Hidden Bodies & the Representation of Breast Cancer

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This essay argues that the women with breast cancer face competing demands for visibility and invisibility. Although breast cancer has a long history, the disease and the women who have suffered from it have been concealed by the traditional medical model until the past half-century. Since then, activists have made breast cancer a prominent social cause. This struggle for visibility partially overcame the concealment of the disease. However, it has also reproduced the invisibility of breast cancer by substituting pink products for signs of the disease and by failing to overcome the social pressures that dictate how women cope with the effects of treatment.

Women with breast cancer face contradictory demands; they must simultaneously struggle to be visible and to be invisible. Until recently, women’s bodies and diseases affecting them received little public attention. Doctors treated the female body as an inferior variation on the male body or ignored it entirely. When treated, women were frequently denied information about their health and given little control over their treatment (Olson, 2002). Activists working to correct this inequity have done much to improve treatment by making the female body visible and asserting women’s right to determine their own treatment. They challenged the traditional medical model, which takes a paternalistic approach to treatment and which has, until the past half-century, marginalized women’s health concerns (Sherwin, 1992). However, for many, suffering from breast cancer and surviving breast cancer means trying to appear normal. The struggle for normalcy often begins as soon as the disease is detected, intensifies as treatment becomes more aggressive, and continues long after the disease is cured.

The women’s health movement is carried out on multiple fronts and is largely defined by its rejection of the longstanding practice of medical paternalism. As Wolf explains, until the 1960s and 70s, this was paternalism in a literal sense. It was “the physician dominating and deciding as a father would” (Wolf, 1996, p. 11). Some of the most significant progress in women’s health as a social cause has come from breast cancer activism. It set records for government spending, initiated
many new programs focused on disease research, transformed cause-related marketing, and continues to be an extremely powerful social movement. It is no exaggeration to say that breast cancer is one of the most prominent diseases, if not the most prominent, in the social consciousness. The pink ribbon is ubiquitous, appearing on countless products; it symbolizes the progress women’s health activism has made over the past century. Nevertheless, the progress conceals the fact that the affected bodies are nearly as invisible as they were when breast cancer could not be discussed openly. With the efforts to conceal the disease’s effects and the proliferation of pink products, the only thing that does not visibly bear the marks of breast cancer are the bodies affected by it.

This essay will argue that women with breast cancer, and breast cancer activism in general, are caught between the contradictory pulls toward visibility and invisibility. In the past, the invisibility was primarily the result of how the disease was treated by medical practitioners and by society as a whole. It was hidden by cultures that did not talk openly about women’s health issues and that restricted women’s control over their own healthcare. Although the traditional medical model and the patriarchal style of treatment that it encourages has been partially overcome as activists have made breast cancer and other women’s health concerns more visible, women still face significant challenges. Despite the high visibility of the disease as a social cause, it seems that the social values that encouraged invisibility remain; even as pink products dominate store shelves, women suffering from the disease are still under intense pressure to hide any signs of it.

The struggle between visibility and invisibility persists on both a personal and a social level. For individuals, it means choosing between physical reconstruction or facing social pressures toward conformity. For organizations, it means choosing between a marketing-based approach to activism that conceals the disease even as it expands funding for research and the less popular, but far more radical, approach of challenging the social conventions that continue to constrain how women cope with the effects of the disease. This ongoing struggle indicates that the priority for breast cancer activists should be making another progressive step forward, by distancing themselves from the symbols of breast cancer marketing and making more direct attempts to challenge the social pressures that continue to conceal the disease.

Some diseases are more embedded in cultural meaning than others (Conrad, 2010), but the pressures to conceal disease are not unique to breast cancer, nor are they unique to women’s health. Others who undergo diseases that affect parts of the body that are culturally significant or that are associated with deviance, such as men who suffer from testicular cancer or people who suffer from AIDS, face similar
pressures to raise awareness for research and to hide the effects of the disease. This essay’s focus on breast cancer should not imply that it is the only disease that is associated with strong social pressures or that it is alone in producing a struggle between visibility and invisibility. What makes breast cancer worth special attention is the constellation of factors that produce the struggle over visibility—the debate over the source of the disease, women’s struggle to overcome the traditional medical model, and the association of breasts with femininity—and the extent to which activism has both overcome and reproduced the concealment of the disease.

The first part of this essay will look at the debate over the source of breast cancer, which is divided between those who attribute the disease to external sources and those who argue that it is internal, arising from the body itself. The question of which group is right is one that only medical research can answer, yet the interalist position is problematic from a social science standpoint because the claim that breast cancer has an internal source helps to legitimize discourses that present women’s bodies as defective and in need of the kind of care recommended by the traditional medical model. The second part briefly discusses the historical marginalization of women by the traditional medical model. Breast cancer was a hidden disease for centuries because of the ignorance of women’s medical concerns, fears of cancer, and fears of the morally corrupting effects of the female body. The third section shows that social pressures force women suffering from breast and those who have been cured to hide their bodies. This creates the paradox that once one has suffered from this paradigmatic woman’s disease, one loses the socially valued signs of femininity. This is one of the greatest challenges for breast cancer activism. The final part of the essay discusses prevalence pink ribbons and pink products and argues that these have helped to hide breast cancer by substituting these happy and uncontroversial symbols for anything that evokes the disease or its effects. Only by shifting the focus of activism toward countering the social pressures that conceal the disease can the struggle between visibility and invisibility be completely overcome.

The Enemy Within

War metaphors permeate the disease rhetoric and create the sense that women’s bodies are battlefields (Lerner, 1998, 2001). These metaphors are so common that it is difficult to speak about disease without using the language of conflict. Nevertheless, there is an important difference between the war metaphors as they describe the body with breast cancer and as they are used to discuss other diseases. In most other ailments, the battle lines dividing the person from the disease are clear and the nature of the combatants is well defined. However, this
is not the case for breast cancer because its source is contested. Although some cases of breast cancer are clearly traceable to genetics, the cause of the majority of cases remains open to debate. The lack of certainty about the source of breast cancer makes it an unusual type of risk. The prevalence of risk is a theme of contemporary social theory, but it is usually conceived as an outside risk that threatens a healthy body from outside (Beck, 1992; Dunant, 1996; Franklin, 1998; Giddens, 1987). This is true even when risk is created by disease. Epidemic diseases manifest themselves internally, but they tend to be closely associated with external threats like infected animals and contaminated environments (Bollet, 2004; Crawford, 2007; Turner, 2008). Such diseases are outsiders that invade the body and disrupt its natural functioning; they show the body’s vulnerability, but do not imply that the body is essentially flawed.

Many writers and activists describe breast cancer as an external threat by linking cancer to environmental causes (Batt, 1994; McCormick, 2009; Mitchell, 2006; Sherman, 2000). In doing so, they present an empowering view of the body. For these externalists, the body is a safe space that must be protected against harmful foreign materials. It can resist disease if environmental causes are eliminated or if the body is strengthened and transformed into an impermeable defensive barrier. Although a disease may ultimately affect the body, the initial space of battle is outside the body. If this battle is won, there is no need to prepare the body itself for war and certainly no need to attack parts of the body in order to eliminate the disease. From this perspective, the fight is between the body and an outside entity, with the body playing an active role in its own preservation. Taking an externalist view also weakens the sense of inevitability attached to the disease. It does not imply an essential connection between being a woman and being susceptible to breast cancer, as the elimination of environmental causes of cancer would mean that the body would not contract the disease.

Although externalism has many adherents, most scientific and popular accounts of breast cancer describe it as an internal disease (Henderson, 1999, Williams, 1998, p. 116). Indeed, the possibility of external causation is rarely considered by the popular media (Brown, 2001). The internalist view has been popular for at least two centuries, although the nature of the internal cause has changed. In the nineteenth century, cancer was blamed on insufficient passion (Lupton, 1998, p. 92; Sontag, 2001, p. 20). As medical science developed, the search for the disease’s source and for its cure retained an inward focus (Wilson, 1998, p. 70). Contemporary research usually characterizes breast cancer in terms of mutating cells that transform the body’s own biological material into a threat to its existence. The lack of agency implied by any variety of the internalist view makes the body seem uncontrollable. It also divides
the body between the parts that are reliable and those that are dysfunctional or potentially dysfunctional.

The internalist view has profound implications for theorizing on the body with breast cancer, as it means that the body is not only a battlefield but also an attacker. The body must have external aid that can intervene and help defeat the cancer. What sets internalism about breast cancer apart from an internalist view of other cancers is how perfectly it fits with the still popular ideology of the female body as uncontrollable and irrational. Women’s bodies are commonly described as closer to the earth and biological processes, and therefore as being less rational (Grosz, 1994; Martin, 2001, p. 4). This image of the female body has become an indelible mark of representations of women and it fits with the traditional image of women being victims of uncontrollable bodies (Livia, 2003, p. 144). These sorts of representations make the body seem irrationally autonomous and thus legitimize attempts to regulate the body without the woman’s consent. If the attack comes from within the body, from defective organs or a breakdown in their normal functioning, then the best solution seems to be replacing the defective organs with more reliable prosthetics that rationalize the irrational female body. Thus, the history of breast cancer treatment has been one of external control of the disease and of removing body parts without regard for how the women suffering from the disease wish to be treated. The internalist view of breast cancer may indeed be the correct one from a medical standpoint, but problems arise when this view of the body informs the discourse about breast cancer—when women are treated as though their bodies are faulty, uncontrollable, and in need of paternalistic help. As the next section will show, this is the view that has dominated breast cancer treatment and treatment of women’s health in general. It also plays a role in generating the social pressures against displaying signs of the disease’s effects.

The History of Silence

It seems problematic to describe a disease associated with women in terms of war, as war is an activity that many societies define as essentially masculine. The military culture privileges masculine values to the extent that it can be misogynistic (Benedict, 2010). Traditionally, women have not only been excluded from participating in wars, but also treated as objects to be taken as prizes. Nevertheless, the war metaphor turns out to be apt when one considers the way treatment of the disease has taken place for much of history. Women have been excluded from the fight for their own health and objectified by the kinds of treatment shaped by the traditional medical model. Breast cancer is among the oldest diseases that continues to affect people, and for much of recorded
history women suffering from the disease have been ignored or treated as bodies without agency (Olson 2002).

Breast cancer’s past invisibility had much to do with two longstanding fears. Cancer of any type was mysterious and terrifying in the time when it was poorly understood. Even openly using the word ‘cancer’ was avoided until the twentieth century (Patterson, 1987, p. 30). The second fear was of women’s bodies. Women’s bodies have long been considered a source of moral corruption and were consequently ignored by medical researchers, who were more interested in the male body. Until the 17th century, medical discourses treated the female body as an imperfect variant of the male body (Laqueur, 1990). During this time, the only perceived difference between women’s reproductive organs and men’s was that they were interior rather than exterior (Duroche, 1990, Laqueur, 1987, p. 2). As medical science progressed, women’s bodies were distinguished, but usually for the sake of showing their inferiority. Various metrics were devised to measure women’s bodies and these actually reinforced their invisibility by misrepresenting them (Gould, 1996). The research performed ensured that they would not be understood as anything other than as confirmation of the superiority of the male body. Even now, at a time of increasing gender equality, women are used as weapons of interrogation and humiliation in the war on terror, a clear indication that the female body is still widely regarded as potentially dangerous (Oliver, 2008, 2010).

Fear of women’s bodies kept breast cancer debates hidden well into the 20th century. The shortage of information about breast health before the 1940s can be explained by the fact that this body part could not be discussed or represented in public forums (Lerner, 2001, p. 56-8). During the post-war period, representations of the breasts and women being examined became far more common. However, the information was largely restricted to the doctors themselves; women remained patients who were told little aside from self-examination procedures. Restrictions on information prevented women from receiving adequate information about their treatment options and about coping with the disease. Without information, women facing treatment had little choice but to accept a doctor or a husband’s decision (Gamarnikow, 1978). This paternalistic treatment was common for women suffering from other diseases as well (Wolf, 1996, p. 11), yet, as Rosenbaum explains, the treatment of breast cancer was especially sensitive given the part of the body affected:

This emphasis on silence reflects both the stigma of having a potentially fatal disease and of having an illness whose treatment involves the alteration of such a value-laden body part. Hence, women with breast cancer are confronted with the implicit societal
rules that they should control where, how, and to whom they speak about their illness (Rosenbaum & Roos, 2002, p. 155).

There were some early initiatives to promote breast cancer awareness, such as the activities of the Women’s Field Army in the 1930s, but women generally had few opportunities to discuss the disease amongst themselves. Furthermore, ethnic and class differences played a role in making certain groups affected by breast cancer more hidden than others. Women who could not afford checkups or treatment had difficulties obtaining medical care. They were, and continue to be, under represented by the breast cancer activist organizations, which are primarily composed of upper and middle class white women (Lerner, 2001, p. 47). Nevertheless, regardless of ethnicity or class, the restrictions on communication about breast cancer were produced by the same kinds of social pressures and the persistence of the traditional medical model.

Terese Lasser reports that hospitals and doctors resisted her attempts to speak with women who had breast cancer during the 1950s (Klawiter, 2008). She formed the support group Reach to Recovery in order to create a context in which the disease could be discussed. Many other women have taken similar grassroots actions. Over the past three decades, support groups have become more prevalent and more inclusive. They now allow women undergoing treatment and survivors to break their silence, at least when speaking to each other. New communications technologies like the internet have made these groups even more popular and inclusive (Pitts, 2004). These forums remain limited because they only reach those who actively seek them. However, activists who work for more equitable treatment use support groups as the starting place for direct action to generate awareness. They have created a private discourse and then used this to take the disease into the public sphere. Early in the breast cancer movement, the necessity of operating outside the system turned out to be a strength, as it allowed women affected by the disease to retain control of the breast cancer social movement and to make it a political cause.

As this brief history shows, breast cancer has traditionally been a hidden disease. Its invisibility drove women to seek support from each other and to form associations that could serve as the basis for organizing and taking action to improve treatment and to increase public awareness. Breast cancer activism of the 1970s and 80s was a struggle for visibility, both of the disease and of women as agents capable of taking part in their own treatment. Batt links the rise in activism to the growing awareness that women have a right to determine the treatment of their own bodies. "Underneath the conflict over the best way to control breast cancer is a more fundamental difference of opinion. It has to do with how we, as women, can best assume control of our bodies and our lives"
The breast cancer movement is therefore part of the larger struggle against the traditional medical model—a struggle that has been waged on many fronts in addition to breast cancer activism (Morgen, 2002). It was also linked to the newfound concern for men and women who were undergoing medical treatment and medical testing, which informed the development of bioethics in the 60s and 70s (Wolf, 1996, p. 10). These forces collectively undermined the traditional medical model, but as the next section will show, the victory for breast cancer activism was incomplete. It has been unable to overcome intense social pressures to conceal any physical manifestations of the disease’s effects on the body.

Attacking & Repairing the Body

The medical and social attitudes toward breast cancer are paradoxical, as they simultaneously legitimize disfiguring surgeries that remove women’s breasts and pressure those women to adhere to an essentialist standard of how women should look. The mastectomy has gone through many variations, including radical and super radical variants; all are extremely destructive to the body and to the psyche of the women who must endure them. Some argue that radical surgeries that damage the body may not deserve to be called cures because they only replace one kind of physical damage with a less serious, but still life-altering destruction of body parts (Shinder, 1972). Many women who undergo radical mastectomies not only lose their breasts but sometimes also limbs, chest muscles, parts of the stomach, the shoulder, and other organs (Lerner, 2001, p. 69). This raises the question of why these kinds of treatments were ever deemed appropriate. Enthusiasm for Halsted’s radical mastectomy, which removes the entire breast and pectoral muscle, was driven by the desire to make medicine into a true science (King, 2008, p. 23). This connection between the scientific discourse of the nineteenth century and the mechanistic view of the body makes it tempting to argue that extreme treatments are an expression of a new understanding of the body as a thing composed of distinct parts. Indeed, such prominent scholars as Michel Foucault and Erving Goffman have found links between the changing discourse about the body and the treatment of the body as though it were a machine with replaceable parts (Foucault, 2003; Goffman, 1961).

There is some affinity between the conception of the body as a machine and the treatment of breast cancer. The body in contemporary social theory is alterable; it can be constructed and reconstructed. It is often described as something intrinsically malleable, lacking any essential physical borders (Bauman, 2001; Deleuze, 1985; Giddens, 1991; Zylinska, 2005). From this viewpoint, there is nothing unnatural about amputation and prosthetics, yet it is striking that breasts were
considered removable parts long before the nineteenth century. At least as far back as the Greeks, there is evidence of doctors treating them as unnecessary parts, despite the prevalence of essentialist views of the body as an indivisible whole. Galen, one of the first to write about the disease, partially abandoned his holistic view of illness by calling the breast a removable part (King, 2008, p. 16). He considered cancer a sign of unbalanced humors, and therefore a systemic disease, but still recommended removing the breast when the tumor is visible because this is where the larger problem of unbalance manifests itself (King, 2008, p. 16). As far back as historical records show evidence of breast cancer, they provide reports of surgeries to remove large sections of the body in an attempt to destroy the cancer (Lerner, 2002; Martensen, 1994; Olson, 2002).

The long history of breast removal and treating the female body as an object without agency show that extreme surgery is more than just the expression of the modern discourse about the body and the replaceability of its parts. It is also linked to the idea of the female body as a defective male body or as internally unbalanced. Thus, this narrative excuses the removal of distinctly feminine body parts. Discussion of the disease in medical literature make this explicit. As Lerner explains:

> Multiple articles on breast cancer in the medical literature thus characterized the aging female breast as expendable. The breast, as described by one surgeon, was a "nonvital and functionless gland." New York's Roald Grant termed the breast "one of the most dispensable parts of the body" (Lerner, 2001, p. 89).

During the 1970s, many women who wrote about their experiences with breast cancer criticized radical surgeries and advised others to seek other treatment options or to resist these at all costs (King, 2008, p. 10). Activists encouraged women to maintain control of their bodies by deciding what treatment they would receive. The medical value of this advice was later confirmed by studies showing that radical surgeries were no more effective than more moderate ones that only removed the breast or the tumor. Extreme treatments like the radical mastectomy seem to have no greater chance of curing a person than more moderate surgeries that do not have to reshape the body to the same degree (Batt, 1994, p. 61, also see McCormick, 2009). Over the past three decades, moderate surgeries have become more popular and these have reduced the extent of the physical damage done in removing tumors. Surgeries, chemotherapy, and other cancer treatments still leave marks on the body that survivors must cope with, but the marks are less pronounced than they once were. Nevertheless, despite the reduced
damage of treatment, women face the same pressures to modify themselves in order to appear unaffected.

As one of the most socially significant marks of femininity, there is strong pressure to have breasts that match the ideal form. According to some researchers, humans evolved into a species more interested in vision than in the other senses and this made breasts an important indication of whether women were able to reproduce (Olson, 2002, p. 109). Thus, there are grounds for arguing that breast obsession is ‘natural’. Nevertheless, whatever the source of interest in them, their status is changed as they become the objects of social significance. They are symbols of femininity and beauty; the marks of being a woman (Olson, 2002, p. 110-111). Olson argues that the breast obsession and the identification of breasts with femininity are products of the popular culture of the 1950s that has continued to the present. This view is supported by constructivist studies of the changing standards of female beauty, which reveal that the breasts have become much more than just a sign of reproductive capacity (Gimlin, 2002).

Women face immense pressure to maintain their breasts according to a certain, culturally determined ideal (Buchwald, 1993; Dworkin, 1994). Breast augmentation is one of the most popular cosmetic surgeries because of feelings of inadequacy (Ott, 2002, p. 188). Although all women are vulnerable to these feelings, those who have lost a breast are particularly vulnerable to it, as they feel defeminized by the experience (Zalon & Block, 1978). Between 1965 and 2000, around 700,000 women had reconstructive surgery to repair lost breasts (Olson, 2002). There are medical, emotional, and practical reasons for undergoing reconstruction. The damage done removing the cancer can make even simple tasks like finding clothes that fit difficult (Altman, 1996). Prosthesis and surgical reconstruction can help to repair the emotional damage of having the disease and give survivors a renewed sense of wholeness. However, many feel forced into reconstructive surgery by those who want them to reinforce stereotypes (Rosenbaum & Roos, 2002). The same pressures that encourage cosmetic breast surgeries push cancer survivors of breast cancer toward masking the effects of the disease.

Some criticize reconstruction and prosthetics as inauthentic. Audre Lorde compares them to masks (Lorde, 1980, p. 16). Iris Marion Young sees them as a concession to a patriarchal image of beauty (Young, 1990, p. 189-209). There may also be more tangible consequences. As Batt points out, prosthetics and wigs can be expensive and take more money from women who must already deal with the intense financial strain of treatment (Batt, 1994). Even worse, covering the evidence of cancer means covering the signs that could connect affected women. With each afflicted body covered in a shroud of
normalcy, there is no way for women to see that others are suffering from the same symptoms and associating with them. This can interrupt the formation of the communications networks that are integral to activism (Freeman, 1999). There is something empowering about affirming the identity and using it as a starting point for action. Artists and activists have used the image of the scarred body, unhidden by prosthetics as one way of protesting against “the oppressive representational practices that make everyday erotic spectacles of women’s breasts while erasing the fact of the amputated breast.” (Garland-Thompson, 2006, p. 263). Opportunities for awareness are lost if the signs of the disease are always considered offensive and hidden from public view.

It would be misguided to blame women who have undergone the pain of disease for the ways they choose to cope with treatment. This is especially true when the decision to wear prosthetics or undergo reconstruction reflects an autonomous decision, since personal control over one’s own body is the basis for the critique of the way breast cancer has been treated in the past. To the extent that reconstruction or wearing prosthetics is not coerced, it should be considered a justifiable personal decision. The problem is that it is extremely difficult to discern voluntary action from subtle coercion within the hyper-genderized societies we live in. Critics are right to draw attention to the way that these procedures depend on the pressure to have a socially acceptable appearance, one that does not remind others of the body’s vulnerability. Products designed to restore the body’s appearance rely heavily on an essentialist notion of how the body should appear and promise to return the diseased body to this natural state, restoring its femininity and completeness. Gardner finds that “all inventors of breast forms, whether their products were designed for cosmetic or medical purpose, stressed the importance of natural appearance in an artificial form” (Gardner, 2002, p. 103). She goes on to say that “both aesthetic and medical breast forms relied on similar popular conceptions of femaleness, womanhood, and ‘wholeness’” (Gardner, 2002, p. 103). The ideal is not simply a criterion of judgment, it is also something that women are supposed to aspire to. The contemporary understanding of the body as something malleable, that can and should be changed to approximate an ideal form, encourages reconstruction and is deeply anti-essentialist, as it challenges notions of physical completeness. Nevertheless, when it comes to repairing the damage done by breast cancer, the narrative of reconstructibility is linked to the essentialist view that only one kind of body can be the true feminine form.

The paradox of breast cancer treatment is that breasts are considered removable while women still face enormous pressures to maintain them, even after surgery. If they fail to do so, then they lose the
socially valued marks of femininity. Infection by a disease associated with a particular group is usually a sign of membership in the risk group, yet suffering from breast cancer means the destruction of the sings of femininity that are used to categorize women and to include them in the risk group. The disease attacks the identity it is associated with, assaulting one of the most socially valued signs of femininity and threatening to destroy it. Homosexuals can be infected with AIDS without losing membership in the perceived risk group; others may even incorrectly see infection as a mark of homosexuality that proves group membership. By contrast, women who contract breast cancer may feel that they lose their status as women, even as they experience a rebellion of the body that is portrayed as the feminine experience of the body. Breast cancer distances them from the essentialist identity that the disease is associated with. This is only a paradox because of the way the bodies harmed by breast cancer are removed from public view and represented as being female only when they can hide the evidence of the disease. They are increasingly not even a visible part of the breast cancer movement because they are often hidden by the happy images that have been created to appeal to consumers.

Activism Leaving the Body

Breast cancer has gone from being a private disease—one to be hidden from public view and rarely discussed—to one of the most prominent health-related social causes. Activists have initiated many changes to the US government health policy, including the first stamps to raise money for disease research, new medical research programs run by the Department of Defense, and an unprecedented level of spending by the National Health Institutes. By relocating the medical discourse from the doctor’s office to the public realm, activists introduced the possibility of taking greater personal control over treatment and research. The transformation was initiated by popular action on multiple levels and it reflects the widespread dissatisfaction with the way women’s health has traditionally been marginalized. The revolution in women’s healthcare was produced by many actors working independently or in groups with few associational links, some of them ideologically divided, but all contributing to a common goal (Auerbach, 1995). The heterogeneity of the early movements in breast cancer activism was a major strength, as it ensured that women would have multiple opportunities to organize.

What started as a radical movement lacking institutional hierarchy became dominated by a few major charities and corporate partners during the 1990s. These organizations have been the leaders in presenting a happier image of the disease. The clearest sign of this is the disease’s close association with cause related marketing (Ehrenreich,
Hundreds of pink products link the disease to corporate sponsors, making them some of the most visible representatives of the breast cancer movement. For companies, there is much to gain from taking a prominent role in raising money for disease research. They improve their image and can usually make a profit, even when they donate some of their earnings (Singer, 2005). They also face very little risk or backlash, now that breast cancer has become a socially acceptable topic. As Cindy Pearson puts it, "breast cancer provides a way of doing something for women, without being feminist" (Cited from Ehrenreich 2001). Nevertheless, many activists see disease marketing as a threat to popular control over the breast cancer social movement (Twombly, 2004).

Cause-related marketing has a dualistic character. It has helped to fund breast cancer research programs and it has spread awareness of the disease in a way that would have been impossible through other means. Yet it has also done much to keep the women affected by breast cancer as invisible as they were decades ago. It is striking how common pink products are and how little they directly contribute to the understanding of the disease or the experience of it. As Nickel and Eikenberry argue, they commodify the disease experience and create the impression that resistance is a matter of buying the right products (Nickel & Eikenberry, 2009). Breast cancer is a safe cause for companies to become associated with because it can be advertised without invoking any signs that bring the disease to mind. The ubiquitous pink ribbon stands for the disease, leaving any real signs of it safely hidden. With the disease overlooked even in the discourse that is supposed to be maintaining its prominence, it has been easy for alternate images of the breast cancer experience—one based on extreme positivity and hopefulness to replace more realistic assessments of the disease and the social pressures associated with it. In recent years, this has become one of the most prominent complaints voiced by activists.

Batt argues that "cancer charities hold up the Rosy Filter to breast cancer" (Batt, 1994, p. 233). They create the impression that once cured, life resumes as it was before the disease. This impression is certainly false, as it overlooks the ongoing emotional costs and the issues of body transformation discussed in the previous section. Decisions about how to cope with the stress and whether to repair the damage done to the body must still be made. Even more problematic is the image of breast cancer as a mode of self-fulfillment. There have been such intensive efforts to normalize the disease and portray the experience in a positive way that it can actually take on the appearance of being a way of achieving happiness (King, 2008, p. 104). King concludes that the construction of a happy disease experience leads to complacency and acceptance of the disease, when activism is the more appropriate response (King, 2008, p. 104-105). It is difficult to say whether this is true,
but it is at least clear that the character of activism has changed as the representation of the disease has. Instead of political action, the most popular activities are now apolitical charity walks that are usually heavily dominated by corporate sponsors and pink ribbon products.

The use of the color pink is one of the most often criticized elements of the breast cancer symbolism, as this not only helps to hide affected body but also replaces it with a color that evokes vulnerability and traditional female roles. Barbara Ehrenreich argues that the “cult of pink kitsch” has infantilized what was previously a central part of the feminist movement (Ehrenreich, 2001). The prevalence of pink indicates the lost radicalism and return to a traditional conception of women and actually helps to prevent them from taking meaningful action. King sees the pink ribbon as a sign of innocence, but thinks that part of this innocence is ignorance and a refusal to know, which could really be antithetical to political engagement (King, 2008, p. 43). Along with the ribbons and the positivity about the disease experience, the prominence of the color pink encourages a superficial understanding of the disease. It privileges friendly imagery over real representations of the disease or information about it. Furthermore, the prevalence of pink conceals the popular activism that brought breast cancer out of obscurity and made women’s health issues more prominent. Taken together, the various symbols normalize breast cancer and sacrifice the potential of using health activism for purposes more radical than raising more funding for research.

The critical assessments of breast cancer marketing are right to call attention to the many problems associated with marking based approach to activism, but it is important to bear in mind that the commodification is not entirely negative. The breast cancer movement has lost its former radicalism, but it has also gained from this loss as the disease’s happier image has made it less stigmatized than it once was. The lesson that should be drawn from this is not that the current course of activism should be abandoned, but that it must stop reproducing the struggle between visibility and invisibility that has characterized breast cancer throughout history. Activists have made enormous progress drawing public attention to breast cancer and to women’s health in general. However, the problem now is that even with the disease’s new prominence, it is largely seen in terms of products, pink ribbons, and an idealized view of what women’s bodies should look like. The past ignorance of the female body and readiness to remove any parts that appeared dysfunctional has been replaced with widespread attention to women’s health and new sensitivity to physical and emotional needs. Nevertheless, this attention is often directed away from where it is most needed. Survivors to face pressure that they will appear abnormal unless the signs of the disease are erased.
CONCLUSION

As a disease linked to an essentialist view of the female body, breast cancer is often hidden by the stereotypical signs of femininity. This association makes it vulnerable to this cooptation; imagining the disease as the women’s disease makes it easily linked with all symbols of femininity, even those that, like the color pink, seem contrary to the spirit of activism that has been characteristic of the breast cancer social movement. The use of the color pink and the pink ribbon as marketing tools, has deepened this association and has dissociated the signs of breast cancer from the body, thereby maintaining breast cancer’s invisibility even as it has become a popular social cause. The challenge activists face is continuing to spread awareness about the disease and building on successful research funding programs, yet at the same time recognizing that the disease will remain invisible and survivors will continue to feel intense pressure to hide their bodies until activists can attack the social pressures that continue to hide conceal the disease and its effects.

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