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# LIVING AND DYING IN THE CONTEMPORARY WORLD

*A Compendium*

Veena Das and Clara Han, editors



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# 21

## THE GOOD AND THE BAD BREAST

*Cosmetic Surgery and Breast Cancer*

Bernadette Wegenstein

I have studied the phenomenon of cosmetic surgery both historically and ethnographically: as a media scholar and feminist theorist in my book *The Cosmetic Gaze: Body Modification and the Construction of Beauty* (2012); and as a cinema verité filmmaker in my most recent project, the documentary feature *The Good Breast*.<sup>1</sup> In studies whose foci range from the eighteenth-century Swiss physiognomist Johann Kasper Lavater to today's televisual extreme-makeover shows, I have found a persistent connection between beauty and the promise of moral betterment and happiness. A person's transformation of her body through cosmetic surgery is not inspired by a single principle, be that rejuvenation, aesthetic change in the service of an internalized racism (Munzer 2011), or sexism (Blum 2005; Weber 2005). Rather, while these cultural hegemonic principles are definitely real and the female body is one of the first places to showcase them, I am interested in the extent to which this change of the body is experienced as a "greater good" to the person undergoing it.

One can trace this sense of *bettering* or "self-improvement" to the principle of the Platonic (and pre-Platonic) *kalokagathia* (literally, *beautiful and good*) that started to evolve in the sixth century B.C.E. At that time, the new social class of Athenians was no longer defined purely via an aristocracy by birth but rather via an aristocracy of merit and money organized around the implicit mandate: *You must improve and better yourself in order to thrive!* In other words, this physical change aims at framing a moral change from *good* to *better* that is supposed to overwrite the subjective impression of "appearance," and that expresses itself on the "outside" while pointing to a happiness that is more than skin-deep. It is at this intersection that my study of cosmetic surgery—what Meredith Jones has

labeled makeover culture's most quintessential expression (2008)—connects with my research into the culture and history of breast cancer, an illness that, as S. Lochlann Jain (2007, 505) has it, “demands a surrender to femininity and to the mortality doled out by the feminine body.”

I came across breast cancer via my interest in cosmetic surgery and the construction of beauty, and their place in twenty-first-century makeover discourses. I was specifically curious about the overall increase in demand for breast augmentation in the United States over the past decade.<sup>2</sup> I wondered if there was a connection between breast cancer and cosmetic surgery, and to what extent women's suffering through the loss of the breast due to cancer was related to the Christian theme of martyrdom and the consequent idea of being rewarded with a new and better breast after surviving this life-threatening illness. I started working with twelve breast-cancer patients at the Greater Baltimore Medical Center, a top U.S. breast clinic, where I learned that about half of the patients diagnosed with breast cancer who have to undergo a single or a double mastectomy opt for either breast augmentation or (rarely) reduction to customize their breasts to their individual needs and imaginations—as well as those of their partners, children, and others. This suggests that about half of the estimated breast-cancer population for 2013—that is, more than one hundred thousand women<sup>3</sup>—had cosmetic surgery done on their breasts, amounting to about a *third* of all breast augmentations listed by the American Association for Aesthetic Plastic Surgery.

While this is an interesting fact per se—one that demands attention and more qualitative interpretation than I can currently provide—this chapter deals in particular with beauty's “dark side,” with the question of the “good” and the “bad” breast, and with the coupling of a deadly illness such as breast cancer with the question of the makeover's irresistible promise of happiness through, despite, and even because of an illness such as cancer. As Susan Sontag and others have shown in their semiotics of cancer, there is a long history of interpreting breast cancer as something bigger or “other” than its biology—that is, the uncontrolled division of a single cell. In 1826, for instance, the English surgeon and anatomist Sir Astley Cooper said that “grief and anxiety” provoked a woman's breast cancer (quoted in Bradley 1852). This perspective resonated with the story of one of my current documentary characters: that of Doris, whose boyfriend, Randy, explained that she got cancer because she was “too stressed out” and because she “went back to school”—not a woman's place. In *The Good Breast*, her experience with breast cancer and reconstructive surgery is shown in full detail.

Innumerable testimonies of cancer patients have shown that they can experience the overcoming of a life-threatening illness such as cancer as rebirth and a chance at a second life. In particular with the case of breast cancer—more so than, for instance, the experience of pancreatic cancer—enduring the loss of a part of one's body has been a source of women's desire to share this experience as something existential and an opportunity for expressing who they are or are not as a person and as a woman. The reason for this is obviously the fact that a pancreas does not have the symbolic power to stand in for the whole body or identity of a woman. There is a quite expansive literary and cinematic

oeuvre—growing exponentially—that documents the experience of breast cancer, in genres such as the domestic ethnographic documentary (e.g., *Naked, Baring It All, The Education of Dee Ricks, Tig*), the activism documentary (e.g., *Pink Ribbons, Inc.*), prose (e.g., *Before I Say Goodbye, Pretty Is What Changes*), photographic series (e.g., *The SCAR Project*), and more recently blogs and online forums (e.g., *ihatebreastcancer.wordpress.com, mbcn.org*). Some literary testimonies have become very prominent. One example is the American poet Audre Lourde's well-known *Cancer Journals* (1980), in which she gave voice to a silent struggle with the loss of her breasts and delved into what losing the breast to cancer meant to her individual identity as a black lesbian. In recent years, and partly as a result of the “infantilizing pink-ribbon-kitsch-discourse” (Ehrenreich 2009), overcoming breast cancer has been connected not only to a sense of general rebirth, but specifically to the experience of a *renewed or reborn beauty*. If one considers once again the concept of *kalokagathia* in the sense of overcoming breast cancer with a “better” or “better suited” breast, this change through breast cancer is strongly tied to the rebirth of a *new, reconstructed*, and overall *better* breast than the one before.

In other words, we cannot look at the cancer-affected or ill breast alone to understand the blurring lines between illness and beauty. Rather, the ways in which women opt to reconstruct (or not, although it is a very rare choice not to have a breast reconstructed) speak to their entire identity as women, and not just to their breast cancer as such. This realization was a pivotal point in my current work documenting women's breast cancer, and their breast reconstructions as renewed beauty, in *The Good Breast*. Further, it was the moment when I understood the “pink-ribbon discourse” not just from an economic and consumer-driven standpoint, but as an answer to the question, What is the relationship between the breast and its reconstructed double in the case of breast cancer?

#### THE GOOD AND THE BAD BREAST

I have described the place where beauty and death unite as “beauty's dark side” (Wegenstein 2012, 61–97). This is strongly connected to the ancient concept of femininity and female beauty as masquerade. While beauty is related to the “good” of *agathos* (see the story below of Saint Agatha), it is equally related to the concept of desire. Thus beauty is not something static or eternal but something that we want and desire to acquire or achieve: every promise of beauty has a vector of desire built into it that says, “I want beauty”; beauty always aims at something *beyond itself*. Going back to the physiognomists of the eighteenth century and their wish to understand facial expression as revealing a moral behavior underneath the skin, the fear of a “beautiful appearance” is always an expression of the fear that underneath beauty's perfection and seduction are hidden the abyss and the ugly, which can “erupt” at any time. This cultural topos expresses precisely the idea that beauty is an acquired good, one that need not have always been the way we see it here and now.

What does this mean for breast cancer and cosmetic surgery? Perhaps the beautiful breast that has been reconstructed on the site of “ugliness” where cancer revealed itself

“covers up” an ill or cancerous breast, and becomes a *masquerade of cancer* itself. To better exemplify this conceptual relationship between the “good” and the “bad” breast in breast cancer, I want to briefly allude both to Simon Richter’s reading of Melanie Klein and to the story of the Sicilian Saint Agatha, who in 251 c.e. gave up her breasts, which were tortuously shorn off as a sacrifice for her religious belief in Christ—a sacrifice that made her into the most celebrated female saint in the Catholic world.

“I have repeatedly put forward the hypothesis that the primal good object, the mother’s breast, forms the core of the ego and vitally contributes to its growth and integration” (Klein 1975a, 118). In her psychoanalytic, object-relations theory of the *good and bad breast*, Richter (2006, 65) notes, Klein notably diverges from Freud’s theory of sublimation to the theory of the breast as double, and as signifying both plentitude and lack: “In the baby’s mind, one part of the body can stand for another part, and an object for parts of the body or for people. In this symbolical way, any round object may, in the child’s unconscious mind, come to stand for his mother’s breast. By a gradual process, anything that is felt to give out goodness and beauty, and that calls forth pleasure and satisfaction, in the physical or wider sense, can in the unconscious mind take the place of this ever-bountiful breast, and of the whole mother” (Klein 1975b, 333).<sup>4</sup>

As a *primal good object*, the breast assumes the status of phallic symbol; but unlike a phallic symbol, which is based on oneness, the breast is based on duality. One breast represents the continuation of life and the source of pleasure, the other, “devouring” breast representing the imminent presence of frustration, loss, and of mortality itself.

The good and the bad breast can be illustrated in the myth of Saint Agatha’s sacrifice of her breasts. During the persecution of Christians under Decius in the third century c.e., the Roman prefect Quintinian threatened the young Sicilian virgin and early Christian Agatha with having her breasts amputated if she did not respond positively to his advances. Two folk tales of the story tell a slightly different version of Quintinian’s threat: in one he wanted to marry her and she refused him, upon which he decided to remove her breasts as an assault on her femininity (hence, making it impossible for any other man to desire her); in the other, a Christianized version, he wanted to dissuade her from her love of Jesus Christ, which prevented her from loving him as a pagan, and as a worldly god in his own right.<sup>5</sup> The effect of the prefect’s threat on Agatha, however, is consistently narrated according to the canonical tradition of the martyrdom,<sup>6</sup> in which Agatha is first broken on the rack, then flayed, and then burned with hot irons. During this torture, Quintinian is said to have asked Agatha one last time to “abandon this idea from your soul, so you can save your life.” Agatha responds by explaining why she chooses torture over following Quintinian’s offer: “I feel much joy in these pains: like someone who is delivered a happy notice, or someone who is reunited with someone he has longed for, or someone who finds a great treasure, so also do I, posed into this suffering of short duration, take great pleasure [*gioisco*].”<sup>7</sup> At this point, Quintinian orders the torturers to amputate her breasts, as has been represented in many famous paintings—for instance, in Sebastiano del Piombo’s *Martyrdom of Saint Agatha*. (See figure 21.1)



FIGURE 21.1  
*Il martirio di Sant'Agata* (1520), by Sebastiano del Piombo, Pitti Palace, Florence.

But Agatha warns the prefect once more, “You cruel, inhuman tyrant, do you not feel shame for taking away a woman’s breast, from which you yourself have sucked on your mother? But I have other breasts, that are intact, in my most intimate soul and with which I nurture all my sentiments.” Agatha’s breast sacrifice turns her breast into Klein’s *primal good object*. Sebastiano del Piombo has rendered her sacrifice with a masculinized Agatha, whose “quasi-phallus-shaped knot in her drapery” (Richter 2006, 27) has been compared to a stand-in for Christ, and her torture a visual allusion to the crucifixion itself. Agatha, “the good,” sacrificed her breast not as an organ that represents fertility, reproduction, and motherhood, but as the symbol of the *sacred* and the untouchable. Hence, her sacrifice becomes the *primal sacrifice* by which a loss is turned into a gain, her disfigurement into an aesthetic experience of beauty, and her bad breast into the good and unattainable “über-breast.”

#### THE GOOD BREAST: A DOCUMENTARY IN PROGRESS

In the second half of this chapter, I would like to attempt the academically “forbidden” and perhaps “unthinkable”—which is to apply the above concepts to four of the living cinema verité characters in my documentary *The Good Breast*.<sup>8</sup> “Forbidden” because cinema verité supposedly finds the truth in the field and not the other way round (although, as Errol Morris says in *Believing Is Seeing* [2011], “seeing is also believing”), and “unthinkable” because I want to present these four characters and their desire for cosmetic change and beauty within the experience of their mortality from the point of view of the *semiotic square of breast cancer*—a qualitative schema that is based not on data and extensive field work, but entirely on interpretation (Greimas 1966). During the film’s editing process we were looking for its story—a normal procedure that, especially with cinema verité, can reveal something different from what one set out to produce. One of

the storylines that emerged in this laborious process is that of our female characters finding new beauty in the place of ugliness, and exchanging the bad, cancerous breast for the good breast;<sup>9</sup> another one is about constructing masculinity in the place of femininity. For all of the following examples, the vicinity and possibility of mortality in the construction of this new femininity and beauty are crucial. After the brief case studies, I will show how these concepts are related in the semiotic square of breast cancer.

Elizabeth Hammond, an accountant and home-schooling mother of six from Westminster, Maryland, was diagnosed with breast cancer at age forty-nine, when she went for her annual mammogram on November 15, 2010, the day before her birthday.<sup>10</sup> The pathology reported a stage IIB ductal carcinoma in situ (DCIS).<sup>11</sup> Her largest tumor was 6 mm, and she had two of them. Elizabeth had two lumpectomies in December 2010, and the first one revealed that out of five of her lymph nodes, two were positive. She started chemotherapy shortly after her surgeries in January 2011. Between her third and fourth treatment, Elizabeth sought the advice of a plastic surgeon, Dr. Gedge Rosson, who specializes in the DIEP flap breast reconstruction, in which blood vessels (deep inferior epigastric perforators), along with the skin and fat connected to them, are removed from the lower abdomen and transferred to the chest to reconstruct the breast. Elizabeth's mastectomy was done on May 6, 2011, when Dr. Rosson first put in her tissue expanders to help decide whether a DIEP flap could be done. Her reconstruction was done in stages to make sure there was no tumor close to the chest wall; a total of five MRIs and biopsies and their path reports ensured that a DIEP flap could be done, and one was performed on July 25, 2011. A half a year later, in December 2011, Dr. Rosson grafted Elizabeth's nipple. After a one-year healing process Elizabeth decided to have abdominal modifications (liposuction) and nipple alteration. In April 2013 she had her areola and nipple tattooed by tattoo specialist Vinnie Meyers, recently dubbed the "Michelangelo of nipple tattoos" by *Vice* magazine.<sup>12</sup> This constituted, in Elizabeth's own words, the "icing on the cake."

Although Elizabeth did not increase her overall breast size, she says her breasts have improved dramatically because they are "fuller on top." This allows her to show more cleavage than before, and she feels that she is able to fit into her clothes better. While waiting for her nipple reconstruction, Elizabeth decided to have liposuction done to her flanks, putting back a contour into her waistline; but with this procedure a fold was created on her waist "where the front was pulled down and the back wasn't. It kind of made a strange fold." Elizabeth explains that because the surgeon took out a lot of flesh from the abdomen, the surgery rearranged her body in the wrong way. She felt uncomfortable when sitting down. When modifying the fold, the surgeon additionally liposucted her hips and upper thighs. She had always wanted to have this additional cosmetic procedure, but would not have done it only for the aesthetics of it. However, with the breast reconstruction spanning over a year, she felt it was an opportune moment to have it done. Today there are still holes and



FIGURE 21.2  
Elizabeth Hammond, on the set of  
*The Good Breast*, May 17, 2013.  
Photograph by Sandra Geroux.

depressions in her thighs that Elizabeth wants smoothed out. She is also dissatisfied with a “dog ear” at the end of her scar; additionally, her right hip feels flattened out, but on her left hip there is still extra skin, which she would eventually like to have removed. Finally, the abdominal scars on her hips require more work. She underwent a last cosmetic intervention to fix these features in the fall of 2014, three years after her original diagnosis.

As Elizabeth puts it, “I feel I am so much of a better person after being through this. I feel just like Jesus Christ. Seriously, I am more of a conqueror. I have overcome so many things that I would not even have realized. [*Like what?*] Such as being willing to be vulnerable to people. I say what I really think. I am an influence for positive overcoming. Being able to encourage other people that they can get through a trial. Be those financial problems, marital or health problems . . . there is always something that I can draw on from my experience.”

Elizabeth says she is now truly satisfied, more so than ever before, with who she is. Her breast cancer was a process and a trial to help her become a more beautiful human being, not only physically (she finds her body definitely more attractive than it was before), but in her relationships, which she feels are a fuller and richer experience; “I like the new person better.” The most interesting aspects of her testimony are the emphasis on the theme of the breast sacrifice. Elizabeth’s renewed, middle-aged beauty, and a feeling of *femininity* that she says she had never felt before as intensely, reveal themselves as a makeover strategy to becoming a better person.

2

Debra Nelson, a fifty-six-year-old nurse from Baltimore, was diagnosed with stage 0 DCIS in 2009 at age fifty-one. Her biopsy revealed that one axillary lymph node was positive, while her sentinel lymph nodes were all clear of cancer. After a long reflection with her breast surgeon and the plastic surgeon, Debra decided to have a single mastectomy on



her left cancerous breast, and to keep the other “good” breast intact. While many women opt for a double mastectomy exclusively for the purpose of symmetry, for Debra this was never an option. She mourns the one breast she has lost more than any other woman whose case I have documented over the course of two years, and said she could never have imagined losing a breast that was in fact originally healthy. Debra did feel the need to make her breasts—one “good” and one “bad”—feel more symmetrical; but more than that, she felt the need for the breasts to exchange each other’s flesh and “get closer” to each other in size and shape. After her single mastectomy, she decided to augment the healthy, and originally quite small, breast slightly, to attain a size the reconstructed breast had reached. But that was not enough. After a few years, Debra desired to exchange the nipples, making her original, smaller nipple smaller, and increasing the reconstructed left nipple slightly (see transcript below). Debra’s story is not as straightforwardly positive (to put it mildly) as Elizabeth’s, and this may be due to a troubled femininity that preceded Debra’s cancer diagnosis. Debra maintains not only that she perhaps did not have cancer, but that she does not *deserve* the treatment she received. At her checkup appointment with her oncologist, Dr. Robert Donegan, in August 2013, Debra arrived in tears and, because of the recent media debate about DCIS and whether it could even be labeled *cancer*, questioned whether she had had her mastectomy in vain. She said that perhaps she would not have to lose her breast if she were diagnosed today, five years later, when the debates and recommendations around DCIS were being scrutinized. The oncologist calmed Debra down by saying he did not think it was in vain, but he also admitted that many cases of DCIS are indeed overdiagnosed. In the end, he blamed the dilemma of diagnosing and treating DCIS on the preventative culture of overscreening the breast for cancer, and the fact that once you find something, you have to act on it because you don’t know if that particular case of DCIS will spread or not. Debra countered that she somehow wished to be a more “normal” cancer patient, one who had also undergone chemo treatment and radiation, and for whom cancer was a “clear” situation. She compared this to her running team and the experience of vomiting and falling unconscious at the end of a marathon. If that was missing, to her, it felt like she had not earned the “success.” When Debra was prompted by the doctor to share what the loss of her left breast meant to her overall, she answered without hesitation, “It represents everything that I have lost, including my femininity, and especially the fact that I did not have a daughter.”

For Debra the loss of her breast is symbolic. She is uncertain if she had cancer and if she lost her breast in vain. This loss now becomes something bigger than cancer. It represents all the losses and missed opportunities in her life, including the daughter she never had. If we consider Klein’s theory in this context, one could claim that she never nourished with her own breast. Debra cannot accept her new breast as “good” because she does not feel that her “old” one was truly ill. For her, as for many people undergoing a bodily transformation in the process of a makeover, the outcome needs to feel “earned” in order to be experienced as a *reward*, and it needs to display the struggle that the subject endured to achieve betterment. Debra’s dilemma is not easily solved.



FIGURE 21.3  
Debra Nelson discussing her nipple  
exchange with plastic surgeon Dr. Sheri  
Slezak, January 18, 2013. Film still from  
*The Good Breast*.

In figure 21.3 we see Debra at what she herself calls her “six-month self-imposed doctor’s visit” with her plastic surgeon, Dr. Sheri Slezak. During this visit Debra expressed her desire to have a nipple exchange. Her reasoning revealed her psychological confusion over her own body trauma. The following are portions of the transcript of Debra’s visit with Dr. Slezak from November 30, 2011, during which she displays a clear confusion over two paradoxical sensations in the nipple that showcase her breast trauma: on the one hand, the rubbing of her own “good” nipple against her shirt, which she says bothers her as a marathon runner; and on the other hand, the lack of sensation in the nipple of the “bad” breast due to the missing nerves. In other words, the good nipple in Debra’s mind is “too good” and the bad nipple “too bad.” The doctor listens to Debra’s needs and decides that nipple sharing may be the answer to her problem.

- DR. SHERI SLEZAK: Has it [the sensation] changed at all over the past six months to a year?
- DEBRA NELSON: Not really. It’s not just the fact that it’s numb. I mean, I have sensation, it’s just not pleasurable.
- DR. S: So you can feel it being touched but it’s just not pleasurable? That’s interesting.
- DN: Yeah. And this nipple [points to the right, healthy breast], as you said, “You have dominant nipples.” [Laughs.] It still rubs against the inside of a bra, and it is just kind of annoying to me. So I didn’t know if there was anything you could do with it.
- DR. S: Well, so do you think it’s the size of the nipple?
- DN: Yeah. The protrusion.
- DR. S: Because you could certainly make it smaller. But would that help, is the question.
- DN: But it wouldn’t rub inside of a brassiere then.
- DR. S: Can I look? [She examines her.] Looks great. Perfect shape. One of the best that I’ve ever done. [They talk about how they both enjoy the

*documentary crew filming Debra's beautiful breasts.] So this nipple bugs you when you're in a bra, and it chafes?*

DN: Yeah. And I'm still running.

DR. S: Yeah, well, I hear that from women who haven't gone through what you've gone through. Like marathon runners have bleeding nipples and they get really irritated.

DN: It's not that bad.

DR. S: You can make it smaller, but the more you cut away, the more chance you have of more numbness. So you say right now you can feel it, but it just isn't pleasurable. Would it be better if it were numb? Like, does it actually hurt?

DN: Sometimes.

DR. S: So you certainly could make it smaller. But I'm kind of surprised that you asked that, because that's your normal side.

DN: I know. I know. And I liked it before, I mean when I had two that size. But after the augmentation, it became even more pronounced.

DR. S: And it's true. When you augment, your breast is more forward, so you probably see it more than you used to.

DN: Sure.

DR. S: But would smaller be better? Is that the question? A smaller nipple? Not sticking out as much?

DN: In my mind, that's what I wanted to talk with you about. So you're saying one of the consequences could be that there would even more change in sensation?

DR. S: Yes. So what you'd do is essentially what you did before, the nipple sharing—you'd take the lower half and make it even a little bit smaller, which would match this one better. Do you ever want that one bigger?

DN: Well, you said something one time about putting a little purse string around it?

DR. S: I could do that, but if you want that one smaller I could take a little bit of that and put it over here again.

DN: Oh really?

DR. S: Yeah.

DN: And you think it would take again?

DR. S: Mmm-hmm. Nipple sharing.

DN: You could do it as an outpatient? [*Looks excited and satisfied.*]

Two weeks later, the plastic surgeon performed the nipple exchange and, still under local anesthesia, Debra felt much better. Debra has been going back to her doctors, the

plastic surgeon or the oncologist, to request and relive her breast trauma. The one thing that seems to make her happy is to *feel* her breasts, and her nipples, in a new way. As pointed out recently by Joanna Montgomery (2013) in her *Huffington Post* piece about her breast reconstruction postmastectomy, women who receive new breasts after a mastectomy struggle with the reception and acceptance of these new breasts in two ways that are absent from women who merely have “boob jobs” done: one, they may have never imagined these breast augmentations before their cancer, as in Debra’s case, and therefore have a harder time incorporating that new body image into their overall identity; and two, as Montgomery points out, these new “foobs” are far from being real breasts: “What is attached to my chest right now are a pair of silicone implants with no breast tissue in front of them. I am essentially sporting implants covered with skin.” This difficulty is evidently a result of the mastectomy and sometimes radiation treatment; they make it very hard to surgically reconstruct a breast in the place of cancer.

Debra struggles with accepting her reconstructed “good” breast as good, and her nipple sharing is an attempt to “go back to normal,” as she puts it, or “as it was before.” Debra refers to herself as the “old” and the “new” Debra. The cancer and the breast reconstruction have changed her identity, and she is working on accepting her new body image. It is hard for her doctors and us documentarians to understand her perceived failure. The plastic surgeon stresses that with patients like Debra, reconstruction never ends. It is impossible to really “cure” such patients, and Debra is one of them.

3

Katherine (Katie) Martinez is a PhD student working in Cancer Prevention and Treatment Demonstration at the Department of Epidemiology at Johns Hopkins Bloomberg School of Public Health.<sup>13</sup> Katie was diagnosed with a 1.7 cm invasive ductal carcinoma throughout her breast at the young age of twenty-seven in 2009. After a successful chemo treatment, her lymph nodes were clear of cancer, yet her tumor had a high KI-67 proliferation index and was moving very fast.<sup>14</sup> The FDA approved the drug Herceptin, used to treat HER2-positive metastatic breast cancer, the day Katherine was diagnosed. Her breast cancer was in fact HER2-positive, and Herceptin saved her life. At the time of her diagnosis, Katie was married to a man and was trying to get pregnant. She had to undergo several lumpectomies, and four difficult treatments with the chemo drug Taxil that led to the yellowing of her skin and abrupt menopause. In addition, she experienced nausea and depression during the entire treatment.

After this experience, Katie elected to have a double mastectomy and breast reconstruction. Further, she divorced when she realized she was gay. Katie reports having experienced a sexual reawakening in a newly found masculinity that gave her a new sense of beauty and self-esteem. In a way, by negating her hetero-normative femininity, she was able to regain strength and find new love as a lesbian. She remembers how her illness influenced her heterosexual relationship in a negative way: “I had a husband and

he was physically present but he was like addicted to the video game *World of Warcraft*. It was like his escape route. When I was sick, he would put on his headphones and play that. I spent a lot of time lying in bed watching movies, and he never came in and watched a movie with me or anything, so it was pretty lonely.”<sup>15</sup>

Katie talks about her femininity as a heterosexual woman before her cancer diagnosis and a gay woman afterward:

I don't think femininity is something that is determined by parts, but instead it's in your brain. And the way you see yourself and the way you interact with the world. I was always in a way better position dealing with these things. I have always been pretty confident, sexually independent. I have not felt shame about my body in my lifetime, where there are other women who have felt that way before they get cancer and it just adds to it. I have had partners that have not cared or not been grossed out. To be honest for my own sense of confidence I wear a bra if I am having sex. It gives me an illusion that everything is normal. I can look down and be, like, right, that's what it looks like. It hasn't affected me too much, but I do think it has an impact on a lot of people.

Recently, at the age of thirty-four, Katie went into menopause and realized that she won't be able to have children anymore, which she admits affects her sense of femininity: “I know that having children does not make or break a woman, but sometimes it just feels unfair that I never got the opportunity all because of a 1.7 cm tumor. For being so small, it really upended my life.”

Katie has been cancer-free for seven years now, which technically signifies that she is cured of the disease. As a result of her breast cancer she gained a new self and a new happiness that she finds in a certain negation of a traditional femininity that she left behind. She refuses the title “breast cancer survivor,” and instead prefers to think of herself simply as a cancer survivor.

If I hadn't gotten cancer I wouldn't be as happy as I am now. If I hadn't gotten cancer what would've happened is that I would've gotten pregnant with his kid, and I would have never come to Hopkins, never would've got a PhD, and I would still be living in a subdivision in San Jose, and I would be miserable. But I don't like to say that cancer is the best thing that happened to me. Because cancer is never the best thing that happens to anyone. The trajectory of getting cancer and then not being able to have a baby, then wanting to pursue other things, ultimately made me a lot happier now. But also destroyed my marriage, because I couldn't settle for anything less than what I really wanted. After you have confronted death it's really hard to go back to mediocrity.

By negating the term “breast cancer survivor” Katie points to the mastectomy as gendered stigma and the “femininity trap” that it produces: it forces women into the markedness of the breast and doesn't let it become a political question. S. Lochlann Jain asks the pivotal question, Can women not show their chests in public because they are women,



FIGURE 21.4  
Katherine Martinez. Image © David Jay/  
The SCAR Project.

or because they have breasts? (2007, 515). She bases her answer on her experience of a mastectomy without breast reconstruction, recounting the taking off of her shirt during a yoga class in small-town Canada and saying, “Look or don’t, I used to have another body that you couldn’t by law look at, but now I have this body that you can, because its breasts have been taken off and in that place remains a flat space that is sort of coded male but really is very different, and when I take off my shirt you can see that, and anyway, why should males get to hoard masculinity and shirtlessness to themselves?” (516). Jain elaborates on what it means to have breast cancer as a gay woman, pointing to the fact that there is no subject position available for cancer butch: “[T]he public coding of breast cancer provides a strange inter-gendered space such that the butch woman literally cannot be tough ‘battling’ cancer, and still maintain a gender identity as butch” (521).

Jain is right in that the “adopted masculinity” through the experience of breast cancer is equally feminized, in that it is a negation of femininity and not its own subject position. (See the semiotic square of breast cancer that follows the next case study.)



FIGURE 21.5  
Shelia Westry during a prayer the night  
before her mastectomy on May 24, 2012.

4

Shelia Westry was fifty-two when she was diagnosed with stage IV triple negative breast cancer on November 11, 2011. Her right breast contained a 17 cm tumor, and she also had regionally advanced breast cancer. Because of this late discovery, Shelia had poor response to induction chemotherapy. Shelia was a religious person before her diagnosis, but she faced her mortality with a renewed and strengthened faith in the midst of her caring family. Breast cancer runs in Shelia's family: her mom died of it, and several aunts. The night before her mastectomy the family gathered to talk about the past and the future. The younger family members were scared. Pastor Parker uttered a special prayer for Shelia's upcoming mastectomy, but clarified that only the Lord would if Shelia will survive or not. The family members referred to Shelia as a saint. But she countered with modesty: "A saint is someone who walks with Jesus. I am not saint. I wish I was."

#### THE SEMIOTIC SQUARE OF BREAST CANCER

The semiotic square was introduced by Algirdas J. Greimas (1966) to interpret semiotic signs through the opposition of concepts. In the case of breast cancer, it helps us see the apparently paradoxical promise that breast cancer holds for some of its victims: not exclusively a threat of death, but also the possibility of escape from a prison constructed by the desires of others. (See figure 21.6.) The myth of Saint Agatha is, in many ways, the primal exploration of this paradoxical relation between femininity, death, and freedom through the excision of the very symbol of femininity and, indeed, of life itself. By equating the bad breast of cancer with constraints of a variety of kinds, the choice to mastectomize and replace that breast with one of one's own making becomes like Agatha's choice to render up her own breasts rather than give up her virtue. Thus it turns into an ultimate demonstration of *kalokagathia*, of the good that real beauty—beauty that is more than skin-deep—should always hold. When one of the subjects of *The Good Breast* was asked what was more

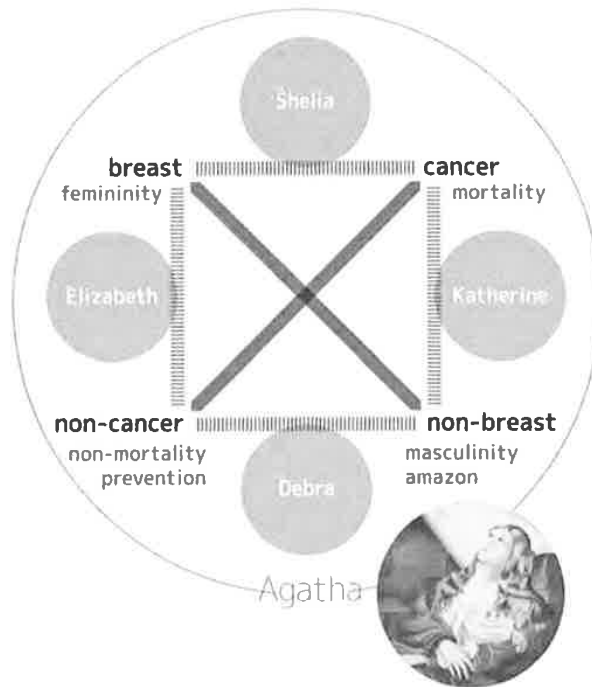


FIGURE 21.6  
The semiotic square graph for breast  
cancer. Design by Maarten Ottens.

important to her in the reconstruction of her breast—her life or the breast itself?—she answered immediately that it was her breast. The fixation on the breast is what drives our culture. Cosmetic surgery, cancer rallies, and domestic ethnographies are only the effects of this fixation. But in order to understand cosmetic surgery, we need to understand the body parts that demand the change.

#### NOTES

1. I began developing the documentary *The Good Breast* in 2011, shooting a total of approximately five hundred hours through 2015. The independently funded film was produced by Jon Reiss and coproduced by Rebecca Messner, edited by Victor Livingston, and directed by Bernadette Wegenstein. It will be released in Fall 2015.

2. The American Society for Aesthetic Plastic Surgery (ASAPS), "Cosmetic Procedures Increase in 2012," <http://www.surgery.org/media/news-releases/cosmetic-procedures-increase-in-2012>.

3. The National Cancer Institute estimated that 232,340 women would be diagnosed with breast cancer in 2013. See SEER n.d.

4. Klein's theory is important because it describes women's ability to contribute to culture in a primal and not secondary sense. This is unlike that of Freud, for whom the "riddle of the



nature of femininity” was “reduced to a function and functioning whose historic causes must be reconsidered: property systems, philosophical, mythological, or religious systems—the theory and practice of psychoanalysis itself—all continually, even today, prescribe and define that destiny laid down for women’s sexuality” (Irigaray 1985, 129).

5. It is likely that these two stories are a pagan and a Christianized version of the same story.

6. These are oral tales by the people of Catania.

7. The dialogue here represents my own translation from the Italian of the hagiographic acts of Agatha’s martyrdom. See “Il Martirio” 2011.

8. I would like to thank my producer Jon Reiss for his efforts in helping me bring my theoretical ideas onto the screen in the shape of a cinema vérité essay film.

9. I would like to thank my editor, Victor Livingston, for his help in articulating the story of breast cancer and martyrdom in relation to my characters.

10. All patient-characters in *The Good Breast* signed HIPAA privacy agreements to disclose their health information in the context of this study. This patient story, however, was not included in the feature documentary but only in the form of an individual webisode.

11. See the recent debate on whether or not to call DCIS (ductal carcinoma in situ) cancer at all, because of the recommendation from a working group at the National Cancer Institute published in the *Journal of the American Medical Association*, discussed by Tara Parker-Pope in the *New York Times* blog on July 29, 2013 ([http://well.blogs.nytimes.com/2013/07/29/report-suggests-sweeping-changes-to-cancer-detection-and-treatment/?\\_r=0](http://well.blogs.nytimes.com/2013/07/29/report-suggests-sweeping-changes-to-cancer-detection-and-treatment/?_r=0)).

12. <http://www.vice.com/read/breast-cancer-survivors-find-the-michelangelo-of-nipple-tattoos>.

13. I met Katie when I was doing my research on breast cancer, outside the breast clinic where I filmed *The Good Breast*.

14. A KI-67 proliferation index over 35% is considered high, and Katie’s was 95%.

15. The original interview was conducted by my research assistant and student Komal Kumar on November 17, 2011, and followed up by me on September 6, 2013.

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