This paper contends that breast cancer information is written for a dominant, ‘ideal’ patient, who is white, Canadian-born, middle class and middle aged. We draw on the results of a study that examined the perspectives of women of colour and immigrant women on mainstream breast cancer information. This study found that racially marginalized women are excluded from the dominant discourse around breast cancer and that they do not see their identities, concerns and cultures reflected in cancer information materials. Yet, we suggest that there is more at stake than simply exclusion when some women are marginalized. We employ Homi Bhabha’s work on ‘mimicry’ to examine the complex ways in which participants engaged with the information studied. The discursive construction of a dominant patient/woman suggests to women of colour that they must behave and become more like this dominant figure in order to cope with their cancer and to get well.

In this paper, we contend that breast cancer information materials constitute discourses of subjectivity and belonging that produce an ‘ideal’ patient/subject and we look critically at what this subjectification makes possible. In doing so, we are drawing on the results of a study in which women of colour examined and analyzed commonly-available, mainstream breast cancer information. Our reading of this data has lead to some central contentions about how dominant discourse effectively interacts with and shapes the behaviour of subjects to whom it is not addressed—in our case, racially and culturally marginalized women. First, we find that the information studied effectively excludes women of colour from discourses about breast cancer. But further, as women of colour do (and to an extent must) engage with the material despite its shortcomings and lack of relevance to them, the discourse remains central and is normalized. In fact, breast cancer discourse, embedded in institutionalized power relations, becomes normative; it outlines what the subject of breast cancer should be and do. The racialized Other, immigrant, or outsider is rendered deviant from the norm and is forced to adapt, revise, resist, or reject the discourse. As such, marginalized women who engage with it glean a sense that they must conform to dominant standards in order to get well - to in fact become the correct subject of the mainstream breast cancer community.

1 This study was generously funded by the Canadian Breast Cancer Research Alliance/National Cancer Institute of Canada. The authors would like to acknowledge and thank Leslie Norville for her extensive work in coordinating the advisory committee, participant recruitment and focus groups. For inquiries, please contact Jennifer Nelson, 8 Havelock Street, Toronto, Ontario, M6H 3B4. E-mail: jennifer.nelson@utoronto.ca
Our research suggests that many women of colour engage in self-regulation and in forms of mimicry (Bhabha, 1994; 1990) even while they contest and resist dominant norms. In considering mimicry, we are referencing Bhabha’s theory about how marginal bodies engage with hegemonic discourse - in this case, mainstream discourse about how women can best understand and cope with breast cancer. While resistance discourses necessarily engage with hegemonic ones, the women in the study tend to perform the discourse, albeit while introducing particular inflections as they adapt it to their needs. They live the ‘suggestions’ of the material in a form that attempts to transform, or at the very least adapt, the hegemonic discourse on breast cancer to their lives. Finally, we suggest that there are particular parameters within which dominant cancer discourse can be resisted and which shape and constrict its contestation so that, despite critique and resistance, its position of authority is secured.

In what follows we will discuss our methodological approach and some background to the study and then explore the above contentions through various themes that emerged in our data—themes that embody racialized and class-specific discourses about the representation and care of the cancerous female body.

**The Study**

This study was designed as an analysis of mainstream breast cancer resources from the perspectives of women of colour. We hoped to gain a sense from them of what was wrong—if anything—with these materials, as well as anything they liked or found useful. We asked them about who they felt the materials addressed and also their vision of the kind of information they would have preferred when they were diagnosed. Our thirty-eight participants were all from immigrant communities of colour in the City of Toronto and some of its surrounding suburbs (see Table I). They constituted a fairly representative sample of the area’s major immigrant communities. These include, in descending order of size, South Asian, Chinese, Black, Filipino and Arab/West Asian (Statistics Canada, 2001). Our participants were principally from these communities, but represented a broader scope as well. Although it was not a requirement, all participants were first-generation immigrants; none was Canadian-born. They had a range of income levels and class backgrounds, from lower working to upper middle class and they tended to have relatively high levels of formal education.

2 Statistics Canada’s data on different racial/ethnic groups was used initially to determine which groups were most populous in the Greater Toronto Area, in order to form recruitment strategies for a participant sample that was as representative as possible of the local communities. When we gathered participant data before each focus group, the women were asked to fill out a questionnaire that asked ‘How do you identify?’ Some broad headings were listed (continent of origin, along with a few communities within each that are common sources of immigration to the GTA) but they were given the option to describe their identities in any way they wished. The compiled information here is grouped according to these descriptions, using the women’s words as much as possible. For example, different participants identified as ‘African’ while one wrote ‘black’ in the provided space and another ‘South Asian.’ We appreciate that categories for classifying groups are both ideologically produced and always problematic—and also sometimes necessary as a starting point to describe identities and the power relations that shape them.
Most participants had been living in Canada for at least ten years, the majority over twenty years and many over thirty. All had had a breast cancer diagnosis and they were of varying ages (from 37 to 71) and stages of treatment and recovery. There were no other stipulations to their recruitment except that participants required a level of facility with English that would allow them to read and comment on the information. Recruitment was carried out by contacting approximately fifty health, social service and community agencies serving immigrant and marginalized communities. Many were groups with whom the researchers had worked or had contact in the past; some were recommended by the project advisory committee. In most cases, we made contact with a gatekeeper at a community organization, explained the project through a letter, telephone conversation, or meeting and enlisted that person to help accrue participants from her community. In some cases, cancer support group leaders were also instrumental in directing their participants to the study. In addition, the call for participation was posted on various women’s health and related web sites and broadcast on several local radio stations. The majority of successful recruits, however, came from word-of-mouth through community leaders.

Since the goal was to study mainstream information, the materials studied were all in the dominant language. The lack of language-specific materials for immigrant populations is a topic extensively studied within social service fields (Burkemper et al., 2003; Chand, 2005; Dias, Norman & de Paula, 2005; Hurtado et al., 2005); it was also an obvious and unsurprising issue that arose in our study. While we do not underestimate the importance of translation, for the scope and purposes of this paper we have chosen to focus on more subtle, normative characteristics of breast cancer information and the women’s engagement with it.

The participants met in small focus groups, with the exception of three individual interviews (by the participants’ request). Each group met for a four-to-five-hour workshop, in which they read and discussed a number of breast cancer information materials that had been preselected. A facilitator conducted the conversation as to the materials’ content, quality, communication style, appearance, language, target audience and their overall effectiveness and relevance to the women’s lives and communities.

As the goal was to study commonly-available, ‘mainstream’ resources, we asked support groups, hospitals, fundraising groups and resource centres in the Toronto area to supply samples of the information that they commonly give to breast cancer patients. From these materials, we chose eight that covered a broad spectrum of themes or topic areas; we tried to avoid duplication of similar information. Topics covered included: nutrition, exercise, treatment decision-making, emotional issues, financial problems and ‘general overviews’ of breast cancer diagnosis.

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3 We did not collect data specifically about education on our questionnaire, but many women discussed their professions/work. Some spoke of post-high school technical training or business diplomas and a number had completed university; several held doctorates. The majority spoke of working outside the home.
staging and treatment. We also included magazine excerpts of women’s personal stories of breast cancer and we collected booklet and magazine covers in order to examine the images. All groups were able to cover about six of the materials in the time allotted, sometimes discussing the others briefly. (In the case of the three individual interviews, the women were sent four materials to look at ahead of time, as the time allotted was shorter.) Normally, informal discussion continued over the lunch break and we often used this time to talk about the images in the materials.

Methodologically, we were concerned that the study not duplicate some of the common essentialist traps found in much qualitative health research about racialized groups. With some exceptions, many studies are founded on a culturalist paradigm that aims to determine the characteristics, behaviours, values and practices of distinct groups, in order to adapt services to better meet their needs and sometimes to counter (implicitly inferior) cultural beliefs. Along these lines, ‘cultural competence’ has been the leading strategy in North America by which to manage the service needs of an increasingly ethnically diverse population

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Number</th>
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<tbody>
<tr>
<td>Black Caribbean (Jamaican, Guyanese, Barbadian)</td>
<td>9</td>
</tr>
<tr>
<td>East Asian (Chinese, Filipino, Korean, Malaysian)</td>
<td>10</td>
</tr>
<tr>
<td>South Asian (Pakistani, Indian)</td>
<td>11</td>
</tr>
<tr>
<td>African born (South Asian or Black African)</td>
<td>3</td>
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<tr>
<td>Mixed race</td>
<td>1</td>
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<tr>
<td>West Asian</td>
<td>1</td>
</tr>
<tr>
<td>Latin American (Chilean, Native)</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Age range</th>
<th>Number</th>
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<tbody>
<tr>
<td>30-39</td>
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<tr>
<td>40-49</td>
<td>8</td>
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<td>50-59</td>
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<tr>
<td>60-75</td>
<td>4</td>
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<td>n/a</td>
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<tr>
<th>Years since migration to Canada</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>3-9</td>
<td>4</td>
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<tr>
<td>10-19</td>
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<td>20-29</td>
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<td>30+</td>
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<td>n/a</td>
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<table>
<thead>
<tr>
<th>Time of diagnosis</th>
<th>Number</th>
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<tbody>
<tr>
<td>1990-1994</td>
<td>6</td>
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<tr>
<td>1995-1999</td>
<td>9</td>
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<tr>
<td>2000-</td>
<td>21</td>
</tr>
<tr>
<td>n/a</td>
<td>2</td>
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</table>
While it persists, this approach has come under substantial criticism for the vast generalities and notions of essential racial difference that it relies on and, indeed, reinforces (Dean, 2001; Fassin, 2001; Gunaratnam, 1997; Jeffery & Nelson, 2007; Park, 2005). Moreover, ‘cultural’ approaches entrench a notion that services and resources for ‘Other’ or non-dominant communities are simply add-ons which continue to pivot those of the dominant, ‘model’ patient. Much health research follows this conceptual model, failing to critically examine dominant discourses as outcomes of cultural production, rather than simply the norm. Focus remains on accommodating those persons and groups who have ostensibly been ‘left out’—a goal which sounds admirable at first glance, but which reproduces a sense of their innate Otherness, as well as the dominant group’s normalcy and subjectivity as legitimate citizens.

Our hope for this study was to subvert tendencies toward culturalism and essentialist thinking by focusing critically on dominant discourse as a sociopolitical invention that both addresses and constructs particular subjects. We explicitly did not set out to study the cultures or cultural practices of the women. Nor did we aim, primarily, to document the experiences of our participants. (They were informed at the beginning that the sharing of personal experiences was not required or expected, but that they could share such information if they wanted to and felt comfortable.)

It was important that experiences and ‘cultural’ knowledge not come to be seen as representative of whole cultures or communities; rather, the dominant material and its embedded knowledge, rather than minoritized people’s Otherness and difference, were centrally positioned and examined as the source of ‘the problem.’ As such, the characteristics and needs of particular immigrant communities (even if, or to the extent that, they might be determined), were not the focus of this project.

What we did find was that aspects of the women’s cultures, backgrounds and experiences emerged in the discussions to illuminate how the dominant literature is constructed and the kinds of constraints it raises for those whom it does not address. Many women did share experiences and the informational resources often seemed to lead quite naturally to personal examples. Their own stories are woven in the alternative discourse they construct around dominant information. In articulating what the material leaves out, the participants both resist and embrace it. They tentatively enter a discursive terrain that is rendered all the more powerful by its promise, whether real or perceived, of survival.

Cancer Materials as Discourses of Subject

Breast cancer information materials reveal discourses through which subjectivities are constituted—subjectivities that women of colour engaging with these discourses recognize as exclusionary. The materials
are understood, in our analysis, as socially constructed discourses that delimit not only what can be said about cancer, but also who is considered the target of the discourse. Such an understanding borrows from a Foucauldian conceptualization of discourse as the multiple and competing sets of ideas that interrelate with one another to constitute reality and subject (Foucault, 1990; 1994). Discourse, understood in this way, allows us to see how specific human activities are brought into the realm of “explicit calculations,” (Foucault, 1990, p.143), transforming activities normally considered private and intrinsic into calculable actions regulated by power (Foucault, 1990, p. 155). In other words, we understand breast cancer discourse as something that brings the experience of illness into the public realm, allowing for the elaboration of normative practices within which the experience of cancer is given meaning.

Additionally, discourse, in a Foucauldian sense, determines not only how an experience of illness will be understood and calculated, but also how the subject of the discourse of illness will be constructed (Foucault, 1995). Thus, in constructing understandings of the experience of illness and health, the diseased and the healthy body, breast cancer information serves to constitute the subjects/patients themselves. For instance, the category of ‘people with cancer’ that Clive Seale (Seale, 2002) identifies in news reports about the illness can be understood as a socially and discursively constructed category that actively contributes to a social understanding of the subject of cancer. In the same way, information material designed to assist patients with issues such as diet, self-care and treatment can be understood as actively constituting a category of patients with specific characteristics.

As feminist scholars such as Susan Bordo (1992) and Catrina Brown (1994) suggest, Foucauldian conceptions of discourse prove valuable for the deconstruction of the disciplinary practices articulated in discourses of femininity; discourses that render female bodies “docile, regulated bod[ies] practiced at and habituated to the rules of cultural life” (Bordo, 1992, p.13). If we locate ourselves solely within this critical feminist stand, we begin to see the discursive construction of cancer and its effect on the constitution of the cancer patient as deeply influenced by gendered constructions of knowledge that contribute to a process of feminization of the illness (Klawiter, 2000). Literature concerning breast cancer awareness (Klawiter, 2000), for instance, traces how breast cancer activism permits the emergence of a specific category of ‘breast cancer survivor,’ a category that is highly gendered. This gendering of breast cancer permits the articulation of discourses that, at times, reproduce and reinforce conservative, normative conditions of hetero-femininity, which position women with breast cancer as victims (Montini, 1996), while, at other times, images of survivorship are evoked to call attention to the role of activism within breast cancer awareness (Klawiter, 2000; Seale, 2001; 2002; Taylor & Van Willigen, 1996). These studies seem to suggest that breast cancer discourse plays a major role in defining concepts of commu-
community—concepts that in late modernity are no longer associated with claims to space and territory, but with claims to specific identities (Ferguson & Gupta, 1992).

However, as our analysis is complicated by the use of an interconnected conception of race, class and gender (Fellows & Razack, 1998; Razack, 1998) and processes of racialization (Goldberg, 1993; Omi & Winant, 2002), as dynamic discourses that concurrently and simultaneously shape and construct the experiences of the participants in this study, the use of gender as a sole point of entry to our analysis proves rather limiting. Critical readings of Foucault in tandem with anti-racist (hooks, 1992; Lorde, 1988) post-colonial (Stoler, 1995; McClintock, 1995; Butler, 1993) and transnational feminist (Grewal & Kaplan, 1994) articulations of post-modernity come to aid us as they provide us with a theoretical framework to theorize the experiences of women of color within normative cancer discourses. Thus, it is our contention that breast cancer resource materials construct a category of ‘cancer patient’ that, in addition to being gendered, is evidently and predominantly white, western, middle class, heterosexual and well educated in a manner that concretely affects women’s engagement with cancer discourses.

The discursive construction of the subject of breast cancer material can not be, to borrow from Stuart Hall’s argument (Hall & Gieben, 1995), ideologically innocent. That is, breast cancer discourse cannot be separated from the social power relations that bolster social hierarchies and, in this way, claims of community remain embedded in the social relations that create categories of citizenship. Even when claiming ‘pure’ scientific knowledge, discourses cannot be extrapolated from power, as power operates through discourse to serve specific social interests by authorizing truth claims that ultimately constitute an ideal subject (Foucault, 1980).

Although the objective of our research was not to deconstruct breast cancer resource materials as they constitute subjectivity, the way in which women of colour took up the material allowed us to elucidate the normative and exclusive character of mainstream cancer discourse. It became evident that the breast cancer information constructed a category of patient and survivor—an ‘ideal subject’ of cancer discourse - that was not only highly gendered, as some other studies have suggested (Ehrenreich, 2001; Seale, 2002), but also specifically defined along race and class lines in ways that limited the means for addressing the class, racial and ethnic specificity of experiences of women survivors (Cartwright, 1998). For instance, when analyzing the images portrayed in breast cancer resources, women in the study constantly referred to the lack of diverse ethnic and class representation in the material. One participant made the following observation when referring to a specific visual representation in cancer resources: “… not only black, but ... these don’t reflect women of color on the whole.”

The photographs and images of breast cancer survivors in the infor-
national literature most often depicted white women. Most participants noted right away that there were very few women of colour pictured; as one stated, “I was really happy to see a black person’s face [laughs]... at least one woman is a colored woman. The rest belong to a section of the society ... that [laughs], I don’t belong to.” Several also noted that when women of colour were pictured in the material, they tended to be light-skinned and represented few different ethnicities, for example: “… again, you know, it’s kind of like, all these usual magazines, they try to get the light-skinned women.” Some commented that the materials never pictured women in different traditional cultural forms of dress such as hijab.

There were intertwined elements to do with social class as well, that evoked at least as much discussion and criticism. As one woman noted:

I mean they make an effort to show women of color, but it’s also... I work with low-income communities. And it’s not even middle-class women, OK - with jobs, with cells, with bicycles [laughter] ... And I’m not saying that, you know, you have to portray misery, but the reality is that a lot of women are not going to identify with this picture.

Indeed, the images tend to depict women who are not only white or light-skinned, but healthy-looking, well dressed in Western style, with professional-looking makeup and with socially acceptable body types. Even though the audience for this material would presumably include women who had undergone mastectomies, the material commonly portrayed women who appeared to have both breasts. Women are shown participating in activities that require a middle or upper class income and lifestyle (biking, gardening) and they possess other specific class signifiers (office jobs, cell phones, jewelry). Participants often noted that people from working class or poor backgrounds were absent. One woman said that the people pictured all appeared to be both “corporate” and “middle aged.” Another was met with nods and group laughter when she said, about a breast cancer magazine cover, “She looks like she retired on a pension!”

Beyond the representation of bodies, breast cancer resources were also considered by the women as exclusive of their cultural lifestyles and class locations. One important aspect in which that lack of representation was observed was in the area of nutrition. Nutrition was probably the most talked-about issue in the focus groups, although only one information brochure dealt with it. Nearly all the women had something to say about the lack of racial and cultural diversity in the diets represented in the material. In general, the majority of participants agreed that the menus suggested in nutritional information represented, “North American, very western” diets. As one participant observed, the food and diet recommended in the material was “a white person’s food.” Another woman humorously stated:
when I got diagnosed with breast cancer, talking about the diet, I never heard of tofu in my entire life. [Laughter] And there was nowhere for anybody to tell me, what in the world is tofu. So, when I read something that says, OK, get a dessert with tofu, I’m like, what is tofu? And where do I get it?

Financial concerns often intersected with the issue of what to eat. Although the information materials that they examined did not state it explicitly, there was a general perception among most participants that it was better to buy organic food when diagnosed with cancer; for fear that chemical additives in regular produce might be linked to tumor growth. (This issue is now, of course, commonly discussed and debated in mainstream public discourse and remains under scientific study.) However, since organic food and other recommended items, like vitamins and supplements, require extra money, it raised the issue of who could afford to take care of herself in this way. One woman noted, “Even now, I think twice before going to places like [a large health food store]—they are expensive, they are really expensive. So... just mentioning it as if this is the normal way of life is really not fair.” Another told the following story:

I went to [a support organization] and they kept on telling me things that I couldn’t afford… They kept on mentioning things like, oh, you went through chemotherapy, you must take ... those energy drinks and all. And ... she kept on insisting that I should take them and really, I couldn’t afford to take them at that time... Those people have no idea, they’re just a bunch of privileged people who made it good, you know, even if they are ... from an ethnic group, they have made it good in Canada and they have no idea how people [live] out there.

As in the above example, race and class are intimately intertwined in many women’s narrations of their exclusion. Immigrants of colour and others from visible minority communities in Canada face significant discrimination in employment opportunities and income levels (Canadian Council on Social Development, 2000). They also face underemployment and barriers to accreditation according to their education and skills (Mulvihill, Mailloux & Atkin, 2001; Pendakur, 2000). Additionally, racialized women are disproportionately represented in lower socioeconomic sectors and in lower status jobs (Ontario Women’s Health Council, 2002). It is, therefore, unsurprising that many immigrant women will face specific financial barriers that might be exacerbated by a serious illness like cancer and its associated costs, which have been shown to be significant (Longo, 2005). What we see in many participants’ statements is the interlocking effects of racism with both social class and socioeconomic status - the former in their references to class signifiers and images, the latter in a more material sense.
A third significant area that participants discussed was body image. Most spoke of concerns over the effect of cancer treatment on their appearances and bodies - for example, through hair loss, loss of a breast(s) and other effects of being ill. Several made reference to programs that were designed to help with appearance concerns, but only supplied cosmetics and wigs for white skin and hair. Some of the black women identified hair as a particularly important concern for them.

Various women noted that prosthetic breasts did not match their skin tone. One told the group, “I went to a pharmacy at [hospital name] and asked to get a prosthesis... And they’ve given me a white breast because they didn’t have a brown breast.” Another woman said, “I remember when I had my mastectomy and I went to get a prosthesis, they didn’t have anything for women of color. Nothing!”

It became evident in our study that although breast cancer discourse generally did not represent or speak to the experiences of women of colour. Various feminist scholars have addressed both the gendered and racialized dimensions of body image. Audre Lorde (1988), in particular, illustrated her own choices around the representation of her body after her breast cancer diagnosis—her alternative choices around treatment, her refusal to wear prosthetics—as a black lesbian with a critical feminist and antiracist perspective on beauty and the body. bell hooks, too, has written extensively on the challenges for women of colour in reclaiming notions of beauty and personhood (hooks, 1992). Among our participants, there remained a widespread impetus to carve out some kind of space as patients/subjects/survivors. In doing so, they engaged with the material and the discussions in various ways, which were neither static nor straightforward. We turn now to a discussion of the ways in which the women engaged with and resisted breast cancer discourse, as represented in the information they analyzed.

Engagement & Resistance

We want to be clear that our analysis is in no way intended as a judgment of what participants ‘should or shouldn’t do’; thus, we are not faulting the women for making use of the materials and adapting them to their own needs, nor are we suggesting that participants should have ‘seen through’ the Eurocentrism of the materials and dismissed them outright. Not only was this not the intent of the study, but we were aware of our own positions as young women who have not experienced cancer. Rather, what we have found interesting is that the women’s treatment of the materials entails a much more complex engagement, marked by varying degrees and combinations of critique, acceptance, discomfort, compromise and caution. Moreover, we did not find it difficult to imagine that women facing a life threatening illness would consider any available sources of information and be willing to make particular changes in their lifestyles.
What is at issue, for the purpose of our analysis, is how the dominant narratives in existence shape and constrain the kinds of engagement that are possible. We are particularly concerned that the relative lack of alternative visions or perceptions of ‘how to live with breast cancer’ leaves women feeling guilty and fearful, often unnecessarily. As we have suggested above, such disempowerment is constructed from particular racialized, gendered, sexualized and classed tropes.

In the following examples, in reference to information about diet, women were critical of the lack of diverse food choices, but at the same time, they wondered about the implications of the invisibility of their own diets. One woman stated, “I don’t see my normal diet here. Do I ignore this altogether and assume that my regular diet is fine, or do I ignore my diet and switch to whatever it says here?” Another participant noted: “So, my question would be, what do I eat? Because my breakfast is probably going to be green bananas and salt fish and some [laughs] mackerel, maybe. So I’m going to be wondering, when I look at this booklet, is it OK for me to eat my stuff, because it really isn’t in here and it’s not telling me anything about the diet that I would normally eat.”

Yet another woman made specific reference to inappropriate items in her booklet, when she noted: “people from Somalia... I mean, they don’t eat grapefruit and they don’t eat peanut butter and they don’t have split pea soup and apple sauce [laughter]! None of this is relevant.”

The information lead participants to question the legitimacy of their usual diets, although some also speculated and suggested that substitute ingredients could be used to adapt the information to different diets. What came out was a mixture of criticism, advice, questioning and uncertainty, with the gravity of the situation underlined by the following statement: “...I felt like ... s-h-i-t, I have to now follow this diet, because this is what’s going to keep me alive and if I don’t, I’m going to die.”

One participant noted, “You’re sick so you have to have Western food,” while another stated, about treatment in general, “You’re in their country so you have to accept what they have.” These statements suggest that a tenuous sense of entitlement to question the recommendations underlies women’s struggles to survive. This is particularly striking given that most had lived in Canada for a considerable length of time. There remains a sense that one never fully belongs and perhaps can never fully inhabit Canada as ‘home,’ as well as a troubled and ambiguous perception of the demand to become more like the dominant subject and of what might be at stake if one fails to do so. These factors allowed a glimpse of our participants’ marked vulnerability, as minority group members facing a life and death situation, within an overwhelmingly dominant discourse.
about self-care and recovery.

Although the information studied did not directly address appearance-related concerns, like prosthetics and cosmetics, women tended to broach these issues frequently in their discussions, particularly in reference to images and lack of representation. As we have noted, examples such as the lack of brown or black skin colour products at make-up seminars or the difficulty of finding breast prosthetics that matched their skin tone indicate the degree of exclusion of women of colour from dominant narratives. At the same time, we noted that most of the women did not question the value of these products or the need to maintain a ‘normal’ appearance during cancer treatment. The focus group discussions demonstrated something of the consideration that goes into the presentation of the female body and the racialized female body in particular, following the loss of a breast. Any cancerous body is already rendered problematic; for example, Lisa Cartwright has analyzed the representation of the cancerous body in the media, stressing that such representation is dominated by discourses of female sexuality that constitute the cancerous female body as deviant. ‘Alternative’ attempts to represent the cancerous body cannot avoid engaging with dominant norms of sexuality, through which they are constituted as Other (Cartwright, 1998). At the same time, for women of colour, the relationship with their ‘new’ diseased bodies is also deeply racialized.

Participants engaged in some depth with the impetus to embody normative standards of female beauty, which they seemed to feel was an inherent feature of breast cancer discourse – for example, the importance of hair, ‘healthy’ faces with appropriate make-up and bodies with two breasts. The desire to conceal the effects of cancer treatment is not surprising in a society in which standards of beauty are bound up with healthiness and where ill-health comes to signify ugliness in ways that are also racialized (Gilman, 1995); however, it was interesting to us in our study that the standards themselves, including their inherent whiteness, were not questioned. What was at issue was the difficulty of adapting the standards to accommodate black and brown bodies; as such, the critique became centered around the need to embody dominant expectations of beauty, sexuality and femininity, while the products to do so were often hard to come by. At the same time, the women tended to be critical of the mostly-white images in magazines and information brochures. As noted previously, they remarked on the apparent class status and whiteness of the women represented and felt their own lives and images were usually absent. There is, again, a troubled engagement with the body and imagery around illness, femininity and race. It is not devoid of critique, but the parameters within which the discourse takes shape are rarely disrupted—with the occasional exception, as we will soon explore.

We have found Homi Bhabha’s (Bhabha, 1994) theorization of ‘mimicry’ particularly useful to understand the situation of our partici-
pants. His theory is concerned with how cultural adaptation and reformulation occurs during colonialism and the early stages of decolonization and postcoloniality. Mimicry, in this context, refers to how colonized subjects embrace values and practices of the colonizing society. Although our participants construct their identities in a different context—as minoritized immigrants in a dominant, white (post)colonial society, rather than as colonized subjects in newly invaded territories - we find that the theory remains relevant. Bhabha argues that engagement with difference, whether it is a willing adaptation to dominant norms or a grudging acceptance of imposed power relations, is a central feature in colonial projects. The degree to which historically marginalized subjects engage with dominant standards, in our study, is also one in which choices are shaped and restricted in important ways: they are in a dominant, host society, to whose resources they do not feel wholly entitled; they are invisible in the discursive constructs with which they must engage, while they face discrimination, invisibility and numerous combinations and iterations of both, as systemic features of their ‘new’ society. They are also facing a life-threatening illness in a culture that places little value on brown and black women’s lives in the first place. The possibilities for resistance to dominant norms are profoundly constrained and life itself is at stake.

Another conceptual aspect of mimicry is that it actually illuminates difference and distance from its object. This is the irony of becoming, as Bhabha (1990) writes, “almost the same but not quite” (p. 85, emphasis original); it is, for instance, “the difference between being English and being Anglicized” (p. 89), where “to be Anglicized is emphatically not to be English” (p. 87, emphasis original). In his words:

… the discourse of mimicry is constructed around an ambivalence; in order to be effective, mimicry must continually produce its slippage, its excess, its difference. The authority of that mode of colonial discourse that I have called mimicry is therefore stricken by an indeterminacy: Mimicry emerges as the representation of a difference that is itself a process of disavowal (p. 85).

Through mimicry, then, difference is illuminated. When women of colour attempt to embrace and live the normative discourses of breast cancer survival, the points of departure and impossibility are all the more evident; the Otherness of women who are not model patients, the subjects of the discourse, is reified. The woman of colour has an uneasy and restricted engagement with mainstream discourse; she cannot inhabit the dominant body, she can mimic, not become.

Importantly, mimicry occurs only through engagement with dominant discourses—there is nothing to resist if one is not engaging. What results, in our data, is that participants embrace dominant norms to some degree but also demand that they be represented more often and
better—having brown prosthetics instead of white, having the right makeup, including more diverse pictures, or adding culturally specific foods to diet plans. The boundaries of the dominant subject of breast cancer are challenged but not significantly altered as participants struggle to become ‘more like’ this subject, for example, in demanding brown prosthetics but not challenging the underlying need and desire for prosthetics in the first place, or adjusting to specific dietary recommendations while also questioning the invisibility of their own foods and practices and the expense of the recommended items. What is at stake is that they fear not getting well if they do not embrace particular facets of dominant advice.

In keeping with the ambivalence of their engagement, there were various ways in which participants more blatantly resisted or rejected the dominant information/discourses they studied. While they were not widespread, there were key moments or ruptures in their engagement with the materials that we find especially interesting.

An article that dealt with emotional issues around coping with cancer offered further insight into both the dominant subject of breast cancer information and the ways in which our participants viewed her. The article opened with what is a common narrative in breast cancer stories: The subject is a woman whose life is going ‘perfectly.’ She has a loving husband, wonderful children, a beautiful home, a great job and interesting hobbies and friends. And then one day, breast cancer strikes. The impression given is that this is somehow all the more shocking and disruptive because of her perfect life—which also, significantly, epitomizes racialized and classed heteronormativity. Breast cancer is implicitly situated as not only a threat to the subject’s life, but specifically to her gendered identity within a professional, heterosexual, nuclear family.

While some of the participants said they were happy to see this article because there was very little emphasis on emotional issues in the literature, others described a sense of alienation from this kind of story, saying that they did not lead such lives to begin with, so it was not relevant. In fact, the rosy picture of the subject’s life was considered somewhat laughable; one said, “for us, it’s more like ‘this on top of everything else!’” Someone else noted that she felt sorry for the woman in the story because it seemed like she would not have the tools to cope with crisis or hardship, given that her life had been “perfect.” In response to this, another woman mentioned that her doctor, who was also a woman of colour, had told her when she was diagnosed that she was strong and had the right tools to deal with this hard time because she had already faced grave difficulties in her life as a racialized, immigrant woman. Another woman said, with some apologetic laughter, “I think women of colour are just stronger!”

As the article went on to offer advice about how to cope emotionally, one participant, a young Chinese woman, criticized the author’s appropriation of Buddhist philosophy, feeling that she had taken elements of the religion out of context, as Westerners often do and adapted
it in a superficial way for the purposes of the reader. More generally, several other participants addressed what they saw as an assumption, in the information, that everyone has a supportive family who will automatically be willing to do all they can and who need only to be told the best ways to show support. One woman said that “it wasn’t like that at all,” noting that she had not been able to talk openly with her family about her cancer. Another stayed after a focus group to tell the principal investigator in private about a painful experience with her husband, who had abandoned her during her cancer treatment.

Again, calling on the concept of mimicry, it is interesting to keep in mind how ruptures and resistance are still formed in relation to existing discourses and shape newer forms of critical discussion in particular ways. Take, for example, the participant who criticized the article about emotions and Buddhism. Rather than directly engaging Buddhist philosophy to help her cope, she must first negotiate how Buddhism is appropriated and represented in dominant discourse. She reads this material, engages in a critique of it, rejects it and then goes on (perhaps, she did not speak specifically of her own beliefs) to re-engage with religion and philosophy in her own way.

Overall, the responses seem to indicate that the women felt they were better equipped to face hardship on an emotional level than were privileged white women, due to their life histories, struggles and perhaps cultural strengths. This made for an interesting contrast with their sense that they lacked resources to take care of themselves physically in many of the dominant ways that were recommended. It also revealed key moments of resistance to the dominant, (white) racialized narrative of the survivor.

One moment of rupture occurred during a discussion of body image and hair loss. A participant described how her hair did not grow back after her chemotherapy, taking off a hat to show the group her bald head. Another woman in the group commented, “It’s very sexy.” This called to mind other alternative discourses around body image and breast cancer that have gained some attention, although they are still far from dominant and are normally also from white, relatively privileged authors (for example, see Cartwright, 1998). The participant who displayed her head was a black woman from the Caribbean. She did this following a discussion with a few others of how hair was a particularly important issue for black women. This was one moment in which an alternative image surfaced, although it remained an isolated example of the acceptance of baldness.

The following quotation represents another unique subversion of body image norms.

*I think you should match [a prosthetic] to the color of your bra,*
*because if you’re a black woman and... you’ve got a dark brown*
breast and it’s sitting on your floor in the middle of the morn-
ing and you’ve got to get dressed, you ain’t going to find it! So
you need something pink! [laughter]… that’s my whole analy-
sis, it’s got to be pink! [laughter]… [My friend] likes things to
match her skin-tone just in case her shirt comes up… [voices
agreeing]. So we were able to find the exact same brown that
matches her. But usually you can’t.

This speaker engages with the dominant discourse, the need to
have a prosthetic and accepts it. She further takes up the common senti-
ment among women of colour that a matching prosthetic breast is need-
ed; she validates this with the example of her friend, but not before inter-
jecting her own preference, which is for a pink breast, for practical reasons
that were rather unexpected, not to mention humorous. The use of
humour and the refusal to accept either common narrative seemed to
illustrate a reclaiming of her body against dominant standards. She is
even slightly self-mocking in her humour, noting, “that’s whole my analy-
sis.” She does not reject the underlying imperative to appear double-
breasted and she endorses others’ need to adapt this imperative racially,
but she also moves beyond both norms to an entirely new place.

A kind of creative self-reclamation was occasionally articulated by
others as well. For example, a participant in one group showed a sample
of prosthetic breasts that she knits from scratch and stuffs to different
sizes, while a few other women took out the prosthetics they were wear-
ing and passed them around to show everyone, comparing them to the
knitted prosthetics (which were many different colours) and speculating
about what was the more comfortable option. In such examples, the
boundaries of existing bodily and aesthetic responses to breast cancer
were explored and extended.

Implications for Change

Throughout the study, key statements resound as participants
struggle to embrace, conform, depart from and reject what they see and
read and to chart new territory with no models or maps: This is not my
food. This is not my body. This is not my family, my culture, my emotion.
Again, a common solution to such assertions, particularly from a service
provision standpoint, is to add in cultural references for different groups,
or to ‘tailor’ information based on assumed cultural characteristics. We
are not arguing against adaptation as a partial redress for the exclusion
women of colour face. However, as many critical theorists have noted,
essentialist understandings of the Other are not only problematic, they are
also fundamentally unable to affect change (Fassin, 2001; Grillo, 1995;
Gunaratnam, 1997; 2003; Razack, 1998). In this sense, we both understand
and depart from the view of one participant who said, “I think it’s not that
they are excluding anyone, but they just think that it’s just the same for
everyone."

We would argue that the failure to provide diverse services and resources is not simply a matter of ignorance as to different cultural practices, which can be solved by the addition of the correct information. And it is in this sense that this research might have the most direct implications for changes in practice and policy: To truly disrupt racial and other hierarchies, to meaningfully promote social justice, we first need to understand inequality as a systemic and institutionalized phenomenon that relies on the production and management of distinct, unequal subjects. We suggest that there is more going on in women’s critical statements about their exclusion—more than being left out, more than missing information; they tell us that they are not the subject they see. They both engage and struggle against this dominant figure and, in so doing, reveal much about the oft-invisible underpinnings of marginality and domination. We need to better understand what these underpinnings look like and how they are lived in women’s experiences of illness, if we are to effect a paradigm shift that might in turn influence how services and information are rendered. Again, we recall Foucault’s basic premises, that knowledge and power are intertwined or, simply, how we think about a problem shapes the actions we will take in addressing it. If health providers and community-based support organizations envision the production of information materials as a process of simply ‘adding on’ diverse foods and cultural references, they will only partially and superficially meet the objective of inclusive practice. What is needed is a fundamental de-centring of the dominant model of patient/woman who is the recipient of information. Assumptions about the material effects of cancer on women’s lives and the strategies women are able to employ to cope with these effects need to be questioned and overturned at their roots. Were that to happen, we wonder, what might the new information and resources look like?

Bhabha writes that “[t]he menace of mimicry is its double vision which in disclosing the ambivalence of colonial discourse also disrupts its authority” (1990, p. 88). What we see in subjects’ ambivalence is the emergence of alternative ‘gazes,’ places from which the Other is permitted to look and to know, though in a limited sense. And it is this very “doubleness” that is at the heart of our analysis—the “partial representation/recognition of the colonial object” (p. 88) that is both deficient (as revealed in its inability to become) and challenging to colonial, dominant desire. Bhabha describes this as:

[a] desire that, through the repetition of partial presence, which is the basis of mimicry, articulates those disturbances of cultural, racial and historical difference that menace the narcissistic demand of colonial authority. It is a desire that reverses ‘in part’ the colonial appropriation by now producing a partial vision of the colonizer’s presence; a gaze of otherness, that shares the acuity of
the genealogical gaze which, as Foucault describes it, liberates marginal elements and shatters the unity of man’s being through which he extends his sovereignty (p. 88).

Women of colour in our project engage and partially reject or accept, aspects of dominant precepts about breast cancer care. As they do so, they effectively write themselves into this discourse. They are still not able to inhabit the dominant body or to fully utilize/operationalize the dominant advice/help that is available, since it does not address them; they also do not, on the whole, reject many underlying assumptions it holds. Yet, they find ways to be visible and critical in the space of dialogue created through the project. Their critical vision of the dominant subject—the gaze of Otherness—does serve as a disruption to an overwhelmingly white and privileged story of living with breast cancer. What would new resources and information look like were this gaze, this visibility, incorporated from the beginning of their conceptualization and throughout their production? For instance, what if similar focus groups were held to review new materials before they are circulated? What if different communities participated from the outset in their development? And what if research into self-help and supportive care needs incorporated critical feminist and anti-racist perspectives from the beginning?

In this sense, what we’ve tried to illustrate is something of the complexity behind a problem that might otherwise be articulated as simply the ‘unmet needs’ or ‘exclusion’ of racialized women. Instead, the project’s methodology suggests key ways in which we might subvert more simplistic analyses and transform outcomes. For community projects, research, healthcare and policy initiatives, the faces around the table must be diversified, but so must the analytic gaze that is brought to bear on the process. By turning the gaze on the dominant group, rather than on the Other’s points of difference and by paying attention to the intricacies of engagement, we might forge new ways to speak and to be.
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