational capitalism as creating a "borderless world." See Masao Miyoshi's "A Borderless World? From Colonialism to Transnationalism and the Decline of the Nation-State," Critical Inquiry 19 (Summer 1993): 726-751.
Martin's work suggests that the cultural production of bodies involves a cyclical process: not only are the frameworks and metaphors through which we think about the body produced in the social, but they in turn structure the social in that they become central to the way we comprehend and organize various aspects of our lives. In one of the more interesting sections of Martin's work, she chronicles the "extremely pervasive use of the immune system as a kind of 'field' against which many phenomenon have been given new interpretations and understandings" (184):

For instance, Saab advertises its design as "the antibody to the auto accident"; credit cards stress the flexibility of their services; psychology has recently coined the term "social intelligence" (or EQ) which is defined as the ability to read, adapt and respond to one's surroundings; "flexibility" and "responsiveness" are key terms in the rhetoric of corporate diversity management. This saturation of various social arenas with immune system imagery leads Martin to conclude that "It is clear to me that what is at stake in our understanding of 'health' are the broadest issues of the survival and death of the social order itself" (240). Haraway puts this slightly differently. She argues, "Scientific discourses [of the body and health] are 'lumpy': they contain and enact condensed contestations for meanings and practices" (204).

The "lumpiness" of discourses of the body, however, is not a twentieth-century phenomenon. Several scholars have investigated the ways in which the body has been utilized to establish, reformat, and/or cement social relations. For example, Foucault examines the ways that discourses of the body were used to reconsolidate class-consciousness in late eighteenth/early nineteenth century Europe. At this time when egalitarian political discourses blurred class distinctions, at least
rhetorically, those distinctions were reaffirmed via the creation of a sexualized body.

While little attention was paid to the sexuality of the lower-classes, the ruling classes were demarcated through an intensification of the body, a problematization of health and its operational terms: it was a question of techniques for maximizing life. The primary concern was not repression of the sex of the classes to be exploited, but rather the body, vigor, longevity, progenitor, and descent of the classes that 'ruled'... This class must be seen rather as being occupied, from the mid-eighteenth century on, with creating its own sexuality and forming a specific body based on it, a 'class' body with its health, hygiene, descent, and race. (122-3)

The novelty of Foucault's work is that it examines the ways that social control is maintained via the production of certain types of bodies, not necessarily in the repression of an ahistoric, "natural" body. As such, class relations were reestablished and ensured by providing the ruling classes "with a body to be cared for, protected, cultivated, and preserved from the many dangers and contacts, to be isolated from others so that it would retain its differential value" (123).

According to Foucault, the lower classes did not develop a sexualized body until the first half of the nineteenth century. The sexualized proletarian body emerged as the result of several "conflicts" and "economic emergencies" -- epidemics, overcrowding, "the development of heavy industry with the need for a stable and competent labor force" (126). Technologies of control and surveillance were required in order to manage properly these new bodies. Foucault argues that these bodies emerged for "the purpose of subjugation" (127), not affirmation as with the bourgeoisie. As such, he concludes that the emergence of the sexualized body...
did "not operate in symmetrical fashion with respect to the social classes, and consequently, . . . it does not produce the same effects . . . it induces specific class effects" (127).

Katherine Stubbs' "Mechanizing the Female: Discourse and Control in the Industrial Economy" uses Foucault's insights to analyze the ways that the discourse of "body as machine" worked to reproduce social relations of power in the early decades of the twentieth century in America. This period was characterized by an increase in industrialization and immigration, demands by feminists for women's inclusion in the professions, and "the steadily increasing presence of working-class women in economic spaces that had previously been the preserve of men" (145). Stubbs argues that these developments produced male anxiety about the loss of power in the economic and social spheres, and that this anxiety was in part negotiated through a representation of the female body as mechanical.

Yet, this representation did not play out in the same way for women of differing social classes. The discourse asserted that working-class women would remain healthy as long as their labor focused on mechanized motion and avoided any mental labor. The "higher forms of labor," which involved the use of reason and rational thought, produced "physical breakdowns, mental breakdowns, and aberrations in the menstrual cycle" (Stubbs 146). In this way, managerial and professional positions were reserved for men, and working-class women were encouraged, in the name of health, to be docile bodies: obedient and machine-like workers (146).
For white, middle-class women, the discourse of the mechanized female worked to discourage their entrance into the workforce and the social sphere. During this time, as white middle-class women entered college in record numbers, postponed or refused marriage, and white, middle-class birth rates declined, scholars like Edward Clarke and G. Stanley Hall argued that intellectual development had adverse effects on reproductive and emotional health. Hall's research on Vassar, Smith and Wellesley graduates concluded that "absolute or relative infertility is generally produced in women by mental labor carried to excess" (qtd in Russett 123).

Stubbs notes that the discourse of the mechanized female not only worked to prevent white middle-class women from entering the social, but also cemented them in the domestic by defining them as consummate consumers. White middle-class women were represented as emotive, incapable of rational thought, and "hard-wired for an automaticity of response," and advertising manuals used the discourse to develop marketing strategies that would appeal to this population. Stubbs argues:

The rhetorical construction of women as analogous to machines seemed to make possible the supervision, manipulation and control of women throughout the economic sphere, for the flexibility of the discourse meant that it could be used both in the sphere of production (where working-class women could be represented as 'mechanical' workers) and in that of consumption (where the discourse could be used to facilitate the control, management, and engineering of middle-class women's consumption habits). (142)

Stubbs and Foucault highlight a similar process: the emergence of new bodies (sexual/mechanical) that serves to ensure hegemony during times of social and economic transition. In turn, this dissertation seeks to understand tactical
productivity and strategic integration of emergence of the immune system body in our contemporary era. It argues that the immune system body performs invaluable cultural work in the service of hegemony.

Comprised of $10^{12}$ (10 to the 12th) cells, the immune system protects the body against disease by recognizing foreign elements that enter and threaten the body, and then killing them. As immunologist Irun Cohen explains, "It is generally assumed that the main job of the immune system is to distinguish between what is 'self' and what is 'not self.' Once the distinction has been made, 'self' is preserved and 'not self' is destroyed" (52).

Although it is not definitively known how the immune system destroys the harmful, "not self" elements, the most widely accepted explanation is clonal selection. In clonal selection, B lymphocytes, commonly referred to as "B cells," manufacture antibodies. These antibodies rest on the cells' surface, and act as receptors, binding to foreign antigens and marking them to be eaten or destroyed by other cells in the immune system, macrophages and complements. As immunobiologist Charles Janeway explains:

If a B cell finds such an intruder, it divides rapidly. Because all the daughter cells come from one parent, they are known as a clone (hence the term 'clonal selection.') All the cells in each clone have the same receptor. These cloned B cells then differentiate into cells that secrete antibodies, which like the B cell receptor, bind to the microbes. (74)

The difficulty of this process lies in the infinite possibility of pathogens ("not self" elements) that a body could be exposed to in a lifetime. How is it that one body can secrete antibodies that produce individually tailored receptors for all of the
potential pathogens it might encounter? The answer lies in the immune system's inherent capacity for flexibility and diversity. This diversity is generated several ways. First, antibody genes are inherited as fragments, not as complete genes. (One type of fragment is even called a D segment, short for "diversity gene segment.") Receptors are formed by piecing together these fragments. Because any cell can choose from among a variety of fragments, and each cell can piece these fragments together differently, a large number of potential receptors is possible.

Second, the enzymes that glue these fragments together add random DNA bases during the joining process, which again multiplies the number of possible receptors. Last, when B cells attach to foreign substances, they mutate rapidly. These "hypermutations" again add to the possible number of receptors that can be created. As Janeway explains, "In effect, the immune system is constantly experimenting with slight variations on successful receptors in pursuit of an optimal immune response" (75). The experimentation "generate[s] sufficient diversity," and this diversity and flexibility of response is what allows the body to remain healthy, function efficiently, and meet any pathogen that comes its way. According to Dr. Avrion Mitchison, "So far our storehouse of variability has enabled us to survive" (143).

However, while diversity is the key to the body's health and survival, it is also a potential threat. The body's flexible response system, the way it experiments with various combinations of gene fragments in order to produce receptors for any antigen it might encounter, introduces a dangerous possibility. According to immunologists Phillips Marrack and John Kappler, "because the composition and
structure of the receptors are determined somewhat at random, some receptors are likely to bind to the chemicals of their host" (82). As Cohen explains it, "this very flexibility is the source of a problem: self-recognition. If the immune system can recognize almost anything, why not the molecules that belong to the self?" (54). Self-recognition results in Autoimmune disease, a malady where the body attacks and destroys its own cells. In order to avoid autoimmunity, the body's diversity must be controlled and managed carefully. However, since the body "has no absolute control over the complete amino acid sequences of the receptors [control must be exerted in some other way, at some other stage" (Marrack and Kappler 82).

Fortunately, our bodies come equipped with their own diversity management programs. These programs teach the immune system "to tolerate every tissue, every cell, every protein in the body . . . [while] managing to repel innumerable different kinds of invading organisms and yet not attack the body" (Marrack and Kappler 81). Tolerance is produced through several processes. Marrack and Kappler explain: "If an immune cell reacts to a self-product while it is developing in the thymus or bone marrow, it is usually killed or inactivated. A mature lymphocyte will usually suffer the same fate if it responds to a self-product and does not receive a second chemical message" (81). Janeway points out another mechanism that induces tolerance. The cells that comprise the innate immune system, "innate in the sense that the body is born with the ability to recognize certain microbes immediately and to destroy them" (73), are equipped with proteins that inactivate the destroyer cells and ensure the survival of the body's own cells. As immunologists Eli Sercarz and Syamal Datta conclude, "despite the potential in each of us to become diseased via autoimmunity,
most individuals remain healthy owing to a variety of regulatory mechanisms that maintain our balance on the tightrope of life" (880).

Tolerance, therefore, allows a body to maintain both its identity and its integrity. Crucial to our survival, this maintenance requires certain "compromises or trade-offs":

The fact that the metabolic resources of an organism are not unlimited makes such economic choices necessary. Investment in effector systems, the cutting edge where killer cells and antibodies wallop bacteria and viruses, must be balanced by investment in regulatory systems [which suppress autoimmune response] necessary for keeping the entire enterprise under control. Thus, in the human immune system there are more regulatory T cells . . . than any other kind. (Mitchison 139)

As the language of the above passage evidences, the discourse of the immune system body has much in common with the rhetoric of diversity management utilized by corporate America. Both stress diversity as a necessary survival strategy, yet both assert that diversity must be strictly managed. Like the corporation, bodies make "investments," are forced to make economic choices, and are constrained by limited resources. It should not be surprising, then, to discover that the body and corporation share many other characteristics as well.

First, the body is described as a competitive system where cells struggle against one another for profit and reward. "What a perfect microcosm of the market the lymph nodes and spleen offer. In the germinal centers of these organs, mutating B cells furiously compete with one another for the tiny amount of antigens needed for survival. The winners are assured the reward of massive replication. Cells that do not find antigen die" (Mitchison 139). Cohen utilizes similar language to describe
the process, asserting that a receptor that fits most closely the invading antigen "enjoys an advantage over its competitors: it replicates faster, and soon it may come to predominate over the other T and B cells in its vicinity" (Cohen 52). In short, effective receptors can monopolize the market.

Second, like the American economy, the body's ability to thrive has been threatened by globalization. As multinational capitalism has eroded the power of American business, modernity has challenged the body's power to fight disease. Previously, the immune system and the world existed in "an ongoing, mutual" relationship "in which all parties have adapted to each other through a variety of means, from open warfare to accommodation and even symbiosis" (Mitchison 136). This relationship was built on a "shared agenda," the recognition that each needed the other to survive: "Seldom, if ever does it pay a parasite to kill its host, a fact for which we should be profoundly grateful" (Mitchison 143).

However, changing conditions have threatened that shared agenda. "For perhaps a century . . . about 20 percent of us have lived in modern industrial society, an artificial environment of our own construction, notably free of parasites and many pathogens . . . questions arise concerning the effect underemployment might have on our defenses" (Mitchison 136). Additionally, technological innovation, for example in transportation, have reduced the amount of time that the immune system has to respond to newly introduced pathogens; Mitchison's article includes a chart which shows the parallel between airline transportation routes and the spread of the lethal H3N2 influenza virus.
Like the American economy, Mitchison questions whether the immune system can thrive in the new world order. He asserts, "As a result [of modernity], our immune system has never faced more daunting challenges" (136). Much like the corporate rhetoric, diversity is the key to survival: "Although our cleverness in manipulating the immune system continues to grow in sophistication, our best natural defense against most pathogens, new and old, consists of the immune system's polymorphism" (143).

However, there are a growing number of bodies that are not thriving in the new world order but, instead, suffer from a whole host of autoimmune diseases -- multiple sclerosis, juvenile diabetes, environmental immune response, lupus, scleroderma, Sjogren's syndrome. According to Lawrence Steinman, professor of neurological sciences at Stanford University, autoimmune disease strikes five percent of adults in North America, two-thirds of whom are women (107). Some autoimmune diseases exhibit even higher ratios of female-to-male victims: ninety percent of those with lupus are female; eighty percent of those diagnosed with scleroderma are female; women are nine times more likely to develop Sjorgen's syndrome (National Women's Health Report 3).

The majority of autoimmune diseases affect women from all racial groups relatively equally. However, there are two notable exceptions. Systemic lupus erythematosus, which Dr. Michelle Petri calls "the prototypic autoimmune disease" (433), has a higher incidence rate in women of color. W. J. Fessel found the following incidence rates in the United States: 71/100,000 in white females (vs. 7/100,000 in white males); and 283/100,000 in black females (vs. 53/100,000 in
black males). Johnson et al. reported similar findings in Great Britain: 36.2/100,000 in white females, 90.6/100,000 in Asian females; and 206.0/100,000 in Afro-Caribbean females. The second exception is asthma. While asthma is just recently being defined in many circles as a result of autoimmune response, it has long been known that the disease disproportionately strikes people of color in the U.S.

Autoimmunity occurs when the control mechanisms that produce tolerance do not function properly; it is the result of diversity run amok. Misrecognizing self as other, the body destroys its own cells. While there is no cure for autoimmunity, experimental treatments involve artificially inducing the control that these bodies lack. These therapies seek to shut down the part of the immune system that destroys itself without hindering the system's ability to ward off disease. As Steinman argues, "The perfect treatment for autoimmunity would involve silencing or removing only the part of the immune system that is self-destructive, while leaving the rest intact to fight infection" (114).

While it seems certain that autoimmunity is the result of the malfunctioning (or non-functioning) of the body's internal control mechanisms, or to rephrase Mitchison, an underinvestment in regulatory systems, researchers have yet to discover what induces this malfunctioning. One theory, called antigenic mimicry, suggests that "viruses and bacteria attempt to fool the body into granting them free access" by mimicking the body's own cell structure (Steinman 109). As the body attacks the foreign microbes, it simultaneously attacks itself in the process. For example, adenovirus type 2 mimics a basic protein in the body called myelin. In
certain bodies, when the immune system attacks the foreign adenovirus type,\textsuperscript{25} it destroys myelin, resulting in multiple sclerosis. However, Steinman asserts:

Obviously, not everyone responding to adenovirus type 2 mounts an immune response to myelin basic protein and develops multiple sclerosis. The reason seems to rest for the most part with the difference in individuals' HLA types . . . One individual's HLA structure may bind a self-mimicking fragment and present it to the immune system, whereas another's may bind a fragment unique to the pathogen that does not mimic self. In the latter case, the pathogen is attacked, but self-tolerance is not violated. (110)

The origins of autoimmune response remain a mystery, and much research is currently being conducted in the hope of finding a cure. One of the results of this research is that a new way of thinking about the immune system, and I would argue about the relationship between the self and the world, is emerging. The current paradigm, which sees the immune system as the last defense of bodily integrity, the mechanism which clearly delineates between self and other, is being replaced by "a new picture in which self and world are no longer absolutely distinct" (Cohen 52).

This new model, pioneered by Niels Kaj Jerne, suggests that immune system receptors (which bind to foreign antigens) are recognized by other receptors in the body as antigens. Once this recognition occurs, the process repeats itself, i.e., more receptors are produced to disarm the antigen (which, in this case, is really a receptor). This second set of receptors, however, matches the structure of the original foreign antigen\textsuperscript{2}. Jerne postulates that this constant self-recognition establishes an equilibrium that regulates the immune system and keeps the body

\textsuperscript{25} If the foreign antigen is a key, the body's receptor is a lock. When this lock is recognized as an antigen and new receptors are produced, this second set of receptors, in order to fit the lock, will shape themselves like the original key.

79
healthy. As Cohen argues, "Self-recognition is not merely a sin punished by autoimmune disease... On the contrary, it is central to health as well as to illness" (60).

According to Jerne's theory, the immune system does not demarcate between the self and the world because "the system contains not only itself, but the world" (Cohen 58). Rather than preserving the distinction between the two, the immune system renders the partition meaningless. Interestingly, Cohen attributes the emergence of this new paradigm to "the insight... provided by the autoimmune disorders" (52) because bodies that exhibit autoimmunity were subject to periodic attacks, but seemed to be able regulate the disease for large stretches of time. This ability to control autoimmunity led researchers like Jerne to redefine the immune system as a mechanism that establishes equilibrium between the self and the world, not as a mechanism that mediates a war between the two.

However, although this new model retheorizes self and other as necessary partners rather than enemies, it does not dismantle the representational relationship between autoimmunity and lack of control. In Jerne's paradigm, autoimmune response may result from "being out of equilibrium" rather than "lacking the proper control mechanisms," but there is but a fine line between the two. Bodies that suffer from autoimmunity still need readjustment.

Safe

The previous chapter argued that one of the ways that hegemony is being ensured and maintained is by enticing white, middle-class women into the public
sphere and then managing their participation effectively. Like the immune system, the system of hegemony will function efficiently only if it silences or removes those elements that threaten self-destruction while it retains its capacity to ward off the foreign elements that seek its realignment.

Todd Haynes' 1995 film, Safe exemplifies how the discourse of health facilitates this dual process of enticement and management. Safe chronicles the story of an upper middle-class housewife, allegorically named Carol White. Carol develops an autoimmune disease, Environmental Sensitivity, and concern for her health propels her from the domestic into the public sphere. Yet, the rhetoric of what keeps one healthy manages that participation by emphasizing individual responsibility at the expense of structural critiques of power imbalances.

From its very beginning, Safe critiques the upper middle-class lifestyle as sterile and impersonal. The opening scene, shot from the vantage point of a front seat of car, traverses the landscape of a suburban neighborhood at dusk. There are no people present, no noise except for an ominous soundtrack. As the car enters through an electronic gate and parks, we see it is a Mercedes, and a well-dressed man and woman get out and go into a house. Their dialogue is trivial and terse: she sneezes and he utters, "God bless you." The scene fades to black, and opens up shockingly on this man and woman during intercourse. We see only his back and her face, first disinterested, then somewhat uncomfortable. The woman mentally absents herself from the interaction until the man orgasms, when she kisses him dutifully on the cheek. Again, there is no dialogue.
Safe's critique of the upper middle-class lifestyle centers on the way it utilizes women as markers of status and robs them of individual subjectivity. The next few scenes follow Carol through her day as she picks up drycleaning, gets flustered at a designer furniture store because they have delivered the wrong couch, and manages her latina housekeeper who performs the manual labor needed to maintain a household. What is striking about Carol's day is how silent it is. There is little conversation, and when Carol does speak, it is to utter polite social niceties that she is clearly unable to develop into full-blown conversations. She asks her drycleaner how her little girl is, and when the drycleaner responds, "Good," Carol stands there for several seconds, awkwardly, and finally mumbles, "Good. Uh... ok... Have a nice day." Even when she complains to the furniture store worker, she is timid, and her speech is stunted, halting, and uncomfortable.

The critique of bourgeois femininity extends beyond Carol to encompass other white middle-class females as well. For example, in the locker room after an aerobics class, Carol's fellow aerobicizers compliment her because she doesn't sweat. Characteristically, Carol responds, "Yes, it's true." The other women then launch into a spirited conversation about how the 12-step program strips its participants of control over their own lives. One woman touts the work of a male self-help guru, arguing that following his program correctly will help them regain a sense of autonomy in their lives. No one seems to realize the irony of that statement. Carol listens; she is clearly interested in the topic, but she does not add to or join in on the discussion.
Importantly, it is not the sterility of the lifestyle or the lack of individuality that moves Carol out of the domestic sphere; it is a concern for her health. As the film progresses, Carol literally develops an allergy to her domestic surroundings -- her new couch, drycleaning chemicals, her husband, milk. She has coughing attacks and loses her ability to think clearly. Additionally, the allergy prevents her from performing her gendered duties. At a dinner with her husband's business client, she falls asleep while the client is telling a dirty joke, mortifying everyone at the table. She is too sick to have sex, and too fatigued to finish an aerobics class. Carol cannot even perform her usual beauty rituals: the chemicals from her new permanent give her a nose bleed; makeup causes a skin rash.

At a friend's baby shower, with another woman's daughter on her lap, Carol has an asthma attack, scaring both herself and the child nearly to death. During the attack, Carol cannot speak when her friends ask her what is wrong, and the camera zooms in on her panic-stricken face until the scene ends. A few days later, in a drycleaning store being sprayed with pesticides, Carol collapses on the floor, convulsing and bleeding from her nose and mouth, and is rushed to the hospital.

Carol's sickness destroys what little individuality she had to begin with. In several scenes, we witness her staring blankly into a mirror, ostensibly searching for some sense of who she is and what is going on. As the asthma attack evidences, her illness weakens her already insufficient ability to communicate. She even starts to lose her sense of time and place. While recuperating in bed after the asthma attack, Carol breaks down crying. She mumbles to her husband, "I don't even ... oh god ... . what is this ... where am I? right now?"
Carol seeks medical advice, but her doctor cannot pinpoint the cause of her illness. The doctor sends her to a psychiatrist, a cold and intimidating man whose first question is, "Do you work?" Carol begins to say she is a housewife, then changes her answer to "homemaker," and goes on to explain that she is drawing designs for renovations to her house in her spare time. She is clearly embarrassed by her answer.

Then Carol accidentally comes across a flier at her health club and a late night TV infomercial, both of which discuss a new disease caused by toxic chemicals. The flier catches her eye because the header, set off in boldface, asks, "Who are you?" and then goes on to list the characteristics of those stricken with Environmental Sensitivity. Searching for answers about her ill health, Carol decides to attend the information session that the flier advertises.

We get information about the disease in a particularly interesting way. We hear a calm, soothing, well-spoken, female voice-over explaining Environmental Sensitivity while we see Carol altering her lifestyle — making a toxic free bedroom, gulping massive amounts of vitamins, listening to a tape through headphones, perhaps even the tape we are hearing. We see relatively short shots of the information session, and a longer scene when Carol is tested by an allergist who is sympathetic to those affected by the disease.

The film presents Environmental Sensitivity almost as an allegory — the aforementioned flier, which we get occasional glimpses of, asks, "Are you allergic to the 21st century?" The female voice-over explains that the disease is brought on by a crisis: after systematic overexposure, something triggers a reaction. After this
reaction, the elements that one could once tolerate are suddenly dangerous to one's
health. Those who are sensitive are described as "canaries in the coal mine" who
are uniquely positioned to signal those less sensitive to the dangers of the future.
And Safe makes perfectly clear what those dangers are: we see shots of crowded
cities and highways; Carol's stepson Rory reads an essay he wrote for school about
black and latino gangs invading and attacking the white suburbs.

Carol is clearly disturbed by Rory's report, and asks if it's not too gory. Carol's husband supports Rory by proclaiming that the report is "reality." The
response harkens back to the scene at the baby shower, when a little girl, bored by
the event, draws a picture of Carol. The girl says, "See, it's you. She's a princess,"
and Carol responds that the drawing is "very realistic." Carol delivers the line
unconvincingly; she compliments the child ostensibly to keep the girl entertained.
Yet through these scenes the film introduces two competing realities: 1) the middle-
class white woman as protected princess, 2) the middle-class white woman as victim
of 20th-century America, coded here as pollution, overcrowding, and uncontrollable
racial violence. Carol's experiences and concomitant ill health contest the first
scenario, leaving the latter to stand as true, even though Carol doesn't seem to want
to believe it.

Again, this links to the information we are given about the disease via the
female voice-over. The voice-over explains that the only cure for Environmental
Sensitivity is active management of one's surroundings. The allergist explains to

---

26 Safe's description of environmental sensitivity meshes with others' descriptions of the disease. For example, naturopathic researcher Christopher Hobbs calls autoimmune diseases "peculiarly modern maladies." Hobbs describes the case of a farmer diagnosed with environmental immune response as
Carol, "We can turn it off and on like a switch. We just don't know how to make it go away." Since prevention is not possible, the most effective defense is the introduction of artificial control mechanisms, creating a safe place by readjusting one's relationship to the world. The language through which this ideology is introduced is the metaphor of the "load." We are told that Environmentally Sensitive individuals must reduce their load, then slowly build up resistance by reintroducing what is dangerous. The logic of the disease is not isolation; it is reentry into the social after learning how to manage and control. By implication, not learning these skills can cost you your life.

Importantly, the film represents Environmental Sensitivity as a disease that primarily strikes white women. Neither Carol's husband nor her latina housekeeper is affected by the disease, even though both live in the same surroundings. At the information session Carol attends, the moderator is a white female. During this scene the camera pans the session's attendants, and although we see a sprinkling of white men and people of color, the overwhelming majority are white females. When the moderator asks those in the audience to stand and share what brought them there, two of the three speakers are white women. The third, an Asian American woman, is clearly middle-class. Last, during a break in the session, we witness an impromptu consciousness-raising discussion among six women -- 5 white and one black. Importantly, the black woman is not Environmentally Sensitive herself, but her child is.

such: "His immune system had been stressed for so many years by toxic sprays that it had become oversensitive to anything synthetic" (72).
In combination, these scenes present a fascinating logic: the body is under attack by the changing conditions in America, and the middle-class white female body, as canary in the coal mine, is uniquely capable of pointing out these dangers. However, it is crucial to remember that canaries are sacrificed -- their death signals that conditions are not safe. In order to prevent the metaphor from achieving its fruition, white privileged women learn to exercise control over their environment.

Education is a key element in the development of control. As previously mentioned, Carol's educational program begins when she runs across the informational flier, attends the informational session, and listens to the tape that explains Environmental Sensitivity. Carol's education grants her experience a certain legitimacy and allots her some measure of power. For one, it allows her to exercise some power in her marriage --she rejects her husband's sexual advances, and insists that he attend the information session. During this session, she prods him to stand up and speak about why he's there; it is the first time in the movie we have seen her make any sort of demand on him.

Carol also speaks at this meeting, the first of several moments in the film where we see her slowly "coming to voice." Another significant moment occurs during her hospitalization when she contests, although hesitantly, her doctor's refusal to recognize the cause of her illness. As the doctor repeats that there is no medical proof that she has environmental allergies, she asserts angrily, "I have a chemical sensitivity."

Carol's experience represents education as a tool of empowerment. Emily Martin notes that this representation is rampant in American culture, and is often
offered as the most effective way to survive the changing conditions of the modern world. For example, Martin points to the rhetoric shared by President Clinton and corporate diversity trainers which stresses the need to reeducate and retrain the workforce to thrive in the global economy, and to health discourse, which emphasizes the need to educate and train the immune system to respond to the new pathogens it is exposed to. However, Martin fears that what is often overlooked in this language is that "for lack of resources, not everyone can obtain the same quality of amount of training or education" (15). In this context, education as empowerment, which "draw[s] from the specifically American connection between education and liberal democracy" (15), results in a blame-the-victim mentality where those who are sick (or not thriving in the new world order) are seen as stubborn or ignorant, either refusing retraining or incapable of it.

*Safe* seems to concur with Martin's fear. In the name of health, Carol moves to Wrenwood, a new age health spa designed to retrain the immune systems of those with Environmental Sensitivity. Although Wrenwood is advertised as a non-profit center, the film suggests that this is inaccurate by showing glimpses of the founder's mansion-like home on the hill near the center. Wrenwood's well-dressed staff and residents evidence that it is a very profitable enterprise, and only those who have the resources to afford it can participate in this retraining.

Wrenwood's advertising touts itself as "A safe haven for troubled times." Again, the overwhelming majority of the spa's residents are white. Although Carol is greeted by a black woman, Susan, like the black woman at the information session, she is not Environmentally Sensitive herself. Rather, she is a worker -- she
greets Carol at the gate, helps her with her luggage, introduces her to the director (a white woman who has Environmental Sensitivity), and shows her to her room.

Additionally, Wrenwood is overly populated with white women. Wrenwood's Director, Claire, is a white woman; Carol's therapy group consists of four white women and one white male. The exception to this demographic is Wrenwood's founder, Peter Dunning. Dunning, who started the retreat in 1978, is both HIV positive and Environmentally Sensitive, a situation that Susan explains, gives him "an incredibly vast perspective." Yet Dunning does not conform to dominant codes of masculinity. First, his HIV positive status marks him as potentially homosexual. Second, Dunning's politics and behavior locate him within an alternative masculinity -- he favors the men's movement, sensitivity training in the workplace, and stresses feelings, emotions, and expression. In one scene, Dunning relates a dream he had where his body was covered by oozing sores, but as he touched them, they magically turned into flower petals (pansies).

Wrenwood combats Environmental Sensitivity by providing a "safe" toxic-free space as well as one-on-one counseling, group therapy, and nightly inspirational lectures by Dunning. According to Wrenwood, Environmental Sensitivity is the result of negative relationship to the world: if one sees the world as a destructive place, the body responds in a similar manner by self-destructing. In one of his nightly talks, Dunning tells the residents:

I have a confession I'd like to make: I've stopped reading the papers. I've stopped watching the news on tv. I've heard the media doom and gloom . . . and I don't need it. And so I transform that negative stimuli into something that will not do harm to me. Because if I really believe that life is that devastating, that destructive, I'm afraid
that my immune system would believe it, too. And I can't afford to take that risk. Neither can you.

The road to health, according to the rhetoric of the center, lies in a regime of self-love. Dunning's nightly talks culminate with the group singing a song whose refrain is "Give yourself to love." During Carol's first day at Wrenwood, Claire tells her that:

When I came here I couldn't even walk... all I could do was just sit in my safe room and every day, every hour of every day, I would look at myself in the mirror and I would say to myself, 'Claire, I love you. I really love you.' At the end of the month I could leave my room, and shortly thereafter I was walking... everything got taken away from me, and what was left was me.

Self-love is an effective cure because it allows one to see the world differently, to celebrate the positive. In turn, the body celebrates the positive and returns to health.

During one of his lectures, Dunning tells the residents to reflect on an image of the world outside as positive and as free as the world we've created here. Because when you look at on the world from a place of love and a place of forgiveness, what you are seeing outside is a reflection of what you feel within.

He then tells them what he sees from within: multiculturalism, sensitivity training in the workforce, the growth of environmentalism, a men's movement, in short, "a global transformation identical to the transformation I revel at within."

Dunning recognizes that social change is necessary in order for all bodies to be able to live a healthy and happy existence; after all he advocates for environmentalism and diversity training in the workplace. But in Dunning's equation, individual transformation culminates in social change: a positive
individual attitude creates a positive and life-affirming environment. Personal transformation is emphasized because it has a dual effect: it not only alters the self, it changes the world as well. According to Dunning's philosophy, self is world, and that recognition is the key to health.

The collapse of self and world, however, also necessitates careful control -- anger or negativity results in one's self-destruction. Precisely because self is world, certain types of responses are demarcated as "unhealthy." For example, during a group therapy session, Dunning questions Nell, a woman whose husband has recently died from the disease. Nell is clearly angry, and resistant to Dunning's line of questioning. When he asks her how she felt when she got sick, she responds, "I just wanted to get a gun and blow off the heads of everyone who got me like this." Dunning tries unsuccessfully to elicit a different response from Nell, and finally chastises her, "Nell, the only person who can make you get sick is you . . . if our immune system is damaged it is because we have allowed it to be, through exactly the kind of anger you are showing us now . . . put that gun of yours away."

This emphasis on "self is world" collapses into a blame-the-victim mentality. In one of the most devastating scenes in the film, we watch a group therapy session where Dunning asks leading questions and browbeats each participant into accepting full responsibility for their illness, as is demonstrated in the following dialogue between Dunning and an incest survivor:

Dunning: Why did you get sick?

Woman: I was deeply wounded as a child, and had completely blocked it out for years and then suddenly became very ill.
Dunning: Why do you think?
Woman: Maybe to let myself know something was wrong?
Dunning: Ok. And the person who hurt you the most?
Woman: Was me.
Dunning: For?
Woman: Not forgiving him.

Dunning uses the death of Nell's husband to prove what can happen if one does not perform the regime of self-love correctly. He tells the other residents, "Let's throw away any negative, destructive thought we might have and look around ourselves with love. I tried to teach him this, to give up the rage, to strive for a quiet might." His speech trails off in midsentence, and he throws up his hands as if to signify that he did all he could but the man just wouldn't listen. And in this case the consequence of not following Dunning's advice is death.

Safe presents Dunning negatively. He appears cruel in the group therapy session, just a tad too slick and rehearsed in his nightly lectures. The movie doubts his sincerity: after proclaiming his concern for all of the residents, Dunning gets one of their names wrong. Safe also takes stabs at the profit motive behind Wrenwood. During one of his nightly talks, Dunning asks the residents to pass all their valuables to the front. They laugh, but the irony is clear. In another scene the camera pans the tent-like structures that the residents live in, and then shows Dunning's expansive and expensive house in the distance.

Yet it is at Wrenwood that Carol undergoes a transformation. Throughout the film she has been portrayed as inarticulate and passive. Even after arriving at
Wrenwood, she does not speak at the group therapy session; she tells Dunning, "I'm still learning the words." The film's last three scenes, however, evidence the changes occurring. After a surprise birthday party, Carol stands up and makes a public speech. Though somewhat stunted and halting, it stresses public education and the need for self-love:

I've never made a speech in my life . . . I don't know what I'm saying. It's just that I really hated myself before I came here and umm so I'm trying to see myself, hopefully, more as I am, more more positive, like seeing the plusses. Like I think it's slowly opening up now, people's minds, like educating, and AIDS and, and other types of diseases . . . and make people aware and ourselves like reading labels . . .

Carol receives a standing ovation from the residents.

She is also able, in the name of health, to put some distance between herself and her passionless marriage. When her husband comes to visit, Wrenwood's rules prevent any kind of sexual interaction. Additionally, Carol begins a flirtation with another resident at the spa, Chris. The only man to speak at Wrenwood besides Peter, Chris is clearly attracted to Carol and begins courting her. He signs up for cooking duty with her, throws her the surprise birthday party, walks her home. The two have a chemistry Carol lacks with her husband; with Chris she laughs like a schoolgirl. Not surprisingly, Carol extends her stay, telling her husband, "I just think it's true what they say and that is up to the individual and that it takes time."

Although Safe critiques Carol's previous existence in the private sphere of bourgeois femininity, it does not offer Wrenwood as an unproblematic alternative. At the end of the movie, it is questionable whether Carol's health actually improves.
--- Carol moves into an isolation house at Wrenwood, and continues to need an oxygen tank periodically. Although Carol is decidedly happier, in essence, she has traded imprisonment in the domestic for imprisonment in a controlled public that stresses education but warns against activism. As such, Safe chronicles the way that the discourse of health produces a Public woman who, in the name of health, rejects domesticity, yet whose participation in the public sphere poses no serious threat to relations of power. To put this another way, Safe chronicles the way white privileged women can benefit from this health discourse without any systematic changes being made to relations of power.
WORKS CITED


CHAPTER 4
SKINNY WOMEN AND GOOD MOTHERS: THE RHETORIC OF RISK, CONTROL, AND CULPABILITY IN THE PRODUCTION OF KNOWLEDGE ABOUT BREAST

The past three years have witnessed an explosive proliferation of information about breast cancer in the popular media. Part of this increased visibility stems from the growing awareness of the number of women affected by this disease — the National Cancer Institute estimates that one in eight American women will develop breast cancer in her lifetime.27

Inseparable from this growing consciousness is an insurgence of grass-roots activism. Breast cancer survivors,28 health care providers, scientists, and legislators have formed coalition groups in order to lobby for an increase in research funding as well as changes in the direction of research. These groups have utilized the media as an effective tool to raise awareness about the disease and to invite participation from the general population. For instance, in 1992, the National Breast Cancer Coalition (NBCC) encouraged women to write letters demanding more funding for breast

---

27 This figure is somewhat misleading in that it assumes a lifespan of 95 years and does not adequately address the way that various factors such as age, race, and genetic history alter risk. See Dr. Susan Love's Breast Book, 2nd ed., pp. 176-180.

28 This term has been the focus of much discussion. As Sandra Steingraber argues, some women find the term 'survivor' empowering. Steingraber, however, feels "the term divides us in half and at the same time denies the uncertainty of our prognosis, one of the major issues with which we have to struggle." She prefers to call herself a 'breast cancer victim' in order "to highlight the notion that cancer is both a preventable disease and a human rights issue." See Steingruber, p. 97.
cancer research. Expecting 175,000 letters, they received 600,000 in six weeks, and presented them to Congress and the White House. After intensive lobbying, in 1993 Congress approved a $325 million increase for breast cancer research.

This activism and its use of the media has helped make breast cancer a "hot" topic. In many ways, this increased visibility seems like a hopeful sign. The number of articles in the popular media about breast cancer has increased exponentially, and many would argue that the more information women have, the more likely they are to prevent, detect, and survive the disease. However, the work of Foucault complicates the notion that more information is necessarily better. Foucault asserts that knowledge production (in this case, information about breast cancer) is never a neutral operation, but rather, is always infused with relations of power. Foucault argues that power "produces effects . . . at the level of knowledge. Far from preventing knowledge, power produces it" (1980, 59). As such, knowledge is not a neutral expression of objective reality, but its production is an invested process. Because power and knowledge are so inexorably imbricated, Foucault advocates for a careful analysis of the relations of power that produce discourse, as well as an examination of which relations of power are ensured by that production (1978, 102).

Foucault's emphasis on the "birthing conditions" and "effects" of discourse is particularly useful when examining the recent explosion of information about breast cancer. What historical circumstances and power relations contribute to the current attention paid to breast cancer? What types of knowledge are being produced? And what are the effects of that knowledge production?
Drawing from Foucault's theory of knowledge, discourse and power, this chapter focuses on representations of breast cancer in the popular media as well as texts geared towards those diagnosed with the disease and their health care providers. Specifically, this chapter investigates the use of risk factors in mainstream discussions about the disease. An examination of the literature evidences that two risk factors are highlighted above others -- diet and reproduction. Importantly, these two risk factors are represented as controllable behaviors: one can alter one's diet and "plan" childbearing whereas there is little one can do about family history, age, or the onset of menses and menopause.

Yet, how is it that these factors become highlighted, and equally important, what are the effects of this emphasis? This chapter argues that there is a Foucauldian "will to truth" in operation in the production of knowledge about breast cancer. The "will to truth" is a historically contingent process that shapes knowledge production. As Foucault defines it, the will to truth "relies on institutional support; it is both reinforced and accompanied by whole strata of practices such as pedagogy . . . the book-system, publishing, libraries . . . and laboratories. But it is probably even more profoundly accompanied by the manner in which knowledge is employed in a society" (1972, 219).

As Linda Alcoff and Laura Gray point out, Foucault is not necessarily addressing "what is true and what is false, but what can have a truth-value at all" (6). Foucault argues that certain statements are "in the true" not because they are true or

---

29 I am loosely defining the popular media as literature outside the scientific/medical community. Arguably, this encompasses a great range--from mainstream media such as the New York Times through the alternative presses (feminist and/or gay and lesbian journals/newspapers).
false, but rather, because they take place within the parameters of legitimated statements. This creates a symbiotic relationship between truth and knowledge; knowledge validates what becomes known as "true," and truth determines what can be called knowledge. Foucault's will to truth can help us understand the specific emphases currently in play in breast cancer discourse. In this case, we see a focus on areas that stress individual responsibility and highlight risk factors that emphasize control and choice.

However, the emphasis on individual responsibility and choice is not exclusive to breast cancer discourse, but is seen widely throughout biomedical literature, even in discussions about diseases that are not specifically female, for example type II diabetes and cardiovascular disease.\(^\text{30}\) While this is certainly true, I argue that "responsibility and choice" take on a particularly gendered meaning in breast cancer discourse. First, the two risk factors that are privileged, diet and reproduction, have been understood historically as feminine concerns, and both house ideological assumptions about femininity. For instance, women are traditionally represented as responsible for food preparation in the household, and most often are. Additionally, the culturally valued feminine body (i.e., slender) requires strict discipline over one's food intake, and therefore controlling one's diet is connected to the proper performance of femininity. Reproduction is also enmeshed in questions of femininity, often represented as a "natural" desire of adult women.

\(^{30}\) Additionally, the rhetoric of individual responsibility is not limited to biomedical literature, but has great currency in other cultural arenas. Note current discussions about welfare reform and their emphasis on individual responsibility.
As such, diet and reproduction have specifically feminine resonances, resonances that echo throughout breast cancer discourse.

Second, the emphasis on individual responsibility and choice produces specifically gendered effects. In other words, breast cancer discourse not only emerges from ideological assumptions, but performs cultural work as well. Discussions of breast cancer are often packaged in a rhetoric of culpability that produces a particular kind of gendered guilt: one contracts breast cancer because one has not made the "proper" dietary and reproductive choices. In short, breast cancer discourse tacitly (and sometimes not so tacitly) implies that the way to prevent the disease is to follow dominant codes of femininity.

However, rather than read the popular media as radical mistranslations of scientific research and/or activist interpretations of the disease, this chapter argues that scientific and activist discourses are also underwritten by the same "will to truth." Because of this, this chapter does not see these groupings (scientists/activists/popular media) as rigidly distinct categories, but rather as three elements that participate in the production of knowledge about breast cancer and contribute to the formation of a "breast cancer discourse."

Blurring the Lines: Science, Activism and the Politics of Knowledge Production

It would be easy to see scientists and activists as opposing camps in the debate about breast cancer. Many breast cancer activists have strongly criticized science as a largely all-male institution and have questioned research methodology
and direction. Activists have attempted to intervene in the process of scientific research and become participants in the production of knowledge about the disease. This process echoes what AIDS activist Brian Epstein calls a "conventional left approach." Epstein defines this as:

the working assumption that knowledge is power -- meaning that whoever has access to, or can monopolize, knowledge is powerful as a result. Traditionally this view has lent itself to a simple political objective . . . : get access to that knowledge monopolized by the expert elite and share it democratically. (54)

However, this democratization has not gone uncontested in scientific circles. Clearly, certain scientists are concerned about the effects of breast cancer activism. We can find an example of this in the debate over funding allocation.

As previously mentioned, the National Breast Cancer Coalition (NBCC) lobbied for an increase in funding, and in 1993, Congress approved $325 million for breast cancer research. In order not to exceed the cap on domestic spending, the money was channeled into the military budget. The Army Medical Research and Development Command became custodians of the funding, even though no one on the AMRDC team had any experience in breast cancer research (Marshall, "An Expert Panel" 1068). The AMRDC asked the Institute of Medicine (IOM) for advice and critique. The IOM put together a panel to help guide the Army's plans, and interestingly, Kay Dickersin, epidemiologist from the University of Maryland and a leader of the National Breast Cancer Coalition, was seated on the IOM's panel.

The NBCC (National Breast Cancer Coalition) also made suggestions about how the $325 million should be distributed. Fran Visco and Dr. Susan Love
presented the National Cancer Institute’s [NCI] National Cancer Advisory Board with a list of demands: they requested that at least two study sections be specifically devoted to breast cancer, and asked that NBCC members be seated on those panels. Additionally, they wanted to be involved in the monitoring of data from ongoing clinical trials and advocated for mechanisms that would secure input from participants. As science writer Eliot Marshall notes, "The members of the board were shocked to learn how intimately the activists want to become involved" (Marshall, “The Politics” 617).

Marshall further explains that "This would set a new precedent for NIH, and Samuel Broder, NCI's director, grumbles that people who want to do this just 'don't understand how NIH works'” (“The Politics” 617). Some scientists clearly feared an encroachment on their territory. Frederick Becker, research chief of the M.D. Anderson Cancer Research Center in Houston, expressed this concern: "The tidal wave of advocacy . . . may wash away certain bulwarks of basic science that have been the greatest contributors towards the potential for cancer prevention and cure” (“The Politics” 616). Becker not only fears that activist participation prevents scientists from doing "their" job, but that it also erodes the basic tenets of scientific methodology, in effect, rendering science less effective.

However, a closer examination of this situation reveals that the lines between science and activism are far blurrier than they might appear at first. Although the National Breast Cancer Coalition asked for input into research decisions/direction, they originally advocated that the money be allocated to the

---

31 This was prior to the funding being allocated to the ARMDC.
NCI, a traditional stronghold in cancer research. In other words, the NBCC did not advocate to take research out of traditional scientific hands, but merely argued for an increase in their resources.

Further, a second glance reveals that it is difficult if not impossible to clearly delineate between scientists and activists. For example, Susan Love, a founding member of the NBCC, is a clinical and research physician and a founding director of the UCLA Breast Cancer Center. And although Love is critical about certain directions in scientific research, she shares (as do many "activists") Frederick Becker's concern about "basic science." However, she understands advocacy not as an erosion of basic science, but as a tool to bring about its return. Love states:

> It's clear that surgery, radiation, and chemotherapy -- 'slash, burn, and poison' . . . are rather crude ways of dealing with the problem. Even so, the research establishment continues to spend enormous sums of money on them asking tired, old questions like "Should we give chemotherapy for three months or four months?" . . . What we need to do instead is put more of our funds into figuring out how the disease progresses at the molecular level, because that's where the real answers lie. " (Technology Review 50)

For Love, a focus on prevention is a return to basic scientific tenets. She states, "We have to stop business as usual. We have to change the direction and really put our emphasis on basic science and prevention, and not such a large emphasis on treatment" (Marshall, "The Politics" 616). Importantly, it is in that return to a "truer" science that "the real answers lie."

---

32 Liane Clorfene-Casten defines 'the cancer establishment' as The National Cancer Institute (NCI), The American Cancer Society (ACS), the Memorial Sloan-Kettering Cancer Center (MSKCC), various grantees and contractees at universities, and major pharmaceutical firms.

33 Note, too, epidemiologist Kay Dickersin.
What's crucial to notice here is that Becker's and Love's statements, though seemingly at odds with each other, are not all that different. In fact, they use the same phrase, "basic science." Both are founded on a belief in science as a legitimating discourse, the site where answers will be found. What's at stake here is the definition of terms, a debate about how science will be performed, but not a questioning of science's status itself. In other words, these discussions take place within the parameters of scientific discourse; a counterpart to that discourse is not produced.

The fact that scientists and activists work within the same discursive formation, or as Foucault might phrase it, emanate from the same "will to truth," explains the common set of statements that emerges about breast cancer prevention, in particular the focus on risk factors that are seen as personalized and controllable. However, the will to truth does not preclude other types of statements from being uttered. Certainly, it is not the case that the only type of research being conducted is on risk factors that emphasize individual responsibility and control, nor is it true that popular representations of the disease address only these two risk factors. For example, there is a body of research that explores risk factors that are not understandable through the framework of control/choice, most notably, research on the possible environmental causes of breast cancer. Additionally, there are a few activist groups advocating for more research on environmental causes, and there have been articles in both scientific journals and popular media that address this issue.
However, Foucault argues that the will to truth being "reliant upon institutional support and distribution, tends to exercise a sort of pressure, a power of constraint upon other forms of discourse." (Foucault, "The Order of Discourse" 219). In other words, it is not solely a matter of the absence of "alternative" statements, but rather of how that "alternative" information is presented and packaged -- which "facts" are highlighted over others, which research gets funded, etc.\(^4\)

The work of Bruno LaTour can be read as a fascinating application of how Foucault's will to truth works in the realm of scientific research and scientific journalism. Although LaTour does not mention Foucault's theory, he argues in *Science in Action* that "Fact construction is . . . a collective process" (41). LaTour describes scientific discourse as a rhetoric of fact building, a complicated process that involves the use of authority and reference to transform research into "tacit knowledge." Like Foucault, LaTour is not necessarily interested in what is true and false but, rather, in how something comes to be established as true. For LaTour the communal process of scientific fact building exercises a form of "constraint" over what comes to be seen as true. He argues, "No matter what a paper did to the former literature, if no one else does anything with it, then it is as if it never existed at all. You may have written a paper that settles a fierce controversy . . . but if readers ignore it, it cannot be turned into a fact; it simply cannot" (40). Foucault and LaTour, rather than articulating a consciously insidious conspiracy theory of

\(^4\) For an example, see Foucault's discussion of the work the nineteenth-century botanist Mendel. Foucault states, "the deployment of a totally new range of objects in biology was required before Mendel could enter into the true and his propositions appear, for the most part, exact" ("The Order of Discourse" 224).
knowledge production, help uncover the complex and often subtle mechanisms that influence the way knowledge is produced.

It is valuable to examine the research on and discussions of environmental causes through the framework that Foucault and LaTour set up. As I mentioned previously, there is a body of research/discussion on the possible role of environmental toxins in the development of breast cancer. Much of this research focuses on the role of dietary contaminants (toxins) in the animal fat we eat, and xenoestrogens, environmental toxins that mimic the way estrogen works in our bodies. Importantly, not all of this research is new. In 1969, A.I.T. Walker et al. conducted a two-year study on carcinogenic pesticides. Walker et al. argued that pesticides such as DDT, chlordane, and dieldrin that concentrate in animal fats induced breast cancer in rodents. Interestingly, the National Cancer Institute's 1977 Bioassay of Chlordane for Possible Carcinogenicity found similar results. Samuel Epstein, one of the founders of The Cancer Prevention Coalition argues that "[t]his creates a strong presumption for a causal role of such dietary contaminants and breast cancer in women, particularly as the sites of tumor induction are generally similar in experimental animals and humans" (30).

There is more recent research that examines the relationship between the environment and breast cancer. For example, in 1992 Frank Falck conducted a study that found higher levels of PCBs and DDT in malignant breast lumps than in those judged benign. Also in 1992, Ernest J. Sternglass and Jay M. Gould conducted an independent study on the possible relationship between breast cancer and radioactive releases. They found "a strong correlation does indeed exist between the published
releases of airborne iodine-131 and other fission products on the one hand and the regional breast cancer mortality rates on the other hand, such that the probability of this association being due to chance is less than 1 in 1000" (783).

These findings and others have not gone completely unnoticed. Several groups have formed in order to lobby for more research on the environment and breast cancer. Breast Cancer Action, The Women's Community Cancer Project and The Cancer Prevention Coalition are three such groups. In 1994, The Women's Community Cancer Project presented their document, "A Woman's Cancer Agenda," to the National Cancer Institute and the U.S. Congress. Number eight on the agenda demands "Direct research to focus on prevention, the environmental causes of cancer and new, non-toxic therapies." Also, the past two years have witnessed a series of conferences on the possible links between environmental toxins and breast cancer: "Breast Cancer and the Environment: What We Know, What We Don't Know, What We Need to Know" at Adelphi University, Garden City, NY, November 1993; "Breast Cancer and the Environment: Our Health at Risk" Boston, October 1994; and "Breast Cancer and the Environment," Dayton, Ohio, October 1994.

Additionally, several media articles have addressed the possible link between the environment and breast cancer. The May/June 1993 issue of Ms. focused on breast cancer, presenting several articles on various topics. One article examined the potential link between environmental toxins and the disease. Mother Jones' May/June 1994 issue was dedicated to the possible environmental causes of

---

35 The Women's Community Cancer Project's and The Cancer Prevention Coalition's scope includes all cancer; Breast Cancer Action focuses specifically on breast cancer.
breast cancer. The title for that issue reads "Breast Cancer Cover Up: Despite mounting evidence, scientists have avoided investigating the environmental link to breast cancer."

It might seem as if a large amount of time and energy is being put towards investigating the possible link between the environment and breast cancer. Yet Foucault's will to truth reminds us how crucial it is to contextualize this information. It is not enough to have an alternate philosophy of cancer causation in existence, but rather, a matter of how that alternate information is packaged and disseminated. When the larger picture is taken into consideration, I assert that this link is overshadowed by a focus on dietary fat and reproduction, risk factors understood through the control/choice paradigm.

Mother Jones' Michael Castleman attributes this "overshadowing" to a series of complicated factors. I read Castleman's arguing as a fleshing out of Foucault's will to truth as it applies to scientific knowledge production. Castleman's factors include:

1) "the research mind-set" similar to the one LaTour describes;

2) the competitive structuring of grant money where "Those who have devoted their careers to Topic A are rarely thrilled to see Topic B come into vogue and snatch their funding. Increased support for the organochlorine theory threatens those who are heavily invested in other areas";

3) a "medical mind-set" with an emphasis is on detection, diagnosis and treatment;

4) a "blame the victim" mentality;
5) "a close relationship between the cancer establishment and offending industries." (32)

Ms. contributor Liane Clorfene-Casten supports Castleman's fifth factor. Clorfene-Casten argues that the parameters of current research have been in large part determined by the relationship between cancer researchers and pharmaceutical companies. She claims:

For years the national dialogue in the United States on cancer has been virtually controlled by the NCI, the ACS, the Memorial Sloan-Kettering Cancer Center, various grantees and contractees at universities, and major pharmaceutical firms... Instead of concentrating on prevention, the focus of research has been on cancer 'management' and a search for a cure. What we have is a golden circle of power and money, where many of the key players are connected, either directly or indirectly, with corporations that -- depending on the policies and priorities the establishment sets -- have much to gain or to lose. The monetary stakes are enormous. (57)

In support of her theory, Clorfene-Casten notes that Richard Gelb, the chair of Bristol-Myers Squibb, the nation's largest chemotherapy drug producer, chairs the MSKCC's (Memorial Sloan-Kettering Cancer Center) board of managers. Additionally, for most of the last decade, the NCI's advisory panel was chaired by Armand Hammer, who was at the same time the chair of Occidental Petroleum, a major producer of carcinogenic materials. Clorfene-Casten argues that this relationship between pharmaceutical/chemical companies and the "cancer establishment" explains why the major cancer research organizations have not supported legislation to reduce carcinogenic exposure, nor funded research to investigate the link between breast cancer and environmental toxins.
Samuel Epstein makes a similar argument. He accuses the National Cancer Institute of "trivializing the importance of occupational carcinogens" as a cause of all cancers, and of stressing the role of "diet per se, in spite of tenuous and inconsistent evidence and ignoring the important role of carcinogenic dietary contaminants" (15). As evidence, Epstein cites the 1992 NCI budget. With a total budget of over $2 billion, $645 million targeted for prevention, only $50 million was set aside for research on the role of carcinogenic exposure. This amounts to 2.5% of the total budget, and a little less than 8% of the funds allotted for prevention. Additionally, Epstein notes that the National Cancer Advisory Board (a sub-section of the NCI) "is clearly in violation of Section 407(a)(1)(B) of the National Cancer Act, which requires that no less than five members 'shall be individuals knowledgeable in environmental carcinogenesis' "(17). Although the figures presented above pertain to the research budget for all cancers, this limited funding for research on the possible environmental link carries over to breast cancer research as well. Earlier in this chapter I referred to the $325 million generated for breast cancer research that was channeled into the military budget. Epstein notes that none of this funding is earmarked for research on environmental causes.

We see the will to truth operating in the media representations of breast cancer causation as well. The Mother Jones issue that includes Castleman's article also includes two full pages of behaviors individual women can "choose" in order to prevent the disease. These include eating a low-fat diet and breastfeeding. Similarly, Ms.'s issue dedicated to breast cancer stresses heavily the role of dietary fat. Of twenty-three pages, thirteen are dedicated to a discussion of dietary fat. The cover
I am not arguing that it is environmental carcinogens and not dietary fat that causes breast cancer. Rather, my attempt is to highlight the way the will to truth operates in the extremely complicated production of knowledge about breast cancer. My goal is to look at what kind of knowledge is being produced, to examine how we know what we know, and to begin tracing the effects of knowledge production and dissemination. In order to investigate this process in greater detail, the next section will investigate the controversy over the connection between dietary fat and breast cancer.

Choosing Bagels Over Croissants: The Controversy Over Fat-Intake

A. Conflicting Data

There has been a tremendous amount of research on the possible link between dietary fat and breast cancer. A myriad of studies has been conducted, and the results are contradictory and confusing at best. Of the studies that argue for a correlation between a high fat diet and breast cancer incidence, the most often cited are the cross-national studies that have explored the relationship between national diet and breast cancer rates. Armstrong and Doll's 1975 study showed that nations with higher fat intakes also have higher breast cancer rates. Wynder, Rose, and
Cohen drew similar conclusions in 1986. Brian MacMahon's study concluded that as the average fat intake in Japan increased from about 12 to 25 percent, the incidence of breast cancer rose as well. A fourth study examined Japanese women who migrated to the United States. This study (Buell, 1973) found that as immigrants switched to a more westernized diet, the rate of breast cancer rose. Interestingly, Buell found a significantly higher increase among the daughters of immigrants who had spent the majority of their lives in the United States.

However, there have been numerous studies that contradict the above findings. Probably the most famous was conducted by Walter Willett of Harvard University's School of Public Health. Willett surveyed 120,000 women over a number of years, asking them questions about overall health, smoking, diet, use of birth control pills and postmenopausal estrogen supplements. In 1987, Willett et al. concluded that there was no link between breast cancer and dietary fat. A 1992 follow up by Willett drew similar conclusions.

Research on the association between dietary fat and breast cancer incidence continues to be heavily funded. Currently, NCI is supporting the Women's Intervention Nutrition Study, a five-year trial designed to examine whether a low fat diet prevents breast cancer recurrence and increases patients' survival rates. Additionally, in the fall of 1993, the National Institutes of Health launched the Women's Health Initiative, a three-pronged, multi-year study of post-menopausal women. The most expensive part of the Women's Health Initiative is a nine-year clinical trial involving 57,000 women which will examine whether a low-fat diet, vitamin A/calcium supplements, and hormone therapy affect women's development
of breast cancer, osteoporosis, and heart disease. Estimated costs for this one section of the Initiative range from $600 to $625 million. By far, the low-fat diet section is the most expensive and involves the largest number of women -- 48,000.

While the debate over dietary fat continues to be researched, many scientists offer cautionary advice about lowering dietary fat, even while acknowledging that no direct evidence exists. Often, they argue that fat intake has been proven to be a cause of other health problems, and for that reason alone, dietary fat should be contained to a minimum. For instance, Sheila Bingham of the MRC Dunn Clinical Nutrition Centre states, "At the moment, there is not enough evidence to have a consensus view about fat and breast cancer, but there are very good reasons for reducing total fat consumption" (12).

B. Medical texts

The increased awareness about breast cancer has resulted in a plethora of books aimed at both the medical community and breast cancer patients/potential victims. These texts take a negotiated position on the relationship of dietary fat to breast cancer. Often, they explain that science has not reached a consensus on the issue, and the two texts that I will examine both cite the Japanese immigrant study (which found a correlation between dietary fat and breast cancer) as well as Willett's findings (no correlation). However, the lack of consensus is often offset by pages of information on the value of reducing one's fat intake. Additionally, these texts often slip into a rhetoric of behavior modification that overshadows the contradictory findings about fat intake and breast cancer.

For example, the inside cover of Breast Cancer: A Complete Guide touts the book as "an indispensable handbook women need as they join with their doctors in
their fight against breast cancer" and comes complete with an epigraph from well-known breast cancer victim Dotty Rollin. After briefly discussing the Japanese immigrant study, the text's authors, Yashar Hirshaut and Peter I. Pressman, M.D.'s, claim, "there is very little to be lost from taking your cue from these data and lowering fat and calorie intake" (243). They then go on to list three ways for American women to reduce fat intake, despite this warning: "All that can be said at this point is that there is no convincing evidence that such drastic regimens do what their proponents claim" (244).

**Dr. Susan Love's Breast Book** presents another interesting case in point. Love troubleshoots her way through the various research, helpfully complicating the research findings. Of the cross-national studies that found a correlation between high-fat diets and high breast cancer rates, she asserts, "if women in country X get more breast cancer than women in country Y, and they also eat more fat, that doesn't necessarily prove that fat causes the increased cancer. These women may... also do a hundred other things differently... any of which may or may not relate to their cancer rate" (154-5). Love also looks at Willett's 1987 study, critiquing the research's definition of a low-fat diet: "all the women in the study ate a lot of fat: the lowest had a fat intake of 32 percent. In rats, remember, the reduction of fats didn't seem to make much difference until it got down to 20 percent or below" (156).

Despite her concerns about the conclusions drawn from the research, Love favors the studies that argue for the link between a high-fat diet and breast cancer. She asserts:

*Overall, it seems likely, from the material in the various studies, that fat consumption and calorie intake do have some effect on your*
vulnerability to breast cancer. While there isn't nearly as solid proof as there is with smoking and lung cancer, the data are strong enough to make it worthwhile to seriously consider cutting back your animal fat consumption — especially when you consider that animal fat has been proven to be a factor in many other illnesses, and nothing good has ever been shown about high animal fat consumption, except perhaps that it tastes good. And if you're the parent of a teenage daughter, it may be particularly wise to consider encouraging her to eat a low-fat diet, since the evidence suggests that much of the fat-related damage may be done early in life. (159)

Almost paradoxically, Love ends her section on diet with these cautionary words:

"Don't, however, expect miracles. Even if lowering the amount of fat in the diet does have an effect, it is likely to be a small one. Women on low-fat diets should not neglect screenings" (159). Still, this last-paragraph critique comes at the end of eight pages that effectively offset these final statements. Additionally, the appendix to the text includes a section on "How to Lower the Fat in Your Diet."

C) Mainstream media

I assert that discussions of risk factors emerge from cultural assumptions about women, and second, perform certain cultural work, in this case, a confirmation of hegemonic codes of femininity. But how is it that this process works? In order to gauge the overall effect of the use of risk factors in mainstream media discussions of breast cancer, it is first necessary to analyze the rhetoric that risk factors come packaged in. In other words, how do these articles represent breast cancer? How do risk factors function in that representation? Last, how does the rhetoric shape readers' interpretations of risk factors?
In general, the disease is packaged in a language of panic -- breast cancer is on the rise and reaching epidemic proportions. Although many articles explain that the increasing numbers of women diagnosed with the disease stem in part from more effective screening tools like mammograms, that is offset by the language employed in this literature. The titles alone are usually enough to scare anyone to death. For example, Judith Brady's anthology of women's writings on cancer is entitled *1 in 3: Women with Cancer Confront an Epidemic*. The Washington Blade ran an article whose byline read "1 in 3 Lesbians May Get Breast Cancer, Expert Theorizes"; and The New York Times published an essay titled "You Can't Look Away Anymore."

The content of the articles is often equally terrifying. An article in *American Health* began as follows: "Every three minutes, on average, a woman in the U.S. learns she has breast cancer. Washing over the lives of nearly 500 women each day, this relentlessly expanding wave will engulf 180,000 women this year alone." Here, breast cancer becomes an unavoidable natural disaster, and importantly, an unsurvivable one. Who after all, can live through a tidal wave?

Sally Jessy Raphael opened her January 21, 1994 show on breast cancer in a similar manner. Her opening monologue states:

> Every three minutes in America, women, like myself, like you, maybe your wife, your daughter, your niece, will be told that they have breast cancer, and if that statistic doesn't alarm you, eight minutes later, one of these women will die. You're probably thinking it won't happen to you. Well, we don't want you to be a statistic. This show is too important for you to miss.

As Raphael's statement illustrates, panic is also created by the use of statistics (especially around risk factors) without sufficient explanation of those numbers. As
Susan Love states, "when media headlines say that three alcoholic drinks a week increase breast cancer risk by 50 percent, they don't mean one has a 50-50 chance of getting breast cancer, but rather that these drinks increase the relative risk by 50 percent, and that one's lifetime risk is now about 5 percent rather than 3.3 percent" (156). Love also demystifies the oft-cited statistic that 1 in 8 women will develop breast cancer by looking at how that statistic is altered drastically according to a woman's age:

Future risk at any one time depends to a great extent on your age. For the average white woman, it is something like 1/1000/year at age 40, or 0.1 percent. This number increases with age, since breast cancer becomes more common as women get older: for example, at age 50 the average white woman has a 1/500/year (0.2%) risk of getting breast cancer. For lifetime risk you add up all the yearly risks to age 110, which comes to about 10 percent. For women of color, the risk is actually less. (139)

Love's emphasis on age and race and her explanation of risk factors present a different picture from the one constructed in *American Health* and the Sally Jessy Raphael episode. In both, all women appear to be equally at risk. Shockingly, in Raphael's portrayal one woman dies a mere eight minutes after her diagnosis! This is not to say that breast cancer rates have not risen, nor to make light of the serious implications of this increase. Rather, it highlights the way many articles initially represent breast cancer as a disease without form or logic.

This panic is also constructed by an emphasis on the solitary nature of the disease. Despite the fact that the tidal wave sweeps away thousands of bodies each year, "experts theorize" that one individual out of every three individuals will be
affected with the disease. A radically different effect is produced when The New
York Times tells women "You Can't Look Away," rather than "We Can't".

This individualization of breast cancer is exemplified by the aforementioned
essay in American Health. Here being diagnosed with the disease marks the
inevitable "start of a long, lonely road" (50). The article then goes on to use the
personal experience of several seemingly unconnected women. The use of these
separate stories only further entrenches breast cancer in a rhetoric of individualism.
For instance, Weiss cites Judith Hooper, a woman living with breast cancer, in the
following manner: "It's like being shot by a sniper . . . One day you're just living
your life, standing in the supermarket check-out line with everybody else, and within
a second your life is irrevocably changed" (50). This analogy not only portrays
breast cancer as a one-on-one conflict where victims are chosen almost at random,
but also points to how comfortably individualization collapses into a rhetoric of
culpability. If breast cancer is a sniper, by implication, it is caused by being in the
wrong place at the wrong time. Hooper's metaphor expresses a lack of control over
the disease, but ironically also uncovers the relationship between individuality,
personal behavior, and guilt that sets the parameters for many discussions of breast
cancer. Breast cancer discourse often implicates one's behavior (in this case, one's
physical location) in the development of the disease.

Not surprisingly, this relationship results in a certain shame about the disease
because it implies that individual women are responsible for their illnesses. As Susan
Sontag argues, this is not a recent development, but rather a characteristic of the
historical representation of cancer itself.
the evidence that there are cancer-prone families and, possibly, a hereditary factor in cancer can be acknowledged without disturbing the belief that cancer is a disease that strikes each person, punitively, as an individual. No one asks 'Why me?' who gets cholera or typhus. But 'Why me?' . . . is the question of many who learn they have cancer. (38)

The punitive nature of cancer is exemplified in the way American Health's uses Cynthia Grant's story. Importantly, "Cynthia Grant" is an assumed name. All we know of her is that she is 38, married, lives in New York, and "had no particular reason to suspect that a cancer might secretly be growing within" (50). It is crucial to note that Grant's story is immediately followed by a section entitled "Prevention," which provides a list of risk factors, and outlines some behaviors that might reduce one's risk of developing breast cancer. A high-fat diet is listed as a possible risk factor.

Certainly, many media articles translate faithfully the contradictory findings of the scientific research on dietary fat and breast cancer. American Health offers this negotiated position: "Definitive proof of a link . . . in humans is still lacking, but several major epidemiological studies have singled out dietary fat as a possible culprit" (52-53). Yet, the article also claims, "Of all the aspects of daily life that may affect breast cancer risk, the easiest to change is diet" (52).

This last statement is quite telling because it shifts attention back onto individual behavior and reintroduces an emphasis on control. If breast cancer is a "random epidemic," a sniper that strikes unexpectedly, the only possible option is to adopt a defensive posture towards it. Diet, because it is understood as a personalized, controllable behavior, creates the illusion of defense. Truly, it is an illusion since we
have conflicting data about its relationship to breast cancer incidence, and since 75% of women diagnosed with the disease evidence no risk factors! Yet, when staring at a tidal wave, it is not unreasonable to hold tightly to the canoe.

However, it's important to examine how cultural understandings about women's relationship to food shape our ability to see diet as a controllable behavior. As Susan Bordo argues, "The body -- what we eat, how we dress, the daily rituals through which we attend to the body -- is a medium of culture" (165). Bordo further asserts that in 20th-century American culture, discussions of women and food are placed in a rhetoric of control/indulgence. In order for women to obtain the slender, and hence feminine body which is culturally valued, they must exercise restraint: choose Sugar-Free Jell-O over Haagen-Dazs. Regardless of what decisions women make about food intake, they are seen as decisions, as choices, and not necessarily as a biological need for sustenance. It is this framework of restraint/indulgence that allows diet to serve the particular function it does in discussions of breast cancer.

Although I am not claiming that breast cancer discourse intentionally seeks to create the idealized feminine body, I do argue that discussions of diet are overdetermined by the cultural meanings ascribed to women and food intake.

This idea of "food as choice" and its connection to the "restraint/indulgence" dichotomy is quite common in popular media representations of breast cancer. In short, the debate about fat intake quickly collapses into behavior modification. Ms.'s May/June issue that focuses on breast cancer devotes a tremendous amount of

\[36\] This number ranges from 70-75%. Breast Cancer Action's outreach pamphlet cites 75%; Susan Love's Breast Book uses 70%.
attention to fat intake controversy. In that issue Susan Rennie argues that there is a correlation between diet and breast cancer. She asserts, "the evidence connecting diet and breast cancer is hard to ignore. By the late 1960s epidemiologists had uncovered an almost identical association between fat consumption and breast cancer mortality rates across an international spectrum. The higher the fat intake in a country, the higher the breast cancer mortality rate" (68).

As I mentioned earlier, the cover of Ms.'s issue has the following heading, highlighted in bright green: "PULLOUT! The Diet Censored by the Cancer Industry." Inside, after an eight-page discussion of the fat controversy, are four full pages of suggestions on how to change one's diet -- an explanation of "good" fats and "bad" fats, a table on how to calculate one's fat "allowance," a sample low-fat diet, "quick tips" on low-fat food preparation, a list of low-fat substitutes for high-fat favorites (complete with the headings "AVOID/CHOOSE"), and a page of recipes! (My personal favorite is the recipe for "Green Goddess Salad Dressing.") Although this list sounds more appropriate for a Ladies' Home Journal article, it is represented as feminist subversion; after all, the diet is "censored" by the patriarchal cancer establishment. Ironically, freedom is gained through restraint, through a process of choosing the "proper" foods.

Patricia Kelly's Understanding Breast Cancer Risk provides another fascinating example. Kelly, a medical geneticist who specializes in risk factor analysis, spends pages exploring the debate about fat intake, finally arguing that although nothing is certain, it is wise to alter one's diet. However, this advice quickly turns to an entire section on behavior modification. Arguing that many patients are
unsure "how to effect changes in their own or their family's lives" (67), Kelly launches into the following case study:

Susan is an attractive, thoughtful woman in her mid forties; she lives with her husband and three daughters, all of whom were accustomed to steak, hamburgers, ice cream, puddings, and snack foods on a regular basis. Susan works outside her home, and so is often exhausted at the end of the day. 'I find myself feeding them anything,' she said, 'just to have them happy and the mealtime over. I want to cook healthy meals, but I don't have the energy at the end of the day.' Susan was distressed, because the more she learned about the connection between breast cancer and diet, the more she wanted her daughters to grow up as protected as possible. Also . . . she was increasingly concerned about herself. She realized that a change in diet would not guarantee a reduction breast cancer risk . . . but said, 'I know we don't eat well anyway, so it's time for a change. And I want to do something about my breast cancer risk. This is one way for me to feel in control.' (68-69)

Kelly follows this case study with tips on how to "slowly" replace hamburgers with salads and steamed vegetables.

This case study is quite fascinating on several levels. First, it exposes the relationship between control, behavior, and risk factors characteristic of breast cancer discourse. Susan's dietary change is not necessarily related to its actual capacity to lessen the risk of breast cancer, but to her ability to feel "in control" of the disease. The effectivity of her behavior becomes secondary to her feeling of agency.

Second, it's crucial to note how this passage reconfirms hegemonic representations of femininity. Susan is a woman to be emulated; after all, she is attractive, thoughtful, and a concerned mother. In fact, she expresses fear for her daughters before she talks about herself. Susan "naturally" assumes primary
responsibility for her family's food preparation, and feels guilty about being tired after working a full day outside the home.

Whether we identify with Susan or not is secondary, however, to the way that this passage articulates the relationship between breast cancer risk and motherhood. In short, it tacitly implies that one way to prevent breast cancer is to be a good mother! Rather than examining cultural assumptions about mothering and possibly relieving some of Susan's stress, Kelly teaches her how to make a healthy salad. Traditional codes of femininity are reconfirmed as a defense against breast cancer.

In summary, the debate over fat intake as a risk factor is heavily influenced by the relationship between control, personalized behavior, and culpability -- all three shaped in part by cultural assumptions about women and food. Practicing certain behaviors is seen as "courting" the disease, and by altering one's behavior, women might be able to reduce their risk. This trajectory makes discussions of risk factors truly problematic in the discourse of breast cancer. The next section provides another, slightly more subtle example of this process. It will investigate the discussion about the possible link between hormonal factors and the risk of breast cancer.

37 Remember, too, the passage from Susan Love's text that encourages mothers to control their teenage daughters' fat intake.
Hormones, Reproduction and the Lesbian Panic

Science journalist Susan Rennie argues that the focus of breast cancer research has shifted from an emphasis on dietary factors towards an examination of the role of hormones in the development of the disease (38). Eliot Marshall agrees, asserting that the high-fat thesis "seems to have bombed out, and with it may have gone one of the best hopes for stemming the rise in breast cancer through changes in lifestyle" ("Search for a Killer" 618). Rennie and Marshall are correct to point out that there is a growing amount of research on the relationship between hormones and breast cancer risk. However, Marshall's contention is incorrect that this shift away from dietary factors has dashed hopes for prevention through "changes in lifestyle."

Although research on hormonal factors includes a variety of elements (age at first menstruation, age at menopause, reproduction, and the use of artificial hormones like birth control pills and estrogen replacement therapy), the risk factor of reproduction is the site where "lifestyle" is reintroduced into breast cancer discourse. The reasoning behind this is that many scientists believe that long-term exposure to estrogen (early period/late menopause without the break in exposure that pregnancy provides) stimulates cell growth in breast tissue, which leaves the breast more "vulnerable" to developing breast cancer.

Reproduction is represented as a lifestyle choice; however, it is simultaneously assumed to be the "natural" course of the mature female body. This
words, women can "choose" not to follow the "natural" course of their bodies, yet as we saw in discussions of fat intake, to choose wrongly has serious repercussions. Therefore, even if the fat intake thesis is truly in decline (although I would argue the Women's Health Initiative shows it is still an active research area), the hormonal hypothesis that replaces it, through an emphasis on reproduction, will serve the same function -- shifting breast cancer risk onto personalized behavior and away from other possible factors.

One of the most popularly cited studies on the relationship between reproduction and breast cancer was conducted by Harvard epidemiologist Brian MacMahon in 1970. MacMahon's cross-national study concluded that late menarche, early menopause, and a first full-term pregnancy prior to age 30 reduced breast cancer risk: a full-term pregnancy before age 20 carries half or less the risk of a first full-term pregnancy after age 30. MacMahon also found that high parity (multiple births, usually five or more) was not significant when age at first full-term birth was factored in. MacMahon's research has been well received; fellow scientist Alex Kalache claims that since MacMahon "it has generally been accepted that the main reproductive variable related to breast cancer risk is age at first full-term pregnancy" (34).

Many studies have confirmed MacMahon's findings. In 1983, Brinton et al. concluded that a first full-term birth after the age of 30 carries a 4-5 fold excess risk when compared to a first birth prior to age 18. In the same year, Helmrich et al. found that risk decreased with first full-term pregnancy prior to 25 (not 30), but they contradicted MacMahon's findings regarding high parity, concluding that it did
reduce risk. Kvale et al.'s 1987 study of over 63,000 Norwegian women supported Helmrich et al.'s conclusions about high parity. Still, both studies asserted that "the best indicator is age at first birth" (Helmrich 43).

In January 1994, Kalache et al. conducted research with Brazilian women that examined age at last full-term pregnancy [FTP]. Immediately after stating that "other studies have also failed to demonstrate any association between breast cancer risk and age at first birth," they draw these conclusions:

"Our findings are in line with the well-established positive association between age at first FTP [full-term pregnancy] and breast cancer risk and the equally common observation that nulliparous women [women who have never given birth] are at higher risk. (35)"

However, Patricia Kelly highlights two problems in many of the reproductive studies. First, Kelly argues that most do not separate out other potential risk factors, most notably, family history. Only one study (Brinton et al., 1982) analyzed "risk separately for women who did and did not have a mother or sister with breast cancer. Although distinctions between different types of family history were not made, and paternal family history was not considered, this was one of the first studies on reproductive history to include family history in a meaningful way" (77). Interestingly, two recent studies, Andrieu et al. (1993) and Parazzini et al. (1992), conclude that reproductive factors, including age at first birth, do not significantly reduce risk for women who have a family history of breast cancer.

Second, Kelly asserts that these studies are based on women who became pregnant some years ago, when women tended to marry and give birth at younger ages than do some groups of women today. It has not yet been shown that the increase
in risk with older age at first birth applies to the many women today who choose to wait to have their first baby or who choose to be nulliparous. (83)

Kelly concludes, "Early age at birth of first child appears to reduce risk, but these results are based on populations whose reproductive decisions and options differed from those of many modern women. Reproductive decisions may be a marker for different lifestyles, each with different factors influencing risk" (82).

As Kelly's statement points to, research on reproduction often separates reproduction from cultural/historic concerns. Reproduction is seen as a constant, natural in the sense that it can be traced unproblematically across generations and across international lines. Because of this, Kalache can use MacMahon's research to support his Brazilian study, and Kalache's research can be understood as pertinent to American women, without any consideration of living conditions, etc. Clearly, research on hormonal factors houses ideological assumptions about women's bodies and "naturalness," in this case, the transhistoric nature of reproduction.

We find another assumption about the naturalness of reproduction in Susan Love's explanation of why pregnancy decreases breast cancer risk:

between menarche and the first pregnancy, the breast tissue is especially sensitive to carcinogens . . . So it may indeed be that the 'developing breast' is more susceptible to carcinogens than the breast that has gone through its complete hormonal development. This increased sensitivity may relate to the breast cells' capability of mutating up until the first pregnancy. There may be something about the first pregnancy that stops them from being able to mutate; thus the more time cells have to mutate, the greater the chance that they'll mutate in response to a carcinogen and in a way that develops into cancer. (144-45)
Here, Love equates "complete hormonal development" with pregnancy. In other words, the mature breast is the one that has experienced childbirth. Love imposes a teleology onto the female body, and pregnancy is the "natural" threshold that marks full development.

Alex Kalache's study on age at last full-term pregnancy highlights a third ideological assumption housed in discussions of reproduction. In Kalache, it is not that reproduction is assumed, but rather that when it occurs, it always takes place within a heterosexual matrix. Describing MacMahon's research, Kalache writes, "They found that single women and nulliparous women had an equivalent risk, which was higher than for parous women" (35). Here single women are assumed to have never given birth, and married women are associated so strongly with reproduction that he needs to mark those who haven't had children as nulliparous.

These examples shed light on the narrative that forms about the naturalness of reproduction. I am highlighting this narrative not solely to critique its ideological stance, but to show how it exists as the tacit backdrop to discussions of reproduction as lifestyle choice. This backdrop influences our interpretation of the reproductive choices women make. Women can exercise control over their reproductivity, yet if reproduction carries with it a natural teleology, then that choice is already overdetermined. It is this overdetermination that allows reproduction to follow the same trajectory we saw in the fat intake debate: control leads to behavior modification, and behavior modification to culpability.

Susan Love's text exemplifies the first half of this equation -- control to behavior modification. Love separates her discussion of risk factors into two
sections: 1) hormonal and genetic, and 2) external factors. Each category is constituted by its relationship to control. "Unlike the hormonal and genetic influences just discussed, diet, alcohol, and certain medications carry risks over which we have control" (152). Reproduction is included in the first, the uncontrollable, yet because reproduction is also a controllable behavior, she can't maintain the distinction. For instance, we find the following discussion in the section allegedly examining risk factors out of our control. Love states, "Dr. Anthony B. Miller has concluded that if every woman in the world were to have a baby before 25, 17% of the world's breast cancer would be eliminated. If you were looking at this from a public policy perspective, you'd have to weigh the possible advantages of pushing early pregnancy against the problems of young and possibly immature parents, and of possible population growth" (141). Here, the connection between control and behavior modification is quite clear. The move to behavior modification is not in question; what Love fears is certain possible ramifications that don't deal with breast cancer, i.e., population growth and immature parents.

Alex Kalache and W.R. Miller provide the second half of the equation: behavior modification to culpability. For example, Kalache's closing paragraph reads as follows: "Our findings may have implications for family-planning. Women may well be prepared to consider completing their families before the age of 35, if they are told that by doing so they may considerably reduce their risk of breast cancer" (35). Here, timely reproductive behavior can "considerably reduce" risk, and similar to what happens in the fat debate, motherhood becomes a way to reduce the risk of
breast cancer. By extension, breast cancer can be induced by making the wrong choice -- choosing not to reproduce or to have children "late" in life.

W.R. Miller's "Hormonal Factors and Risk of Breast Cancer" concludes in a similar way. He asserts: "Finally, what are the implications of these studies in terms of preventive measures? The concept of blocking oestrogenic hormones during pregnancy to reduce breast cancer risk in offspring seems impractical. A policy of discouraging women from having children late in life is more feasible, but will probably be less acceptable to the nulliparous women who seem to be at greatest risk" (25-26). According to Miller, all women reproduce. His statement collapses nulliparous women with those who will eventually have children, but will have them late in life. Additionally, these women (whose reproduction goes against the "natural" time schedule; they are "late") are seen as resistant to the practical advice he wants to give them, and since they are at the greatest risk, that resistance could cost them their lives.

B. Popular Media

We see the repercussions of these assumptions most clearly in literature outside of the scientific community, particularly in gay and lesbian presses where there has been much recent discussion about the relationship between breast cancer risk and lesbianism. Similar to what we saw in the section on dietary fat, that discussion takes place in a rhetoric of panic. The titles of many articles are enough to strike fear in the heart of any lesbian. Kristina Campbell's article is called "1 in 3 Lesbians May Get Breast Cancer, Expert Theorizes"; Quest ran a story called
"Lesbians At Risk." Deb Price's editorial in The Detroit News has this byline "As cancer assaults lesbians, they can learn to fight back," and Cindy Kirshman's byline in The Advocate reads "Rising Cancer Rates Prompt Lesbian Grass-Roots Health Project." The latter's content is also frightening. Kirshman refers to breast cancer as "the worsening epidemic" and "the newest plague" (56).

Again, this panic is created by an emphasis on risk factors, most notably, reproduction. In gay and lesbian presses, reproduction is highlighted as a risk factor, often topping the list. For example, Campbell discusses hormonal factors first, and then dietary fat. Importantly, "hormonal factors" are discussed primarily in terms of reproduction -- menarche and menopause become secondary. The section starts: "Breast cancer studies show that women who have never had children are about 80% higher risk for breast cancer than women who have children" (23). Only at the end of the paragraph does she mention age of menarche/menopause. An article in off our backs makes a similar claim: Louise Gates asserts, "We do know that lesbians are at higher risks for some cancers because of not having as much childbearing [sic]" (12).

However, notice that these claims are built upon a certain slippage in the definition of lesbianism. As I argued previously, scientific research does not overtly mention sexuality, but rather categorizes women as either nulliparous and parous. In these articles, however, nulliparous becomes synonymous with lesbianism and, by implication, heterosexuality with reproduction. This collapse serves an important function -- it allows lesbianism itself to become a risk factor rather than reproduction. For instance, Craig Dietz's piece in Quest argues "While one in nine
women in the U.S. will die of breast cancer, the risk for lesbians is three to five times higher" (18). Campbell's article follows a similar trajectory. Her opening lines read "One in three lesbians may develop breast cancer in their lifetimes because they are more likely than other women to fall into high-risk categories for the disease, says Dr. Suzanne Haynes with the National Cancer Institute" (23). Lesbianism and its presumed concomitant lifestyle become the culprit for increasing the risk of developing breast cancer.

Once lesbianism has been located as a risk factor, it opens up a space to expand the risk to other characteristics that lesbians may possibly have in common. For example, Campbell cites Haynes' "five general reasons why lesbians are at such high risk: not having children, higher alcoholism rates, higher body mass, fewer gynecological exams, and fewer breast cancer screenings" (18). Haynes' information comes from Caitlin Ryan's 1985 National Lesbian Health Care Survey, whose sample size was remarkably small -- 2,000 women. Interestingly, Ryan did not find a higher cancer rate among those surveyed, yet her research is used to support a folkloric belief that lesbianism itself is a risk factor.

I use the term folkloric because in fact no studies have been done on lesbians and breast cancer risk. As Haynes herself admits, "It's all speculative . . . because there are no studies" (22). Yet, the "1 in 3" statistic is constantly recycled in the media in ways that highlight the riskiness of a lesbian lifestyle. And many have supported Haynes' attempt to locate risk. Susan Hester, who founded the Mary Helen

---

18 Because many lesbian communities resist hegemonic notions of beauty, lesbians are often described as fatter than heterosexual women. Whether this is true or not, it's important to note that lesbians are often seen as doubly at risk -- they do not exercise the proper restraint in food consumption, and they make the wrong reproductive choice.
Mautner Project for Lesbians, asserts, "Finally, somebody who's an epidemiologist
has tried to separate out the facts about some of these cancers and their relevance to
Lesbians" (24).

However, not all have been so supportive of Haynes' conclusions. Many fear
that the emphasis on lifestyle will end up, much like it did with dietary fat, in a
rhetoric of culpability. Kate Rounds notes that Ryan herself

was horrified by the implications of the misinterpretation of her study. 'It makes it seem as if our lifestyle put us at higher risk ... which could make insurance companies red-line lesbians and charge higher insurance rates.' Susan Liroff ... puts it more bluntly.
'People will say, 'So that's why Susan got breast cancer. She's a big lesbian who smokes and drinks too much.' (Rounds 44)

Indeed, culpability has entered the picture. Rounds cites Joe Nicholson, the medical
reporter for the New York Post, who wrote: "Dr. Suzanne Haynes, an epidemic
expert, said lesbians are more likely to be stricken primarily because they do a poor
job of taking care of their health" (44).

Importantly, gay/lesbian presses do not advocate that lesbians get pregnant
in order to reduce the risk of breast cancer. Although most are uncritical of the
association between lesbian and nulliparous, which in turn reestablishes sexuality
and its concomitant lifestyle itself as a risk factor, lesbianism as a category of risk
plays out quite differently than the dietary thesis. Whereas an emphasis on diet
resulted in descriptions of individual women altering their food intake, the idea of
"Lesbians at risk" provides the ground for the formation of a particular kind of
identity politics. Breast cancer risk acts as rallying cry for unification and action.
Jackie Winnow's keynote speech at the 1989 Lesbian Caregivers and the AIDS Epidemic Conference provides a fruitful example. Entitled "Lesbians Evolving Health Care: Our Lives Depend On It," Winnow asserts, "Just as we were healers, experts in our fields in the Middle Ages, we need to lay claim to our heritage now. We have many people in nascent stages of expertise, but few experts . . . We need practitioners and clinics that are supportive of us as lesbians and experts in their fields" (58). Winnow constructs an originary moment of community, and argues for contemporary political action based on that shared ancestry. It is a rearticulation of a Lesbian Community, the need stemming from growing concern over cancer rates.

Other writers/activists parallel Winnow's strategic invocation of community. Consider these titles of articles from off our backs and The Detroit News, respectively: "Lesbians Unite Vs. Cancer," and "As Cancer Assaults Lesbians, They Can Learn To Fight Back." Cindy Kirshman's article in The Advocate, "Taking Care of Our Own: Rising Cancer Rates Prompt Lesbian Grass-Roots Health Projects" explores several agencies which have sprung up specifically to serve the needs of lesbians with cancer, most notably the Mary Helen Mautner Project in Washington, D.C.

This invocation of lesbian identity can serve as the basis for oppositional practices and discourses, for example, the creation of support services and calls for research that specifically focuses on the relationship between lesbianism and breast cancer. Ms. notes that Haynes and Ryan are currently working on a joint project that examines lesbians' breast cancer risk. However, it is crucial to recognize that this
identity is formed in part by embracing uncritically the collapse of nulliparous with lesbian.

Summary

As Susan Love argues, "The basic problem is that no one quite understands the disease yet. We're just beginning to fill in the gaps in our knowledge" (Technology Review 46). Yet the work of Foucault reminds us that knowledge production is never neutral or objective but, rather, is always an invested process. The production and dissemination of knowledge is the result of a complicated network of power relations and serves to affirm or dismantle those relations. As such, it crucial to critically examine the information we have about breast cancer and its effects. For example, we must question why at a time when many women are delaying motherhood and/or choosing not to participate in that institution, breast cancer discourse implies that motherhood can considerably reduce our risk.

This chapter does not intend to present an argument about what does or does not cause breast cancer. However, it asserts that the will to truth that underwrites and shapes breast cancer discourse privileges personalizable behaviors at the expense of risk factors that cannot be understood through the control/choice paradigm. This privileging is problematic on several levels. First, it results in a blame-the-victim mentality. Second, it discourages research along other possible avenues -- environmental toxins, the quality of marketed foods, etc. Removing the overriding emphasis on individual culpability might clear a space for adequate investigation into risk factors that are beyond our control.
Further, this chapter advocates that the women's health movement examine the ways in which it has embraced the individual culpability model. This movement has been extremely beneficial in many ways; it has brought breast cancer to national attention and has increased the resources we have to combat this disease. However, a critical stance towards the knowledge we have and will continue to produce can increase our effectiveness in solving the mystery of breast cancer.
Works Cited


Clorfene-Casten, Liane. "Inside the Cancer Establishment." Ms. 3.6 (May/June 1993): 57.


Rounds, Kate. "Are Lesbians a High-Risk Group for Breast Cancer?" Ms. 3.6 (May/June 1993): 44.


CHAPTER 5
RESISTANT DISCOURSE: THE IMPOSSIBILITY OF HEGEMONY

This dissertation has examined how the health discourse of new temperance operates to justify the entrance of white middle-class women into the public sphere as legitimate social actors and, at the same time, manages their public participation to ensure that relations of power will not be altered significantly. This dual process of legitimization/management has been identified as a necessary hegemonic sacrifice -- a compromise made to elicit consent and, ultimately, maintain hegemony. Such sacrifice is necessary because hegemony is never permanently secured; it is probably best understood as an equilibrium that is always already partially out of balance.

As the previous four chapters have shown, discourse can be deployed as a means of restoring or shoring up balance. But Foucault reminds us that it can also be "a stumbling-block, a point of resistance and a starting point for an opposing strategy" (Foucault, 1980, 101). This chapter focuses on three literary texts that act as points of resistance to the predominant paradigm of new temperance. All three reject the narrative offered by the discourse of new temperance. Each features a white middle-class, female protagonist who struggles with disease. However, each text either refutes that disease is caused by individual behavior or characterizes
individual behavior as a reflection of larger structures/events such as capitalism or modernization. In other words, these texts represent individual behavior as having little to do with the individual at all. As counter discourses to new temperance, these texts mark the inherent instability of hegemony.

In Don DeLillo's *White Noise*, the health of the novel's characters is a reflection of the health of white middle-class America, and not a reflection on the individual's personal behavior. The premise of the novel is that contemporary America suffers from too much data and a lack of interpretive frameworks. The result is confusion and paralyzing absurdity, what John Frow calls a "profound interpretability" (187). *White Noise* examines and critiques the way that white middle-class America relies on a number of illusions – meritocracy, bourgeois femininity, trust in and respect for institutions of authority – in order to survive this epistemological chaos. This examination/critique is achieved via the trope of health: the novel's two main characters, Jack Gladney and his wife, Babette, both develop disease, and through this, the mythologies that white middle-class America relies on are exposed as illusory.

Almost immediately, health becomes associated with the state of white middle-class America. *White Noise*'s main character, Jack Gladney, is the chair of the Department of Hitler Studies at the local university, the College-on-Hill. In the opening scene of the novel, Jack watches the annual parade of station wagons as parents bring their children back for the fall semester. Jack tells us that the parents see:

> images of themselves in every direction. The conscientious suntans . . . They feel a sense of renewal, of communal recognition. The
women . . . in diet trim . . . Their husbands . . . something about them suggesting massive insurance coverage. This assembly of station wagons, as much as anything they might do in the course of the year, more than formal liturgies or laws, tells the parents they are a collection of the like-minded and the spiritually akin, a people, a nation. (3-4)

Jack says of the parents: "They've grown comfortable with their money . . . They genuinely believe they're entitled to it. This conviction gives them a kind of rude health. They glow a little" (6).

But shortly after this, the illusion that everything is fine in middle-class America is shattered. A chemical spill caused by a multinational corporation releases a cloud of dangerous toxic fumes near the middle-class town where the Gladneys live and the College-on-the-Hill is located. The whole community is forced to evacuate, although interestingly, the neighboring working-class town is unaffected. At first, Jack refuses to go, arguing in effect that disasters don't happen to the middle-class. "I'm not just a college professor. I'm the head of a department. I don't see myself fleeing an airborne toxic event. That's for people who live in mobile homes out in the scrubby parts of the county, where the fish hatcheries are" (117).

As White Noise progresses, it becomes evident that the real danger is not the chemical spill but rather, the epistemological crisis produced by modernity. Specifically, rapid technological advances and the increasing globalization of everyday life39 have inundated the American cultural landscape with so much data that misinformation abounds, and often one set of data conflicts with another. In this

39 For example, the novel remarks on how local grocery stores have been transformed into mega-supermarkets where one can buy foods from all over the globe, and at several points in the novel the Gladneys gather around the tv to watch footage from overseas disasters.
world, nothing is certain; reality and truth are fleeting if at all possible. As Jack asserts, "In a crisis, the true facts are whatever other people say they are" (120). The point is driven home by both the media coverage and the public response to the chemical spill. Three times the media alter the way they refer to the event, and with each change the spill takes on a new identity and new measures are called for. A true postmodern crisis, even the symptoms of toxic exposure change. For example, when the spill is a "feathery plume," the experts advise people to stay indoors; the symptom is sweaty palms. By the time the spill has been upgraded from a "black billowing cloud" to its final moniker, "the airborne toxic event," the symptoms have become deja vu and heart palpitations, and evacuation is required. The Gladneys follow the advice of the experts, the oldest child and keeper of the radio informing his sisters when they need to upgrade their symptoms.

During the evacuation, Jack is briefly exposed to the toxins. The epistemological crisis is again evident in Jack's search to discover the ramifications of this exposure. Jack visits multiple medical and scientific experts, but it is clear that no one really knows anything. Yet amazingly, each expert asserts that Jack will definitely die eventually. Consider the following exchange between Jack and a lab technician. After the technician explains to Jack that exposure has caused "nebulous masses" in rats, the technician explains:

"Knowledge changes every day," he said. "We have some conflicting data that says exposure to this substance can definitely lead to a mass."

"What is a nebulous mass, just out of idle curiosity?"

"A possible growth in the body."
"And it's called nebulous because you can't get a clear picture of it?"

"We get very clear pictures. The imaging block takes the clearest pictures humanly possible. It's called a nebulous mass because it has no definite shape, form, or limits."

"What can it do in terms of worst-case scenario contingencies?"

"Cause a person to die." (280)

The irony here is thick; poor Jack is sentenced to die by a mass that is not a mass because it has no parameters.

This culture of misinformation is crucial to understanding the importance of Jack's current wife, Babette. For Jack, Babette serves as a much-needed interpretive framework in this postmodern landscape. Importantly, Babette's ability to function as Jack's sense-making mechanism rests on her belief in and approach to the body:

I think everything is correctable. Given the right attitude and the proper effort, a person can change a harmful condition by reducing it to its simplest parts . . . I'm not a very ingenious person but I know how to break things down, how to separate and classify. We can analyze posture, we can analyze eating, drinking and even breathing. How else do you understand the world, is my way of looking at it. (191-192)

In an era of epistemological and ontological confusion, Babette has a comfortable and comforting way of understanding the world; as Jack describes, she has "a trust in the tangible and the real" (185). In White Noise, this trust in materiality becomes conflated with and represented by codes of bourgeois femininity, altered slightly to fit the late twentieth-century cultural landscape. Babette is a stay-at-home mom,
and Jack tells us "She gathers and tends the children, teaches a course in an adult
education program, belongs to a group of volunteers who read to the blind . . . I
watch her all the time doing things in measured sequence, skillfully, with seeming
ease, unlike my former wives, who had a tendency to feel estranged from the
objective world" (5-6).

Babette's belief in objective reality makes Jack feel secure in the chaos that
surrounds them. Operating as his benchmark is a function that she seems acutely
aware of, and one that she performs in the public sphere as well -- her volunteer
work includes teaching a health-related adult education course. Babette is cognizant
that these classes are less about sharing information than about providing a soothing
balm for people struggling with the postmodern condition. She explains to Jack:

Knowledge changes every day. People like to have their beliefs reinforced. Don't lie down after eating a heavy meal. Don't drink on
an empty stomach. If you must swim, wait at least an hour after
eating . . . We didn't grow up with all these shifting facts and
attitudes. One day they just started appearing. So people need to be
reassured by someone in a position of authority that a certain way to
do something is the right way or the wrong way, at least for the time
being. I'm the closest they could find, that's all. (171-172)

Babette's sense-making capabilities are not only found in her relationship to
the body; they are marked by her body itself. Physically, she is a stark contrast to
Jack's two ex-wives. Both are public women with ties to the intelligence
community, are secretive, obsessed with their jobs, and lousy mothers. Jack says
to Tweedy Browner, ex-wife number one, "You all had high cheekbones. Every one
Marvelous bone structure. Thank God for Babette and her long fleshy face" (88).

As one can surmise from this quote, Babette is a sheer relief to Jack because she embodies the opposite characteristics of the former wives. Part of her appeal is that her honesty is an effect of her body. Jack tells us:

Babette is tall and fairly ample; there is a girth and heft to her. Her hair is a fanatical blond mop . . . If she were a petite woman, the hair would be too cute, too mischievous and contrived. Size gives her tousled aspect a certain seriousness. Ample women do not plan such things. They lack the guile for conspiracies of the body. (5)

When Babette complains she is too heavy, particularly her hips and thighs, Jack suggests that there is "an honesty inherent in bulkiness if it is just the right amount. People trust a certain amount of bulk in others" (7). Jack relies on her stability, an embodied stability for comfort, and often finds a safe harbor by placing his head between her breasts. He tells her, "I depend on you to be the healthy and outgoing Babette. I need this as badly as you do, if not more" (263).

During the course of White Noise, Jack is forced to recognize that Babette is a facade. He has read Babette's body incorrectly, and she turns out to be not healthy and outgoing, but suffering from a paralyzing fear of death. In the name of health, Babette ends up being just like the ex-wives -- she is secretive, covert, participating in health research to find a treatment for her paralyzing fear of death. She even has an affair with one of the scientists in order to ensure her participation in the research.
In a long and brilliantly written conversation during which Babette confesses her affair and participation in the research, Jack is furious, not necessarily with her adultery, but with the fact that Babette is not what he thought she was. Throughout the conversation, both Babette and Jack talk about Babette in the third person, highlighting the ideological construction of the persona "Babette." Jack begins:

"I thought it was my former wives who practiced guile. Sweet deceivers. Tense, breathy, high-cheekboned, bilingual."

[Babette] "If I'm going to tell you the story at all, I have to include this aspect of it, this grubby little corner of the human heart. You say Babette reveals and confides."

[Jack] "This is the point of Babette." (194)

As the conversation continues, Jack reiterates again and again while talking to Babette: "This is not Babette. Babette does not...."

In the end, however, the novel holds up bourgeois femininity as a needed mythology, a valuable interpretive framework in a world that needs some order. Importantly, both Jack and Babette agree to believe in the facade of Babette in order to survive. As Jack tells Babette: "We're going to come through this thing all right . . . We're determined to be well. Babette is not a neurotic person. She is strong, healthy, outgoing, affirmative. She says yes to things. This is the point of Babette" (220). For Babette, believing in the construct and performing bourgeois femininity becomes the most effective way to deal with her disease. Babette tries to live a

---

42 The secret research is funded by a multinational corporation, suggesting that enough people suffer from Babette's disease to make the development of a cure or treatment protocol profitable. In fact, we later find out that Jack has this anxiety as well.
healthy lifestyle – she exercises regularly and buys wheat germ, but only when she is with her youngest son Wilder does she experience relief from her anxiety attacks.

Jack arrives at this conclusion via a different path: he shoots the scientist Babette had the affair with and, then regretting it, brings him to a medical clinic for treatment. The clinic is run by an old sect of German nuns, and while they are treating the scientist, the sisters confess to Jack that they, like Babette, are a facade. In fact, the sisters do not believe in God, in heaven or hell, but perform religion for the good of "all the others":

It is our task in the world to believe things no one else takes seriously. To abandon such beliefs completely, the human race would die. This is why we are here. A tiny minority. To embody old things, old beliefs . . . If we did not pretend to believe these things, the world would collapse . . . Our pretense is a dedication. Someone must appear to believe. Our lives are no less serious than if we professed real faith, real belief . . . We surrender our lives to make your nonbelief possible . . . We are your fools, your madwomen, rising at dawn to pray, lighting candles, asking statues for good health, long life. (319)

Jack responds: "The odd thing is I found it [non-believing nuns who pretend to believe for the greater good] beautiful" (320).

After his interaction with the atheist nuns, Jack, deciding "There was nothing to do but wait for the next sunset" (321), returns home. Sunset becomes a critical metaphor in the final chapters of White Noise; the chemical pollutants released during the airborne toxic event have created stunningly beautiful sunsets. Sunset watching has become commonplace in the neighborhood, and the last scene of the novel shows Babette and Jack (and the youngest child Wilder) joining their
neighbors for the nightly ritual. It is a celebration of the use-value of facades, a collective agreement to see beauty and ignore the pollution that subtends it.

Taken as a whole, White Noise is a searing critique of the institutions that middle-class America relies on to provide meaning: after corporate America releases toxic waste, the medical and scientific establishment, even with all their advanced technology, can produce mountains of data, but no knowledge about these chemicals and their effects. The media report confusing and contradictory facts. Devoted wives have affairs; nuns are revealed to be atheists. In spite of this, however, the characters make a conscientious decision to continue to believe in these facades. The final scene satirizes this decision; it is reminiscent of a Norman Rockwell painting except for the fact that they watch the sunset from the highway overpass and the sunset is toxic and potentially dangerous to their health. The satire uses the trope of health -- Babette's anxiety attacks, Jack's exposure to toxic chemicals, a medical center staffed by nuns -- to expose the illusory quality of our everyday lives and draw a brutal and funny rendering of contemporary America.

Like White Noise, Richard Powers' novel Gain rejects the logic of causation housed in the discourse of new temperance. There are two protagonists in Gain: Laura Bodey, a mother of two who is diagnosed with and ultimately dies from ovarian cancer; and Clare, a soap and chemical company founded in 1802 by Jepthah Clare. The novel identifies Laura's lifestyle as the cause of her cancer; however, it defines lifestyle not as a set of personalized choices but, rather, as a result of the

43 Even the educational system is parodied as the novel's main character runs the Department of Hitler Studies yet cannot speak German and, despite his title, is shown to be just a man as confused as everyone else.
American capitalist system. This point is driven home by both the content of the story as well as its narrative structure which alternates between the stories of its two characters without breaking them into separate and discrete chapters, suggesting to the reader the interconnectedness of the two events (Laura's diagnosis with cancer and Clare's inception and growth) long before the relationship makes any historical sense.

The last person to grasp the connection is Laura herself. Despite the mounting evidence, she is resistant to accepting any link between her cancer and Clare's existence. For example, when her ex-husband alerts her to two class-action lawsuits against Clare, one by company employees diagnosed with cancer and the other by the EPA charging Clare with releasing toxic emissions into the air, Laura refuses to participate for several reasons -- the studies are flawed; she never worked at or had any connection to Clare. But a number of events lead Laura to recognize the relationship between her illness and Clare's existence:

1) A woman passing out religious pamphlets door to door immediately recognizes that Laura is sick and asks her what department at Clare she worked in. This woman's husband, a lifetime Clare employee, had recently died from cancer. When Laura tells her that she never worked at Clare, the woman replies, "I think it's in the air and in the water, and now it's in the ground. Builds up in the food. Every year a little more. You don't have to work for them. They'll come to you. You don't even have to live in town" (190).

2) Shortly after this interaction Laura goes to the local library to research whether the chemicals Clare makes are carcinogenic; the librarian takes one look at
Laura and hands her a file, telling her that "sick" people come in every few days requesting the same information.

3) A few chapters later Laura takes her kids to the county fair, where she realizes that she is in the midst of an epidemic:

Not just that packed cancer room at the hospital, the ring of bodies circled around their IVs, a new batch each time she visits. Not just the neighbor's sister-in-law's father. It's everywhere. She cannot turn around without running into someone else. Everybody is battling cancer. Why did she never see these people before? (213)

By the end of Gain Laura has come to accept that her cancer has been caused in large part by the fact that she lives in a company town. But this realization comes slowly, gradually, and there is no dramatic epiphany to serve as the novel's climatic moment. This is because Gain, at its core, is not a narrative about one woman's cancer and the company that caused it. Rather, it is a sustained, historical discussion of how the American capitalist system came to be in its current form and the disastrous effects of such a formation. Gain merely uses the stories of Laura and Clare to stage this discussion. While the novel ultimately judges this system to be dangerous and ruthless, more concerned with profit than with the lives of its customers, its focus is in understanding the various, and often arbitrary, historical events that gave our current system its shape. And in a surprising move, the final scene of the novel actually suggests the possibility of an ethical form of capitalism.

44 Gain makes it quite clear that Clare is not an anomaly in the American capitalist system. Noticing the number of people at the county fair whose skin has a "cancer green" tinge, Laura asks her daughter if she thinks it's like this everywhere, in Decatur, in Champaign. The seventeen-year-old responds, "I don't know, Mom. You think they have any fat, filthy, money-grubbing capitalists in Decatur?" (214).
Gain asserts that the American capitalist system has been driven by one primary purpose: its survival. This emphasis on survival (and not, for instance, on the public good) has not necessarily been in the best interest of workers or consumers. For one, survival requires making/selling quality products cheaper than the competition, which means that wages must be kept as low as possible. It also means a constant search for more efficient processes, which usually results in an increased workload for line workers. In Clare's case, the quest for efficiency resulted in a system of interlocking dependencies where waste products from soap became the core elements of other products. This expanded Clare's product lines, moving them into the business of industrial chemicals, which ultimately causes Laura Bodey's death.

Survival also meant that Clare had to create a system of interlocking dependencies between herself and her consumers:

For Clare to survive, it would need to sell not just soap . . . but familiar friends. In short, Clare had to offer a whole new way of living. It would have to train its clients to master filth and misery. Beating squalor was now a matter of life or death, for the American, for American enterprise, and finally for America at large. (194)

The novel chronicles, both structurally and narratively, the process through which consumers come to desire their own poison -- the sections which detail the histories of Clare and Laura are bridged by advertisements for Clare's products from both historical and contemporary campaigns. The goal of each campaign, regardless of the specificities of the current historic moment, is always to make Clare a necessary part of each consumer's life and lifestyle. Certain campaigns actually touted Clare's
product as the signature of a particular lifestyle. For example, one product called "Native Balm Soap" with "secret extract of Healing Root" had a profile of a Native American male on its wrapper. During the Industrial Revolution, the text tells us that the soap was advertised in a way that evoked the simpler and purer times of pre-industrial America. A few decades later during the xenophobic 1910s, the same product was advertised as the "measure of civilization" -- modern technology which had the know-how to harness nature. This ad campaign worked because it allowed its white consumers to distance themselves from the swarming hordes of uncivilized immigrants as well as promised a measure of assimilation to those same immigrants. Equally as interesting are the modern day ads which mark Clare's products as representative of a hip, on-the-run consumer smart enough to take advantage of the most recent scientific discoveries: "Hock it, Shock it, Squeeze it, Tease it! Infiltrate, Confabulate, Equilibrate, Defibrillate ... Knick-Knockers! (Now with a quarter of your RDA of Beta Carotene, not to mention a whole grit brickload of other celebrated antioxidants)" (334).

Gain leaves little doubt as to how effective such advertising campaigns have been. For example, when Laura invites the woman passing out religious pamphlets into her house, they engage in a discussion of the cause of Laura's and the woman's husband's cancer. Laura argues that the scientific studies linking certain chemicals to cancer are flawed. The woman responds, "Seems to me like we're just sitting around waiting for proof to poke us in the eye. And it's going to take a whole lot of proving to make people give up their Clean 'n Neat. Who's going to throw away all
their health and beauty products on a maybe? Hell ... Not me." (190). Eventually,
Laura draws a similar conclusion:

She vows a consumer boycott, a full spring cleaning. But the house is full of them ... Clare hiding under the sink, swarming her medicine chest, lining the shelves in the basement ... Too many to purge them all. Every hour of her life depends on more corporations than she can count ... Who told them to make all these things? But she knows the answer to that one. They've counted every receipt, more carefully than she ever has. And wasn't she born wanting what they were born wanting to give her? ... The newspapers, Don [Laura's ex-husband], the lawyers: everybody outraged at the offense. As if cancer just blew in through the window. Well if it did, it was an inside job ... She brought them in, by choice, tooted them in a shopping bag. And she'd do it all over again, given the choice. Would have to. (304)

Concern about survival affected Clare in other crucial way — it led to the company's incorporation in 1867. At first the Clares, like the American populace, eschewed incorporation because they saw it as cheating -- corporations were legal entities in the eyes of the law, and no stockholder could be held accountable for the debts or actions of the incorporated entity. In essence, incorporation defrayed liability and risk while still allowing for the former owners to profit from the business. As Samuel Clare states, "Corporate franchises played fast and loose, a kind of cheating that nobody cottoned to. ... If an owner couldn't manage his own firm without special privileges, he had no right to stay in business" (155).

But as more and more respectable companies incorporated, and popular reception to the idea of incorporation warmed, the Clares decided in favor of such a move, primarily because it ensured Clare's survival:

The idea of incorporation opposed all the business virtues he [Samuel] had ever stood for. ... And yet: an incorporation could live forever. It carried on beyond the span of any owner's life. It passed
itself down through the generations of those assembled thousands who would, in time, work its engines. Its dynasties surpassed the longest family. That vision of continuance clinched Samuel's choice. For the end of business was to outlast the needs it satisfied.

(194)

Once incorporated, Clare was no longer a family-owned business, but a public company that had to answer to a Board of Directors and stockholders. To get around this, the Clares bought up all of the public stock and packed the Board of Directors with family members and friends. As one of the Clares noted, the family had nothing to lose but "paper sovereignty and family pride" (156). However, there was much to gain since once incorporated, the Clares themselves were no longer personally responsible for the actions of the company but of course would continue to reap its profit. Clare became a discrete legal being in its own right, and within a few years, was bestowed upon it all the legal rights of a human being. As the anonymous, third-person narrator of the novel explains:

If the Fifth and Fourteenth Amendments combined to extend due process to all individuals, and if the incorporated business had become a single person under the law, then the Clare Soap and Chemical Company now enjoyed all the legal protections afforded any individual by the spirit of the Constitution. And for the actions of that protected person, for its debts and indiscretions, no single shareholder could be held liable. (158)

We see the effects of incorporation in the last section of the novel to deal with Clare. The narrator tells the reader that concern over various class action lawsuits has driven Clare's common stock price down to 40, and she is in the midst of fighting a hostile takeover by a tobacco company. To survive, Clare is planning to chop herself up -- spin off smaller companies, buying back common stock with
the money from the sales, launch an all-out offensive against "Tobacco," and do the
best spin job possible. This may allow Clare to survive, but will be negative for her
workers and consumers. The novel tells us:

Whatever the outcome, change will be massive and massively
expensive. That is the nature of markets . . . whoever ends up with
what is left of the company will be saddled with a lasting legacy of
debt and downsizing. Debt that gets shouldered by the fifty thousand
people who work for him [Franklin Kennibar, the reigning CEO] in
one way or another. Debt that gets passed on to the consumer . . .
The order goes out to bug Tobacco's offices, down South. They will
use the same people who tapped the phones of their own labor
organizers, last year. (350)

Gain argues that the historical quest for company survival creates a situation
that pits the needs of workers and the general populace against the company.
Capitalism's modern form, where high profit = survival (if stock prices are too low
the company is vulnerable to takeover and the reigning senior executives lose
power), is truly dangerous as Laura Bodey's cancer evidences.

Despite the anti-corporate tone of the novel, especially in the sections about
modern day Clare, Gain ends by suggesting an alternative vision of capitalism. The
last three pages of the novel rapidly race through the fifteen-year period after Laura's
death. We learn that Clare does sell parts of herself off, and then relocates to
Mexico leaving the town in economic shambles. Laura's daughter, Ellen,
experiences problems with infertility, but during her attempts at in vitro fertilization
the doctors find her ovarian cancer early which "gained her many years" (354).
Laura's son, Tim, becomes a full-fledged MIT computer nerd who eats only organic
food and marks the anniversaries of his mother's death with hunger vigils at One
Clare Plaza. Tim gets involved with an interdisciplinary research group that creates a computer program that can be used to cure cancer and a host of other illnesses. The novel ends with Tim's suggestion that the research group form a corporation with the settlement money from Laura's participation in the class action suit. The implication is that the purpose of this business will not be self-survival but the public good, and that perhaps this alternative form of capitalism can fix the ills of its precursor.

Terry Tempest Williams' *Refuge: An Unnatural History of Family and Place* is another text that refutes new temperance's emphasis on individual lifestyle as the primary cause of disease. *Refuge* accomplishes this by chronicling two parallel events -- the flooding of the Great Salt Lake region in Utah and the death of the author's mother, Diane Tempest, from breast cancer. The connection between the six-year flood and Diane's five-year bout with cancer is immediate and overt. In the first full paragraph of the prologue we are told:

> In the past seven years, Great Salt Lake has advanced and retreated. The Bear River Migratory Bird Refuge, devastated by the flood, now begins to heal. Volunteers are beginning to reconstruct the marshes just as I am trying to reconstruct my life. I sit on the floor of my study with journals all around me. I open them and feathers fall from their pages, sand cracks their spines -- and I remember the country I come from and how it informs my life. Most of the women in my family are dead. Cancer. At thirty-four, I became the matriarch of my family. The losses I encountered at the Bear River Migratory Bird Refuge as Great Salt Lake was rising helped me to face the losses within my family. (3)

The connection between the flood and her mother's cancer is more than a mere fact of chronology (i.e., they occurred simultaneously). For Tempest Williams, it comes
from a mixture of Mormon ontology and the specificity of her family history. In the Mormon belief system "each human being, bird and bulrush, along with all other life forms had a spirit life . . . Each occupied an assigned sphere of influence, each has a place and a purpose . . . And if the natural world was assigned spiritual values, then those days spent in wildness were sacred" (14). Not surprisingly, the natural world became an important element in the Tempest family's spirituality. "We learned at an early age that God can be found wherever you are, especially outside. Family worship was not just relegated to Sunday in a chapel" (14).

This philosophy resulted in the Tempests having an active relationship with the natural world. In many ways, it became another member of the family or, put less dramatically, an integral component of the family's everyday life. Tempest Williams asserts, "As a people and a family, we have a sense of history. And our history is tied to the land . . . Our attachment to the land was our attachment to each other" (14-15). For example, the Tempest family spent a great deal of time hiking and camping in the wilderness of the Great Salt Lake Region. Terry's grandmother instilled in her a love of bird watching; the two ritually tracked the various species that inhabit the area. As an adult, Tempest Williams became a naturalist/environmentalist at the Bear River Migratory Bird Refuge near Salt Lake City.

This ontology in which humans are but one element in the natural schema provides the narrative roadmap between the flooding of the Great Salt Lake region and Diane's illness and death. *Refuge* switches back and forth between these two events seamlessly: the Lake rises as her mother notices the rise of the tumor in her
belly (22); a flooded-over island represents Diane's body floating in the uncertainty of a life-threatening illness (64); Diane's chemotherapy parallels the city government's technological attempts to rechannel the rising waters (45). Tempest Williams is aware of the slippage between these two events. She states: "I could not separate the Bird Refuge from my family. Devastation respects no boundaries. The landscape of my childhood and the landscape of my family, the two things I had always regarded as bedrock, were now subject to change. Quicksand" (40).

This narrative strategy highlights the way that the momentous changes occurring in her natural surroundings, i.e., the various forms of death and destruction brought about by the flooding of Great Salt Lake, inform the way she and her mother theorize the changes occurring in their familial surroundings, i.e., Diane's illness and death. For example, both mother and daughter call on their sense of being part of a larger life cycle as a way to help them adapt these impending changes. When Diane first notices the tumor, she goes on a month-long canoe/backpacking trip with her husband, telling her family about the cancer only upon her return. She argues, "In the long run I didn't think one month would matter. In the short run, it mattered a great deal . . . traveling through the inner gorge of Vishnu schist, the oldest exposed rock in the West, gave me a perspective that will carry me through whatever I must face" (29). Upon reflection, Tempest Williams draws a similar conclusion: "I am desert. I am mountains. I am Great Salt Lake. There are other languages being spoken by wind, water and wings. There are other lives to consider: avocets, stilts, and stones. Peace is the perspective found in patterns. When I see ring-billed gulls picking on the flesh of decaying carp, I am less afraid of death" (29).
In essence, both Diane and the author rely on the lessons from the natural world to help them come to an understanding of death as an integral part of the life cycle, a change that must be adapted to rather than resisted. This is a lesson that is lost on most of the men in the text and the decidedly male institutions of the Mormon religion as well as the governments of Salt Lake City and the State of Utah. For example, in one of the funnier moments in the text Tempest Williams explains that "In 1975, the Utah State Legislature passed a law stating Great Salt Lake could not exceed 4202'. Almost ten years later, at lake level 4206.15', Great Salt Lake is above the law" (58). Several ensuing chapters in Refuge chronicle the government's various proposals to stem the flooding. Not surprisingly, the option chosen is the one that benefits business interests the most.

While it might seem reasonable to try to prevent the billion dollars of damage to the railroads, the airport, residential housing, and other businesses from the floodwaters, Tempest Williams makes clear that the philosophy which subtends these actions is quite dangerous. As the Governor states at the ribbon-cutting ceremony of the West Desert Pumping Project (the winning proposal), "This was the kind of decision you wish you didn't have to make, but when the lake is lapping at your doorstep, you do what you have to do to solve the problem. And let me tell you, Great Salt Lake is a big problem" (250).

Understanding Great Salt Lake as a "problem" is a symptom of a thought process that does not recognize the value and dignity of the natural world but rather,

---

45 See the chapter "White Pelicans" (pp.96-107) for Tempest Williams' discussion of the collapse of Brigham Young's attempts at collective living. In summary, she blames the collective's inability to adapt to change and concomitant lack of diversity as its Achilles heel.
sees it as ripe for intervention and "improvement." For example, Tempest Williams explains that a proposal was introduced into the Utah State Legislature that advocated turning Great Salt Lake into "Lake Wasatch." Lake Wasatch would be created by diking and draining a section of Great Salt Lake, and then diverting the fresh water that currently flows into the Lake from four surrounding rivers into the section that was diked off in the hopes of creating a fresh water resort area for tourists: "there would be opportunities for unlimited lakeside development.

Promoters already have plans for Antelope Island. They see it as an ideal site for a theme park with high-rise hotels and condominiums. Lake Wasatch is a chamber of commerce dream. Finally, the Great Salt Lake would be worth something" (265). Of course, the creation of Lake Wasatch would disrupt the alkaline balance of the lake, kill any number of species who live in the proposed Lake Wasatch area, upset the complicated pattern of biodiversity in that area, etc. Ultimately, Tempest Williams fears that business interests might outweigh the interests of the lake itself.

This lack of respect for Great Salt Lake's integrity highlights another commonality between the flooding and Diane's death: in Tempest Williams' eyes, both the earth and women share a history of subjugation, attempts to control and use them as resources, a disavowal of their dignity and right to life. After her mother's death, the death of one grandmother from cancer and the diagnosis of the other grandmother with cancer, as well as the author's own discovery of two benign cysts and one "borderline" cyst in her breasts, Tempest Williams discovers that the military conducted above-ground atomic testing in Nevada for an 11-year period between 1951 and 1962. She asserts that this testing was permitted because the U. S.
government did not recognize the dignity and right to life of either the land or the people who inhabited it. As an official from the Atomic Energy Commission said of the "blank spot" on the map (the desert area between Utah and Nevada), "It's a good place to throw used razor blades" (242).

A similar philosophy was taken towards the citizens who lived in or downwind from the testing area. Tempest Williams argues that the tests occurred during the height of the Cold War and the McCarthy trials, a time when "Public health was secondary to national security" (284). Despite widespread complaints of burns, blisters, nausea in humans and the death of livestock in the area, the testing continued for nearly a decade. The government assured its citizens that the testing was perfectly safe. Lest we find this an embarrassing moment in our nation's history, Tempest Williams points out that this behavior continues in the present. In 1984, several Utahns sued the government for causing their cancer and won. In 1987 (a mere three years before Refuge was published), the Tenth Circuit Court of Appeals overturned the judgment on the ground that the government was protected by 'sovereign immunity.' In 1988, the Supreme Court refused to review the Appellate's decision. As Tempest Williams explains, "To our court system it does not matter whether the United States government was irresponsible, whether it lied to its citizens, or even that citizens died from the fallout of nuclear testing. What matters is that our government is immune: 'The King can do no wrong'" (285).

Refuge takes pains to disassociate itself from the discourse of new temperance that locates personal behavior as the primary cause of disease:

The "word of wisdom" in my family aligned us with good foods -- no coffee, no tea, tobacco, or alcohol. For the most part, our women
were finished having their babies by the time they were thirty . . . Most statistics tell us breast cancer is genetic, hereditary, with rising percentages attached to fatty diets, childlessness, or becoming pregnant after thirty. What they don’t say is living in Utah may be the greatest hazard of all. (281-82)

If there is any personal culpability for the disease in Tempest Williams’ family, it lies in their obedience to the Mormon church, which taught them not to "make waves" and to the U.S. government, which ultimately disregarded their lives:

In Mormon culture, authority is respected, obedience revered, and independent thinking is not. I was taught as a young girl not to make waves . . . 'Just let it go,' Mother would say. 'You know how you feel, that's what counts.' For many years I have done just that -- listened, observed, and quietly formed my own opinions, in a culture that rarely asks questions because it has all the answers. But one by one, I have watched the women in my family die common, heroic deaths . . . I cared for them, bathed their scarred bodies . . . I held their foreheads as they vomited green-black bile, and I shot them with morphine when the pain became inhuman . . . The price of obedience has become too high. (285-286)

By the end of the text, Tempest Williams has become a full-fledged public health activist. While she previously described her role as an environmentalist as being "quietly subversive on behalf of the land" and "waking people up to their surroundings" (44), she comes to believe that she must take a far more public stance on behalf of the land and women. "If I am to survive, I must let my secrets out like white doves held captive too long. I am a woman with wings" (273). This activism, however, is decidedly different from the type of activism Peter Dunning espouses in Safe. While Dunning advocates that Wrenwood residents must teach the public about Environment Sensitivity, that education is devoid of blame or anger and focuses on what individuals can do to improve their health. In contrast, the final
scene of *Refuge* shows Tempest Williams committing civil disobedience at the Nevada Atomic Test Site.

This chapter has analyzed three texts that diverge from the reigning logic housed in the discourse of new temperance. In *White Noise*, disease reflects the ill health of American culture, and is caused by modernity and technology, not the actions of individuals. *Gain* blames the American system of capitalism for its protagonist’s cancer, and uses that disease to launch a critique of the system. Lastly, *Refuge* lays responsibility for the death of Diane Tempest at the foot of the government specifically and patriarchy at large, and urges women to enter the public sphere, but in a way that will definitely challenge hegemony. All three texts point to the inherent instability of both hegemony and discourse, and act as an important rejoinder to the rest of the dissertation about multiple affects that discourse can produce.
WORKS CITED


LIST OF REFERENCES


Clorfene-Casten, Liane. "Inside the Cancer Establishment." Ms. 3.6 (May/June 1993): 57.


Miller, W. R. "Hormonal Factors and Risk of Breast Cancer." *The Lancet*


Rounds, Kate. "Are Lesbians a High-Risk Group for Breast Cancer?" Ms. 3.6 (May/June 1993): 44.


