

**PROTECTING THE BREAST AND PROMOTING FEMININITY:
THE BREAST CANCER MOVEMENT'S PRODUCTION OF FEAR
THROUGH A RHETORIC OF RISK**

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ABSTRACT

Tremendously popular in American society, the breast cancer movement functions through a rhetoric of risk to persuade women to monitor their breasts and thus medicalize their bodies. The vast majority of breast cancer literature available is specifically aimed at women *with* breast cancer, while the research here examines the way the breast cancer literature actually includes women *without* breast cancer in its audience, expecting these women to see breast cancer as an eventual experience. The rhetoric of risk focuses on lifestyle choices, the body, genes, and the environment in order to encourage women to engage in body projects to prevent breast cancer. The attention to risk factors without reliable facts produces fear of the body. Prevention of breast cancer, really impossible, becomes synonymous with early detection, thus displacing responsibility for the disease from society to the individual. Through the rhetoric of risk, the breast cancer movement promotes the ideology of femininity by manipulating women to become complicit subjects in their subordination. Furthermore, the directives, as yet unproven, to prevent breast cancer are the same directives to attain the white heterosexist ideal of beauty. The woman is thus reinscribed into the traditional feminine role of caretaker (of her body) and femininity is not only preserved but produced despite a disease that physically threatens a woman's most visible marker of her femininity, the breast.

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INTRODUCTION

I am not over fifty or even over thirty. I exercise on a weekly basis and eat a somewhat balanced diet. No one in my direct family history has had breast cancer. I hope to have children before I am thirty-five and to breastfeed them. Yet I, like many young women, fear my breasts because I fear breast cancer. I see the pink ribbon everywhere, and I know the pink ribbon means breast cancer. I have read the horror stories of women in their twenties and thirties who realize too late that they have breast cancer, and so I learn I must be vigilant with my breasts, monitor them. I have read the survivor stories and seen women proudly marching to a cure, and so I think, I too can beat the disease and still be a feminine woman, without breasts, if I were to contract it. I do not want to disparage the need for research about breast cancer or the positive aspects of the pink ribbon campaign and broader breast cancer movement that seek to help women cope with their breast cancer. But I do not like fearing my breasts, and since they are attached to my body, I feel like I cannot escape this fear.

If I were to be diagnosed with breast cancer and told I would lose one or both my breasts, I am sure that I would be terribly distraught. Writing this analysis, I still remain within the ideology of femininity, and I know that if I am ever diagnosed with breast cancer, I will encounter the same conflicts as most other women. On her website, Dr. Susan Love offers pictures of real women who have had mastectomies or lumpectomies. The pictures represent a multitude of options for women, ranging from reconstructive surgery, to prosthetics, to bare scars. The women smile and proudly show their chests in an attempt to make women who may be considering mastectomy as treatment feel better. But when I saw the woman who lost both breasts and did not opt for any reconstructive options, I felt disturbed. I immediately superimposed her image onto my body and it scared me. At the same time that I can use feminist theory to analyze the social construction of breast cancer and the construction of femininity through the breast, I can also recognize that I exist firmly within and cannot escape these social constructions.

I run into trouble sometimes when I am asked what I am researching, depending on my audience. It is easier for me to qualify my questions and say that I am not arguing that breast cancer activism is negative here when I am writing, but when I try to give a succinct summary of my research in a few sentences, I find it hard to do so adequately. For example, when a friend of

my mother's asked me about my thesis, I replied that I was researching the various breast cancer awareness organizations, taking a look at those that identified themselves as pink ribbon organizations versus those that did not. She, a breast cancer survivor who did not lose her breasts but has been on Tamoxifen for years, then asked, "Well what is the main difference?" I responded that most of the pink ribbon organizations focused on how breast cancer can threaten a woman's femininity because it threatens her breasts. I also commented on the difference between a focus on genetic causes with the pink ribbon organizations versus a focus on environmental contamination (caused by some of the same corporations who fund the pink ribbon organizations) within breast cancer activism. She easily agreed about the corporate influence as potentially negative but reverted back to the issue of femininity. Immediately, I felt I had said something offensive because she said, "Well how can it [breast cancer] not [threaten a woman's femininity]? That is what breasts are all about." She then affirmed that she felt lucky not to have lost her breasts but that if she had, she would have immediately had them reconstructed to maintain the appearance. I agreed that I would probably want the same.

My mother's friend wasn't angry with me, but I did feel like I was saying something about breast cancer she didn't agree with and that I, as a woman who has not had breast cancer, could not understand. And I can't understand, not in the same way as she does. However, what I can know is how I feel as a young woman in her twenties *without* breast cancer who feels that she is being sent the message that she should fear her breasts. Thus, I am looking at breast cancer activism as a part of the target audience—a woman without breast cancer but a potential "victim." I am also looking at constructions of femininity to which I also, like her, feel compelled to conform. I include this woman's story now to explain that this research is neither about the disease breast cancer itself nor about women with breast cancer and their experiences. Rather, this research concerns the *rhetoric* generated by the breast cancer movement and how that rhetoric functions to encourage body projects and produce fear of the body.

It's hard to argue, though, with the pink ribbon, at least initially. The breast cancer movement has been unquestionably successful in raising the public's awareness of the disease as well as in raising money for research and lobbying for legislation to aid the search for a cure. For example, according to the Susan G. Komen Foundation website, during its twenty-year existence, this private organization "awarded more than 850 international grants totaling more than \$112 million for breast cancer research projects." The National Breast Cancer Coalition

(NBCC) is an organization that chooses not to use the pink ribbon and defines itself as a grassroots advocacy organization. According to information on its website, the NBCC includes over 600 organizations nationwide in addition to 70,000 individuals and has increased federal funding “from just over \$100 million before the Coalition began, to more than \$800 million in 2002.” The NBCC also boasts having “Brought about the development of an unprecedented multi-million dollar breast cancer research project within the Department of Defense that has attracted more than 9,300 research proposals. Federal funding for this program since its inception in 1991 has reached more than \$1 billion.” These numbers alone show the power of the breast cancer movement to promote awareness of the disease and to spur funding for research. And yet, how much of the success and popularity of breast cancer activism in general lies not in the prevention of sickness and death but rather in the idealization of the breast and subsequent fear based on its loss?

The breast cancer movement endeavors to educate women to be aware of the potential for disease, to encourage early detection as a means of prevention (a semantic paradox if there ever was one, much like the “risk factor” rhetoric that identifies femaleness as a risk), and to raise money and lobby for legislation to increase funding for research. Furthermore, breast cancer activism champions breast cancer survivors as women who are strong, powerful, and capable, as well as still sexual and feminine beings.

Now these are commendable goals. While women’s bodies have long been subject to excessive medical examination, the actual research conducted on women and for women’s health has failed to come close to equaling the expenditure and focus on men’s bodies and health.¹ Many breast cancer awareness organizations, while still continuing to overmedicalize women’s bodies, have also, admirably, contributed to funding research using women, such as the NBCC. Furthermore, what feminist would want to argue that breast cancer activism is “bad” because it

¹ Dr. Vivian Pinn is the National Institutes of Health (NIH) Director of the Office of Research on Women’s Health (ORWH). The ORWH was created immediately following a 1990 U.S. General Accounting Office’s report that found “that women were routinely excluded from medical research supported by NIH. The report also stated that although NIH policy encouraged researchers to analyze study results by gender, the implementation of the policy for including women in research studies was not uniform or consistent” (Pinn 1). In an interview, Pinn argues that the creation of the ORWH in 1991 was necessary for women and the future of women’s health research because “Traditionally, the concept of women’s health focused on the reproductive system, especially during the childbearing years, without emphasizing the major non-reproductive diseases and illnesses that affect women. This narrow view of women’s health was reflected in the underrepresentation of women in clinical studies of conditions that affect both men and women, but it also was an outgrowth of a biomedical research system that traditionally tended to view health and illness only in terms of the male model. We now know that research results obtained from studies on men do not always apply to women” (1).

seeks to educate women about their bodies? No, breast cancer activism is not a bad thing for women, nor do I wish to argue that it is or should be eliminated. Rather, I wish to examine the ways in which breast cancer has been constructed as a disease for women to fear and thus as something women need to prevent through body projects.

Where then does the pink ribbon campaign fit in? Western women have internalized the cultural construction of the breast as the ultimate symbol of femininity, and such a powerful icon cannot be removed immediately or easily, if ever. Whether or not we like the connection of the breast to femininity, the connection exists, and breast cancer threatens that connection. There seems to be a relationship between femininity, the breast, and the popularity of the breast cancer movement. How did breast cancer become so prominently publicized as a disease for women when it is not even women's number one killer?² After all, heart disease is the number one killer of women, not breast cancer.³ And while the new red dress/purple ribbon campaign for women's heart disease awareness is becoming more well-known, (though by modeling itself after breast cancer activism, it is probably inheriting the same problems) the fight for the breast was first and is still more popular.⁴

How does a campaign supposedly functioning to "save" and empower women become an inducement of fear? How did breast cancer become a disease that women, all women, should fear simply because they possess breasts? How many women are truly at risk for breast cancer, and how does the rhetoric of risk produce fear? Why are young women being targeted, and more specifically, young, white, heterosexual, middle- and upper-class women? What about the women who are not targeted, what happens to them? Obviously, breast cancer is a very real disease, and yet where does the promotion of awareness stop and the construction of the disease

² Unless noted otherwise, it should be assumed that my research focuses on the American woman and how she experiences breast cancer as constructed in American society. As such, statistics used will be for the United States.

³ According to the American Heart Association's website, "Heart disease is women's No. 1 killer. It's one of the cardiovascular diseases that kill nearly 500,000 women each year. That's more than the next seven causes of death combined, including all forms of cancer." Compared to breast cancer mortality rates, "In 2000, coronary heart disease claimed the lives of 254,634 females compared with 41,872 lives from breast cancer [. . .]." (Coronary heart disease numbers do not even include all female deaths from heart disease.)

⁴ On its website, the American Heart Association cites a 1997 study that found "[. . .] a mere 8% of women in America believe that heart disease and stroke are the greatest health threat to women."

as something to be feared above all else start?⁵ How much information and attention is too much? When does awareness become hypochondria? How medicalized does the body need to be? The attention to the many unknowns—about the body, lifestyles, genes, and the environment—that in turn generate body projects produces fear of the disease and the body. This production of fear seems to be unnecessary and inappropriate.

These questions about risk and fear could be related to any medical issue (weight, sodium-intake, exercise, other cancers, etc.); they are not solely related to breast cancer. Almost every day, there is a new segment on the news telling us to take such and such a vitamin or to drink a glass of wine a day or that one kind of food is good or one kind of plastic may be hazardous. Studies claim to have found new information, and we should use this information to reduce our risk factors for certain diseases and conditions. However, what was said to be healthy or hazardous is often overturned within the year. And yet, we are still encouraged (by whom? The media? Doctors? Each other?) to monitor our bodies, to monitor what goes into our bodies and what we do with our bodies. Furthermore, even though we have experienced the reversal of these studies in the past, we are expected to accept subsequent information unequivocally. Medical studies have come to be equivalent to the “truth,” and so acceptance, followed by compliance, is mandatory. Those who do not accept and comply run the risk of later being held responsible or accountable for their situations.

There is no “natural” way to live, eat, and breathe in a body, not in this day and age. What we eat and drink and how we do (or don’t) exercise and live is judged, analyzed, and criticized by every aspect of our pop culture—the magazines we read, the news we watch, the advertisements we see, the stories we hear. This infatuation with monitoring our bodies has become the lifestyle for American society, to the point where we feel the need to monitor every aspect of our bodies and fear our bodies’ susceptibility to disease if we are to be “good” and “healthy” people—subjects.

The advice, do’s and don’ts, risk factors, suggestions, recommendations, warnings—whatever you want to call them—become part of the ever-present rhetoric of risk. I am twenty-four years old, and my chance of developing breast cancer in the next six years is approximately

⁵ According to the latest statistics available from the American Cancer Society in their publication, *Breast Cancer Facts and Figures 2003-2004*, “an estimated 211,300 new cases of invasive breast cancer are expected to be diagnosed among women, as well as an estimated 55,7000 additional causes of *in situ* breast cancer” (3). Of these women expected to develop breast cancer in 2003, “In 2003, 39,800 women are expected to die from this disease. Only lung cancer accounts for more cancer deaths in women” (3).

0.05% or 1 in 2,152, according to the American Cancer Society's *Breast Cancer Facts and Figures 2003-2004*, yet I am persuaded that I should fear breast cancer *now*.⁶ Part of the argument is that I should change my lifestyle and monitor my body now to prepare for future increased risk, but part of the argument is also that I just might develop breast cancer right now, so I should fear it now. When I open a women's magazine and read that I should have a mammogram once a year after I turn forty, that I should exam my breasts each month, that I should increase fiber intake and reduce fat intake, or that I should maintain a healthy body-mass-index, I am exposed to the rhetoric of risk. Repeatedly, I read and see what I should do to prevent breast cancer. It is assumed that I see breast cancer as *the* horrible disease for women, which of course I do because I am a woman who lives in a society where breasts are valued as the marker of femininity, and I want to be seen as a woman who is feminine. Ironically, the ways in which I am encouraged to monitor my body to prevent breast cancer are also the ways in which women are persuaded to monitor their bodies to maintain the white, heterosexist ideals of feminine beauty. I learn I can prevent breast cancer by making my body better match the feminine ideal, and in this manner, the rhetoric of risk also produces femininity. The message is effective overall because I am persuaded to fear breast cancer by the messages I see about the disease, and preventing the disease becomes part of a daily regimen of maintaining feminine beauty.

When I was in middle school, I watched Brenda Walsh on *Beverly Hills 90210*, a widely popular teenage drama of the nineties, undergo a biopsy as a teenager because she found a lump

⁶ **Age-Specific Probabilities of Developing Breast Cancer**

If current age is...	Then the probability of developing breast cancer in the next 10 years is:†	or 1 in:
20	0.05%	2, 152
30	0.40%	251
40	1.45%	69
50	2.78%	36
60	3.81%	26
70	4.31%	23

*Among those free of cancer at beginning age interval. Based on cases diagnosed 1988-2000. Percentage and "1 in" numbers may not be numerically equivalent due to rounding.

† Probability derived using NCI DEVCAN software.

American Cancer Society, Surveillance Research, 2003.

that was later determined to be benign.⁷ Just this past October (National Breast Cancer Awareness Month), I received an email that reaches almost urban legend status with the story of a man who wears a pink ribbon not only for his wife or mother, who both survived breast cancer, but also for his daughter who did not survive because she did not examine her breasts. These are just two examples of how I have been exposed over the years to the idea that I should fear breast cancer and monitor my breasts because I just might find a lump; these are two examples of the messages out there that become part of the rhetoric of risk. Teenagers like the character Brenda are dutiful and responsible because they exam their breasts, and although Brenda was “lucky,” I may not be so lucky if I do not examine my breasts, like the daughter of email fame.

There have already been analyses and histories of the social construction of breast cancer focusing on women with the disease, as well as about the breast and femininity in general, but what I find more interesting for my research is the construction of breast cancer for women *without* the disease but marked as potential victims. Breast cancer awareness campaigns construct how society views the disease. There is a biological and physical reality to the disease, but that is not what we are exposed to in our popular culture or how most of us experience the disease. We are exposed to a rhetoric of risk. I cannot speak as a breast cancer patient or survivor, but I can speak as a potential victim of breast cancer because that is what the breast cancer awareness campaigns have marked me as. I fall into the category perfectly (although I would be a much better subject if I didn’t study feminist theory) because I am a white, twenty-something, middle-class, heterosexual woman. I have a very low chance of developing breast cancer now or in the next ten years, yet I see the argument everywhere that I need to fear the disease *now*. How does this rhetoric of risk affect women and construct breast cancer for women without the disease? What are the different aspects of this fear? How do the body projects become another way of controlling women’s bodies?

First, women are encouraged to monitor their bodies and lifestyles to counter the so-called “risk factor” of being a woman and possessing breasts. Here, an analysis of what becomes a risk factor and how that is determined is important. Simply having breasts becomes a kind of risk factor for the disease. The term “risk factor” alone is disturbing; is having a heart a “risk factor” for heart disease, having skin a “risk factor” for skin cancer? My answer is no, having a

⁷ Benign: non-cancerous
Malignant: cancerous

body part is not a risk factor, but in the case of much of the information available, being a woman with breasts has come to be defined as a risk factor. Furthermore, women who do not follow the risk factor recommendations can be seen as somehow responsible for causing their breast cancer.

Second, some organizations like Breast Cancer Action (BCA) emphasize the possibility that environmental pollution causes cancer. But the positive concentration on what many people and organizations feel to be the real cause for the dramatic increase in cancers in the twentieth century becomes yet another production of fear. Zillah Eisenstein's frenzied *Manmade Breast Cancers* is a perfect example of this rhetoric of risk of environmental contamination. I find the argument that there must be environmental causes to cancer in this advanced age of production and consumption to be quite compelling. Still, the idea that I need to be afraid of the water I drink or the air I breathe bothers me almost as much as the idea that I need to be afraid of my breasts. Most people cannot control their environment individually; yet as individuals we must fear environmental pollution. Granted, people must act as individuals coming together to enact social change, but what started as a fresh new focus on the causes of cancer has come to incorporate the same rhetoric of risk that produces fear.

Third, there is the fear of the unknown; the message that any woman and every woman has the potential to develop breast cancer applies to all women. There is no test to determine a woman's susceptibility for breast cancer, not with any reliable answer.⁸ The known risk factors that we are encouraged to avoid, if we can, are not definite either.⁹ There are many hypotheses of the ways to reduce breast cancer risk, but a woman who follows all of these recommendations who is still not considered high-risk (due to, for example, family history) can still develop breast cancer. At the same time that we need to monitor our lifestyles every day, we also receive the message that no matter what, we still need to fear breast cancer because as women we are all susceptible, no matter what body projects are conducted.

⁸ According the American Cancer Society's *Breast Cancer Facts and Figures 2003-2004*, "Approximately 5% to 10% of breast cancer cases result from inherited mutations, or alterations, in breast cancer susceptibility genes, such as BRCA1 and BRCA2. These mutations are present in far less than 1% of the general population" (9).

⁹ The ACS's *Breast Cancer Facts and Figures 2003-2004* states, "A number of factors associated with increased risk of breast cancer (age, family history, age at first birth, early menarche, late menopause) are not modifiable. Other factors (postmenopausal obesity, use of postmenopausal hormones, alcohol consumption, physical inactivity) are modifiable. Some factors directly increase lifetime exposure of breast tissue to circulating ovarian hormones (early menarche, late menopause), and some are only correlates of reproductive factors (higher socioeconomic status)" (8).

But fear of what? Besides the obvious fear of possible death, not to mention pain and sickness, breast cancer also induces the fear of the loss of femininity. As I will discuss in Chapter Three, breasts are the most visible marker of a woman's femininity, signifying both her sexuality as well as her maternity. At the same time that our culture values the breast as a marker of femininity, there is also the message conveyed that if a woman does develop breast cancer, then she can still retain her femininity—a seemingly positive message. After all the messages we receive to fear breast cancer and to prevent it at all costs, we still see the message that it is not the end of the world. This message can be good for women, of course, but how does this paradox function? Women should fear the disease right until they develop it? That doesn't seem very logical. Furthermore, issues of socially constructed gender roles and femininity still come into play; a woman can be feminine without breasts, but the more complex issue at hand is still that a woman is encouraged to be feminine, perhaps even more so, *because* of the loss of her breasts. And by conducting preventative breast cancer body projects, a woman may present herself as a feminine subject, adhering to the ideals of feminine beauty. The ideology of femininity works to bolster fear of the disease.

Finally, although the obvious target of breast cancer activism has been white, heterosexual middle- and upper- class women, this focus is starting to change. There are programs to provide free mammograms and to educate poor women about the advantages of early detection. Medicaid provides reimbursement for treatment to poor, uninsured women. This funding and information is certainly necessary: while white women are more likely to contract breast cancer, according to the ACS's *Breast Cancer Facts and Figures 2003-2004*, "African American women with breast cancer are less likely than white women to survive five years: 74% vs. 88%" (7). Educating women of other races and of lower socioeconomic status seems to be positive; the higher mortality rates for these women alone speak for the need. Lesbian women, sometimes said to be at higher risk because they may not have children or may have children later in life, can now find information solely geared toward them. (Ironically, any woman, regardless of her sexual orientation is at the same risk if she does not have children or has children late in life. The labeling of lesbian women here may not be entirely positive, but they are at least starting to be recognized as a population of women who may have specific needs

or risks related to breast cancer.)¹⁰ And yet, the messages these women receive are no different than the messages white women have been receiving—the rhetoric of risk persists.

These elements of the rhetoric of risk combine to mark the breast cancer movement and its construction of breast cancer. Here, in this introduction, I have attempted to qualify my intentions and my future arguments about breast cancer activism. Chapter One introduces the history of ribbon campaigns and addresses the mythological status of the pink ribbon. In Chapter Two, I present a review of the literature that has contributed to my analysis. In Chapter Three, I use a Foucaultian analysis to understand women’s complicity in a phallogentric model of modern power. I then examine the representations of the breast as sexual and maternal which both contribute to the sum of a woman’s perceived femininity.

The bulk of my primary analysis is presented in Chapter Four. Here, I examine what messages young women receive today and how those messages become a rhetoric of risk. These messages come from health books, cancer survival guides, websites, women’s magazines, breast cancer fundraisers, and autobiographies/narratives from breast cancer survivors. Finally, in Chapter Five, I discuss the function of the breast cancer movement today in contemporary American society—what it represents and how it affects women—based on the rhetoric of risk from the previous chapters. Breast cancer activism has the opportunity to produce a new construction of the breast and thus femininity that defies the dominant sexist cultural construction of the breast and femininity. But the question remains, does the breast cancer movement do so, or does it perpetuate phallogentric constructions of the breast and convince women to continue to “think pink” and fear their bodies in order to be feminine women? I believe that some aspects of breast cancer activism take an originally feminist idea (empowerment of one’s body) and transform it into yet another way of maintaining the

¹⁰ The ACS has a working relationship with the Mautner Project, an organization that provides education, support, and services to lesbians with cancer. The Mautner Project states that lesbians may be at a higher risk for breast cancer because

- Lesbians are less likely to seek health care because of the discomfort of coming out to health care providers.
- Lesbians are less likely to visit a doctor for routine gynecological services such as birth control and prenatal care. Therefore, lesbians are less likely to have cancers detected at earlier, more tangible, stages.
- Lesbians are at higher risk of breast, cervical and ovarian cancers because they are less likely to have children by age 30, if at all.
- Lesbians are affected more directly by women’s lower earning power and do not have the benefit of a spouse’s health insurance coverage. (The Mautner Project)

subordination of women, now through fear of the very aspects of the body that have been marked as feminine. A woman who fears her breasts as a site of disease cannot feel empowered by ownership of her body. She does not own her body, her breasts—breast cancer, past, present, and future, does.

The breast cancer movement uses a rhetoric of risk to encourage women to see their bodies as eventual sites for disease. This rhetoric then prescribes body projects as a means for women to monitor their bodies in order to prevent breast cancer. Yet these body projects call attention to the body and the environment without facts and thus produce fear—fear of the body and fear of breast cancer. Breast cancer activism garners its power from its production of fear. Women today come to fear the disease, and thus their female body, more than they fear the social inequality as women, let alone any other disease. Fear then motivates women to be complicit subjects in their subordination by preserving as well as producing femininity. These body projects are the same kinds of body projects used to achieve and maintain the ideal of feminine beauty. Women thus prevent breast cancer by maintaining feminine beauty. Furthermore, this attention on the body as a site of disease, in its production of fear, pathologizes the female body because it is seen as disorderly and diseased and must be controlled and monitored. In this manner, women are reinscribed in the ideal of femininity.

CHAPTER ONE: THE PINK RIBBON AS A SIGN

Where Did the Pink Ribbon Come From and What Does It Mean?

Today, there are too many ribbon campaigns to count, let alone name. When and how did this phenomenon of representing one's participation in a cause begin? Gerald E. Parsons, a folklorist for the Library of Congress, has traced the present-day ribbon campaigns back at least four hundred years as evidenced by a reference to an older version of the song, "Round Her Neck She Wore a Yellow Ribbon" in Shakespeare's *Othello*. The song's girl with the ribbon wore it in honor of her soldier boyfriend. In the 1950s, a legend surfaced of an illiterate prisoner requesting his family to tie a yellow ribbon around a tree in the yard to signal his welcome home; if he did not see the ribbon, he would know not to come home. A newer version of the song, "Tie a Yellow Ribbon," written by Irwin Levine and L. Russell Brown, gained national popularity in 1973 when recorded by Tony Orlando and Dawn. The 50s legend became a reality in 1975 when Jeb Stuart Magruder's wife, Gail, festooned her front yard with ribbons to welcome home her husband from prison.

The yellow ribbon became fully established during the 1979 Iran hostage crisis when Penelope Laingen wanted to represent her support for her husband, Bruce Laingen, U.S. Ambassador. Having heard the song and seen Magruder on the news, she tied a yellow ribbon around a tree in their yard, vowing it would stay there until her husband returned to remove it himself. The Family Liaison Action Group (FLAG) took Penelope Laingen's idea and promoted it to the American public, selling ten thousand yellow pins to support the hostages ("How the Yellow Ribbon Became a National Folk Symbol"). The yellow ribbon re-emerged during the Gulf War of the early nineties, but ribbon campaigns in general really took off with the creation of the red ribbon AIDS campaign in the early 1990s.

In 1991, in the midst of a flurry of Desert Storm yellow ribbons, Visual AIDS Artists Caucus, a New York-based, art-centered, AIDS organization created the concept of the red ribbon as a symbol of the need for AIDS awareness. The website for the organization cites its foundation:

The Ribbon Project was created in 1991 by the Visual AIDS Artists Caucus, a group of artists who wished to create a visual symbol to demonstrate compassion

for people living with AIDS and their caregivers. Inspired by the yellow ribbons honoring American soldiers serving in the Gulf war, the color red was chosen for its, ‘connection to blood and the idea of passion—not only anger, but love, like a valentine.’ (“About Visual AIDS”)

To introduce the Ribbon Project, Visual AIDS mailed red ribbons with a letter of explanation to invitees of the 1991 Tony Awards. Actor Jeremy Irons proudly wore the red ribbon, but few others did, at least initially. Soon, however, wearing the red ribbon became a sign of political and social consciousness and morality; all the stars were wearing them, so they became popular and thus the Ribbon Project was not only launched, but launched successfully (“About Visual AIDS”).

The red ribbon campaign for AIDS awareness opened the door for the seemingly infinite ribbon campaigns we see today. We are familiar with the red, white, and blue ribbon as a representation of patriotism, the yellow ribbon to represent support for American troops, the red ribbon to raise AIDS awareness, and the pink ribbon to represent breast cancer awareness, but there are also a wide variety of other ribbons representing just about any cause a person could think of. Carolyn Gargaro has compiled a collection of all the ribbon campaigns she has found online or people have submitted to her for inclusion. Her personal website features pictures and links to the campaigns, many of which are relatively unknown. Some examples: a green ribbon promotes organ donation, an orange ribbon recognizes families with loved ones in prison, a blue ribbon promotes free speech online, a black and white ribbon supports victims of church bombings, and a metallic ribbon represents awareness for childhood cancer, and on and on.

The use of ribbons is prevalent, but the meaning behind the ribbons can sometimes be hidden or overlooked. The popularity of ribbons can be seen everywhere—look at the countless lapel buttons and pins, bumper stickers, license plates, jewelry, and endless consumer products that use the image of a ribbon. It is easy to find the ribbons, but it is much harder to find or explain the message of the ribbon beyond a seemingly benign message of support and awareness. The ribbon has come to represent an organization’s fight for awareness and support, in a culture where even nominal awareness and support of a socially-condoned organization signifies a person’s political and social consciousness. The messages, furthermore, are typically hard to contradict. These seemingly benign messages of support eliminate the possibility for argument

and thus demand uncontested support. And yet, as my research here seeks to prove, the message behind the pink ribbon is anything but benign.

The pink ribbon, as well as other ribbons, has secured a position of status and admiration in American culture. When a person wears a ribbon, we are to understand that he/she is dedicated to the cause in a sincere manner. We can just pin a loop of color onto our clothing without much dedication involved and evoke the myth of the pink ribbon. To refuse to wear these ribbons or support those who wear them is socially unacceptable. I experience this reaction when I try to explain my research to someone outside of feminist theory; it is hard to argue against a movement that parades the image of a woman fighting for her life against a horrible disease. Peace advocates experience this reaction when they do not support the yellow ribbon; whether we support the war or not, we are expected to support the men and women fighting the war, and yet this is a slippery slope. It is hard to argue against supporting an eighteen-year-old who is far removed from the political maneuvering of the war, and yet to support that soldier is to support the government, ultimately. At the same time that we are expected to separate what we don't agree with from the individuals that we should support unconditionally, there is no separation in the ribbon.

There are organizations, such as the National Breast Cancer Coalition (NBCC), that definitively do not use the pink ribbon. And yet these groups, even when they do not use the image, can still not escape its mythological pervasiveness. Fernandez, in what I argue is premature optimism, believes the pink ribbon is falling out of popularity, but I believe it is still as prominent as ever. In fact, rather than remaining within the realm of the white, middle-to upper-class, heterosexual woman, the messages of the breast cancer movement are simply being distributed to women of different races, classes, and sexual orientations. The movement has spread its focus over a larger group of women, first incorporating what Foucault would call the dominant bourgeois, and now moving on to perpetuate the ideology and maintain subjects with a more diverse population. Fernandez does note, however, that the pink ribbon is not the only sign of the breast cancer movement: "When the fashion industry took on breast cancer, they made their own symbol, a blue bull's eye, which is now in six countries. Groups on the West Coast substitute the more 'powerful' purple loop. In Canada, BCA [Breast Cancer Action] Ottawa has turned the loop upside down, for the tears shed at diagnosis and lined it with black, to remember the women who have died. San Francisco's BCA has a white-on-black button that reads 'Cancer

Sucks” (5). Yet even when organizations refuse the myth, the myth pervades mainstream culture; the movement has been so successful in distributing its message that breast cancer is now synonymous with the pink ribbon and, subsequently, its inherent ideology of femininity.

The founders of the pink ribbon campaign intentionally linked the message of awareness to femininity. Breast Cancer Action Executive Director Barbara Brenner explains that the pink ribbon breast cancer campaign began in the early nineties when a 68-year old woman, Charlotte Haley, started distributing handmade peach ribbons along with cards stating, “The National Cancer Institute’s annual budget is \$1.8 billion, only 5 percent goes for cancer prevention. Help us wake up our legislators and America by wearing this ribbon.” Haley’s grandmother, sister, and daughter each had breast cancer; the peach ribbon was a form of *protest*, not support. In 1992, Liz Smith reported Haley’s efforts in her newspaper column. Soon after, Estée Lauder and *Self* magazine contacted Haley for the rights to use the peach ribbon, but Haley refused because she did not want the ribbon to be associated with commercialization. Estée Lauder and *Self* magazine then created the pink ribbon in a conscious move to associate their new breast cancer awareness campaign with femininity, and within the next year, the pink ribbon campaign for breast cancer awareness was born and widely successful (Brenner 1). In “Pretty in Pink,” another slightly different summary of the history of the ribbon, Sandy Fernandez quotes Amy Langar, the executive director of the National Alliance of Breast Cancer Organizations (NABCO), as justifying the choice for the change to pink because “It’s [breast cancer] about body image, it’s about nurturing—it’s certainly about femininity,” as she told the *New York Times Magazine* in 1996 (4).¹¹

In a fluid movement of usurpation, Estée Lauder and *Self* magazine took a non-gendered-colored ribbon promoting political action for the prevention of all cancer and gendered their new campaign with the pink ribbon that promotes early detection as a kind of prevention for breast cancer. The pink ribbon campaign, a creation of a cosmetics company and a woman’s health magazine, has come to be the “darling” of corporate America, as Barbara Ehrenreich calls it. She writes, “[. . .] breast cancer would hardly be the darling of corporate America if its complexion changed from pink to green. It is the very blandness of breast cancer, at least in

¹¹ A minor difference in the story that nonetheless results in the creation of the pink ribbon: Fernandez reports that *Self* magazine editor in chief Alexandra Penney had the idea of using a ribbon, in partnership with Estée Lauder Senior Corporate Vice President Evelyn Lauder, as part of the magazine’s second annual Breast Cancer Awareness Month issue. The week after Penney first had her ribbon idea, she saw Liz Smith’s article about Charlotte Haley and approached her to use the pink ribbon.

mainstream perceptions, that makes it an attractive object of corporate charity and a way for companies to brand themselves friends of the middle-aged female market” (48). Ehrenreich quotes Cindy Pearson, director of the National Women's Health Network; “Breast cancer provides a way of doing something for women, without being feminist” (48). Supporting the pink ribbon campaign came to be a way for corporations to support women without the dirtiness of a disease like the still socially controversial AIDS epidemic and also without the liberal and thus controversial connotations that would result from aligning with a feminist cause like abortion or contraception. The pink ribbon campaign evolved and became so popular so quickly in part because it was *not* a feminist campaign or a campaign that challenged corporations to change their environmental policies, even though it still neatly implied the form of protest with which it began. The pink ribbon, once a form of protest, now connotes a political and moral stance that does not protest but rather is formed from within the dominant ideologies of the phallogocentric model of modern power.

Rapidly, the pink ribbon campaign was widely successful in distributing money to raise breast cancer awareness: Estée Lauder issued 1.5 million ribbons in the fall of 1992, and “Between 1991 and 1996, federal funding for breast cancer research increased nearly fourfold to over \$550 million” (Fernandez 4-5). Fernandez comments, “With the ribbon’s message of ‘awareness’ translating most often into a familiarity with early detection techniques, all a company has to do, to do good, is to put a ribbon on its merchandise” (4). Fernandez quotes Barbara Brenner criticizing the widespread corporate involvement in the pink ribbon campaign: “There is a value to awareness, but awareness of what, and to what end? [. . .]. We need changes in the direction the research is going, we need access to care—beyond mammograms—we need to know what is causing the disease, and we need a cure. The pink ribbon is not indicative of any of that” (4). Fernandez criticizes, as does Breast Cancer Action, corporate influence of how money raised by the pink ribbon campaign is spent, as well as how corporations can profit from displaying the pink ribbon and donating a small sum to an organization, but not really doing anything other than promoting “awareness” of the disease.

The pink ribbon has come to represent the fight against breast cancer. The historical context of ribbon campaigns, dating back to welcoming prisoners home and supporting wartime efforts, is neglected at the same time that it is brought to the center. The language of the pink ribbon campaign—victim, survivor, battle, attack and so on—recalls the history of the origin of

the yellow ribbon at the same time that the pink ribbon has become a campaign for women's health and awareness. The history of Haley's peach ribbon, her original grassroots protest intentions, are forgotten in the realm of the pink ribbon marketplace where corporations produce and women buy pink paraphernalia to support the campaign. Fernandez's and Brenner's critiques of the corporations that sponsor the pink ribbon with the goal of "awareness" rightfully question the actual success of the campaign. Early detection is important, but so is prevention and treatment, and yet the campaign has adopted early detection, from the very beginning as its main message (Leopold 156).

The pink ribbon can be understood to function as a myth within Barthesian cultural semiotics. In *Mythologies*, Barthes explains how a signifier means something which is manifested in the signified, or form. Together, the signifier and the signified create the sign. Barthes argues that a myth is a more complex system that comes from two or more layers of signifiers, signifieds, and signs. The first layer, that of language, comes to formulate the second layer, that of myth. Through this formulation, the first layer is hidden and it is the myth that is primarily seen and comes to be perceived as a reality, when in fact it is a second order sign system overlaying another set of meanings. Barthes writes, myth "transforms history into nature" (129). What was once a part of history has now become integrated into what people consider to be a true reality. Thus, "[. . .] what allows the reader to consume myth innocently is that he does not see it as a semiological system but as an inductive one. Where this is only an equivalence, he sees a kind of causal process: the signifier and the signified have, in his eyes, a natural relationship" (Barthes 131). For example, my mother's friend sees breasts as the equivalence of femininity, and while I can recognize that I exist within that ideology, I can also recognize that breasts do not "naturally" equal femininity. Rather, the possession of breasts as a marker of sexuality and maternity, thus femininity, has come to function on a mythological level and is so pervasive that it appears to be reality when it is in fact an ideological production of the phallogocentric power structure.

Women who experience breast cancer necessarily experience the disease in the historical context of their time. Breasts have become the mythological sign of a woman's femininity; the

historical context of how this myth has been socially constructed is elided.¹² The popularity of the breast cancer movement, despite other more probable fatal diseases for women, indicates the great fear of breast cancer because of the loss it incurs. The disease attacks the breast, the marker of a woman's femininity. At the same time that narratives and guides reassure women that they will not lose their femininity, the very presence of this literature substantiates the existence of the idea that breast cancer threatens a woman's femininity.

The myth of the ribbon, again, becomes synonymous with breast cancer. The pink ribbon has achieved mythical status through its popularity and widespread recognition, and thus mandated support. It is not possible to separate the myth from reality, whether the ribbon image is used or not, the production of femininity inherent in the image is not forgotten. It is in its mythological status that the breast movement has accrued such great power and produces femininity.

¹² For the application of Barthesian cultural semiotics to the ideology of gender that inspired this application, see Hausman, Bernice L. *Changing Sex: Transsexualism, Technology, and the Idea of Gender*. Durham, NC: Duke UP, 1995.

CHAPTER TWO: WHAT PEOPLE ARE SAYING ABOUT BREAST CANCER (LITERATURE REVIEW)

Introduction

I started to write this chapter as the traditional literature review component of thesis research, but through the help of my readers, I have realized that many of the texts that I present here need to be understood as part of the stories that construct breast cancer. Thus, while the texts I present are summarized, it is understood that, for the most part, they are also part of the rhetoric of the breast cancer movement—the rhetoric of risk—in much the same way as the texts of my primary analysis in Chapter Four.

Narrative theory offers a way of understanding how breast cancer stories function. In “Do Boys Have to Be Boys?” Bernice L. Hausman looks at the infamous John/Joan case of sex reassignment through narrative theory. Hausman argues that by understanding “gender” as a story that people tell, the constructed-ness of gender is revealed. The story of gender, Hausman argues, and the idea that boys have to be boys because they have penises and thus they act in certain (stereotypical) ways, is just that, a story, but it has been accepted without question or examination as “the truth.” People who accept the story of gender would see the John/Joan case as proof: the little boy whose penis was damaged was reassigned as a girl, but because his gender was somehow innate, he could not accept his new gender assignment and eventually changed his gender assignment back to a boy. These stories told about gender, such as boys like trucks and girls like dolls, become the truth that constructs what it means to be one gender or another.

Narrative theory can be useful in examining the stories told by the breast cancer movement. Women tell stories of the reaffirmation of their femininity and their (hetero)sexuality after breast cancer; these stories serve to reassure women that although they may feel their femininity and (hetero)sexuality to be threatened, they do not have to worry because they can regain their feminine identity and (hetero)sexuality. Thus, the story of recovery from breast cancer comes to mean not only the story of survival from a life-threatening disease, but also the story of reaffirmed femininity. Likewise, Zillah Eisenstein’s *Manmade Breast Cancers* spreads a different message of risk and thus fear—that of the environment. As enlightening and perhaps relevant as her message may be, it ultimately still falls into the category of a rhetoric of risk.

The rhetoric of risk works because there are few solid answers. We do not know what causes of breast cancer, why some tumors act differently than others, why some respond differently to the various treatments, how to determine which women receive which surgeries or treatments, or how to hypothesize who will develop the disease, who will die from it, and who will survive it. The billions of dollars funneled into research as a result of the success of the breast cancer movement have not improved our knowledge to any great extent, as many of the following texts argue. And without knowledge, fear exists. These stories construct the rhetoric of risk on which the breast cancer movement rests, and these are the messages which I will closely examine in Chapter Four.

Given the prominent public position of breast cancer and the breast cancer movement in the last twenty or so years, it should not come as a surprise that there is a great deal written about the disease. There are the general body health books as well as more focused breast health books for women who may or may not have cancer. Women who have had breast cancer write survival guides for women who are now dealing with the disease. There are countless magazine articles which also offer health and survival advice. Breast cancer organizations publish a great deal of information on their websites, as well. Beyond these primary texts, there are also texts tracing the history of breast cancer and examining the social construction and politics of the disease. I have organized the ideas found in the secondary texts about breast cancer and breast cancer activism into the following categories:

1. Breast Cancer as a Social Construction
2. Criticism of the Pink Ribbon
3. Forming a Woman's Perspective: Breast Cancer Narratives
4. Protecting the Breast: Analyses of Reconstruction and Prosthetics

These sections constitute a summary of the literature currently available about breast cancer and breast cancer activism.

In the first section, I recapitulate the general arguments usually presented in analyses of breast cancer. Next, I present more specific criticism of organizations which identify themselves using the pink ribbon. Here, there are two arguments: (1) pink ribbon organizations are typically more dependent on corporate sponsorship that will often neglect focus on environmental

contamination or prevention of breast cancer; (2) pink ribbon organizations usually contradict the perceived loss of femininity due to breast cancer. In section three, I cover some of the major writings about women's narratives and autobiographies, written while or after they have breast cancer. Here, I present some primary narratives as well as some secondary criticisms of these narratives. The final section moves from narratives to texts which more specifically analyze the consequences of reconstruction or use of prostheses after mastectomy. While Chapter Four provides a more thorough analysis of selected primary texts targeting women without the disease, in this chapter, I seek to review criticism of breast cancer as well as narratives of women with the disease.

Breast Cancer as a Social Construction

Ellen Leopold in *A Darker Ribbon: Breast Cancer, Women, and Their Doctors in the Twentieth Century* (1999), Barron H. Lerner in *The Breast Cancer Wars: Hope, Fear, and the Pursuit of a Cure in Twentieth-Century America* (2001), and James Olson in *Bathsheba's Breast: Women, Cancer, and History* (2002) trace the history of breast cancer, starting with the ancient history of the disease. Before the nineteenth century, women were left with few options, and breast cancer often manifested itself in debilitating disfigurements due to tumors growing to large sizes without treatment. Olson provides several insights into the lives of specific historical women and their experiences of cancer, typical of their time; similarly, Leopold focuses on the experiences of two women by examining their correspondence with their doctors. Leopold uniquely addresses the effects of breast cancer as a silent killer that threatened a woman's ability to perform her domestic duties and thus challenged gender roles in the family. All three authors cover the history of the evolution of breast cancer treatment, most notably the Halsted radical mastectomy.¹³ By treating cancer as if it were a local disease rather than a systemic one that

¹³ The Halsted radical mastectomy was developed and perfected by William Stewart Halsted in the 1890s. Surgery had long been a response to breast cancer, dating back to the late 1700s when doctors finally began to abandon Galen's humoral theory (Olson 29-31). However, the surgery was often clumsy and incredibly painful, as well as likely to lead to infection and possibly death because there was no understanding of germs, no anesthesia, and no way to identify tumors as cancerous (Olson 46). Halsted promoted the radical mastectomy "en bloc," meaning "removal of the breast, chest muscles, and axilla lymph nodes in one motion, without even cutting into the tumor [. . .]" because the common understanding of cancer at the time was that it was a local disease (Olson 46). As a local disease, the idea persisted that if the tumor were excised in time, then the cancer would not spread. Halsted used rubber gloves and clean operating rooms to prevent infection, transfused blood to keep patients alive, cut around the tumor in a wide margin to prevent spreading cancer cells with his knife (Olson 59-61). Because he first perfected his technique, kept records to indicate his success, and educated future surgeons in his technique, Halsted

could affect the entire body, the Halsted radical mastectomy attempted to remove the cancer from the woman's body and allow her to resume her domestic duties as wife and mother.¹⁴

As medical technology improved, and the idea of cancer as a systemic disease became more accepted, women were offered more options. Leopold, Lerner, and Olson each follow the message of prevention and its role in creating and perpetuating the idea that through individual maintenance, women could detect breast cancer earlier and thus seek available medical treatment. The idea of early detection became synonymous with prevention, and soon, as Leopold explains, the American Cancer Society with its massive force of women volunteers, spread the message of prevention as a woman's responsibility.

One particularly fascinating part of both Leopold's and Lerner's histories is how they detail the way in which the American Cancer Society, as early as the 1930s, in cooperation with doctors and surgeons, amassed the support of women as volunteers. Leopold summarizes,

In other words, the campaigns traded on and reinforced all of society's sexist expectations of woman: that she take responsibility for her own health without forgetting her responsibilities for others and that she carry out, on an unpaid basis, the labor-intensive strategies that were drawn up by medical men but packaged as serving not their 'best interests' but her own. (13)

Women, then, who were not necessarily feminist—often times, even opposed to feminist ideas—would volunteer to spread leaflets and do the footwork necessary to publicize the need for women to “prevent” breast cancer through early detection. Sinisterly, as Leopold presents, women became at fault for not taking the various precautionary measures to prevent the disease and for not finding the disease early enough. Furthermore, Leopold presents the history of the

managed to make the Halsted radical mastectomy the standard breast cancer treatment (Olson 61-63). Ninety percent of the women who had treatment for breast cancer in 1960 had a Halsted radical mastectomy (Boston Women's Health Collective 625). Until 1979, the majority of women undergoing treatment for breast cancer had a Halsted radical mastectomy that would often result in a sunken chest, a swollen arm caused by lymphedema, and restricted arm mobility (Boston Women's Health Collective 625). Then, the NCI recommended a two-step breast biopsy to first diagnose the tumor before surgical decisions were made (Boston Women's Health Collective 625). For decades, doctors had questioned the effectiveness of the Halsted radical mastectomy, the reliability of his statistics, the availability of less destructive options, as well as the concept of cancer as a local disease.

¹⁴ Cancer is now understood to be a systemic disease; rates of spread vary greatly depending on the biology of the tumor, but it is possible almost immediately for cancer cells to spread through the lymph nodes and the bloodstream, even before a tumor is palpable (Olson 86-99). The humoral theory once saw cancer as a systemic disease and the tumor as merely a symptom, and modern day understanding of cancer seems to have returned to this systemic concept, modified of course because the humoral theory itself is no longer in practice.

American Cancer Society to illustrate that women have traditionally been the vehicles for the distribution of messages of awareness and personal responsibility to themselves.

Victoria L. Pitts offers a more detailed close analysis of one breast cancer movement publication in her article, “Popular Pedagogies, Illness, and the Gendered Body: Reading Breast Cancer Discourse in Cyberspace” (2001). Pitts examines Women.com’s “Breast Fest 2000,” a National Breast Cancer Awareness Month special website publication that uses a seemingly feminist discourse to empower women through their bodies. Pitts argues that “Breast Fest 2000” emphasizes biomedicine and technology too much as it encourages women, even healthy women, to monitor their bodies themselves, which ultimately leads to seeing women’s bodies as sites for potential illness. Furthermore, the excessive corporate and advertising presence in cyberspace persuades women to gain control through consumerist participation. Women.com stresses a personal and individual responsibility for breast cancer, such as diet, exercise, hormones, and sexuality.

Pitts concludes that even though Women.com’s “Breast Fest 2000” ostensibly uses feminist discourse of empowerment through the body, the message still remains grounded in the male gaze and perpetuates the female body as subject to the biomedical, technological, and consumerist dimensions. Pitt’s analysis of “Breast Fest 2000” is a less extensive example of what I analyze closely in Chapter Four. I am very much in agreement with Pitts for the majority of her article, except that she ignores environmental issues.

There are several texts available that analyze the social construction of breast cancer. Through a social constructionist perspective, breast cancer is much more than a biological disease; it is a creation of society and its dominant ideologies, and how women experience breast cancer as a biological disease cannot be separated from how they experience breast cancer as a social construction. The major difference in these books and my research is in the population of emphasis. These books mainly focus on how women who *have* breast cancer experience that disease, but I examine how women *without* a diagnosis of breast cancer still inevitably experience it. Roberta Altman (*Waking Up / Fighting Back: The Politics of Breast Cancer*), Sharon Batt (*Patient No More: The Politics of Breast Cancer*), editors Anne S. Kaspar and Susan J. Ferguson (*Breast Cancer: Society Shapes an Epidemic*), and editor Laura K. Potts (*Ideologies of Breast Cancer: Feminist Perspectives*) all present an extensive analysis of the social construction of breast cancer.

Kaspar and Ferguson (2000) and Potts (2000) compile a wide variety of essays analyzing in detail the various ways in which women's experiences with cancer are constructed by society. Both *Breast Cancer* and *Ideologies of Breast Cancer* present an analysis of breast cancer organizations and awareness campaigns, an emphasis on the need for environmental awareness, and a recognition of common biases in the male-dominated medical field. *Breast Cancer* concludes with a call for future attention on the construction of the disease, with an emphasis on the impact of the breast cancer movement, federal legislation, and funded research. *Ideologies of Breast Cancer* presents essays that consider why breast cancer is such a popular disease, and examine how autobiographies and narratives shape women's identities.

Different from these compiled analyses of breast cancer are the more personal analyses written entirely by women who have had breast cancer themselves and incorporate their experience into the text. Both Sharon Batt (*Patient No More*) and Roberta Altman (*Waking Up / Fighting Back*) wrote after their experiences with breast cancer. Both authors critique the regime of detection, diagnosis, and treatment, arguing that because there is no consensus of reliable information, women are left to decide on their own. Batt describes her move to involvement with the breast cancer movement and concludes that while a biological cure for the disease may not be possible, political activism is certainly a positive step. Altman also includes an in-depth look at the psychological issues women face post-treatment, dealing with their bodies, their sexuality, and their relationships. She briefly addresses the various issues of minority women and the need for legislation to provide equal diagnosis and treatment opportunities. Like Batt, Altman also closes with a call to action and the need for support of the national breast cancer movement to make progress in the problems she has outlined.

The critical analyses of the social construction of breast cancer—Altman, Batt, Kaspar and Ferguson, Pitts, and Potts—while different in their approach (personal or general), similarly address the issues of women with breast cancer. As a whole, these texts, address the same issues: the history of the disease, risk factors, detection and diagnosis, doctor-patient relationships, treatment, recurrence and possible metastasis, reconstruction, recovery, and survival. Logically, these analyses follow the disease chronologically, through its history in American culture and through the path of women's experience. Sometimes critical of the breast cancer movement, sometimes positive and inspirational, sometimes both, these books present a

close examination with a great deal of primary medical research about the disease and how it affects women.

In this project, however, I do not address how breast cancer affects women with the disease. As I have presented, there is already a wealth of scholarly information widely available about women *with* breast cancer. But what about women *without* breast cancer? These texts, though valuable analyses of the disease, ignore a crucial element of the breast cancer movement. These texts ignore the effects of the rhetoric of risk on women without the disease. Breast cancer is quite relevant to women without the diagnosis; breast cancer pervades the public space due to the popularity of the pink ribbon. Awareness is a constant aspect of their experience in popular culture; they see it on television, in the news, in the papers, in magazines, on email, from friends, from doctors, from family—literally, everywhere there is a media presence. And the message is always the same—be “aware” of breast cancer and its risks because breasts are a potential site of disease.

Criticism of the Pink Ribbon

I am not the first person to notice the pervasiveness of breast cancer awareness, specifically the pink ribbon. There are many texts that criticize corporate involvement, use of fundraising money, distribution of research grants, and possible environmental causes for cancer. Of these texts, the most influential for me have been Barbara Ehrenreich’s “Welcome to Cancerland” and Zillah Eisenstein’s *Manmade Breast Cancers*. The idea that breast cancer is a social problem rather than an individual one is an issue Eisenstein raises and Roger S. Gottlieb continues. Also valuable for its wealth of information, Breast Cancer Action, a San Francisco-based organization, emphatically speaks out against corporate involvement and possible environmental causes.

Thrown into “Cancerland” by her diagnosis of breast cancer, Ehrenreich sees the pink ribbon organizations as “a cult of pink kitsch” (2001). As she has a mammogram, Ehrenreich looks around the room and feels overwhelmed by the optimistic prayers, words of encouragement, cartoons, poems, pink ribbons, and other “photocopied bits of cuteness and sentimentality” (43). As she receives chemotherapy, Ehrenreich finds herself immersed in “Cancerland” and finds some disturbing aspects that embrace the disease rather than reject it.

First, Ehrenreich sees the marketplace of the pink ribbon campaign—the many items a woman can buy that label her as a woman, as a fighter, as a supporter, and perhaps as a survivor as she fights breast cancer. Ehrenreich recognizes the dominance of corporate funding behind the pink ribbon and realizes that corporations fund the pink ribbon to help women without being “feminist” or “dirty,” but also, corporations fund the pink ribbon to direct research away from perhaps more relevant studies of environmental causes of cancer (i.e. industrial pollution). She finds herself encouraged to regress to a little girl by coloring with crayons, collecting pink bears, and giving control over to her doctors. Ehrenreich concludes, “You are encouraged to regress to a little-girl state, to suspend critical judgment, and to accept whatever measures the doctors, as parent surrogates, choose to impose” (52). While the Women’s Health Movement of the seventies encouraged personal informed decisions and control over treatment, the “culture of pink kitsch” compels women to regress to little girls and blindly accept their doctor’s advice. Disturbingly, Ehrenreich meets women who embrace the disease in online discussions, making it a rite of passage that all women will and should someday encounter, rather than a life-threatening tragedy.

Finally, Ehrenreich, after she receives the phone call notifying her that she may now consider herself a “survivor” questions the meaning of survivorhood. Unlike the many breast cancer survivors who extol the virtues of having had the experience, Ehrenreich rejects the typical pink ribbon identity and states, “For me at least, breast cancer will never be a source of identity or pride. What it is [. . .] is an abomination, and, to the extent that it’s manmade, also a crime. This is the one great truth that I bring out of the breast-cancer experience, which did not, I can now report, make me prettier or stronger, more feminine or spiritual—only more angry” (53). For Ehrenreich, to support the pink ribbon campaign was mostly to accept a regression into the phallogcentrically-mandated femininity, although she also addresses corporate dominance.

For Zillah Eisenstein, the possible and likely cause of breast cancer comes from environmental pollution. In *Manmade Breast Cancers* (2001), a feminist response to the disease, Eisenstein argues that

Commercial fetishization of the breast and the overstated estrogen narrative [as opposed to an environmental narrative] contaminate the scientific discourses of breast cancer. Each woman’s breast cancer is unique to her own circumstances

and also shared with other women, while it is problematically universalized by a masculinist culture that denies the diversity among women. (109)

She criticizes the increasing medicalization of women's bodies at the same time that there is not enough research on the diversity of women's bodies and diseases. Eisenstein argues that the body, as well as breast cancer, "is intimate and public; personal and political; genetic and environmental; economic and racialized; local and global" (66). Thus, the body and the disease cannot be understood outside of the ways it is socially constructed. Eisenstein argues that the patriarchal capitalist economy that allows corporations to thrive while they pollute endangers our bodies, and more specifically, causes cancer. Race, class, and gender must be understood, she contends, as factors in the disease because these factors make each woman's experience of the disease different.

Eisenstein speaks out against the production of femininity inherent in the pinkness of the pink ribbon campaigns, stating she would have preferred purple because it would have been much more aligned with the history of women's empowerment (127). The white privileged breast, Eisenstein argues, represents the ideal of femininity, and yet it cannot represent all women (141). Eisenstein concludes, through these factors of patriarchy, capitalism, fetishization, consumerism, and medicalization, women's experience with breast cancer has not only been created but also subordinated. After her tirade against the established ideologies, however, she ends with a call to action because she does not "see the breast as simply a passive site for corporate agendas, pollution, and disease. Rather the breast can also be an empowering place from which to recognize the vulnerability of the human body and demand protection and resources for its health" (135). Eisenstein still supports the breast cancer movement for its possibility to raise awareness, if it will only recognize the environmental, capitalist, and patriarchal influences.

Much like Eisenstein, Roger S. Gottlieb argues in "Beyond Our Private Sorrows: Spirituality and Politics as Responses to Breast Cancer and Disability" (2001) that while having breast cancer is certainly a personal experience, it is not an individual, but rather a social experience. He argues that while the causes of all cancers are predominantly environmental, individuals lack the capacity to change their environment, and so the causes are grounded in a social context. Emphasis and research (including corporate funding) need to be redirected to prevention of cancer rather than a cure because pollution is the cause, hence the cure can only be

found in prevention. In this manner, both Eisenstein and Gottlieb confirm the existence of the social construction of breast cancer as it affects more than just the individual.

Ehrenreich, Eisenstein, and Gottlieb each recognize the ways in which corporate participation in breast cancer activism complicates the movement's goals. Ehrenreich finds herself encouraged to become a consumer and thus reaffirm her femininity, Eisenstein finds herself endangered by environmental contamination. Both Eisenstein and Gottlieb emphasize the social scale of breast cancer that far exceeds an individual's responsibility. These texts are useful for their critique of some aspects of the breast cancer movement and of corporate involvement. Environmental concerns are often overlooked and may provide some answers to the cancer problem, but as I argue in Chapter Four, these critiques also contribute to the rhetoric of risk by adding another area to fear—corporate involvement and environmental contamination.

Forming a Woman's Perspective: Breast Cancer Narratives

There is also a great deal of literature written by women with breast cancer as a means of creating a personal identity as well as critical analyses of these narratives and autobiographies. Until recently in the twentieth century, these stories were not a large part of popular culture. As Mary Anne Borrelli relates in her study of First Lady Betty Ford's experience with breast cancer in 1974, having breast cancer once was considered a stigma, much like the prevalent view of AIDS. Betty Ford allowed a presidential spokesperson to announce to the nation that she had found a lump in her breast and would be having a biopsy to determine if the lump was cancerous, which indeed it was. The nation bombarded Ford with an unprecedented amount of support and empathy in the form of cards, letters, flowers, and donations. As a result of her admission, as well as those of other prominent women such as Happy Rockefeller, breast cancer became less stigmatized.

Not much later, Audre Lorde narrated her experiences with breast cancer in *The Cancer Journals* (1980), focusing mostly on the issues surrounding the surgical loss of her breast. However, different from Betty Ford, Audre Lorde was not the privileged white heterosexual wife of a powerful man, nor did she submit so easily to the treatment of the male-dominated medical field. *The Cancer Journals* are frequently referred to in women's cancer narratives and have become a sort of founding text of defiance. Situating her experience as unique—as a black lesbian poet—Lorde writes her experience in an eclectic way, utilizing poetry, prose, speeches,

and journal entries. Lorde discusses the cultural conflict she faces with her decision not to wear a prosthesis or to undergo experimental reconstructive surgery. She thus exposes reconstructive surgery and prosthetics as disempowering to women because both practices silence the nature of the disease and reinforce feminine stereotypes. Lorde writes in praise of the power of women to heal and support each other outside of the male/heterosexually-dominated medical world.

Commenting on the structure and prevalence of narratives, often seen as founded by Lorde, Barbara F. Sharf n argues that breast cancer and the chest of the mastectomy patient are no longer hidden or stigmatized, but rather very present and also powerful in “Out of the Closet and Into the Legislature: Breast Cancer Stories” (2001). However, as Sharf examines the power of personal narratives to influence legislation, she concludes that while the response has been mainly positive, personal narratives play to the heart and to the conscience. Sharf thus questions the distribution of funds:

Narratives about disease invariably lead to the question of how we decide which disease deserves the most notice. Should disease incidence rather than visibility be emphasized as a more important criterion for policy concern? If so, then heart disease, which hasn't generated as many moving stories as have AIDS and breast cancer, should be our nation's central focus. The public and Congress have heard most about AIDS and cancer because of the vocal strength of those constituents. But heart disease, the biggest killer in the country, affects far greater numbers: More than 500,000 women die from cardiovascular disease each year, compared with 43,000 from breast cancer. Yet the National Institutes of Health budget to research heart disease is half a billion dollars less than that for AIDS, which ranks seventeenth among diseases causing mortality in the United States. (218)

Sharf recognizes the good in personal narratives but also the danger in allowing emotional stories to overpower logic and the reality of disease fatality and incidence numbers.

Rather than legislation however, Kay Cook (“Filling the Dark Spaces: Breast Cancer and Autobiography,” 1991) argues that women need comfort from other women via narratives. Cook realizes autobiography and breast cancer go complement each other as a result of her personal experience with breast cancer (85-86). Cook comes to incorporate her experience with breast cancer with her dissertation research and discovers a uniquely woman’s voice in texts. She finds

solace because she is able to express herself and her experience through her writing and because she can relate to other women's experiences.

Narratives also provide women with the opportunity to create knowledge for themselves when breast cancer and medical research offer few facts. In a chapter of *Ideologies of Breast Cancer*, Jennifer Fosket interviews nine women of various races and different experiences with breast cancer who are mostly middle-class. Fosket uses the interviews to provide evidence of the disjuncture between the discourse and supposed legitimacy of biomedical knowledge versus the supposed illegitimacy of women's personal experiential knowledge. Most problematic for the biomedical knowledge may be the fact that it cannot be trusted; the scientific tests are unreliable and may cause cancer themselves, she argues. Fosket concludes that women who experience breast cancer must come to terms with the interplay of biomedical as well as personal experiential knowledge to create their own personal understanding of the disease thus challenging the dominant presence of the biomedical discourse.

Also creating a personal identity and reminiscent of Audre Lorde, Deena Metzger finds that the stereotypical breast cancer narrative does not fit her experience or empower her. *TREE* (1978) is Deena Metzger's poetry-within-prose collection of journal entries where she writes about her cancer as a metaphor for the problems and injustices in society—industrialization, capitalism, sexism, racism. She struggles with her healing process and her identity as a woman, questioning why she cannot find the power within to heal herself from within. She compares herself to an Amazon warrior who cut off her breast to shoot arrows better, and so like a warrior, while allowing herself to be treated by doctors, she also fights to heal herself from within. It is from within herself rather than from the medical treatment that Metzger believes she finally heals, when she realizes she can be a woman, can be sexual, and can be herself after she loses one of her breasts.

The hesitation to trust doctors' judgment as well as the creation of individuality through artistic expression surfaces frequently in the narratives. Like Metzger, Kathy Acker could not trust her doctors, so she refused chemotherapy all together. Diagnosed with breast cancer and left with bleak promise for the future, in "The Gift of Disease," (2003) Acker narrates nine months of her experience first rejecting chemotherapy, and then searching for and utilizing various alternative healing methods. Acker refused to allow a surgeon to control her disease, her body, her life—she resumed control through her choice for alternative medicine and rejected the

uncertain business of conventional western medicine. In an analysis of Acker's final texts, "The Gift of Disease" and "Eurydice in the Underworld," Nicole Cooley argues that the pain of the body changes the way in which Acker writes. Acker wanted to believe that writing could make the body a site of resistance, that writing could save the body (201-202). Acker wrote to heal, but she also wrote to perform identity.

Two notable analyses of breast cancer narratives are "Poison: Fallout in the Breast Cancer Veteran's Jungle" (2001) by Marcy Jane Knopf Newman and "'You're Marked': Breast Cancer, Tattoo, and the Narrative Performance of Identity" (2001) by Kristin M. Langellier. Both detail the experiences of women who could not find solace in current narratives, unlike Cook. Newman finds an absence in the typical cancer narrative when it comes to describing the traumatic effects of chemotherapy, so she analyzes an atypical narrative. Newman argues that Christine Middlebrook uses a socially acceptable metaphor of trauma—war and battle—to explain her personal experience of trauma in a world that sometimes sees women's emotional traumatic issues as hysterical—thus unfounded and without value. Newman concludes that Middlebrook creates a new identity for herself, inclusive of her cancer experience, from her use of metaphor to move past her gender shock. Similarly, Langellier analyzes the ways in which a Franco-American woman, Rhea, twice diagnosed with breast cancer, narrates, or performs, her story of illness and subsequent tattoos in several interviews. Inspired by Metzger's famous "Warrior" poster, Rhea chooses to have a flower tattooed over the scar of her mastectomy in lieu of reconstruction. Langellier linguistically examines the way in which Rhea speaks about experiences of her tattoo and concludes that for Rhea, her tattoo is a way in which she regains control and power over her body and makes her story of breast cancer her own. Both the stories of Rhea and Middlebrook exemplify the need for women to define their individual experiences with breast cancer which may fall outside of the norm.

Also falling outside the norm of the written narrative and ranging from tattoos and poetry to the traditional written autobiography, artwork has increasingly gained attention in the breast cancer movement as a means for women to create an identity for themselves during and after breast cancer. Sponsored by the Breast Cancer Fund, the American Cancer Society, and the Susan G. Komen Foundation, *Art. Rage. Us. Art and Writing by Women with Breast Cancer*, is a charitable compilation of women's creative responses to their breast cancer and is published in an effort to raise public awareness of the disease. The art and writing compiled here is not

always mainstream or conservative, and it certainly allows women to express their sometimes more negative feelings about breast cancer. In a related critical piece, “Poster Art as Women’s Rhetoric: Raising Awareness about Breast Cancer” (1995), Barbara F. Sharf examines different posters created by the American Cancer Society, the Office of Cancer Communications and the National Black Leadership Initiative on Cancer, Polly Strand, Jersey Matuschka, Deena Metzger, and Hollis Sigler. Sharf concludes that perhaps, given that these posters are created for women about a primarily women’s disease, that there is a new kind of rhetoric being used, one that “creates and sustains an atmosphere that enables, but doesn’t demand, transformation” (78). Art, in this manner, becomes a means of self-expression and catharsis, but also a means for a call to action—or at least an advertisement that there are other forms of action available.

The body as a site for disease and death can be a traumatic concept for some women, as Acker and Metzger illustrate. Trying to make a connection between the body and disease, as well as geography and ancestry, in *Refuge: An Unnatural History of Family and Place* (1991) Terry Tempest Williams provides a detailed account of the many different Utah birds that she observes from 1982-1987 during an unprecedented rise in the Great Salt Lake that endangers the Bear River Wild Bird Refuge. Written with much poetry, metaphor, and detail (of birds and their habitats), Williams juxtaposes the happenings of this period in her life as she tries to make sense of these events over which she has no control. Williams works through her feelings of grief and loss as she watches her mother and grandmother die of cancer and as she faces her own mortality when she finds a lump in her own breast. Finally, the reader learns that Williams’s family was exposed to nuclear testing in Nevada during the 1950s and 1960s. Here, Williams highlights the government’s (and consequently, the environment’s rather than biology or genealogy’s role) role in her family’s continued and sudden susceptibility to cancer in a way similar to Zillah Eisenstein.

Breast cancer narratives are as diverse as the individuals who write them. Overall, these narratives function to represent how the woman overcomes her anxieties before and after a breast cancer diagnosis and treatment. Some narratives allow women to create new identities that reconstruct themselves to incorporate how they have changed as a result. Some narratives fight the norms women are expected to accept and thus present a different model for the female breast cancer patient and survivor. Some narratives are merely outlets for expression of the vast array of feelings women may have. Others serve as criticisms of the experience a woman is expected

to have and its clash with her actual experience. The examples I have summarized here are samples of the different kinds of narratives out there that shape and contest a woman's experience of breast cancer.

Protecting the Breast: Analyses of Reconstruction and Prosthetics

The breast as a marker of sexuality and maternity, thus femininity, is a topic I cover in more depth in the next chapter, but there has been much written about the social construction of losing a breast and either having it reconstructed or wearing a prosthesis. There are certainly rather famous examples of women who have found reconstruction and prostheses to be problematic. Audre Lorde refused to wear a prosthesis because she did not see it as necessary and yet was chastised by her clinic for showing such a "negative" image to other patients. Deena Metzger has a tree tattooed on her mastectomy scar and proudly bares her asymmetrical chest to the world in a famous poster. Jersey Matuschka revealed her scar on the cover of *Time* magazine in an attempt to raise awareness of breast cancer while creating a positive image of a woman who has had a mastectomy. These women have faced the loss of a breast and found the expected alternatives of reconstruction or prostheses to be incompatible with their loss and identities as women.

Many breast cancer patients and feminist critics argue that reconstructive surgery is often seen as a mandatory aspect of treatment. The American Society of Plastic Surgeons (ASPS) reports that "Breast reconstruction, the recreation of a breast removed due to cancer or other disease, was performed on 74,090 patients [in 2002] with 50 percent of them having the procedure at the same time as mastectomy" ("More than 6 Million Reconstructive Surgery Patients Treated in 2002" 1). In support of plastic surgery, Long Beach, California ASPS President Dr. James Wells argues that

Breast reconstruction is one of the most rewarding surgical procedures plastic surgeons perform [. . .]. Unfortunately, according to a recent study in *Plastic and Reconstructive Surgery*® the likelihood that African American, Hispanic and Asian women have breast reconstruction after mastectomy is significantly lower than Caucasian women. This is most disconcerting because breast reconstruction plays an important role in a patient's emotional healing after mastectomy. ("More than 6 Million Reconstructive Surgery Patients Treated in 2002" 1)

Clearly, Wells feels that reconstruction should be the standard of care for mastectomy patients, and he laments the failure for non-white to follow suit. Here, Wells cannot see any of several possibilities explaining women's "failure" to opt for reconstruction. First and most importantly, these women may be rejecting white middle- and upper-class heterosexual ideals of feminine beauty by refusing surgery. Second, depending on their socioeconomic position, these women may not have the means to pursue reconstruction, although reconstruction is typically covered under most medical insurance policies. What Wells sees as a problem of availability and knowledge may really be an indication of women's protest.

In a similar article, Cleveland, Ohio ASPS President Dr. Edward Luce comments that breast reconstruction "improve[s] the patient's body image and quality of life by making a woman less self-conscious of a body area with which she was dissatisfied" ("Nearly 180,000 Women Receive Health Benefits of Surgical Breast Procedures" 1). For the ASPS, providing the semblance of the breast, all the while neglecting the added cost of the procedure, time for rehabilitation, as well as pain from surgery, is beneficial to a woman's self-image. Of course, a reconstructed breast cannot lactate or sense touch in the same way so it will no longer function for the woman as it previously may have.

Almost all survival guides and health books cover reconstruction, paralleling it with prostheses. Most texts offer women information on the various procedures, perhaps first-person narratives of personal choices, and sometimes take a clear stance one side of the issue or the other. Reconstruction, the expected standard of care, certainly does not elicit a standard response from women. Rather, it is a personal choice that most women must make, although they are always making that choice from within the social construction of the breast.

In "The Social Construction of Breast Loss and Reconstruction," Anne S. Kaspar interviews twenty-nine white middle-class women of various ages living on the East coast who have been diagnosed with breast cancer sometime in the past three months to ten years (at the time the article was written in 1995). Kaspar interviews the women to study the ways in which the social construction of the breast affects women post-surgery and their decisions of reconstruction. Kaspar contends, "It is not simply that breasts are admired, valued, viewed as objects of beauty, or conversely, are not. By extension, women themselves are admired, valued, viewed as objects of beauty, or not, in large measure because they have breasts" (198). Because breasts play such a crucial role in feminine beauty, Kaspar argues, "A diagnosis of breast cancer

becomes not only a health crisis, but a deeply disturbing emotional crisis that challenges a woman's identity as a woman" (198). Kaspar presents many examples of women's different responses to and decisions about reconstruction—the result is more of a varied response based on the individual rather than a single conclusion.

However, Kaspar does make some conclusions about some surgical decisions. Of the twenty-nine women, twenty had a mastectomy, and "Although large clinical trials have demonstrated equal disease-free survival rates with lumpectomy plus radiation as with mastectomy, many of the 20 women believe their survival is better assured with removing the breast" (209). Women fight the battle of physical health and mental health: do they treat the cancer of the body and remove the breast or do they preserve the breast for their mental health? Scientific evidence of the comparative validity of lumpectomy, however, did not aid many of the women in their decision. Furthermore, of the twenty women who had a mastectomy, sixteen opted for reconstruction. Of reconstruction, Kaspar surmises,

Most of the women sought reconstruction because they hoped to prevent the anticipated devastating effects of breast loss on their well-being. However, the majority discovered that the results of breast reconstruction did not match their anticipations of erasing the reality of cancer or of returning a sense of normalcy to their lives. Neither did reconstruction virtually replace the lost breast. Rather, the reconstructed breast is only a physical approximation of a female breast, one that has none of the sensory, sexual, or maternal capacities of the normal breast. In sum, its sole purpose is to appear to be what it is not. (215)¹⁵

Because the reconstructed breast cannot replace tactile ability, or lactating ability, or even hormonal sensibility of the biological breast, most of the women realized the reconstructed breast, while providing the physical presence of the breast, did not replace the breast or aid very much in their mourning the biological breast. Kaspar concludes that breast cancer attacks not

¹⁵ Dr. Susan Love explains sensory loss after reconstruction:

What's constructed is not a real breast. When it's well done, it will look real, but it will never have full sensation, as a breast does. Any surgeon who tells you, "We're going to take off your breast and give you a new one, and it'll be as good as new" is either naïve or dishonest. Sometimes they'll tell you that the new breast "feels normal"—at best, a half-truth. It will feel normal to the hand that's touching it, but it will have little sensation itself. However, feeling is only about one-half skin sensation and at least one-half cerebral. You may have some "feeling" return, but it will never feel completely normal to you. (447-448)

only the body but also the mind and, oftentimes, a woman's sense of value in terms of her femininity.

In a similar examination of women's experience with reconstruction, in "Mastectomy, Misogyny, and Media: Toward an Inclusive Politics and Poetics of Breast Cancer" (1995), Roseanne Lucia Quinn challenges the notion of a universal women's experience, especially in relation to women's experience with breast cancer, where the woman is so often assumed to be white, heterosexual, and middle-class. Quinn examines the ways in which women writers—such as Audre Lorde—have rebelled against the universalizing pressure breast cancer patients encounter. Examining an advertisement for mastectomy and a study on the racial differences of breast cancer patients, she concludes that the advertisements and the supposedly scientific studies perpetuate the myth of the white, heterosexual, middle-class breast cancer patient. Quinn questions the often contradictory advice women receive, such as when to have children, the use of birth control, diet, and exercise. Although the rhetoric suggests an individual means of prevention, Quinn argues that the actual causes of cancer are environmental and hence social rather than individual and therefore uncontrollable. Quinn closes her article with a utopian vision of Amazon women of old with the women of today, together demanding society and consequently the law to protect women and search for a cure that is free of the misogynistic, classist, and racist assumptions so often found in research on breast cancer today.

While I wish to focus on the messages women without breast cancer receive, and reconstruction is more of a specific issue for women with breast cancer, it still plays a substantial role in how women without breast cancer perceive the disease as well as their bodies. The first thing a woman thinks of when she hears the term "breast cancer" is probably the loss of a breast rather than the loss of life. In the next chapter, I will examine more closely the ways in which feminist theory offers ways of understanding women's complex responses to losing a breast and its representation of femininity.

Conclusion

As I have illustrated, there is a vast array of diverse information available to women about breast cancer. In these past four sections, I have classified and organized the various issues of a wide range of texts. Many texts present the history of the disease and movement; others present an analysis of the social construction of the disease and movement. Criticisms of

the pink ribbon campaign that call for environmental awareness descend out of the first analyses. All of these analyses provide a wealth of information seeming to target a more educated audience who already question the social construction of the disease and the politics of the movement. Narratives form a woman's perspective of the disease, but function in vastly different ways as they do so. The narratives seem to target an audience filled mostly by women who have or have had breast cancer. Finally, analyses of reconstruction options illustrate the connection between the disease and the ideology of femininity. Yet, as I have noted above, a common characteristic of the analyses seem to target or at least discuss women *with* breast cancer.

Given the prevailing concentration of the awareness campaigns on women *without* breast cancer, I see a need for an analysis of the rhetoric these women receive and how it becomes a way to medicalize the bodies of healthy women. The result of the breast cancer movement has been a massive production of awareness messages targeting women without the disease. Early detection as a means of prevention is *the* message of awareness. "Awareness" means awareness of risk and consequently implies necessary body projects. And despite this widespread message targeted to women without the disease, the effects of this message on these women are ignored. Herein lies the need for this research. Awareness focused on risk forces unnecessary attention and body projects to prevent or reduce risk ensue. Yet the risk is based on the unknown, and without facts, fear is produced. The ways in which risk produces this fear and thus manages to convince women to participate in body projects is where the opportunity for research lies. Furthermore, the reasons why this rhetoric exists deserve research, for through women's fear of their bodies and participation in body projects, femininity is produced. At the same time that the rhetoric produces fear, it produces femininity, and this insidious reinforcement of the phallogentric model of modern power continues to target women without breast cancer. These women may not be suffering from a physical attack on their bodies, but they are bearing the brunt of an ideological attack on their bodies and identities as women, and so this research is very necessary and relevant.

CHAPTER THREE: PARTICIPATING IN THE IDEOLOGY OF FEMININITY

Introduction

How has the breast cancer movement become so successful? Why is it so appealing to women? How does participation in the breast cancer movement, and subsequent body projects, produce femininity? Michel Foucault's model of modern power, functioning through ideology and acceptance of that ideology rather than through violence, offers a way to understand how women are complicit subjects in their subordination within the ideology of femininity. The breast is the ultimate visual marker of a woman's femininity; it is seen and assumed to be a characteristic of the female, whereas genitalia are not. Laura Mulvey's analysis of the male gaze in film offers a perspective on the phallocentrism inherent in the ideology of femininity that thus constructs the breast as the representation of femininity. Marking both maternity and sexuality, the breasts are the physical representation of phallogentric femininity. The pink ribbon thus functions alongside the ideology of femininity and complicit participation to ultimately produce femininity, despite the physical threat breast cancer makes on the breast and its representation of femininity.

Foucault's Model of Modern Power and the Ideology of Gender

In *The History of Sexuality: An Introduction*, Michel Foucault presents two models for understanding how power works to create and maintain subjects. First, the model of traditional power is like a triangular-shaped tree where those in power at the top are considered outside of the law. Power here is maintained through (the threat of) violence. This model was generally found in feudal and patriarchal societies. Second, in Foucault's model of modern power, power functions much more like a weave where the strands hem subjects in and *all* subjects are susceptible to the law. The dominant ideology functions as the strands of the weave and relies on the individual subject's complicit participation to first create himself/herself as a subject and to second remain subject. This model is a product of the Enlightenment-era emphasis on the social contract and is generally how one would draw a power model of the contemporary United States.

In “Ideology and Ideological State Apparatuses,” Louis Althusser uses the terms repressive state apparatuses and ideological state apparatuses to explain how ideologies are reproduced in the two models of power. Within ideological state apparatuses (modern power), Althusser uses the term “interpellation” to describe the ways in which individuals identify themselves as subjects. He uses the metaphor of hailing to explain interpellation: an individual responds to his/her name being called/hailed—here both the individual who responds and the hailer who calls are both identifying the individual as a subject within the ideological state apparatus. The caller recognizes the individual as a subject, and the responder recognizes himself/herself as a subject. Education is an example of an ideological state apparatus that creates subjects who believe in and accept the established ideologies. Ideology is not just a set of views, but also the imaginary relationship of individuals to their real conditions of existence—ideology is how existence is explained and thus rationalized based on the way an individual creates his/her identity. As with Foucault, the individual acceptance of the ideology reproduces the power.

Both Foucault and Althusser neglect to address gender and women’s position within the model of modern power, but in “The Technology of Gender,” Teresa de Lauretis applies Althusser’s theory to the ideology of gender. Gender, de Lauretis argues, is much bigger than just categories of sex difference—it is an ideology our society has produced and functions as those metaphorical weave strands to hem subjects into the model of modern power. Through the subject’s compliance with gender norms, gender is reproduced. De Lauretis also argues that one cannot have an identity without a gender. If the individual were to reject the concept of gender, he/she would still be assigned a gender category based on his/her performance and how other subjects interpret that performance.

De Lauretis concludes that in order for feminists to recognize the ideology of gender and thus to combat the oppressive tendencies of gender, feminists needs to be both inside and outside of the ideology of gender. Feminists need to see gender as a constructed ideology at the same time that they recognize themselves as subjects of that ideology; to fail to see beyond the ideology will only reproduce that ideology. However, because feminists are part the ideology of gender and have been indoctrinated to see gender as real and natural, it is sometimes difficult to see outside of this imagined reality. The imagined reality here is the reliance on genitalia as the basis for difference and thus the subordination of women within an ideology that devalues the

female gender because of the perceived genital lack. However, it is still feasible, de Lauretis argues, for feminists who can recognize themselves as complicit subjects within the system to analyze and criticize that system.

Through the theories of Foucault, Althusser, and de Lauretis, it becomes possible to understand the complex ways in which power functions in Western culture. Repeatedly, I find myself feeling guilty because I do not make what would be considered feminist choices, and yet at the same time, they are still choices that feel right to me. Joan Williams's analysis of women and their conflict with work and family in *Unbending Gender* addresses in a more concrete form what de Lauretis theorizes more abstractly. Williams illuminates the idea that women make "un-feminist choices" all the time, but, as she argues, these are not truly free choices because of the ideology of gender. When a woman makes the "un-feminist choice" to stay home to raise her children, she is not necessarily un-feminist, but rather, she has realized she cannot perform as an ideal worker and as an ideal mother at the same time, at least according to the ways in which society has constructed these "ideals," which are, again, based on the ideology of gender. In a similar fashion, women who "choose" to perform their gender as feminine do not really enjoy free choice because their performance has already been constructed through the ideology of gender.

Personal choices of subjectivity are reflected in the performances we "choose" to and not to perform. There is not always an infinite range of options, but choice, nonetheless, exists in some (limited) form. People attribute gender based on the perceived performance.¹⁶ In *Gender Trouble: Feminism and the Subversion of Identity*, Judith Butler explains that gender is always performed and thus recognized: "Such acts, gestures, enactments, generally construed, are *performative* in the sense that the essence or identity that they otherwise purport to express are *fabrications* manufactured and sustained through corporeal signs and other discursive means [italics in original]" (136). She elaborates, "In other words, acts and gestures, articulated and enacted desires create the illusion of an interior and organizing gender core, an illusion discursively maintained for the purpose of the regulation of sexuality within the obligatory frame of reproductive heterosexuality" (136). One's acts, gestures, and clothing, for example, are categorized as masculine or feminine. A person's gender is thus constructed from the choices he

¹⁶ In addition to Butler, see also Kessler, Suzanne J. and Wendy McKenna. *Gender: An Ethnomethodological Approach*. Chicago: University of Chicago Press, 1978.

or she makes in nearly every aspect of life—of performance. Personal choices for performance place individuals as subjects within the weave of modern power. Individuals accept and maintain their position through their performance.

Understanding our complicit participation in our subordination is an important concept to grasp. Reflecting back on the introduction, my mother's friend, somewhat offended at my criticism of the representation of breasts as the marker of femininity, could not understand that at the same time that I could recognize the problem of representation, I could also recognize my complicity in the ideology of gender. Just as Barthes argued that the unexamined myth masquerades as truth, my mother's friend accepts the role breasts play in femininity as the truth, rather than a social construction.

The Breast as a Visual Marker:

The Representation of Femininity As Defined By the Male Gaze

The tremendous popularity of breast cancer activism—even when breast cancer is not the leading killer of women—continues to grow in part, I believe, because of the social meaning of the visible breast for women. The breast cancer movement, in its attempt to preserve the breast for femininity, thus serves to reinforce phallogentrism. The phallogentric construction of femininity—the ideology of femininity that adheres to the idea of the male gaze and constructs the Phallus as superior—ignores the vagina as an organ and speaks of it as an absence. The female body is constructed as inferior to the male body because it lacks a penis, but the female body without breasts loses its status as feminine because breasts mean more than the vagina. Breasts have often been referred to as genitalia, replacing the vagina as the “real” female genitalia: in her fight to reclaim the breast for the breastfeeding mother, Katherine Dettwyler finds, “[. . .] an article in *Time Magazine* even referred to women's breasts as ‘human genitalia’” (175). Breasts thus function as a presence within the phallogentric construction of femininity, and so the loss of a breast to breast cancer threatens the physical representation of femininity on the female body.

In “Visual Pleasure and Narrative Cinema,” her essay using psychoanalytic theory for feminist ends, Laura Mulvey focuses her analysis on films and their effects on the male audience. Mulvey looks at visual representations in film and analyzes how they are creations of the male gaze; similarly, one can look at the breast as well as the pink ribbon and see them as

representations and analyze how they too are creations of the male gaze. Her discussion of the woman as a subject of the male gaze designed for his viewing pleasure is useful in analyzing how the breast cancer movement seeks to protect a very important part of the female body—the breast—for the male gaze and femininity. Mulvey considers psychoanalytic theory and Lacan's theory of the Phallus to explain the male spectator's participation in and construction of a phallogocentric world that places women as the object of male gaze. Mulvey argues that woman is defined by her sexual difference, meaning lack of penis, but she also functions as a source of pleasure for the male gaze from her (inferior) difference through scopophilia (pleasure in looking). In this view, because man possesses and woman lacks, man can overcome his fear of castration (illustrated by woman's lack) through his fantasy of her as an object. The fantasy constructs the ideal woman, hence the term, "male gaze." The male gaze defines woman, and through this definition, he is the actor and she is oppressed as the passive subject. Through the fulfillment of his desire with the woman, the woman reinforces his possession of the phallus and therefore his superiority. The cycle continues with reproduction, and the child will see the possession/lack in the same manner, thus perpetuating the ideology of gender based on sex differences.

Just as Helena Michie and Naomi Cahn apply Mulvey's film theory to women's issues with in/fertility in *Confinements: Fertility and Infertility in Contemporary Culture*, film theory can also be applied to an analysis of the breast cancer movement. Michie and Cahn relate Mulvey's film analysis to the real world woman: "In the context of cinema studies feminists have posited a dominant cultural 'male gaze,' suggesting that while anyone can of course look at anyone else, it is women in our culture who are constructed as objects to be looked at and men as subjects who look" (105). Women become the objects and men the subjects who view, or gaze at, the object, but also simultaneously construct the object through their fantasy.

The feminine ideal relies first and foremost on breasts, and women cannot escape their breasts, even if they want to; the power of this visual marker is too strong. Breasts dominate every aspect of American media; if there is an image of a beautiful woman, then she has breasts. In *A History of the Breast*, Marilyn Yalom traces the multiple meanings of the breast over time. While Yalom conditions her examination with the caveat that we cannot infer the position of real women and their breasts based solely on art, she argues that we can see how various different time periods represented the breast through art and interpret subsequent ideologies based on

those representations. Reaching back to antiquity, breasts were the visible markers of fertility goddesses where more breasts (i.e., more than two) typically meant enhanced fertility. In the Medieval period, Christian artists converted the image of the breast to be a symbol of divine nurturance—the naked breast was painted (rather unrealistically as almost a separate entity) onto the Madonna as she nursed Jesus. In a rather different direction, the Renaissance artists separated the breast from its holy maternity and emphasized the eroticism of the breast. While the breast could still symbolize maternity, sexuality was its main feature. In the late eighteenth century, in response to the French Revolution, many artists depicted the naked breast as a political statement, most usually in the form of Liberty leading her followers to freedom from tyranny.

All of these past representations of the breast have continued in some form or another to the present day, but Yalom asserts that today, the breast is mainly represented commercially; that is, the breast is used to sell products or ideologies, no matter what the relation (or lack thereof) to the breast. Yalom's point that the breast can function commercially for the ideology of femininity relates to the perpetuation of the phallogentric model of modern power. Again, as it is the most visible marker of sexual difference, no matter the actual physical size of a woman's breasts, breasts function to advertise a woman's identity as a woman, thus classifying her as a subject.

Breasts, through their maternity and sexuality, symbolize femininity. If a woman wants to be recognized as a woman—meaning feminine—she needs breasts; her breasts can be any kind or size, although of course the modern trend has been to judge the bigger as the better. To maintain her femininity, a woman needs to maintain her breasts. Breast cancer activism seeks to protect the breast because our society uses the breast as a representation of femininity. The shadow behind the pink ribbon campaign, as well as breast cancer organizations in general, uses a rhetoric of risk to encourage women to “think pink” in order to maintain their femininity, but by maintaining their femininity as constructed by our society, meaning through the breast, women remain entrenched within the phallogentric ideologies of women as the mother and the sexual object thus perpetuating the subordination of women.

First and foremost in Western industrialized cultures, breasts symbolize sexuality. Breasts function as an object of attraction and fetishization (and yet they, unlike other body parts, such as the feet, are acceptable fetishes for men and as an object of obsession for women).

Katherine Dettwyler, a breastfeeding advocate, argues, “Western culture is obsessed with the sexual nature of women’s breasts and their role in attracting and keeping male attention, as well as their role in providing sexual pleasure for men and women” (174). Men desire breasts for their sexual enjoyment, and women desire breasts to attract men—in, of course, the context of heterosexual relationships. Dettwyler maintains that the sexualization of the breast appears to be a cultural construct rather than an innate or “natural” phenomenon:

[. . .] there is no evidence that the human female breast is *intrinsically* erotic.

Men and women in Western industrialized countries are taught by their culture to think of breasts this way, from a very early age, but it is only a cultural belief of limited distribution, shared by relatively few cultures around the globe. (177)

Because the male gaze constructs breasts as sexual in Western cultures, breasts mark the maturity and progression of a girl to a woman, hence entrance to adult sexuality. Breasts, more than any other body part, represent the sexual maturity of a woman because breasts are the most visible female secondary sex characteristic.

The representation of breasts and femininity continues in children’s toys: Barbie provides perhaps the most blatant example of the sexualization of the breast in Western culture. In their study of the ways in which Barbie perpetuates an ideal body image, Jacqueline Urla and Alan C. Swedlund argue that Barbie represents sexuality through her “unobtainable representation of imaginary femaleness” (298). Barbie is the fantasy fulfilled for both the man and the woman. And yet, Barbie’s breasts, if she were a real woman, would be thirty-eight to forty inches—an extraordinary and generally unnatural size in proportion to the rest of her body (Youth Resource). Girls’ play with Barbies functions like an ideological state apparatus which indoctrinates young girls to become subjects of the phallogentric model of modern power. By the time a girl matures to a woman who can recognize Barbie’s impossible measurements, she has already internalized the image of the ideal female body. She is thus within the ideology of femininity, even if she can recognize its faults.

Young girls in America cannot escape the presence of Barbie and her disproportion: a 1992 study by Eben Shapiro found that “Mattel estimates that in the United States over 95 percent of girls between the ages of three and eleven own at least one Barbie, and that the average number of dolls per owner is seven” (qtd. in Urla and Swedlund 278). Urla and Swedlund conclude, through their play with Barbie children “acquire a very tactile and intimate

sense of Barbie's body" (300). This "tactile and intimate sense" powerfully provides girls with a model of the ideal feminine body. Through girls' experience with Barbie's body, they can observe an unnatural and often unattainable model of the female body. Barbie's breasts, although not the only visible body part, are most noticeably the only visible body part usually covered. In other words, Barbie has breasts (without nipples) but no visible genitalia; she has no vagina, and thus the vagina is represented as an absence. Breasts may not be Barbie's only body part, but they are certainly Barbie's most protruding body part, especially given her disproportionate dimensions. Girls used to Barbie's idealized body may grow up to be women who likely have internalized the idea of voluptuous breasts as an integral part of femininity or who have essentialized the definition of femininity to be synonymous with breasts.

Ironically, Ruth Handler, the creator of Barbie and her gargantuan breasts as well as a breast cancer survivor, later created Nearly Me, a company that produced realistic-looking prosthetic breasts targeted toward women with mastectomies (Sieders). Handler essentially conditioned her future consumers of prosthetic breasts by giving young girls a model of femininity with large breasts, and these girls would later grow up to be women who placed a great deal of importance on breasts and thus "needed" prosthetic breasts after mastectomy. Handler herself has fully benefited financially from the capitalist economy, but she has also aided the phallogocentric ideology of femininity. Women who lose their breasts to breast cancer may feel pressure to wear prosthetic breasts in order to maintain their femininity. Barbie is just one concrete example of how Western culture represents breasts as femininity; the dominance of breasts exists as a cultural phenomenon and is manifested in visual representations of the female body.

The Western world's sexual fascination with the breast often supercedes its representation of biologic maternity (realized in pregnancy and breastfeeding or not, the potential is still there). People in Western industrialized cultures seem to be losing the ability to conceptualize breasts as anything other than sexual objects. The description of breasts as "genitalia" leads one to think that they are intrinsically related to the act of vaginal intercourse, and yet vaginal intercourse can occur without the breasts. Breastfeeding, however, cannot occur without the breast, obviously; hence breasts must represent more than simply sexuality; breasts also represent maternity.

Fiona Giles, also a breast-feeding advocate, suggests that the Western sexual infatuation with breasts actually connects to perceptions of motherhood, although unlike Dettwyler, Giles encourages the sexualization of the breast as ultimately compatible with breast-feeding. She argues, the ideal-sized breasts—which rarely occur in nature—represent motherhood because the enlarged breasts “[. . .] mimic nothing if not the engorged bosom of the day-three post-partum mother” (“The Nipple Effect”). Western culture takes the ideal maternal bosom and sexualizes it, but the “engorged bosom” still remains grounded in the origin of the lactating mother, and thus the image of the voluptuous, sexualized breast is really the maternal breast. Of course, a woman needs to engage in heterosexual activity to become a mother (barring new reproductive technology), and yet much of Western culture would like to separate sexuality and maternity.

Women who breastfeed experience a wide range of sensations from pain, comfort, total absence of sensation, and sometimes physical pleasure. Unlike Dettwyler, Giles argues that the breast is not sexualized enough. She critiques the separation of maternity from sexuality as unnatural and phallogocentric because the breast has been appropriated solely for the sexual pleasure of men (the male gaze), while simultaneously neglecting the sexuality of the wet, lactating breast (“The Nipple Effect”). Giles represents a more developed independent standpoint, as she advocates both the appropriation of the wet breast for the further enjoyment of men and women as well as breastfeeding (as opposed to Dettwyler who would like to see the sexual side of the breast negated). Giles would like to see women using their breasts for personal pleasure, (with and without a partner, of either sex) rather than the continuation of the breasts as part of the fulfillment of the desires of the male gaze. One may imagine that Giles would also oppose the idea that women should fear their breasts as a site of disease because this representation of the breasts further reinforces the phallogocentric ideology of femininity that devalues the female body except as it may serve the male gaze.

However, the positive aspects of breast cancer activism at least nominally reinforce Giles’s standpoint: the movement upholds the importance of the breast to women and recognizes its importance in women’s self-esteem and confidence as a feminine woman. In general, breast cancer activism empowers women in relation to their breasts because it encourages the least invasive procedures in order to preserve as much of the breast as possible. Historically, male doctors have been quick to cut off the breast, especially the breasts of older women because they do not see the value of the breast to a woman supposedly past her sexual prime and certainly past

the possibility of procreation. However, the question must still be asked, why is there such an intense emphasis placed on the preservation of the breast? Certainly, as I will examine in Chapter Four, the messages of early detection encourage women to monitor their breasts in order to find lumps at the earliest stage possible. Clearly, these messages of early detection (successful through the rhetoric of risk) encourage the preservation of the breast.

Conclusion

In this chapter, I have presented the major theories of influence in my analysis of the breast cancer movement—the Foucaultian model of modern power, the ideology of gender and femininity, phallogentrism and the male gaze, and the femininity represented by the breast applied to the stories of the breast cancer movement. Foucault, Althusser, and de Lauretis offer a way of understanding how individuals monitor themselves into the ideology of gender. Mulvey defines the male gaze and phallogentrism, opening the door to understanding the Western cultural importance of the breast in maternity and sexuality thus femininity. Through the intersection of these theories, the power of the rhetoric of risk inherent in the breast cancer movement to induce women to engage in body projects and to fear their bodies becomes evident.

CHAPTER FOUR: THE BREAST CANCER MOVEMENT'S USE OF A RHETORIC OF RISK

Introduction

Chapter Four presents a close analysis of the breast cancer movement literature, focusing on select organizations' websites, survival guides, health guides, and women's magazines. In this material, I have found trends in the messages constituting the rhetoric of the breast cancer movement. The encompassing message of this rhetoric is *risk*. First are risks from the body and lifestyle via the messages and warnings regarding health, diet, and exercise; these risks are seen to be choices or decisions that can be controlled by the individual for the most part. Second are the risks of the environment and genes; these risks are seen to be factors that usually cannot be controlled by the individual. Combined, these risk factors are based on theories and probabilities rather than fact, and it is the attention without facts that produces fear, fear of the body and of the potential to develop breast cancer. Furthermore, these risk factors result in the expectation of monitoring to prevent breast cancer made necessary by the motivating factor of fear. Finally, this rhetoric of risk that produces fear, once focusing on the elite class of white, upper- and middle-class heterosexual women, is now being conveyed to women of all classes, races, ethnicities, and sexual orientations. This rhetoric of risk functions as part of the myth of the pink ribbon and the myth of the breast, conforming to the ideologies of gender to reinforce the phallogocentric model of power that relies on the male gaze. It is this rhetoric that upholds and produces the phallogocentric power structure, continuing women's subordination as the feminine class.

A Review of the Primary Texts of Analysis

There is a seemingly infinite wealth of information available to educate and raise awareness amongst women about breast cancer, ranging from organizations' websites, fundraising events, body and breast health books, survival guides, magazine articles, news reports, and so on. For the purposes of my research, I have chosen a wide sample a range of breast cancer information. I have made my choices based on what seems to be most widely

available, advertised, popular, and accessible to the breast cancer movement's mainstream audience.

Among the body and breast health books, *Our Bodies, Ourselves* is one of the most famous feminist general body health resources, originating out of the Women's Health Movement of the 1970s. The book project seeks to empower women by providing a woman-centered perspective with a variety of medical approaches for the female body. Dr. Susan Love's *Breast Book* has a highly-esteemed reputation as a comprehensive resource for all women throughout much of the breast cancer movement information I have found. Specializing in breast surgery and breast cancer care, at seven hundred pages, the book is a detailed, illustrated, and comprehensive guide to the healthy breast and non-cancerous breast problems, as well as the central topic of breast cancer. Dr. Miriam Stoppard's *The Breast Book* is a colorfully illustrated, more accessible breast health book. Stoppard addresses breast myths, the physical breast, breast care, the sexual breast, the nurturing breast, and cosmetic surgery in the first one hundred pages; she then devotes the entire second half of her book to the topic of breast cancer—definitions, detection methods, treatment, reconstruction options, and rehabilitation therapy. Throughout, I also supplement information with statistics and statements from the ACS's *Breast Cancer Facts and Figures 2003-2004* to provide the reader with statistical information. I use the ACS as a source because it is widely known and respected as a reputable cancer organization whose facts would be the most up-to-date information available. Finally, as a text sponsored by the National Black Women's Health Project (NBWHP), Linda Villarosa's *Body and Soul: The Black Women's Guide to Physical Health and Emotional Well-Being* ranks highly (in the top two) in an Amazon.com search for black women's health books, thus a popular consumer choice.¹⁷ Villarosa and the NBWHP intend *Body and Soul* to serve as a resource specifically for black women addressing the female body, medicine, and physical and spiritual well-being.

I have classified books dealing with the breast cancer experience directly as survival guides. While the health books give information about breast cancer to women in general,

¹⁷ Amazon.com customers' comments ("All Customer Reviews—*Body and Soul*"):

"This is a book that every African-American woman should add to her book collection. I have referred to this book throughout my life. It has helped inform me about many issues that black women face everyday."

"Particularly, African-American woman have been in the dark about health issues that can cause emotional stress and issues that doctors feel we aren't smart enough to understand. [. . .]. We all do self-diagnosis when we are ill though not necessarily the best thing, but now I can confirm what I may think with a more educated reiview [sic] of my symptoms and share in the treatment with my doctor instead of accepting the typical prescribed remedy. A 'must-read' for every woman and her daughters."

survival guides tend to be geared more towards women with the disease, although most survival guides do indicate that there is a need for all women to read the guides. Some guides, such as Elaine Ratner's *The Feisty Woman's Breast Cancer Book*, present the author's personal experience with the disease as a model for how to experience and ultimately survive the disease. Ratner exudes a positive attitude, confronts many stereotypes of femininity and body image, and intends the book to serve as an emotional and psychological guide for women with breast cancer. Also addressing the psychological effects and attacking the conception that losing a breast threatens a woman's femininity, Deborah Kahane's *No Less a Woman: Femininity, Sexuality and Breast Cancer* combines the author's personal experience with the stories of several other women. Kahane interviews ten very different women who tell their breast cancer stories and answer her questions about how breast cancer affected them and their identities as feminine women.

Some survival guides are less personal and thus seem to speak to a wider audience of women with as well as without breast cancer. Rather than originating out of the personal experiences of the authors, these guides often capitalize on celebrity endorsements but also include a wide range of narratives from women interviewed. When Rosie O'Donnell wrote *Bosom Buddies: Lessons and Laughter on Breast Health and Cancer* with her doctor, Deborah Axelrod, O'Donnell was a very popular celebrity among white heterosexual middle-class women, and she co-wrote and advertised *Bosom Buddies* in the midst of her popularity.¹⁸ The guide is designed to inform women about breast cancer while letting them know they can laugh; Axelrod and O'Donnell create an accessible and useful guide to breast cancer, organized in a question-answer format. Throughout, Axelrod and O'Donnell send the message that breast cancer is an issue for all women of all ages. Similar to the media popularity of *Bosom Buddies*, *Fighting for Our Future: How Young Women Find Strength, Hope, and Courage While Taking Control of Breast Cancer* by Beth Murphy is endorsed by twenty-something actress Melissa Joan Hart, introduced by *Today* host Ann Curry, and sponsored by Lifetime, "the network for women." *Fighting for Our Future* provides a survival guide for the young (meaning pre-menopausal—typically younger than forty years old) woman with cancer and her unique

¹⁸ Ironically, Rosie O'Donnell has radically changed her celebrity image recently; she has publicly announced that she is a lesbian, married her partner in San Francisco, and was embattled in a lawsuit with a magazine based on her previous image as the "Queen of Nice" as she was formerly dubbed as the famous talk show host. The "Queen of Nice" may have been the ideal celebrity for *Bosom Buddies* and its mainstream audience, but O'Donnell's new image certainly is not mainstream.

difficulties as a young woman with what is, as the author maintains, a disease culturally designated for older women.¹⁹ Murphy compiles many anecdotes from young women who have survived breast cancer that offer a more personal side to the other informative aspects of the book. In my analysis, I tend to pull from Murphy and O'Donnell and Axelrod much more so than Kahane and Ratner because Kahane and Ratner tend to be directed more at women experiencing the disease while Murphy and O'Donnell and Axelrod tend to be more directed to all women in order to educate them about the disease.

The magazine articles tend to be more personal, more consumer-oriented, and more targeted toward women without breast cancer than the health books and survival guides. Although the survival guides certainly indicate that they are for the general population, and the health books cover overall health as well as breast cancer, they are probably more likely to be read by women specifically looking for breast cancer information. Women who read the magazines may or not have breast cancer, and so the magazine articles typically address their audience with that perspective in mind. The magazines can be seen as a starting place for women who are not actively pursuing this type of information, perhaps planting the idea of body projects and daily self-monitoring through diet and exercise, while the survival guides and health books can be seen as more of a resource for the seriously-interested reader who is looking for such specific information.

In magazines, there is no better month to take a look at the rhetoric of the breast cancer movement than October, National Breast Cancer Awareness Month (NBCAM). To balance this look at October 2003 issues, I include issues of the same magazines from January 2004 as well. The eight magazines I look at reach a mainstream audience of American women and are popular enough to be well-known; thus the information about breast cancer that they circulate has the potential to reach a large population of women and to become the dominant idea that helps to construct breast cancer as a disease. *Self* magazine was a natural choice, as *Self* editor-in-chief Alexander Penney collaborated with Estée Lauder Senior Corporate Vice President Evelyn Lauder to create the pink ribbon and its subsequent campaign. To represent the mainstream audience of white middle- and upper-class heterosexual women, the original audience of the breast cancer movement, I include *Good Housekeeping*. With Lifetime Television's targeting of

¹⁹ This is a point which I strongly disagree with, given the vast media coverage of the disease that targets women of all ages, but especially pre-menopausal women.

this same group of women, *Lifetime* magazine is appropriate. Because I wish to closely examine the messages young women receive, *Self* again fits the criteria, as do *Glamour* and *Vogue*. To counter the traditional women's magazines, I include *Ms.* magazine in my study.

Finally, to include an examination of the ways in which the rhetoric of risk, originally aimed at women who fit the feminine ideal, is being replicated to non-white women, I include *Ebony* and *Essence*. *Ebony*'s publisher describes the magazine: "*Ebony* is a black-oriented, general, picture magazine dealing primarily with contemporary topics. Feature articles deal with education, history, politics, literature, art, business, personalities, civil rights, sports, entertainment, music and social events" ("Editorial Reviews—*Ebony*"). From this description, *Ebony* seems to be more politically minded than *Essence*. *Essence*'s publisher describes the magazine: "The editorial focus of this magazine is on today's career-minded, independent, sophisticated African American woman. The magazine is dedicated to helping its readers meet their maximum potential through articles stressing career and educational opportunities, investing and money management tips, fashion and beauty ideas and health and fitness trends. In addition, it features information on parenting, home decorating, cultural reviews and profiles of celebrities and achievers" ("Editorial Reviews—*Essence*"). Commenting on the way *Essence*'s articles typically target middle- to upper-class women, one reader notes, "Although *Essence* magazine is a decent magazine for women of color in general, the [sic] editors and staff tend to forget that there are women of color out here that are NOT best-selling authors, CEO's, or [sic] millionaires [sic] with their [sic] own television talk shows! I would like to see more articles about the extraordinary [sic] efforts of the everyday, blue [sic] collar woman of color!" ("All Customer Reviews—*Essence*"). Thus, while *Essence* reaches a non-white audience, it still caters to a mainstream audience of the middle- to upper-class, at least as indicated by this reader. These eight magazines together constitute a wide range of the information widely available and accessible to the mainstream population.

Because the breast cancer movement is present in functions as well as in texts, I attended two common types of fundraisers, a luncheon and a walk. As part of National Breast Cancer Awareness Month, cancer organizations across the nation sponsor events in support of the fight against breast cancer. To benefit breast cancer awareness programs of the American Cancer Society, Carilion Health System sponsored the Pink Ribbon Gathering to fundraise and to promote awareness of breast cancer. The Gathering offered a luncheon, a fashion show, Susan

Ford Bale's keynote address, and a diamond giveaway in exchange for a \$35 registration fee. For the first hour of the event, attendees registered, received their nametags, and mingled or walked around the various tables. For sale (\$10 for one chance, \$25 for three chances), attendees could choose to enter a raffle of their choice. Further along, there were two tables with breast health information managed by Carilion Health System. The first table had general information about breast cancer, and the second table promoted Carilion's "Every Woman's Life" campaign that targets lower income women or women without insurance who would qualify for free mammograms and pap tests. Lunch began and Lee Ann Necessary-Brownlee, a local television anchor, welcomed everyone, and the luxurious professional class fashion show began. Next, Susan Ford Bale addressed the conference with her message promoting early detection.

As I watched the attendees socialize, I could not help but look at the appearances of the attendees. I estimated that there were about five hundred people in attendance;²⁰ all afternoon, I only saw one man with a nametag to signify that he was a registered attendee of the conference (other men present were waiters, hotel employees, and reporters). I saw a handful of black women, a couple of Asian women, and one Indian woman. I saw two women with young children and one pregnant woman. Most women were middle-aged to elderly, and there were quite a few pairs of women who appeared to be mother and daughter. I felt quite out of place as no other women were recognizably in their early twenties, but quite a few women appeared to be in their late to early thirties. When Lee Ann Necessary-Brownlee asked survivors to raise their hands for us to applaud them, approximately one woman out of every ten at a table raised her hand; I was surprised that nine out of ten women thus appeared to be at the luncheon in support of the disease but not because they had it. The women were all well-dressed in professional attire and well-made up with hair neatly coiffed. Quite noticeably, although Bale's speech briefly referred to lower-class women and the Carilion table posters and brochures showed multicultural faces, there was really only one class and race of women in attendance at the conference.

The Making Strides Against Breast Cancer 5K Walk, of Wilmington, Delaware, was indeed a different experience than the fashion show and luncheon of the Pink Ribbon Gathering. For the past fourteen years, a woman's sports store sponsored the fundraiser as a run, but it was not very successful. This year for the first time, the store joined hands with the American Cancer

²⁰ There were fifty-one tables seating ten people each and just about every table was full.

Society and added a walk to the traditional run, resulting in an exponential growth in participation and consequent fundraising. Several times, announcers remarked that the walk was the biggest breast cancer fundraiser for the (small) state.

Congressman Mike Castle opened the ceremony with a few words of encouragement, and a former Olympic woman runner gave her cheer before joining the line-up. At 8:55 a.m., the runners lined up to start the event with a competitive women's race—no men were allowed to run. Walkers and runners alike were dressed for exercise in the chilly morning sunlight—no business suits and heels here, as were common for the Pink Ribbon Gathering. Many of the women, however, while not dressed professionally, could have been pulled from a Nike advertisement; most women looked well-dressed and well-groomed in their brand-name workout gear. Runners ranged from high school athletes decorated in team uniforms to middle-aged women—all looked healthy and relatively young, probably all younger than fifty or so. After the runners, the walkers lined up, and men were allowed to walk as well. The walk ran along the newly constructed Wilmington Riverfront—an area many Delaware business owners and corporations would like to see revitalized, hence the new shopping outlets and various eateries. No doubt, the walk served as an advertisement for the new Riverfront district for the more than 3,000 people present. The runners and walkers finished their race/walk at their own pace and were encouraged along the way by various volunteers. Water and fruit were available at the end of the race, and afterwards, all participants were free to resume their Sunday activities.

As became obvious from attending the events, reading the magazine articles and books, and seeing the magazine advertisements, what I have been calling the mainstream audience is really a white, middle- to upper-class heterosexual female audience. The existence alone of guides and magazines specifically targeting black women demonstrate how much the other texts target a white audience. And the *Essence* reader's comment illustrates that much of these texts still target a middle- to upper-class audience. These messages intended for the mainstream audience are based on a limited feminine ideal—that of white beauty. The mainstream audience is the dominant audience, and while being female may be considered a disadvantage in phallogentric ideology, being white, middle- to upper-class, and heterosexual allows women many other advantages. These are the women most likely able to adhere to the ideal of feminine beauty, and thus also stand to lose the most from an attack on their feminine beauty from breast cancer. It makes sense then, that the mainstream audience for the breast cancer movement is not

the social minority. And yet in order to reproduce femininity, the breast cancer movement needs to address all women, and so the latest trend has been to do so. I recognize the limited mainstream audience intended by the breast cancer movement, and so, at the end of this chapter, I address specifically how much of the current breast cancer literature is making the move to incorporate a broader female population using the same rhetoric of risk.

These texts—health books, survival guides, magazine articles, and functions—constitute the primary texts of my analysis of the breast cancer movement’s rhetoric of risk. In the next sections, I first look at the messages of risk related to the body that serve to encourage women to monitor their bodies and engage in body projects to prevent breast cancer. Next, I examine the same message of risk related to the environment that is much complicated by involved corporations who would like to shift discussion away from environmental issues and concentrate on the issue of family history and possible genetic causes of breast cancer. These first two messages of risk culminate in a general fear of the unknown, where all women are encouraged to fear their breasts because of their sex, and so all women become the target audience for breast cancer. Also, the lack of reliable factual information about the disease makes it hard for women to prevent the disease and only fires their fear. Finally, I find the same messages of risk in texts targeted directly to non-white women; in a move to incorporate more women into the breast cancer movement, the message of risk is simply replicated, still founded on its idea of white feminine beauty and fear, to non-white women.

Risks of the Body and Lifestyle: That Which Should Be Controlled

The most overwhelming message of the breast cancer movement is related to fear of the body. Diet, exercise, weight, age of menarche, age of menopause, contraceptive methods, abortions, use of alcohol and cigarettes, self-monitoring via the breast self-examination (BSE), and professional monitoring via the mammogram are the major points of emphasis here. The breast cancer movement has latched onto the idea of prevention via diet, exercise, and lifestyle choices as a means of educating women about breast cancer. Encouragement to monitor the body is the second half of prevention, where methods of early detection are often used to suggest prevention of the disease. These directives for body health and monitoring come to be the responsibilities of women, and women who do not follow these directives sometimes come to be

seen as personally responsible for the development of their breast cancer. The breast cancer movement has become another kind of body project in which women are expected to engage, much like shaving their legs, styling their hair, and maintaining their figures.

In *The Body Project: An Intimate History of American Girls*, Joan Jacobs Brumberg uses the anecdotal evidence of the diaries of adolescent girls, ranging from the nineteenth century to the late-twentieth century, to show the evolution of the body projects of American girls. Although twentieth-century girls seemingly have more freedom with and more knowledge of their bodies, Brumberg argues that they are in a less desirable and more vulnerable position than girls of the nineteenth century. Brumberg seeks to prove that body projects today are excessive and dangerous, and girls need to be protected from the consumer marketplace that encourages this attitude. The analysis Brumberg provides of the origins of these body projects is easily applied to the breast cancer movement. Body projects to prevent and detect breast cancer early are a chief aspect of the breast cancer survival guides and magazine articles and can place women in the vulnerable position of victim as well as caretaker.

The advantages of a well-balanced diet go far beyond preventing breast cancer to forming part of a healthy lifestyle that will prevent many diseases, but much of the breast cancer literature seems to fall upon diet as a means for women to prevent breast cancer specifically, without much proof. Posited as a reader question in the October 2003 issue of *Glamour*, “Is it true that the right diet and exercise routine can actually prevent cancer?”, the response is an emphatic “Absolutely” (qtd. in Berry and Levine 108). Dr. Mitchell Gaynor, President and Founder of Gaynor Integrative Oncology, explains,

Your first step is to eat foods such as garlic, green tea, soy, resveratrol (found in the skin of red grapes) and omega-3 fatty acids (found in cold-water fish like salmon) as much as possible—these foods may increase levels of cancer-fighting enzymes in your body. You should also eat at least five servings a day of green leafy and yellow veggies and citrus fruits, which contain disease-fighting antioxidants. And cut back on refined sugars (think soft drinks, sweets and some of your favorite junk foods), which cause your body to release insulinlike growth factors, substances that appear to increase cancer risk. Exercise is also associated with a lower risk of breast and colon cancer: 30 minutes a day of brisk walking

works. There's no guarantee these steps will keep you cancer-free, but I believe they offer significant protection. (qtd. in Berry and Levine 108)

In a similar move, O'Donnell and Axelrod first caution their readers that "[. . .] no one has directly shown a reduction in breast cancer risk as a result of changed diet" (92). Yet O'Donnell and Axelrod then continue to advise readers on how to reduce fat intake and increase fiber intake. On the same page that they say there is no proven relation between diet and breast cancer risk, they still recommend that women take these possibly unproven measures to change their diets, again falling back on the general consensus that a healthy diet is "good" anyway, so to recommend it as a preventative action for breast cancer cannot be misleading even if it is unproven.

Through these recommendations women are encouraged to monitor their diet as a body project that will help to prevent breast cancer. Jeanne Triplehorn tells *Self* readers in the October 2003 issue that she always makes eating broccoli and brussels sprouts a daily routine: "[. . .] when I go out for lunch or dinner, I always order a side of them," and she keeps them in the fridge "cut up and ready to eat" (qtd. in Rentmeester 230). Triplehorn, a slim, beautiful actress who looks a decade younger than her forty-one years, makes preventing breast cancer a daily body project, and she serves as an impossible ideal that encourages readers to monitor themselves through similar body projects. The overwhelming message here is not only that women who do not have breast cancer should be always working to prevent it, but also that even if the measures are unproven, they should still be incorporated into an overall body project of a healthy diet.

Weight seems to be a more proven risk factor for breast cancer, thus it too becomes a body project: the ACS estimates that "[. . .] overweight women are 60% more likely to die from breast cancer compared to normal weight women" (*Breast Cancer Facts and Figures 2003-2004* 10). Thus, the ACS concludes that there is

a small protective association between physical activity and breast cancer. The protective effects may be greater among lean women, women who have carried children to term, and premenopausal women. The underlying mechanism of this potential protection is not well understood, although it has been hypothesized that the benefit may be due to the effects of physical activity on hormones and energy balance. (*Breast Cancer Facts and Figures 2003-2004* 10)

Dr. Susan Love explains, exercise and weight seem to play a role in breast cancer because “your fat cells can make estrogen, so it is also possible that if you’re obese you have an oversupply of estrogen, which could increase your vulnerability to cancer” (239). What is not known about exercise, however, is how much and when it will affect breast cancer risk, according to Love. Yet she still advises exercise as a plan to an overall healthy lifestyle, of course: “Exercise in adult women is undoubtedly of value as well, in terms of a number of health concerns, although its effectiveness in terms of breast cancer is less clear” (294). Again, while I am not arguing with the health benefits of exercise for other concerns such as cardiovascular disease, despite its unproven relation to breast cancer, exercise has been adopted by the breast cancer movement as a preventative measure. And so like diet, exercise and weight become yet another mandatory body project for women if they are to be body- and health-conscious in preventing breast cancer specifically. Conveniently, these directives potentially result in the thin body that is the feminine ideal of beauty. Thus the directives *already* fit into expectations of women and their feminine body projects.

Diet and exercise, at least, seem to be manageable body projects in which women may have some choice, although the extent of the manageability and choice is often exaggerated in order to put the responsibility on the individual. Women of course cannot change their age of menarche or menopause, but other estrogen-related factors such as age at first full-term pregnancy, contraception choices, and abortion choices also come to be part of a woman’s responsibility to prevent breast cancer. These aspects of a woman’s reproductive life—represented as lifestyle issues although reproductive situations are not always chosen—are often indicated as risks for breast cancer, and thus women’s choice in their reproductive lifestyles becomes limited as far as the breast cancer movement is concerned. To explain the relation, estrogen seems to play a part in stimulating tumors in *some* cases of breast cancer, thus reproductive activities are lumped into preventative guidelines because a woman’s estrogen levels change if she becomes pregnant. Murphy explains, “Estrogen is known to feed some tumors, and some researches believe that it generally promotes breast cancer, making the disease more likely to spread throughout the body” (12). Although not all breast cancers are fed by estrogen, reproductive lifestyle becomes a part of the overall risk factors.

As Love explains, estrogen and reproductive factors may play a role in breast cancer because a woman’s breast tissue is not fully developed until she has carried a baby full-term, and

then “The hormones of a pregnancy carried to term will mature the breast tissue in a young woman. The same hormones after 30 *may* [italics added] actually stimulate breast tissue that has already been mutated” (234). Again, note the “may”; nothing here is proven, only speculated. Thus, women who carry a baby full-term before they are thirty *may* reduce their breast cancer risk, while women who carry their first baby full-term after they are thirty *may* increase their breast cancer risk. Love concludes her chapter on internal risk factors like estrogen with the conclusion, “As you see, we’re still very much in the theorizing stage: as yet, we don’t know why there is this vulnerable time in a woman’s life and why or how internal hormones affect breast cancer. Theories are interesting, but more useful to scientists than to individual women, who can’t control heredity, ethnicity, or menarche” (236). Love admits the unknowns, (she admits women cannot control these risks although she does not include childbirth in these choices women cannot control), and yet these “interesting” theories become guidelines for how women should live their lives.

O’Donnell and Axelrod present one way for women to modify their estrogen levels: “[. . .] women who exercise vigorously early in life—say, in school sports—tend to menstruate later than those who are more sedentary. Or, for another example, if you have a number of full-term pregnancies and breastfeed afterward, you will reduce the number of menstrual cycles you experience throughout your lifetime, thereby reducing your risk” (79). The first example indicates that prepubescent girls should be aware of breast cancer, educated by their watchful mothers, and thus exercise before menstruation in an attempt to delay menarche and later to reduce menstrual cycles. The second example, more disturbingly, while not advising women to have more children, still lists it as a way “to modify some estrogen-related factors” (79) and also suggests breastfeeding as a way to avoid breast cancer. Reproduction choices then become another way for a woman to monitor her breasts and prevent breast cancer, and yet, again conveniently place women into the feminine ideal of mother.

Reproduction in this age is usually perceived as a choice for the mainstream population; contraception is widely available, especially for the kinds of women who are most targeted by the breast cancer literature. While the breast cancer movement literature may not directly instruct women to have children before age thirty, the message that children before thirty reduces breast cancer risk is still out there; thus it functions more like a subconscious guideline for women to keep in mind. Murphy quotes Dr. Beverly Rockhill, an assistant professor of

epidemiology at the University of North Carolina, on reproduction: “Breast cancer rates are very low in societies where women have their first child very soon after puberty [. . .]. Obviously, in America, this is not a solution” (92). Murphy explains Rockhill’s statement, stating, “While her [Rockhill’s] goal is not to advocate a particular medical or social policy, this example illuminates the difficulty of understanding the relationship between estrogen and breast cancer in young women” (92). These observations of the protection a woman gains through pregnancy are common occurrences throughout the breast cancer literature, and even without being structured as directives for action, they undoubtedly become so.

Exposure to estrogen via contraception or hormone replacement therapy (HRT) may also affect a woman’s breast cancer risk. Although controversial and subject to further research, the American Cancer Society reports that “Recent use of oral contraceptives may slightly increase the risk of breast cancer; however, women who stopped using oral contraceptives 10 years or more in the past have the same risk as women who have never used the pill” (*Breast Cancer Facts and Figures 2003-2004* 9). Planned Parenthood offers the only definitive statement denying a correlation: “**Most experts agree that taking the Pill does not increase the overall risk of developing breast cancer**—no matter how long a woman takes the Pill or even if she has a close relative with breast cancer” (“You and the Pill”; bold in original). Stoppard reassures her readers that “Only those pills that contain estrogen remain at all controversial. The progesterone-only pill, or ‘mini-pill,’ carries no risk at all of breast cancer” (145). O’Donnell and Axelrod attempt to put the risk into perspective, stating that “According to a study by the U.S. Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologists, oral contraceptives add about 11 [breast] cancers per 100,000 women per year” (85). *Our Bodies, Ourselves* states,

Researches disagree about the relationship between the Pill and breast cancer. Most studies show that women who take the Pill are not more likely to develop breast cancer than women who do not. However, several recent studies indicate that women who start using the Pill before the age of 25 and use it for more than four years are at an increased risk of developing breast cancer before the age of 35. (314)

And yet using the pill for more than four years or before the age of twenty-five is not unusual at all, in fact, it is quite common.²¹ I certainly am not an authority on biology or medicine but as a young woman receiving, like many other young women who also lack the authority or medical education to truly understand these messages, the message I hear is that I am probably at risk for using oral contraception. One of the most popular methods of birth control in the United States, to question the role oral contraception plays in increasing breast cancer has the potential to scare a large population of women and their confidence in their birth control method.²² Or, if there is indeed an increased risk between oral contraception and breast cancer, the conflicting evidence at least means that there is a disconnect between the doctors who prescribe the pill and the information about the risk.

Likewise, the recent controversy over HRT and the discovery that it may increase breast cancer risk has scared many women previously taking the drugs for menopausal symptoms. The American Cancer Society concludes,

Among 10,000 women who use HRT for 5.2 years, the estimated number of breast cancers expected to be diagnosed is 38. Among 10,000 women of the same ages who never used HRT, 30 cases would be expected over the same period. Therefore, the 26% increased risk results in a total of 8 additional cases per 10,000 women to be diagnosed over a period of 5.2 years. (*Breast Cancer Facts and Figures 2003-2004* 10)

For many women, this new finding has caused them or their doctors to discontinue HRT use, although most sources still recommend that women make this choice on an individual basis with their doctors. Again however, the statistics that are “interesting” to doctors and scientists do not really provide individual women with answers, only more questions, more fears, and more reasons to monitor their bodies.

²¹ The Alan Guttmacher Institute (AGI), a “not-for-profit Corporation for Reproduction Research,” reports in its “Facts in Brief: Contraceptive Use”: “Of the 2.7 million teenage women who use contraceptives, 44%—more than 1 million women—rely on the pill.” Also, “The pill is the method most widely used by women in their 20s.” Furthermore, in a AGI Special Report, Jill L. Schwartz and Henry L. Gabelnick state, “To achieve the family size she desires, a fertile woman today must practice birth control throughout most of her potential reproductive years—as many as 30 of the roughly 36 years between menarche and menopause. The amount of time a woman needs contraception has increased dramatically as women have become sexually active at earlier ages and increasingly have entered the workforce, delayed childbearing and planned smaller families.”

²² The AGI reports in its “Facts in Brief: Contraceptive Use”: “Female sterilization, the pill and the condom are the most widely used methods in the three major racial and ethnic groups. However, black women and Hispanic women are most likely to rely on female sterilization, while white women are most likely to use the pill.”

Abortion—the ever-present controversy over women’s reproductive rights—has not escaped at least nominal mention in breast cancer literature. *Our Bodies, Ourselves* presents the argument that adding abortion as a possible breast cancer risk factor is used as propaganda for pro-life organizations:

The antiabortion movement continues to mount new campaigns on many fronts. Most recently, it has aggressively put out the idea that abortion increases the risk of breast cancer. In January 1997, the results of a Danish study, the largest to date (involving one and a half million women), showed that there is no connection. Unlike previous studies, this one did not rely on interviews and women's reports but instead used data obtained from population registries about both abortion and breast cancer. Despite the lack of medical evidence and the fact that the scientific community does not recognize any link, the antiabortion movement continues to stir up fears about abortion and breast cancer. (412)

The American Cancer Society, citing an even more recent study, continues to support the view of *Our Bodies, Ourselves* (8). The reasoning behind abortion as an increased risk factor rests upon the misconception that abortion (or miscarriage for that matter) stops the production of the hormones mid-cycle and thus alters the body’s state. However, while it is not true that an abortion or miscarriage raises risk, nor do they reduce risk; a pregnancy must be carried to full-term before the age of thirty for the supposedly beneficial hormonal changes to take place. I did not find information supporting abortion as a risk in my primary texts; I only found the argument refuted, although the presence of this stance suggests the existence of the opposing argument. In this context of conflicting information, many women cannot know what to think or who to believe. And whether women contemplating an abortion would even consider breast cancer as a risk is debatable; it is probably only after an abortion, when faced with this conflicting information, that a woman might worry about her increased risk.

Lifestyle choices such as use of alcohol or cigarettes are typically the final kind of body risk factor listed for breast cancer. Murphy reports (and the ACS confirms), “Women who have two or more alcoholic drinks a day are more than twice as likely to get breast cancer as nondrinkers. That’s probably because alcohol seems to increase the levels of estrogen in the blood, perhaps because of alcohol’s toxic effects on the liver, which interfere with that organ’s ability to cleanse the blood of excess estrogen” (106). The use of alcohol, while socially

acceptable in moderation, is generally accepted as a risk factor, so discouraged only in what would be considered excessive use. Women are thus advised to monitor their alcohol intake as another way of monitoring their bodies.

Smoking, however, is more controversial. Widely known to cause lung cancer, smoking may ironically slightly reduce breast cancer risk, though this theory is noticeably absent from the ACS's *Breast Cancer Facts and Figures 2003-2004*. Because smoking is already losing its social acceptance, and the slightly reduced risk of breast cancer cannot outweigh the much increased risk of lung cancer, this message is not found often in the breast cancer literature. Stoppard, however, explains:

Rates of breast cancer are lower in smokers than in nonsmokers, though this can never be advocated as a reason for smoking—the risk of dying from a smoking-related disease far outweighs that of dying from breast cancer. It is thought that smoking exerts an anti-estrogenic effect, accelerating the onset of menopause; smokers typically reach menopause three to four years earlier than nonsmokers. Smokers tend to be thinner than nonsmokers; we know that estrogens are manufactured in the fatty tissues and that obesity is a risk factor for breast cancer. (149)

Murphy takes a less direct route: “[. . .] scientists cannot even say conclusively that smoking is bad for breast cancer” (103). Rather than emphasize the possible reduction in risk for smokers, though unproven, as she and most other authors and organizations do for diet, exercise, and reproductive factors, Murphy words the sentences to embed the fact that there may be a reduced risk. Reducing breast cancer risk cannot become more important or sacrifice overall health, but when overall health may play a factor in reducing breast cancer risk, as in diet and exercise, the directives are certainly given and emphasized.

These messages of diet, exercise, reproductive choices, and lifestyle choices all assign women with the responsibility of watching their bodies, of taking care of what goes into their bodies, and of making choices about when to do what with their bodies. Monitoring and controlling dominate the rhetoric of risk, providing the need for body projects. Furthermore, the messages throughout—be slim, have babies, control your body—are represented as means of preventing breast cancer, and yet they are really means of maintaining and producing femininity. The advertised risk factors become ways for women to combat the possibility of breast cancer,

and that possibility applies to all women simply because of their sex. In addition to these previously discussed messages, breast self-exams and mammograms—methods of detection—become part of the body projects in which women are expected to engage in order to be responsible subjects who are adequately taking care of their bodies. The previously discussed risk factors are supposed to be methods of prevention; whether they are freely chosen is up for debate. Detection, however, insidiously becomes grouped into these messages. The woman who does not monitor her body becomes a risk factor for breast cancer. In this way, early detection comes to stand in for prevention.

At the Pink Ribbon Gathering, awareness seems to mean awareness of the possibility of early detection through mammograms and breast self exams. Welcome speaker Lee Ann Necessary-Brownlee, a Roanoke, Virginia news anchor, asserts “Breast cancer *is* curable with early detection”—note her emphasis on early detection (as a woman’s responsibility) rather than prevention (as the world’s and corporations’ responsibility). Necessary means that breast cancers that are detected early are often smaller and easier to treat. However, there is no cure for breast cancer, and it may recur several decades later regardless of original size; the familiar five-year survival rate does not really mean a woman is cured when it comes to breast cancer. And yet, awareness of the disease as a potential threat to all women based on their sex becomes a method of prevention, although how my being aware of breast cancer is going to actually prevent that disease from developing in my breasts, I don’t know, and early detection will not necessarily be a *cure*. Even if I monitor my diet, exercise, have a baby by thirty, and breastfeed—all part of being *aware*—I cannot *prevent* the breast cancer cells from growing. No matter how afraid I am of the disease, no matter how many other women I know with the disease, no matter how much I recognize the disease as a potential threat, no matter how many body projects I conduct, I cannot really *prevent* breast cancer.

Early detection through breast self-examinations is no longer even recommended by the American Cancer Society. The ACS states,

In 2002, the American Cancer Society dropped its recommendation that all women perform breast self-examination (BSE) monthly. The Society still recommends, however, that women be told of the benefits and limitations of BSE, and those women who wish to do it should receive instruction from their health care providers. These guidelines are for women who have no symptoms or breast

cancer and who have not been identified to be significantly higher risk for the disease. (*Breast Cancer Facts and Figures 2003-2004* 11)

This brand-new recommendation is making its way into mainstream media: in its October 2003 issue, *Good Housekeeping* notified its readers of the ACS's change in guidelines but noted,

The ACS still believes that a monthly breast self-exam is a good way for a woman to become familiar with her breasts so she can recognize abnormalities. But most women find a lump when they're not looking—in other words, while they're showering or getting dressed. Bottom line: It's a smart idea to do a regular breast check, but don't feel guilty if you skip it. (Moss 112)

This is doubletalk: readers receive the message that they do not need to feel responsible, and yet the “smart” and aware woman who cares about her breasts will still examine her breasts.

The message that it is no longer mandated though still a good idea to conduct breast self-exams runs across the most recent breast cancer literature (since 2003). Whether BSEs are an official guideline or not, they have been a part of the awareness message from the start and are unlikely to fade away now that the ACS has dropped its recommendation. When I went for my annual gynecological exam this past December—note, *after* the guideline was changed—my doctor recommended the BSE, showed me how to do it, explained its importance, and never once mentioned the ACS's change. Either she feels the BSE is still important and is not going to spread the message that I do not need to do them, or sometimes doctors are not informed of recent changes, which may indicate her recommendation. Ultimately, the BSE is another body project, and the woman who does not do it, while seemingly less to blame than before, can still be susceptible to blame for failing to detect a lump.

Mammograms have a history of controversy because of the exposure to radiation but are recommended by the ACS for all women over forty years of age:

Although there has been some debate about the benefit of mammographic screening in reducing breast cancer mortality, numerous randomized trials as well as population-based screening evaluations have clearly shown that early detection of breast cancer through mammography greatly improves treatment options, the chances for successful treatment, and survival. Mammography is the single most effective method of early detection, since it can identify cancer several years

before physical symptoms develop. Treatment is more successful when cancer is discovered early. (*Breast Cancer Facts and Figures 2003-2004* 12)

Simple enough right? All a woman has to do with this recommendation is go to her radiologist once a year and endure having her breasts squeezed by two plates and the anxiety over the result. And yet, women cannot remain passive with their mammograms, at least not according to the breast cancer literature, because radiologists and doctors make mistakes. Women must be vocal advocates for their health and actively research their mammography center and radiologist.

The title and subtitle of an October 2003 *Good Housekeeping* article warns readers, “Get a mammogram you can trust: It’s the best tool we have for finding breast cancer. But it’s only as reliable as the doctor who reads it. How to get it done right...and (maybe) save your life” (Moss 106). This kind of article is quite common in the October magazine issues. Stoppard, Love, O’Donnell and Axelrod, Ratner, and Murphy all advocate BSEs and mammography. Not only must women be aware of the need for mammograms, but they also need to be aware (read: afraid) that their doctor may not interpret the image correctly. The aware woman will (maybe) save her life, as the title says, with the emphasis on saving her life and the “maybe” de-emphasized with the parentheses.

In addition to these articles informing women how to make sure that their mammogram is reliable, the most common kinds of breast cancer narratives I have read are about the women who felt a lump, asked for a mammogram, but were refused. These stories triumph the woman’s attention to detail and persistence in the face of the doctor’s unwillingness; she wins and receives a mammogram, and the lump is consequently determined to be malignant. Her awareness (read: fear) saves her life. Murphy provides countless narratives like these, as do the magazines. These stories, when understood with narrative theory, become understood to be the “truth” and function as master narratives about breast cancer. The message here, the “truth,” is first to be observant of the body and to be determined to receive care even when the doctor thinks otherwise, but the second, more disturbing message here is to observe the body in fear of breast cancer. With an understanding of narrative theory, these stories signify a kind of truth that when women monitor their breasts because they fear the potential for disease, then they will be saved.

For example, Murphy presents the case of Roberta Levy-Schwartz, diagnosed with breast cancer at twenty-seven, in her own words:

And I was uncomfortable with his recommendation that I come back in 6 months, so I went to an ob-gyn 2 months later. He said the pap smear was fine, everything else was fine, but did I know I had a lump in my breasts? [. . .]. I finally found somebody, and he said it was nothing, just a fibroadenoma, which is quite normal for young women and nothing to worry about [. . .]. But I happened to bring my mother to that appointment and she was sitting in the corner with a white face saying, 'Take it out, take it out [. . .].' Now it's 4 years past my diagnosis. I'm married to Lee; I've gotten pregnant and become a mother. (9)

Levy-Schwartz was diligent enough to switch doctors, and her mother was afraid enough to recommend taking out even a benign lump. Levy-Schwartz was diagnosed with breast cancer and subsequently treated, and she ends her story with the conclusion of a marriage and a baby; her ending implies that she has been rewarded for her body monitoring by being reinscribed into the appropriate feminine role as wife and mother. This is Levy-Schwartz's personal story, but it is also a master narrative of the woman who *deserves* to survive breast cancer and her reward for monitoring and fearing her body.

Stories of death, rather than life, marriage, and birth, also reinforce the message of mandatory self-monitoring and individual responsibility. Last October, I received the following forwarded email as a message of awareness for the need of early detection:

PLEASE KEEP THIS ONE GOING:

I am respecting the request to keep this going since I believe firmly in the message myself. So I am sending it on to you with my best wishes. Here goes: A handsome, middle-aged man walked quietly into the cafe and sat down. Before he ordered, he couldn't help but notice a group of younger men at the table next to him. It was obvious they were making fun of something about him, and it wasn't until he remembered he was wearing a small pink ribbon on the lapel of his suit that he became aware of what the joke was all about. The man brushed off the reaction as ignorance, but the smirks began to get to him. He looked one of the rude men square in the eye, placed his hand beneath the ribbon and asked, quizzically, "This?" With that the men all began to laugh out loud. The man he addressed said, as he fought back laughter, "Hey, sorry man, but we were just commenting on how pretty your pink ribbon looks against your blue jacket!" The

middle aged man calmly motioned for the joker to come over to his table, and invited him to sit down. As uncomfortable as he was, the guy obliged, not really sure why. In a soft voice, the middle aged man said, “I wear this ribbon to bring awareness about breast cancer. I wear it in my mother's honor.”

“Oh, sorry dude. She died of breast cancer?”

“No, she didn't. She's alive and well. But her breasts nourished me as an infant, and were a soft resting place for my head when I was scared or lonely as a little boy. I'm very grateful for my mother's breasts, and her health.”

“Umm,” the stranger replied, “yeah.”

“And I wear this ribbon to honor my wife,” the middle aged man went on.

“And she's okay, too?”, the other guy asked.

“Oh, yes. She's fine. Her breasts have been a great source of loving pleasure for both of us, and with them she nurtured and nourished our beautiful daughter 23 years ago. I am grateful for my wife's breasts, and for her health.”

“Uh huh. And I guess you wear it to honor your daughter also?”

“No. It's too late to honor my daughter by wearing it now. My daughter died of breast cancer one month ago. She thought she was too young to have breast cancer, so when she accidentally noticed a small lump, she ignored it. She thought that since it wasn't painful, it must not be anything to worry about.”

Shaken and ashamed, the now sober stranger said, “Oh, man, I'm so sorry mister.”

“So, in my daughter's memory, too, I proudly wear this little ribbon, which allows me the opportunity to enlighten others. Now, go home and talk to your wife and your daughters, your mother and your friends.” “And here,” the middle-aged man reached in his pocket and handed the other man a little pink ribbon. The guy looked at it, slowly raised his head and asked, “Can ya help me put it on?”

October 2003 is breast cancer awareness month. Do regular breast self-exams and have annual mammogram if you are a woman over the age of 40. And encourage those women you love to do the same. (Thompson)

This intentionally shocking story exhibits several aspects of the breast cancer movement that I have already discussed. First, the man appreciates his mother's breasts because she breastfed him—the maternal aspect of femininity. Second, he appreciates his wife's breasts because they

are a part of their sexual relationship and because she breastfed their daughter—the sexual and maternal aspect of femininity together. But more disturbing for me is the death of the twenty-three year-old daughter. Young women do die of breast cancer, as do women of any age, but it is the story of a young woman emphasized here, first her death, and second her negligence to monitor her body. The inherent message here is that her death is her responsibility because she ignored the lump. The message I am expected to learn from this email forward is that I need to monitor my breasts now, as a twenty-four year old, because this young woman died, and so might I, if I am not appropriately fearful of my body.

Stories like this email and Levy-Schwartz are representative of the stories that become truths in breast cancer literature. Fear of the disease serves to motivate women to monitor their bodies and to demand action when doctors refuse. Fear of the disease progressing unstopped and undetected should motivate women to action, but fear of actual diagnosis should not. Both Stoppard and Ratner specifically address the fear of detecting a possibly cancerous lump, each countering the usual arguments. In summary, Ratner decrees, “To me, a missing breast says, ‘Here is a woman who is lucky,’ because she detected her breast cancer early enough to treat it. It says, ‘Here is a woman who is sensible and decisive,’ because she death with her problem quickly and effectively” (208). Likewise, Stoppard comforts readers, “By getting screened you are not inviting disaster; you are giving yourself the best chance of health” (67), and “Early detection automatically means earlier treatment and so increases the chances of a full recovery if a lump is found that turns out to be breast cancer” (64). The overall message is that fear, embarrassment, or discomfort that may accompany early detection methods are inappropriate because the benefit of detecting cancer early (by being afraid) far outweighs these other feelings.

All of these guidelines for risk factors—diet, exercise, reproductive choices, and use of hormones, alcohol, and cigarettes—become mandatory methods of prevention, or body projects, for aware women to conduct. The woman who does not conduct these body projects and monitor her body with BSEs and mammograms is negligent thus responsible for her breast cancer. In spite of the fact that these projects and detection methods do not prevent cancer, she is still responsible for her cancer because if she had been a responsible subject, she would have at least found her cancer sooner. It seems that because of the unique physical presence of the breast as well as its importance in marking femininity, the woman is expected to monitor not only her breast but her entire body and lifestyle choices. No other body part may be palpated monthly, no

other body part offers itself for examination, where lumps may be easily detected, quite like the breast. If a woman develops ovarian cancer, she could not have detected it earlier through monthly ovary self-exams, and so she is not as responsible. But given the physical presence of the breast, in spite of the many unknowns or definites, women are still plagued with messages to be aware of breast cancer, which really means to be afraid of breast cancer, and to thus be vigilant. Body projects conducted out of fear of the disease drive the breast cancer movement, medicalizing the woman's body and maintaining—admittedly through her complicity—her continued subjectivity in the ideology of femininity.

Risks of the Environment and Genetics:

That Which Cannot be Controlled But Must Still be Feared

Secondary to fear of the body is the message that when we cannot look to the body for methods of prevention or for causes of cancer, we can always look to environmental contamination as a source. The extent to which any text addresses environmental pollution as a possible cause of breast cancer varies greatly. Breast Cancer Action, a San Francisco-based organization, strongly emphasizes the ways in which corporations readily join the breast cancer movement without closely analyzing their contribution to environmental pollution or its possible relation to breast cancer. At the opposite end of the spectrum, other texts simply do not address environmental issues at all. And of course, many other texts remain in the middle ground of the unknown, stating that the environment may be a factor, but that there is no factual evidence to support or deny the relation.

The American Cancer Society actually comes down quite strongly against the possible role of the environment in cancer. In the *Breast Cancer Facts and Figures 2003-2004*, the ACS states, “Despite concern that rising breast cancer incidence in the latter half of the 20th century may have been caused by environmental pollutants, such as the rise of organochlorine pesticides, numerous studies have found no relationship between exposure to common organochlorines and breast cancer in the general population” (8-9). To explain the rapid increase, the ACS explains,

Much of the long-term underlying increase in incidence is attributed to changes in reproductive patterns, such as delayed childbearing and having fewer children.

The more rapid increase between 1980 and 1987 is due largely to greater use of mammography screening and increased detection of breast cancers too small to be

felt, with diagnoses of smaller, more easily treatable cancers. (*Breast Cancer Facts and Figures 2003-2004* 3)²³

Clearly, the ACS has removed environmental contamination from its list of possible causes, and yet while their explanation for the recent increase in detected cancers certainly makes sense, many other authors still raise the possibility of environmental contamination.

Dr. Susan Love also addresses the issue of environmental pollution; she begins, “There are number of other things we now believe may contribute to your vulnerability to breast cancer. Among them are DDT and PCBs, persistent environmental contaminants that have been identified throughout the global ecosystem, including in fish, wildlife, and human tissue, blood, and milk” (254). Love cites a well-known study conducted by Dr. Mary Wolff: “Wolff and her group looked at the levels of DDE (a breakdown product of DDT) in the breast fat of women with breast cancer, comparing them to the fat of women without breast cancer. The levels were significantly higher in women with breast cancer. This doesn’t mean that DDE is the cause of breast cancer, but it certainly suggests a possibility” (255). Love, however, also notes that Wolff’s study is often criticized because it failed to measure DDT levels in women before diagnosis, and when a subsequent study by N.K. Krieger and others did so, there seemed to be no relationship (255). *Our Bodies, Ourselves* also presents Wolff’s study, *without* however, the added note that further studies do not find similar relationships (139). Clearly, women cannot even rely on the studies conducted for reliable information, not when different sources give different reviews of the findings. After presenting environmental pollutants as a possible cause, or at least a factor increasing a woman’s vulnerability, Love concludes, “There still might be an environmental relationship, but it is probably small. Nonetheless, this lack of definitive answers is no excuse for not cleaning up the environment. There are enough known health problems from environmental pollution to convince us that it needs to be seriously curtailed” (256). Thus Love examines the possibility of environmental contamination, presents several inconclusive or conflicting studies, and finally concludes that there are no reliable facts to date. But, in an

²³ The ACS reports, “Between 1973 and 1980, incidence was essentially constant; Between 1980 and 1987, incidence increased by almost 4% per year; Between 1987 and 2000, incidence rates increased by 0.4% per year” (*Breast Cancer Facts and Figures 2003-2004* 3). Furthermore, in reference to the size of the tumors detected, “During this short period [of 1980-1987], incidence rates of smaller tumors (≤ 2.0 cm) more than doubled, while rates of larger tumors (3.0 cm or more) decreased 27%. For the most recent period [1987-2000], the trend in diagnosis of smaller tumors (≤ 2.0 cm) continued, increasing by 1.9% per year since 1988” (*Breast Cancer Facts and Figures 2003-2004* 4).

argument strikingly similar to the messages about diet and exercise, she advises environmental awareness because it will benefit other health concerns, if not specifically breast cancer.

Most breast cancer movement texts mimic this attitude, stating that there are many possible factors, acting alone or in cooperation. *Glamour's* October 2003 issue tells its readers, "Experts aren't sure why, but around the globe, breast cancer rates are suddenly soaring. Possible theories range from westernization (fatter diets, less exercise) to industrialization (more chemicals and pollutants in the air). The net result: One million women are diagnosed each year with breast cancer, and 372,000 die of the disease annually [worldwide]" (Guttman 190). Regardless of the ACS's statement on environmental factors, the message that circulates amongst the breast cancer movement typically includes environmental contaminants as possible factors, and women receive these messages continually.

The language used to address the issue of environmental contamination is misleading. Whether environmental pollutants may directly cause breast cancer or simply lead to vulnerability to breast cancer is unclear as a fact and also unclear in the language across texts. *Our Bodies, Ourselves* and all Breast Cancer Action literature definitely say that there are environmental concerns. The ACS argues pollutants do not *cause* cancer, but I still must ask, do they create a vulnerability to cancer? Love somewhat addresses this issue as her language is a bit clearer, but her wavering conclusion leaves the reader in doubt. Murphy does address this issue somewhat as well; she presents Dr. Bert Petersen, a breast surgeon, who explains the idea that mutated genes may play a role in cancer. Petersen states, "One of the things we notice is that with each new generation, the onset of the cancer is earlier and earlier" (77). Murphy continues, summarizing Petersen's argument that suggests "that perhaps environmental factors are causing genes to mutate earlier, or causing already mutated genes to 'misbehave' earlier" (77). In this testimony, Murphy allows for an understanding of how environmental contamination could certainly play a role in breast cancer when coordinated with genes that are mutated or have the susceptibility to do so.

In a similar manner, O'Donnell and Axelrod comment, with a bit more emphasis on the environment, that "[. . .] the data does seem to underscore the fact that a genetic predisposition probably plays a smaller role than environment in promoting such changes in risk—or at least that environmental changes play a major part in promoting risky hormonal effects and triggering cancer genes" (15). Here, O'Donnell and Axelrod note the likely possibility that it is neither

entirely genes nor environmental pollution that causes breast cancer, but rather a combination of the two. Furthering indicting the environment, in response to the posed question, “Are There Areas in the Country With a High Incidence of Breast Cancer Due to Pesticides and Other Toxins?”, O’Donnell and Axelrod reply with an emphatic yes. They write, “For example, parts of Long Island, New York; Cape Cod, Massachusetts; the Great Lakes region; and San Francisco and Los Angeles, California, are among a number of areas noted for higher than usual numbers of breast cancer cases. The reasons are unclear” (101-102). The authors explain,

In the case of Long Island, for example, it used to be common practice to spray pesticides all over farms and even suburban neighborhoods to help produce grow and lawns thrive. Agricultural uses stopped in the early 1970s, but by then hundreds of thousands of gallons of carcinogenic pesticides like DDT and other compounds had seeped into the shallow groundwater, and in turn got to women’s bodies, promoting the risk of breast cancer. The theory goes as follows: DDT is what’s known as a ‘xenoestrogen,’ a foreign estrogen compound that can raise levels of harmful estrogens in the human body [. . .]. When we are exposed to potentially *harmful* xenoestrogenic chemicals, our bodies convert the product into by-products or metabolites which can pump up total estrogen levels in the body. (102)

By citing these examples and explaining the possible role of xenoestrogens, O’Donnell and Axelrod link breast cancer to the environment, even though they are not working from any more facts or different studies than Love and the ACS. Yet O’Donnell and Axelrod present environmental contamination as a more likely partner in the development of cancer than do other authors.

When authors or organizations do not want to emphasize the environment, genes typically are their focus. Scientists have discovered that “The genes known as BRCA1 and BRCA2 are responsible for repairing damaged DNA. Scientists believe that either or both of these genes are defective, DNA damage will occur in the breast or ovarian cells, increasing the likelihood that cancer will develop” (Murphy 73). Women who have a family history of breast cancer may now be tested for the BRCA1 and BRCA2 genes, and yet presence of these genes is not an automatic sentence of cancer. The ACS states that “Approximately 5% to 10% of breast cancer cases result from inherited gene mutations, or alterations, in breast cancer susceptibility

genes, such as BRCA1 and BRCA2. These mutations are present in far less than 1% of the general population” (*Breast Cancer Facts and Figures 2003-2004* 9). Stoppard, somewhat ominously, states, “A family history of breast cancer is far and away the risk that should concern you the most” (10). Family history is probably the most well-known risk factor for breast cancer, at least amongst the mainstream population.

Family history, however, is not always directly tied to genes. Love educates her readers, stating that 70% of women who develop breast cancer “have no known family history of the disease” (224). Love then divides breast cancer occurrences into three groups: 1) without family history; 2) with family history and pure genetic hereditary breast cancer; and 3) with family history but without pure genetic hereditary breast cancer (224). Women with pure genetic hereditary breast cancer fall into that 5% to 10% ACS statistic, who are, remember less than 1% of the general population; genetic testing would only benefit these women. Women without family history may have other risk factors, or not, since even risk factors are not guarantees. Trickiest of all is the third group: these women may have some inherited genes that make them more likely to menstruate earlier or more susceptible to estrogen, for example (Love 225). Furthermore, both Love and ACS state that while these women may seem to have a genetic linkage to breast cancer, “[. . .] most of the occurrence of breast cancer in families is the result of the interactions between similar lifestyles among family members and low-risk variations in genetic susceptibility that may be shared by the women in the family” (*Breast Cancer Facts and Figures 2003-2004* 9). Here, as O’Donnell and Axelrod more directly stated, environmental pollution may be a factor, but so may genes, diet, exercise, and so on. With a more aggressive approach, *Our Bodies, Ourselves* also states, “[. . .] even though genes may play a role in causing cancer, the environment is a far more significant factor” (614). Thus family history, as Stoppard misleadingly presented, is *not* the easiest indicator to characterize for breast cancer vulnerability.

And yet women, relying on family history as a kind of indicator for breast cancer possibility, include this factor into their overall lifestyle and response to the disease. As I discuss later, Zillah Eisenstein does so. Furthermore, in an aggressive preventive measure, some women are choosing to have one or both of their breasts removed in a prophylactic mastectomy as a means of preventing breast cancer. The ACS states that prophylactic mastectomy may result in “a greater than 90% reduction in risk of breast cancer in high-risk women with family history [. . .]” (*Breast Cancer Facts and Figures 2003-2004* 11). The ACS warns, however, that “While

the operation reduces the risk of breast cancer, it does not guarantee that cancer won't develop in the small amount of breast tissue remaining after the operation" (*Breast Cancer Facts and Figures 2003-2004* 11). Stopping short of recommending the prophylactic mastectomy, the ACS cautions women that "A woman considering this operation should discuss these considerations carefully with her doctor. A second opinion is strongly recommended" (*Breast Cancer Facts and Figures 2003-2004* 11). The ACS seems to remain ambivalent about prophylactic mastectomy. Though it may greatly reduce a woman's risk of breast cancer, cancer could still develop. Plus, what is not said, though certainly present, is the fact that a woman is removing her breasts, thus removing her marker of femininity. Of course, with all the options of reconstruction available, she may create the semblance of these breasts, create perhaps more culturally appealing breasts, and simultaneously reduce her chance for breast cancer.

As Yalom discusses in *A History of the Breast*, the breast, once a site of femininity, is now becoming a site for disease and thus fear. Bonnie Estridge reports the story of thirty-three-year-old Vicki Jones who voluntarily chose to have a prophylactic mastectomy following the breast cancer death of her mother at forty-one and the diagnosis of her sister at thirty-eight. Jones comments, "My breasts were not for me objects of femininity—they were objects of fear" (25). She made her choice out of fear: "But after everything that had happened, I became increasingly fearful that I too, would get breast cancer in my thirties" (25). Estridge recognizes the common messages of risk that women receive, stating "With an avalanche of information and scary stories urging women to be more aware of breast cancer in the environment and the food we eat, many are becoming increasingly fearful that they're particularly susceptible" (25). Although Jones did not know if she would test positive for the BRCA1 or BRCA2 genes, she had the surgery because "Whatever the results of the gene test, I would never have felt reassured" (25). Jones feels relief at having her breasts removed because she has seriously reduced her future risk of breast cancer, stating "[. . .] I am overjoyed to be rid of the breasts that plagued my life" (25). For Jones, having breasts that looked good and contributed to the ideal feminine body was not as important as having peace of mind. She no longer felt that her breasts were useful or desirable; they were instead potential sites for disease and perhaps death. She felt she could not trust genetic testing or methods of early detection to inform her of her risk or to protect her.

Information on environmental risk factors overall is misleading, unproven, and confusing. One reason for this lack of reliable information is the lack of research; *Our Bodies, Ourselves* reports,

Still of 722 NIH [National Institutes of Health] grants for breast cancer research in 1996-1997, only 33 (5%) involved a possible environmental connection. The NCI [National Cancer Institute] and other research institutions have published articles stressing 'prevention' that shift responsibility for cancer on to individuals by advising us to change our lifestyles, and the Harvard Report on Cancer Prevention completely ignores the difficulties most women face in assuring our safety at work, or in avoiding hazardous chemicals that we may not even know are present in our environment. (139)

What then are women supposed to think? And what may be even influential for some women about this confusing rhetoric of risk of the environment is that most women are not in the position to change that much about their environment. Women do not have much control, if any, over the environment of their childhood, when their breast tissue forms. Women may or may not have much more control when they are adults, either. Career opportunities and perhaps decisions made for the family as a whole as well as the countless other ties to a geographical area may limit a woman's ability to live as an adult where she chooses. If she happens to live in one of those higher incidence areas, she may be subject to even higher levels of environmental pollution. Individual women often do not have control over the environment. Individuals can make a difference, but environmental contamination is a bigger issue than an individual woman; it is a social issue. What then, is the benefit of this confusing environmental information (other than to raise "awareness," as always)? This information produces fear by the risk rhetoric, but there are few possible projects, as was true for the body projects with the bodily risks.

Zillah Eisenstein's *Manmade Breast Cancers* is a perfect example of an individual woman who does everything she can to reduce environmental contaminants in her life, and yet she still feels ultimately helpless and lives in fear of breast cancer recurrence in her body and its development in her daughter's body.²⁴ Eisenstein describes her efforts for her daughter, Sarah:

²⁴ Eisenstein has witnessed the fatal effects of breast cancer: "When I first learned my beloved mother Fannie had breast cancer I had no idea what was to follow. She was forty-five years old; I was sixteen. My sisters Sarah and Giah were diagnosed while they were in their mid-twenties [both ultimately died from the disease]. My breast

We began to deal more aggressively with a proactive diet for Sarah when she started menstruating. All that we do is with measure because otherwise it won't work for the long haul. We eat a low-fat diet, but she loves cheese. I try to get her to eat whole grains with mixed success. She now drinks a soy protein smoothy about four times a week, with a bit of protest. She likes and is willing to eat tofu sandwiches for lunch. She is pretty good about adding broccoli sprouts to salads and other foods. We eat organic chicken. I try to have lots of fruits, especially in the summer, but no strawberries, unless they are organic, because of high pesticide use. She drinks skim milk that is not treated with rbST [hormones injected into cows to increase milk production], and organic cheese. She uses olive oil instead of margarine or butter.

Along with this I try to get her to do sports pretty regularly. Sarah ran cross-country and plays racquet ball and likes to canoe. She likes games more than routine exercise, so her dad plays tennis with her" (38).

Sounds like an attentive and caring mother right? Eisenstein would win points across the board for watching her daughter's diet and encouraging exercise because she adheres to the feminine ideal as a nurturing mother. The end result seems to be that Eisenstein's "awareness" of breast cancer and her dedication to preventing it has overtaken her daily life and created an underlying constant fear. Her concern is caused by her fear, and healthy though the results may be, a life of living in fear cannot be healthy for the mind or body. Eisenstein's realization of the role the environment potentially plays has induced her to monitor her body and her daughter's body; the rhetoric of risk is present in areas of the body as well as the environment.

A major factor in the breast cancer movement and what messages about the environment are advertised depends on the corporations involved.²⁵ Breast Cancer Action is the most anti-

cancer was diagnosed when I was forty. My Aunt Nettie, my mother's sister who lived with us, was diagnosed with ovarian cancer when she was fifty-seven [and also ultimately died from the disease]" (4).

²⁵ For more a more extensive analysis of corporate involvement in the breast cancer movement, see:

Breast Cancer Action. *Homepage*. 26 Jan. 2004. 17 Feb. 2004. <<http://www.bcaction.org/>>.

Brenner, Barbara. "Why Do We Say 'Cancer Sucks'?" *Breast Cancer Action Newsletter*. 77. (2003). Breast Cancer Action. 2004. 12 Feb. 2004. <<http://www.bcaction.org/Pages/SearchablePages/2003Newsletters/Newsletter077G.html>>.

Ehrenreich, Barbara. "Welcome to Cancerland: A mammogram leads to a cult of pink kitsch." *Harpers Magazine* Nov. 2001: 43-53.

Horton, Mary Jane. "Think Before You Pink: Wear a Ribbon, But Donate Carefully." *Ms*. Fall 2003. 16-17.

corporate organization I found that speaks out consistently, on its website, in its publications, and in more liberal magazines like *Ms.* Corporations that may play a role in creating pollution also tend to sponsor breast cancer awareness events because it looks like they care about women. Also, manufacturing any product with a pink ribbon on it or with a note that a (small) portion of the proceeds will be donated to breast cancer research typically boosts sales.

To provide one example of this corporate involvement in spite of its simultaneous production of pollution, Nancy Evans, President of Breast Cancer Action, writes of the history of National Breast Cancer Awareness Month (NBCAM) in the organization's monthly newsletter. Evans illuminates some unknown facts about the creator of NBCAM, Zeneca Pharmaceuticals, and its connections to breast cancer. First, Zeneca produces Nolvadex (commonly known as Tamoxifen), a widely-prescribed drug for breast cancer treatment. Second, Zeneca produces carcinogenic organochlorines in many of their other products. Third, with ultimate veto power, Zeneca gets to moderate all material produced under the NBCAM name—thus, “in none of these materials is the word environment mentioned as a possible cause of breast cancer” (2). In the equation, “[. . .] NBCAM = more awareness = more mammograms = increased diagnosis of breast cancer = more prescriptions written for Nolvadex/Tamoxifen,” Evans summarizes the economic incentive for corporations to keep breast cancer alive (2). Zeneca gets to support a woman's cause without being feminist, as Barbara Ehrenreich would surely describe it, while they still produce toxins that may play a role in the development of breast cancer, and yet this kind of involvement is often obscured by the breast cancer movement. Awareness of the disease takes center stage while prevention of potentially dangerous environmental factors is obscured. Also, because these corporations may sometimes use their money and their sponsorship to control the research funded, attention can be driven away from environmental factors, thus contributing to the lack of factual information—thus fear—for women.

The Ultimate Risk of the Unknown:

Producing Fear

It is the attention without facts that produces fear. As I have already made clear, there are few real facts about breast cancer, and the vigilant woman who monitors her body and her environment as much as possible, even without a family history of breast cancer, may still develop the disease. The unknown plays a major role in breast cancer awareness, and while

scientists and health officials cannot make definite statements, they all make recommendations and suggestions for how women should monitor their bodies—medicalize their bodies—in order to prevent breast cancer at all costs.²⁶ This emphasis on the body as a site for disease is not unique to breast cancer, as I discussed in the Introduction, but in breast cancer, it makes use of the other aspects of the ideology of femininity and becomes even more powerful because it reinscribes women into the prescribed gender role, as I discuss in Chapter Five.

Women are taught to make themselves part of the breast cancer population through the messages of awareness and early detection. Femaleness becomes a risk factor in much of the breast cancer movement literature.²⁷ In its very language, the ACS denotes femaleness as a risk factor: the ACS reports, “Besides being female, age is a woman’s single most important risk factor for developing cancer. Currently, a woman living in the United States has a 13.4%, or a 1 in 7, lifetime risk of developing breast cancer” (*Breast Cancer Facts and Figures 2003-2004* 9).²⁸ Furthermore, although breast cancer is predominantly a disease for post-menopausal women, pre-menopausal women—women as young as teenagers and twenty-somethings—are taught that they must monitor their breasts now as well as take action now to prevent the disease.²⁹ It is in the message of awareness and early detection that women’s bodies are medicalized, and the healthy body becomes an audience for messages of disease, thus fear.

The survival guides typically advertise their books as texts all women should read because all women have the potential to develop breast cancer. In the overview, O’Donnell and Axelrod recommend that all women, “Especially healthy women, who have a tendency to believe that this disease doesn’t affect them, should read *Bosom Buddies*” (2). Editor-in-chief of *Lifetime* magazine, Sally Koslow, encourages all women to support the movement; she argues women should participate because they never know if they will develop the disease: “Do it for

²⁶ For a discussion of how women must create their own knowledge because of the severe lack of reliable medical information, see Fosket, Jennifer. “Problematizing Biomedicine: Women’s Constructions of Breast Cancer Knowledge.” *Ideologies of Breast Cancer*. Ed. Laura K. Potts. NY: St. Martin’s, 2000. 15-36.

²⁷ Women are more likely to develop breast cancer because they have more breast tissue, although men can develop breast cancer: “In 2003, about 1,300 cases and 400 deaths from breast cancer are expected to occur among men, accounting for less than 1% of all breast cancers” (*Breast Cancer Facts and Figures 2003-2004* 3).

²⁸ A woman reaches this 1 in 7 lifetime risk when she reaches old age. Refer to the Introduction for risk based on age. This is the newest figure available, updated from the commonly quoted 1 in 8 lifetime risk.

²⁹ According to the ACS’s *Breast Cancer Facts and Figures 2003-2004*, “Ninety-four percent of new cases and 96% of breast cancer deaths reported during 1996-2000 occurred in women ages 40 and older” (1).

other women. But mostly, do it for yourself” (15). In response to *Lifetime*’s October 2003 issue, a reader thanks the magazine for its various breast cancer awareness articles, stating “The disease attacks young women, too. Breast cancer is not just a disease for those over 40” (Mason 18). In *Self* magazine’s NBCAM issue, four famous actresses speak about their commitment to breast cancer awareness. Thirty-eight-year-old model Cindy Crawford states, “I have two breasts, so I have two connections to the disease right here” (qtd. in Rentmeester 229). Crawford specifically links femininity and disease here. Téa Leoni, thirty-eight-year-old actress, comments, “I’m extremely familiar with my children’s bodies—I know when one of them has swollen glands or a bruise. But we women have to remind ourselves to look after our own [bodies]” (qtd. in Rentmeester 229). Coming from readers, doctors, editors, models, and actresses, these messages are prevalent across the breast cancer movement literature—all women, no matter how old, should be concerned with and thus “aware” of breast cancer, which comes to mean actively engaged in monitoring their body.

This attention to the female body comes to mean that femaleness is the potential for death via the breasts, as Crawford indicates in her comment. The result of this attention means that bodies need to be monitored, watched and regulated, for changes. Women need to be aware of the possibility for their breasts to harbor disease, and so women need to look for signs of the disease. This kind of attitude encourages women to medicalize their healthy bodies, to place their bodies under the same kinds of inspection and fear that women who have unhealthy bodies encounter. A woman without a lump is not considered healthy—she is considered a candidate for disease in the future.

There is no such thing as being too young for breast cancer, even if most women who do develop breast cancer are over forty. While I certainly agree that it is important for women in their twenties and thirties to recognize the fact that young women can sometimes develop cancer, and while I do not wish to argue with this physical fact, the medicalization of women’s bodies and the messages of risk that surround this awareness do not seem to be a positive thing for women and their bodies. In her introduction to Murphy’s *Fighting for Our Future*, Ann Curry, host of the *Today* show, includes young women in her message for awareness: “Since that day [that I learned that my forty-year-old mother had breast cancer] I have learned that more than 10,000 young women—undergraduates planning college courses, professionals planning new careers, brides planning weddings, mothers-to-be planning baby showers, women planning

lives—are diagnosed every year” (ix). There is something disturbing in the way Curry chooses to describe these young women; they are all in the midst of something deemed socially positive when they are stricken with the very negative news of breast cancer. Curry seems to want to educate women about the fact that young women do develop breast cancer but also to scare women who are happily involved in their lives, their education, their careers, their families—scare them into being “aware” of breast cancer. Her warning is more than just a call to awareness but rather a call to fear. Inciting this fear for women otherwise occupied, giving breast cancer the center stage, is part of the medicalization of women’s body where femaleness, whatever the age, becomes death.

Addressing the common fear of the disease is a common entry point for breast cancer movement literature. The idea behind “awareness” is that women are afraid of the disease because it may result in the loss of a breast, painful surgery, and traumatizing treatment, not to mention possible death. The motive then becomes to provide information about the disease so that more women are aware of it and can thus detect it early when it is most treatable. Stoppard justifies the fact that breast cancer dominates her general breast health book, arguing, “I have aimed to demystify it [breast cancer] because I believe that understanding it we can manage it. We shouldn’t allow the fear of breast cancer to tyrannize our lives” (9). And yet, despite the admonition not to let breast cancer “tyrannize our lives,” women *are* supposed to allow the fear organize how their lives are lived. The October 2003 *Self* magazine provides an interview with Dr. Larry Norton to address common breast cancer fears, such as the question, “Many young women fear breast cancer, but it is fairly rare prior to menopause. Has awareness gone too far?” (34). Norton replies, “The way to avoid fear is with knowledge. People carry anxieties around with them that they’re not even aware of. One is not touching your breasts because you’re afraid you’ll find a lump. Most of them aren’t cancer. It’s important to know what you can control” (34). Norton does not address the question asked; he argues that information combats fear, but he assumes it is fear caused by ignorance.

And yet, the unreliable information about breast cancer does not alleviate this ignorance that supposedly exists; rather, fear is produced because of the contradictory information. The awareness messages do combat the fear caused by ignorance by spreading the contradictory information, but it only replaces this fear with another fear—fear of the female body. It is no longer thought that breast cancer is a possible disease that a woman may develop but also may

not; instead, breast cancer has come to be seen as a disease that all women must continually prepare themselves for, look for, and ultimately experience. Breast cancer is expected, and so fear of the female body becomes a major message produced by the rhetoric of risk inherent in the breast cancer movement.

The Multicultural Spread of the Rhetoric of Risk

While the mainstream audience for the breast cancer movement is white middle- to upper-class heterosexual women, the breast cancer movement is starting to incorporate non-white women who do not fall into this mainstream audience. White women of higher socioeconomic status still have a higher incidence of breast cancer, but black women are more likely to die from breast cancer.³⁰ While it is still unclear why white women have a higher incidence of breast cancer, it is quite clear that the higher mortality rates among black women are due to limited access to detection and treatment.³¹ However, despite the inequalities inherent in non-white women's experience of breast cancer, the breast cancer movement seems to be moving in the same direction for these women as it has done for its mainstream white audience. Due to the scope of my research, I do not specifically address the unequal access to detection and treatment, the white middle- to upper-class heterosexual body so often seen in the breast cancer movement literature, or the effects of a white mainstream message spreading to a non-white audience. To begin to do so here would result in an inadequate and thus trivializing look at the injustices women who fall outside of the mainstream audience experience in relation to breast cancer. Rather, my intent in this section is to illuminate the continued message of risk that is

³⁰ The ACS reports, "White women have a higher incidence of breast cancer than African American women after age 40, while African American women have a slightly higher incidence rate before age 40. In contrast, African American women are more likely to die from breast cancer at every age. Incidence and death rates from breast cancer are generally lower among women of other racial and ethnic groups than in white and African American women" (2). More white women survive the disease than non-white women, the ACS states: "From 1992 to 2000, female breast cancer death rates declined overall by 2.6% per year in whites, 1.4% in Hispanics, and 1.1% in African Americans and Asian and Pacific Islanders, while rates were constant among American Indian and Alaska Natives" (*Breast Cancer Facts and Figures 2003-2004* 7).

³¹ For a detailed analysis of the limited access to detection and treatment based on socioeconomic status or for the injustices non-white women experience at the hand of the medical establishment, see: Eisenstein, Zillah. *Manmade Breast Cancers*. Ithaca, NY: Cornell UP, 2001. Kaspar, Anne S. and Susan J. Ferguson, eds. *Breast Cancer: Society Shapes an Epidemic*. NY: St. Martin's, 2000. Potts, Laura K., ed. *Ideologies of Breast Cancer: Feminist Perspectives*. NY: St. Martin's, 2000. Roberts, Dorothy. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. NY: Vintage Books, 1997.

always a part of the breast cancer movement. The breast cancer movement's reliance on fear as a motivating factor for women to monitor and medicalize their bodies is now placed on non-white women.

In her article, "Toy Theory: Black Barbie and the Deep Play of Difference," Ann du Cille explores the problems of creating a black Barbie in the likeness of whiteness, which can be related to the problem of distributing a message of breast cancer awareness founded on ideals of (white) feminine beauty to non-white women. Du Cille asserts, "Barbie is both product and purveyor of many of the dominant white ideals of beauty" (28). Creating a black Barbie in the likeness of whiteness makes white normal and black abnormal; it also suggests that non-white people can never be beautiful because they can never be white. Eisenstein states a similar view: "The breast, in representing femininity, is simultaneously implicated in whiteness. The female body, despite its racial identity and multiplicity of colors, exists as a fantasized icon [. . .]. And the white body becomes a universalized abstraction: thin, large breasted, small waisted, with blond hair. If bodies are given imaginary status, pretense itself becomes naturalized" (141). Du Cille cites a study by the authors of *The Color Complex: The Politics of Skin Color Among African Americans*, presenting the theory that "countless Black girls in the United States share the fantasy of being White. How could it be otherwise [. . .] in a society whose ideal beauty—blond, pale skinned, with blue eyes—embodies everything the average Black female lacks?" (12). By playing with a Barbie that represents an extreme version of the (white) feminine ideal, non-white children incorporate this ideal into their understanding of beauty at the same time that they can never achieve the ideal.

In a similar manner, the breast cancer movement originally targeted white women who could potentially be a part of this ideal to engage in body projects to prevent breast cancer. Now, to reach the women previously ignored, the breast cancer movement incorporates non-white women into their intended audience, but the messages are still founded in the (white) feminine ideal. Non-white women, traditionally left out of these messages, are now also vulnerable to the same victimization via body projects and monitoring, motivated by fear. Where once they may have escaped because of racism, they are now included and similarly disadvantaged. Furthermore, non-white women are not allowed to be different from white women and are

instead lumped into the same categories as white women; thus, their differences become erased and they are encouraged to conform to the ideals of whiteness even more.³²

The messages of risk continue in texts directed specifically at the non-white audience. For example, Linda Villarosa educates her black women readers, “Our breast cancer is caught later, and we are more likely to die from it” (xvi). She later writes, “For Black folks, another part of the [disease] problem is the ‘quicker and sicker’ syndrome: We Black women tend to overlook preventive care because we’re too busy or too busy taking care of everyone but ourselves. Then, when we do need medical treatment, we come in sicker and die more quickly than we should” (92). Black women do have a reason to be cautious with the medical establishment, dating back to slavery and Dr. Sims’s cruel gynecological experimentation with black women slaves and more modern exploitation of poor non-white women involuntary sterilization.³³ Villarosa recognizes black women’s history of vulnerability, yet she emphasizes the need for black women to set aside this fear and caution in order to take care of their bodies—to medicalize their bodies. Villarosa then encourages women to take care of themselves in the same ways I have already discussed—by monitoring the diet, exercise, lifestyle choices, and the environment. She recommends, “Avoiding obesity [. . .],” “Eating fewer foods that have high cholesterol levels,” “Cutting down on total fat intake [. . .],” “Eating bulkier, high-fiber foods [. . .],” “Eating at least five servings of fruits and vegetables each day [. . .],” “Limiting alcohol intake, if you drink at all,” “Cutting down on salt,” “Reduce intake of sugar,” “Keep fat to 30 percent or less of total calories” (50-51). Villarosa tells her readers that breast cancer is the leading cause of death from cancer; in this way, she promotes vigilance using the motivation of fear.³⁴

³²For further discussion, see hooks, bell. “Selling Hot Pussy.” Representations of Black Female Sexuality in the Cultural Marketplace.” *Writing on the Body: Female Embodiment and Feminist Theory*. Eds. Katie Conboy, Nadia Medina, and Sarah Stanbury. NY: Columbia UP, 1997: 113-128.

³³ For a detailed analysis of Dr. Sims, see Kapsalis, Terri. *Public Privates: Performing Gynecology From Both Ends of the Speculum*. Durham, NC: Duke UP, 1997.

For a detailed analysis of recent involuntary sterilization of non-white women, see Roberts, Dorothy. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. NY: Vintage Books, 1997.

³⁴ Villarosa does not provide statistics for her readers here, but given the most recent ACS statistics in *Cancer Facts and Figures for African Americans 2003-2004*, breast cancer is *not* the leading cause of cancer deaths for African American women: the mortality rate for lung cancer from 1995-1999 per 100,000 African American women was 40.2, while the rate was 37.1 for breast cancer (4).

Like many other guides, Villarosa incorporates personal narratives to give women a first-person perspective. These stories also function in the same manner—to promote personal responsibility for detecting breast cancer. One woman recalls,

It's funny too, that when I first called the diagnostic clinic to make the appointment for the mammogram, they told me it would cost \$150. That seemed too high, so I found another hospital that would do it for half the price, except they couldn't give me an appointment for two months. But I thought about a woman at work whose grandmother had died of breast cancer and of a friend whose sister had it, and I paid the \$150 and went in right away. And that early detection really paid off. (309)

This woman was vigilant and insisted on monitoring her breasts, and so she was rewarded with early detection and thus survival. The fear of the unknown and the idea that any woman can develop breast cancer, no matter what measures she takes, also surfaces. One woman remembers, “*When I was diagnosed with breast cancer in January of 1987, I [. . .] felt betrayed by my body. I had exercised it, fed it ‘healthy’ food, gotten my proper rest, and checked my breasts once a month. How could this happen to me?*” (98; italics in original). This woman’s story serves as evidence that even though women should conduct body projects to prevent breast cancer, they also need to monitor their bodies because breast cancer can still happen to anyone—again, the power of the unknown works here as in the rest of the literature.

Magazines present similar messages and stories. An article in the October 2003 issue of *Ebony* begins, “It can become a part of a woman’s life when she’s too young to drink or vote and certainly too young to run for president” (Kinnon 72) and ends, “Don’t let [anyone] tell you that you’re too young to get breast cancer” (qtd. in Kinnon 78). Quite clearly, this article targets young women who might have thought they did not have to think about breast cancer yet. Certainly, black women do seem to be at more of a risk for breast cancer at younger ages than white women, but the rhetoric of risk here is no different than Curry’s introduction to *Fighting for Our Future*: all women should be afraid, even when they are young.³⁵ Again addressing the unknown risks, readers learn that one of the described women, McClure, “had no family history of the disease” (Kinnon 76). She was not safe because she did not have family history. Early

³⁵ The ACS reports that “[. . .] African American women have a slightly higher incidence rate before age 40” (*Breast Cancer Facts and Figures 2003-2004* 2).

detection as the best chance for survival is also encouraged: “[. . .] the key to that survival is early detection” (qtd. in Kinnon 77). Breast self-exams are recommended because “[. . .] it can be considered a first line of defense because it increases a woman’s comfort level with her body, familiarity with the topography of her breasts and awareness that breast health is part of total well-being” (qtd. in Kinnon 78). Through this particular article, *Ebony* recommends that its readers incorporate monitoring their breasts into their everyday routine, using the same message that what is good for the whole body certainly cannot hurt when it comes to breast cancer. These messages encourage body projects and medicalization of the female body, both of which maintain the white ideal of femininity.

Also triumphing women who take the initiative to conduct body projects, the January 2004 issue of *Essence* presents the story of a woman, Valkyr Branker, who was diagnosed with breast cancer and treated and now has changed her lifestyle. She tells *Essence*,

The cancer gave me a new perspective on staying healthy. After a mastectomy and reconstructive surgery, I was sent to Pilates class for rehabilitation and was instantly hooked. This prompted me to become a certified fitness specialist in 1986. Upon retirement I became a personal trainer [. . .]. I stick to a low-carbohydrate diet. It works for me. I also participate in a lot of biking tours [. . .]. Watch your health, and listen to your body. Get your checkups and your mammograms, and don’t forget to monitor your bone density. (Edwards 108)

Through her story, Branker encourages readers to do as she does to stay healthy, in hopes of preventing breast cancer—again, the same exact messages (with the same consequences) as the white women audience receives.

There is no difference in the ways in which the breast cancer movement has made its attempts to raise women’s awareness of breast cancer reach non-white women. The advertisements will sometimes incorporate faces of different ages and races. The statistics will address women of different ages and races. The magazines will include women of different ages and races. And so on. Even though most non-white women fall outside of the feminine ideal of beauty, they are still encouraged to fear a disease that attacks the physical marker of femininity.

Conclusion

The rhetoric of risk used by the breast cancer movement affects all women and their subsequent experience of breast cancer, regardless of age, race, or sexuality. Fear is produced from these messages of risk that are based on the unknown. The message to fear the body and what goes into it becomes a body project for women to engage in to protect their femininity. The message to fear the environment also becomes a body project. And yet, the effectiveness of these body projects is questionable. Women may not be able to prevent breast cancer, certainly not when the causes of breast cancer, in its many forms, are not known. But early detection is still manipulated as way for women to ensure their survival, sometimes, disturbingly, as a means of prevention. Early detection is not a cure or a method of prevention, but because it is a way for women to monitor their bodies, it is compatible with the rhetoric of risk. The consequences of this rhetoric of risk and the ways in which women experience breast cancer, even when they do not have the disease, is the topic of the next chapter.

CHAPTER FIVE: THE IMPACT OF THE BREAST CANCER MOVEMENT ON WOMEN'S LIVES: THE INTERSECTION OF REPRESENTATION, SUBJECTIVITY, AND BEHAVIOR

Introduction

The breast cancer movement uses a rhetoric of risk to motivate women through fear of the body, environment, and unknown. By making women fear their bodies, the environment, and the unknown, the breast cancer movement is successful in making women complicit subjects in the ideology of femininity. Indoctrinating women to engage in body projects through the messages of risk plays on the fear of breast cancer while simultaneously making women individually responsible for the care of their bodies, in addition to that of their families. The fear of breast cancer is grounded in a fear of women's bodies, as sites for disease. Femaleness becomes a risk factor for disease, and breast cancer becomes an expectation. The argument of preserved femininity in the face of the loss of a breast succeeds because every other aspect of the breast cancer movement reinscribes women into the ideology of femininity. It is through the message of risk and the motivation of fear that the breast cancer movement functions to preserve femininity when women engage in body projects; this is the relationship between the representation of the breast and femininity, women's subjectivity, and their behavior.

Making Women Complicit Subjects Through Fear

Seeing the female body as a site of disease is not limited to the breast cancer movement. Thomas Laqueur presents a history of the body in *Making Sex: Body and Gender from the Greeks to Freud*. Laqueur notes that much of medical history has seen the female body as an imperfect derivation of the male body:

Galen, who in the second century A.D. developed the most powerful and resilient model of the structural, though not spatial, identity of the male and female reproductive organs, demonstrated at length that women were essentially men in whom a lack of vital heat—of perfection—had resulted in the retention, inside, of structures that in the male are visible without. (4)

The female body was seen as the deformed and inverted replica of the male body. Just as breast cancer is a disease socially constructed as well as physically experienced, Laqueur posits that any medical understanding of the body across history has been socially constructed according to the gender ideologies of the age. The belief that the female body is less than or an imperfect derivation of the male body stems from the gender ideology that to be a woman is to be less than or an imperfect derivation of man. Seeing the female body as less than or imperfect is only a step away from seeing the female body as diseased; after all, what does not fit the norm is not just different, but bad.

The rhetoric of risk used by breast cancer movement persuades women to see their bodies as not only *potentially* but *eventually* diseased. And given the tremendous meaning behind the breast, it is not surprising that breast cancer receives such overwhelming media attention. To suggest that the very marker of femininity is a site for disease is to suggest that femininity itself is diseased. Indeed, while waiting for a mammogram, Ehrenreich comments, “I have picked up this warning vibe in the changing room [from the overwhelming presence of the pink ribbon], which, in my increasingly anxious state, translates into: femininity is death” (44). Thus women are encouraged to exam their breasts monthly (in spite of the new ACS recommendation, as I presented in Chapter Four), to have doctors exam their breasts yearly, and to undergo mammograms yearly after a woman is forty years old. The monitoring is emphasized because the disease is expected to occur by virtue of femaleness. Through this intense monitoring, the female body is medicalized. The assumption that women should monitor their breasts, bodies, and environment goes beyond encouraging individual responsibility for breast cancer to reinforce the belief that every aspect of life should be medicalized. Women become complicit subjects, willingly monitoring and medicalizing their bodies as dutiful measures to prevent breast cancer, as explained by a Foucaultian analysis. The body projects of the breast cancer movement are not violently forced upon women; rather the body projects become responsibilities that “good” subjects follow.

The rhetoric of the breast cancer movement has been so successful in its awareness campaigns that breast cancer is no longer stigmatized but rather embraced. Participation in and support of the movement becomes obligatory not only for women but for any well-intentioned subject, male or female, individual or incorporated. Ehrenreich first states this argument during her breast cancer experience: “[. . .] the equanimity of breast-cancer culture goes beyond mere

absence of anger to what looks, all too often, like a positive embrace of the disease” (48). She continues, suggesting that internet forums for women to discuss their trials have moved to a kind of extreme where “[. . .] cheerfulness is more or less mandatory, dissent a kind of treason” (50). Women are chastised by survivors for their negativity. Women emphasize the positive side effects of treatment, such as weight loss and new, fuller, softer hair; the internet abounds with advice on attractive head scarves and other advice for the body’s appearance (49). Studies have shown that a positive attitude will aid a patient in her recovery from cancer, but Ehrenreich feels that much of the breast cancer movement has turned the disease into a rite of passage for all women:

First there is the selection of the initiates—by age in the tribal situation, by mammogram or palpation here. Then come the requisite ordeals—scarification or circumcision within traditional cultures, surgery and chemotherapy for the cancer patient. Finally, the initiate emerges into a new and higher status—an adult and a warrior—or in the case of breast cancer, a ‘survivor.’ (49-50)

Embracing the breast cancer experience as a rite of passage demonstrates the pathologization of women’s bodies. As a rite of passage, breast cancer is an eventual expectation, assuming the woman lives long enough.

Examples of this attitude abound. Ratner comforts her readers, “Regardless of your age, you are now an elder among the females of our tribe, someone who carries a special knowledge that deserves to be honored and shared” (225). Emphasizing the need for a positive outlook, Murphy comments, “Indeed, finding ways to love your body, feeling that you are in partnership with it rather than at war with it, can be very helpful to both your physical and your emotional recovery from breast cancer” (69). It seems that the breast cancer movement goes beyond the jaded cliché, “when life gives you lemons, make lemonade,” to actual gratitude for the experience of breast cancer. The embrace of this disease, to the extent that it becomes an expectation rather than one of many possibilities for the future, reinforces the pathologization of women’s bodies.

Women without breast cancer are not immune from the embrace, either. As I discussed in Chapter One using a Barthesian cultural semiotics, the myth of the pink ribbon obscures its history and affiliations, seeming to appear to be a bland and totally positive movement for women. My mother’s friend, outside of the realm of feminist theory, simply could not

conceptualize that I criticize the breast cancer movement at the same time that I recognize that I do not want to lose a breast either. People who do not blindly support the breast cancer movement are perceived as negative and lacking in compassion for women with the disease. Women who do not accept the awareness messages and subsequently monitor their bodies are not doing everything they can to prevent (i.e., detect early) the disease, and so they are responsible for their disease. Corporations can support (and control) the movement of awareness without truly contributing to research and thus divert emphasis from a social responsibility for the environment to an individual responsibility for the body as well as obscure their role in environmental pollution. The pervasiveness of the breast cancer movement's awareness messages cannot be ignored, let alone criticized. Furthermore, when women become complicit subjects, they allow for the production of femininity.

Producing Femininity

In *A Darker Ribbon*, Ellen Leopold researches breast cancer in the nineteenth century and finds that breast cancer threatened not only the woman but also her family that depended on her fulfillment of the prescribed feminine gender roles. Leopold explains,

As her illness worsened and she began to relinquish domestic responsibilities, the family would begin to experience an inversion of the expected hierarchy of roles. A terminally ill woman could no longer maintain even the fiction of managing or caring for her household. Those traditionally dependent on her were now called upon to serve. Unlike the woman dying in childbirth (a much more common death for women before the turn of the century), a woman with late-stage breast cancer might linger for months, in a state of pain that could only reinforce the helplessness of those attending her. And her death left no compensating new life in its wake. (31)

Failure to fulfill family obligations was an extreme disadvantage to a family, but breast cancer was silenced and hidden nonetheless. Leopold explains that "Once the loss of a breast came to be understood as a harbinger of this larger family tragedy, it was almost inevitable that the disease would be concealed" (32). Because there were such devastating consequences for the family, breast cancer became stigmatized. To advertise a woman's breast cancer might damage her husband's reputation, Leopold argues: "If a wife's illness carried even a suggestion of a

sexual failure, no husband, especially one now in a position to remarry [after his wife died from an unstated disease], would want this to become generally known. Secrecy worked in his favor” (32). Leopold concludes that to safeguard a man’s position, the woman’s disease and ultimate cause of death would be hidden.

Leopold does not explicitly argue that the breast cancer movement originated out of a need to keep women healthy enough to fulfill household responsibilities, though she makes the suggestion through the presentation of her research. I would like to emphasize the relationship between the breast cancer movement and keeping women healthy so they could still adhere to the feminine gender role. If a woman suffered from a disease that left her lingering in life yet unable to fulfill her household responsibilities, she was more than useless—she was a disadvantage to her husband and her family. A breast cancer movement that encouraged women to monitor their breasts in an effort to detect breast cancer early as a means of prevention would eventually help women continue their role as mother and caretaker, responsible for the home.

Leopold does address the move to make women individually responsible for their breasts. She explains the phenomenon of individual responsibility:

And passing on responsibility to women serves to relieve the consciences of men. First, by allowing society to express their hostility for them [women with breast cancer], men as husbands and fathers escape the burden of guilt imposed by the conflict between their need to discourage women’s emancipation on the one hand, and their wish to remain concerned for the well-being of their wives and children on the other. Second, as physicians, men cannot be held responsible for their failure to cure or prevent a disease that women have brought upon themselves. (37-38)

Here, Leopold recognizes that by assigning individual responsibility for breast cancer, men could expect their wives to monitor their bodies to maintain good health while simultaneously removing social responsibility for the husband and male-dominated medical field. The beliefs of individual responsibility that Leopold presents here are foundations of the breast cancer movement today, with its message of awareness that targets women on account of their femaleness.

In the first half of the twentieth century, the American Cancer Society began with the message of awareness and early detection as a means of prevention. Leopold summarizes women's involvement from the start in the breast cancer movement:

First mobilized by the American Society for the Control of Cancer [ASCC] in the late 1920s, the high point of their voluntary participation occurred ten years later when they were recruited on a national basis into the ASCC's newly formed Women's Field Army. Enlisted in the thousands, these women raised the operating income for the parent organization while they leafleted, broadcast, and delivered the message of early decision to American womanhood. (13)

Leopold explains the connection between prevention and early detection: "Medical science at the time [1913] still understood breast cancer as a local disease. If, therefore, early detection was pursued vigorously enough and women came to their doctors at the very first sign of disease, then theoretically the disease could be run down virtually to its source, preempting the manifestation of symptoms, if not eradicating the disease entirely" (156).³⁶ Thus, founded on medical knowledge of the early 1900s, the breast cancer movement's message began with the message of early detection as a means of prevention and continues to do so, even in the face of new medical knowledge that classifies breast cancer as a systemic disease today.

The breast cancer movement simply takes the woman's role of caretaker of the family and expands it to her body. Because she must be responsible for her family, she must keep her body healthy. Because early detection was thought to be the best way to stop the spread of breast cancer, monitoring the body became the message of the breast cancer movement, dating back to the Women's Field Army of the ASCC. The message of awareness teaches women to fear their bodies and the environment, and though the directives given are not reliable or failsafe, women are nonetheless held responsible, even for factors an individual cannot possibly control, such as the environment.

The fear that women's bodies will not perform as they are expected to runs throughout American culture but also through the breast cancer movement rhetoric. Women's bodies have long been men's domain; there is the expectation that women's bodies should be functional according to phallogentric roles of the wife and mother, and there seems to be a vast fear in American society about women's bodies failing to function as they are expected. In

³⁶ See footnote on local versus systemic disease in Chapter Two.

Confinements, Helena Michie and Naomi Cahn analyze the fear that women's bodies may not be able to function properly in order to become pregnant and to sustain the pregnancy full-term. In *Mother's Milk*, Bernice L. Hausman examines the fear that women may not be able to produce enough milk to sustain their babies. These fears that women may not be able to bear children or to lactate are similar to the fear that breast cancer may inhibit a woman from performing her caretaker responsibilities for the family.

The fear that women's bodies will not function as expected is manifested in the expectation that women should protect these functions. For example, pre-menopausal women are expected to be aware of the threats to their fertility while undergoing chemotherapy. Murphy cautions her target audience of young women: "Although permanent premature menopause is common among women over 40, who are a bit closer to menopause to begin with, many young women do suffer short- or long-term fertility problems from chemotherapy" (62). Regarding the decision to undergo chemotherapy at all, she asks, "Are you willing to give up your fertility for a 5 percent reduction in recurrence?" (64). As a cautionary tale, Murphy relates the story of Joy and concludes, "But Joy is painfully aware that her doctors were not concerned about her fertility—largely, she thinks, because they were used to dealing with older women" (211). Murphy presents Joy's story as a warning for women to be vigilant in protecting their fertility, even if they are receiving treatment for breast cancer; this vigilance becomes yet another way to ascribe individual responsibility onto women for their bodies as well as ensure that women retain the ability to function as wife and mother.

Protecting the function and health of women's bodies is only a part of the breast cancer movement; the second part encourages women to maintain and preserve their beauty during the devastating effects of cancer treatment. These messages spread the idea that the woman must continue to look physically attractive, most specifically with the semblance of a breast after mastectomy. Thirty years ago, Audre Lorde faced resentment and outright chastisement for refusing to wear a prosthesis because "she was bad for the morale" (52). And while times have changed, I still question women's ability to freely choose after a mastectomy. Today, women certainly have more options for reconstruction beyond prosthetics, and plastic surgeons certainly emphasize the need for reconstruction for women to feel better after surgery.

Some women in the survival guides do state that they no longer feel the need for a prosthesis and always refused reconstruction. Elaine Ratner explains her choice: "As I thought

about what getting back to normal meant to me, I realized it didn't necessarily mean that my body had to be the same. I wanted to go on feeling strong and healthy; whether I did that with one breast or two didn't really matter. It was my life, not my body, that I wanted to get back to the way it was" (100). However, despite her refusal to attribute vast importance to her breast, Ratner still encountered objections to her choice; she writes, "In my case, reconstruction was not offered as an opportunity; it was presented as an obligation and I had to fight to avoid it" (194). In her study of women with breast cancer, Deborah Kahane finds that

The mastectomy patients began the process of rebuilding their body image by choosing from a variety of methods that would help them feel whole again: wearing a prosthesis, *not* wearing a prosthesis, or having breast reconstruction. It did not matter which method they chose: What was important was that their choice helped them to recreate a normal body image. It is important to remember this point and do what is most comfortable for you. (208-209)

Kahane argues that there is not one solution for women who have had a mastectomy, but what she does not examine are the forces that influenced these women's choices. What factors made them think that a prosthesis or reconstruction would or would not allow them to create a "normal body image?" Even her choice of the phrase "normal body image" is questionable—who has a "normal body image"? Is it the culturally idealized image of the female body? Is it whatever image the woman feels comfortable with? There is no "normal body image."

Given our society's dependence on the visual to understand the body and our ideals of femininity that are marked visually on the body, a woman's choice to have or not to have reconstructive surgery following mastectomy cannot be free.³⁷ A woman without at least the semblance of breasts—surgical or prosthetic—is not viewed as a feminine woman because she lacks the fundamental visual marker of femininity. And yet, the breast cancer movement promotes the idea of continued femininity in spite of the loss of a breast. Generally, breast cancer organizations reassure women of preserved femininity to prevent fear of the disease.

³⁷ See Oyěwùmí, Oyèrónké. "Chapter One: Visualizing the Body: Western Theories and African Subjects." *The Invention of Women: Making an African Sense of Western Gender Discourse*. Minneapolis: University of Minneapolis Press, 1997. 1-30.

Oyěwùmí breaks down the Western concept of gender as uniquely founded on what is seen, the visual, as opposed to other ways of knowing in non-western cultures. The body is what is seen and what becomes important in the organization of Western society.

Historically, women have feared the disease because they feared the treatment, especially the deforming and debilitating radical mastectomy. To combat this fear of deformation and thus loss of femininity, breast cancer organizations present triumphant stories of women who have survived breast cancer and continued their lives as mothers, lovers, caretakers, and nurturers. The theme of continued preservation of femininity following breast cancer, always a consideration in breast cancer survival guides, however, serves to illuminate the real fear of the loss of femininity.

The message of preserved femininity itself is an indication of the importance of the breast in representing femininity. Women fear because they know; they know the meaning of the breast and its role in femininity. Some women, like Audre Lorde, triumphantly reject our society's demand for the breast, but not all women can be so radical. Losing a breast means losing a marker of one's adult sexual maturity, a marker of one's possible maternity, a marker of one's femaleness—all usually essential components of one's identity as a woman. When a woman loses a breast, it is easy to say that one should be a feminist and reject reconstructive surgery or prostheses, but given the ideological ramifications of such a choice, the choice cannot be free. Thus, when a woman loses a breast and chooses reconstructive surgery or prostheses, she does reinscribe herself into the ideology of femininity. Here, the male gaze determines the shape of the female body; she is complicit in her subordination, but she is also not free.

I could continue to examine women's choices post-mastectomy, but that would open up an issue too large to approach here. Rather, I briefly present this issue to indicate the messages of the breast women *without* breast cancer receive; fear of the loss of the breast plays a large role in motivating women to monitor their breasts. If the breast were not such a powerful marker of a woman's femininity, she would not fear its loss. And despite the many arguments that a woman does not lose her femininity when she loses her breast, the loss of the breast is still a motivating fear to encourage women to monitor their breasts in the attempt to detect breast cancer early and thus secure a better chance for survival, not to mention preservation of the breast.

The argument of preserved femininity in spite of breast cancer persists throughout the breast cancer literature. Ratner proclaims, "In fact, I am more of a woman—more productive professionally, more active sexually, self-assured, a better wife and mother, healthier, and a good deal happier than I was when I had two breasts. Nothing bad or embarrassing has happened to me because of my lopsidedness. Nothing" (192). Well isn't she perfect? Ratner's book, from

its title, *The Feisty Woman's Breast Cancer Book*, to the entire body of text, emanates this positive feeling that dares anyone to challenge her happiness and optimism. In a toned-down fashion, Kahane presents the stories of ten different women and their personal experiences with breast cancer. Unlike Ratner, all of these women did not emerge happier and better from breast cancer—many had marital and sexual problems that challenged their femininity—and yet, Kahane concludes,

Though all of these women had been functioning well in the 'normal' world before they were diagnosed, breast cancer sorely tested their repertoire of coping skills and sometimes they required more help to get their needs met. In response to the crisis, they learned to utilize a variety of new coping methods to alleviate both their physical and emotional problems: Learning new ways to communicate and share, finding creative ways to live with treatment side effects, and creating rewards and pleasurable activities for themselves. (230)

These women shared traumatic experiences, and they faced challenges to their femininity in relation to their relationships, sexuality, and body image, and yet they managed to survive and preserve their femininity in the long run. Kahane argues, “The question of breast cancer and ‘lost femininity’ is based on an outdated societal attitude that equates a woman’s femininity almost exclusively with her breasts. It arose from a male worldview that a woman’s breasts and appearance are crucial to attracting men, and that nothing is more important to a woman than attracting a man” (247). Kahane is right; a woman will certainly not lose her femininity because she loses her breast, although she may feel a tremendous amount of trauma because “outdated” as the view is, it persists.

What Kahane, however, does not address is the issue of femininity itself. A woman does not lose her femininity when she loses her breast because at every step of the breast cancer experience, she is reinscribed back into the feminine role in other ways. Femininity is not a concrete entity that is lost with mastectomy; femininity is a performance, as Judith Butler demonstrates in *Gender Trouble*. A woman who loses her breast can still perform her femininity in countless other ways, as she had done before. For example, when treatment endangers her physical beauty, she finds endless support in maintaining her appearance, as Barbara Ehrenreich found. Also, the organization Look Good, Feel Better provides women with cosmetic advice and demonstrations in order to help women repair and regain the feminine ideals of beauty that

deteriorated from their cancer treatment. In doing so, *Look Good, Feel Better* upholds the stereotypes of femininity that demand women to wear make-up, style their hair, watch their weight, and conform to a specific body type.

Submitting to the authority of the male-dominated medical field also makes women the passive feminine subject, and while many women rebel, the pressure to submit is frequently present. Ehrenreich resists when she is encouraged to regress to a little girl and pass authority of her body to the male-dominated medical field. Murphy relates the story of Randi Rosenberg: “Suddenly, instead of a young woman who’s just had the pleasure of being told she has cancer, I felt like a schoolgirl whose daddy just yelled at her for misbehaving” (36). Ratner similarly remembers, “When I asked [my doctor] what my alternatives were, he said I had no choice. I accepted his medical judgment, but I rebelled against the ‘no choice’ part [. . .]. I felt he was treating me like a child, or like someone too scared and upset to make responsible decisions” (11). Ehrenreich tries to explain the phenomenon:

Possibly the idea is that regression to a state of childlike dependency puts one in the best frame of mind with which to endure the prolonged and toxic treatments. Or it may be that, in some versions of the prevailing gender ideology, femininity is by its nature incompatible with full adulthood—a state of arrested development. Certainly men diagnosed with prostate cancer do not receive gifts of Matchbox cars. (46-47)

The woman with breast cancer is reinscribed into the role of passive object, susceptible to her doctor’s opinion, in a way that is inextricably linked to the ideology of femininity.

Ehrenreich also comments on the encouragement to become a consumer in the pink ribbon market: “The ultrafeminine theme of the breast-cancer ‘marketplace’—the prominence, for example, of cosmetics and jewelry—could be understood as a response to the treatments’ disastrous effects on one’s looks” (460). The woman with breast cancer is reinscribed into femininity through the goods she purchases and the very act of being a consumer.³⁸ The most prevalent aspects of the breast cancer movement, and perhaps more specifically the pink ribbon campaigns, encourage women to comply with feminine ideals, regardless if they actually have the disease or not.

³⁸ For a thorough analysis of femininity and shopping, see Radner, Hilary. *Shopping Around: Feminine Culture and the Pursuit of Happiness*. NY: Routledge, 1995.

The argument of preserved femininity in the face of breast cancer supposedly functions to help women be less afraid of the disease; however, it only serves to reinforce the ideology of femininity, placing women back as the passive subject and caretaker. Women usually do not come to doctors with massive tumors as they did in centuries past because the awareness message has generally worked. Women have learned that early detection is a means of prevention, and most women do find their tumors at a much earlier stage. The passing of the stigma of breast cancer allows women to be public about their experiences and also demand research monies and attention. And yet these advances, seemingly positive for women's health, also require women to monitor their bodies and assume personal responsibility for the disease. Women are the caretakers of their bodies as well as their families. The breast cancer movement's rhetoric of risk produces fear that motivates women to monitor their bodies. The movement capitalizes on this fear and becomes successful. The argument of preserved femininity is yet another way to combat fear of the disease only to instill fear of the body, as well as maintain the ideology of femininity.

Conclusion

The rhetoric of risk distributed by the breast cancer movement functions to preserve femininity by producing feminine gender performances via body projects. To motivate women to be subjects, the rhetoric of risk depends on fear. Fear of breast cancer is part of a long history of fear of the female body, and the breast cancer movement capitalizes on this fear to be effective in getting women to be complicit in their subjectivity. The tradition of pathologizing the female body makes it "natural" to see the female body as a site of disease in the case of breast cancer. Through this expectation for disease, the disease becomes an expected rite of passage for all women—something for all women to fear. Although the breast cancer movement reassures women in a seemingly positive manner that they will not lose their femininity because they lose a breast, the movement fails to look critically at the feminine ideal itself. Threatening a woman's ability to take care of those around her, breast cancer threatens a central gender role of the ideology of femininity. The woman's physical beauty may also be compromised, depending on her treatment, and so her role as an object for the male gaze is also threatened. To combat these threats, the breast cancer movement first reinscribes the woman into the feminine gender role as caretaker of her body and beauty, thus reinforcing the ideology of gender. Women monitor

themselves through body projects out of fear; the awareness messages are successful and femininity is preserved, without examination, thanks to the breast cancer movement.

APPENDIX: BREAST CANCER AS A BIOLOGICAL DISEASE

The following description of breast cancer, from detection to treatment, first is summarized from the most recently available *Our Bodies, Ourselves* (1998) and second is necessarily part of the breast cancer literature analyzed in this research. As such a text, it must be understood to be vulnerable to the same kind of critique offered throughout this research. However, given the limited availability of reliable information on breast cancer, what follows is explained as accurately as possible. For a more detailed description of breast cancer, see directly *Our Bodies, Ourselves* or *Dr. Susan Love's Breast Book*.

Cancer is generally defined as the uncontrolled division and growth of abnormal cells. It is unclear what causes cancer, but there seem to be a multitude of factors. *Our Bodies, Ourselves* explains, "Certain genes and viruses have caused cancer in laboratory animals, and similar processes are suspected but not conclusively proved in human cancers" (614). The conclusion we are left with is that "It seems most likely that cancer is caused by a buildup of one or more factors to the point (different for each person) where the body's immune system can no longer handle the load" (614). Both genetics and environmental factors are thought to play roles in the development of cancer. For example, a hereditary vulnerability to a certain carcinogen may cause one person to develop cancer while another person exposed to that same carcinogen may not develop cancer.

To prevent cancer, *Our Bodies, Ourselves* recommends that its readers avoid smoking and smoky environments; avoid exposure to X-rays; avoid hormone therapy; minimize salt intake, additives, preservatives, and refined ingredients; reduce fat intake; minimize alcohol consumption; maintain a healthy body-mass index; have regular bowel movements; avoid hair dyes with petroleum bases; increase fiber intake; and maintain a diet high in beta-carotene (614-615). These are general guidelines offered as a way to maintain overall health in an attempt to prevent cancer of all kinds. *Our Bodies, Ourselves* does acknowledge the difficulty in following some of the above guidelines, admitting that "[. . .] many other factors, such as air pollution and the many environmental carcinogens that bombard us in our daily lives, are not so clearly under our personal control. Diet changes, such as eating more organically grown foods, can be expensive; dietary recommendations are sometimes controversial; and eating is a complex

behavior that is hard to change” (614). Thus, the health book offers these guidelines but realizes that such preventative measures are for the individual as well as for society at large.

Before breast cancer is detected, many women who do not have the disease may experience aspects of the disease experience as it is determined whether their tumor is cancerous (malignant) or non-cancerous (benign). Breast lumps are common; lumpiness, swelling, or discomfort may be a normal experience as part of the menstrual cycle. Breast tissue is not consistent from woman to woman or for an individual woman from month to month. If a lump is found, the woman should monitor the size and presence of the lump for a month or two, noting if it changes or disappears during the menstrual cycle. If the lump does change shape or disappears all together, it is probably benign. Obviously, a woman who frequently experiences lumps cannot see a doctor every time she feels a lump, and so these suggestions offer a way for women to monitor their own breasts and assuage their fears. If the lump is new and does not seem to change or disappear according to a woman’s menstrual cycle, then she should seek medical advice, especially if she does not have a history of lumpy breasts. The doctor will conduct a clinical exam of the breasts and will decide if a mammogram and/or a biopsy needs to be conducted. *Our Bodies, Ourselves* explains that a malignant lump tends to be “more irregular, harder and less freely moving than benign growths” (605).

If further testing is needed, with a needle aspiration, the doctor will insert a fine needle into the suspected lump and seek to withdraw fluid. A needle aspiration can be performed in the doctor’s office, is usually painless, and avoids the problems of minor surgery in a biopsy. If fluid is extracted, then the lump is a cyst, is benign, and usually deflates. If no fluid is extracted, it may still be benign, but further testing is required. If the needle aspiration is inconclusive, a biopsy will be performed. If a biopsy is needed, then part or all of the lump will be removed for further testing. Needle biopsies remove the cells, incisional biopsies remove part of the lump, and excisional biopsies remove the entire lump. Core needle biopsies can be done in the doctor’s office as well; a larger needle used here to withdraw a small amount of the lump. Cells withdrawn in a biopsy are then sent to the lab for testing to determine if they are cancerous.

If cancer is detected, the patient will be informed of her condition and options for treatment. Before the 1980s, one-step biopsies were commonly performed, and a woman may have been anesthetized only to wake up missing a breast. Now however, doctors have realized that there is not such a strict time constraint, and so women may be informed of their options and

have the right to make their choices with all the facts in front of them. If cancer is detected, *Our Bodies, Ourselves* offers the following advice: 1) “Inform yourself,” 2) “Resist the pressure to rush,” and 3) “Talk to others with cancer” (615). In this manner, individuals can take the time to research the vast quantity of information available on cancer as well as talk to other people with cancer in order to make informed decisions.

The tumor and lymph nodes will be examined and sized according to the breast cancer stages. There are five stages of breast cancer. Stage 0 “refers to noninvasive breast cancer, either ductal carcinoma in situ or lobular carcinoma in situ” (624). Stage I “means that there is a small lump (less than or equal to 2 centimeters in diameter), and the lymph nodes or other parts of the body do not appear to be involved” (624). In Stage II, “Nodes are palpable and/or tumor size is larger (greater than 2 and up to 5 centimeters). Tumor sizes over 5 centimeters are also included in this category if the lymph nodes are not involved. There is no evidence of distant metastasis [spread of cancer cells to other areas of the body]” (624). With Stage III, “The lump is large (greater than 5 centimeters), and the lymph nodes are involved with cancer. Smaller tumors are included in this category if they involve the skin or chest wall or if the lymph nodes are so involved with cancer they are matted together” (624). The final stage, Stage IV, refers to breast cancers that have “spread to other parts of the body, as seen on X rays or scans. At this stage, a cancer is not considered curable [. . .]. Mastectomy is not useful unless the breast is infected or ulcerated. The goal of treatment is to control symptoms for as long as possible. Many women with stage IV disease live for years with only occasional symptoms” (624). Staging is necessary in order to determine treatment.

The noninvasive cancers, ductal carcinoma in situ (DCIS) and lobular carcinoma in situ (LCIS) look like cancer cells, but are not really cancer because “[. . .] they remain within their normal environment—inside the duct or lobule. In contrast, invasive (also known as infiltrating) breast cancer goes through the walls of the ducts and lobules, invading the surrounding fatty/fibrous portion of the breast tissue where blood vessels and lymphatic vessels lie” (624). Women with DCIS who are monitored but not treated have a 30% chance of developing invasive cancer in that area; women with LCIS who are monitored but not treated have a 20 to 40% chance of developing invasive cancer anywhere in the breast (624). DCIS is considered preinvasive whereas LCIS is not, but LCIS is considered to be a risk factor for future breast cancer development. Thus, LCIS does not need to be treated, but the woman should be

monitored via self breast exams and yearly mammograms. However, because DCIS is preinvasive, it is usually treated with mastectomy: “The risk of recurrence following total mastectomy for DCIS was less than 2%,” whereas “Wide excision with clear margins (similar to lumpectomy as a procedure, but DCIS rarely forms a lump) has local recurrence rates of 10 to 20%, which seemed to continue to increase over time” (625). Women must make the procedure decision themselves because both are presented as options. Newer studies are being conducted to see if further treatment, such as taking Tamoxifen, decreases the likelihood of recurrence.

For invasive cancers, there are local treatment options (surgery and radiation) and systemic treatment options (chemotherapy and hormone therapy). Depending on the size of the lump, degree of lymph node involvement, and possible metastasis, different local treatments are suggested. Women with Stages I and II who have had mastectomies or lumpectomies have not been shown to have different survival rates, but women who have had lumpectomies without radiation had a local recurrence rate of 40% whereas women without radiation therapy had a local recurrence rate of 8% (626). A lumpectomy “removes the lump and a varying amount of surrounding tissue with a goal of microscopically clear margins” (626). A total mastectomy “removes the nipple/areola and all of the breast tissue but leaves the underlying muscles and the lymph nodes” (627). A modified radical mastectomy “is a total mastectomy plus removal of the lower axillary lymph nodes to stage the cancer” (627). Lymph nodes are removed to determine the spread of the cancer and possible need for systemic therapy, but not all nodes need be removed, or swelling, lymphedema, may occur in the arm. A radical mastectomy, also known as the Halsted mastectomy, “involves removal of the nipple/areola, all of the breast tissue, the muscles underlying the breast, and a more extensive axillary lymph node removal. This operation is no longer recommended by the NCI and should almost never be performed” (627). Radiation therapy “consists of external electron beam treatments to the breast five days a week for five to six and a half weeks” (626). Lumpectomy is now almost always performed in coordination with radiation therapy. For a lumpectomy, the tumor must have “microscopically clear margins (no microscopic cancer cells seen at the edge of the tissue of the edge of the tissue removed)” (626). Also, the original size of the breast and tumor matters: a larger tumor removed from a smaller breast will leave the breast more misshapen than a smaller tumor removed from a larger breast. Lumpectomy is an option for about 70 to 75% of women with breast cancer, yet *Our Bodies, Ourselves* notes that actual use of this equally successful breast-conserving fails to

match this percentage, due perhaps to women's fear that it will not be as successful or doctors' failure to promote the procedure.

Systemic therapy includes chemotherapy and hormone therapy. While cancer may not have spread detectably to other parts of the body, "As approximately 25% of [lymph] node-negative women eventually show signs of metastatic disease, increasing numbers of women in this group are also treated [. . .]" with systemic therapy to decrease the likelihood of metastasis (629). Thus, "[. . .] as many as 75 to 80% of node-negative women are treated with systemic therapy in the hope of catching the 25% who do have microscopic metastatic disease" (629). Chemotherapy consists of a variety of drugs, usually combined in a "cocktail," to achieve the best results in order to kill remaining cancer cells. It is not known what combination works best for which women, which women should undergo chemotherapy, or for how long or when chemotherapy should be performed, and so a woman's experience with this treatment can start as a trial-and-error to see which seems to be working best (with the least amount of adverse side effects) for her. Hormone therapy is often used for breast cancer that has been determined to be estrogen-receptor positive, that is, noted to be stimulated to growth by estrogen. Hormone therapies, like Tamoxifen, "cut off the estrogen supply to such breast cancer cells, inhibit growth of the cancer, and eventually kill it" (630). Other procedures related to hormone therapy may include oophorectomy, removal of the ovaries, in order to suppress estrogen production, or adrenalectomy, removal of the adrenal glands, in order to limit estrogen production.

Deciding between treatment options is not easy, and although treatment is partially dictated by the stage of the disease and the size of the tumor, there are, again, no reliable directives for treatment. Women must thus become informed and seek second opinions prior to making treatment decisions. If surgical treatment is necessary, women must then face another choice—what to do with their scar and modified breast tissue. Some women, like Deena Metzger (shown with her tattoo in *Our Bodies, Ourselves*) choose to forgo any kind of prosthetic or reconstruction. Today's prostheses offer women the option of choosing a comfortable, made-to-order synthetic breast that may be inserted into a bra or even directly onto the chest. Prostheses, however, may be uncomfortable, heavy, hot or cold, or shift.

Reconstruction offers women another option, and it may be performed immediately following the initial surgery or any time afterwards. *Our Bodies, Ourselves* explains that women should make the decision for reconstruction for themselves and on their own time:

Some doctors used to imply that undergoing reconstruction was vain, but over time this attitude has changed; now women are often advised that we will feel better if we have it done. This is a matter of personal choice, and we have the right to learn about surgical options. While nothing can make up for the loss of your breast, reconstruction can help you regain its appearance. Deciding to have breast reconstruction has helped many women both physically and emotionally.

(627)

Reconstruction may be use an implant, “a rubber-like envelope filled with salt water (saline) or silicone” (628) or fatty tissue from another part of a woman’s body.³⁹ In such an operation, “The implant is placed behind the pectoral muscle; then the skin is sewn together, making the area bulge into a breast-like form” (628). Or, “Another type of implant, know as an expander, places a hollow sac behind the pectoral muscle, and the overlaying skin is sewn together. A valve with a port, which has a tube leading to the hollow sac, is inserted under the skin. Over a three- to six-month period, the doctor injects saline through the port, which expands the sac and stretches the skin out” (628). In another reconstructive option, fatty tissue may be taken from the back, stomach, or buttocks and moved to the chest area and is known as a flap reconstruction. In other instances, implants and fatty tissue from the body may be used together. Problems that may result due to reconstruction, in addition to the general risks of surgery and anesthesia, include the loss of feeling or sensation, burst or leaking implants, and/or loss of lactating ability.

Following a woman’s treatment, whatever the method, she will necessarily endure a period of convalescence and rehabilitation, according to the nature of her treatment. With breast cancer, a “cure” is not easily defined by a five-year remission: “Many physicians no longer speak in terms of cure because no one can tell which individuals have been cured. Instead, they refer to long-term remission or survival rates” (630). There are certain characteristics that offer higher long-term survival: “no axillary lymph nodes with cancer,” “cancer is estrogen-receptor (ER) positive,” “tubular carcinoma and no positive axillary nodes,” and “tumor cells are well-differentiated; that is, they retain more of the characteristics of normal breast cells rather than the embryonic appearance of advanced cancer cells” (630-631). However, these characteristics

³⁹ *Our Bodies, Ourselves* reports that “In 1992, the Food and Drug Administration (FDA) imposed a moratorium on the sale of silicone gel breast implants, particularly for cosmetic breast enlargement. Exceptions to the ban were made for women who wanted breast reconstruction following cancer surgery, but only if their physicians used approved protocols and participated in a registry” (628). Today, this ruling is currently under research and may be overruled or upheld in the near future.

cannot ensure a woman's survival or foresee her death; each woman is different, and each cancer is different. Thus, a summary of breast cancer, detection to treatment, ends as it begins, without reliable information.

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CURRICULUM VITAE

EDUCATION:

MA. in English; Virginia Tech; Blacksburg, VA Expected May 2004

- Women's Studies Graduate Certificate
- GPA: 4.0/4.0

B.A. in English,; University of Delaware; Newark, DE May 2002

- English Education Major, History Minor
- *Magna cum Laude*, GPA: 3.85/4.0

TEACHING EMPLOYMENT:

Graduate Teaching Assistant; Virginia Tech; Blacksburg, VA August 2002 –Present

- Instruct first-year composition courses (ENGL 1105/1106), focusing on helping students to read critically, think analytically, and compose sophisticated forms of written and oral communication.

Extended Time Teacher; Middletown High School; Middletown, DE June - August 2001, 2002, 2003

- Provide academic support in reading/language arts for students, 9th and 10th grade, identified as in need of support who may not qualify for special education. The program specifically addresses the students' needs as indicated by the Delaware Student Testing Program (DSTP) and prepares students for subsequent retesting of the DSTP and meeting the established state standards.

Substitute Teacher; Middletown High School; Middletown, DE January 2001 - February 2001

- Serve as an emergency long-term substitute, continuing study of 11th grade general level American Literature with an emphasis on reading comprehension and analytical/critical writing skills.

OTHER TEACHING EXPERIENCE:

Student Teacher; Glasgow High School; Newark, DE February 2002 - May 2002

- Grade 10 Academic American Literature
- Grade 12 College Preparatory World Literature
- Prepare and instruct lesson plans as the sole teacher using state standards, curriculum requirements, and various student ability levels.

Classroom Observations:

- Grades 10 and 12; Glasgow High School; Glasgow, DE August 2001- December 2001
- Grade 8; Shue-Medill Middle School; Newark, DE February 2000 - May 2000
- Grade 11; Hodgson Vo-Tech High School; Bear, DE February 1999 - May 1999
- Observe a teacher in the classroom for at least twenty hours each semester and prepare observation reports in preparation for future classroom instruction.

Creating Independence through Student-Owned Strategies; Dover, DE April 2002

- Participate in a two-day workshop focusing on reading skills applicable across subject areas intended to aid students in reading comprehension and critical thinking.

OTHER EMPLOYMENT EXPERIENCE:

Support Representative; MBNA America; Newark, DE September 1997 - August 2002

- Provide administrative secretarial support, gaining experience with a variety of computer-based productivity tools, corporate communication methods, and customer satisfaction skills.

Resident Assistant; University Courtyard; Newark, DE August 2001 - May 2002

- Responsible for a 64-person building; educational, recreational, social, and cultural programming, as well as policy enforcement, conflict resolution, and diversity issues at an apartment complex.

Resident Assistant; University of Delaware; Newark, DE August 2000 - May 2001

- Responsible for a 35-person residence hall floor; educational, recreational, social, and cultural programming, as well as policy enforcement, conflict resolution, and diversity issues at a major university.

SERVICE:

Yearbook Volunteer; Blacksburg High School; Blacksburg, VA September 2003 - Present

- Assist students and faculty advisor in the creation, layout, design, and editing of the school yearbook.

Graduate Student Conference; Virginia Tech; Blacksburg, VA September 2003 - Present

- Serve as webmaster and assist in preparation details for the conference.

Teaching Assistant Orientation; Virginia Tech; Blacksburg, VA August 2003

- Present issues in GT A classroom authority and instruction in grading methodologies for written assignments.

ACTIVITIES/ORGANIZATIONS:

English Graduate Student Organization; Virginia Tech; Blacksburg, VA August 2002 – Present

- Serve as President and Webmaster. EGSO sponsors weekly meetings, Fall and Spring book fairs, poetry readings, clothing drives, recycling, and social gatherings.

Sigma Tau Delta; University of Delaware; Newark, DE May 1999 - May 2002

- Serve as Treasurer. Sigma Tau Delta, the English Honor Society, sponsors monthly meetings, poetry readings, guest speakers, book drives for children, and an annual faculty-student tea.

London Study Abroad; University of Delaware; Newark, DE January 2000

- Study elements of performance, character analysis and portrayal, voice, improvisation, movement, and dance based on observed performances.

HONORS/AWARDS:

Phi Beta Kappa, Humanities Honor Society	2002
Golden Key Honor Society	2001
John P. Nields Scholarship	2001
Education Alumni Scholarship	2000, 2001
Alpha Lambda Delta Honor Society	1999
University of Delaware Academic Incentive Award	1999
John B. Lynch Trust Scholarship	1998 - 2002
University of Delaware Scholar Award	1998
Women's Club of Odessa Scholarship	1998