“The Experience of Illness in all of its Complexity”: Breast Cancer, Healthy-Mindedness, and New Momism Movements at Work in the Illness Narratives of Rosalind MacPhee & Kathlyn Conway

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By
Brette Ehalt

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Abstract

Picasso's Woman: A Breast Cancer Story (1994) and *Ordinary Life: A Memoir of Illness* (1997) tell of the breast cancer experiences of Rosalind MacPhee and Kathlyn Conway, respectively. This thesis examines how three particular social movements—the breast cancer, healthy-mindedness, and "new momism" movements, all described in Chapter One—affect how MacPhee and Conway experience breast cancer and then write about it in the 1990s. Chapter Two examines the language of war that MacPhee and Conway adopt to describe illness and how such language leads them to examine the possibility proposed by the healthy-mindedness movement: that they are personally responsible for bringing a "determined killer" (Conway 125) into their lives. Chapter Three studies their active patient behaviours, as advocated by the breast cancer movement, as well as their more passive ones. I consider the relation between these active and passive behaviours in light of the severe nature of mastectomies and the presentation of post-surgical options. Chapter Four investigates how MacPhee and Conway struggle to maintain their roles as supermoms, busily attending to responsibilities at home and work, while simultaneously managing their recoveries. In each Chapter, the influence of the social movements named above becomes apparent as MacPhee and Conway attempt to move themselves and others out of the breast cancer experience and back into "a sense of normality" (MacPhee 106).

Acknowledgements & Dedication

Thank you, Hilary, for making this better with every edit and thank you, Keldon, for listening to my "I *need* to focus" spiels over the last two years. I know now that what I should have been saying was "I *need* to not procrastinate."

Half of this thesis is dedicated to specific women in my McWilliam family, all of whom are deceased and most of whom I never met: my great-grandmother, Leona, and her sisters—Christina, Adeline, Amanda, Agatha, Marian, and Madeline.[1] All of them died from breast cancer-related causes. And then, to my Grams, as well, because she checks her breasts every time she has a bath (although she's more concerned about her swollen foot than her breasts these days) and because she tells me to "paddle my own canoe" and not to cheat on my husband.

One-quarter of this thesis is dedicated to Mary, a woman who explained to a group of young women, myself included, that repressed anger caused her breast cancer.

The other quarter of this thesis is dedicated to English Majors everywhere who have, at some point, asked themselves: does what I do matter? Is what I write applicable? For the longest time, I struggled to spit out a "yes" to both questions. I struggle no more. I dare say that, on almost a daily basis, I hear, read, or see *something* that relates to the issues brought forth in this thesis. And so, I feel that the chapters you are about to read actually *matter* because I know that someday I, too, will examine myself daily in the tub (in fact, I've been told I should *already* be doing this), and that you or someone you know will be doing the same thing. And if it should be me that finds a lump—let's face it, I'm genetically screwed—then the way I feel, speak, and write about breast cancer will become very, very important. I know that now. I didn't before.

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[1] When Grams told me her aunt's names I asked, "Madeline and Adeline? Rhyming names? Really?" To this she replied, "They were hard up for names on the farm, you know. If you want to change their names you can."

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Introduction

Of primary interest in this thesis are two "supermoms" (Hays 132) with breast cancer and the way in which they address, explain, and consequently live out this illness as recorded in their autopathographies: *Picasso's Woman: A Breast Cancer Story* (1994) by Rosalind MacPhee and *Ordinary Life: A Memoir of Illness* (1997) by Kathlyn Conway. In addition to being a wife to Peter and mother to sixteen-year-old Jenny and nineteen-year-old Katherine, MacPhee is a paramedic and station chief in British Columbia, a fine arts student, a poet, and a friend. MacPhee makes clear that her many roles help to define who she is and what is important, and so, too, does Conway. As a Harvard graduate, with degrees in literature and social work, and a psychotherapist with a private practice in New York City, Conway considers herself a "professional" (210); additionally, she calls herself a wife to David, a mother to eleven-year-old Zach and seven-year-old Molly, a daughter, and a friend.

In the decade that "witnessed an explosive proliferation of information about breast cancer in the popular media" (Yadlon), both women adopted another role: the role of breast cancer patient. MacPhee was diagnosed in 1991 at the age of 45, and two years later, Conway, 43, was told she had first-stage breast cancer. Not long after diagnosis, MacPhee and Conway each authored a breast cancer narrative; their pathographies were among many published at this time. In the 1990s, when stories of illness authored by patients themselves were widely received by the public (Diedrich 38, Leopold 254), the breast cancer narrative became a "distinctive autobiographical subgenre" (Couser 42) with characteristic features, both of the authors and their texts. Like many pathographers with breast cancer, MacPhee and Conway are white and somewhere between middle- and upper-class. They have access to adequate medical care, support from friends and family, enough leisure time to write about their experiences, and contacts in the publishing world (Couser 38). Like other breast cancer memoirs, *Picasso's Woman* and *Ordinary Life* are organized around the following events, in this order: "discovery…of a suspicious lump in her breast; diagnosis of cancer; the assessment of treatment options; some form of surgical treatment, lumpectomy or mastectomy; some form of adjuvant treatment—radiation, chemotherapy, hormone therapy, or a combination of these; recovery and resolution in the form of favorable reports and restoration of (relative) peace of mind" (Couser 42).

MacPhee begins by recalling her discovery of a lump in the shower, and how her family doctor and surgeon believe the lump a cyst until a biopsy reveals cancerous cells. She writes, next, of the medical examinations and decisions that follow her diagnosis: her ultrasound, liver scan, chest X-ray, bone scan; her decision to have a modified radical mastectomy and to forego reconstruction and chemotherapy; her daily post-operation exercises, physiotherapy, and check-ups. She tells how another lump is found, biopsied, diagnosed as hyperplasia,[1] and removed. And in between these cancer-specific details are those about work shifts, school tests, visits with good friends, family dynamics, and walks with the dog.

Conway begins her memoir by explaining how a mammogram detected a lump in her left breast many years after her bout with Hodgkins Disease.[2] She recalls her referral to a specialist, tests (an EKG and chest X-rays), a biopsy, and the diagnosis of cancer. Initially it is supposed that she should have a lumpectomy and radiation; later, she undergoes a mastectomy, chemotherapy, and breast reconstruction. Conway records her regular appointments with the cosmetic surgeon, Dr. Breckman, to have her breast expander inflated and with her oncologist,

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[1] Dr. Harris explains that the cells of this second lump were "in the process of changing" (215) but not yet malignant and he calls this state "hyperplasia." Dr. Susan Love defines "hyperplasia" as, simply, an "excessive growth of cells" (606) while *Stedman's Medical Dictionary* defines it as "an increase in the number of normal cells in a tissue or organ, excluding tumor formation, whereby the bulk of the part or organ may be increased."

[2] In her mid-twenties, Conway was diagnosed with Hodgkin's Disease, a malignant lymphoma that most commonly affects individuals between fifteen and thirty-five years old ("Hodgkin's"). She refers to experiences of this first cancer in many passages throughout *Ordinary Life*.

Dr. Moore, to have twelve rounds of chemotherapy. In fact, the latter half of her memoir focuses mainly on the events surrounding her chemotherapy treatments, such as her symptoms (including hair loss and nausea), wig-shopping, and associated feelings of despair and frustration. Also included intermittently are details regarding her work (she sees her patients steadily throughout her entire cancer experience), friends, family, and travel.

Overall, both memoirs end "'happily,' with some significant recovery" (Couser 39), and in this way these narratives are consistent with most other illness narratives. In the Afterword that follows *Picasso's Woman*, activist Judy Caldwell reflects on the severity of breast cancer. Caldwell begins: "Imagine yourself picking up the newspaper one Saturday morning to find a front-page headline screaming, '747 crashes. All 415 passengers killed. Onlookers shocked and horrified'. . .This year, 5400 Canadian women will die of breast cancer—the same number as would perish in . . . thirteen imaginary crashes" (263). She later writes that neither women nor men are "safe" (264) from the disease, and that MacPhee will always be at risk—her restoration may only be temporary. (MacPhee notes, too, that "there might be challenges ahead" [262].) Caldwell continues with further statistics, research news, and advice about breast cancer. G. Thomas Couser notes that this "call for mobilization" (38), to supplement MacPhee's story, is another common characteristic of the breast cancer narrative.

Picasso's Woman and *Ordinary Life* are primarily restitution narratives. In *The Wounded Storyteller* (1995), sociologist Arthur Frank identifies three types of the illness story—restitution, chaos, and quest narratives—but notes how "no actual telling conforms exclusively to any of the three narratives. Actual tellings combine all three, each perpetually interrupting the other two" (76). The restitution narrative focuses on the restoration and expectation of health, emphasizing repair, remedy, and cure; "the teller of the restitution story wants the body's former *predictability* back again" (85), writes Frank. The chaos story, on the contrary, speaks to the lived experience of illness and so stresses a lack of order and control; the teller is overcome with troubles and unable to adequately articulate them. Frank writes that “the person living the chaos story has no distance from her life and no reflective grasp on it” (98). Yet, in writing or speaking the story, the teller does implement some degree of control and reflection, and so, the chaos story can never truly be told. Last, the quest narrative equates illness with a journey of transformation. Although the teller returns to good health, she is changed by illness (118) and uses her experience for some kind of gain or insight. Although MacPhee’s story is marked by aspects of a quest, in terms of personal and relationship development, and Conway’s story repeatedly hints at chaos—that is, what she feels are her uncontrolled emotions and continual bodily complaints—both stories are restitution narratives in that they focus primarily on the teller’s recovery of health and the steps taken to get there, such as visiting doctors and having medical tests performed. Illness is viewed as “temporary” (Conway 180); all efforts are taken to reestablish a pre-cancerous body and life.

MacPhee’s narrative, particularly, is guided by a desire to resume her regular, vigorous activities so that she might restore (and even defend) her “kinship with Superwoman” (4). In the first chapter, alone, she tells of how she has hiked throughout British Columbia and Alaska; how she has canoed hundreds of miles; and how even high waves and winds fail to stop her from kayaking near her home. Then, she addresses her health specifically, admitting that, initially, she believed herself “too healthy” (8) for breast cancer and that she “had always held on to [her] good health tenaciously” (56). She recalls, following surgery, telling another patient that she is “‘healthy and well’” (94); she recounts her vigorous walks in hospital hallways and her eventual routine of biking, dancing, and walking at home. MacPhee also mentions that by the time she returns to work, she is “in better physical condition than [she’d] been in for many years” (185).

Conway’s narrative is preoccupied less with the idea of good physical health and more with a return to life without poor health, for she has “no time for an illness that so aggressively forces itself to center stage" (117). She repeats, during the latter half of the memoir especially, her desire for normalcy and her efforts, in the meantime, to feign normalcy (124, 132). She writes about how she began to console herself with the belief that "treatments will end, and I will return to ordinary life….There are no guarantees that this cancer will not recur, but this episode will probably be the end of it" (189). And after celebrating her one-year remission, she records how wondrous it is to feel healthy again (250).

Frank describes the restitution narrative as the type preferred by audiences because "contemporary culture treats health as the normal condition that people ought to have restored. Thus the ill person's own desire for restitution is compounded by the expectation that other people want to hear restitution stories" (77).[3] For Rosalind MacPhee and Kathlyn Conway, however, I argue that restitution is not merely expected but required due to the overwhelming feeling of responsibility for their own health that intersecting gendered social ideologies bring into their lives. Indeed, the breast cancer movement, which initially sought to give women patients autonomy (and has done so), has morphed into a culture that holds women responsible as both patients and individuals to overcome their illness with the fervor of Rose Kushner and warrior spirit of Audre Lorde. The healthy-mindedness movement proposes that the "character causes the disease" (Sontag 6), but that optimism and soul-searching may cure it. Finally, the new momism movement insists that good mothers place their children's needs above their own no

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[3] Arthur Frank explains that this expectation of health was articulated in the mid-twentieth century by Talcott Parsons in *The Social System* (1950). In a discussion of the "sick role," Parsons clarifies that "the sick person is helpless and therefore in need of help" (440). The sick person is neither responsible for being sick nor expected to partake in normal activities (443), but must seek direction from trained professionals so he or she may return to normal life as quickly as possible. At the heart of the sick role, says Frank, "is the assumption of restitution: returning the sick person to the status quo ante" (83), and this assumption continues today. I, however, will include no further discussion of the sick role in this essay as the restitution narrative of breast cancer now emphasizes the responsibility women have for their own health and healing alongside responsibilities related to work and home. In *Ordinary Life* and *Picasso's Woman*, specifically, Conway and MacPhee *are* presented as responsible for being sick and *are* expected to partake in normal activities, in addition to choosing their treatment options. For MacPhee and Conway, the sick role does not apply.

matter what; thus, for the sake of their children, mothers with breast cancer either compromise or criticize their expression of illness. That is, they do not openly communicate thoughts, feelings, and fears about the disease, their changing bodies, and their altered lives or “accept illness fully” (Frank, *Will* 3) because that would interrupt their “unwavering affection and devotion” for their children (Lafrance 34). These movements will be discussed more fully in Chapter One; together, they significantly impact the breast cancer experiences and narratives of our two authors.

In Chapter Two, I discuss how MacPhee and Conway, as both patients and authors, conceptualize breast cancer with the military metaphors common in breast cancer culture and consequently examine their own involvement in bringing an enemy or “evil” illness into their lives. In Chapter Three, I observe how they behave actively as patients—and so in accordance with breast cancer and healthy-mindedness cultures—but also how they are unable to avoid behaving passively in response to post-surgical options and the severe nature of their treatments. In Chapter Four, I consider the ways in which they uphold new-momist beliefs as they attempt to manage duties of home and work in supermom style, all while “battling” breast cancer. It becomes clear that the breast cancer, healthy-mindedness, and new momism movements influence patients Conway and MacPhee to believe that they must do whatever it takes to maintain or regain control—of their minds and bodies, and in their homes and workplaces—in the midst of experiencing a potentially fatal disease.

As authors with opportunity to comment retrospectively on their patient experiences, they reflect little on these ideological influences. They do not consider that breast cancer discourse may not necessitate language of war, that they may not have *any* responsibility in becoming ill, and that they, as mothers, do not have to be “super” amidst surgery and treatment. It seems, they accept the ideological messages presented to them and do not seriously consider how their “chosen” language, beliefs, and ideas actually reflect those of society. Their stories, then, serve to demonstrate the North American tendency to make illness “wholly personal” (Diedrich, Rev. 111), and—perhaps—their publishers’ desire to profit on account of this. Motivated by money, publishers “are focused on capturing the widest possible audience and thus, one rarely reads a story about death, devastation, anger, or political activism. Such stories invoke controversy and unease, which contradicts the ‘feel good’” response designed to satisfy readers (Fosket et al 321). Ultimately, MacPhee’s and Conway’s memoirs join other media in depicting breast cancer “as a private issue and not as a public concern” wherein individuals, rather than institutions, are held responsible for widespread disease (Fosket et al 320). It is my belief, however, that breast cancer *should* be seen as a public concern and discussed, not only in terms of individual lifestyles of women, but in relation to their collective exposure to the contaminants in air, food, and water produced by industry and agriculture in our nations. Indeed, responsibility for breast cancer causation lies not with women but with the corporations that pollute their bodies through the mass production and distribution of environmental toxins.[4]

My analysis is important, I believe, because little has been said on this particular conjunction of cultures in the commentaries on breast cancer narratives by scholars like G. Thomas Couser, Lisa Diedrich, and Laura K. Potts. While these scholars have identified patterns and characteristics of these stories, discussed the prevalence of personal responsibility discourse, and studied motives for writing memoirs, they have not recognized the role of social ideologies *collectively* in the construction of such memoirs—nor have scholars Arthur Frank and Anne Hunsawker Hawkins. This thesis, however, builds upon Frank’s thoughtful reflections on the illness experience, his acknowledgement of social expectations of the ill, and his distinction of

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[4] See Sandra Steingraber’s article, “The Environmental Link to Breast Cancer,” in *Breast Cancer: Society Shapes and Epidemic* for a more detailed discussion of environmental carcinogens and breast cancer.

illness narrative types. It adds, too, to Hawkins' thorough account of pathographies greatly influenced by tenets of healthy mindedness.

This particular study of *Ordinary Life* and *Picasso's Woman* is significant because both works—neither of which has been examined at length—reveal the pervasiveness of the ideologies mentioned above and so remind us, the readers, that the responsibility of depersonalizing breast cancer is not only the authors' but *ours*, and not just with regard to these specific memoirs, but with regard to breast cancer memoirs already written and future memoirs to come. By the end of 2009, it is expected that 22,700 Canadian women and over 190,000 American women will have received a new diagnosis of breast cancer (Canadian Cancer Society, *Statistics*; American Cancer Society). Each of these women will be affected by the physical realities of this disease and by the complex social forces surrounding it. Some may even go on to write and publish their stories; if they do, the challenge will be whether they and we "can be responsible enough to hear and see what illness is" for each of them and for ourselves (Frank, *Will* 128).

Chapter 1

Shaping the Disease: Breast Cancer, Healthy Mindedness, and New Momism Movements

The Breast Cancer Movement

For most of the twentieth century, women with breast cancer "had only one decision to make—whether or not to undergo a radical mastectomy . . . but proceeding without it meant certain death" (Olson 6). Used originally to treat advanced breast cancer cases in the early 1900s, the procedure involves the removal of the entire breast along with the underlying pectoralis major and minor muscles and all the lymph nodes in the axillary area. In the mid-twentieth century, despite criticism from some physicians who argued for less aggressive surgery, the radical mastectomy prevailed in America as *the* standardized treatment for breast cancer at any stage (Olson 89-92). It was not until the late 1970s, when research findings favored more conservative treatments and when "women with breast cancer began to demand less mutilating operations as well as full participation in medical decision making" (Lerner 27), that circumstances changed. Certainly, their demands and the consequent beginnings of the breast cancer movement were influenced by the success of the AIDS movement and were built upon the tenets of the Women's Health Movement and second-wave feminism.

In the United States, in 1969, "a woman who placed herself under doctor's care had the duty to do what she was told" (Morgen 11); in 1971, one group of American surgeons stated that "women have no business making a decision about the extent of surgery for breast cancer on grounds that one cannot make a wise selection when disturbed by tensions and emotions" (Ruzek 114). In the decades to follow, however, women gradually began to make decisions for themselves as they became increasingly educated on their own health issues, due largely to bold female educators.[5] The women of The Boston Women's Health Book Collective, for example, committed themselves to "print-based consciousness raising" (Morgen 22) and saw their comprehensive text, *Our Bodies, Ourselves: A Book By and For Women* (1970), achieve success worldwide. The Collective writers covered a range of topics from female anatomy, sexuality, nutrition, rape, abortion, and menopause, to the health care system. Between commentary on hypertension and crabs, in the 1976 edition, there is a section on breast problems, self-examinations, and breast cancer, with special attention paid to the radical mastectomy. "There is no longer any justification for any version of the radical mastectomy" (133), they write:

> If keeping your breast is of vital importance to you, there are highly reputable doctors who can help to plan treatment which may permit that . . . . If you are a very high-risk patient, you can decide how you want to fight your battle against breast cancer, which approaches would give you the most will and strength to cope with the disease. This is rarely the same from woman to woman, and we need to be helped to demand the choices that will give us the greatest sense of confidence. Again, do not expect this type of support from your physician. (135)

Similar statements were made around the same time by feminists in Canada who were analyzing the treatments women received (Cohen and Sinding 2), discussing their bodies and health issues in self-help groups and "Know your Body" courses, and establishing women's health centres and clinics (McDonnell "Women's" 19-20). In 1972, the Vancouver Women's Health Collective published a booklet with a story, mission, and content similar to *Our Bodies, Ourselves.* The writers included the results of their own health survey along with information

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[5] Sandra Morgen highlights many of these educators in *Into Our Own Hands* (2002): Carol Downer and Lorraine Dothman, who traveled the country demonstrating cervical self-examination; members of Jane, an underground clinic in Chicago, who spoke to thousands of women about the nature of abortion and its risks, in addition to performing illegal abortions; and members of the National Women's Health Network, who convinced the Food and Drug Administration to include informational inserts with estrogen-based pharmaceutical drugs to alert female patients to potential side effects.

related to contraception, abortion, pregnancy, socialized sexism, free health clinics, and childbirth. Included in the second edition is a one-page contribution submitted by reader Sheilah Thompson entitled, "Breast Cancer and Informed Consent." After commenting on the high frequency of radical mastectomies, she states her doctor's opinion—that such surgeries are absolutely unnecessary—and encourages patients to become more informed so that they can make their own decisions (85).

Indeed, the concept of patient autonomy was central to the women's health movement. By the 1980s, "a new consciousness about health care" ("Taking" 86) had emerged, according to Kathleen McDonnell in *The Healthsharing Book: Resources for Canadian Women* (1985): "We now routinely use the rhetoric of 'patients' rights,' talk of 'taking responsibility for our health,' and feel free to explore a variety of treatments" (86)—except when faced with life-threatening illness. She continues:

> Because we are frightened, our tendency is often to panic, to fall back on our old conditioning and deliver ourselves over to the experts to be saved. But these periods of extreme stress may be just the times when it is most vital to hold on to our new health consciousness. When we face a serious illness such as cancer it is more important than ever to be well informed, to consider all our options, to ask questions, to feel that we are truly in control. Just because the stakes are so high, and because some of the treatment options have such powerful side effects, we need to remember that our bodies are our own, that the decisions are ours, and that the health professionals we consult are there to help us, not to take over and make the decisions for us. (86)

Also by the 1980s, figures like Betty Ford and Happy Rockefeller had spoken publicly about their own mastectomies; mammography screening was widely discussed; local support groups were well established; and an increasing number of breast cancer narratives were being published. *Breast Cancer: A Personal History & Investigative Report* (1975) by Rose Kushner and *The Cancer Journals* (1980) by poet Audre Lorde were particularly popular. Both works demonstrate and argue for the power of patient control.

In her first chapter, Kushner summarizes the early events of her cancer experience. After locating a lump, she hurriedly sees her medical internist, insists upon seeing a specialist should a biopsy be necessary, and tells her husband, "'Nobody's hacking off my breast while I'm unconscious unless I'm convinced that that's the only thing there is to do'" (11). She receives a xeromammograph,[6] borrows the only breast cancer book from the public library, and then visits the National Institutes of Health library. She learns about the routine one-stage procedure, wherein the diagnostic biopsy and mastectomy are performed in one surgery and the patient is anesthetized from beginning to end. Believing this procedure "barbaric" (16), Kushner decides to have a two-stage procedure, with a modified radical mastectomy performed on its own, should she have cancer. Of course, when a biopsy later reports cancerous cells, she goes to great lengths to find a surgeon who does not insist upon a radical mastectomy. Near the end of the chapter, she reflects that "the important thing is that what I chose was my own decision" (29), even though she had to declare her choice very loudly in order to be heard.

Kushner's *Breast Cancer* has been deemed "the first self-help manual for women with breast cancer" (Knopf-Newman 25), likely because her remaining chapters are mostly instructive: she discusses breast cancer and its history; potential risk factors and possible causes; breast self-examinations; problems with the one-stage procedure; the kinds of mastectomies available to women; post-surgery realities, both physiological and psychological; chemotherapy and radiation; and so forth. Indeed, the entire work is a testament to Kushner's personal commitment

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[6] *Taber's Cyclopedic Medical Dictionary* defines "xeromammography" as "an obsolete radiological technique formerly used to image the breast." Kushner is told that a xeromammogram is a "new way to take mammograms" (Kushner 6).

to self-education on breast cancer. Her commitment is even praised by her oncologist, Dr. Dao, in the book's Foreword: "As soon as she recovered from her mastectomy, she found a publisher and was on her way to Europe to visit various institutions and interview numerous experts for her book. This demonstration of energy and zest for life after a mastectomy should be an inspiration to women everywhere" (xi).

One woman who was most likely inspired by Kushner was Audre Lorde, who read *Breast Cancer* (Knopf-Newman 110) and recorded her own breast cancer experience in *The Cancer Journals* (1980). Lorde does not aim directly to educate her audience; rather, she emphasizes significant events following her own diagnosis. She minimizes medical details to illuminate the trying on and rejection of a prosthesis, the excruciating physical pain and emotional grief she felt, the healing power of female friendships, and the deep learning of the self that occurs when death is near. Lorde does make clear, however, that her decision to have a modified radical mastectomy, three days post-biopsy, was made after examining every possibility (30), and that because she was "conscious of being able to choose" (32), she was empowered by her decision. But empowerment, she suggests, ultimately comes with responsibility. She asks, "How do I give voice to my quests so that other women can take what they need from my experiences?" (15), and then poses a similar question to her audience: "What do you need to say?" (19). For Lorde, silence is unacceptable; a "female outcry against all preventable cancers" (8), by the thousands of women who have experienced cancer, is the objective. Lorde uses her own voice to expose the false promises of breast prostheses. Unlike Kushner, who wanted to look "as normal as possible" (Kushner 20) and readily embraced her silicone prosthesis, Lorde argues that a prosthesis promotes societal expectations of the female body, denies difference, encourages invisibility, and prohibits self-scrutiny. Lorde also uses her voice to alert other, perhaps future female warriors, to the necessity of cancer education: "Every woman has a militant responsibility to involve herself actively with her own health. We owe ourselves the protection of all the information we can acquire about the treatment of cancer and its causes, as well as about the recent findings concerning immunology, nutrition, environment, and stress" (75).

By the 1990s, the kind of cancer education Lorde describes became a national priority in America, and due to national advocacy efforts and consequent government initiatives, breast cancer was deemed *the* women's health issue in America. While organizations like Y-Me (1979) (now called the Breast Cancer Network of Strength) and the Susan G. Komen for the Cure (1982) were already in place, it was not until 1991, when the National Breast Cancer Coalition (NBCC) formed and demanded government action, that major change occurred. The NBCC, writes Carol Weisman, positioned breast cancer "as a problem for *all* women;" thus, "the illness was labeled an epidemic by activists and journalists, whose rhetoric emphasized that most women (including younger women) were at risk, that access to screening and treatment services therefore should concern all women, and . . . that the failure of public policy to address breast cancer was an issue of gender equity" (220).

In Canada, volunteer-led organizations like the Canadian Breast Cancer Foundation (1986) and the Breast Cancer Society of Canada (1991) formed with a shared vision: to eliminate breast cancer by fundraising for prevention, detection, and treatment research. In 1993, the federal government joined their efforts, committed millions of dollars in research initiatives and carried out a national forum on breast cancer. Forum participants addressed the "national problem" (*Report* 1) affecting one in nine Canadian women and offered 44 recommendations to the government in the areas of prevention, screening, treatment and care, and research. All recommendations stemmed from the basic belief that "the woman with breast cancer is recognized as an important member of the treatment team, with the right to make informed choices, to ask for a second medical opinion, and to combine conventional treatments with complementary therapies should she so wish" (*Report* 8).

By the turn of this century, the efforts of individuals, organizations, and consequently, governments across both countries enabled breast cancer patients to take a "central role" (Lerner 45) in choosing from many conventional treatment options. As Dr. Susan Love explains in her *Breast Book* (1995), patients could, in terms of local treatment,[7] have surgery alone or with radiation. Surgery might involve a lumpectomy or partial mastectomy, wherein a wedge or quadrant of breast tissue is removed along with the cancerous lump; or surgery could involve a total or modified mastectomy, wherein some lymph nodes and most, if not all, breast tissue is removed. Daily radiation treatments, if used, could precede or follow surgery for nearly seven weeks, followed by a boost. For systemic therapy, patients with tumor-sensitive hormones could undergo hormonal treatment, using tamoxifen, and any or all patients could receive a combination of chemotherapy drugs (Love 322-7, 364-9, 374-6).

Certainly, patients then and especially now are fortunate to have more treatment options than ever before, although even with the added options, the mortality rate has not improved much (Altman 170). Additionally, with these choices comes the responsibility of choosing, and with a potentially life-threatening illness, this responsibility is great. Former breast cancer patient Roberta Altman writes, "It is crucial to make sure you know all you have to know to make the best treatment decisions for yourself. You cannot rely on anyone else" (335). According to this view, the patient must hurriedly educate herself by taking advantage of the multitude of resources now available: she must read many books and reports, contact advocacy groups, join support groups, phone hotlines, go online, and question doctors but then, ironically, make feeling-based

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[7] Local treatment refers to "treatment of the tumor only," while systemic treatment refers to "treatment involving the whole body, usually using drugs" (Love 607, 610).

decisions. Dr. Love admits, “Sometimes a patient asks me what I’d do if I had breast cancer. I never tell her. . . . My choice would be based on who I am—my values, my feelings about my body, my priorities, my neuroses. It would be valid only for me. My patient comes to me for my medical expertise, but she is the expert on herself” (319-20). While such a response supports patient autonomy, it fails to acknowledge the enormity of the task that is indirectly presented to the patient: to save herself. Recognizing that decisions may be “difficult” (329) and “complicated” (335) and after reviewing all treatments, Love concludes: “We really have no certainty; to some extent, it’s a crap shoot. You have to just search your heart and make your own choice” (337). In the end, the one responsible for saving the patient is the patient herself.

Added to the burden of patient responsibility for treatment choices is that of personal responsibility, which, as Fosket et al note, is “a dominant, recurring pattern in representations of breast cancer….Women are depicted as responsible for detecting, preventing, and surviving breast cancer” (304). Over the last few decades, mainstream media and women’s magazines have repeatedly presented breast cancer as a personal problem rather than a social issue. They all but promise that if women exercise regularly, eat healthy foods, perform regular breast self-examinations, avoid cigarettes, drink less alcohol, have sex and children, and are happy, then breast cancer can be avoided. Thus, “the idea of women having a *crucial role* in their own health care [has shifted] to women being *held responsible* for their health care” (Fosket et al 309), and the idea of breast cancer being linked to lifestyle choices to the exclusion of social and environmental forces, is widely circulated—especially by mainstream breast cancer culture.[8]

Barbara Ehrenreich, in her widely known article, “Welcome to Cancerland,” discusses how, as the 1990s progressed, the breast cancer movement was replaced by mainstream breast

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[8] For further insight on this topic, see pp. 258-60 of Ellen Leopold’s *A Darker Ribbon.*

cancer culture,[9] which focused less on finding a cause and more on positively embracing the disease. In stores, one can choose from an endless array of pink, corporate-sponsored items including clothing, jewelry, household décor, office supplies, and cookware. Clothed in pink, breast cancer "poses as an innocent disease" (Jain 519), encourages "implacably optimistic" talk (Ehrenreich 49), and "diffus[es] other kinds of emotion, rendering them illegitimate, or worse, making them into something illegible. Fury or fear can barely be expressed over the din of survival rhetoric and pink kitsch" (Jain 519). Consequently, women diagnosed with the disease have found themselves, not just adopting the cheery appearance of ill individuals,[10] but attempting to be "youthful, ultrafeminine, immaculately groomed, radiant with health, and seemingly at peace with the world" (King). Some have even chosen and still choose to see the good in cancer: Katherine Russell Rich, author of *The Red Devil* (1994), credits cancer for helping her to forget complaining, following useless trends, and pursuing perfection; cancer has helped her to remember that she is "glad to be alive" (122). Likewise, Fanny Gaynes of *How am I Gonna Find a Man if I'm Dead?* (1994) claims that her cancer story is "much less about dying than it is about coming alive" (12) in all areas of her life. She died before her memoir was published.

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[9] Lisa Diedrich, in *Treatments: Language, Politics, and the Culture of Illness* (2007), identifies the shift from breast cancer activism to breast cancer culture when commenting on Ehrenreich's article (50). In this essay, I will use "movement" and "culture" interchangeably, as patient autonomy, personal responsibility, and a "fight" for recovery are integral to both.

[10] In *At the Will of the Body*, Arthur Frank writes that the cheerful patient persona is commonly adopted by the severely ill because cheerful behaviour is praised, promoted, and expected by society. "I have never heard an ill person praised for how well she expressed fear or grief or was openly sad," he writes. "On the contrary, ill persons feel a need to apologize if they show any emotions other than laughter" (65). My point here, however, is that breast cancer patients, 99% of them women in Canada (Canadian Cancer Society, *Men*), are held to a much higher standard: for them, "cheerfulness is more or less mandatory, dissent a kind of treason" (Ehrenreich 50).

The Healthy-Mindedness Movement

Even before pink ribbon culture, breast cancer patients were encouraged to adopt a positive attitude and accept responsibility for health and so counter the negative force[11] that is illness by what Anne Hunsaker Hawkins calls the mythos or movement of healthy-mindedness. Spearheaded by the Simontons,[12] Norman Cousins, and later by Bernie Siegel, the movement claims that, although medical aid and accommodating doctors are important, illness may be cured only if causality is fully understood and if patients actively participate in recovery, especially by using alternative methods.[13] In *Getting Well Again* (1978), Carl and Stephanie Simonton explain that when psychological stresses are coped with inadequately, feelings of depression consequently suppress the immune system and create an environment in which cancer cells flourish. To restore balance to the body, the patient must examine her emotional state prior to diagnosis, accept responsibility for participating in her illness, learn more effective coping mechanisms, and adopt positive beliefs and expectations with the help of visualization. This philosophy is referenced and embraced by Audre Lorde in *The Cancer Journals* (1980) and *A Burst of Light* (1988). “I believe,” she writes, “that one of the ways in which cancer cells insure their own life and depress the immune system is by creating a physiologically engendered despair. Learning to fight that despair in all its manifestations is not only therapeutic. It is vital” (*Burst* 131-2). She goes on to describe her “fight” with bodily despair:

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[11] Negative beliefs about cancer being an “enemy” to be battled will be discussed further in the next chapter.

[12] In their book, *Getting Well Again,* the Simontons are joined by a third author, James Creighton. Most commentaries on the healthy-mindedness movement and illness pathographies neglect to mention Creighton with regard to this text. In this essay, I will refer to the Simontons as the authors of *Getting Well Again.*

[13] Anne Hunsaker Hawkins notes that alternative medicine is a “term for therapies and approaches that often have little in common except for the fact that they are *not* a part of the traditional biomedical model” (125). She lists many examples of alternative medicine in the first part of Chapter 5 in *Reconstructing Illness.*

> I visualize daily winning the battles going on inside my body, and this is an important part of fighting for my life. In those visualizations, the cancer at times takes on the face and shape of my most implacable enemies, those I fight and resist most fiercely. Sometimes the wanton cells in my liver become Bull Connor and his police dogs completely smothered, rendered impotent in Birmingham, Alabama by a mighty avalanche of young, determined Black marchers. . . . I train myself for triumph by knowing it is mine, no matter what. (*Burst* 132-3)

Similarly, in *Anatomy of an Illness* (1979), Norman Cousins emphasizes the simplicity of the mind-body connection: negative emotions create negative bodily changes, and conversely, positive emotions create positive changes. He suggests that illness recovery requires men and women alike to muster emotions like hope and a fierce "will to live" (49) in addition to medical treatment. This notion influences Lucy Shapero in *Never Say Die* (1980): "Cousins spoke of illness in terms of possibility: believe, control, share, hope, protect. I liked that. If I chose life, I preferred to live positively, contributing to and understanding my existence . . . . If I could think positively, my thoughts would affect my body. I could transfer my will to live into a physical reality" (132).

Author Bernie Siegel, in *Love, Medicine, and Miracles* (1986), adds to Cousins' notion that the patient should envision himself or herself as exceptional: as assertive, self-reliant, optimistic, and most importantly, loving. Love of self and others, he says, leads to happiness, and happiness leads to health. On the contrary, self-hatred and repressed emotions—especially those linked to personal tragedy or loss—cause cancer: "If a person avoids emotional growth at this time [of tragedy], the impulse behind it becomes misdirected into malignant physical growth" (124). Thus, cancer delivers a call to deal with emotions and provides an opportunity for self-development which, in turn, promotes the return of physical health. Siegel's theory may be seen at work in *The Red Devil.* Although she initially mocks *Love, Medicine, and Miracles,* Katherine Russell Rich explores and enforces the connection between her disease and loss of relationship, particularly. She becomes convinced she has "'breakup cancer'" (115) after discovering a lump three weeks following the end of a marriage that had, for the previous six months, made her feel "like [she] was dying" (13). Later, she links another rocky relationship with the side effects of her cancer treatment: "I've never had so little control in a relationship, just as, no coincidence, I'm sure, I've never had so little over my body" (172). By the Epilogue, Rich believes wholeheartedly in the mirroring powers of her disease. She emphatically links the death of her mother—"the ultimate breakup" (237)—with the recurrence of cancer. Throughout the memoir, too, Rich identifies how she invited cancer into her life: she repressed emotion, went shopping in lieu of feeling, used men and work for validation, and sulked over trivial matters. Thus, she endeavors to change. She resists the urge to complain, questions the pursuit of perfection, chooses to find lessons in everyday situations, uses her voice, and becomes more relaxed, happy, and spiritual—or at least, she tries to make these changes.

Rich, Lorde, and Shapero record mind-body observations in their memoirs, and they are by no means alone in doing so. Hawkins observes that "pathographers with cancer especially tend to attribute their disease to psychological causes" (139) and that during the 1990s, particularly, many pathographers representing all kinds of illnesses recorded their adoption of healthy-mindedness beliefs (130).[14] Such beliefs are attractive in that they offer the individual a sense of control over the body and seem to lessen the severity of both the disease and the patient's experience of it. In *Illness as Metaphor* (1977), Susan Sontag argues that "'physical'

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[14] Hawkins speculates that Western interest in healthy-minded beliefs in the late 20th century grew from increased exposure to Eastern practices and traditions (127) and overall dissatisfaction with the health care system (128). The incentive to write about such beliefs, she adds, comes from "the conviction that [the healthy-minded] approach really works" (130).

illness becomes in a way less real…so far as it can be considered a 'mental' one" (56). Sontag criticizes healthy-mindedness notions, stressing that although emotions may *affect* disease, they do not *cause* it, and she emphatically attacks the cancer-prone personality concept. The association of repression with cancer, she argues, shames and condemns the cancer patient, and it indicates how little experts understand about the physical nature of the disease itself. She continues:

> Scarcely a week passes without a new article announcing to some general public or other the scientific link between cancer and painful feelings. Investigations are cited—most articles refer to the same ones—in which out of, say, several hundred cancer patients, two-thirds or three-fifths report being depressed or unsatisfied with their lives, and having suffered from the loss (through death or rejection or separation) of a parent, lover, spouse, or close friend. But it seems likely that of several hundred people who do *not* have cancer, most would also report depressing emotions and past traumas: this is called the human condition. (50)

Hawkins furthers Sontag's critique, adding that that the patient is expected to exchange pessimistic beliefs and attitudes with hopeful and optimistic ones, all for the sake of reversing what may not be a reversible illness (149). Musa Mayer then problematizes the joining of standard medical treatment with such hopeful beliefs in reference to her own breast cancer experience:

> What about chemotherapy? By submitting myself to the treatment, I was, in a sense, actually betting on the possibility that I might not be cured, that the worst might happen. It was like buying insurance, wagering on catastrophe. If beliefs could kill or heal, weren't some beliefs dangerous, in and of themselves? Surely that was implied in what I

> was doing. Perhaps I was subtly acknowledging—some might say actually *inviting*—the cancer back, through my beliefs about needing chemotherapy. (64)

The absurdity of this final idea—that wanting chemotherapy may actually invite cancer—suggests the problematic logic of healthy-mindedness beliefs.

Despite the concerns of Hawkins, Sontag, and Mayer, and recent article titles such as "Personality-Breast Cancer Link Debunked" (Dunham), the basic tenets of healthy-mindedness prevail in popular culture. In *The Secret,* which has sold more than twelve million copies since 2006, Rhonda Byrne writes that when stress and negativity create disease, love and gratitude can cure it. Byrne promises that "no matter what you have manifested in regards to your body, you can change it" (133) and that "if you have attracted some affliction to you, reduce it in your mind" (135). She also references Norman Cousins and includes a personal story by Cathy Goodman who, following a diagnosis of breast cancer, cured herself through faith and laughter, and without medical intervention. "I truly believed in my heart," notes Goodman, "with my strong faith, that I was already healed. Each day I would say, 'Thank you for my healing.' On and on and on I went, 'Thank you for my healing.' I believed in my heart I was healed. I saw myself as if cancer was never in my body" (128). Goodman's story is meant to demonstrate how the responsibilities for health and healing belong to the individual alone, affirming a fundamental principle of both healthy-mindedness and breast cancer movements.

The New Momism Movement

The final movement of relevance to an understanding of MacPhee's and Conway's breast cancer memoirs is that of "new momism." The authors of *The Mommy Myth* recall that in the 1940s, the term "momism" was used to describe how American mothers were so "smothering, overprotective, and invested in their kids" (4) that they inevitably raised them—and particularly boys—to be weak, fragile, and incompetent adults who were in no way prepared for the real world, much less the possibility of fighting in war. The authors are reusing the term to describe the current trend in which mothers are now *expected* to be wholly immersed in their children's lives and inevitably suffer themselves on account of it: *they* become weak and fragile due to overwhelming exhaustion. The "new" momism insists that women are fulfilled only when they have children and become the primary caretakers of them, and that "to be a remotely decent mother, a woman has to devote her entire physical, psychological, emotional, and intellectual being, 24/7, to her children" (Douglas 4). To be a decent career mother, she must identify herself as Mom, first, and still manage to execute "intensive" (Hays x) mothering skills. Intensive mothering, a recent phenomenon according to Sharon Hays, has the Western mother believing that when in the presence of her children, she must be patient, content, and nurturing. She must spend

> copious amounts of time, energy, and material resources on the child. A mother must recognize and conscientiously respond to all the child's needs and desires, and to every stage of the child's emotional and intellectual development. This means that a mother must acquire detailed knowledge of what the experts consider proper child development, and then spend a good deal of time and money attempting to foster it. (Hays 8)

Her quest for "detailed knowledge" is part of what author Rima Apple specifically identifies as "scientific" (2) mothering.[15] The mother trusts her parenting instincts—and is even told to do this by Dr. Spock—but is also told that they are not enough. Similar to the active breast cancer patient, she actively seeks expert advice from child-development resources and partners with physicians who value her own judgments and attend to matters with which she is concerned.

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[15] In *Perfect Motherhood* (2006), Rima Apple provides a history of what she calls scientific motherhood, tracking it to 19th century America when child-rearing manuals first became readily available and issues of health and hygiene were of particular interest to mothers.

Always, she maintains a "cautious outlook" (Apple 157) and continues to seek newer and better information pertaining to her child.

Although they give partial credit to unsupportive governments and failing school systems, *The Mommy Myth* authors credit the media, mainly, for the rise of new momism. More than ever, since the 1980s, motherhood and all kinds of mothers—good, bad, rebellious, welfare, divorced, teen, celebrity—have been an obsession of books, news stories, television, and magazines. The authors provide many examples and statistics to support this claim. Between 1970 and 1980, twenty-some books on motherhood were published; between 1980 and 2000, more than seven hundred were published (Douglas 8). In the 1970s, news networks rarely featured stories about mothers and their kids; by the 1980s and into the 1990s, news was filled with sensationalized stories about kidnappers, molesters at day care centres, infections, hazardous toys, poisoned Halloween treats, suspicious summer camps, murdering mothers—all things potentially dangerous to children—and the message to mothers was two-fold: first, be all-knowing and have the ability to perform as "physician's assistants, pharmacists, child product safety testers, nutritionists, crafts people, and district attorneys" (83). Second, be on guard of becoming like the often reported delinquent Mom—the poor, inner-city, drug-using, promiscuous, typically unmarried African American woman who inevitably abandons and abuses her many children. Meanwhile, primetime television encouraged moms to be relaxed and spontaneous like Clair Huxtable on *The Cosby Show* and even laugh at loud and mouthy Roseanne on *Roseanne*, while magazine covers made clear how Mom should be: like the celebrities, who smiling, stylish, and with seemingly endless energy, successfully and rather easily balance their careers with raising healthy children whom they absolutely adore. In essence, Mom should be perfect.

The Mommy Myth authors write that the new momism is still inescapable for most women in the twenty-first century. In a recent *Audi Magazine* issue, an article about singer-songwriter and mother Chantal Kreviazuk reads, “Wherever she is, whether on the road or at home, wherever home may be, family takes precedence over everything else in [her] life . . . . ‘everything else comes second. So [she] work[s her] schedule around them and make[s] some sacrifices here and there’” (Freed 29). Meanwhile, stay-at-home moms, likely influenced by current news stories about Internet child pornography, deadly diseases, and questionable vaccinations, are to take behave like “‘contemporary June Cleaver[s]’” by keeping house, feeding organic meals, volunteering, and educating children with the help of brain-boosting toys or, ideally, through home-schooling (Memmott). The overall message of the media is still the same: Moms, do your best, always do more, and never forget that motherhood is the single most important, fulfilling, and rewarding responsibility imaginable.

Moms, however, rarely feel their best is enough. The media neglects to show that although today’s moms do more and try harder than ever before, they “feel ever-increasing guilt about [their] inevitable shortcomings” (Maushart 180). Working mothers, deemed “supermoms” by Sharon Hays (132), are particularly prone to depression on account of “incompatible expectations” (Nolen Hoeksema 79). In the office, they are supposed to be unfeeling, critical, aggressive, even cutthroat and manipulative, but at home, they are to be precisely the opposite. These opposing “pressures can lead to ‘role overload’” and at best, to feelings of inadequacy or low self-esteem and, at worst, to mental breakdown (Nolen Hoeksema 79). That mothers simply let go of supermom expectations is out of the question, however. According to social scientist Susan Maushart, women are unwilling “to abandon ship, or even share the wheel” because they believe that “‘having it all’ means ‘doing it all’” (202). But more importantly, women are made to feel that if they relinquish these expectations they will become unfit mothers. Thirty-some years ago, if a mother failed in her eyes or those of others, her “very character, her status as a woman [was] in question” (Rich 52). Today, there is more than character at stake: if mom fails in any way, or if her children fail, she may be charged with neglect or abuse by other mothers, schools, or the legal system (Douglas 71). Often, these charges are laid to women of lower social status: those who are "poor, single, divorced, lesbian, or disabled . . . are often regarded as less competent and suitable mothers" (Lafrance 31). But even upper-class mothers have been blamed for everything from childrens' moodiness to their depression, phobias, sleepwalking, tantrums, and homosexuality (Villani 51).

Social scientist Susan Maushart writes that "what we see of motherhood is not what we get" (8). This is true of what we see via the media, but also of what we see of mothers themselves. In their own homes, many create the illusion—indeed, are encouraged to create the illusion—that what they do is easy, effortless, and natural. To maintain the illusion, too, they remain silent about the reality of their experience as mothers, for "public revelation of [motherhood's] indelicate, murky depths is a clear breech of cultural protocol. And we would rather die, many of us, than reveal its scars. We are expected instead—and we expect of ourselves—to 'take it like a woman': stoically, singly, silently" (Maushart 244). What is required for change is open communication amongst mothers, families, and communities. Diane Eyer adds that mothers must also demand accommodating work environments and more support from immediate, extended relatives, and society (9), while *The Mommy Myth* authors conclude that there must be a "change in consciousness among women themselves" (336) before the media will promote realistic standards of motherhood. In the meantime, "being a citizen, a worker, a governor, an actress, a First Lady"—and even a cancer patient—are "to take a backseat to motherhood" (22).

In the following chapters, I will consider how the cultures of breast cancer, healthy mindedness, and new momism greatly influence the illness experiences of Rosalind MacPhee and

Kathlyn Conway by observing how they construct these experiences in their memoirs. I will begin, first, by examining how their employment of breast cancer culture's military metaphors prompts them to consider the "healthy-minded" belief that they are personally responsible for incurring illness.

Chapter 2

“Alarming Metaphors” and the Discursive Construction of Breast Cancer

In the Western world, breast cancer is synonymous with “the fatalistic, the catastrophic, the disastrous, and the evil” (Olson 169). In the media and throughout popular culture, the disease is characterized as a cancer to “combat” (Love 301) and “to ‘beat’” (Ehreinrich 47); the experience of the illness is likened to a battle or war, wherein the patient must occupy her “body with a sense of watchfulness, the way a military occupies a newly conquered nation, hoping to create a sense of order out of anarchy” (Cahn). These descriptions of breast cancer and others like them have been widely circulated since the early twentieth century, according to Barron Lerner.[16] He explains how the volunteers of the Women’s Field Army, a group formed by the American Cancer Society in 1936, demanded “‘trench warfare with a vengeance against a ruthless killer’” (33) while they promoted early detection. Ellen Leopold adds that “to ‘man’ this new Army, women were ‘enlisted’ by appointed ‘Commanders’ in every participating state”; effectively, these women became soldiers armed with pamphlets portraying battle scenes, and the disease became the enemy (165). By the 1950s, the idea of early detection was widely circulated (Leopold 182) and so too was the language of war. By the late 1970s, cancer generally had become “encumbered by the trappings of metaphor”; it was a “killer” and even its treatment “aim[ed] to ‘kill’” (Sontag 5, 57, 65, respectively). Some breast cancer patients declared themselves warriors—Audre Lorde did in 1980—and committed their efforts to a more important “war” against alleged cancer-causing agents. Others called themselves injured soldiers, as Christina Middlebrook did in 1996: she was “destroyed and saved, returned from war, at home

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[16] For more on the “association between the military and the medical” (Hawkins 65) relating to all cancers, see Chapter 3 of Anne Hunsaker Hawkins’ *Reconstructing Illness*.

injured and recuperating" (77). She did, after all, undergo systemic treatment or what Dr. Susan Love describes as "guerilla war" (322).

In different decades, Susan Sontag, Arthur Frank, and Barbara Ehrenreich criticized the use of these metaphors for their moral implications. In treating cancer as a "mysterious malevolency," we make cancer "not just a lethal disease but a shameful one," writes Sontag (6, 57). Similarly, Frank asks: "If the name of cancer is unspeakable, what evil does the person with cancer believe can be brought by his presence?" (*Will* 97). Ehrenreich agrees that the very word "cancer" evokes a "fatally dispiriting effect" (50), and she is especially critical of how its metaphors have encouraged society to honour the "'survivors'" but pity, even forget, the so-called "fallen soldiers" (48). But the metaphors persist. Anne Hunsaker Hawkins writes in *Reconstructing Illness* (1999) that battle metaphors occur frequently in all kinds of pathographies, and the autopathographies of Rosalind MacPhee and Kathlyn Conway are no exception.[17] Both MacPhee and Conway employ military language throughout their works because, I suggest, they are unable "to resist or rework the cultural meanings of [their] illness" (Kleinman 26). As patients and authors, they readily embrace the language adopted and promoted by breast cancer culture and used by the media, the public, and medical experts, and in doing so, they accept the common answers as to how such an overwhelmingly negative force was brought into their lives: they explore the possibility that they are responsible for both creating the "enemy," personally, and curing it, publicly. As women with breast cancer, they effectively live out the central tenets of the healthy-mindedness and breast cancer movements.

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[17] Hawkins notes that "the military myth seems particularly appropriate to cancer, since cancer is so often characterized as an alien intruder or an invading enemy, and its various therapies considered as weapons with which to attack or destroy the disease. As we might expect, military imagery is found in a great many pathographies about cancer" (66).

During the period in which MacPhee and Conway experienced breast cancer, each medical insight about the disease "produced as many questions as answers, generated complex philosophical and political dilemmas, and triggered new controversies. Almost weekly, some laboratory issued a press release announcing the latest findings, warning women of some new risk" (Olson 194). Meanwhile, there was "hyperbolized terror associated with the disease" as "journalists perpetuate[d] cancer's mythic horror [with] alarming metaphors" (Batt 279). As we shall see, MacPhee and Conway frequently refer to common statistics and occasionally critique unsatisfying theories about breast cancer yet continue to perpetuate the same "alarming metaphors" of popular culture.

MacPhee is exposed to breast cancer culture, both before and after her diagnosis, by way of magazine articles and photographs (like the one of Deena Metzger shown in Figure 1), scientific reports, radio programs, Terry Tempest Williams' memoir, *Refuge*, and breast cancer-specific events. Following her biopsy, she happens upon a documentary about breast cancer: a stadium full of cheering women becomes a still frame, and the narrator announces that the number of women shown will equal the number of women to die in Canada every year from breast cancer. From these media, she becomes familiar with common phrases like "'Find it early—cancer can be beaten'" (7). She also learns that one in nine women are diagnosed with breast cancer and that breast cancer is the "number-one killer" (14) of middle-aged women. MacPhee quickly becomes aware of the language used in conjunction with such statistics—"now I was caught on phrases like 'riddled with it' or 'died in battle'" (56)—and begins to see the cultural context surrounding the disease. While conducting cancer research, she reads an article that suggests that "the cutting off of a woman's breast [is] a direct attack on the very symbols of femininity and eroticism celebrated by our society….the disease [has] the reputation of ruining one's love life, marriage, or friendships, costing a promotion or even a job, and making it

Figure 1: MacPhee is captivated by this photo, noting that it is "'full of…possibilities'" (244). The photo© was taken in 1980 by Hella Hammid and featured on the cover of *Tree: Essays & Pieces*, authored by Deena Metzger

impossible to get health or medical insurance" (60). Much later, she is told by a grief counselor that a mastectomy is a "symbolic castration" that leads to the "destruction of [the woman's] body image" (234). She does not criticize this language or its implications, however; she merely makes note of it. Moreover, when she learns that breast cancer is an "epidemic," she immediately articulates her surprise with a conventional metaphor: "How could this have happened? How could such a terrible disease not be known for the killer it was?" (59). In saying this, however, she also exposes an often-hidden truth of breast cancer culture—that very little is actually known about the disease. Much like Dr. Susan Love, she concludes that, regarding prevention and cure, "it [is] all guesswork" and that "some of the answers might lie in factors we [know] nothing about" (145).

Following her suspect mammogram, Conway enters Dr. Cody's crowded clinic and is surprised how many women, like her, must see a breast surgeon. After her diagnosis, she learns that one in nine women are affected by breast cancer, that women undergoing chemotherapy generally lose half their hair, and that support groups may increase survival rates. Like MacPhee, she learns that little is actually understood about the nature of the disease, so she and her husband take time to educate themselves on the disease with *Dr. Susan Love's Breast Book*. Frequently, she also comes across articles in *The New York Times* and *Ms.*—in fact, her memoir begins with a reference to the mammogram controversy discussed in the *Times*—and she is quick to criticize the shortcomings of these articles and their images, such as the one of breast cancer activist Matuschka shown in Figure 2. She describes Matuschka's appearance as "deathlike" and her depiction of breast cancer as "horrific," and suggests that in actuality, post-surgical bodies look far less extraordinary (184). Shortly hereafter, however, she criticizes autopathographies and their "glib, cute stories about cancer not being so bad" (193). Here, her criticism is inconsistent, and although she at least recognizes the disconnect between the public conceptualization of breast cancer and her personal experience of it, she, like MacPhee, articulates her experience as her culture does.

An examination of both memoirs suggests that MacPhee's and Conway's exposure to breast cancer media heightened their fears and powerfully influenced the ways in which they lived through and thought about the disease. As a patient, MacPhee rationalizes that her greatest fear is not death but "the disease itself" because of her second-hand experiences of it as a paramedic (56), but this explanation is far from adequate. Both in her introductory and closing

Figure 2: This image, entitled "New York Times Cover of Beauty out of Damage,"© appeared on the cover of the "Sunday Magazine" section of *The New York Times* on August 15, 1993. The photograph is by Matuschka and reprinted with her permission. www.beautyoutofdamage.com.

remarks, MacPhee calls cancer an “adventur[e]” (3, 251) but then proceeds to describe it using the language of war. “Adventures,” she says, “are about being brave, fighting back, and keeping your wits about you. Adventures are about taking control. Survival” (1). While awaiting her official diagnosis, a dictionary confirms her own definition of cancer: “the word meant anything bad or harmful that spreads and destroys . . . . I thought of the one word I did not want to enter into my personal collection [of words], then said it quietly to myself: cancer. It had an inescapably fatal sound” (8-9). Throughout the memoir, such connotations of cancer are perpetuated by the simple word choices of MacPhee and others. MacPhee calls cancer a “catastrophe” (36), a “betrayal by [her] own body” (51) wherein her lymph nodes had become “conspirators” (69), and a “disaster” (93). She listens to her friend, Pat, who tells her that she will “‘beat this thing’” (66), and to Dr. Harris when he calls breast cancers “‘sneaky’” (119). She describes radiation treatment as “bombard[ing]” and “killing” (62); chemotherapy as a “search-and-destroy mission” and “chemical warfare” (62); and surgery as “mutilating” (63) and a “physical assault” (82). She compares her post-surgical body to “a war zone” (96) and describes her scarring as “thick and red and angry” (117). Ten days after her surgery, she comforts herself with the idea that she is “‘from a long line of professional soldiers’” (117); then, after another biopsy, she likens herself to a “veteran” (214). Frequently, she reflects on the Gulf War, suggesting that it directly corresponds with her own personal war. “Where, I wondered, was the smart bomb for breast cancer?” (50), she asks, after learning of new technology implemented in Iraq; while watching more commentary on the War, she discovers another lump, this time in her left breast. For MacPhee, the experience of breast cancer is not like war, it *is* war, just as it is for Conway.

Near the end of *Ordinary Life*, Conway laments how, because of breast cancer, she and her family are “in a war that won’t end” (225). But long before her actual experience of breast cancer, Conway is consumed by thoughts of suffering and death (21). Granted, Conway’s perceptions are likely shaped by her previous bout with Hodgkin’s disease. She recalls her experiences of her previous illness and how she has been “down this road before” (40). This may explain why, in part, her fearful reaction to the possibility of another cancer is felt so acutely in her body. When the technician takes additional x-rays of her breasts, she immediately feels “panic” and her body becomes “numb” and “rigid” (9); when Dr. Balick discusses her calcifications, her heart pounds and her breath quickens. Following her diagnosis, she awakens from sleep and is momentarily paralyzed by fear. However, I suggest that these strong bodily reactions are due only in part to her previous illness, for its treatment process differed greatly and eventually resulted in recovery. I propose, instead, that her fears are primarily breast-cancer specific as a result of her exposure to the vocabulary of various media. Conway calls breast cancer a “horror” (20) and a “murderous threat” (37) that brings with it “nightmarish possibilities” (18). She likens her cancer to a “miserable partner” and herself to a “battered wife who feels she cannot leave” (94). When describing tests and treatments, Conway is especially severe. The mammography machine is “like a medieval instrument of torture” (8) and the outpatient surgery waiting room is “like a prison” (28). The very idea of a mastectomy is “monstrous” (16), “completely barbaric” (52), and “grotesque and unimaginable” (68). When the day of her surgery arrives, she feels like she is on “death row” (76); following the operation, she feels “exposed, like the people in war photographs whose faces give you a glimpse of their private terror” (87). She identifies chemotherapy as her “most dreaded fear” (92) and as “toxic, a poison, a killer” (125). She is told by Marta, a member of her treatment team who, ironically, “views chemotherapy in a positive light,” that chemotherapy is a “very powerful weapon against cancer" (121). Conway then uses the word "kill" (124) four times when describing the "ugly intruders" (131) to her children and later concludes that "the difference between the beginning and the end of chemo is like that between a soldier going to war, brave and committed, and returning, beaten down by the horrors suffered" (201).

At one point, Conway recognizes that she has adopted a cancer vocabulary and implies that she had no choice in doing so. She writes, "I have come to think of my body in very concrete terms and the cancer as a determined killer out to destroy my cells. I have been steeped in the medical world's vision of attacking the cancer, of killing it before it kills me" (125). Here, Conway acknowledges only one influence—the medical world—but does not acknowledge how her words inevitably shape her breast cancer experience. Although she can see how her son minimizes the disease through simple language, she does not see how her own metaphors complicate and dramatize it as the "enemy." As a patient, she becomes frustrated when those around her express terror at the mere mention of chemotherapy but later admits that she expresses similar terror at the mention of cancer; yet she does not consider that it is the ways in which chemotherapy and cancer are described, by herself and others, that produce such terror and worry. Without this consideration, she and MacPhee effectively send the message to readers that military metaphors, although convenient to use in articulating their circumstances, are without any lasting impact. In reality, however, their memoirs reveal that this vocabulary moves breast cancer from being a "disease itself" (MacPhee 56) into something in which they are responsible for, as we shall see.

While recovering from surgery, MacPhee reflects, "I had no desire to see myself as a victim, and that was the way much of what I read made me feel. I wanted only to grow stronger and put the experience behind me" (145). And yet, in the very next sentence, she affirms the need "to know and understand the enemy" and "to know how to fight back" (145). Here, her own language creates an inescapable logic: in making cancer the enemy, she is inevitably fashioning herself as its next opponent and the experience as a bloody battle. In the words of Katherine Russell Rich's friend, "'So long as you think of yourself in battle with cancer, you'll never transcend cancer. You'll always be engaged with it'" (*Red Devil* 227). Thus, in an ironic twist, MacPhee's engagement with cancer is deepened by the very language she uses to distance herself from it. It is intensified, additionally, as she learns to "fight back" with methods of healthy-mindedness.

MacPhee's familiarity with tenets of the healthy-mindedness movement progresses as her breast cancer experience does. As she learns about potential connections between lifestyle, the environment, and health, she begins to assess her own risk-factors: she criticizes her fatty diet, her alcohol consumption, her exposure to pesticides and radiation as a child, her decision to keep her ovaries before undergoing a hysterectomy, and her use of the birth control pill. She even identifies cancer-causing items in her home—the microwave, television, insulation, furnishings—and suggests that these things may pose the greatest dangers to her health. In that moment, she concedes that breast cancer is "associated with the toxic effluvia of an industrial economy that created affluence, a disease associated with excess" (165). However, in other moments, she contemplates how it may also be associated with mental well-being, or the lack thereof. She is told, by her doctor, that wellness is a decision and, by her physiotherapist, that healing is dependent upon attitude. She applies their advice with a visualization technique and familiar war language. She imagines her white blood cells as an "army of dune buggies silently crossing the deserts of Iraq" that "knoc[k] out the enemy cells with laser guns" (173). She also learns through her own research that childhood loss and chronic stress suppress the immune system and may, consequently, allow cancer to occur. She reads *Love, Medicine and Miracles* and *Getting Well Again*, finding that both works link breast cancer with "dysfunctional childhoods and mismanaged emotions later in adulthood" (180). Although she admits to a traumatic childhood and a stress-filled life, and suggests that positive thinking may hasten her recovery, she resists the idea that she may "have allowed the illness to happen" (180). Later, she concludes, as Dr. Susan Love does, that women are not responsible for their breast cancers; it is because "'the stress picture is being presented so attractively we're ready to go for it'" (247). Thus, she affirms that cancer is not self-created. The construction of her memoir, however, suggests otherwise.

In the very first chapter, MacPhee reflects on her tumultuous childhood and how she learned, at a young age, to suppress her feelings and deal with hardships—such as her parents' suicides—independently. When she was ten years old, her father killed himself and her mother, suffering from depression, was emotionally unavailable to MacPhee shortly thereafter; much later, her mother took her own life, too. Frequently, MacPhee finds herself reflecting on childhood difficulties. She recalls her tendency to stare out the window in order to escape reality and, more specifically, seeing her father's dead body and watching his funeral from afar. Due to her "long history of losing people [that she] loved" (229), she becomes particularly interested in the correlation between cancer and childhood, loss, and stress. When she questions her doctor on the theory, he replies that it is merely an "indication of how much is not understood" (159) about the disease; his answer echoes what Susan Sontag claimed in the 1970s, that "theories that diseases are caused by mental states and can be cured by will power are always an index of how much is not understood about the physical terrain of a disease" (55). Despite his dismissive answer, however, MacPhee inquires further as to the connection of cancer with loss. His next reply is that loss is more about the meaning of the disease rather than the cause of it. Breast cancer, he says, is generally "'connected with loss—loss of a breast, loss of something that is one of the ways our society defines femininity, loss of a way of life, loss of a sense of security'" (160). Without a definitive answer, MacPhee is left to make her own conclusion which is, I suggest, that cancer is strongly associated with an individual's inability to cope with emotional trauma. Although she outwardly dismisses the "'stress picture,'" in the careful construction of her memoir, she hints repeatedly that cancer, like any other "adventure," is something she has "gone to great lengths to bring into [her] daily life" (3), beginning in her childhood.

Conway, too, is prompted to discover how she has brought breast cancer into her life. After Conway is diagnosed with breast cancer, she is asked by friends if it could be genetic or related to consumption of red meat and fat, lack of exercise, or too much stress. (Later, she does confirm that she avoids red meat, eats fruits and vegetables, and lives a cigarette-, drug-, and alcohol-free life.) She is also asked by her doctor if she has taken birth control pills; when she tells him she has, he acts as though they are the cause. But Conway repeatedly suggests another cause—previous radiation treatments—for she believes this might explain why she is the only one in her family who has experienced breast cancer. Eventually, however, she admits that this may not be the case. Following her mastectomy, Conway is brought movies to make her "laugh à la Norman Cousins" (88) and is given a book emphasizing the importance of body detoxification, nutrition, and spirituality for healing. She is even told that cancer can be cured with carrots. Conway resists these ideas for they make her feel "set apart, isolated, and viewed as responsible" (58) for her disease. Moreover, she is disbelieving. When asked to visualize cancer cells under attack, she is immediately "skeptical about the efficacy of a positive attitude. Why not be honest about one's misery?" (123). However, "like a good patient," Conway tries to envision her Cytoxan pills on a "mission to kill cancer cells" (141). Then, in utter desperation for a speedy recovery, she sees an acupuncturist who suggests that she must redirect her energy: "I sense in his theory about my energy an accusation that I'm to blame," she writes. "It's the chemo, not my misguided energy, that is at fault, I feel like screaming….Of course, I am the one who thinks that the nausea and cancer are my fault and that someone with a different personality would know how to get help from acupuncture" (153). Here, a belief in the mind-body connection and personal responsibility surfaces, as it does again in another passage:

> I don't believe good behavior will keep me from losing my hair any more than I believe good thoughts will keep me from being nauseated. I have a bad attitude. I am failing at visualizing an army of chemical soldiers attacking the evil cancer cells. I'm angry but worried that my attitude makes things worse. (160)

Although she wills herself not to believe in a mind-body connection and directly attacks it in her Preface, in vulnerable moments as a patient, she admits to the possibility that she may be in control of her condition. With this in mind, the negative thoughts and ideas she frequently expresses throughout her work become significant.

Unlike her healthy, optimistic husband, Conway is a self-identified pessimist. In the Preface to *Ordinary Life*, wherein Conway calls her story "untriumphant," she notes that she was especially "cranky, angry, and ungrateful" (ix) throughout her illness experience. And indeed, the story that follows reads like a record of bad attitudes. Often, especially during chemotherapy, she occupies a world wherein she is "depressed, sick, worn down, angry" (188). In these times, she attempts to be positive but instead, screams at her children and unleashes her fury onto David. Her pessimism continues as she mulls over the "worst possibilities" (209) and is "unable to rise above [her] inner turmoil" (212). Following chemotherapy and in the midst of family chaos, she is "filled with self-loathing….if I would get my feelings under control, everyone would calm down. But I can't" (226). Indeed, Conway's preoccupation with how she "can't" control her attitude and how she wishes that she could spills into every chapter of her memoir. This tells us first, that she is honest and second, that she believes she should be positive in thought and feeling so that she can restore her health. In discussing her efforts to come out of post-chemotherapy depression in the last chapter, she explains, "At some point I *simply decided* to resume my life as it had been before my diagnosis. I glory now in ordinary life and the feeling of health" (250; emphasis added). In acknowledging that a mere decision enabled a return to healthy living, Conway confirms that personal action and responsibility are paramount for recovery.

Anne Hunsaker Hawkins writes that acceptance of personal responsibility with regard to disease may encourage "active participation in therapy" (66), and certainly, MacPhee and Conway are prompted to participate actively as patients, as will be discussed in the next chapter. But additionally, in accepting responsibility for an "evil" disease that she may have prevented, MacPhee is prompted to perform an act of absolution—that is, to write a memoir. For MacPhee, a poet with a self-proclaimed passion for words, writing, and books, this act is particularly meaningful. She writes about the disease, generally, and about the causes of the disease in her own particular experience so that others may learn from her mistakes. Arthur Frank notes that "storytelling is *for* an other just as much as it is for oneself. In the reciprocity that is storytelling, the teller offers herself as guide to the other's self-formation" (*Wounded* 17-18). In MacPhee's case, the "other" is not one reader or even a large audience of readers, but an entire female *population* confronting "the leading killer of women" (59). When Shannon, another breast cancer patient, asks MacPhee how she has contributed to finding a cure, MacPhee replies: "'I've started a book . . . . In film they say nothing exists unless you show it. That's what I'm going to do. I'm going to show it'" (253). But, in fact, MacPhee wants her work to do more than merely *show* her particular experience of breast cancer—she wants it to eliminate misconceptions of the disease so as to assist women in the prevention of its advance: "'I have to do something about this disease for my daughters, your daughters, Deirdre's…for all our daughters'" (259). Although this is a common intention of autopathographers—"to expose to public view a deadly disease that warrants individual wariness, public concern, and aggressive research" (Couser 37)—for MacPhee, exposure is not enough. As a woman, she claims responsibility for her disease; as a writer, she takes it upon herself to educate the world on breast cancer and to ensure the public's health. Although she does not clarify these responsibilities until later in her work, she hints at them early on. After gathering statistics about breast cancer, she wonders, "How could such a terrible disease not be known for the killer it was? . . . . Was the disease still on the rampage simply because women had not spoken out?" (59). Interestingly, MacPhee's first reaction is not to hold politicians, scientists, or medical professionals accountable for their inadequate efforts; instead, she immediately blames individual women for not speaking out. She wonders about "all the stories that had been written about war and battlefields. Where were *our* stories?" (60). Here, again, she stresses the importance of individual stories and thus the individual in the "war" against cancer.

Like MacPhee, near the middle of her memoir, Conway wonders about the importance of individuals and their collective responsibility. At a Breast Center, she finds herself

> admiring how well [other women with breast cancer] have hidden what they are going through. I realize that this is what I aspire to—looking as if everything is fine. But maybe this effort to appear fine, to wear wigs and breast prostheses, does in fact contribute to the invisibility of breast cancer. Maybe we should be showing the world, by refusing to cover up our disease, how numerous we are and how many more resources are needed to do something about this disease. (111)

Years later, she realizes that her act of writing serves as a kind of uncovering, as her contribution to the visibility of breast cancer: in writing, she becomes like the woman who loses a breast to surgery and her hair to chemotherapy, but refuses to wear a prosthesis or a wig so as to communicate the devastation of the disease. Perhaps without such a public declaration Conway would feel irresponsible, as though she had cheated "the world" by not telling of her experience.

Granted, Conway also realizes the importance of her story for herself.[18] She explains how, in the act of writing, she found her way out of depression, distanced herself from the disease, and created a "manageable" (3) story of illness not only for herself, but for her children. In Arthur Kleinman's words, she writes to "give coherence to the distinctive events and long-term course of suffering" (49); in her own words, "the writing relieves me of the burden of my feelings . . . . the writing is like a magnet that draws together all the stray parts of myself . . . . it feels as though I am writing to save my life" (240) and to mark "the end of this experience with cancer" (258). For Conway, the very act of writing a restitution narrative helps to restore her more fully to health and affirm that she will have breast cancer "no more" (258). Although she also acknowledges that she might enjoy this renewed health only temporarily,[19] she chooses to emphasize "the end" of the disease so that she can direct her attention to other aspects of her life.

On the final page of *Breast Cancer Journal: A Century of Petals* (1993), Juliet Wittman makes the following plea: "Cancer patients must come together with those who love us and those at risk for the disease—which is everyone in the country . . . . We must take our mutilated bodies and our bald heads, our tears and our anger out into the streets and tell the others. First comes a time for introspection. Then comes the time to act" (278). Wittman's call for introspection and action, clearly influenced by the cultures of breast cancer and healthy mindedness, is one that MacPhee and Conway answer. Equipped with the language of war, they examine harshly their lifestyle choices and emotional states, and identify all things negative in their minds that may have, collectively, attracted the ultimate negative force—breast cancer—into their bodies. As

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[18] In her analysis of breast cancer memoirs, Laura K. Potts concludes that in and through the act of writing, memoirists assert their "individual identities" (104) and unique experiences while, at the same time, placing themselves within the collective experience and shared stories of others with breast cancer. See pp. 99 – 106 in "Publishing the Personal" for further discussion.

[19] She admits that is "never completely free of the threat of cancer" (257) and there "can be no closure on this disease" (258).

women, they quite literally accept “militant responsibility” (Lorde, *Journals* 75) for their illness and so, their health. As authors, they offer writing as action, but do so without observing that their introspection as patients was detrimental to their emotional well-being, and that alternatively, they could have—and should have, in my view—at least acknowledged the notion that causation is still a mystery, that much of what scientists do know is “guesswork” (Love 145) at best, and that environmental pollutants likely affected the development of their own cancers. Instead, they reiterate their illness experiences and realizations so that they might, on some level, help save the world or at least “everyone” in their respective countries from a similar, *self-induced* breast cancer, and likely influence other women in believing that they, too, are responsible for breast cancer.

Chapter 3

Patient Behaviours: Active and Passive Responses to the “Grotesque and Unimaginable”

Fundamental to both breast cancer and healthy-mindedness movements is the idea of the autonomous, active patient. Like Rose Kushner, who chose to have a modified radical mastectomy, and Audre Lorde, who was “conscious of being able to choose” (32) the same, this patient fully participates in and even directs all aspects of the recovery process. Although she may vigorously seek counsel from many doctors and consult educational materials relating to her particular case, she is “truly in control” (McDonnell 86) in that she makes decisions by and for herself. She chooses treatment options based on “intuition, trust, and self-knowledge” (Mayer 28); that is, she decides, as Dr. Susan Love suggests, to follow her heart throughout the entire illness experience (337). In doing these things, she is an active patient who refuses to become what Arthur Frank calls the “passive object of investigation” (*Will* 52). In the passive patient experience, the individual in treatment is an observer: she observes as her identity is lost completely to her body, which quickly becomes an anonymous, diseased “it” to be tested and treated. (Frank notes how, in his own cancer experience, he was referred to as a “‘this . . . to be investigated’” [51] and by the name of his disease, lymphoma.) Fearful and uncertain, the passive patient anxiously awaits her doctors’ infrequent visits and brief explanations; hurried and pressed to make treatment decisions, she might “lose [her] capacity to make choices, to decide how [she wants her] body to be used” (56). Ultimately, she submits herself to the authority of her practitioners.

In this chapter I examine the patient experiences of Rosalind MacPhee and Kathlyn Conway, which include both active and passive components. As seen in the last chapter, both explore how their actions and attitudes contributed to their illness. Here, I will show how both patients strive to create personalized treatment plans on their “own terms” (MacPhee 67)—although not without great difficulty—and choose doctors who affirm their identities as individuals. But both also devalue and dismiss the importance of their breasts and frequently suppress emotion in medical settings in order, ironically, to make the difficult decisions required of active patients, thus denying the “relationship between what is happening to [their bodies] and what is going on in the rest of [their lives]” (Frank, *Will* 42). It seems, however, that MacPhee’s and Conway’s denial of this relationship and associated denial of illness identity are, first, personally required given the inevitable “hacking off’ (Kushner 11) of their body parts and, second, publicly encouraged. Breast cancer patients are to lose a breast, quickly reconstruct it, and “obses[s] on the mysteries of chemotherapy” while “feeling compelled to handle things with style and grace” (Gaynes 44, 65). Neither author acknowledges these complex realities or examines critically her activity or passivity as a patient. And yet, both of their stories work to dispel the myth that the breast cancer “journey” is one wherein a woman must simply follow her heart.

Before first examining just how MacPhee and Conway are, indeed, active patients, the shared socioeconomic status that affords them this privilege must be acknowledged: both are white, middle- to upper-class, well-educated, working married women with familial support and easy access to medical resources, support, and practitioners. Thus, they are like most other women “who have the literacy, leisure, and inclination to write their stories—and the contacts to get them published” (Couser 38). Moreover, as a paramedic, MacPhee is already familiar with the medical system, its procedures—she even corrects a student nurse who nearly gives her the wrong medication—and its people. She admits that, because of her profession, she feels “a kind of bond, with other medical people” even as a patient, and notes that this connection likely results in preferential treatment (80). Conway, too, reflects on her own advantages as an American patient who has more than adequate medical coverage. Although she describes the insurance claim process as tedious and never-ending, she notes that she and David are especially fortunate: they incur just two percent of all health care costs and are also able to bear the more subtle, non-medical costs associated with breast cancer—the many cab rides, meals out, and the like. On more than one occasion as a patient, Conway finds herself wondering “how people without financial and educational resources manage this [illness] experience” (159).

Even before her official diagnosis, MacPhee becomes active. She thinks about “all the things” she must do should she have cancer (16); following her diagnosis, she is told by her surgeon to “‘make the right decisions’” (47) for herself regarding treatment. Consequently, her experience as a patient is shaped by the idea that she must *do all the right things*. When contemplating surgery, chemotherapy, and radiation, she endeavours to find the option that is, in her words, “best for me” (56).[1] MacPhee spends hours, even days, conducting research. The articles she discovers at the Cancer Agency, however, seem to confuse rather than clarify her choices; she becomes frustrated and overwhelmed, but insists that she can “find the right way” (63). Eventually, she decides to have a mastectomy rather than to undergo chemotherapy and reconstructive surgery. After surgery, she directs calculated questions to her doctor: she inquires about her physical pain, enlarged nodes, numbness, phantom pains, and paranoia; the age of her tumor, her recovery time (specifically, when she can work and drive again); her chance of survival; and the connection between cancer, work-related stress, and loss. She also executes her

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[1] According to G. Thomas Couser, MacPhee’s experience is common. Frequently, narrators of breast cancer memoirs comment on how difficult it is to make decisions concerning treatment. While contemplating treatment options, Audre Lorde writes in her diary, “I don’t even know if I’m doing it right” (*Journals* 34). Similarly, In *Examining Myself* (1993), Musa Mayer asks, “How could I ever be sure…if what I had been given was the right treatment? If the choices I made were the right ones?” (87). Marla Shapiro adds, in *Life in the Balance* (2006), “Breast cancer sets off a cascade of decision-making….No matter how much you think them through, there is always that sense of urgency to make a quick decision and make the right decision” (218). In part, notes Couser, this freedom to choose makes breast cancer especially fitting for autopathography: because “choice of treatment reflects personal values and circumstances rather than medical mandate” (43), every woman has a unique story of treatment to tell.

own rehabilitation program “with total and absolute determination” (174); this includes doing daily arm exercises, practicing visualization techniques, performing additional cancer research, and meeting with doctors. Her program is briefly interrupted following another surgery—this time a lumpectomy of her left breast—but is reestablished after she addresses her grief with a counselor. MacPhee’s return to health (if only temporary) requires that she maintain the program of duties listed above, in addition to attending organized events pertaining to breast cancer and learning about supplements and organic foods so that she might prevent future cancers. Since she believes she is still living with cancer despite its remission, she strives to maintain an active patient role.

Initially, Conway is also preoccupied with the idea that she will need the “right,” “best,” and even “perfect” medical care (12). But as Conway discovers that her care is ultimately self-determined, she becomes overwhelmed, even burdened, by the responsibility of decision-making and just “want[s] to get on with it” (49). During her first attempt to read *Dr. Susan Love’s Breast Book*, she becomes panicked, admits to feeling frightened, and decides to let her husband, David, do the research for her. She does, however, come to grasp the medical information and becomes uncomfortable when David’s voice replaces her own, when she finds herself hesitant to interject in his conversations with her doctors. She also begins to make decisions for herself, but not without great difficulty. The decision to have a mastectomy is essentially made for her—she cannot be exposed to the radiation required with a lumpectomy[2]—but other decisions are her own. Each decision, she says, “moves me to a new plane where an entirely different set of questions awaits me. I’m to have a mastectomy. Will I have an implant? What does that mean?

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[2] Conway learns that radiation, when coupled with a lumpectomy, is as effective in treating breast cancer as a mastectomy, but because Conway previously received radiation on her upper chest to treat Hodgkin’s Disease, her doctors conclude that additional radiation might cause skin ulcerations (48, 53). Additional radiation can only be performed if it “does not overlap the previously radiated area or, if it does overlap, without exceeding the maximum allowable dosage for a given area” (44).

What will it be like? What doctor, what surgery, how many appointments?" (54). When it is time to contemplate chemotherapy, she "cannot bear [to make] another decision" (92). Although, initially, she feels in control and leads the conversation about chemotherapy with David and her oncologist, she finds herself greatly troubled about whether or not she should undergo six months of this treatment; however, she eventually decides to do so. But again, her frustration escalates when she is presented opposing opinions regarding a second mastectomy. She wishes she could "simply follow orders" (115), finds the decision "impossible" (116), and thus, expresses relief when Dr. Moore suggests that they collaborate to make the decision. Essentially, the decision not to have a second mastectomy is Conway's last significant medical decision, but her return to wellness is not without continued responsibility: she still researches, considers taking more treatment (such as tamoxifen, a drug that "blocks the production of estrogen and seems to prevent the growth of estrogen-fed tumors" [242] like her own), and seeks to hear other breast cancer stories.

Despite all of these efforts and difficulties, MacPhee and Conway do not commend themselves for their perseverance, both as patients during the illness and after it, as authors in reflection. In fact, as ill patients, they tend to *minimize* their actions, while as authors reflecting upon their patient behaviour, they say nothing of this tendency. When another patient asks MacPhee, for example, how she made the decision to have a mastectomy, MacPhee replies that she "'certainly considered the other possibilities'" (92). "Considered" is hardly accurate. MacPhee investigates her options fervently and thoroughly—even orchestrating imaginary conversations in her mind between chemotherapy, radiation, and surgical specialists—but she does not acknowledge this fact in the moment or in hindsight. Similarly, she tells her doctor how grateful she is to have been prescribed exercises so that she might finally "help things along" (121) and no longer contribute "so little" (158) to her recovery. She also reflects, privately, on the things she should have done prior to her diagnosis: she admits that she regularly dismissed bodily problems and that she ignored pains in her chest for a month and the actual lump for a week before seeing a doctor.

Whether or not MacPhee's minimization is common to women who experience breast cancer and then write about it is unclear; I could find no academic commentary on the subject. One theory suggests that women generally tend to engage in "excessive humility" and to be "self-derogatory" in many aspects of their lives—and that this propensity might contribute to causing greater rates of depression (Nolen-Hoeksema 132). It is said that breast cancer patients, specifically, may minimize the severity of their experience when in the presence of family and friends so as to appear cheerful (Frank, *Will* 64-71) or if they "only" have a lumpectomy as opposed to a mastectomy (Crompvoets 82-83). But there is nothing said of a gendered propensity to overlook or minimize extraordinary efforts in illness—perhaps because such efforts are no longer considered extraordinary. They are, rather, expected and readily endorsed within breast cancer culture. MacPhee's own Afterword, written by activist Judy Caldwell, reads like a list of expectations for the newly diagnosed: be assertive, seek answers, become an expert, find the best doctors, and make life-altering decisions. Then, go public: tell your story and educate governments and corporations. "Form a delegation and ask for specific commitments when you meet with your MP face to face" (273), urges Caldwell. "Educate [corporations] on the severity of breast cancer. Find out how many women work for them, and then figure out how many of these women will be affected by breast cancer over their lifetimes" (274). Following these calculations, do as Roberta Altman advises in *Waking Up/Fighting Back* (1996):

> Organize a rally or demonstration. Offer to talk to girls at the local high school. Give a talk at a woman's organization. Pass out flyers. Donate some books on breast cancer to the library or talk the librarian into purchasing some. Hold a bake party with the proceeds

> going to a breast cancer support group or for breast cancer research. Your goal should be twofold: to raise the awareness of every woman and to encourage more and more women to join the movement. (341)

In light of these last—and what I believe are extreme and excessive—recommendations, MacPhee's efforts as an active patient seem much less than remarkable: even the completion of her memoir becomes, not a major feat, but just one check mark on a very lengthy list of to-dos. It is, perhaps, these social expectations that shape MacPhee's perspective of herself, both as a patient and author.

Even more than MacPhee, Conway undermines and criticizes her own efforts as she compares herself with other ill patients and their activities. Prior to an appointment, she concludes that, being with David, she is less brave than unaccompanied patients; while recovering from surgery, she deems herself less good natured than her recovered friend, Jan, and less selfless than the patient beside her; and when she attempts to give advice to a newly diagnosed woman who has already researched her options, she feels less optimistic and competent in comparison. As an author, Conway recalls how she was a "cranky, angry, and ungrateful" patient; how she was the opposite of the optimistic and triumphant kind frequently depicted in illness narratives available in the 1990s (ix).[3] In her Afterword, too, the author identifies not the great efforts she made to execute the duties required of an active patient, but her failures: her "self-centered" and "angry" (254) behaviours. Accordingly, she concludes that her memoir reveals how "you can only get through [breast cancer], barely and ignobly" (255).

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[3] One such triumphant memoir is Elizabeth Gee's *The Light Around the Dark* (1992), wherein the reader is told how breast cancer provides opportunity for introspection. Following her mastectomy, Gee can no longer "go a day without reflection" (40) on the meaning of life's wonders and death's mystery. One year later, she is still reflecting and ultimately, transformed: "The questions raised by cancer and the prospect of death are torchlights of truth that illuminate unknown bends on a dark road. So now I know better how to live in this world and where to spend time. Every morning I open on joy, each day I discover much to love . . . . I feel a peace now, a certainty that there is truth which stretches forever from one crest of life to the next, and that there is nothing to fear in life or death" (71-2).

Although Conway supplements this statement by briefly recognizing that “any behavior is understandable under those circumstances” (259), she fails to acknowledge how many of her actions were remarkable under those same circumstances.

The kind of self-criticism that Conway offers as a patient and affirms as an author is not uncommon, perhaps due in part to women’s inclination to self-deprecation, generally. Katherine Russell Rich says she was “self-absorbed” (85) in the midst of treatments and Christina Middlebrook says she was “self-centered” (80). Barbara Rosenblum writes that in her “despair,” she could not muster the “courage, bravery, steadfastness, conviction [and] valor” she believes was required for a Stage IV breast cancer experience (36-37). Musa Mayer also remembers comparing herself to the narrators of pathographies: “In my reading, I had found only models of women whose brave optimism and fighting spirit had brought them ‘victory’ and the admiration of others . . . . Compared with them, I could only find fault with myself” (78). She adds that “it was all [she] could do to follow [her] daily routine” and even then, she found herself “anxious,” “out of control,” unstable, exhausted, and “complain[ing] too much” (78). Like Conway, these patients emphasized their supposed failures rather than their triumphs, and as authors, they continue to do the same in neglecting to evaluate this inclination.

One triumph MacPhee and Conway do share as active patients and emphasize as authors is this: both choose physicians who recognize their individual feelings and emotions, and in turn both are able, as Arthur Frank might say, to hold onto their own identities and even appreciate the company of their doctors. When MacPhee visits her longtime family doctor, it immediately becomes clear that she chose wisely long before her diagnosis with breast cancer. Duncan greets her “warmly” (5) and then, following a breast examination, informs her of her options and asks if she has “any feelings” (6) about what she would like to do. In another appointment, he proves he is “supportive [and] a good listener” (47) as he inquires about her family and informs her that he is always available, if just for conversation. Overall, Duncan affirms and appreciates MacPhee's identity as an individual, as does her breast cancer surgeon. In her words, Dr. Harris "made me feel my life mattered to him. When he looked at me, his eyes seemed to say, 'I want you go get through this.' I liked him" (36). Later on, when MacPhee questions him about protocol for another lump, Dr. Harris, like Duncan, reminds her to act according to her feelings. He insists that her worry does not constitute "'overreacting'" (192). In validating MacPhee's worries, he helps to alleviate them and to reiterate that she is making yet another "right" decision in her recovery process.

Conway, too, chooses physicians who connect to her on a personal or emotional level. Upon meeting breast surgeon Dr. Cody, she is impressed by his credentials and physical appearance, but mostly by his "warm and professional" (14) manner. She concludes that he is likeable and trustworthy and so becomes his patient. She notes how he calms and reassures her before her biopsy, makes himself available for questions regarding her mastectomy, and comforts her prior to surgery. She heeds his advice to see Dr. Moore, an oncologist, who treats Conway "warmly" (96) and as an "equa[l]" (97), and validates Conway's humanity and role as a mother, especially:

> [Dr. Moore] inquires about my children and responds to my worry about them by maintaining that children are pretty resilient in these situations. I gratefully take in this first gift from her. She inquires how I am feeling after the mastectomy, acknowledging its significance without making it too big a deal. Because she has asked about me, my emotions run very close to the surface and threaten to erupt at any moment. (97)

Dr. Moore also acknowledges Conway's role as a "cancermom"[4]: "She speaks with the utmost respect about women with breast cancer, who are able to manage the disease alongside the demands of jobs and families" (210). This validation of her everyday identity is paramount for Conway.

Certainly, Conway also encounters medical personnel who dismiss her entirely.[5] She recalls seeing an aloof receptionist, a silent EKG technician, a grumpy x-ray technician, and a flippant nurse all in one day. Hence, she quickly deduces that at the hospital she is "just a body" (20) and so briefly experiences on this occasion and several others the passive patient experience described by Arthur Frank. On the day of her biopsy, in the waiting room for outpatient surgery, she "notice[s] once again how little interest the staff has in the patients. We are a job to them. If they were to make contact with us, they might know that we are frightened and would have to talk to us; they could not move us through so efficiently" (28). Here, she adds to Frank's point, that anonymity is encouraged within hospitals so that "no individual physician is responsible" for mistakes made in treatment and so that the patient, "nameless," is no longer a "person who experiences" (*Will* 51, 52). Conway's recognition and criticism of this reality, along with her awareness that hospitals are under-staffed and employees are overworked, however, do not bring to an end her passive patient experiences. Shortly after waking from surgery, Conway is told by a nurse's aide that she will have to attend to the bathroom by herself because the staff is busy; should she fall on her way there, she should let them know. When hours go by and she is still

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[4] The responsibilities of the "supermom" (Hays 132) with breast cancer—or "cancermom"—will be discussed in the next chapter.

[5] Fortunately, MacPhee is spared almost completely from such encounters. She offers criticism, albeit silently, on just two occasions. First, she comments on Dr. Harris's bedside manner when he uses the words "'God forbid'" in reference to cancer. She wonders "if he knew what those two little words meant to me" (35). Second, she comments on an anaesthetist who starts an IV in her arm with great difficulty and proceeds to tell her how she could hemorrhage. To this, MacPhee thinks: "I didn't want to hear it—any of it. What had happened to the concept of reassuring the patient?" (40).

ignored by nurses, Conway once again concludes that she is "just another task, not a person in pain" (80). Because of these realizations, however, Conway becomes appreciative of those who give her "recognition" (*Will* 54).[6] She is grateful, for example, when a radiology technician affirms the difficulty of her experience and so talks to Conway "like a real person" (29). Similarly, she is moved when an admitting nurse tells about her own friends with breast cancer—thus seeming "attuned to the reality and impact of this disease"—and provides a detailed account of what Conway's mastectomy will entail (63). These last encounters, combined with those with Dr. Cody and Dr. Moore, allow Conway to step more easily into action as a patient.

It is curious, however, that Conway chooses to remain under the continuous care of Dr. Breckman, a fast-talking plastic surgeon who fails to acknowledge any emotional upset associated with Conway's reconstructive surgery. When he reviews potential procedures with a joking attitude, she concludes that he desires to know little about her. Twelve appointments later, she complains that he has still not "asked me how I am doing, no matter green I appear or how crooked my wig is" (191). Although Dr. Cody, Dr. Moore, and even David recommend Dr. Breckman and Conway eventually comes to like him, her decision to stay under the care of a doctor who clearly medicalizes her body is puzzling, given that she thrives on the emotional connection between doctor and patient. She rationalizes that his behavior merely reflects the nature of his specialty and that all plastic surgeons are likely the same. Additionally, Conway admits her uncertainty about reconstruction but agrees to it due to emotional exhaustion—because she "can't bear to make yet another careful decision" (61). It is, perhaps, this same exhaustion that also affects her ability to choose a reconstructive surgeon. It seems, then, that in

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[6] Frank describes his understanding of "recognition" in this way: "I may not expect emotion or intimacy from physicians and nurses, but I do expect recognition . . . . It is no small thing to have cancer—to realize you are becoming ill, to suffer that illness and risk death, to be dying or to have returned to the living and be starting life over again with the knowledge of your own mortality . . . . Critical illness takes its travelers to the margins of human experience. One step further and someone so ill would not return. I want that journey to be recognized" (*Will* 54).

this particular part of her patient experience, she is passive—that she loses her "capacity to make choices" and forgets her "tastes and preferences" (Frank, *Will* 58).

Historically, breast cancer patients have been encouraged to embrace—and so become passive to—the entire reconstructive process, including the presentation of prostheses. In the 1970s, Audre Lorde reflected on the way each woman who loses a breast is encouraged to believe that

> she is no different than before, if with a little skillful pretense and a few ounces of silicone gel she can pretend to herself and the watching world . . . that nothing has happened to challenge her. With this orientation a woman after surgery is allowed no time or space within which to weep, rage, internalize, and transcend her own loss. She is left no space to come to terms with her altered life. (*Journals* 64)

Today, this is still the reality. In *Breast Cancer and the Post-Surgical Body* (2006), Samantha Crompvoets explains that, after a mastectomy, the post-mastectomy body is deemed "incomplete and abnormal" (96) and so "temporary, existing as a hiatus until breast restoration decisions are made" (121). To deny reconstruction "is to not fully participate in the recovery process" (96) and participation, we know, is crucial for Conway (and MacPhee). Moreover, adds Einat Avrahami, surgeons often persuade their patients to decide about reconstruction even before the mastectomy so that an additional surgery can be avoided (53). We see this in Conway's case.

In the same appointment wherein Conway is told that a mastectomy is likely, Dr. Cody also tells her she must decide about reconstruction. He offers that if she chooses to begin reconstruction during the mastectomy operation, she will spare herself an additional operation. He then recommends that she meet with Dr. Breckham and schedules the mastectomy so that Dr. Breckham is available should she decide to have implants. Consequently, Conway agrees to reconstruction rather quickly, and it is not until the months following the initial reconstructive procedure that she thoughtfully considers its meaning and significance to her personally:

> Many people have reconstructive surgery, I know, but I increasingly wonder why. This decision has always seemed strange to me—having this foreign object, this balloon, inserted into my body so that I can pretend to have a breast. People report feeling better about themselves afterward, and I reasoned that I would feel more comfortable wearing a T-shirt or bathrobe in front of the kids.[7] But I see now that I would have grown comfortable with my body even without reconstruction. Still, I've made my decision and I'll live with it. (202)

This, Conway's "genuine judgmen[t]" about her own reconstruction, is not "fettered by uncertainty and self-doubt" in the way that many women's are (Avrahami 50). Instead, it is characterized by honesty and acceptance: if she had known then what she knows now she would have decided differently, but she will "live with" her choice regardless. Even as she admits this, however, Conway has yet to survey her reconstructed body in great detail. Another month goes by before she finally makes time to purposefully address her greatly changed body:

> I look hard at my reflection in the mirror. I see my mostly bald head, my many scars, and my breast in all its inflexible roundness. I look tired, old, mutilated. I try to absorb the reality of what my body is like now, and I feel, at this remove from treatment, not just the humiliation but some deep sadness about all that I have suffered. Yet I also feel that I can accept this body, even love this body that has been hurt so much. (208)

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[7] Interestingly, "dressing behaviour" (van Wersch 191) can greatly influence the reconstruction decision. According to Anna van Wersch, women most commonly have reconstruction so that they do not have to wear a prosthesis, so that they can "wear a greater variety of clothing," and so that they do not have the "inconvenience of not being able to wear ordinary clothes" (191).

In being "remove[d] from treatment" and the urgings of practitioners, Conway is finally able to view her body, "not in terms of how [it looks] and feel[s] to others" (Lorde, *Journals* 65-6), but with her own eyes and from her own experience.

Fortunately, breast reconstruction is presented to MacPhee with less persistence. During the appointment wherein she tells Dr. Harris she will have a mastectomy, Dr. Harris shows her photographs as he describes the "wonderful" (68) options available to her. She immediately tells him, however, that she is not interested due to the surgery's complexity and because "it wouldn't be me" (69); the conversation ends there. Post-mastectomy, however, another idea—a prosthesis—is suggested, and this gives MacPhee more to consider. Before even leaving the hospital, while in a particularly "critical and vulnerable period following surgery" (Lorde, *Journals* 57), MacPhee is met, just as Audre Lorde was, by a representative from Reach to Recovery, a support group run by women who have had breast cancer. The representative, assuming MacPhee will want to fill the space where her breast was, offers her bra stuffing to use until she can wear a prosthesis. At this point, MacPhee has yet to even see her one-breasted body; like Conway, she examines herself much later. During a shower, she

> gasped as I looked down at where my breast should have been. Somehow I had managed not to really look at myself since the dressings had been removed. I looked at anything else I could: curtain, tiles, showerhead. But this time, no matter what I looked at, I said over and over to myself: it's not there . . . . I realized that a certain kind of familiarity with my body had been lost. (131-2)

But it is before this self-examination that MacPhee is encouraged to conceal her new reality. Embarrassed and confused, she accepts the stuffing (which she does later attempt to use) but silently admits her uncertainty about a prosthesis. Not long after this, Dr. Harris, upon seeing that MacPhee has used socks to fill her bra, suggests she use foam and assures her that she will "feel better" (123) once she has a prosthesis. Embarrassed once more, MacPhee is unsure what to make of "that word," and can hardly pronounce it to her daughter, following the appointment (123). Nonetheless, she purchases a temporary prosthesis and examines a real one whose brochure promises a "'new world of freedom'" (130). She wonders: "did I even want one? Surely some women must choose to get on with their lives looking lopsided. But I didn't want to draw attention to myself. And I certainly didn't want to upset people" (125). Perhaps, here, she is concerned about "'the morale'" (Lorde, *Journals* 60) of other women with the disease, or of other women, generally; she does not specify. Despite her uncertainty, she does buy a prosthesis. Initially, she does not wear it, and when she does begin to wear it, she takes it out frequently. Eventually, after seeing a "sexy" (245) picture of Deena Metzger (Figure 1), she dismisses it altogether, deciding that her husband will "like [her] body" (252) and that she can "feel sexy again" (132) without it. With this realization, she is finally able to move from a place of passivity to one of action, and even suggests that, to gain political power, women with breast cancer should become "'more visible'" by rejecting prostheses altogether (254).

Even before they enter the realm of reconstruction, however, both Conway and MacPhee emotionally detach from their breasts—almost instinctively, it seems—and so, become somewhat passive as patients in response to the inevitable "chopping off [of] flesh and sinew" (Feldman 76). In the same appointment wherein Conway earnestly seeks to make a personal connection with Dr. Cody, she also "withdraw[s] all emotional significance from [her] breasts" (16) as she lets him examine them and, accordingly, identifies her breasts as "mere appendages, parts of [her] body to be examined and felt for tumors" (17). This withdrawal continues: later, she calls her breasts "useless" (39)—noting that they have already served their maternal purpose (65)—and "offending" (49). Throughout her memoir, she rationalizes that her right breast should be removed as well; she imagines herself "relieved to be rid of all breasts" (115). Conway clings to emotionally detached reasoning so that she can move, as an active patient who must make decisions, more swiftly from one treatment to the next. When she falters, when she allows herself to express her liking and even love for her breasts, she experiences immediate doubt: “How can I choose to do this? How can I consciously agree to have my breast removed?” (65). Even after the mastectomy, Conway must ignore the severity of what she has already gone through so that she can focus on further treatment. Otherwise, she experiences a profound sense of loss. By the end of her memoir, she focuses on a return to health and ordinary living which will likely no longer include an emotional attachment to her remaining breast.

MacPhee also emotionally disconnects herself from her breasts by adopting Conway’s passive perspective—that “there are certain things one simply must do, however grotesque and unimaginable” (Conway 69) on account of breast cancer. In the same appointment in which she is diagnosed, she is told that a mastectomy, although recommended, is essentially an amputation. She propels herself to have the “mutilating” surgery, however, by reaffirming that she is “dealing with a life-threatening disease” and that a “breast is not a vital organ” (64). Like Conway, she assesses the value of her breast in relation to its function: she concludes that since her breasts have already brought her sexual pleasure and have nourished her babies, they are no longer useful. And yet, when she sees her left side following surgery, she is shocked, disoriented, and sad. She quickly attempts to stifle these feelings, though, by reminding herself she should feel fortunate to have the tumour removed and should be optimistic about her lab results. Later, she struggles to maintain this optimism, for “the truth was, [she] felt cheated….The scar was so ugly” (132). But she keeps her mourning brief[8]; she is interrupted by her daughter, and then by a

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[8] MacPhee’s words—that she “felt cheated” and “wanted to feel sexy again” (132)—indicate indirectly to the reader an attitude that the un-reconstructed, post-surgical body is “incomplete and lacking femininity and sexuality” (Crompvoets 98), and thus, that she is likely influenced by society’s conceptions of the ideal female body. Such conceptions will not be discussed here. My point is that MacPhee dismisses her feelings, period.

vigorous to-do list of exercising, studying, and researching breast cancer. She eventually readdresses her feelings, again momentarily, when asked directly about them by her grief counselor. But immediately, she dismisses the "'shock of [her] missing breast'" by focusing on the necessity of surgery: "'as far as I'm concerned, it was the breast or my life'" (237). While the "'breast or my life'" rationale may be true—and common, according to Dr. Susan Love—it dismisses the value of her lost breast and her feelings associated with that loss. And, as I have shown here, such dismissal begins even before surgery. To echo Arthur Frank, MacPhee must lose some emotional connection to herself so that she can allow and endure the physical loss of one part of herself. In the reality that is breast cancer, both MacPhee and Conway reveal that "tastes and preferences" can hardly be considered—and in fact, must be rejected—in the midst of being "cut up [and] sewn together" (Conway 61).

When they are not concerned with surgery or reconstruction, MacPhee and Conway make great efforts to *appear* as though they are entirely active and in control. Inside clinics and hospitals, they suppress what might be deemed negative emotions like fear, anger, and sadness. As patients, they are fully aware of this tendency; as authors, they are commendable for confessing it in their memoirs.While waiting to see Dr. Harris, for example, MacPhee purposefully executes a "sense of business as usual" (21). With intention, she greets a nurse enthusiastically before her mastectomy and "trie[s] to make light conversation" (193) in a discussion with Dr. Harris about another potentially malignant lump. Over time, her pleasantries earn her the title of a "'model patient'" (155), one who is loosely defined by her general practitioner as someone who is "'incredibly strong'" (157), does "'exceptionally well'" (159), and is "stoic and reasonable and accommodating" (234). In other words, she is praised for being entirely unlike Shannon, another breast cancer patient, whose unrestrained screams create panic for an entire room full of women. MacPhee is resistant to such praise, however, admitting that her imposed behaviors are part of a self-directed “act of bravado” (227) and that it is impossible to be “‘wonderfully well’” with breast cancer (234). Interestingly, though, she does not follow these rather passionate admissions, as a patient or an author, with a consideration of why she engages in these behaviours in the first place. Instead, she, as patient, ignores the “strange trembling deep inside” (237), regains composure, and focuses on other troubles.

Similarly, Conway strives to “look nonchalant” (29) before her biopsy. She then tries desperately to “hold [her]self together” (32) after her diagnosis and to “calm [her] terror” (76) before her mastectomy. While still in the hospital, she conceals her feelings—that she feels “assaulted, neglected, and trapped” (81)—from Dr. Cody and then, as he removes her stitches, she admits to “acting” as though she is fine (91). Additionally, upon hearing that a second mastectomy may be necessary, she tries “to remain calm and sound rational, though [her] emotional barometer registers shock” (113); during her first chemotherapy appointment, she tries “to hold back the terror” (131). These examples reveal Conway’s desire to perform well. Indeed, from the beginning, Conway, as patient, is aware of the possibility of “performance evaluations” (29) from medical staff, perhaps especially because in her previous cancer experience, she was called “‘bad’” (47) by her doctor. But, in wanting to be “good” during *this* cancer experience, she and MacPhee, too, deny themselves the opportunity to address and release their emotions in the moment.[9] As authors, they do not address this need to be good, and in not doing so, they suggest that performance is without consequence and that it is best to silence authentic emotion in order to feign being the “perfect patient, joking at all the poking and prodding, smiling at all the surgeries and scans, never missing a single appointment, always

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[9] Of course, feminist psychologists would argue that a woman’s desire to be good is a gendered trait and one that forms in early childhood: while “boys are allowed and encouraged to express more anger, aggression, and competition; girls, even now, continue to be praised for interpersonal sensitivity, for being ‘nice’ to others” (Jack 92). Then, in adulthood: “forcing themselves to stop thinking, judging their own thoughts, and silencing their voices and opinions are methods by which women keep themselves from expressing anger and resentment” (Jack 137). For Conway and MacPhee, then, this ingrained desire to be good is further encouraged by social expectations of the ill.

opting for the biggest gun, forever taking the hugest risk, even when the chances [are] slim to none" (Gaynes 173).

Despite the lack of critical evaluation in *Picasso's Woman* and *Ordinary Life*, however, both stories articulate the reality that is the breast cancer "journey"—that passive behaviours are inevitable even as one resolves to be an active participant. Between sickness and health there are hundreds of questions and even more decisions that can be made only after relentless researching and with the guidance of trusted practitioners. But then, when the breasts are cut and the body is drugged, the patient must disengage herself; she must ignore or dissociate from these assaults on her body so that she can allow them to occur in the first place. This emotional disconnect, although necessary, may deny or limit "self scrutiny" (Lorde, *Journals* 59) in the face of reconstructive options and allow the patient to feign composure as she tries to become like the "stalwart women who show up in the women's magazines every October" (Rich 53). This reality is hardly ideal, but neither is the idea that the breast cancer patient, wholly active, may move from "puking, trembling, swelling…and oozing post-surgical fluids" (Ehrenreich 45) into healing and recovery simply by following her heart.

Chapter 4

Restoring “the normal rhythms of the family”: Cancermoms at Work

In his introduction to *The Illness Narratives* (1988), Arthur Kleinman defines “illness problems” as those practical, “principal difficulties that symptoms and disability create in our lives” (4). Difficulties arise, he says, when ordinary and necessary tasks performed at home, work, or school, become difficult or impossible to perform due to symptoms. The patient may find it difficult, he offers, to maneuver stairs or sit at a desk for long periods of time; or she might find it impossible to shower or make a cup of tea. Certainly, she may find it difficult to care for her children, should she have any. And yet, for the “supermom” (Hays 132) or “cancermom” in the new momism culture, illness problems that might affect her children are to be dismissed, if mild or manageable, or compensated for, if severe, with “a lot of thought to [the] children” (Brophy 93). Beth Brophy, writer and mother of two, records how she spent her time in the sick bed planning “how my daughters’ bat mitzvahs should be handled…which of my single friends might make acceptable stepmothers…who should take my children clothes shopping” (93). But in her children’s presence, she made sure to be “stoic and optimistic” (93), with her wig securely fastened. Meanwhile, Kelly Corrigan, another writer and mother of two, describes how she threw herself into birthday party planning before she was too fatigued from chemotherapy and because she could not “possibly let cancer have its way with [her] daughter’s first real birthday party” (“Can’t” 202). Corrigan allowed herself to cry only when her daughter, playing in the backyard, “need[ed] absolutely not one more thing from [her]” (206).

In *The Feminine Mistake* (2007), Leslie Bennetts highlights how our “patriarchal society encourages women to subordinate their individual needs to those of the family” (203). Of interest here is the way in which cancermoms MacPhee and Conway, like Brophy and Corrigan, subordinate their illness problems or more broadly, their illness experiences, so that they can attend to responsibilities at work and home. At the beginning of her illness, for example, MacPhee converses about world news, Peter's household projects, and her daughter's schoolwork rather than the discovery of her lump, and later cycles hundreds of kilometers on her exercise bike so that she can physically prepare herself to do "something for someone else again" (174). Meanwhile, for half a year, Conway juggles "appointments, naps, nausea, and early bedtime" (118) with working and making lunches so she can "maintain a semblance of normal life" (132) for her children. Eventually, however, their attempts to maintain control of their work and home environments fail. Conway then criticizes her parental performance, especially in light of her husband's, while MacPhee blames herself for not sufficiently minimizing her illness. Both hold themselves responsible for creating chaos and view their illness primarily in terms of its effects on others.

It must be understood that MacPhee and Conway embark on their "cancer career[s]" (Ehrenreich 45) when they are already full-fledged supermoms with professional careers they find challenging and rewarding. MacPhee, in her own words, has "everything" (73) and Conway suggests she has the same: "I love my life, my family, my work" (17), she writes. It could even be said that for both women "meaningful work is an important component of who [they] are—and therefore a significant part of what makes [them] good mothers" (Bennetts 283). Both introduce their memoirs by stating their professions: MacPhee is a paramedic and a poet (in addition to being a student), and Conway is a psychotherapist with a home practice. Both proudly recall stories of their work. Conway recollects daily appointments with patients, noting their worries and fears, while MacPhee tells of collisions and suicide. Outside of work, MacPhee is "manic in [her] need to be off on [her] own" (27) so that she might write in her study or the mountains, search for missing persons in the wilderness, or kayak on the ocean nearby. Meanwhile, Conway loves to travel and to be with her children, friends, and family at their country home. All of these activities leave MacPhee "stretch[ing] time" (4) and Conway with "no time" (8, 119) long before they become breast cancer patients.

As a paramedic, MacPhee is able to assess critical situations, make "fast and compassionate" (12) decisions, and provide comfort when it is needed. As a boss and with a reputation for being "indestructible" (8) to her patients and "upbeat" (73) to her crew members, MacPhee admits she is "proud of being perceived as someone able to bear up no matter what the challenge" (73). It comes as no surprise then, that when presented with the challenge of breast cancer, MacPhee proceeds with an intensive recovery program and returns to work exactly two months after her first surgery.[10] MacPhee hints that work is "good for [her]" (226) while she heals. It may be that MacPhee identifies her work, like many other women do, "as a source of enormous strength and resiliency in times of need" (Bennetts 192); it may be that her preoccupation with work is related partly to her belief that in keeping busy she can more effectively "dea[l] with terror" (67)—or ignore her terror—and that the station will operate poorly without her. Additionally, it could stem from her expectation that, even in illness, she should still be able to juggle her other roles in "Superwoman" (4) fashion and attend to others' emergencies. When she finds she can no longer be the independent, "brave," and "fearless" (32) professional doing things for others, she is gravely disappointed. She then makes every effort to recover and return to work so that she can reassert herself as "the most put together woman" (181) possible.

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[10] Ironically, she attempts to heal herself with the same "gruelling" and "chaotic" pace (135) that she thinks may have played some part in bringing about her illness in the first place. After finding an article that suggests an inextricable link between cancer and stress, MacPhee admits that, previously, she thought she "'thrived on stress'" (77). When she comes across the same suggestion again—this time from the Simontons—she defends that she copes well with stress, but does confess to being a "workaholic" (182) and to filling her life too fully.

Conway, too, attempts to be "put together" as she continues to work throughout most of her illness and undoubtedly, she is successful. "It remains uncannily true," she writes, "that I pull myself together to see my patients" (189). Even when she feels like she has been physically beaten up and abused, as she does after reconstructive surgery, or when she is filled with terror after unfavorable lab results, she still sees all of her scheduled patients. And when she is not with them, she is thinking about them. When considering a second mastectomy, she laments that she cannot leave them on account of another operation; when worrying about a scheduling mishap that moves her chemotherapy treatment to the day before patients' appointments, she refuses to rebook her patients. She rationalizes her determination to work—during a visit to the radiologist, no less—by emphasizing her love for it and her need to focus on the fears of others rather than her own; she knows, from her previous bout with cancer, that she cannot have "too much time alone to think" (50). Besides, she claims to use her illness—which she discusses with her patients—as a tool by which she can help them to identify their "feelings about illness and death" (104); in doing this, she can ignore her own feelings about chemotherapy and maintain something of the professional reputation she so cherishes. Only once does she question her unfaltering commitment. When she sees Dr. Moore, who advises her not to worry unnecessarily about her patients, Conway decides she must "withdraw some of [her] energy from others and focus more of it on [her]self" (103). She immediately follows this statement, however, with a report on how, during her week off, she struggles to find the best approach for telling her patients she has cancer. It seems that Conway is intent on being a kind of supermom to her patients: she wants to protect them, fears that she will abandon them, and hopes they will not lose her because "they would miss [her] if [she] died" (188). In other words, she believes she is irreplaceable, and so she "staggers on relentlessly," for if she does not, she might "discover that her [patients] can manage perfectly well without her" (Comer 5). Of course, in her memoir Conway does not specifically recognize or critique her efforts to mother them—but then, she hardly appreciates her great efforts to mother her own children.

Although Conway and MacPhee make clear that they do not identify themselves wholly as "moms," their actions indicate a shared belief in the myth that they, as mothers, are absolutely essential to the social order of their homes (Comer 4) and a conviction that "the very best moms"—even the ones with cancer—are those "whose lives are totally defined by self-sacrifice" (Douglas 310). In other words, they demonstrate that cancermoms are to behave like healthy moms, busily attending to domestic duties and obligations in an "intensive mothering" (Hays x) fashion. Upon receiving the news that she likely has breast cancer, Conway responds immediately with concern for her children: "My God, no. My kids," she thinks, and then wonders who will pick Molly up from school the next day (12). Although she quickly finds herself in a place where she "can feel no hope," she still goes "through the motions" (10) of making meals, folding laundry, helping her son, Zach, with homework and reading a book to her daughter, Molly. After telling them about her diagnosis, she regularly affirms to them that she will be "'all right'" (21, 124) and "fine" (27, 35), even when her upset emotions likely indicate otherwise and when she does not believe those words herself.[11] As though to prove her words in action, however, Conway embarks on a pre-planned family vacation wherein she conceals her fears and scolds herself for not enjoying the children. She also plans Easter festivities and in doing so, thinks: "I must resurrect myself for Molly by putting aside my preoccupation and meeting her needs . . . I must meet the challenge of her expectations of a basket of candy, hidden in an unusual place, a festive breakfast table, and a cheerful mother" (57). Although here she, the patient, identifies the "cheerful mother" expectation, she does not allow herself to let it go, even

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[11] Conway questions her affirmations with regard to her patients, as well. She admits, "I worry that I sometimes insist too vigorously that they believe I will be fine" (190).

when her husband reassures her that the children can handle seeing her upset; instead, she criticizes herself for not fulfilling it. As an author, she offers no critique of such behaviour.

Conway is influenced to make two major illness decisions, in part, because of her children: she decides to have reconstruction so that she will "feel more comfortable…in front of the kids" (202), and she decides to undergo months of chemotherapy—which will only slightly increase her chances of survival—"for the sake of Molly and Zach" (107).[12] Ironically, it is during chemotherapy, when she wears a wig so that she does not embarrass her children's friends and feels she still has to arrange extracurricular activities and play dates despite her nausea, that Conway believes she "struggle[s] fairly unsuccessfully to be a good mother" (142).[13] She believes herself unsuccessful, I suggest, because she cannot wholly participate in her children's lives while, in the meantime, her husband can and must. Fatigued from chemotherapy, she is distracted when listening to Molly play the piano or Zach discuss his homework. She laments that she has not made enough time for Molly and tells herself she will redeem herself later. Meanwhile, her husband becomes the "good parent" (142). With Conway, he helps the children understand their mother's surgery and treatment. He gradually assumes "the endless errands" (118) normally attended to by Conway—he shops, schedules activities, prepares meals, and puts the children to bed—so that eventually "most of the burden" (189) of managing family life falls onto him.

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[12] Conway is also told by Marta, a nurse helping with chemotherapy, that she "must focus on getting better for [her] children, even if it means being less available to them in the short run" (123). Here, again, the emphasis is on the children.

[13] It is interesting to note that at the same time she believes she is a bad mother, Conway also suggests she is a bad daughter, especially to her mother. Crying, she wonders, "How can I do this to her [that is, have cancer] again?" (34). Conway relays her diagnosis by apologizing profusely: "I tell her how sorry I am to cause her more pain" (38). Later, she comments again as to how her mother does not "deserve an ounce more pain" (146). Not surprisingly, when Conway's mother offers to help with the children, Conway declines the offer.

In response to David's support, Conway is most often grateful, but occasionally irritated. During a family outing, she wonders: "Why am I angry rather than grateful to him? Because he is not as morose as I? Because I have been robbed of my ease with my children and envy his ability to stay connected to them?" (25-6). It is largely, I believe, her own sense of disconnection—both physically and emotionally—to her children, in relation to David's increased connection, that spurs Conway to anger. When he comes to visit her in the hospital after surgery, "fresh from home and the children" (81), and when she is recovering from chemotherapy, "away from David and the kids, who are busy with their friends" (140), she becomes envious not only because their obvious health emphasizes her lack thereof, but because she learns that she is not entirely essential to her family's well-being. Moreover, she realizes how dependent *she* is on her family—namely, David—for her own health. When he is not attending to his children, David is attending to Conway. He accompanies her to her first appointments with the breast surgeon, radiologist, both oncologists, and plastic surgeon, and to her biopsy, pre-operation tests, mastectomy, chemotherapy treatments, liver and bone scans, and reconstructive surgery. His presence helps to keep Conway "grounded" (13); his help in researching and decision-making serves to keep her "on track" (127); his optimism offsets her pessimism. He gives her parents "encouraging information" (34) about her diagnosis, finds the first-stage breast cancer statistics "reassuring" (55), "presses for more reassurance" from doctors (91) about her negative nodes, and "celebrates [her] progress" with chemotherapy (161).[14] But in spite of all of this, Conway finds herself struggling to "compete" (142) with Molly and Zach for David's attention, feels abandoned when she does not receive it, and deems herself a "needy child" when she does (174).

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[14] On one occasion, Conway notes that a spouse can become *too* supportive or perhaps inappropriately supportive. When David asserts to Dr. Moore that "*we* will do anything that is necessary to improve [Conway's] chances of survival" (101; emphasis added), Conway becomes critical of his language in that moment: "There is a thin line between emphatically identifying with my experience and confusing mine with his. Sometimes David crosses the line" (101), she says.

Throughout her illness, Conway frequently expresses her feelings to her husband, and in return, he gives her the gift of “bearing witness” (Mayer 80); that is, he “tolerate[s] and simply acknowledge[s] the grief, anger and fear of what has happened” (Mayer 79) and is happening to her. In fact, David is one of few people in her life to “simply be there” for her (Mayer 79). Many of her friends, for example, tell stories about themselves and their own health or of others’ cancer recoveries rather than listen to Conway’s story, so as to talk themselves into their own immunity, Conway believes. On one occasion, when she attempts to tell a friend her miseries and the friend responds that Conway sounds like “her depressed mother” (200), Conway is hurt and concludes:

> This is the part of cancer I loathe the most. I hate that I am so worn down that I can’t even fake being good natured, that I am so demoralized that the slightest hurt reverberates for days. I have no sense of humor; nothing rolls off my back. I am no fun to be with. Others don’t want to be with sick people, unless they are noble, long suffering, and silent about their illnesses. (200)[15]

In this passage, Conway once again indentifies the ideal patient of breast cancer culture—the endlessly “perky and entertaining” (Gaynes 203) woman who expresses no actual symptoms of illness; briefly, she recognizes, as Arthur Frank does, the social expectations the healthy have for the ill but then laments that she cannot fulfill this patient role or meet these expectations. Indeed, there are times when Conway “communicate[s] nothing but rage” (192)—whether in the hospital, at home, or in the outside world—and she feels guilty on account of this mostly, it seems, because of how she believes her anger affects her family. After all, “mother-love is supposed to

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[15] It is interesting, given Conway’s lengthy discussion of her friends’ witnessing behaviours, that when it comes time for Conway to offer witness to friends Laurie and Estelle, also diagnosed with breast cancer, she is unable to do so. In fact, she avoids seeing them in person for fear of being “overwhelmed” (144, 194) and because she feels she cannot “offer much in the way of encouragement” (144). She attempts to rationalize her disconnection to them and other women: “we are all too needy to attend to each other; it’s a feat simply to keep ourselves going” (206). And yet, by refusing to at least acknowledge their pain or explain her lack of support, she becomes just like the friends whom she criticizes. She does not comment on this issue as an author.

be continuous, unconditional. Love and anger cannot coexist [and] female anger threatens the institution of motherhood" (Rich, *Woman* 46). Thus, it is around the time when David becomes "trapped in misery" (188) and the kids continually yell at each other that Conway claims responsibility for creating a family that is "out of control" (193). As conflict overcomes the entire family, complete with door slamming, huffing, and yelling, Conway is horrified by her intense emotions and wills herself to calm down so that she might be more like her friend's mother, who "complained little" (145) while she had breast cancer. Her shame continues even after recovery. Conway writes in her Afterword—added at least a few years following her recovery—that she behaved in "morose, self-centered" (253) ways while sick and thus effectively failed and forever changed her family: Zach is now prone to denial while David and Molly are more prone to anger. "Since my illness," she says, Molly "possesses an intense rage. When tired and frustrated, she becomes a living embodiment of my more desperate moments during treatment; her anger escalates quickly into a fury that echoes my own" (262). This character alteration serves as one more consequence of breast cancer. In my opinion, this is Conway's most significant self-criticism, for in making it, she—now the author with some alleged perspective—claims whole responsibility for the temper tantrums of a young girl who may have developed such behaviours regardless.

Like Conway, MacPhee is greatly concerned with how she experiences her illness as a mother: she makes sure to dismiss her feelings and minimize her feelings of illness so as not to disrupt "the rhythms of the house" (12). Following her first appointment with Duncan, MacPhee arrives home only to put the family dog's needs before her own: she feeds the Great Dane, who has "no time for [MacPhee's] preoccupations" (8). She gives her husband, Peter, and her daughters, Jenny and Katherine, a wide smile, ignores thoughts of cancer, and listens to the stories of their day. Unlike Conway, who immediately falls into the arms of her husband and depends on his support from thereon in, MacPhee hardly involves her spouse. For a moment, she considers telling him her news but decides, instead, not to bother him with only a potential diagnosis. Similarly, after her mammogram, she smilingly sends Peter on a business trip, refusing to share any of her worries. Upon his return home, she listens to his travel stories and admits she has had "'a bit of a week'" (53). In neither instance with her husband does she reveal how serious she believes her breast cancer to be. She hides her belief that it is a personal "catastrophe" (36) and an expression of her body's own "betrayal" (51), and her fears of its many treatments. When she finally does receive an official diagnosis, she laments that she "'can't do this'" to her family because Jenny still "'needs a mother'" (47). Interestingly, though, she later tells Jenny that the disease is "'nothing to worry about'" and that "'lots'" can be done to cure it (53). For MacPhee, it is paramount that she "do everything" she can to protect her family from the "hellish experience" that is cancer (56) by minimizing her own experience of it. Hence, she decides she must restore family normalcy, although she admits she is uncertain as to whether she can fulfill the expectations she believes her family has of her; she decides not to have chemotherapy in part because she does not want its potential symptoms to affect her family; and at the discovery of a second lump in her left breast, she decides against calling anyone right away after rationalizing that no one will want to know her upsetting news. When MacPhee does decide to tell her family about her second lump, she calls it "'little'" and assures them that it is "'probably nothing'" (194). Moreover, she attempts to stifle or downplay emotion, just as she does for her doctors. When tears stream down her face for an entire day, she apologizes for her unexpected, weak behavior.

Despite her best efforts to maintain normalcy for her family, however, MacPhee still believes she fails. When she is notified of Jenny's crying at school, MacPhee immediately blames herself for not organizing her entire illness experience into more "manageable steps" (67). She then wonders what she can do for Jenny and decides to delay her mastectomy so that they can vacation together in Mexico. "I want Jenny," says MacPhee, "to have this experience with me" (70). Even here MacPhee subtly shifts the focus from her own desire to have an experience with her daughter, to her desire to fulfill Jenny's wishes. Not surprisingly, she does not discuss her diagnosis during the trip or after it: on the evening before her surgery, they chat about "everything except the next morning's surgery" (81). While she recovers, however, MacPhee speaks less with Jenny and forgets the conversations they do have. She realizes that she can no longer keep track of her daughter's activities, and when Jenny is injured in a biking accident, she once again blames herself: "I had lost control of my family. I had to get myself well again" (171). Like Conway, MacPhee insists that every aspect of the wellness of her family is dependent upon her own health.

With her closest friends, whom she essentially regards as family, MacPhee also acts to minimize her illness. She tells her best friend, Deirdre, with a "nothing-much-has-happened tone" (37) about her scheduled biopsy only because she needs a ride to the hospital. On the day of the surgery, MacPhee smiles and insists that it is all "'no big deal'" (38). When results indicate otherwise, however, they intentionally omit talk of illness from their next conversation so as not to make difficult their "routine of easy banter" (103). When the reality of the disease inevitably settles in, however, their friendship weakens. Although MacPhee does eventually confront Deirdre about her lack of support, MacPhee concludes, rather simply, that her bout with breast cancer came at a difficult time for both of them. Similarly, when MacPhee tells another good friend, Pat, about her diagnosis, she immediately "tries to lighten things up a little" (65). Perhaps unthinkingly, Pat encourages this minimizing behaviour. She tells MacPhee: "'So many people will need you to survive this—they will need *you* to help them through it'" (66) and "'You can't get *depressed* on us. We need you'" (143). Instead of bearing witness to MacPhee's experience, Pat attempts to control it, as friends often do, by encouraging her to become the "perfectly brave, positive, cheerful cancer patient" (Frank, *Will* 66).[16] Not surprisingly, MacPhee reacts by isolating herself somewhat in recovery. She refuses to call Pat for a time because MacPhee feels she has little to offer and worries, before she does allow a group of friends to visit, that she will perform inadequately.

What Lee Comer might call "pathetic" (5) about MacPhee's account of these events is that there is no accompanying critical commentary from the perspective of patient or that of author, especially. Not once does she examine the ways she reduces her illness experience for the sake of her family. In fact, she further attempts, on two occasions, to diminish her role as an ill mother by emphasizing that her experience would be so much more terrifying and her responsibilities would be so much greater if she had very young children to look after, thus implying that her fears and responsibilities as a mother of young adults are negligible. On another occasion, while she claims that she "expect[s] the whole family to pull together to make [their] home livable" (27), her great efforts and overwhelming guilt make it apparent that she actually expects a great deal more from herself, although she seems unaware of this. It is my sense that MacPhee, both during illness and even after it, does not recognize her acts as self-sacrificing.

As patients, Conway and MacPhee frequently shift the focus from themselves to others with regards to their own illness. There are but a few days, upon returning home from surgery, that Conway concentrates on herself alone. Although she feels it is "strange" not to take care of the children, she finds it comforting to relax with television shows, books, and ice cream. She describes the experience as "peaceful," recognizing that "there are no decisions or obligations

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[16] Surprisingly, in *Picasso's Woman*, it is MacPhee herself who demonstrates what it means to bear witness to the ill. She runs into Shannon—a woman with breast cancer whom MacPhee met in the hospital previously—just after Shannon has found out her illness is terminal. MacPhee hugs Shannon, gives her space to cry, and is present for her. She writes, "So many times in my work I had needed to comfort people dealing with overwhelming loss. I'd often tried to find something to say, but there were no words to lessen the grief. Touch was all that was left" (221).

except to heal" (87)—except when she must calm Molly, who is upset that her mother is receiving too much attention. Most of the time, Conway considers the implications of her illness in terms of her children: "Will I be around for them? Will I be at their graduations from high school or from college? Will I see them make choices about their careers and relationships?" (51). Sometimes, she draws strength from thinking about her children. The children's physical presence reminds her that she is loved and alive, and at one point she asks, "How would I do this without them?" (93). But mostly, thoughts of Molly and Zach, when linked with those of illness, centre on her responsibilities as a mother. In her surgeon's waiting room, she must arrange for the babysitter to prepare the children for Zach's orchestra concert; before her first chemotherapy treatment, she must arrange for friends to take Molly and Zach to the country; when nauseated after injections, she compels herself to stay at her birthday dinner with the children.

Likewise, there are very few moments wherein MacPhee contemplates breast cancer in terms of herself only. At the beginning of the illness, she says, "I had a life-threatening disease, and I hadn't had enough of touching, of kisses, of sunshine, of mountains, of wonder, of laughter. I wanted it all" (49). Before the biopsy of her second lump, she has "fleeting visions of faraway seas I wanted to visit, experiences I had yet to have, books I had yet to write" (194). She acknowledges, albeit briefly, that receiving strength from others aids in healing, and she hears from her grief counselor that she "'can't get through life helping others and pretending [she is] never one of the needy'" (234). To her counsellor's comment, however, MacPhee merely nods. Most of the time, she attempts to heal by losing herself in tasks at school, work, and home, and hopes to heal quickly so that she can become productive again and no longer inconvenience others.

It is only when "the normal rhythms of the family [are] restored" (MacPhee 262), when MacPhee and Conway can fully reengage in their supermom roles, that they declare themselves recovered. Both memoirs conclude with a depiction of renewed family life. In *Picasso's Woman*, Peter is playfully roping a chair with a lasso, Jenny and the dog are sprawled on the floor, Katherine is sporting her new paramedic's uniform, ready for her first shift, and MacPhee is once again the healthy mom. She offers Katherine advice that is motherly, professional, and perhaps excessive: "'Now remember: never stand in front of a door, watch your back, always make sure you know where the exit is, don't lean against anything, double glove, watch for stray gunfire'" (261-2). MacPhee insists Katherine wear her raingear, hugs Jenny on the porch, and then offers this optimistic conclusion:

> Tomorrow would be another day. A new morning. Life was full of endless possibilities, and I was eager to live as fully as I could for the rest of the sweet life that was given to me. Because now I was not dying of cancer—I was living with it. I knew there might be challenges ahead. But then, I've always liked adventures.[17] (262)

In *Ordinary Life*, Conway and her husband stroll along Park Avenue after a successful mammogram. Both are happy. Although Conway's illness experience negatively impacted the family, as mentioned earlier, the family is for the most part "back in [their] ordinary life" (246). David teaches, Zach happily attends public school, and Molly enjoys her friends. Conway has resumed working (not that she ever stopped), cooking, redecorating, shopping, picking up the kids, planning birthday parties, exercising, and entertaining; that is, she becomes the "good" mom she was before cancer but now has a great appreciation for "the feeling of health" (250). She makes sure to affirm this feeling to her children, as well. While lying with Molly before bed, Molly asks, "'Is it over, Mom?'" and Conway, no longer weary and depressed, responds, "'Yes, Molly…breast cancer is over'" (251).

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[17] Sadly, MacPhee's "adventure" with breast cancer ended in 1996; she "lost her personal battle against breast cancer" at the age of 50 ("Rosalind").

Like other restitution narratives, these memoirs begin with the onset of illness and end with the restoration of health. Of course, restoration with regard to breast cancer is tentative: there is always the possibility of recurrence. Often, this possibility is forgotten by pathographers as they attempt to offer closure for readers (and perhaps for themselves). Couser explains that "a subtle but significant difference lies between definitive closure, which implies that the story of illness…is over, and achieving composure, which implies readiness for whatever is in store. The latter seems more appropriate—healthier in every sense—in narratives of an illness like breast cancer" (41). In my opinion, MacPhee attempts composure as a narrator. She knows "there might be challenges ahead" (262) but intends to live fully in the meantime. Conway, on the other hand, records how she rarely thinks of the disease and concludes her work by proclaiming her illness "'over'" (251). It is possible that she truly believes this. Near the end of chemotherapy and in a miserable state, Conway had remarked: "I may very well be free of breast cancer. And, if I'm not, what good does viewing myself as having a chronic disease do?" (189). And yet, given that this is her second experience of cancer, she must believe on some level that it could appear again (which it does, later, as lymphoma). It could also be possible that she imparts closure because she feels, as an author, that this is what others want to hear (Frank, *Wounded* 77), but this too is unlikely, given her boldness in telling an "untriumphant story" in the midst of mostly triumphant ones (ix).[18] I suggest, instead, that Conway brings definitive closure to her illness experience so that she may also bring closure to her role as sick mother, which is not the mother she "want[s] her children to remember" (253). Or said in another way, Conway does this to reinstate her role as supermom. It is as though she wants, as a recovered patient, to reassure her daughter and, as an author, to reassure her audience that illness will no longer prevent her from performing motherly

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[18] Recall that in the triumphant story, the optimistic sick person perceives the illness as "an opportunity for personal growth and transformation" (ix). In *Ordinary Life*, Conway "could not manage" this perspective and was overcome, rather, by "the disruption, fear, and loss that illness entails" (x).

activities (like greeting her children at the bus stop and reading them bedtime stories, both activities she recalls in her last pages) so that she will cultivate, without further interruption, happy and successful children.

Thus, in the midst of accepting personal and public responsibility for an evil disease and allowing the body to be “cut up” (Conway 201), Conway and MacPhee reveal that the task of creating happy children is “exclusively the handiwork of one person: ‘Mom’” (Douglas 326)—even when Mom is sick. They believe that, as moms, they are essential in bringing order to their homes and even to their workplaces (in Conway’s case, her patients’ lives). Ultimately, these cancermoms experience breast cancer mostly in terms of others—their children, spouses, co-workers, and patients—rather than in terms of themselves, and thus think themselves recovered only when they are able to restore the lives of those around them. In other words, they succumb, as many other mothers do, to demands of “selflessness rather than self-realization, relation to others rather than the creation of self” (Rich, *Woman* 42).

Conclusion

Barbara Rosenblum writes of cancer that “to tell is to make real” (47), and Kathlyn Conway suggests that to tell is *necessary*: “In a culture that denies the reality of physical and emotional illness we need stories of people and their families who face the disruption, fear, and loss that illness entails. These stories contribute to a badly needed conversation about the challenge of living with illness or disability” (x). In telling us their stories, MacPhee and Conway make real their experiences, as patients, “of illness in all of its complexity” (Diedrich, Rev. 114), even though they, as authors, do not reflect on possible dimensions of the experience other than the personal. In this thesis, I have set out to understand the complexity of their breast cancer experiences, as recorded and constructed in their narratives, in relation to three intersecting ideologies: the breast cancer, healthy-mindedness, and new momism movements. I have isolated specific parts of their stories that seem directly related to one movement or another; of course, these sets of expectations are all at work simultaneously. But just as one narrative type—restitution, chaos, or quest—may be more evident than another in one moment, so too may one ideology influence the story more than another in that same moment.

Their exposure to breast cancer culture and consequent adoption of its vocabulary—wherein “the words for illness and war [are] so irretrievably intertwined” (Middlebrook 78)—moves them to adopt the perspective of healthy mindedness, as shown in Chapter One. MacPhee examines how she may have self-created her breast cancer due to her inability, since childhood, to cope with emotional stress, while Conway emphasizes her own negativity and acknowledges her desire to become positive and so, healthy. As patients, they individualize their illnesses; as authors, they write to give coherence to chaos, attempt to absolve themselves of guilt, and caution others to beware of a “determined killer” (Conway 125). In the end, their “conversation” about breast cancer is one guided by military language and dominated by the notion that each woman "has a militant responsibility to involve herself actively with her own health" (Lorde, *Journals* 75).

Their behaviours as breast cancer patients, whether active or not, are thus affected by ideas of healthy-mindedness and breast cancer cultures: the patient is to claim full responsibility for sickness and do "whatever it takes" (Altman 335) to restore health. As discussed in Chapter Two, both MacPhee and Conway are immensely active and involved in the decision-making process, especially with regard to choosing practitioners. Yet, at times, they attempt to appear "seemingly at peace with the world" (King) even when they are not, and in response to mastectomy and the presentation of post-surgical reconstruction or prostheses, they become passive so as to remove themselves from "the ugliness of the disease and of the suffering it causes" (Lochlann 506). The authors do not comment on these opposing but expected behaviours, however, nor do they comment on their tendency to minimize and even criticize their actions perhaps because, according to both ideologies, there is always more to be done. That they do not speak to these contradictory expectations is unfortunate: had they done so, they would have exposed the absurdity of them for other readers and potentially helped other women resist performing for others in their own breast cancer experiences.

Finally, their commitment to the notion that they, as good mothers, should maintain control of work and family life even when overwhelmed by illness reveals the influence of new momism, as shown in Chapter Three. When chaos ensues—when husbands wear mismatched socks or take on additional duties, when children misbehave or play recklessly, and when raw emotion replaces cheerful smiles—these moms blame themselves. MacPhee and Conway think of breast cancer mostly in terms of others when at home, work, or with friends, and so neglect to attend fully to their own experience of suffering.

In each chapter, too, I have made reference to other breast cancer pathographers who experience similar thoughts and emotions. These references demonstrate what I believe to be a significant, if not the most significant, finding of my work: that MacPhee and Conway are not alone. They are not alone in their breast cancer experiences, nor are they the only patients affected by the ideologies I have described. Television journalist Geralyn Lucas, for example, "turned her battle with breast cancer at age 27 into a sassy calling card for everything from inspirational speeches to flashing her scar to other survivors" (Lee) in her memoir-turned-movie *Why I Wore Lipstick to My Mastectomy*. Her story, undoubtedly influenced by the cheery ideals of breast cancer culture, follows "a charming protagonist" who laughs her way through a mastectomy and chemotherapy—and in high heels, no less—until she finds a "happy ending" (Lee). *New York Times* cartoonist Marisa Acocella Marchetto eventually provides a happy ending in *Cancer Vixen*, too, after she fights most of the "angry" (4), "Al-Qaeda" (135) cancer cells in her breast via surgery, and eliminates the remaining cells about to "divide and conquer" (151) with chemotherapy[19] and radiation. Prior to her cancer invasion, she was "caught up in the superficial, stupid stuff" (13); after it, she was "changed . . . forever" (210) and dedicated to improving her spiritual, physical, and emotional self. Although stories like those by Lucas and Marchetto may end pleasantly, they offer their readers a false sense of what breast cancer is for most women—scary, negative, painful, disfiguring, and traumatizing—and suggest that the experience should be one that leaves women better than they were before it.

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[19] Marchetto, the active patient, also poses a lengthy list of questions regarding chemotherapy to her doctor: "How long are treatments? How often are treatments? How many treatments will I need? How will I feel afterward? Can I exercise? Will I be tired? What kind of exercise should I do? Can I keep working? Does each treatment get progressively worse? Will I throw up? Can I travel? How nauseous will I be? When will this ever end?" (144). During her first chemotherapy session, she chats with her magazine editor and gifts a lipstick to her mother; before her second, she throws a bachelorette party for a friend and stays up all night finishing a work assignment.

Then, there are the women clearly influenced by tenets of healthy-mindedness and new momism. Christina Middlebrook wonders if she is "furthering [her] disease [with] bad thoughts" (197); Barbara Roseblum asks if she is "being punished" (41); Elizabeth Gee pronounces that it will be her "fault if the cancer has returned" (134); Juliet Wittman, although skeptical, tries "to think of ways in which [she] might have caused [her] cancer" (61); and Joyce Wadler "can't shake Siegel's theory entirely, because a small part of [her] worries that he has a point" (91). In between diagnosis and treatment, these women, like MacPhee and Conway, are encouraged to "fight" for their lives, to claim responsibility for the onset of illness and the recovery of health, and to make order out of chaos for the sake of others. Like MacPhee and Conway, too, these authors generally neglect to recognize the ideologies that so obviously influenced their personal experiences of breast cancer. While they all "speak and act out of [their] experiences with cancer" (Lorde, *Journals* 8) through writing, as Audre Lorde would have them do, they essentially speak and act out of ingrained ideas and cultural narratives about wellness and illness. Without acknowledging social and environmental determinants of the disease, they can only make the "issue of breast cancer . . . depoliticized and decontextualized" (Fosket et al 320). In this sense, *Picasso's Woman* and *Ordinary Life* truly attest to the contemporary, individualized experience of breast cancer, avoiding the real issues of the disease, in all their complexity, and are likely representative of thousands of stories told and untold across North America.

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