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# **SKINNY WOMEN AND GOOD MOTHERS: THE RHETORIC OF RISK, CONTROL, AND CULPABILITY IN THE PRODUCTION OF KNOWLEDGE ABOUT BREAST CANCER**

SUSAN YADLON

The past few years have witnessed an explosive proliferation of information about breast cancer in the popular media. Part of this increased visibility stems from the growing awareness of the number of women affected by this disease—the National Cancer Institute estimates that one in eight American women will develop breast cancer in her lifetime.<sup>1</sup>

Inseparable from this growing consciousness is an insurgence of grassroots activism. Breast cancer survivors,<sup>2</sup> health-care providers, scientists, and legislators have formed coalition groups in order to lobby for an increase in research funding as well as changes in the direction of research. These groups have utilized the media as an effective tool to raise awareness about the disease and to invite participation from the general population. For instance, in 1992 the National Breast Cancer Coalition encouraged women to write letters demanding more funding for breast cancer research. Expecting 175,000 letters, they received 600,000 in six weeks and presented them to Congress and the White House. After intensive lobbying, in 1993 Congress approved a \$325 million increase for breast cancer research.

This activism and its use of the media has helped make breast cancer a "hot" topic. In many ways, this increased visibility seems like a hopeful sign. The number of articles in the popular media about breast cancer has increased exponentially, and many would argue that the more information women have, the more likely they are to prevent, detect, and survive the disease. However, the work of Michel Foucault complicates

the notion that more information is necessarily better. Foucault asserts that knowledge production (in this case, information about breast cancer) is never a neutral operation but, rather, is always infused with relations of power. Foucault argues that power "produces effects . . . at the level of knowledge. Far from preventing knowledge, power produces it."<sup>3</sup> As such, knowledge is not a neutral expression of objective reality, but its production is an invested process. Because power and knowledge are so inexorably imbricated, Foucault advocates for a careful analysis of the relations of power that produce discourse, as well as for an examination of which relations of power are ensured by that production.<sup>4</sup>

Foucault's emphasis on the "birthing conditions" and "effects" of discourse is particularly useful when examining the recent explosion of information about breast cancer. What historical circumstances and power relations contribute to the current attention paid to breast cancer? What types of knowledge are being produced? And what are the effects of that knowledge production?

Drawing from Foucault's theory of knowledge, discourse, and power, this article focuses on representations of breast cancer in the popular media<sup>5</sup> as well as texts geared toward those diagnosed with the disease and their healthcare providers. Specifically, this article investigates the use of risk factors in mainstream discussions about the disease. An examination of the literature demonstrates that two risk factors are highlighted above others—diet and reproduction. Importantly, these two risk factors are represented as controllable behaviors: one can alter one's diet and "plan" childbearing; but there is little one can do about family history, age, or the onset of menses and menopause.

How is it that these factors become highlighted, and equally as important, what are the effects of this emphasis? This article argues that there is a Foucauldian "will to truth" in operation in the production of knowledge about breast cancer. According to Foucault, the "will to truth" is a historically contingent process that shapes knowledge production. As Foucault defines it, the will to truth "relies on institutional support; it is both reinforced and accompanied by whole strata of practices such as pedagogy . . . the book-system, publishing, libraries . . .

and laboratories. But it is probably even more profoundly accompanied by the manner in which knowledge is employed in a society."<sup>6</sup>

As Linda Alcoff and Laura Gray point out, the will to truth does not concern "what is true and what is false, but what can have a truth-value at all."<sup>7</sup> Foucault argues that certain statements are "in the true" not because they are true or false but, rather, because they take place within the parameters of legitimated statements. This creates a symbiotic relationship between truth and knowledge; knowledge validates what becomes known as "true," and truth determines what can be called knowledge. Foucault's will to truth can help us understand the specific emphases currently in play in breast cancer discourse. In this case, we see a focus on areas that stress individual responsibility and highlight risk factors that emphasize control and choice.

The emphasis on individual responsibility and choice is, of course, not exclusive to breast cancer discourse but is seen widely throughout biomedical literature, even in discussions about diseases that are not specifically female, for example, type II (or non-insulin-dependent) diabetes and cardiovascular disease.<sup>8</sup> Although this is certainly true, I argue that "responsibility and choice" take on a particularly gendered meaning in breast cancer discourse. First, the two risk factors that are privileged, diet and reproduction, have been understood historically as feminine concerns, and both house ideological assumptions about femininity. For instance, women are traditionally represented as responsible for food preparation in the household, and most often are. In addition, the culturally valued feminine body (i.e., slender) requires strict discipline over one's food intake, and therefore controlling one's diet is connected to the proper performance of femininity. Reproduction is also enmeshed in questions of femininity, often represented as a "natural" desire of adult women. As such, diet and reproduction have specifically feminine resonances, resonances that echo throughout breast cancer discourse.

Second, the emphasis on individual responsibility and choice produces specifically gendered effects. In other words, breast cancer discourse not only emerges from ideological assumptions but performs cultural work as well. Discussions of breast

cancer are often packaged in a rhetoric of culpability that produces a particular kind of gendered guilt: one contracts breast cancer because one has not made the "proper" dietary and reproductive choices. In short, breast cancer discourse tacitly (and sometimes not so tacitly) implies that the way to prevent the disease is to follow dominant codes of femininity.

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

### **BLURRING THE LINES: SCIENCE, ACTIVISM, AND THE POLITICS OF KNOWLEDGE PRODUCTION**

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

the working assumption that knowledge is power—meaning that whoever has access to, or can monopolize, knowledge is powerful as a result. Traditionally this view has lent itself to a simple political objective . . . : get access to that knowledge monopolized by the expert elite and share it democratically.<sup>9</sup>

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

As previously mentioned, the National Breast Cancer Coalition (NBCC) lobbied for an increase in funding, and in 1993, Congress approved \$325 million for breast cancer research. In order not to exceed the cap on domestic spending, the money

was channeled into the military budget. The Army Medical Research and Development Command became custodians of the funding, although no one on the AMRDC team had any experience in breast cancer research.<sup>10</sup> The AMRDC asked the Institute of Medicine for advice and criticism, and the IOM put together a panel to help guide the army's plans. Kay Dickersin, an epidemiologist from the University of Maryland and an NBCC leader, was seated on the IOM's panel.

The NBCC also made suggestions about how the \$325 million should be distributed. Fran Visco and Susan Love presented the National Cancer Institute's National Cancer Advisory Board with a list of demands. They requested that at least two study sections be specifically devoted to breast cancer and asked that NBCC members be seated on those panels. Additionally, they wanted to be involved in the monitoring of data from ongoing clinical trials and advocated for mechanisms that would secure input from participants. As science writer Eliot Marshall noted, "The members of the board were shocked to learn how intimately the activists want to become involved."<sup>11</sup>

Marshall further explained: "This would set a new precedent for NIH, and Samuel Broder, NCI's director, grumbles that people who want to do this just 'don't understand how NIH works.'" Some scientists clearly feared an encroachment on their territory. Frederick Becker, research chief of the M.D. Anderson Cancer Research Center in Houston, expressed this concern: "The tidal wave of advocacy . . . may wash away certain bulwarks of basic science that have been the greatest contributors towards the potential for cancer prevention and cure."<sup>12</sup> Becker not only expressed fears that activist participation would prevent scientists from doing "their" job but also that their participation would erode the basic tenets of scientific methodology—in effect, rendering science less effective.

However, a closer examination of this situation reveals that the lines between science and activism are far more blurry than they might appear at first. Although the NBCC asked for input into research decisions/direction, they originally advocated<sup>13</sup> that the money be allocated to the National Cancer Institute, a traditional stronghold in cancer research. In other words, the NBCC did *not* advocate to take research out of traditional scientific hands<sup>14</sup> but merely argued for an increase in their resources.

Further, a second glance reveals that it is difficult if not impossible to clearly delineate between scientists and activists. For example, Susan Love, a founding member of the NBCC, is a clinical and research physician and a founding director of the UCLA Breast Cancer Center.<sup>15</sup> And although Love is critical about certain directions in scientific research, she shares (as do many "activists") Frederick Becker's concern about "basic science." However, she understands advocacy not as an erosion of basic science but as a tool to bring about its return. Love states:

It's clear that surgery, radiation, and chemotherapy—"slash, burn, and poison" . . . are rather crude ways of dealing with the problem. Even so, the research establishment continues to spend enormous sums of money on them, asking tired, old questions like "Should we give chemotherapy for three months or four months?" . . . What we need to do instead is put more of our funds into figuring out how the disease progresses at the molecular level, because that's where the real answers lie.<sup>16</sup>

For Love, a focus on prevention *is* a return to basic scientific tenets. She states: "We have to stop business as usual. We have to change the direction and really put our emphasis on basic science and prevention, and not such a large emphasis on treatment."<sup>17</sup> Importantly, it is in that return to a "truer" science that "the real answers lie."

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

The fact that scientists and activists work within the same discursive formation, or as Foucault might phrase it, emanate from the same "will to truth," explains the common set of statements that emerges about breast cancer prevention, in particular, the focus on risk factors that are seen as personalized and controllable. However, the will to truth does not preclude other types of statements from being uttered. Certainly, it is not the case that the *only* type of research being conducted is on risk factors that emphasize individual responsibility and

control; nor is it true that popular representations of the disease *only* address these two risk factors. For example, there is a body of research that explores risk factors that are not understandable through the framework of control/choice, most notably, research on the possible environmental causes of breast cancer. Additionally, there are a few activist groups advocating for more research on environmental causes, and there have been pieces in both scientific journalism and popular media that address this issue.

However, Foucault argues that the will to truth, being "reliant upon institutional support and distribution, tends to exercise a sort of pressure, a power of constraint upon other forms of discourse."<sup>18</sup> In other words, it is not solely a matter of the absence of "alternative" statements but, rather, a matter of how that "alternative" information is presented and packaged—which "facts" are highlighted over others, which research gets funded, and so forth.<sup>19</sup>

The work of Bruno Latour can be read as a fascinating application of how Foucault's will to truth works in the realm of scientific research and scientific journalism. Although Latour does not mention Foucault's theory, he argues, in *Science in Action*, that "[f]act construction is . . . a collective process." Latour describes scientific discourse as a rhetoric of fact building, a complicated process that involves the use of authority and reference to transform research into "tacit knowledge." Like Foucault, Latour is not necessarily interested in what is true and false but, rather, how something comes to be established as true. For Latour, the communal process of scientific fact building exercises a form of "constraint" over what comes to be seen as true. He argues: "No matter what a paper did to the former literature, if no one else does anything with it, then it is as if it never existed at all. You may have written a paper that settles a fierce controversy . . . but if readers ignore it, it cannot be turned into a fact; it simply cannot."<sup>20</sup> Foucault and Latour, rather than articulating a consciously insidious conspiracy theory of knowledge production, help uncover the complex and often subtle mechanisms that influence the way knowledge is produced.

It is valuable to examine the research on and discussions of environmental causes through the framework that Foucault



and Latour set up. As I mentioned previously, there is a body of research/discussion on the possible role of environmental toxins in the development of breast cancer. Much of this research focuses on the role of dietary contaminants (toxins) in the animal fat we eat, and xenoestrogens, environmental toxins that mimic the way estrogen works in our bodies. Importantly, not all this research is new. In 1969, A.I.T. Walker et al. conducted a two-year study on carcinogenic pesticides.<sup>21</sup> They argued that pesticides such as DDT, chlordane, and dieldrin which concentrate in animal fats induced breast cancer in rodents. Interestingly, the NCI's 1977 *Bioassay of Chlordane for Possible Carcinogenicity* found similar results.<sup>22</sup> Samuel S. Epstein, one of the founders of the Cancer Prevention Coalition, argues: "This creates a strong presumption for a causal role of such dietary contaminants and breast cancer in women, particularly as the sites of tumor induction are generally similar in experimental animals and humans."<sup>23</sup>

There is more recent research that examines the relationship between the environment and breast cancer. For example, in 1992 Frank Falck et al. found higher levels of PCBs and DDT in malignant breast lumps than in those judged benign.<sup>24</sup> Also in 1992, Ernest J. Sternglass and Jay M. Gould conducted an independent study on the possible relationship between breast cancer and radioactive releases. They found that "a strong correlation does indeed exist between the published releases of airborne iodine-131 and other fission products on the one hand and the regional breast cancer mortality rates on the other hand, such that the probability of this association being due to chance is less than 1 in 1,000."<sup>25</sup>

These findings and others have not gone completely unnoticed. Several groups have formed in order to lobby for more research on the environment and breast cancer. Breast Cancer Action, the Women's Community Cancer Project, and the Cancer Prevention Coalition are three such groups.<sup>26</sup> In 1994, the Women's Community Cancer Project presented their document, "A Woman's Cancer Agenda," to the NCI and the U.S. Congress. Number eight on the agenda demands "research to focus on *prevention, the environmental causes of cancer and new, non-toxic therapies*."<sup>27</sup> Also, the past few years have witnessed a series of conferences on the possible links between en-

vironmental toxins and breast cancer, such as "Breast Cancer and the Environment: What We Know, What We Don't Know, What We Need to Know" at Adelphi University, Garden City, New York, in November 1993; "Breast Cancer and the Environment: Our Health at Risk," held in Boston, in October 1994; and "Breast Cancer and the Environment," held in Dayton, Ohio, in October 1994.

Additionally, several media articles have addressed the possible link between the environment and breast cancer. The May/June 1993 issue of *Ms.* focused on breast cancer, presenting several articles on various topics. One article examined the potential link between environmental toxins and the disease.<sup>28</sup> The May/June 1994 issue of *Mother Jones* was dedicated to the possible environmental causes of breast cancer. The title for that issue reads "Breast Cancer Cover Up: Despite Mounting Evidence, Scientists Have Avoided Investigating the Environmental Link to Breast Cancer."<sup>29</sup>

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

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

- (1) "the research mind-set" similar to the one Latour describes;
- (2) the competitive structuring of grant money where "[t]hose who have devoted their career to Topic A are rarely thrilled to see Topic B come into vogue and snatch their funding. Increased support for the organochlorine theory threatens those who are heavily invested in other areas";
- (3) a "medical mind-set" with an emphasis on detection, diag-

nosis, and treatment;

(4) a "blame-the-victim" mentality;

(5) "a close relationship between the cancer establishment and offending industries."<sup>30</sup>

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

For years the national dialogue in the United States on cancer has been virtually controlled by the NCI, the ACS, the Memorial Sloan-Kettering Cancer Center, various grantees and contractees at universities, and major pharmaceutical firms. . . . Instead of concentrating on prevention, the focus of research has been on cancer "management" and a search for a cure. What we have is a golden circle of power and money, where many of the key players are connected, either directly or indirectly, with corporations that—depending on the policies and priorities the establishment sets—have much to gain or to lose. The monetary stakes are enormous.<sup>31</sup>

In support of her theory, Clorfene-Casten notes that Richard Gelb, the chair of Bristol-Myers Squibb, the nation's largest chemotherapy drug producer, chairs the Memorial Sloan-Kettering Cancer Center's board of managers. Additionally, for most of the last decade, the NCI's advisory panel was chaired by Armand Hammer, who was at the same time the chair of Occidental Petroleum, a major producer of carcinogenic materials. Clorfene-Casten argues that this relationship between pharmaceutical/chemical companies and the "cancer establishment" explains why the major cancer research organizations have not supported legislation to reduce carcinogenic exposure or funded research to investigate the link between breast cancer and environmental toxins.

Samuel Epstein makes a similar argument. He accuses the NCI of "trivializing the importance of occupational carcinogens" as a cause of all cancers, and of stressing the role of "diet per se, in spite of tenuous and inconsistent evidence and ignoring the important role of carcinogenic dietary contaminants." As evidence, Epstein cites the 1992 NCI budget. With a total budget of over \$2 billion, \$645 million was targeted for prevention, and only \$50 million was set aside for research on the role of carcinogenic exposure. This amounts to 2.5 percent of the total budget, with a little less than 8 percent of the funds allot-

ted for prevention. Epstein also notes that the National Cancer Advisory board (a subsection of the NCI) "is clearly in violation of Section 407(a)(1)(B) of the National Cancer Act, which requires that no less than five members 'shall be individuals knowledgeable in environmental carcinogenesis.'<sup>132</sup>

Although the figures presented above pertain to the research budget for all cancers, this limited funding for research on the possible environmental link carries over to breast cancer research as well. Earlier in this article I referred to the \$325 million generated for breast cancer research that was channeled into the military budget. Epstein notes that none of the \$325 million was earmarked for research on environmental causes.

We see the will to truth operating in the media representations of breast cancer causation as well. The *Mother Jones* issue that includes Castleman's article also includes two full pages of behaviors individual women can "choose" in order to reduce their risk of developing the disease. These include breastfeeding and eating a low-fat diet. Similarly, *Ms.*'s issue dedicated to breast cancer stresses heavily the role of dietary fat. Of twenty-three pages, thirteen are dedicated to a discussion of dietary fat. The cover page, while mentioning both dietary fat and environmental connections, has a diagonal strip in the top left corner highlighted in neon green that reads "PULLOUT! The Diet Censored by the Cancer Industry," and the articles offer a plethora of advice on how to restrict one's fat intake.

I am not arguing that it *is* environmental carcinogens and not dietary fat that causes breast cancer. Rather, my attempt is to highlight the way the will to truth operates in the extremely complicated production of knowledge about breast cancer. My goal is to look at what kind of knowledge is being produced, to examine how we know what we know, and to begin tracing the effects of knowledge production and dissemination. In order to investigate this process in greater detail, the next section will investigate the controversy over the connection between dietary fat and breast cancer.

## **CHOOSING BAGELS OVER CROISSANTS: THE CONTROVERSY OVER FAT INTAKE**

*Conflicting data.* There have been a myriad of studies on the possible link between dietary fat and breast cancer, and the results of the studies conducted are contradictory and confusing at best. Of the studies that argue for a correlation between a high-fat diet and breast cancer incidence, the most often cited are the cross-national studies that have explored the relationship between national diet and breast cancer rates. Bruce Armstrong and Richard Doll's 1975 research showed that nations with higher fat intakes also have higher breast cancer rates.<sup>33</sup> Ernst Wynder, D.P. Rose, and L.A. Cohen drew similar conclusions in 1986.<sup>34</sup> Brian MacMahon's study concluded that as the average fat intake in Japan increased from about 12 to 25 percent, the incidence of breast cancer rose as well.<sup>35</sup> A fourth study, which examined Japanese women who migrated to the United States, found that as immigrants switched to a more westernized diet, the rate of breast cancer rose.<sup>36</sup> Interestingly, this study found a significantly higher increase among the daughters of immigrants who had spent the majority of their lives in the United States.

However, there have been numerous studies that contradict the above findings. Probably the most famous was conducted by Walter Willett and his coworkers at Harvard University's School of Public Health.<sup>37</sup> Willett surveyed 120,000 women over a number of years, asking them questions about overall health, smoking, diet, use of birth control pills and postmenopausal estrogen supplements. In 1987, the researchers concluded that there was no link between breast cancer and dietary fat. A 1992 follow-up study drew similar conclusions.<sup>38</sup>

Research on the association between dietary fat and breast cancer incidence continues to be heavily funded. Currently, NCI is supporting the Women's Intervention Nutrition Study, a five-year trial designed to examine whether a low-fat diet prevents breast cancer recurrence and increases patients' survival. Additionally, in the fall of 1993, NIH launched the Women's Health Initiative, a three-pronged, multiyear study of postmenopausal women. The most expensive part of the Women's Health Initiative is a nine-year clinical trial involving 57,000 women which will examine whether a low-fat diet,

vitamin A/calcium supplements, and hormone therapy affect women's development of breast cancer, osteoporosis, and heart disease. Estimated costs for this one section of the Initiative range from \$600 to \$625 million. By far, the low-fat diet section is the most expensive and involves the largest number of women—48,000.

While this debate continues to be researched, many scientists offer cautionary advice about lowering dietary fat, even while acknowledging no direct evidence exists. Often, they argue that fat intake has been proven to be a cause of other health problems, and for that reason alone, dietary fat should be contained to a minimum. For instance, Sheila Bingham of the MRC Dunn Clinical Nutrition Centre states, "At the moment, there is not enough evidence to have a consensus view about fat and breast cancer, but there are very good reasons for reducing total fat consumption."<sup>39</sup>

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

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

such drastic regimens do what their proponents claim."<sup>40</sup>

*Dr. Susan Love's Breast Book* presents another interesting case in point. Love troubleshoots her way through the various research, helpfully complicating the research findings. Of the cross-national studies that found a correlation between high-fat diets and high breast cancer rates, she asserts: "if women in country X get more breast cancer than women in country Y, and they also eat more fat, that doesn't necessarily prove that fat causes the increased cancer. These women may . . . also do a hundred other things differently . . . any of which may or may not relate to their cancer rate."<sup>41</sup>

Love also looks at Willett's 1987 study, critiquing the research's definition of a low-fat diet: "*all* the women in the study ate a lot of fat: the lowest had a fat intake of 32 percent. In rats, remember, the reduction of fats didn't seem to make much difference until it got down to 20 percent or below."<sup>42</sup>

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

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

Almost paradoxically, Love ends her section on diet with these cautionary words: "Don't, however, expect miracles. Even if lowering the amount of fat in the diet does have an effect, it is likely to be a small one. Women on low-fat diets should not neglect screenings."<sup>43</sup> Still, this last-paragraph critique comes at the end of eight pages that effectively offset these final statements. Additionally, the appendix to the text includes a section on "How to Lower the Fat in Your Diet."

*Mainstream media.* I assert that discussions of risk factors emerge from cultural assumptions about women and also perform certain cultural work, in this case, a confirmation of hege-

monic codes of femininity. But how is it that this process works? In order to gauge the overall effect of the use of risk factors in mainstream media discussions of breast cancer, it is first necessary to analyze the rhetoric in which risk factors come packaged. In other words, how do these articles represent breast cancer? How do risk factors function in that representation? Lastly, how does the rhetoric shape readers' interpretations of risk factors?

In general, the disease is packaged in a language of panic—breast cancer is on the rise and reaching epidemic proportions. Although many articles explain that the increasing numbers of women diagnosed with the disease stem in part from more effective screening tools like mammograms, this information is offset by the language employed in this literature. The titles alone are usually enough to scare anyone to death. For example, Judith Brady's anthology of women's writings on cancer is called *One in Three: Women with Cancer Confront an Epidemic*.<sup>44</sup> *The Washington Blade* ran an article entitled "One in Three Lesbians may get Breast Cancer, Expert Theorizes"<sup>45</sup>; and *The New York Times* published an essay entitled "You Can't Look Away Anymore: The Anguished Politics of Breast Cancer."<sup>46</sup>

The content of the articles is often equally terrifying. An article in the September 1992 issue of *American Health* began as follows: "Every three minutes, on average, a woman in the U.S. learns she has breast cancer. *Washing over the lives* of nearly 500 women each day, this relentlessly expanding wave will engulf 180,000 women this year alone."<sup>47</sup> Here, breast cancer becomes an unavoidable natural disaster and, importantly, an unsurvivable one. Who, after all, can live through a tidal wave?

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

Every three minutes in America, women, like myself, like you, maybe your wife, your daughter, your niece, will be told that they have breast cancer, and if that statistic doesn't alarm you, eight minutes later, one of these women will die. You're probably thinking it won't happen to you. Well, we don't want you to be a statistic. This show is too important for you to miss.<sup>48</sup>

Reflected in Raphael's statement is the panic created by the use of statistics (especially around risk factors) without sufficient explanation of those numbers. Susan Love states that



"when media headlines say that three alcoholic drinks a week increase breast cancer risk by 50 percent, they don't mean one has a 50-50 chance of getting breast cancer, but rather that these drinks increase the relative risk by 50 percent, and that one's lifetime risk is now about 5 percent rather than 3.3 percent." Love also demystifies the oft-cited statistic that one in eight women will develop breast cancer, by looking at how that statistic is altered drastically according to a woman's age.

Future risk at any one time depends to a great extent on your age. For the average white woman, it is something like 1/1000/year at age 40, or 0.1 percent. This number increases with age, since breast cancer becomes more common as women get older: for example, at age 50 the average white woman has a 1/500/year (0.2%) risk of getting breast cancer. For lifetime risk you add up all the yearly risks to age 110, which comes to about 10 percent. For women of color, the risk is actually less.<sup>49</sup>

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

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

This individualization of breast cancer is exemplified by the aforementioned essay in *American Health*. Here being diagnosed with the disease marks the inevitable "start of a long, lonely road." The article then goes on to use the personal experience of several seemingly unconnected women. The use of these separate stories only further entrenches breast cancer in a rhetoric of individualism. For instance, Rick Weiss quotes Judith Hooper, a woman living with breast cancer, in the following manner: "It's like being shot by a sniper. . . . One day you're just living your life, standing in the supermarket checkout line

with everybody else, and within a second your life is irrevocably changed."<sup>50</sup> This analogy not only portrays breast cancer as a one-on-one conflict where victims are chosen almost at random but also points to how comfortably individualization collapses into a rhetoric of culpability. If breast cancer is a sniper, by implication, it is caused by being in the wrong place at the wrong time. Hooper's metaphor expresses a lack of control over the disease but, ironically, also uncovers the relationship between individuality, personal behavior, and guilt that sets the parameters for many discussions of breast cancer. Breast cancer discourse often implicates one's behavior (in this case, one's physical location) in the development of the disease.

Not surprisingly, this relationship results in a certain shame about the disease, because it implies that individual women are responsible for their illnesses. As Susan Sontag argues, this is not a recent development but, rather, a characteristic of the historical representation of cancer itself:

the evidence that there are cancer-prone families and, possibly, a hereditary factor in cancer can be acknowledged without disturbing the belief that cancer is a disease that strikes each person, punitively, as an individual. No one asks "Why me?" who gets cholera or typhus. But "Why me?" . . . is the question of many who learn they have cancer.<sup>51</sup>

The punitive nature of cancer is exemplified in the way the article in *American Health* uses Cynthia Grant's story. Importantly, "Cynthia Grant" is an assumed name. All we know of her is that she is thirty-eight, married, lives in New York, and "had no particular reason to suspect that a cancer might secretly be growing within."<sup>52</sup> It is crucial to note that Grant's story is immediately followed by a section entitled "Prevention," which provides a list of risk factors and outlines some behaviors that might reduce one's risk of developing breast cancer. A high-fat diet is listed as a possible risk factor.

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

This last statement is quite telling because it shifts attention back on to individual behavior and reintroduces an emphasis on control. If breast cancer is a "random epidemic," a sniper that strikes unexpectedly, the only possible option is to adopt a defensive posture toward it. Diet, because it is understood as a personalized, controllable behavior, creates the illusion of defense. Truly, it is an illusion since we have conflicting data about its relationship to breast cancer incidence and because 75 percent of women diagnosed with the disease evidence *no* risk factors!<sup>54</sup> Yet, when staring at a tidal wave, it is not unreasonable to hold tightly to the canoe.

However, it's important to examine how cultural understandings about women's relationship to food shape our ability to see diet as a controllable behavior. As Susan Bordo argues, "The body—what we eat, how we dress, the daily rituals through which we attend to the body—is a medium of culture."<sup>55</sup> Bordo further asserts that in twentieth-century U.S. culture, discussions of women and food are placed in a rhetoric of control/indulgence. In order for women to obtain the slender and (hence, feminine) body that is culturally valued, they must exercise restraint: choose Sugar-Free Jello over Haägen-Dazs. Regardless of what decisions women make about food intake, they are seen as decisions, as choices, and not necessarily as a biological need for sustenance. It is this framework of restraint/indulgence that allows diet to serve its particular function in discussions of breast cancer. Although I am not claiming that breast cancer discourse intentionally seeks to create the idealized feminine body, I do argue that discussions of diet are overdetermined by the cultural meanings ascribed to women and food intake.

This idea of "food as choice" and its connection to the "restraint/indulgence" dichotomy is quite common in popular media representations of breast cancer. In short, the debate about fat intake quickly collapses into behavior modification. *Ms.*'s issue which focused on breast cancer devoted a tremendous amount of attention to the fat intake controversy. In that issue Susan Rennie argues that "the evidence connecting diet and breast cancer is hard to ignore. By the late 1960s epidemiologists had uncovered an almost identical association between fat consumption and breast cancer mortality rates across an

international spectrum. The higher the fat intake in a country, the higher the breast cancer mortality rate."<sup>66</sup>

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

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

Susan is an attractive, thoughtful woman in her mid forties; she lives with her husband and three daughters, all of whom were accustomed to steak, hamburgers, ice cream, puddings, and snack foods on a regular basis. Susan works outside her home, and so is often exhausted at the end of the day. "I find myself feeding them anything," she said, "just to have them happy and the mealtime over. I want to cook healthy meals, but I don't have the energy at the end of the day." Susan was distressed, because the more she learned about the connection between breast cancer and diet, the more she wanted her daughters to grow up as protected as possible. Also . . . she was increasingly concerned about herself. She realized that a change in diet would not guarantee a reduction of her breast cancer risk . . . but said, "I know we don't eat well anyway, so it's time for a change. And I want to do something about my breast cancer risk. This is one way for me to feel in control."<sup>67</sup>

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

This case study exposes the relationship between control, behavior, and risk factors characteristic of breast cancer discourse. Susan's dietary change is not necessarily related to its actual capacity to lessen the risk of breast cancer but to her ability to feel "in control" of the disease. The effects of her behavior become secondary to her feeling of agency. This passage also reconfirms hegemonic representations of femininity. Susan is a woman to be emulated; after all, she is attractive, thoughtful, and a concerned mother. In fact, she expresses fear for her daughters *before* she talks about herself. Susan "naturally" assumes primary responsibility for her family's food preparation and feels guilty about being tired after working a full day outside the home.

Whether we identify with Susan or not is secondary, however, to the way that this passage articulates the relationship between breast cancer risk and motherhood. In short, it tacitly implies that one way to prevent breast cancer is to be a good mother!<sup>58</sup> Rather than examining cultural assumptions about mothering and possibly relieving some of Susan's stress, Kelly teaches her how to make a healthy salad. Traditional codes of femininity are reconfirmed as a defense against breast cancer.

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

## **HORMONES, REPRODUCTION, AND THE LESBIAN PANIC**

Science journalist Susan Rennie argues that the focus of breast cancer research has shifted from an emphasis on dietary factors toward an examination of the role of hormones in the development of the disease.<sup>59</sup> Eliot Marshall agrees, asserting

that the high-fat thesis "seems to have bombed out, and with it may have gone one of the best hopes for stemming the rise in breast cancer through changes in lifestyle."<sup>60</sup> Rennie and Marshall are correct to point out that there is a growing amount of research on the relationship between hormones and breast cancer risk. However, Marshall's contention is incorrect that this shift away from dietary factors has dashed hopes for prevention through "changes in life-style." Although research on hormonal factors includes a variety of elements (age at first menstruation, age at menopause, reproduction, and the use of artificial hormones like birth control pills and estrogen replacement therapy), the risk factor of reproduction is the site where "life-style" is reintroduced into breast cancer discourse.

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

One of the most popularly cited studies on the relationship between reproduction and breast cancer was conducted by Harvard epidemiologist Brian MacMahon in 1970.<sup>61</sup> MacMahon's cross-national study concluded that late menarche, early menopause, and a first full-term pregnancy prior to age thirty reduced breast cancer risk: a full-term pregnancy before age twenty carried one-half or less the risk of a first full-term pregnancy after age thirty.<sup>62</sup> MacMahon et al. also found that high parity (multiple births, usually five or more) was not significant when age at first full-term birth was factored in. This research has been well received; Alex Kalache writes that since MacMahon, "it has generally been accepted that the main reproductive variable related to breast cancer risk is age at first full-term pregnancy."<sup>63</sup>

Many studies have confirmed the findings of MacMahon et al. In 1983, L.A. Brinton et al. concluded that a first full-term birth after the age of thirty carries a fourfold-to-fivefold-excess risk when compared to a first birth prior to age eighteen.<sup>64</sup> In the same year, Susan P. Helmrich et al. found that risk decreased with first full-term pregnancy prior to twenty-five (not thirty), but they contradicted MacMahon et al.'s findings regarding high parity, concluding that it did reduce risk.<sup>65</sup> Gunnar Kvale et al.'s 1987 study of more than 63,000 Norwegian women supported Helmrich et al.'s conclusions about high parity.<sup>66</sup> Still, both studies asserted that "the best indicator is age at first birth."<sup>67</sup>

In January 1993, Kalache et al. conducted research on Brazilian women and age at full-term pregnancy (FTP). Immediately after stating that "other studies have also failed to demonstrate any association between breast cancer risk and age at first birth," the researchers draw these conclusions: "Our findings are in line with the *well-established positive association* between age at first FTP [full-term pregnancy] and breast cancer risk and the *equally common observation* that nulliparous women [women who have never given birth] are at higher risk."<sup>68</sup>

However, Patricia Kelly highlights two problems in many of the reproductive studies. First, she argues that most do not separate out other potential risk factors, most notably, family history. Only one study, by Brinton et al., analyzed "risk separately for women who did and did not have a mother or sister with breast cancer. Although distinctions between different types of family history were not made, and paternal family history was not considered, this was one of the first studies on reproductive history to include family history in a meaningful way."<sup>69</sup> Interestingly, two recent studies, by N. Andrieu et al.<sup>70</sup> and F. Parazzini et al.,<sup>71</sup> conclude that reproductive factors, including age at first birth, do not significantly reduce risk for women who have a family history of breast cancer.

Second, Kelly asserts that these studies are

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

Kelly concludes: "Early age at birth of first child appears to reduce risk, but these results are based on populations whose reproductive decisions and options differed from those of many modern women. Reproductive decisions may be a marker for different lifestyles, each with different factors influencing risk."<sup>72</sup>

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

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

between menarche and the first pregnancy, the breast tissue is especially sensitive to carcinogens. . . . So it may indeed be that the "developing breast" is more susceptible to carcinogens than the breast that has gone through its complete hormonal development. This increased sensitivity may relate to the breast cells' capability to mutating up until the first pregnancy. There may be something about the first pregnancy that stops them from being able to mutate; thus the more time cells have to mutate, the greater the chance that they'll mutate in response to a carcinogen and in a way that develops into cancer.<sup>73</sup>

Here, Love equates "complete hormonal development" with pregnancy. In other words, the mature breast is the one that has experienced childbirth. Love imposes a teleology on to the female body, and pregnancy is the "natural" threshold that marks full development.

Kalache et al.'s study on age at last full-term pregnancy highlights a third ideological assumption housed in discussions of reproduction. In Kalache et al., it is not that reproduction is assumed but, rather, that when it occurs, it always takes place within a heterosexual matrix. Describing the research by MacMahon, Kalache et al. write: "They found that single women and nulliparous women had an equivalent risk, which was higher than for parous women."<sup>74</sup> Here, single women are as-



sumed to have never given birth, and married women are associated so strongly with reproduction that they need to mark those married women who haven't had children as nulliparous.

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

Susan Love's text exemplifies the first half of this equation—control to behavior modification. Love separates her discussion of risk factors into two sections: hormonal and genetic and external factors. Each category is constituted by its relationship to control. "Unlike the hormonal and genetic influences just discussed, diet, alcohol, and certain medications carry risks over which we have control." Reproduction is included in the first, the uncontrollable, yet because reproduction is also a controllable behavior, she can't maintain the distinction. For instance, we find the following discussion in the section allegedly examining risk factors out of our control. Love states, "Dr. Anthony B. Miller has concluded that if every woman in the world were to have a baby before 25, 17% of the world's breast cancer would be eliminated. If you were looking at this from a public policy perspective, you'd have to weigh the possible advantages of pushing early pregnancy against the problems of young and possibly immature parents, and of possible population growth."<sup>75</sup> Here, the connection between control and behavior modification is quite clear. The move to behavior modification is not in question; what Love fears are certain possible ramifications that don't deal with breast cancer, that is, population growth and immature parents.

Alex Kalache and coworkers and W.R. Miller provide the second half of the equation: behavior modification to culpability. For example, Kalache et al.'s closing paragraph reads as fol-

lows: "Our findings may have implications for family-planning. Women may well be prepared to consider completing their families before the age of 35, *if they are told* that by doing so they may considerably reduce their risk of breast cancer."<sup>76</sup> Here, timely reproductive behavior can "considerably reduce" risk, and similar to what happens in the fat debate, motherhood becomes a way to reduce the risk of breast cancer. By extension, breast cancer can be induced by making the wrong choice—choosing not to reproduce or to have children "late" in life.

W.R. Miller's "Hormonal Factors and Risk of Breast Cancer" concludes in a similar way. He asserts:

Finally, what are the implications of these studies in terms of preventive measures? The concept of blocking oestrogenic hormones during pregnancy to reduce breast cancer risk in offspring seems impractical. A policy of discouraging women from having children late in life is more feasible, but will probably be less acceptable to the nulliparous women who seem to be at greatest risk.<sup>77</sup>

According to Miller, all women reproduce. His statement collapses nulliparous women with those who will eventually have children but will have them late in life. Additionally, these women (whose reproduction goes against the "natural" time schedule; they are "late") are seen as resistant to the practical advice he wants to give them, and since they are at the greatest risk, that resistance could cost them their lives.

*Popular media.* We see these repercussions most clearly in literature outside the scientific community, particularly in lesbian and gay presses where there has been much recent discussion about the relationship between breast cancer risk and lesbianism. Similar to what we saw in the section on dietary fat, that discussion takes place in a rhetoric of panic. The titles of many articles are enough to strike fear in the heart of any lesbian. Kristina Campbell's article is called "One in Three Lesbians May Get Breast Cancer, Expert Theorizes,"<sup>78</sup> and *Quest* ran a story called "Lesbians at Risk."<sup>79</sup> Deb Price's editorial in the September 1992 *Detroit News* was entitled: "As Cancer Assaults Lesbians, They Can Learn to Fight Back,"<sup>80</sup> and Cindy Kirshman's article in *The Advocate* was called "Taking Care of Our Own: Rising Cancer Rates Prompt Lesbian Grass-Roots Health Projects."<sup>81</sup> The latter's content is also frightening. Kirshman refers to breast cancer as "the worsening epidemic" and "the newest plague."<sup>82</sup>

Again, this panic is created by an emphasis on risk factors, most notably, reproduction. In lesbian and gay presses, reproduction is highlighted as a risk factor, often topping off the list. For example, Campbell discusses hormonal factors first, and then dietary fat. Importantly, "hormonal factors" are discussed primarily in terms of reproduction—menarche and menopause become secondary. The section starts: "Breast cancer studies show that women who have never had children are about 80% higher risk for breast cancer than women who have children."<sup>83</sup> Only at the end of the paragraph does she mention age of menarche/menopause. A 1993 article in *off our backs* makes a similar claim: Louise Gates asserts, "We do know that lesbians are at higher risks for some cancers because of not having as much childbearing [*sic*]."<sup>84</sup>

However, notice that these claims are built upon a certain slippage in the definition of lesbianism. As I argued previously, scientific research does not overtly mention sexuality but, rather, categorizes women as either nulliparous or parous. In these articles, however, lesbianism becomes synonymous with nulliparous, and, by implication, heterosexuality with reproduction. This collapse serves an important function—it allows lesbianism itself to become a risk factor *rather than* reproduction. For instance, Craig Dietz's piece in *Quest* argues, "While one in nine women in the U.S. will die of breast cancer, *the risk for lesbians is three to five times higher.*"<sup>85</sup> Campbell's article follows a similar trajectory. Her opening lines read: "One in three lesbians may develop breast cancer in their lifetimes because they are more likely than other women to fall into high-risk categories for the disease, says Dr. Suzanne Haynes with the National Cancer Institute."<sup>86</sup> Lesbianism and its concomitant life-style become the culprit for increasing the risk of developing breast cancer.

Once lesbianism has been located as a risk factor, it opens up a space to expand the risk to other characteristics that lesbians may possibly have in common. For example, Campbell cites Haynes's "five general reasons why lesbians are at such high risk: not having children, higher alcoholism rates, higher body mass,<sup>87</sup> fewer gynecological exams, and fewer breast cancer screenings." Haynes's information comes from Caitlin Ryan's 1985 National Lesbian Health Care Survey, whose

sample size was remarkably small—2,000 women. Interestingly, Ryan did not find a higher cancer rate among those surveyed,<sup>88</sup> yet her research is used to support a folkloric belief that lesbianism itself is a risk factor.

I use the term "folkloric" because in fact no studies have been done on lesbians and breast cancer risk. As Haynes herself admits, "It's all speculative . . . because there are no studies."<sup>89</sup> Yet, the "one in three" statistic is constantly recycled in the media in ways that highlight the riskiness of being a lesbian. And many have supported Haynes's attempt to locate risk. Susan Hester, who founded the Mary Helen Mautner Project for Lesbians, asserts: "Finally, somebody who's an epidemiologist has tried to separate out the facts about some of these cancers and their relevance to Lesbians."<sup>90</sup>

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

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

Indeed, culpability has entered the picture. Rounds cites Joe Nicholson, the medical reporter for the *New York Post*, who wrote: "Dr. Suzanne Haynes, an epidemic expert, said lesbians are more likely to be stricken primarily because they do a poor job of taking care of their health."<sup>91</sup>

Importantly, lesbian/gay presses do not advocate that lesbians get pregnant in order to reduce the risk of breast cancer. Although most are uncritical of the association between lesbian and nulliparous, which in turn reestablishes sexuality and its concomitant life-style itself as a risk factor, lesbianism as a category of risk plays out quite differently than the dietary thesis. Whereas an emphasis on diet resulted in descriptions of individual women altering their food intake, the idea of "lesbians at risk" provides the ground for the formation of a particular kind of identity politics. Breast cancer risk acts as rallying cry for unification and action. Jackie Winnow's keynote speech at the 1989 "Lesbian Caregivers and the AIDS Epidemic" conference provides a fruitful example. Entitled "Lesbians

Evolving Health Care: Our Lives Depend on It," Winnow asserts: "Just as we were healers, experts in our fields in the Middle Ages, we need to lay claim to our heritage now. We have many people in nascent stages of expertise, but few experts. . . . We need practitioners and clinics that are supportive of us as lesbians and experts in their fields."<sup>92</sup> Winnow constructs an originary moment of community and argues for contemporary political action based on that shared ancestry. It is a rearticulation of a Lesbian Community, the need stemming from growing concern over cancer rates.

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

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

## CONCLUSION

As Susan Love argues: "The basic problem is that no one quite understands the disease yet. We're just beginning to fill in the gaps in our knowledge."<sup>93</sup> Yet the work of Michel Foucault reminds us that knowledge production is never neutral or objective but, rather, is always an invested process. The production and dissemination of knowledge is the result of a complicated network of power relations and serves to affirm or dismantle those relations. As such, it is crucial to critically examine the

information we have about breast cancer and its effects. For example, we must question why at a time when many women are delaying motherhood and/or choosing not to participate in that institution, breast cancer discourse implies that motherhood can considerably reduce our risk.

This essay does not intend to present an argument about what does or does not cause breast cancer. However, it asserts that the will to truth which underwrites and shapes breast cancer discourse privileges personal behaviors at the expense of risk factors that cannot be understood through the control/choice paradigm. This privileging is problematic on several levels. First, it results in a blame-the-victim mentality. Second, it discourages research along other possible avenues—environmental toxins, the quality of marketed foods, and so forth. Removing the overriding emphasis on individual culpability might clear a space for adequate investigation into risk factors that are beyond our control, or perhaps amenable to social regulation.

Further, this article advocates that the women's health movement examine the ways in which it has embraced the individual culpability model. This movement has been extremely beneficial in many ways; it has brought breast cancer to national attention and has increased the resources we have to combat this disease. However, a critical stance toward the knowledge we have and will continue to produce can increase our effectiveness in solving the mystery of breast cancer.

## NOTES

I am grateful to Elizabeth Taylor, who started my thinking on this topic. I would also like to thank Jennifer Terry and the many others who provided insightful comments during the revision process.

1. This figure is somewhat misleading in that it assumes a lifespan of ninety-five years and does not adequately address the way that various factors such as age, race, and genetic history alter risk. See Susan Love, *Dr. Susan Love's Breast Book*, 2d ed. (New York: Addison-Wesley, 1995), 176-80.

2. The term "survivor" has been the focus of much discussion. As Sandra Steingraber argues, some women find "survivor" empowering. Steingraber, however, feels "the term divides us in half and at the same time denies the uncertainty of our prognosis, one of the major issues with which we have to struggle." She prefers to call herself a "breast cancer victim" in order "to highlight the notion that cancer is both a preventable disease and a human rights issue." See Sandra Steingraber, "Life-

- styles Don't Kill: Carcinogens in Air, Food, and Water Do: Imagining Political Responses to Cancer," in *Cancer as a Women's Issue*, ed. Midge Stocker (Chicago: Third Side Press, 1991), 97.
3. See Michel Foucault, "Body/Power," in *Power/Knowledge: Selected Interviews and Other Writings* (New York: Pantheon, 1980), 59.
  4. Michel Foucault, *The History of Sexuality*, vol. 1 (New York: Random House, 1978), 102.
  5. I am loosely defining the popular media as literature outside the scientific/medical community. This encompasses a great range—from mainstream media such as *The New York Times* through the alternative presses (feminist and/or lesbian and gay journals/newspapers).
  6. Michel Foucault, "The Order of Discourse," in *Archaeology of Knowledge* (New York: Pantheon Books, 1972), 219.
  7. Linda Alcoff and Laura Gray, "Survivor Discourse: Transgression or Recuperation?" *Signs* 19 (spring 1994): 6.
  8. Additionally, the rhetoric of individual responsibility is not limited to biomedical literature but has great currency in other cultural arenas. Note current discussions about welfare reform and their emphasis on individual responsibility.
  9. Steven Epstein, "Democratic Science? AIDS Activism and the Contested Construction of Knowledge." *Socialist Review* 21 (spring 1991): 54.
  10. Eliot Marshall, "An Expert Panel Advises, and the Army Consents," *Science*, 21 May 1993, 1068.
  11. Eliot Marshall, "The Politics of Breast Cancer," *Science*, 29 Jan. 1993, 617.
  12. *Ibid.*
  13. This was prior to the funding being allocated to the Army Medical Research and Development Command.
  14. Liane Clorfene-Casten defines "the cancer establishment" as the National Cancer Institute, the American Cancer Society, the Memorial Sloan-Kettering Cancer Center, various grantees and contractees at universities, and major pharmaceutical firms. See Liane Clorfene-Casten, "Inside the Cancer Establishment," *Ms.* 3 (May/June 1993): 57.
  15. Note, too, epidemiologist Kay Dickersin.
  16. See "Confronting Breast Cancer: An Interview with Susan Love," *Technology Review* 48 (May/June 1993): 50.
  17. Marshall, "Politics of Breast Cancer," 616.
  18. Foucault, "Order of Discourse," 219.
  19. For an example, see Foucault's discussion (224) of the work of the nineteenth-century botanist Mendel. Foucault states that "the deployment of a totally new range of objects in biology was required before Mendel could enter into the true and his propositions appear, for the most part, exact."
  20. Bruno Latour, *Science in Action* (Cambridge: Harvard University Press, 1987), 41, 40.
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41. Susan Love, *Dr. Susan Love's Breast Book*, 1st ed. (New York: Addison-Wesley, 1990), 154-55.
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43. *Ibid.*, 159.
44. Judith Brady, *One in Three: Women with Cancer Confront an Epidemic* (San Francisco: Cleis Press, 1991).
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46. Susan Ferraro, "You Can't Look Away Anymore: The Anguished Politics of Breast Cancer," *The New York Times*, 15 Aug. 1993, 25-62.
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49. Love, 137, 139.
50. Weiss, 50.
51. Susan Sontag, *Illness as Metaphor* (New York: Farrar, Strauss, & Giroux, 1977), 38.
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53. *Ibid.*, 52-53,
54. This number ranges from 70 to 75 percent. Breast Cancer Action's outreach



- pamphlet cites 75 percent. Susan Love's *Breast Book* uses 70 percent.
55. Susan Bordo, *Unbearable Weight: Feminism, Western Culture, and the Body* (Berkeley: University of California Press, 1993), 165.
  56. Susan Rennie, "Breast Cancer Prevention: Diet vs. Drugs," *Ms.*, May/June 1993, 38.
  57. Patricia Kelly, *Understanding Breast Cancer Risk* (Philadelphia: Temple University Press, 1991), 68-69.
  58. Remember, too, the passage from Susan Love's text which encourages mothers to control their teenage daughters' fat intake.
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  60. Eliot Marshall, "Search for a Killer: Focus Shifts from Fat to Hormones," *Science*, 29 Jan. 1993, 618-21.
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  62. The reasoning behind these conclusions is that many scientists believe that long-term exposure to estrogen (early period/late menopause without the break in exposure that pregnancy provides) stimulates cell growth in breast tissue, which leaves the breast more "vulnerable" to developing breast cancer.
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  68. Kalache et al., 35 (emphasis added).
  69. Kelly, 77.
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  71. Fabio Parazzini, Carlo la Vecchia, and Eva Negri, "Menstrual and Reproductive Factors and Breast Cancer in Women with Family History of the Disease," *International Journal of Cancer* 51, no. 5 (1992): 677-81.
  72. Kelly, 77, 82.
  73. Love, 144-45.
  74. Kalache et al., 35.
  75. Love, 152, 141.
  76. Kalache et al., 35 (emphasis added).
  77. W.R. Miller, "Hormonal Factors and Risk of Breast Cancer," *Lancet* 341 (2 Jan. 1993): 25-26.
  78. Campbell, 23-24.
  79. Craig Dietz, "Lesbians at Risk," *Quest*, September 1992, 18-19.
  80. Deb Price, "As Cancer Assaults Lesbians, They Can Learn to Fight Back," *The Detroit News*, 23 Sept. 1992.
  81. Cindy Kirshman, "Taking Care of Our Own: Rising Cancer Rates Prompt Lesbian Grass-Roots Health Projects," *The Advocate*, 23 Apr. 1991, 56-58.
  82. *Ibid.*, 56.
  83. Campbell, 23.
  84. Louise Gates, quoted in Carole Ann Douglas, "The Mautner Project: Lesbians Unite Vs. Cancer," *off our backs*, March 1993, 12.
  85. Dietz, 18.

86. Campbell, 23.

87. Because many lesbian communities resist hegemonic notions of beauty, lesbians are often described as fatter than heterosexual women. Whether this is true or not, it is important to note that lesbians are often seen as doubly at risk—they do not exercise the proper restraint in food consumption, and they make the wrong reproductive choice.

88. Campbell, 18, 24.

89. Haynes, quoted in Price, 22.

90. Susan Hester, quoted in Campbell, 24.

91. Kate Rounds, "Are Lesbians a High-Risk Group for Breast Cancer?" *Ms.*, May/June 1993, 44. See Joe Nicholson, quoted in *ibid.*

92. Jackie Winnow, "Lesbians Evolving Health Care: Our Lives Depend on It," in *Cancer as a Women's Issue*, 58.

93. "Confronting Breast Cancer," 46.