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Nadine Ehlers

University of Wollongong, nadinee@uow.edu.au

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Abstract

This paper argues that breast cancer prognosis potentially produces a circular dialectic in which a) the subject is compelled to perceive the body as vulnerable and separate (alien) to the self, and the treatments required make the body more vulnerable, more alien and b) this is held in tension with the fact that the very alienation and heightened vulnerability of the body in breast cancer treatment is productive; it collapses the boundaries through which the body and self are understood, often demands a conscious intimacy of/with the body, and points to critical enactments and understandings of embodied subjectivity. I use the concept of dialectics here in a broad sense then, to mark the interaction of apparently conflicting states. While vulnerability is generally thought of as a somato-ontology to be avoided, and as a constraining, negative mode of being, through a shift in perspective it also appears as an enabling state. I argue that vulnerability might be seen as a relational ontology between flesh and self that is both restrictive and generative, where the restriction itself can be generative. Understanding vulnerability in this way might engender the critical politicization of risk and function as the place from which a radically altered/re-conceived politics proceeds. Such a politics would be ethico-political work around the issue of cancer. It would, perhaps, function ultimately as an ethics of vulnerability, foregrounding critical responsibility towards oneself, one's life, the life of others, and the life of the community.

Keywords

vulnerability, prognosis, cancer, dialectics, breast, body

Disciplines

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The Dialectics of Vulnerability: Breast Cancer and the Body in Prognosis

Nadine Ehlers
University of Wollongong

ABSTRACT: This essay argues that breast cancer prognosis potentially produces a dialectic in which the subject is compelled to perceive the body as vulnerable and separate (alien) to the self and that the treatments required make the body more vulnerable and more alien, and that this is held in tension with the fact that the very alienation and heightened vulnerability of the body in breast cancer treatment are productive. Such alienation and vulnerability collapse the boundaries through which the body and self are understood, often demand a conscious intimacy of/with the body, and point to critical enactments and understandings of embodied subjectivity.

“I have had to face the fact that I am totally vulnerable, able to die, to feel terror, to be terrorized.”

—Jo Spence¹

The body in cancer prognosis is a vulnerable body. The prognosis—understood as the projected likely outcome or course of disease—confirms this body as *at risk* and operates as a foretelling, a foreboding of what is to come: it forecasts the future, opens the body/self up to certain particularities of medical intervention, and determines the course of treatment. At the level of individual experience, to live in the folds of prognosis can be said to produce a sense of vulnerability stemming from an interruption to generally accepted notions

1. Jo Spence, *Putting Myself in the Picture: A Political, Personal and Photographic Autobiography* (London: Camden Press, 1986).

of corporeal mastery, wholeness, and integrity.² For, while in dominant Cartesian narratives the sovereignty of self supposedly follows from a sovereignty of corpus, to live in prognosis generally means that one's body is experienced as uncontrolled, or out of one's control, that surgery might be required and therefore bodily wholeness, which underscores notions of bodily integrity, may be compromised through cutting off/out parts. But the prognosis is only always a predictive abstraction: it anticipates the probability of susceptibility to disease, the likelihood of death. The prognosis never poses a surety, and this, in itself, means that to live in prognosis is not only to be vulnerable, but also to be actively made subject to precarity: the body's contingency and potentiality—in terms of illness and health, normality and abnormality, capacity and incapacity, mortality and morbidity—become the inalienable stuff of everyday life. To live in prognosis is thus to live in a state of vulnerability—to live, ultimately, with certain uncertainty.

While cancer prognosis works in broad terms to produce these states, my aim in this essay is to think through various forms of vulnerability represented by and initiated through the particularities of living in prognosis following breast cancer diagnosis. Many of these particularities arise due to the gender-laden meanings associated with breast cancer, such that “[w]hile other cancers and other diseases are undoubtedly as significant in terms of their ultimate outcomes, a contemporary diagnosis of breast cancer is also saturated with murkier concerns about identity, body image, and self worth.”³ In her phenomenology of “breasted experience,” for instance, Iris Marion Young has noted the complex ways in which heteronormative culture compels an intimate linking between breasts and women's sense of self.⁴ And, while writers like Audre Lorde have challenged these heteronormative associations, the disease remains enmeshed with conceptualizations of women's identity and sexual-

2. Arthur Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: University of Chicago Press, 1995); Lisa Deidrich, “A Bioethics of Failure: Anti-heroic Cancer Narratives,” in *Ethics of the Body: Postconventional Challenges*, ed. Margrit Shildrick and Renata Mykitiuk (Cambridge, MA: MIT Press, 2005), pp. 135–152; Michael Bury, *Health and Illness* (Malden, MA: Polity Press, 2005); Kathy Charmaz, “The Body, Identity, and Self: Adapting to Impairment,” *Sociological Quarterly* 36:4 (1995): 657–680; Sarah Lochlann Jain, “Living in Prognosis: Toward an Elegiac Politics,” *Representations* 98 (2007): 77–92.

3. Alexandra Leigh McCarthy, “A Rebellious Distemper: A Foucaultian History of Breast Cancer to 1900” (Ph.D. diss., Queensland University of Technology, 2005), p. 12.

4. Iris Marion Young, *Throwing Like a Girl and Other Essays in Feminist Philosophy and Social Theory* (Bloomington: Indiana University Press, 1990), p. 189.

ity, precisely because of the broader centrality of breasts to social understandings of femininity.⁵

The scholarship dealing with these questions of embodiment, identity, and breast cancer is vast, to say the least; it traverses studies in the areas of health and nursing,⁶ historical studies of the disease,⁷ studies of breast cancer activism,⁸ and a panoply of affective histories of breast cancer experience. While accounts such as these have provided complex ways for understanding breast cancer, they have not necessarily, nor explicitly, been attentive to the concept of *vulnerability*.⁹ Let me be careful here to stipulate that I am not suggesting that these accounts do not address corporeal vulnerability, but, rather, that they do not foreground vulnerability as a framework through which to think about embodiment as it relates to breast cancer. It is this idea that interests me in what follows.

Similarly, corporeal vulnerability is conspicuously absent in broader breast cancer culture. As Barbara Ehrenreich has so pow-

5. Audre Lorde, *The Cancer Journals* (San Francisco: Aunt Lute Books, 1980).

6. See, for instance, Dorothy H. Broom, "Reading Breast Cancer: Reflections on a Dangerous Intersection," *Health* 5:2 (2001): 249–268; Roanne Thomas-McLean, "Memories of Treatment: The Immediacy of Breast Cancer," *Qualitative Health Research* 14:5 (2004): 628–643; Jody Pelusi, "The Lived Experience of Surviving Breast Cancer," *Oncology Nursing Forum* 24:8 (1997): 1343–1353; Cathy Charles, Cristina Redko, Tim Whelan, Amiram Gafni, and Leonard Reyno, "Doing Nothing Is No Choice: Lay Constructions of Treatment Decision-Making Among Women with Early Stage Breast Cancer," *Sociology of Health and Illness* 20 (1998): 71–95; E. A. Crockford, I. M. Holloway, and J. M. Walker, "'Nurses' Perceptions of Patients' Feelings about Breast Surgery," *Journal of Advanced Nursing* 18:11 (1993): 1710–1718; Samantha Crompvoets, *Breast Cancer and the Postsurgical Body: Recovering the Self* (New York: Palgrave Macmillan, 2006); and Maria M. Arman and Arne A. Rehnsfeldt, "The Hidden Suffering among Breast Cancer Patients: A Qualitative Metasynthesis," *Qualitative Health Research* 13:4 (2003): 510–527.

7. Barron H. Lerner, *The Breast Cancer Wars: Fear, Hope, and the Pursuit of a Cure in Twentieth-Century America* (New York: Oxford University Press, 2001); Robert A. Aronowitz, *Unnatural History: Breast Cancer and American Society* (New York: Cambridge University Press, 2007); James S. Olson, *Bathsheba's Breast: Women, Cancer, and History* (Baltimore: Johns Hopkins University Press, 2005).

8. See Samantha King, *Pink Ribbons, Inc.: Breast Cancer and the Politics of Philanthropy* (Minneapolis: University of Minnesota Press, 2006); Maren Klawiter, *The Biopolitics of Breast Cancer: Cultures of Disease and Activism* (Minneapolis: University of Minnesota Press, 2008); and Gayle A. Sulick, *Pink Ribbon Blues: How Breast Cancer Culture Undermines Women's Health* (New York: Oxford University Press, 2010).

9. This is not to say that vulnerability has not been the focus of much academic work (see, for instance, the accounts I discuss below). As I go on to note, vulnerability has been theorized as a *concept*. However, *the lived reality of vulnerability* is not specifically addressed in either academic literature on breast cancer or in public campaigning around the disease. I am noting an empirical, rather than a conceptual, problem here.

erfully noted, the relentless “survivor narrative” that underscores breast cancer campaigning can be seen to eclipse vulnerability by reproducing a “mindless triumphalism . . . that denigrates the dead and the dying.”¹⁰ This rhetoric “offers . . . the benefits of spiritual upward mobility,” providing the opportunity for women to improve their lives through “becoming strong” and “surviving.” Such a narrative, however, situates the dead and the dying as having failed, Ehrenreich warns, in that they have failed to survive and, therefore, failed to have cancer improve their lives. What would it mean, instead, to contemplate embodied vulnerability, to take more seriously the permeability of bodily boundaries, and to grapple with the precarities of living in breast cancer prognosis?

In this essay, I do not aim to map out an empirical terrain of breast cancer experience; rather, I move toward new ways of thinking about vulnerability—specifically, as it might work or exist in relation to breast cancer treatment and to living inside the temporal and epistemological folds of breast cancer prognosis. In doing so, I hope to make a contribution to both breast cancer literature (and considerations for activism) and scholarship on embodied vulnerability. Most particularly, I want to suggest that breast cancer prognosis potentially produces a dialectic in which the subject is compelled to perceive the body as vulnerable and separate (alien) to the self and that the treatments required make the body more vulnerable and more alien, and that this is held in tension with the fact that the very alienation and heightened vulnerability of the body in breast cancer treatment are productive: they collapse the boundaries through which the body and self are understood, often demand a conscious intimacy of/with the body, and point to critical enactments and understandings of embodied subjectivity. I use the concept of *dialectics* here in a broad sense, then, to mark the interaction of seemingly conflicting states. While vulnerability is generally thought of as a bodily state of being—or what I am calling a *somato-ontology*—to be avoided and as a constraining, negative mode of being, through a shift in perspective, it also appears as an enabling state. I argue that vulnerability might instead be seen as a relational ontology between flesh and self that is both *restrictive* (limiting corporeal possibilities) and *generative* (creating new realities), where the restriction itself can generate new modalities of embodied selfhood, community, and politics.

In exploring these ideas, I am guided by feminist cultural studies

10. Barbara Ehrenreich, “Welcome to Cancerland: A Mammogram Leads to a Cult of Pink Kitsch,” *Harper’s*, November 2001, pp. 43–53, quote on p. 53.

and poststructuralist conceptualizations of embodiment as always-already formed in and through specific relations of power. Most particularly, this analysis is underscored by Foucauldian understandings of the body and subjectivity as inextricable, the body as an instrument and effect of power, and of medicine as “a power-knowledge that can be applied to both the body and the population, both the organism and biological processes, and . . . [as that which has] both disciplinary effects and regulatory effects.”¹¹ In this vein, medical treatment for breast cancer can be viewed as a disciplinary means of bringing subjects in line with particular regularizing and regulatory norms of health, and that which produces particular kinds of bodies and understandings of vulnerability, subjectivity, and relations of subjects to embodiment. In what follows, however, I look to a series of affective histories (or stories of living with cancer), namely by Ehrenreich,¹² Jackie Stacey,¹³ and Eve Kosofsky Sedgwick,¹⁴ and to the ethno-critical studies of Nina Hallowell,¹⁵ Sarah Lochlann Jain,¹⁶ Dorothy Broom and Anne Kavanagh,¹⁷ and Lenore Manderson¹⁸ to highlight that living in cancer prognosis often slips out of these dominant understandings, producing complicated relations to vulnerability and notions of body and self. While these accounts are heterogeneous, they are linked by a shared insistence that vulnerability be thought of not as a bodily state (a somato-ontology) to be simply abated or disciplined, but, rather, as that which is grappled with as a relational ontology: the (vulnerable) body is never separate from (one’s sense of) self, and an interactivity exists between body

11. Michel Foucault, “*Society Must Be Defended*”: *Lectures at the Collège de France, 1975–1976*, trans. David Macey, ed. Mauro Bertaini and Alessandro Fontana (New York: Picador, 2003), p. 252.

12. Ehrenreich, “Welcome to Cancerland” (above n. 10).

13. Jackie Stacey, *Teratologies: A Cultural Study of Cancer* (London: Routledge, 1997).

14. Eve Kosofsky Sedgwick, “Breast Cancer: An Adventure in Applied Deconstruction,” in *Feminist Theory and the Body: A Reader*, ed. Janet Price and Margrit Shildrick (New York: Routledge, 1999), pp. 153–156.

15. Nina Hallowell, “Reconstructing the Body or Reconstructing the Woman? Problems of Prophylactic Mastectomy for Hereditary Breast Cancer Risk,” in *Ideologies of Breast Cancer: Feminist Perspectives*, ed. Laura K. Potts (Basingstoke, UK: Macmillan Press Ltd, 2000), pp. 153–180.

16. Jain, “Living in Prognosis” (above, n. 2).

17. Dorothy Broom and Anne Kavanagh, “Embodied Risk: My Body, Myself?” *Social Science and Medicine* 46:3 (1997): 437–444.

18. Lenore Manderson, “Gender, Normality and the Post-surgical Body,” *Anthropology and Medicine* 6:3 (1999): 381–394.

and self. In calling on these accounts, the questions central to this essay are: What happens to the vulnerable body in breast cancer prognosis? What is it to live in a state of vulnerability initiated by the diagnosis of breast cancer and subsequent prognosis (what is restricted or disabled)? What are the potentialities of the body in breast cancer prognosis (what is produced or enabled)? To address these questions, I turn first to considering how vulnerability can be understood as a somato-ontology; in the second part of the essay, I move to a more specific focus on breast cancer and consider how vulnerability might be more productively understood as a relational ontology.

The Precarious Body: Vulnerability as Somato-Ontology

In a Foucauldian understanding, the body is a target of control, surveillance, and regulation. The body became a focal point or nexus for disciplinary power, according to Foucault, from the eighteenth century; through situating the body as an object of power/knowledge relations, various state apparatuses established norms of corporeal functioning and set boundaries between distinct “types” of bodies. The aim of disciplinary power has to been to produce politically and economically productive and useful subjects, and one of the primary means to achieve this has been by focusing on the health of the individual and the population. In *The Birth of the Clinic, Discipline and Punish, The History of Sexuality*, and the lectures published as *Society Must Be Defended*, Foucault identifies medicine as a key power/knowledge apparatus and institution of power that has been instrumental in constructing bodies as normal or abnormal and, consequently, as controlled or in need of control.¹⁹ Through his archaeology of medical perception in *The Birth of the Clinic*, Foucault argued that the medico-scientific gaze situates the body within a grid of intelligibility as an object to be analyzed, as an object of knowledge: “In anatomico-clinical experience, the medical eye must see the illness spread before it, horizontally and vertically in graded depth, as it penetrates into the body, as it advances into its bulk, as it circumvents or lifts its masses, as it descends into its depths.”²⁰ Here, the body can be “known” and regulated according to that

19. Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan Smith (New York: Vintage, 1994); *Discipline and Punish: The Birth of the Prison*, trans. A. M. Sheridan Smith (London: Penguin, 1991); *The History of Sexuality*, vol. 1: *The Will to Knowledge*, trans. R. Hurley (London: Penguin, 1998); “*Society Must Be Defended*” (above, n. 11).

20. Foucault, *The Birth of the Clinic* (above n. 19), p. 167.

knowing, with the aim being to “discipline sickness in the name of health.”²¹

As Margrit Shildrick notes, these ways of knowing are premised on a modernist discourse that “figure[s] the human body, or at least the white male body, as ideally closed and invulnerable.”²² In *A Body Worth Defending*, Ed Cohen follows this line of thought to argue that, from the late seventeenth century, the body is understood as individualized, monadic, and as a property of the self.²³ Further augmenting the mind/body or self/body dualism, this logic assumes that the “self *has* a body that it *defends*” and, simultaneously, that the body forms a “defensible boundary” between the self and the world.²⁴ The integrity of the subject, according to Cohen, can only be maintained through a boundary defense that defends against vulnerability. Vulnerability is taken to be a shortcoming—one that discursively positions the subject as weak or unfortunate—and as that which marks the subject as potentially beyond the normative standards of being, as they have been formulated within the medico-discursive model of health. This is not to say that vulnerability is denied; indeed, it is taken as a constitutive precondition of existence. Instead, “the ‘proper’ unfolding of human life, and the exercise of selfhood, is taken to overcome such dangers.”²⁵

Judith Butler echoes the notion that vulnerability is the very condition of embodiment: “in its surface and its depth, the body is a social phenomenon: it is exposed to others, vulnerable by definition.”²⁶ For Butler, this vulnerability stems from the reality that “the very persistence” of the body “depends upon social conditions and institutions, which means that in order to ‘be,’ in the sense of ‘persist,’ it must rely on what is outside itself.”²⁷ To be vulnerable, then, is to be exposed, both to others and to things or events beyond the individual’s control. But, precisely because this exposure is inextricable from existence, there are no invulnerable

21. Nikolas Rose, “Medicine, History, and the Present,” in *Reassessing Foucault: Power, Medicine and the Body*, ed. Colin Jones and Roy Porter (Abingdon, UK: Routledge, 1994), pp. 48–72, quote on p. 68.

22. Margrit Shildrick, “Becoming Vulnerable: Contagious Encounters and the Ethics of Risk,” *Journal of Medical Humanities* 21:4 (2000): 215–227, quote on p. 217.

23. Ed Cohen, *A Body Worth Defending: Immunity, Biopolitics, and the Apotheosis of the Modern Body* (Durham, NC: Duke University Press, 2009).

24. *Ibid.*, p. 75 (emphasis in original).

25. Shildrick, “Becoming Vulnerable” (above, n. 22), p. 217.

26. Judith Butler, *Frames of War: When Is Life Grievable?* (New York: Verso, 2009), p. 33.

27. *Ibid.*

bodies. If this is the case—if to live is to be vulnerable—cancer produces a very particular modality of vulnerability that is the product of both external and internal factors. Cancer may be caused from exposure to environmental toxicity and, as a phenomenon, it renders one dependent on social institutions—such as the clinic, the hospital, access to medical care and health insurance—in order to detect risk, mitigate vulnerability, and to treat the disease.²⁸ In these ways, the subject is made vulnerable to and by external forces. But cancer is also very much about risk or vulnerability that is seen to inhere in or be caused by the body/subject and, therefore, to be the product of internal factors.²⁹ It is these internal factors that, for the subject in breast cancer prognosis, most clearly register as a vulnerability to vital processes.

In each of these framings, corporeal vulnerability is understood as a somato-ontology. In using this term I refer simply to the fact that vulnerability has been configured as a bodily (*somato*) truth (*ontology*): a truth relating to and of the body, or a truth of the nature of bodily being. In this understanding, as I have outlined, the body is always-already physiologically vulnerable (to the world and in the face of precarity) simply by virtue of being alive. But paradoxically, as Shildrick has noted in *Embodying the Monster*, the very idea of an autonomous self is based on a series of exclusions, one of which is vulnerability, a state that she, Butler, and Cohen have argued is coextensive with existence. What I am calling the somato-ontology of vulnerability—this condition of being—indeed threatens the self and notions of self-containment: it is “characterised . . . as a nega-

28. On environmental toxicity, risk, and breast cancer, see Phaedra Carmen Pezzullo, *Toxic Tourism: Rhetorics of Travel, Pollution, and Environmental Justices* (Tuscaloosa: University of Alabama Press, 2007); Klawiter, *The Biopolitics of Breast Cancer* (above, n. 8); and Laura K. Potts, “An Epidemiology of Women’s Lives: The Environmental Risk of Breast Cancer,” *Critical Public Health* 14:2 (2004): 133–147.

29. Here, I am referring specifically to *embodied risks*, which are those risks presumed to be located in the bodies of individuals. Susceptibility to this form of risk is distinguished from *lifestyle risks*, which are supposedly produced by an individual’s actions. Both embodied and lifestyle risks, however, are about the internal functioning or mechanics of the body (even with lifestyle risks, the development of cancer depends on the body’s *response* to behavior that is deemed risky—for example, smoking) and are, as such, more about internality than exposure to external forces. On the distinctions among embodied, environmental, and lifestyle risks in relation to cancer, see Broom and Kavanagh, “Embodied Risk” (above, n. 17). My claim, as I go on to discuss, is that individuals (largely) and biomedical discourse frame cancer as an individualized disease caused by internal functioning. While there are, of course, external factors that cause cancer, these are often eclipsed—in individual understandings of the disease, in biomedical rhetoric, and in dominant forms of public campaigning around breast cancer.

tive attribute, a failure of self-protection, that opens the self to the potential of harm."³⁰ It is, then, inherent to existence, but nonetheless (or perhaps precisely because of this) to be defended against. In reference to health especially, the somato-ontology of vulnerability is disciplined, managed, and regulated in relation to medico-discursive knowledges that prescribe particular modes of embodiment and conceptualizations of health. Medicine thus becomes "a political intervention-technique with specific power effects,"³¹ and the body is objectively figured—and often subjectively understood—as that which can and must be governed. Importantly, the individual is called on to incorporate this relation to their bodies (this idea of vulnerability as a bodily state to be abated) and to regulate (and produce) themselves as particular kinds of subjects in the name of "health" and through specific medico-juridical techniques. As Elizabeth Grosz notes, "subjects thus produced are not simply the imposed results of alien, coercive forces";³² instead, subjects participate in these techniques of regulation through their active engagement with medical protocols and norms: because what medicine offers is "the possibility of vanquishing the sufferings of the flesh, or at least postponing them, through the instrumentalization of life by medical criteria and procedures."³³

Such participation is, in large part, compelled by a certain medical morality that has arisen around issues of health and illness, where the mitigation of vulnerability has increasingly come to be seen as an individual responsibility inter-articulated with a judg-

30. Margrit Shildrick, *Embodying the Monster: Encounters with the Vulnerable Self* (London: Sage Publications, 2002), p. 1. In this work, Shildrick offers a sustained examination of vulnerability in relation to the nonnormative "monstrous" body. In reference to my arguments here, two salient points emerge from her work: first, all bodies are always-already vulnerable, and this vulnerability is seen as negative and to be waged against in order to become an autonomous subject who is protected, clean, and proper; second, and simultaneously, vulnerability is the condition of our emergence and constitutive of the self—an idea that, as she says, "shatters the ideal of the self's clean and proper body" (p. 86). Acknowledging this paradox of vulnerability requires, she argues, that we pursue an ethics of risk. While I have taken up these ideas elsewhere, particularly the idea of an ethics of risk ("Risking Safety: Breast Cancer and the Body in Prognosis" *Journal of Medical Humanities*, forthcoming), due to space constraints I am unable to explore these arguments in any detail here.

31. Foucault, "Society Must Be Defended" (above, n. 11), p. 252.

32. Elizabeth Grosz, "Inscriptions and Body Maps: Representations and the Corporeal," in *Masculine/Feminine and Representation*, ed. Terry Threadgold and Anne Cranny-Francis (Sydney: Allen and Unwin, 1990), pp. 62–74, quote on p. 65.

33. Rose, "Medicine, History, and the Present," (above, n. 21), p. 68.

ment: vulnerability is seen, as Shidrick notes, as a “falling short”³⁴ that must be curtailed. Thus, to avoid the risk of breast cancer—one that is positioned as always-already potentially residing in the female body—the individual must “formulate life strategies, to seek to maximize their life chances, to take actions or refrain from actions in order to increase the quality of their lives, and to act prudently in relation to themselves and others.”³⁵ As Nancy Press, Jennifer Fishman, and Barbara Koenig have argued, for instance, women are advised to partake in vigilant breast monitoring (in the form of self-exams or mammography), to minimize their lifestyle risks or potential vulnerabilities through regulating their diet, reproductive behavior, stress, and exercise, to research and document their family history (and, if necessary, undergo genetic screening), and to keep up to date with the latest biomedical/scientific knowledge.³⁶ Only a brief survey of common slogans in international breast-cancer-awareness advertisements highlights this imperative for individual responsibility: “Protect yourself against breast cancer”; “Cancer: If it takes you too long to find it, it may be too late”; “It’s in your breast interest to have both”; “Unfortunately we can’t test everything for you”; “Don’t let breast cancer eclipse your life: examine yourself today.”³⁷ The self is thus interpellated as an active agent who must abate vulnerability, and medicine is generally constructed as enabling self-empowerment because, as Stuart Murray has suggested, “[w]e are . . . told that medicine is the cure to the problem of the self, the principal technology by which the self ought to relate to itself, through the body.”³⁸

To be diagnosed with breast cancer is to have vulnerability confirmed as a certainty. While the self may have always been vulnerable and called on to act or assume certain disciplinary techniques in relation to this somato-ontology, the diagnosis captures this gen-

34. Shildrick, *Embodying the Monster* (above n. 30), p. 76.

35. Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton, NJ: Princeton University Press, 2007), p. 107.

36. Nancy Press, Jennifer R. Fishman, and Barbara A. Koenig, “Collective Fear, Individualized Risk: The Social and Cultural Context of Genetic Testing for Breast Cancer,” *Nursing Ethics* 7:3 (2000): 237–249. Also see Susan Yadlon, “Skinny Women and Good Mothers: The Rhetoric of Risk, Control, and Culpability in the Production of Knowledge about Breast Cancer,” *Feminist Studies* 23:3 (1997): 645–677, for a discussion of risk avoidance and breast cancer.

37. Women Health Zone, “Most Creative Breast Cancer Awareness Ads.” <http://www.womenhealthzone.com/womens-health/breast-cancer/breast-cancer-awareness-ads/>.

38. Stuart Murray, “Care of the Self: Biotechnology, Reproduction, and the Good Life,” *Philosophy, Ethics, and Humanities in Medicine* 2:6 (2007): 1–15, quote on p. 5.

eralized disciplinary function. Now the subject is entered into, and called on to actively enter themselves into, specific kinds of medical discipline depending on the grade of cancer (the rate of cancerous cell growth that marks its aggressiveness: graded 1 to 3, with 3 being the most aggressive/quick growing) and the stage (determined by the size of the tumor, whether lymph nodes are involved and the cancer has spread: ranked 1 to 4, with 4 indicating that the cancer has metastasized to other parts of the body). The particularities of grade and stage mark out differential vulnerabilities, which are further compounded by the ability to access care and other features of a raced and classed stratified society, and firmly situate the subject in relation to specific medico-disciplinary apparatuses, whether that be surgery, hormone therapy, chemotherapy, or radiation. Following the diagnosis, prognosis (which stems from diagnostic particularities) offers the statistical calculations of the likelihood of death.³⁹ But this prognosis, as Jain notes, “poses both a stunningly specific (one has an x percent chance of being alive in five years) and bloodlessly vague (you, yourself, will either be dead or alive) fact about the future.”⁴⁰ The prognosis, then, operates to actively position the subject in relation to the precarious roulette of futurity.

The prognosis is attached to the individual's body, which is itself seen as the source of vulnerability. Looking to a range of affective histories and ethno-critical studies highlights that this body is positioned within the medical model as having diverged from normal operation, as having “gone wrong.”⁴¹ These affective and ethno-critical accounts demonstrate that medical power/knowledge relations implicitly assume that the body is stable, fixed, and a given, and only differentiates bodies in terms of health and disease, and normality and abnormality. In very basic terms, this model is predicated on a paradigm of reading the body that is indebted to the Cartesian logic of a mind/body split.⁴² Within this understanding, *res*

39. Rebecca Herzig and Sarah L. Jain, “Commentary: Surviving Terrorist Cells,” *Academic Medicine* 84:1 (2009): 11–12.

40. Jain, “Living in Prognosis” (above, n. 2), p. 78.

41. The ethno-critical studies I am looking at are Hallowell, “Reconstructing the Body or Reconstructing the Woman?” (above, n. 15); Broom and Kavanagh, “Embodied Risk” (above, n. 17); Sarah Lochlann Jain, “The Mortality Effect: Counting the Dead in the Cancer Trial,” *Public Culture* 22:1 (2010): 89–117; and Manderson, “Gender, Normality and the Post-surgical Body” (above, n. 18).

42. For earlier devaluations of the body, see Elizabeth Spelman, “Woman as Body: Ancient and Contemporary Views,” in *Feminist Theory and the Body* (above, n. 14), pp. 32–41, who notes that for Plato, “[t]he body's relation to the soul is such that we are to think of the body *vis-à-vis* the soul as a tomb.”

cognitans (the mind) is the seat of intelligence, animation, spirituality, and selfhood, and *res extensa* (the body) is viewed as a machine and generally is limited to causal analysis of functioning. The body is devalued in this formulation and perceived as matter to be governed and regulated by the mind.

Together, the accounts I reference show that for the individual diagnosed with cancer, the body is situated as pathological and as separate from the self that must be protected; the body is “other” to the self. At the same time, however, cancer is interestingly constructed as other to the body; for instance, in the broader social discourse, cancer is said to “invade” or “infiltrate” the body, as if it were something that attacked from an external position or is not part of the body.⁴³ In medical terms, however, we know that cancer develops when the cell growth and division essential for life neglects all growth-control mechanisms and the cells themselves lack the “differentiated, specialized traits of their ancestors.”⁴⁴ Undifferentiated, these cells do not have the representative characteristics of other cells of the organ that houses them, and they replicate until they outnumber healthy cells. So, precisely because cancer models new cell division and only develops when the body fails to recognize these undifferentiated cells, cancer is *of* the body as much as it is an internal outsider.

But the individual in breast cancer is generally seen, both by themselves and the medical arena, as subject to terrorist cells that have gone rogue—“guilty cells” that, as Susan Gubar remarks, “cannot be tolerated.”⁴⁵ The individual is often perceived as at the mercy of their body, and ultimately they become eclipsed *by* the body (the somato-ontology) that must be disciplined. The body becomes the focus of medical intervention; viewed as disordered, precarious, or chaotic, it is positioned as a docile medical object. In “Welcome to Cancerland,” for instance, Ehrenreich remarks on this operation, stating that it was “not the presence of cancer [that was shocking] but the absence of me—for I . . . do not enter into it even as a location, a geographical reference point . . . I have been replaced by it, is the surgeon’s implication. This is what I am now, medically

43. Cancer is said to invade from within, however. See Susan Sontag, *Illness as Metaphor and AIDS and Its Metaphors* (New York: Picador, 1989, p. 15), who notes that cancer has been represented as that which “‘spreads’ or ‘proliferates’ or is ‘diffused.’”

44. Harold Varmus and Robert A. Weinberg, cited in Stacey, *Teratologies* (above, n. 13), p. 80.

45. Susan Gubar, “In the Chemo Colony,” *Critical Inquiry* 37:4 (2011): 652–670, quote on p. 652.

speaking.”⁴⁶ With the cancer occupying medical attention, the tumor is the patient. And women themselves, as Hallowell notes in her study, distance themselves from the body that is seen to have betrayed: “their body [was viewed as] essentially compromised . . . it contained the seeds of its own destruction. They perceived their bodies as potentially out of control and constructed their breasts as biological ‘time bombs’ which could go off at any moment.”⁴⁷ The consequence of these positionings is that the body is viewed as foreign and estranged, as alien to the self.

If the body threatens the subject and renders them vulnerable, treatment can be seen as endeavoring to reassert bodily control, whether it be in the form of surgery, chemotherapy, and/or radiation and subsequent hormone therapy. Yet, with treatment, as Ehrenreich laments, “the dumb old body is . . . transmogrified into an evil clown—puking, trembling, swelling, surrendering significant parts, and oozing post-surgical fluid.”⁴⁸ These efforts to “know” and establish mastery over the body, then, render it unrecognizable—augmenting its estrangement and possibly leading to increasing alienation. Cancer therapies that seek to mitigate vulnerability actually make the body more vulnerable through what Jain has called *treatment injury*: the damage and pain sustained to the body via treatment because more often than not, it is the treatment for cancer that produces a state of tangible illness, rather than the cancer itself.⁴⁹ This necessarily raises the questions of how risk and vulnerability are evaluated, and which risks and states of vulnerability are endowed with greater importance, even if the aim is to avert untimely death. For instance, for Gubar, “[n]ot dread of cancer or death but rather dread of treatments has me in its thrall.”⁵⁰

Key in this treatment are those procedures where bits of the body that put the subject at risk or make the body vulnerable are cut out or off (through lumpectomy or mastectomy) in order to preserve

46. Ehrenreich, “Welcome to Cancerland” (above n. 10), p. 44.

47. Hallowell, “Reconstructing the Body or Reconstructing the Woman?” (above, n. 15), p. 162.

48. Ehrenreich, “Welcome to Cancerland” (above n. 10), p. 44.

49. Jain, “The Mortality Effect” (above, n. 41), p. 93. By this, Jain refers to “how the bodies of cancer patients have been caught up and used in struggles that relate often only marginally to a larger cultural effort to find a cure for cancer” (p. 96), and the physical effects of these treatments on the body.

50. Gubar, “In the Chemo Colony” (above, n. 45), p. 655. Obviously, I am not suggesting that breast cancer treatment should be abandoned; rather, I simply want to consider the frames through which we view vulnerability.

the perceived whole. Corporeal vulnerability is therefore managed through the removal of what are seen as “dangerous parts” that could destroy the self—they are, consequently, cast as separate. As Broom and Kavanagh have stated, “[h]er body could be dissected, hazardous parts identified and removed, while the self remained—no longer under threat from the body.”⁵¹ These surgeries in themselves, however, compromise notions of wholeness, most particularly with mastectomy, where women often recount that they have “lost” parts of their body that are essential to their conceptualizations of femininity.⁵² The surgically altered body is, then, a disrupted body. For through surgery, the very threshold of the body is retraced—where it begins and ends is redrawn. As Manderson argues in her study of the post-surgical body, what remains after surgery acts as a sign of bodily failure or decay.⁵³ The scarring from these procedures is testimony of “what was”: the pre-surgical body that is discursively constructed as being in an *a priori* natural state. Not only rendering the body less familiar and incomplete to the subject, however, this surgical sacrificing also opens the body up to increased vulnerability through the possibilities of infection, necrosis, and the agony of having significant portions of the body sliced off.

In their affective histories, Ehrenreich, Sedgwick, and Stacey each note that the body is also rendered alien through chemotherapy, which wards against its vulnerability to cancer even as it increases other forms of corporeal vulnerability. Infused with vast amounts of chemical “cocktail,” the subject is healed (of cancer) while the body is poisoned, with all rapidly producing cells beginning to die, along with the targeted cancer cells. Within the first few weeks after the first dose of chemotherapy, the subject will usually lose her hair, first on the head, then on all other parts of the body until last, the eyebrows and eyelashes fall out, effectively “disappearing” the face. These drugs are known to cause nausea, anti-emetics to cause constipation, constipation drugs to cause weakened bowel muscles and often dependency, and steroids (used as part of the chemotherapy drug regime) cause the body to bloat and generally lead to substantial weight gain. And, because it is increasingly in danger of

51. Broom and Kavanagh, “Embodied Risk” (above, n. 17), p. 442.

52. See Hallowell, “Reconstructing the Body or Reconstructing the Woman?” (above, n. 15). This will necessarily be conditioned by how the subject identifies. The sentiment I have outlined, however, is the dominant recursive narrative in broader breast cancer culture and in general public perceptions of breast cancer. See Zak Szymanski, “Breast Chance for Survival: A Boy Dyke Faces Cancer and Fights for Proper Care of the Breast She Never Wanted Anyway,” *Curve* 12:4 (2002), pp. 34-37, for a critical alternative to this narrative.

53. Manderson, “Gender, Normality and the Post-surgical Body” (above, n. 18), p. 382.

infection from a low white-blood count and febrile neutropenia, the boundaries of this body require vigilant monitoring and protection. This body looks different, it feels different—the skin is sensitive to the touch—it functions differently, unrecognizably, its habitual ways interrupted.

Together, these side effects of chemotherapy and the altered post-surgical corporeal terrain heighten the recursive narratives of the cancerous body as that which challenges the subject's ability to "be," in the Butlerian sense, or, in Cohen's terms, threaten the integrity of the subject; vulnerable to breast cancer, the body endangers the subject. The body is positioned as a failed mechanism that must be mastered. Simultaneously, however, abating the somato-ontology of vulnerability—mitigating this internal threat—exposes the embodied subject to external threats (that resonate as threats in/to the body), making the body more vulnerable, more exposed, putting the body at increased risk. And each of these treatments/strategies are deemed necessary and justifiable by both medical knowledge and individuals, it would seem, due to the general organizing logic that paradoxically insists that bodily vulnerability must be defended against by whatever means possible in order that the self might persist.

Corporeal Contingencies: Vulnerability as a Relational Ontology

Sedgwick has remarked, in regard to her own experience of breast cancer, that the body is subjected to treatment "in the service of imagining and recovering . . . [the] 'natural' healthy body in the face of its spontaneous and endogenous threat against itself."⁵⁴ More than this, however, the aim and/or assumptive logic of cancer treatment is to recover the *old self*—that is, the pre-diagnostic or pre-surgical self. Body and self are again reinscribed as separate entities, and the self is constructed as that which can only be reestablished through disciplining, mastering, and normalizing the body and returning it to its perceived natural state, where the somato-ontology of vulnerability is controlled by the self. Vulnerability might thus be said to produce, in part, the mind/body split. As I have noted, however, efforts to return the body to its prior state make it more vulnerable, with treatment producing what Stacey calls an "'alien' body taken over by another." This now "unfamiliar body . . . refuses the usual behaviours . . . [and] has lost its form and its integrity."⁵⁵

This estrangement is the corporeal aftermath of breast cancer treatment protocols that forever alter the bodily terrain. But the

54. Sedgwick, "Breast Cancer" (above, n. 14), p. 154.

55. Stacey, *Teratologies* (above, n. 13), p. 85.

vulnerability and estrangement produced through such treatment can be seen to be productive, in that they: 1) refuse the possibility of a “natural body”; 2) collapse the organizing oppositions through which embodied subjectivity is understood; and 3) demand a conscious intimacy with the body, showing the impossibility of the separation of self and corporeality. This simultaneous double operation—where vulnerability produces and forecloses the mind/matter binarism—represents the dialectics of vulnerability and highlights the interaction and mutual constitution (or, at least, mutual conditioning) of a range of seemingly incommensurable modes of being. I want to suggest, then, that rather than thinking in terms of the medico-discursive model that positions vulnerability as a somato-ontology to be abated and the body as a docile object to be disciplined and aggressively rehabilitated back to be in line with dominant norms, vulnerability would be more productively understood as a *relational ontology*. Instead of proposing set boundaries to be re-asserted and states to be controlled, a relational ontology highlights the relations between supposedly distinct states. In such a framework, the somato-ontology of corporeal vulnerability still needs to be addressed (the body is always-already physiologically vulnerable), but a space is opened up to grapple with the relations between flesh and self and between bodies and knowledge. Thinking of vulnerability as a relational ontology means looking at the arranged separations of mind/body, self/flesh, organic/inorganic, order/disorder, inside/outside, and life/death that fail or collapse in the face of illness.⁵⁶ It would be to acknowledge the complicated enmeshment of seemingly disparate states, and to think through how the body and subject are always engaged in a mutually generative relation.

56. The blurring of such boundaries has been the focus of considerable academic inquiry. For instance, Donna Haraway’s seminal work explores these ideas in relation to the cyborg body (see *Simians, Cyborgs, and Women: The Reinvention of Nature* [New York: Routledge, 1990]); Annemarie Mol refutes the idea of an ontological body and instead advances an account of the “body multiple,” which is always co-constituted through and in relation to the objects and bodies around it (*The Body Multiple: Ontology in Medical Practice* [Durham, NC: Duke University Press, 2002]); and Susan Merrill Squier has explored how traditional understandings of the human body and its limits are being transformed through recent biomedical advances (*Liminal Lives: Imagining the Human and the Frontier of Biomedicine* [Durham, NC: Duke University Press, 2004]). While each of these accounts lend considerable weight to understandings of corporeality and bodily being in the world, they do not help think through the particular boundary collapses that are initiated through cancer and its subsequent treatments. The text that most clearly does this is Stacey’s *Teratologies* (above, n. 13). For this reason, I have focused on her work here and the range of affective histories and ethno-critical accounts that foreground breast cancer.

Breast cancer treatment troubles the very possibility of a supposedly distinct and natural body by instead compelling an embodied reality that is a composite of organic and inorganic, biological and technological, living and dead, highlighting that these concepts are, in fact, porous. For instance, chemotherapy requires that the body be inserted with a peripheral cannula in the hand and rigged up to multiple intravenous drips that administer drugs. If this is considered undesirable, or easy access to a vein is ruled out, the subject might be implanted with a port-a-cath. This small device (installed under the skin in the upper chest) becomes a permanent part of the body until the patient has completed treatment, it literally functioning as a corporeal portal; it acts as a new threshold for the body, a mechanical device through which blood can be extracted and medicine introduced. Surgery for mastectomy produces further permutations of supposed corporeal naturalness: the body will be attached to a pain-pump—an infusion device that delivers controlled amounts of local anesthetics to the patient for pain management—and most patients have surgical drains implanted in order to remove blood and lymphatic fluids from the surgery site. The patient is required to maneuver with one to six drains (measuring usually about one to two meters in length) until the drainage flow has slowed to an acceptable level, modifying the bodily movements to account for the new appendages. And for those undergoing breast reconstruction with silicone or saline implants, the body is literally remade through the incorporation of inorganic materials. During reconstruction using implants, the patient will first have expanders placed under the pectoral muscles; these are silicone shells that are gradually expanded (usually over a period of three to six months) with injections of saline, made through a portal to the shell (which is a magnetic device so that it can be detected under the skin), stretching both muscle and skin to accommodate an implant. After being fully expanded, these implants are removed and permanent silicone (and less often saline) implants are placed. Post-surgery, then, the body is lived as an amalgam or assemblage, its boundaries and interior reconfigured through the treatments it undergoes.

The vulnerability produced through treatments and surgeries for cancer also troubles, indeed collapses the organizing oppositions through which embodied subjectivity is understood. The perceived binary of corporeal order/disorder, for instance, is a primary example; in relation to the body, order can be said to represent supposed corporeal wholeness and the uninterrupted “natural” functioning of the organic body. Disorder here would represent chaos and signals the body’s disintegration, disarray, or inability to function

'naturally'. But some forms of breast reconstruction upset this distinction through the harvesting and reuse of patients' own parts and/or the biological material of others. AlloDerm®—which is donated human skin tissue from cadavers—is routinely used in U.S. breast-reconstruction procedures to create an organic sling under silicone implants, to hold them in place and create a more natural inframammary fold. And growing numbers of women are opting for reconstruction without implants, choosing instead to undergo procedures—collectively known as autologous flap reconstruction—that use tissue and muscle from the patient's buttocks, stomach, back, or thighs to create new breast mounds with fully functioning blood supply. Out of disarray and fleshy rearrangements, then, a whole, ordered, and naturally functioning "organic body" is produced.

Additionally, the strict inside/outside opposition through which the body is conceptualized is disturbed through the diagnosis, treatment, and process of living in cancer prognosis. As I have already mentioned, *in* and *out* is blurred in the very detection of cancer, a disease that is constructed as the "other" within. The cancer tumor itself can protrude from the body, enlarging organs, breaking through skin, and making the inside come out. And, as Stacey notes, chemotherapy can lead to the inability to regulate the thresholds between the inside of the body and its exterior: with the side effects of chemotherapy, "the body's flows are set in reverse: where food should enter, vomit exits; where waste should exit, suppositories enter."⁵⁷ Cancer, then, confounds the oppositions of me/not me, self/other, subject/object—representing, instead, what Stacey calls "the horror of undifferentiation."

Finally, the life/death dyad is displaced by cancer. The diagnosis of cancer signals death through what appears as the first signs of life: cell division and growth. And to live in prognosis—where vulnerability becomes a certainty—means that the roulette of futurity/life becomes structured by and contained within the ominous foretelling of death. To live in prognosis, then, is to live with (the presence of) death, highlighting that these are not exclusive states.⁵⁸ The treatment for cancer only augments this slippage: the "bodily turmoil" it produces, Stacey suggests, "has no definite re-

57. Stacey, *Teratologies* (above, n. 13), p. 84.

58. Breast cancer, specifically, cannot be "cured." On life in cancer prognosis, see Jain, "Living in Prognosis" (above, n. 2). Sontag makes a compelling point in terms of the imbrications of life and death in cancer prognosis. She cites St. Jerome, who remarked that "[t]he one with his swollen belly [from cancer] is pregnant with his own death." Cancer, for Sontag, then, can be viewed as "a demonic pregnancy." See Sontag, *Illness as Metaphor* (above, n. 43), p. 14.

sults. It promises life yet feels like the beginnings of death. It destroys in order to preserve. The body is poisoned with the hope of recovery."⁵⁹

These multiple transformations of the body in breast cancer—where embodiment becomes a composite of organic and inorganic and where the supposed oppositional states of order/disorder, inside/outside, and life/death collapse—ultimately underscore that the distinction and hierarchical ordering between self and body, mind and matter, is an impossibility, even as it is endlessly reiterated in discourse. Illness itself, as Lisa Deidrich has suggested, “might be said to transform the slash that separates these boundaries, to make it [the dividing slash of the binary] vulnerable and porous.”⁶⁰ The consequence of the transformations of the body in prognosis—via the vulnerability or permeability of these supposedly distinct states—is the inescapable necessity to transform self-perception. For if, as Descartes insisted, the perceived sovereignty of self is predicated on the sovereignty of corpus, living in prognosis of (and through treatment for) breast cancer evacuates this possibility and calls for new ways of understanding the self. Thinking of vulnerability in terms of a relational ontology highlights that a sense of self is produced through the particularities of vulnerability, and that the embodied self is not static, but emergent.

The various affective histories and ethno-critical studies I have called on insist that to live in prognosis is to live in a state of interruption, where all familiar understandings and experiences of the embodied self go up for grabs. It is impossible to return to the prior, uninterrupted state because breast cancer prognosis functions to contain the embodied self in a now-evident state of lifelong risk. This is not a disease for which there is a “cure,” and this in itself necessarily initiates a hesitant relation to the body. To persist, then, means to actively address and attend to the precarity of the body through *thinking the body*. Most specifically, this might take the form of being compelled to negotiate the vulnerable body through a very conscious embodiment and cultivated bodily intimacy. Stacey talks of her resistance to this necessity, experiencing a “nostalgia for a time when . . . [her] body had a less obtrusive presence in . . . [her] consciousness.”⁶¹ But the body is now always present—a “constant

59. Stacey, *Teratologies* (above, n. 13), p. 85.

60. Lisa Deidrich, “A Bioethics of Failure: Anti-heroic Cancer Narratives,” in *Ethics of the Body* (above, n. 2), pp. 135–152, quote on p. 145

61. Stacey, *Teratologies* (above, n. 13), p. 100.

awareness of physicality . . . accompanied by the knowledge of its fragility."⁶²

Throughout the accounts I have called on here, the vulnerable body—its capacity and incapacity, potentiality and limitation—becomes the only reality when living in breast cancer prognosis and treatment. As Stacey argues, the diagnosis of cancer initiates a recognition that "this matter is all I am," and this matter is constantly changing.⁶³ During chemotherapy, she tells of how daily life becomes confined to the rhythms of the body, with the subject occupied with corporeal sensations: of chemicals coursing through the body, of exhaustion, puking, swelling, a distended stomach, low white-blood count, painful hair loss, thrush of the mouth, skin abrasions, and so on. And, as I have remarked above, these changes to the body render it alien. But despite this, the alien body must be lived; in order to persist, the subject must find ways to reconcile this altered embodiment.

One of the most apparent ways this negotiation of the vulnerable body occurs is through the experience of mastectomy and breast reconstruction, where a consciousness of the body's altered state requires that the subject rework their being in the world. In studies conducted by Samantha Cromptvoets⁶⁴ and Lenore Manderson and Lesley Stirling,⁶⁵ for instance, mastectomy is seen to radically transform not only the subject's relation to the body, but also the body/self's boundedness and relation to space. This can be seen, for instance, in that following mastectomy, women must become familiar with a body with new contours, affecting the way their body feels (and looks) with a suddenly flattened chest and altering how they wear clothes, how their body meets other bodies, and how they navigate the peripheries of their body, with objects literally further way. In addition to boundaries needing to be reworked, the subject must regulate their movements, ones that become hesitant as the subject protects the newly surgically altered body. With possibly damaged pectoral muscles and radical damage to the chest, the subject must relearn to move their arms and regain range of motion. And, if missing lymph nodes, the subject is required to negotiate ways to move the body carefully (through restricting weight-bearing, preventing perforations to the skin, and possibly wearing a compression sleeve

62. Ibid., p. 101.

63. Ibid., p. 85.

64. Cromptvoets, *Breast Cancer and the Postsurgical Body* (above, n. 6).

65. Lenore Manderson and Lesley Stirling, "The Absent Breast: Speaking of the Mastectomized Body," *Feminism and Psychology* 17:1 (2007): 75–92.

for common activities) to avoid the threat (or effects) of lymphedema. These changes might be further altered with reconstruction, where prosthetic breasts once again transform the supposed bounded terrain of the body. These implants will perhaps take up different space, feel different to “natural breasts,” and due to nerve damage to the area (and generally the removal of a nipple), they will lack sensation.⁶⁶ But while boundaries, movement, sensation/touch, and, necessarily, visual appearance are thus challenged through reconstruction, the prosthetic breast implant need not be viewed or experienced as a substitution for a part that is seen to be missing. Rather than existing as a separate, foreign appendage, the breast implant is often subjectively lived: it might be integrated *structurally*, in that it now becomes part of the whole; *functionally*, in that it contributes the subject’s overall movement through the world; and *aesthetically*, in that it becomes a part of the subject’s projected visual field. In these ways, while the prosthetic breast might initially be experienced as foreign and as that which the subject must be more conscious of, with time it may be incorporated.⁶⁷

But while the habitual everyday/lived altered embodiment from breast cancer treatment might lead to incorporation, it might also produce a range of other responses. These may include a continual mourning over permanent loss: perhaps for eyelashes that refuse to return after chemotherapy; for the now-shy nipple that retreats after radiation and cannot be coaxed outwards again; for the absent breast(s) or the “natural breast” that reconstruction fails to approximate. Or, these changes might initiate a sense of continual surprise and wonder: at the ongoing transformations of the body; the ability of the body to regenerate; or the capacity of corporeal reworkings.

Regardless of the particularities of the individual’s response, the affective histories and ethno-critical studies I have drawn on here suggest that the vulnerability produced through breast cancer prognosis compels a transformation of self in relation to the body. While treatment might labor to resuscitate the normalized, pre-diagnostic body/self, life must now be consciously lived through the vulnerable body. And one’s sense of self becomes shifting and precarious in light of matter/body that is constantly changing through surgery,

66. For details of the different types of breast reconstruction, see <http://www.breastreconstruction.org/index.htm>. See also Nadine Ehlers, “*Tekhnē* of Reconstruction: Breast Cancer, Norms, and Fleasy Rearrangements,” *Social Semiotics* 22.1 (2012): 121–141.

67. Vivian Sobchack, “A Leg to Stand On: Prosthetics, Metaphor, and Materiality,” in *The Prosthetic Impulse: From a Posthuman Present to a Biocultural Future*, ed. Marquard Smith and Joanne Morra (Cambridge, MA: MIT Press, 2006), pp. 17–42.

treatment, and ongoing threat. This means that the persistence of self becomes a daily exercise lived in relation to the altered and altering body; it means that in order to live, a critical responsibility to self must be worked on, in, and through the body.

Coda: Living in Vulnerability

This compelled transformation of self in relation to and through the body comprises what can be thought of as the art of being or living in prognosis, where the subject actively formulates ways of being or capacities of operation that renegotiate embodied subjectivity in light of the changes initiated by diagnosis, treatment, and prognostic projections. The examples I have examined here highlight that the vulnerability of the body (when living with breast cancer) operates dialectically to both foreclose and produce certain ways of being in the world. In such an understanding, vulnerability can be viewed as a relational ontology, where the altered and always-altering corporeal terrain becomes the *condition for* a very particular form of subjectivity. The acute experience of vulnerability necessitates and, indeed, inaugurates the production of a certain (new) sense of self: no longer able to take the body or the future for granted—as absent, compliant, or a given—the subject instead grapples with vulnerability and precarity to find new ways of living. This activity produces a specific experience and understanding of self. Moreover, this activity is a practice—it is a form of labor, an art, one that never ends because of the impossibility of return. In Foucauldian terms, the relational ontology of vulnerability might engender a critical ontology of the self, where “the critique of what we are is at one and the same time the historical analysis of the limits that are imposed on us and an experiment with the possibility of going beyond them.”⁶⁸

Medical discourse provides little room for productively engaging with the messiness and precarity produced through living in prognosis. As I have argued, medicine is more concerned with imposing limits—relegating the mind and body as distinct—and with positioning vulnerability as a somato-ontology to be abated and/or disciplined. It is this idea that has also become dominant in breast cancer culture and public campaigning about the disease, and the survivor narrative, which is so central to much of this campaigning, is largely predicated on this medical organizing logic. It takes a relentlessly triumphalist approach, focusing on “fighting” and “overcoming” cancer. In doing so, public breast cancer rhetoric rehearses

68. Michel Foucault, *The History of Sexuality*, vol. 3: *The Care of the Self*, trans. R. Hurley (New York: Vintage, 1988), p. 50.

the mind/body dualism and the imperative to vanquish—that is, to gain mastery over, to defeat, or to subdue—corporeal vulnerability.

Both the medical and dominant public approach to breast cancer can be seen, then, to present bounded models of human subjectivity and the body: they limit agency to a sovereign model (where the self is masterful and proprietor of the body), and they shut down the possibility of being open to uncertainty. However, if vulnerability—the experience of being exposed to that which is out of our control—is central to life in prognosis, it becomes imperative to attend to this reality, both at the individual level and in the breast cancer politics that occupies the public arena. Only then would it be possible to begin to think about vulnerability as an enabling condition, one that produces particular modalities of self and perhaps articulations of community. And only then would it be possible to do justice to those living with breast cancer. Embracing, rather than attempting to discipline vulnerability (as a concept and as a reality) might, indeed, engender the *critical politicization* of vulnerability in relation to breast cancer and function as the place from which a radically altered/reconceived public breast cancer politics proceeds.⁶⁹ Such a politics would not focus on triumphalism, it would not seek sovereignty or control (in the sense of trying to master or overcome cancer or the body), nor would it seek to return subjects to a state of “naturalness,” “wholeness,” or “order.” Instead, it would make visible the terror, grief, and bodily turmoil initiated by the cancer diagnosis, forge a space to wrestle with precarity and uncertainty, and seek ways to live otherwise with vulnerability. This would be ethico-political work around the issue of cancer; it would, perhaps, function ultimately as a *lived* ethics of vulnerability, foregrounding critical responsibility toward oneself, one’s life, the lives of others, and the life of the community.

69. As I have noted above (in footnote 9), vulnerability has been politicized in the theoretical arena and seen as the site from which a potential ethics might emerge. This has been particularly evident in the fields of disability studies, environmental studies, and material feminism. Most recently, studies of biomedicine and bioethics have taken a renewed interest in the theorization of vulnerability and its accompanying ethics (see, for instance, the 2012 special issue “On Vulnerability” of the *International Journal of Feminist Approaches to Bioethics* (vol. 5, no. 2)). My point here, however, is that the *empirical terrain of breast cancer activism* must attend to and acknowledge the corporeal vulnerability of breast cancer patients and use this as a platform for public politics. The stakes of not doing so is that vulnerable lives—often lives in elegy—are denied or overshadowed.