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RECONSTRUCTING PERSPECTIVES: A MOSAIC OF NARRATIVES FROM
WOMEN WITH BREAST CANCER ABOUT BREAST RECONSTRUCTION

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ABSTRACT

Many breast cancer patients have to make the important decision of whether to accept or reject breast reconstruction after breast surgery. Understanding the decision making process of reconstruction can show how women view their breasts in terms of their appearance. Breasts, in many ways, are linked to a woman's cultural and personal identity. My hypothesis is that women's desire to have breast reconstruction post-breast surgery related to their treatment is driven by a desire to regain a feminine appearance that will positively affect how they are perceived. Public self-representation is important, and for women, breasts are indicators of femininity and are connected to female roles in American culture. Other possible factors that may shape a desire to have breast reconstruction may include a desire to regain pre-breast surgery breast size/shape independent of social perceptions, or a desire to increase feminine attractiveness for current or future partners. These possibilities will be considered as part of the testing of the major hypothesis, as will the desire to avoid visibility of breast surgery scars and absence of breast tissue, both of which may create psychological trauma.

In this thesis I have discussed and interpreted the audio-recorded interviews I conducted with participants on the topic of breast reconstruction. Additionally, I have analyzed their narratives regarding what they found most meaningful and relevant to their experiences. My study has tried to understand my participants' attitudes towards accepting or rejecting breast reconstruction, and analyzed the meaning given to breasts as a gendered part of the body. This study is not representative of all women with breast cancer, but it may identify overlooked areas of concern and/or reiterate issues that are important to the women who participated in my research. This thesis has focused on the importance of the narratives of these women and others who are going through this experience.

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Introduction

In 2011, 96,277 women between the ages of 13 and over 55 received breast reconstruction surgery. The age group with the most breast reconstruction surgeries was women aged 50 and older, with 32,685 breast reconstruction surgeries. Combined with the group aged 40-54, that is a total of 81,598 breast reconstruction surgeries for that year (American Society of Plastic Surgeons, 2012). So many women get breast reconstruction that it leads us to wonder—*why*? Breast reconstruction is done by a plastic surgeon for a more aesthetic function, yet it is also a personal and social concern for women who have the surgery after treatments for breast cancer. Breast reconstruction affects thousands of women, and, I would argue, every woman. Judith Butler's (1990) performativity theory suggests that our external language results in our performed behaviors in society and do not represent our inner identity. If we believe that we perform what is expected of us to perform, then based on the representations shown to us through the breast cancer movement, our behaviors will mimic the movement's chief concerns of preserving and recreating breasts to preserve and recreate femininity. Our culture has shared principles about characteristics of femininity that every woman is expected to preserve; one such characteristic is having breasts. Women without breast cancer are expected to relay this message (through breast cancer walks and wearing pink ribbons) and identify with the breast cancer movement's messages because they too are women who should be caring about their breasts as a characteristic of their feminine identity. Not all women identify with femininity, however because it is a culturally shared value for women the pressure affects them just the same.

Women have a unique challenge when deciding whether or not to have reconstruction surgery (assuming they can afford it). It is a major surgery that requires considerable energy on behalf of the patient while energy has already been expended in previous cancer treatments and/or

psychological stress. The surgery itself does not guarantee breasts that look authentic and 'normal', and it does not give back the function of arousal or breast-feeding. It does give a woman the appearance of having natural breasts (when concealed by clothes) in daily life. I wished to explore the contexts in which that decision is made and the extent to which that decision is influenced by cultural norms and assumptions that may create a need for a positively perceived appearance.

We cannot talk about a woman's appearance without discussing the model from which its expectations come. Berlant and Warner (1998) identified American culture as heteronormative, which means our culture is centered on the idea of an ideal lifestyle that champions heterosexual male and female gender roles. Increasingly, there are individuals, groups of people, and organizations who are resisting this model. Even so, we consistently act within social confines that affect our interactions, mobility, and appearance because of this model. There are expectations that exist in America for women that act as standards for their identity as women, such as looking young, being thin and petite, wearing women's clothes, and perhaps most importantly, having (visible) breasts. Not everyone has these qualities but women are still held to these standards every day. For non-heterosexual or transgender women having breast cancer and having breast surgery probably becomes more complicated. They already do not fit the 'norm' for how a woman should appear or act, and now they have something else for people to question about their gender.

Some women may feel that they have to compensate for their lack of femininity after their mastectomy, because without breasts, they no longer fit well into heteronormative culture. They may feel as though breasts make them attractive to future partners, therefore the mastectomy, instead of lessening their chances of recurrence of breast cancer, becomes a mutilation of their femininity. Sedgwick expresses this by saying, "Shit, now I guess I really must be a woman," meaning that if she gets a mastectomy, she must compensate her feminine identity

in alternative ways (Sedgwick, 1992). Moreover, losing a body part is a very traumatic experience for most people, so it is not unusual or unexpected for someone to desire to regain that body part. We should not assume that every woman would like breast reconstruction. Breast cancer imposes a major burden on women and to have yet another surgery can present an additional burden and an added risk to their health.

Recently, Angelina Jolie made headlines for her Op-ed in the New York Times. In her article, she first detailed the struggle of making the decision to elect for a mastectomy to prevent breast cancer and then moved on quickly to the details about her “nipple delay” surgery and reconstruction techniques (Jolie, 2013). She notes that “There have been many advances in this procedure in the last few years, and the results can be beautiful” (Jolie, 2013). This statement brings into play America’s obsession with breasts as linked to a woman’s gender role and to expectations about female beauty. Would Jolie’s decision to prevent breast cancer by getting a mastectomy still be acceptable if she had not done *everything in her power* to save the appearance of her breasts? Jolie wished that her children would “see nothing that makes them uncomfortable,” suggesting that the absence of breasts, or being flat chested like their father, would create such confusion that her children would feel uncomfortable (Jolie, 2013). While scarring Jolie might have experienced from a mastectomy may have been traumatizing to young children, so could the look of reconstructed breasts.

America’s displeasure with “confusing” visual gender markers, such as flat chested-ness in women, is troubling for women who are facing the option of reconstruction. They run the risk of feeling coerced into having the surgery in order to shield their loved ones and their community from whatever discomfort they might feel. If a woman chooses not to receive breast reconstruction surgery, this may change how others perceive her. There are many women who

reject breast reconstruction. Money may be an issue in this decision, though many actively decide not to get the surgery for other reasons.

It is often assumed that, if a woman can afford it, she will have breast reconstruction to return to her previous external physicality. This may be an unrealistic, and sometimes detrimental expectation. When a woman gets a mastectomy, the reconstruction that follows often does not resemble anything that looked like her chest previous to diagnosis. Breast reconstruction is a major surgery, and after chemotherapy treatments and/or radiation, the skin heals less effectively than it would have before treatments—this opens women up to potential harming side effects just as any other major surgery would, including infection. Accounts of women's desires to have reconstruction may help us better understand how assumptions from culture affect their choice. It is possible that culture has no affect on a woman's choice to accept or reject breast reconstruction. Qualitative research may lead to a range of responses that differ from what our society may expect. Reconstruction is not necessary for survival from breast cancer, yet there may be many other benefits from getting the surgery that have yet to be explored.

Literature Review

The literature on women's experiences of breast reconstruction is somewhat limited. I have found that most literature focuses largely on outer frameworks rather than contextualized narratives. For example, King discusses how the breast cancer movement and corporate America abuses women's breast cancer experiences (King, 2006). Some writers, such as Audre Lorde who lived through breast cancer and a mastectomy, have spoken candidly about their experiences and theorized about what it meant to be breastless. For many other women, their experiences (unless asked about) are kept private. The unwillingness of women to share their full experiences aside from private research studies may be a result of our culture's telling women that they should publicly avoid private and unpleasant topics. Their silence also may be due to the breast cancer 'pink' movement.

Lochlann (2007) believes that women have been pushed into fitting the ideals of the popular breast cancer movement, that promotes the idea that women should 'fight cancer' by trying to look feminine again with makeup, prosthesis, breast reconstruction, and other compensations. Sharing any emotion, action, or speech that falls outside the image that the movement has advanced is not encouraged. Mastectomies, lumpectomies, and other breast surgeries cause a cultural reaction that steers women toward regaining 'lost' femininity through reconstruction and use of prostheses (Lochlann, 2007). The cultural reaction to breast cancer surgery is seen in advertisements for Estée Lauder and Avon, as well as in breast cancer campaigns across the nation, such as the Susan G. Komen Foundation (King, 2006, p. xxv). This study contradicts the idea that regaining femininity is the reason women accept breast reconstruction.

Further hindering the sharing of diverse narratives of breast cancer experience is the current patient-medical professional relationship. Klawiter (2008, p. 60) explains the evolution of this relationship from the emerging use of the “clinical gaze” in the early 1900s: “The consultative relationship between patients who narrated their own stories and physicians who listened transformed into a relationship in which the patient’s narrative was narrowed and muted.” Physicians no longer see their patients’ stories; instead they see their bodies as a subject with a potential of diagnosis. Contrary to this method, Klawiter’s research involving “multisited participant observation and emotional engagement” in support groups exposes this shift in the patient-medical professional relationship to one where women feel they cannot and do not know how to fully express themselves (Klawiter, 2008 p.297). Her type of ethnographic approach was what I had originally set out to model my study after, however time constraints and other barriers limited what I was able to do. As a result, my study eventually became more similar to the 30 individual interviews that Samantha Cromptvoets (2006, p. 12) conducted. Cromptvoets (2006) interviews were face-to-face interviews that were about an hour long. From these interviews, she became personally acquainted with the individuals she interviewed and did not wear clinical detachment; instead she became emotionally invested in her participants and her work without becoming detached from her ethical and professional commitments.

Because of the sensitive nature of my topic, I had to consider how detached I would allow myself to be from potentially upsetting observations. I decided to act as I would normally react to upsetting comments and emotions expressed by the participant and be prepared to suggest seeking help while acknowledging distress. Just as Cromptvoets (2006, p. 11) had, I experienced “a certain amount of self-consciousness.” Both her research and mine were conducted in very personal ways and I was constantly aware of how I was presenting myself to my participants.

Many researchers, such as Klawiter and Matthews, choose to focus their attention initially on support groups to find hidden dynamics; however, now that I have conducted my one-

on-one interviews, I realize that groups may influence what is said and what is meant (Klawiter, 2008)(Matthews, 2000). Nevertheless, support groups are efficient at documenting these dynamics and recruiting individual interview participants. Ograd (2005) uses an interesting approach through recruiting and communicating with her participants through the Internet. The approach to using “disembodied” narratives is worth noting because it attempts to understand more about the topic of breast cancer and about “interactions without bodies or presence...” (Ograd, 2005, p. 17). Since Ograd’s topic concerned breast cancer’s existence on the Internet, it was surprising that none of my participants could find such online presence.

It is hard to do a study about a specific topic related to breast cancer because the breast cancer experience is so faceted that it is difficult for patients and survivors to compartmentalize what they went through. The scope tends to be larger when a narrative study is done, and so for that reason, this study will touch on more than just elements related to the women’s breast reconstruction.

In terms of theoretical frameworks, I found that many discourses saw women as being rendered powerless in our male-dominated society. Some researchers even went as far as to say, “breast reconstruction and augmentation are used as forms of social control over women” (Kasper & Ferguson, 2000, p. 53). I partly agree and partly disagree with this statement. We tend to think that acting within a cultural context means submission to powerful norms that control us; however, reconstruction and augmentation may be seen as agency on the part of the woman to live a life as she chooses. Even though those women who accept breast reconstruction may seem to act within our culture’s norms to avoid being “considered deviant,” they may also be acting through individual agency with a different goal in mind (Kasper & Ferguson, 2000, p. 53). Because their choice can seem politicized either way, this adds pressure to a decision they most likely never wanted to make in the first place.

Procedures

As the principal investigator I first received the appropriate Human Participants training through the Collaborative Institutional Training Initiative (CITI). I then started the Institutional Review Board (IRB) process, which I have outlined in the last chapter of this paper. After approval was received from The Pennsylvania State University IRB, I distributed flyers in public locations in State College, Pennsylvania and surrounding towns with permission from location owners (of restaurants, religious meeting places, medical prosthetic stores, and the YMCA). In the flyer (listed in Appendix B) I identified myself as a Penn State researcher, gave a clear statement about the topic of my thesis, and stated that my study was being conducted for research purposes through The Pennsylvania State University. After potential participants contacted me, I explained everything related to my study, including consent and details about the interviewing process. When I met with potential participants, I presented the consent form, my plans for my thesis, anything relevant to their participation, gave them appropriate IRB contact information, and answered any questions they had before the interview.

I sought permission through a paper consent form. In the consent form (listed in Appendix A) I identified myself as a Penn State researcher, and reiterated that the study was being conducted for research purposes. I detailed what my research was about, and what the participant would be asked to do, which was to participate in an audio-recorded interview. I gave them the opportunity to do the interview without being audio-recorded, but instead with notes being taken. None of the participants declined to be audio-recorded. The form made clear that the individual's participation was voluntary, that the participant may end participation at any time, and may choose not to answer specific questions. I listed the appropriate IRB contact information, my contact information, and my supervisor's contact information on the form for

their convenience. There were separate sections for the participant's signature so that their participation was understood. These forms were not seen by anyone other than my thesis supervisor and myself.

My research utilized audio-recordings of unstructured interviews with participants. No other recordings were made and recordings were transcribed in an anonymous and confidential manner. No one other than my supervisor, Dr. Patricia Johnson, and myself had access to recordings. The transcriptions of interviews were used as my main source of data for my thesis. No identifying information was transcribed and no identifying research was made public through my research. The participants' names were not recorded. Any recording devices will be cleared of material within the appropriate amount of time after the research and paper is published. Any consent forms, recordings, notes and transcriptions that were kept will be destroyed within the appropriate period.

Details of Interviewing Process

“Ethnography is the only social scientific method that relies upon the observation of people, power, and the processes in their ‘natural setting’—that is to say, in the time, space, and contexts in which human beings live their lives” (Klawiter, 2008, p. 297).

This study uses ethnographic methods, but cannot be considered classic ethnography due to the limited scope of its methods. After informed consent had been obtained and participants had the correct IRB contact information, the participants picked a public location for an audio-recorded interview. The participant had the option of whether they wanted the interview to be audio-recorded, and whether the principle investigator was allowed to take notes during the interview if not recorded. The interview time ranged from 45 minutes to an hour and focused on questions indicated in Appendix C. First participants were assured confidentiality and thanked for their time. They were then asked to answer the questions I presented, as fully as possible and to the best of their ability, noting that the interview was voluntary and they could stop the interview at any point if they wished. They were informed about what the study was about and of possible

benefits to them and others. They were assured that no identifying information would be revealed in any written form and that their names would not appear on any form other than the signature on consent forms that were secured and private. After the interview, I transcribed the material and used it anonymously for my thesis and a copy of the paper will be given to each participant after it was finished.

All of the participants were willing to be audio-recorded, and one of the participants was audio-recorded over Skype. Of the other participants, I met two at coffee shops and one at her workplace. Our meetings started with chatting about the day. Before the recording device was turned on, I had them sign the consent form and gave them a chance to ask any other questions about my research. Once recording began, I told them to tell me about their experiences with breast cancer. When the interview was over, I stopped recording, and usually the participant and I would talk about other subjects. The appropriate comments were extracted from their individual stories and experiences and written about as material for this paper. None of the participants' real names were written or recorded. Participants' names have been replaced by pseudonyms.

Narratives

Breasts have various ascribed meanings within different social and cultural contexts; however, in America I would argue that there are three recognized connotations: 1) the breast as aesthetically sexual, 2) the breast as a means for breastfeeding and nurturing children, 3) the breast as a potential carrier of life-threatening disease. Breasts are not spoken of as one would speak of a hand, foot, nose, or any other appendage. Rather breasts are not to be shown in public unless a woman is feeding her child, and even then, she may have to excuse herself to a bathroom or nursing room for it to be completely acceptable. I find the relationship between highly publicized campaigns for breast cancer awareness and the personal experiences of women with breast cancer ironic because of the four women I spoke to, their decision was very private and did not have much to do with becoming feminine again (much like the breast cancer movement would lead one to believe).

Before my mother was diagnosed with inflammatory breast cancer, my thoughts about breast cancer were cluttered by images of pink ribbons and mammography. I did not have any preconceived ideas about what having breast cancer really meant. When my mother was diagnosed, I realized much of what the public knew about breast cancer did not seem to fit what my mother had experienced. She was diagnosed the summer of 2010 before I went to Penn State for my freshman year, and there was no arguing with her whether I should stay—she wanted me to go and live my life uninterrupted. I had to witness snapshots of the progression of this horrible disease that had overtaken my mother and confused how I thought about breast cancer. My mother had been healthy until she was diagnosed and then started chemo the very same day. How could things change so drastically? How could I last remember seeing her with rosy cheeks and sparkling eyes, and then come home for Fall break and see her bald, forty pounds lighter, and pale

as a ghost? I ended the semester three weeks later and came home to her in a hospital bed having suffered from a pulmonary embolism after her mastectomy. I became part of her cancer by emptying her draining pouches attached to her bare chest. Seeing pink garbage cans, pink cars, pink teddy bears, and pink vacuum cleaners suddenly disillusioned me because they did not remotely represent the graphic path to being a survivor living in fear and being coerced by society to feel feminine again. My mother has since been in remission for three years this July, and she continues to be the bright, comforting, and supportive mother/best friend that I have always known.

The four remarkable women I interviewed gave four different perspectives on a disease that affects so many women nationally and across the world. Narratives, while highly specific and subjective, can give great insight into overlooked, yet very important issues. Personal testimonies are insightful and offer context to individuals' experiences, and that is why I chose to conduct unstructured interviews. Unstructured interviews are more like conversations in which meaning is created from the speaker and is led by the speaker, not the researcher. By using unstructured interviews one can find out more about the context of the individual as well. For instance, these women all live in the Pennsylvania/New Jersey area and were treated there for breast cancer. Knowing these women's experiences and opinions can inform oncologists and medical providers in the same geographical area about their individual experiences. Perhaps, if a cross-sectional study were conducted, geographical differences in treatment and attitudes about breast reconstruction could be uncovered. In the following sections I will present these women's stories as talked about in the unstructured interviews I conducted.

Christy

When I first met Christy* in her office, she was equipped with a folder of information about her breast cancer treatments. She had breast cancer twice, which meant she was diagnosed

in two isolated instances. She was first diagnosed around 1999. She had a lumpectomy, received hormone therapy for five years, and was declared in remission after treatments. Then she was diagnosed again in 2012. Because so much time had passed since her first diagnosis, Christy, 59, had to look back at her folder of information to be able to remember the chronology of her breast cancer experience. This is not uncommon with women who have had breast cancer. Information about the technicalities of their disease often does not register with them because of the sheer volume of that information.

When describing her decision about what treatment options she should choose, she did not want her life to be interrupted and wanted her treatment to be minimally invasive.

“...at that point I could choose radiation and then five years of hormone therapy, or chemotherapy, and I chose the radiation and the tamoxifen [hormone therapy] because I was pre-menopausal...my only thought was ‘I don’t want my hair to fall out!’ ... I’d like to avoid that, so that’s what I chose”

Her choice revealed her unwillingness to let treatment interrupt her life and her appearance, which meant avoiding visible changes to her appearance such as losing her hair. Hair loss is one of the many disadvantages of being treated with chemotherapy. Having a lumpectomy after radiation treatments did not seem to affect how Christy viewed her body or self-image. She had not felt the need to wear bras or dress a certain way before the lumpectomy.

“I was never well-endowed with large breasts, so even taking a chunk of whatever they take out (fat) and to get the lump out... all that stuff, certainly the scarring and the indentation... and probably when I wear bathing suits you can notice it but to tell you the truth I don’t wear a bra because I really I can’t stand the feeling of a bra on me and I never really thought that I needed one. Probably the last time I did was when I was breast-feeding my son who is now 23!... They tell you after the surgery that you should wear a bra to support yourself— I’m like... Oops! I don’t wear a bra!...because I’m happily married I wasn’t out in the dating field it didn’t matter what my body looks like and self image isn’t that important to me so it didn’t affect me at all”

She mentions that other women who are not in a stable partner relationship may have a more difficult time, especially if they are trying to meet a partner. Being happily married, she felt that if she did not have a supportive partner, it would have been harder for a potential partner to

understand what she had been through. Then again, she claimed, “I thought I would need him more. But it turned out that I didn’t really.” Her husband had been working and living away from home because of a job opportunity, so throughout her treatments he was not geographically close to her. Christy felt her appearance had not changed much because she had never been large-breasted before her lumpectomy; therefore she did not have to worry about something being noticeably different about her chest when she wore clothes. Even though lumpectomies are not as radical as unilateral or bilateral mastectomies, they may still alter the appearance, shape, and proportions of the chest. In many cases, lymph nodes are taken out, the skin under the armpit puckers, and scars are visible if one wears swimsuits or tank tops.

“For example, in the summer when I wear a sleeveless top...you can see the scar, and the indentation, and the shriveled skin, so I can imagine that people that like to dress up for work or something, then they would have a problem.”

Christy could foresee issues that women would have if they chose to wear something less conservative or showed the areas that some types of clothing do not hide. Further describing the look of her chest after treatments, she said: “it wasn’t in a spot everyone could see...one’s tighter than the other...I didn’t have much to start with, but now I have even less. I guess you have to have a sense of humor about it...” Christy’s sense of humor and easy-going nature helped her see her appearance in a new way, rather than a negative way.

Christy’s physical appearance did not matter to her much. She described her style as more conservative. Her “lifestyle has changed as well.” She does not go on beach vacations as often as she did when her children were younger and does not dress up in anything revealing or tight for work. She did not wear a bra before her diagnosis and did not care to wear one after her treatments. She found them uncomfortable to begin with. Christy was happy with her body image before and after breast cancer treatments. Perhaps something she remembered about her childhood had somehow desensitized her to some of the changes her body had gone through:

“When I was young, my neighbor had breast cancer. That was pretty radical in the early seventies to have breast cancer. But she was pretty open about it. She had a bra with things you put in it...a prosthesis. You would see it hanging up on a clothesline! Or on hot summer days she would walk around without it.”

The freedom that Christy’s neighbor exhibited is similar to how she herself felt about her own experience—open and liberating.

Even when Christy found out she had breast cancer the second time and went in for a second lumpectomy, she never felt insecure about her body. The only thing she did not want to lose was her hair. Being bald, especially for a woman, is a very visible marker that a person is sick. As I will discuss later during my mother’s narrative, being noticeably sick changes how people interact with someone who has cancer. Christy made the personal decision to go through five years of hormone therapy (tamoxifen) instead of going through a shorter period of time withstanding chemotherapy treatment because she did not want to lose her hair. As we will see, she may have missed some of the debilitating affects of chemotherapy (which also tend to be visible), however tamoxifen also affects the body in drastic ways (early menopause is one of the most severe). Christy felt lucky to have had the choice to have hormone therapy instead of chemotherapy. She described this feeling when she explained going into the waiting room for hormone therapy and sitting with the other women, some of whom were being treated with chemotherapy; “I would go in there with my long hair and I went, well I guess they can tell I’m not getting chemo!” She thought that even though she was going through a hard time in her life, others were going through ‘worse.’

In the waiting room, Christy saw other women going through treatments, and one in particular was very “private” about her body:

“I do know one woman who would refuse to sit in the waiting room... shy isn’t the right word but private. She would not come out of the changing area to sit. She would change, and then wait until they called her to come out of the room.”

Christy thought that breast cancer made women more open about their bodies, in part because of the process of being treated and having their chest exposed through radiation and surgeries.

Much of the worry Christy felt was for her children. After one of her surgeries, She wanted to go home as soon as possible to be with them:

“Even after the first surgery my children were younger and I had purposefully...well I took off from work. I...was supposed to stay overnight in the hospital but I really didn't want to stay the night in the hospital. So they told me that if I [got] my dinner down I could leave. So I did and kept it down and the doctor gave me permission to leave. Of course, we were out in the parking lot of the pharmacy where my husband was picking up painkillers, and I threw up but I thought whew! I'm glad it didn't happen while I was there. I didn't feel like I needed to [stay at the hospital] and I have young children at home.”

Christy had the advantage of being able to work from home, unlike the rest of the women I spoke to. She tried her best to succeed at living an uninterrupted life for herself and children. This congruency in her experience between her life before and after diagnosis was smoother than most, which may have helped her self-esteem and control of stressors. It may also have helped how she viewed her body in comparison to women who did not have as smooth of a transition in and out of breast cancer. I am not supposing that Christy's experience did not have its own challenges that may have made her experience more difficult in other ways, and I am certainly not comparing Christy to any other woman with breast cancer, but she seemed to be outstandingly prepared in her ability to cope with her breast cancer experience. Christy was more concerned about the cancer coming back than about the possibility of having to get more surgery. Her attitudes about breast reconstruction were hypothetical, but she thought that it was a personal decision “...depending on your age, depending on your profession, depending on what you're used to...I don't know much about the surgery, I guess I would be afraid of dangers inherent in that...is this a safe thing to do?” Christy had some concerns about reconstruction, yet she believed it was up to women themselves and how their lifestyle would be affected.

Donna

Donna* was six years in remission at the time of my interview with her. Contrary to what you will find in brochures about how to conduct a self-breast exam, her lump was found underneath her breast, not in more obvious breast tissue; “I thought it was a rib sticking out.” She found out about the lump in October 2007, but did not see her physician until March of the following year. Finally her family physician strongly advised that she make an appointment. After the visit to her doctor, it was decided she would skip having a biopsy and immediately have a lumpectomy. After the lumpectomy, her doctor told her (with no eye contact and in a very abrupt manner) that she had breast cancer, and also that she was “not going to die.” At first Donna thought that her doctor was joking, but this was not the case. I was surprised to find out how the doctor broke the news to Donna, yet Donna felt his approach actually helped her reaction be less dramatic. After her doctor gave her the option of getting a radical mastectomy, (now knowing she was a stage three), she instead chose to go through chemotherapy and radiation and reject the mastectomy. She lost her hair, and had significant discomfort during chemotherapy, but she said that radiation affected her a lot more severely.

Donna went through many physical appearance changes. Her daughter was noticeably upset about the fact that Donna was losing her hair. One day, Donna was sitting on her deck, and told her daughter to go inside and get some scissors. Her daughter asked, “you’re gonna get a hair cut?” to which Donna replied, “No, *you’re* gonna to give *me* a haircut.” Her daughter sheepishly began to cut her mother’s hair, and by the end of the session Donna’s daughter had no problem finishing the cut. Donna wanted to be strong for her children and take away their fears about her cancer. She also wanted to instill in her daughter the insignificance of having hair compared to more important things in life by telling her, “It’s just hair! It doesn’t matter!” and mentioned “I don’t want her to be shallow...” It was important to Donna, as it was also to Christy, that; “I had to watch my emotions around them... I wanted life normal for them.” When Donna’s mother

came back to the house that day she told her “However bad it looks, don’t react.” Donna’s comment to her mother reminds me of what my mother always says; *it is what it is*. Because these women cannot change their situation, some try to calm things down and avoid the surprised reactions of others.

When it came to Donna’s social support, her husband acted as “the nurse.” He was always there for her and made sure she had everything she needed, even though he must have been struggling to cope because of being recently laid off from his job; “He never let me know he was scared, although I knew he was.” Financially, Donna’s family was struggling; however, her family’s emotional support never wavered. More bad news struck when she found out a year later that her mother was diagnosed with breast cancer. There was irony since Donna originally did not want to tell her mother about her own diagnosis because she did not want to worry her. Donna believed that everything happened for a reason and her mother’s diagnosis was certainly an interesting coincidence. Donna’s mother’s lumpectomy was done in Puerto Rico.

“She had a lumpectomy...They didn’t remove the breast, they destroyed the breast...it’s like they cut whatever they had to cut and they sewed her back up and left her like that. My mom is in her seventies. I asked her ‘mom, are you going to go get breast reconstruction?’ she said ‘nah! I don’t need those, they’re fine!’ But I feel bad because, you know, they destroyed them.”

Donna’s mother’s surgery bothered Donna because it looked as if the surgeons did not do their best to minimize the effect on the appearance of her breast, and in fact ‘destroyed’ it. She wondered why the surgeons had not just removed her breasts altogether. After her mother’s experience, she was confused as to how doctors decide what surgery and treatments to give the patient. To her it felt like the physicians were basing treatments on their best judgment, but that these decisions did not seem to be standardized.

When the choice was given to Donna about whether or not to get a mastectomy, she decided against it. Donna was told that she would have an equal chance of recurrence of the disease if she opted for mastectomy or if she did not. She did not see the sense in getting a

mastectomy if it did not reduce her chances of recurrence of the disease. She still thinks about it every day and wonders if it was the right decision; yet she, like the other women I interviewed, decided not to drive herself crazy with “what-ifs.”

Donna described the result of her own lumpectomy as a “hole” underneath her breast and scarring that went back further towards her armpit. Her breasts themselves were left rather unaffected. When I asked how she would react if she had to get a mastectomy, she said she was unsure, but that she felt that her surgeons did a good job with minimizing the scarring from her past surgery and would be open to prostheses because her friend had them. Her friend had a difficult experience with her breast reconstruction attempt because of trouble with healing, so she was “okay” with breast prostheses. Donna’s other friend explained her reasoning for her bilateral mastectomy: “She had both of them removed and I said ‘Why?’ And she goes, ‘every time I looked at them, I would see cancer, I would see illness, I would see sickness’ ...So she had both of them removed. I said, ‘How do you feel now?’ she says ‘I don’t see it.’ ...Be she’s glad they’re gone, she does not miss them.”

Donna said she would not go out in public without prostheses, but in her own room, she did not care. To her, “people can be cruel” and “don’t realize it.” She did not want others to feel sorry for her: “people would look at you and feel pity, I don’t like that...that makes me mad. Don’t feel sorry for me...I didn’t like to be babied. Don’t tell me I can’t do it, I’ll go do it!” When I mentioned the *Scar Project* (2011) in which women had been photographed without shirts after their breast surgeries, she said, “Did you know those pictures were banned? People didn’t want to see them... but this is life, this is real.” Her indignation showed that she was annoyed that people could not face reality. She also mentioned Angelina Jolie’s Op-ed: “...Angelina...she has a life! She’s young, she beautiful, why does she have to worry? And she knows you don’t know what’s going to happen, so why not? That’s her choice.” Donna saw getting preventative breast surgery and reconstruction as a woman’s personal choice.

After her treatments were over, Donna's physician wanted her to have a hysterectomy to reduce her chances of getting uterine cancer which he said is more likely to happen if a woman had breast cancer. Donna said she was not willing to go through with that surgery and seemed quite reluctant at the idea of having another major surgery.

Donna does not dislike her scars; she wears them with a sense of pride. To her they are a symbol of the importance of life and letting go of things that do not matter. "I won't get rid of my scars. Maybe that's to remind me what I went through because sometimes I forget...It's part of me...in the summer my daughter will go 'Ma! They can see your scars!' I said 'it's okay.'"

Jen

Jen's story began in May of 2011 after a routine mammogram revealed a spot on her left breast. Before this mammogram, she had had other biopsies that were benign. Her mother had been diagnosed with breast cancer a year before. All of her mother's four sisters had breast cancer, and one had ovarian cancer. All of her related female cousins have also had breast cancer. Everyone in Jen's family, female and male, who has been tested, has had the BRCA1 mutation. The BRCA1 gene mutation is the "breast cancer gene" that significantly increases the risk of breast cancer in both females and males, getting breast cancer at pre-menopausal ages (for women), and increased chances of getting ovarian cancer; this means that the most effective treatment is mastectomy and oophorectomy combined with other treatments (Klawiter, 2008, p. 262). Jen had also been tested after her diagnosis, and she tested positive for the gene as well. At first, Jen had the option of getting a lumpectomy or a mastectomy, but she decided that because of her family history, she would get the bilateral mastectomy. She chose to get a complete mastectomy and oophorectomy (removal of ovaries and fallopian tubes). Jen had the oophorectomy because the chances of ovarian cancer are 80% if you have the BRCA1 gene.

Both Jen's mother and cousin had breast reconstruction within the 5 years before Jen's diagnosis. Her cousin had gotten tattooing on her breasts to create the look of nipples. Jen's cousin was not completely satisfied with the tattooing because she claimed it was "very light" and "didn't take completely." Jen and her mother were both large-chested women. Jen's mother was satisfied with reconstruction, even after one of the implants burst nine months after implantation and was replaced. Jen "decided that based on their [her mother's and cousin's] experiences, I would try the same thing." All three surgeries were completed in one day (radical mastectomy, breast reconstruction, and the oophorectomy). In hindsight she probably would have waited on the oophorectomy because of the lengthy and difficult recovery process. Jen is diabetic, so this means she heals poorly in comparison to those without diabetes and had not considered this when she first went in for surgery. The implants that she had put in at the time are a new technology that uses ports to fill the actual implants instead of putting spacers in and then having them removed for the implants. Her surgeon showed her pictures of people who chose reconstruction and had successful surgeries. The surgeon also told her about the different types of surgeries. She had a good idea of what things would look like if her surgery went well. Her own reconstruction was not what she expected:

"For one thing it didn't look as natural as I expected it would. You know your breast has an odd shape and it looked like there were implants there. There's like a rounded kind of shape on the top that most people don't have. After I had the reconstruction, I didn't like the way it felt. You could tell there was something foreign inside you. I could feel it. My mother said she couldn't. She didn't notice it at all, but I did. I didn't like the shape, I didn't like the firmness...even before they were filled I didn't like the really firm feeling. Then, and maybe for the best...through October, I had four more surgeries. One by one, different parts got infected. At first, on one side, the skin wasn't healing by the incision. It was dying. So they had to reopen the entire incision and cut out the dead skin on the outside and the inside and re-seal it back up again to get it to heal...then the port got infected so they took the port out and replaced the port, and a month after that, the same implant got infected, so they ended up having to take out both the implant itself because the whole pocket inside was lined with infection, the implant itself was infected, so they could put another implant back in, you have to wait until the infection heals. So they had to take the implant and the port out. A month after that, the port got infected so badly that it exploded, my skin

exploded. Then that was it, so then the other implant came out too... My entire attempt over four months was very unsuccessful.”

Jen currently has no breast implants. She has the option of getting implants in the future if she chooses; however, she has decided against further attempts at reconstruction. Jen’s treatments also included chemotherapy and radiation. She had the surgery first, then six months of chemo, and finally she had two months of radiation every day.

“I’m so much happier without the breast reconstruction. I like the freedom. There’s so many things that I don’t have to worry about anymore. Number one, I don’t ever have to wear a bra *again!* Having to wear them for years and years, and years, I’ve always found them so uncomfortable and so hot... When I sleep at night, I’m a side-sleeper. I’m a flute player, and when I play, there is *nothing* in the way! ...I don’t have the backaches that I was having before. In terms of appearance, I’m sure that there are people in the world that look at me and notice, but it doesn’t bother me in the least. I’m very accepting of the way I look, it’s just me and I don’t care about what anybody else thinks, I’m really happy with the way things turned out, and so is my husband. I have a *wonderful* husband!”

In fact, while Jen and her husband were dating, she had a biopsy scare, and she was nervous that “he’d run.” He didn’t and she felt confident in his support of her. He was also very supportive when she eventually was diagnosed with cancer. “He had no problem touching things or looking at things.” The encouragement and unflinching attitude of Jen’s husband helped Jen tremendously throughout her experience.

Jen thought there were two things that were lacking in breast cancer education: 1) the awareness that men can get breast cancer, 2) more information about detecting breast cancer through self-exams. Jen said, “That’s not the only way that you feel breast cancer, is in a lump. I didn’t have a lump. I had more like a thickening.” From May when she was diagnosed, to July, her cancer had enlarged from the size of a thumbtack, to that of a grapefruit. The cancer was very aggressive, thus when she was thinking about reconstructive surgeries she did not have the time to ask many questions or to seek people to talk to other than her mother and her cousin.

If Jen were a physician, she would advise women to not have reconstruction right away. She believes that women should have enough time to “heal, and see how they really feel,” to consider possible outcomes and realize life without breasts to make sure they still want reconstruction;

“I think some women might be surprised that afterwards they like how they feel. That it doesn’t make as much of a difference [in one’s life] than they thought it might because of society’s opinions and such. I think there is so much trauma involved that I think you have to give yourself time to work through those emotions, and to heal.”

Her doctors, while leaving the decision of whether to accept or reject breast reconstruction totally up to her, were at the same time, of no help. Jen had to make the decision in a matter of days, and based on her mother’s and cousin’s experiences, she decided to give it a try. The decision also limited her time in surgery. If she had decided later to get breast reconstruction, she would have had to go in separately for more surgery. The doctors gave her information about the surgery, but left it up to Jen to decide.

“They don’t give you any guidance on other women’s thoughts or feelings on the matter, which I wish I would have had from someone other than my family. I wish I would have talked to someone [whose surgery] didn’t work out or who didn’t have reconstruction. But I didn’t have that opportunity, nor the time to pursue that. But that would have been helpful.”

The plastic surgeon only showed Jen pictures of ‘successful’ surgeries. The surgeon did not show her pictures of unsuccessful reconstruction, or of what it would look like if she did not have reconstruction. She would have liked to have at least read something from both sides of the perspective so she could make a more informed decision. She had no idea until she saw herself after her mastectomy what she looked like without breasts. She could not find much information online either. “Can I accept myself if I look like that without reconstruction?...it would be helpful for your partner to see that too.” Jen’s husband left it up to her whether or not she wanted to go through with breast reconstruction. Jen’s other cousin did not have a partner who was willing to let his wife go through appearance-altering treatments and surgeries:

“He [Jen’s cousin’s husband] absolutely demanded that she not have a mastectomy to begin with...and his previous wife had died of breast cancer. And then she got breast cancer and he said ‘no mastectomy.’ And that’s [getting the mastectomy] what she wanted to do. She got the gene testing and was BRCA1 positive, and he said no, and she went with his decision, what he wanted, and she died...None of us could have understood why he felt that way...So apparently for him, appearance was extremely important.”

Her cousin’s husband thought it was unacceptable for his wife to get breast reconstruction. Jen hypothesized that, “If I’d been married to my previous husband, he’d have left me. I’m certain.” She maintained that getting a mastectomy would not affect her femininity and that reconstruction would, in the end, not have made her feel any more feminine; “I cannot find any real reason for me to get reconstruction again. It [reconstruction] would only serve to make others happy, not me.”

One problem that Jen was not happy about is the difficulty she had shopping for clothes. Dressy clothing was hard to find for Jen; “Everything is centered on ‘let’s show our cleavage!...I’m in my mid-fifties. So for me, maybe it’s not quite as hard as it is for people who are in their 20s, and 30s and 40s.” Even though she could not always find clothes that she liked, she accepted the way her body looked and had no problems interacting with her husband; “In terms of sexuality, it hasn’t made a difference for me or my husband...He’s perfectly happy with the way I look because I’m happy with the way I look...I think we have a deeper emotional intimacy than we had before.”

One effect of her treatments that she thought was a particularly negative experience was losing her hair.

“I found that a lot more traumatic than losing my breasts, believe it or not. My mother couldn’t understand that...Everybody could see that. Not everybody could see that I had lost my breasts... You can look at a stranger who’s got a hat and no hair and know right away...It’s not an appearance thing, it’s something that divulges your personal secrets about your health to everyone who’s around you or who sees you. And you don’t have a choice in that either.”

Unfortunately, her mother's cancer came back and has metastasized to her lungs and is now terminal. Because of Jen's family history, she feels she will not live a long life: "...there's a lot of anger because so many people like me go through breast cancer, but percentage wise, I'm in the minority in terms of those who suffer debilitating consequences afterwards. I'm really angry about that." Jen was already retired and on disability before she was diagnosed; "Now it's just way worse...and I'm sad, because there's so many things that I can't do, yet there's so many things that I want to do still." It is a struggle for Jen to stay positive knowing that her odds at surviving a long life are low, but she still has a positive outlook on life..."I'm still here!"

My Mother

My mother, 57, was diagnosed with inflammatory breast cancer July 3rd of the summer before I went to Penn State for my freshman year in 2010. She had some discomfort in her left breast and the area became red around the nipple area. She waited a day or two, but when it did not go away, she went to her primary care physician, where she was told she might have an infection. The doctor put her on antibiotics for a week and the medicine did not seem to help. The area where it hurt also seemed to be getting harder. She went in for a mammogram, which led to a biopsy. When my mother went back to her doctor for the results, she brought my Nanny (my mother's mother) along with her. She was not expecting anything significant to come from the results. When the doctor told her she had inflammatory breast cancer, my mother was surprised.

"she [the doctor] had already made arrangements for me to go that day to go see the oncologist over at the cancer center...so I went over there, it never processed in my head...he told me if I wanted to wait a tiny bit, but I couldn't wait that long as far as starting... I started my first round of chemo that day. It was July 3rd, 2010...I think I was literally in shock...I don't know if I ever totally, totally processed. I know I went through it and I remember it, but because it was so quick, I never had time to really say 'Okay, I have breast cancer.'"

My mother elected to have a bilateral mastectomy, even though her doctors told her she only needed one breast to be removed. She did not want there to be a risk of the cancer coming

back. Throughout her treatments, she could not focus on much other than being sick, but found that volunteers at the cancer center were somewhat helpful: “There was one volunteer there who had not had reconstructive surgery. She just used a prosthesis...she said if I wanted to see, she could show me what her chest looked like and I just didn’t [look] at the time.” My mother had no idea what reconstruction looked like before she had it done. Looking back, my mother said she would have asked to see pictures, but she was not sure it would have changed the outcome. “My mind was sort of numb.” She was diagnosed with stage IIIA breast cancer, which is very aggressive. There was not much time to process her feelings and decisions. She decided to get reconstruction “...because my breasts were really large, I did not want large breasts again, but I didn’t know if I wanted to be totally flat-chested because I just didn’t know how it would look...so I decided to have smaller implants put in.” My mother was a good candidate for reconstruction and had expanders put in the day she had her mastectomy. Although she was a good candidate, her skin started to change after radiation; “You’re skin hardens after radiation. They were just radiating the one side, but if you look or you touch my breasts now, the one side where I didn’t have the radiation is soft...one side is a little bit harder than the other. It looks a little different.”

The dialogue my mother had with her doctors about her reconstruction was very limited. She got the general information from her breast surgeon and plastic surgeon, and was told that everyone’s result was different. They did not show her any pictures of successful (or unsuccessful) reconstructions. They did not tell her about other women’s experiences. The decision was completely left up to her. There was the option of getting nipple reconstruction as well through using skin from her ears, but she said, “I didn’t know if it was necessary for me.” Her concept of breast reconstruction was much different from the results, but not completely unsatisfying after it had healed;

“I guess I thought it would look similar to what I had...but not having maybe the nipple there. I thought it was going to be smooth. I didn't think I was gonna have...I thought the scarring would pretty much go away, it did somewhat, but I still have the full scarring on the front, and then on the side, of my arms, the skin is not tight there. Over the years it's gotten tighter, but in the beginning it was pretty loose there. I do remember Nanny saying to me a couple of times when she first saw it and said 'If you'd known it was gonna be like that... spend the money... you probably shouldn't have even had it done.' And that bothered me a little bit. It's not ugly or anything... but I guess I thought it was going to be like...breast augmentation...But it wasn't like that at all.”

All the tissue had been removed, so the experience of breast reconstruction was very different than how it would have been if she had gotten a cosmetic breast augmentation. My Nanny's comment had not made her impression any better, yet having my Nanny there throughout her treatments was a tremendous support. It was “very strange” for my mother to see herself after reconstruction, especially since she had been large before all this began. “I was thinking about day to day.” My mother was more focused on how sick she felt from the chemo every day than thinking about what she would look like after the reconstruction; “even drinking water was nauseating.”

During the brief period that my mother was able to go to work, she got mixed reactions from customers and coworkers: “either they would avoid me because they didn't know how to talk to me about it, or I would have somebody who would want to just...come up and say they had been through it.” She never got a wig to wear either; “I either wore a hat or I didn't wear anything.” When her hair first started coming out, it came out in handfuls and was very upsetting, so she went and got her hair shaved.

My mother is divorced and does not currently have a partner; however, her friendships changed as a result from her cancer. There were some people who were very supportive, and others who were not as involved as she may have thought. Her interactions with my sister and me were guarded and somewhat distant in terms of talking about her treatments, but she did not want us to worry while we were in school; “I sort of wanted to keep the two of you, whether it's right

or wrong, on the outside...I didn't want you worrying about that, I wanted your lives to be somewhat normal." Finding others to talk to about her experience was difficult because none of her friends or relatives whom she was close to had had breast cancer. Support groups were sporadic and limited to the type of breast cancer treatment, and she was never sure what the volunteers were allowed to talk about or not talk about.

Aside from her changing interactions with others, her life had completely changed during her treatments; "Everything revolved around my body and doctors. My day was set up around appointments with doctors and nurses....That becomes your new norm...and then when that starts to go away and you get back to your other part of life, it's hard at first." Being sick became her life, and it was difficult returning to what she had previously been doing before her diagnosis. Life after her diagnosis also brought unexpected side effects, which her doctors had not described fully;

"I don't know if the doctors don't give it to you because they don't want to make you worry about it...but I would have liked to have been more proactive...know more information because it was such a blur to me...There needs to be more information out there for people just so they know what the changes are going to be...not that you wouldn't have the chemo or the radiation...but just so you know after what's going to happen...for example I didn't know how bad it was going to be on my teeth."

Other physical changes to her appearance include lymphedema from the removal of her lymph nodes. This makes one of her arms larger than the other, which makes it somewhat more difficult when looking for clothes. Besides these side effects, life after treatments is just as difficult as it was before, but she tries not to let negativity get to her as much and tries to focus more on herself; "I think you have to remind yourself, you're what's important."

Analysis

These interviews illustrate that appearing feminine was not a crucial factor for getting breast reconstruction. Appearing *healthy* as a being positively perceived (by others and themselves), or rather, hiding their visible markers of breast cancer, was the most common and important factor cited for a desire to get breast reconstruction. Several themes were introduced by the interviews, all of which are important to understanding the patterns in which women tend to think of their breast cancer experience relating to breast surgery and reconstruction. These themes include the 'blur' of treatment, dialogue lacking information and lack of questioning with medical professionals, appearing 'normal' and living a 'normal' life, and lack of knowledge about breast cancer and reconstruction before diagnosis.

All of the interviews emphasized the blur of time that went by after each woman was diagnosed. Breast cancer is a unique disease because one does not necessarily feel sick before being diagnosed with the disease. The feeling of being sick comes from the treatments themselves before women ever experience painful symptoms from the cancer. Three of the women wanted to separate appearing sick from being sick. None of the women I talked to expressed that they wanted others to recognize that they were sick. It would sometimes be unavoidable for the women to be in public and evade stranger's reactions because of visible markers of the disease such as loss of hair or mastectomy, such as the experience my mother had at her workplace. Visible markers of breast cancer were avoided as much as possible without affecting treatment. Feelings were sometimes hidden from others, particularly from more vulnerable family members (children and elder parents), to minimize worry and pity, and to live 'normally'. These women tried to keep things 'normal' through conserving visible markers of their disease and adjusting to a change in social reactions like avoidance and sympathy. Women conserved their appearance

through choosing alternative treatment methods, such as Christy's decision to be treated with tamoxifen instead of chemotherapy to avoid hair loss. Women adjusted their appearance by wearing hats, shaving their head, and so on. Visibility was an issue that all women struggled with. Many times it came from a selfless attitude of protecting their children from worry and discomfort. Whether or not that was successful is unknown because interviews with the women's children were not conducted.

Faced with the diagnosis of breast cancer, yet still wanting to live a normal life, the women had to strategize which sacrifices they would have to make based on effectiveness and risk of reoccurrence of the disease. Depending on the stage and type of breast cancer, they had to assess, with their medical professional's help, what kinds of treatments—including breast surgery and reconstruction—they would prefer (if they had a choice). The period of time in which to decide what option was best for their survival was often very limited. Often they did not know what questions to ask the medical professional about those options, and the medical professionals kept the dialogue very general and left the decision of accepting or rejecting reconstruction completely up to the women. Some of the women, even though they knew women with breast cancer, did not know about negative consequences, partly because their loved ones and friends who had cancer (and whom they felt close enough to seek advice from) avoided mention of negative realities and consequences of the disease, or had had relatively 'successful' treatments and reconstruction breast surgery. Their doctors certainly did not offer pictures or experiences of women who had negative experiences and failed attempts of breast reconstruction.

One of the women who had a lumpectomy, Donna, was not asked if she wanted any sort of cosmetic surgery to fix the 'hole' under her breast. Donna had received a general brochure about it but did not talk to her doctor about cosmetic surgery. Yet, Donna had lost a part of her. Many people, I'm sure, would say that cosmetic surgery was not required, but the line between 'needing' cosmetic surgery or not is blurry and is subject to what the patient and doctor think is

'taking out too much.' To Donna, it seemed at some point more practical to remove the breasts completely in her mother's case. When is a breast not a breast anymore? How much tissue has to remain? At what point is the breast no longer recognizable as such? Is it possible to reconstruct a breast to look natural? These questions are highly subjective, yet these are questions that might arise when a woman is determining whether she should get a mastectomy to perhaps reduce her risk of the cancer recurring, or to get a lumpectomy and possibly save what remains of her breasts. As with any other part of the body, most people have no desire to be maimed or to have chunks of them disappear. If we avoid extreme ideas about the importance of breasts such as that they make a woman a 'woman', or, conversely, that they do not matter, we can think of them as what they mean to the person, but also what they mean for the person's quality of life, including their sexuality, ability to nurture, and their self-esteem.

Quality of life after breast cancer matters to the women I interviewed, and it can change given a person's standing in life and coping abilities. I received a phone call from a woman who was interested in my research, but who, for physical reasons, could not meet with me. This woman was in her eighties, and had strongly wished she could have breast reconstruction. However, she decided against it because she was concerned that if she went through all of the invasive reconstruction surgery, she would regret doing so if it meant a higher risk of losing her life in the process, or dying within a short period of time after her surgery for another reason. She felt she could do nothing about her quality of life at her stage in life. Her concerns illustrate the dangers of going through breast reconstruction after having gone through treatments of a life threatening disease. Donna's mother did not think that breast reconstruction was worth the trouble at her age either.

Many of the women did not think about the consequences of breast reconstruction. My mother simply could not process what everything meant at the time of her treatments, and Jen had not been aware of the extent of risk to which she was exposed to by getting reconstruction. This is

in part due to the dialogue with medical providers. My mother seemed to think that doctors shielded cancer patients from seeing what their bodies might look like after mastectomy or reconstruction, or omitted certain symptoms they might acquire. Jen wished that more information had been given and that there had been more awareness of the gravity of what the breast reconstruction might cause. A sense of “going back to normal” and a “why not?” attitude were part of the decision making process; however, the realities of reconstruction somewhat fell short compared to women’s expectations, and in some respects, reconstruction was better than an alternative or sparked a realization that reconstruction was not what they wanted after all. For example, my mother believed that reconstruction was better than having a flat chest and she likes her reconstruction even though it was not what she originally expected. Jen, on the other hand came to the realization after her failed attempt at reconstruction that she preferred having no breasts. These outcomes could have been better if the women were more aware of all angles of the procedure. Both Jen and my mother had a lack of knowledge about the look of reconstructed breasts, and other women’s experiences with them.

All but one of the participants had biopsies, two of the participants had lumpectomies (one had two lumpectomies at different times), and two participants had radical mastectomies and attempts at reconstruction. Only one of the attempts at reconstruction was regarded as successful. Breast reconstruction attempts were considered successful if the surgeon was able to insert implants that maintained themselves in the woman’s body and gave the impression of having breasts. Satisfaction was very subjective and not all women mentioned in the narratives were completely satisfied with their results. My mother did not discuss reconstruction with anyone, and encouragement to speak with women who have had the surgery was not facilitated or mentioned by her surgeons. Her decision to accept reconstruction was not well-informed, yet she was still happy with the results, even though her mother was less satisfied. This shows that my mother was not exactly influenced by others’ opinions; however, a decision was made without complete

information. The women who attempted breast reconstruction were also both large-chested pre-diagnosis and wished to regain part of their previous proportions. My mother is now a smaller size, but does not have a flat chest, and Jen is completely happy with the fact that she no longer has breasts because they no longer obstruct her sleeping, hurt her back, or get in the way of her flute-playing.

All but one of the participants had a family history of breast cancer, although lack of expression of breast cancer in family history does not mean that it could not have been carried for some generations before the most recent memory of the family. The women who knew relatives or friends who had been through breast cancer had a better perspective on their choices and were able to process their experiences during treatments. Having family members and friend who have been through breast cancer may be an advantage to coping with the disease. A woman might not feel comfortable asking strangers about their experience that is already producing fear. Some women are more private about their breast cancer experiences than others. This was exhibited in Christy's narrative when the woman refused to come out of the changing area. Perhaps women feel as though by asking strangers to divulge private information about their experiences, they are exposing themselves as well.

Klawiter (2008, p. 53) states "Previously, patients remained clothed during medical examinations. Now their bodies were exposed, touched, and examined by physicians, who adopted a sense of scientific detachment." Breast cancer exposes women's bodies and private health information to the public and perhaps to those to whom they would rather not reveal themselves. In this sense, it is understandable that asking strangers for advice in person would not be a preferable way for women who are already feeling vulnerable, exhausted, and sick, to seek information. On the other hand, women who have had bad experiences with breast reconstruction may not want to frighten or worry women who could potentially experience the same situation. Christy felt very bad after she downplayed the seriousness and emotion she felt about her disease

to the recently diagnosed person she spoke with on the phone. She realized afterward that that probably had not been helpful to her.

Femininity was rarely discussed as a reason for breast reconstruction. Reconstruction was simply a way of continuing a normal life. The idea of returning to a normal life could be challenged by asking: *what is a normal life?* These women have been changed by breast cancer, so having a life that resembles what they had before diagnosis is somewhat unrealistic. Even though femininity was not discussed, looking healthy was important when going out in public to avoid unwanted interactions. There was no room for any indication that the woman was sick, because that brought positive and negative scrutiny. In one instance, Jen told me of a cousin, diagnosed with breast cancer, who had died because her husband wanted her to keep her breasts, even though his previous wife had died of breast cancer. While this was a shocking story, it seems to agree with Lorde's (1980, p.65) discourse on beauty and mastectomy; "...where the superficial is supreme, the idea that a woman can be beautiful and one-breasted is considered depraved, or at best, bizarre, a threat to 'morale.'" It is not only the scrutiny of strangers that seems to be an issue: additionally it is the reactions of loved ones that are kept in mind by women deciding whether to get breast reconstruction.

Although each woman's experience was different, their stories added to the limitless accounts of breast cancer and breast reconstruction narratives.

Discussion

This study aimed to explain the reasons why women accept or reject breast cancer. This decision is important to contextualize within American culture and women's subjective experiences. Medical establishments do not always pay attention to cultural and social contexts and how they affect the decisions of their patients. It is important to recognize these contexts to be able to improve the experiences of women going through breast cancer and making decisions about their surgeries. From the four women that I have interviewed, their thoughts concerning reconstruction show a tendency for reconstruction to be a way of returning to a pre-diagnosis body and apprehension of letting go of having breasts than on femininity. Cromptvoets (2006, p. 3) describes the challenges of their decision: "As women come to grips with the changed landscapes of their mastectomized body and the challenges a breast cancer crisis has brought to their sense of self, they are simultaneously faced with powerful social discourses which situate their body as incomplete, abnormal, and unfeminine without two breasts. Furthermore, the restoration of their health and well-being is positioned as intricately linked to regaining their pre-surgery appearance..." Although it is true that these women were facing many different challenges to how they viewed their body, the women I spoke to never mentioned femininity as being an important part of their decision. They did communicate the need to keep their lives normal and unhindered by any and all treatments of breast cancer.

The results of my study illustrated important themes in the experiences of these women. Treatment seemed like a 'blur' in which they felt that they had less time to make choices and could not comprehend the drastic affects breast cancer would have in their lives. When speaking to their doctors, their dialogue lacked information and the women felt they did not know what questions to ask in the first place. Appearing healthy and living a 'normal' life was by far

the most expressed reason for avoiding changes to their body. The final result was the realization that there was lack of knowledge about breast cancer treatment symptoms and reconstruction before diagnosis and during treatments. These themes are not conclusions for what all women who have breast cancer believe, but they are important notions for people, especially medical professionals, should keep in mind when treating a patient for breast cancer.

My research would have benefitted from a longer period of recruitment and interviewing. If I were to expand this study, I would interview more women and carry out participant observation in a support group. I would have also liked the chance to interview the women's partners if possible in order to learn their attitudes about breast reconstruction. Three of these women were happily married at the time of their diagnoses and treatment and had strong support. This could change my results depending on the type of partner, partner relationship, or absence of a partner.

Although my study is focused on women, men are also susceptible to breast cancer and reconstruction and their stories are deserving of recording, especially since their representation in the breast cancer community is virtually unheard of and not as easily accessible. None of my participants identified as being non-heterosexual or transgender. Adding non-heterosexual and transgender narratives would benefit our understanding of reconstruction because of their current unique position in society.

A historical perspective would have added more depth to this study. All of the interviews I've done were with women who were diagnosed within the last twenty years; however, the majority was diagnosed within the last decade. Breast and cosmetic surgery has advanced considerably in recent years. It would be helpful to hear experiences of women who had had breast surgery and breast reconstruction, for example, from the 1950s, compared to now. Because all of the women were diagnosed more recently, there is also the bias of all of the women being the same generation range of 40-60 years old.

The suggestions I would make for medical providers would be to encourage women to ask others about their breast reconstruction experience, find out what the patient believes is involved with the reconstruction and dispel any misconceptions the patient has, and provide written and/or visual testimonies of both successful and unsuccessful breast reconstructions. Medical professionals should acknowledge that the patient might be disoriented. By recognizing the bewilderment of the patient, the medical professional can improve dialogue with them. Audio-recording patient-medical professional appointments may also benefit women who cannot remember certain details. The involvement of a patient navigator or advocate may help guide women by bringing awareness to certain topics that may not be considered by women diagnosed with breast cancer so that they can ask more relevant questions in appointments with medical professionals.

Conclusion

The outcome of this study was a clearer understanding of the complex decision making process of breast reconstruction. The possibility of breast reconstruction not only affects those who undergo mastectomies, but also affects any breast cancer patient who undergoes any breast cancer treatment. When a woman is treated for breast cancer, many changes to her body conflict with how women are supposed to look and feel in our society. Women are supposed to be nurturing, optimistic, and feminine. Each woman I interviewed had a story that offered something new to be discussed. Although there are many who survive the disease, the effects of the cancer are never completely 'cured' and the disease (and its treatments) affects more than the individual's physical body and psyche. This study involves more than simply the reasons why women accept or reject breast reconstruction. This study holds a mirror to what we think of as the breast cancer experience and how we view women's choices about their bodies. The importance of narratives needs to be highlighted in the clinical setting, for the benefit of patients, medical providers, and for society.

My study showed that there are many complexities that shape a woman's decision for reconstruction. Some women make a conscious choice and others do not. No one chooses to get breast cancer, so to assume that the decisions all women make about their bodies is a choice is sometimes the wrong way to phrase it. Some women refuse to make a decision and go with what their doctor recommends. Deciding to get reconstruction is just as easy for some women as deciding not to.

My research through interviews with cancer survivors, can provide medical professionals and health care providers a view from their patients' perspective and an opportunity to integrate them in consultations for breast cancer patients undergoing mastectomies with the option of

reconstruction. My findings may support future research studies in the area of breast cancer that have a farther reach in the academic research realm. I hope my suggestions can improve the dialogue between medical provider and breast cancer patient about the patient's desires for breast reconstruction, and also enhance public dialogue about gender in broader public health and in American culture. I strongly hope this research can help bring the benefits of public awareness, cultural change, and improved knowledge in the medical and social realm to those who chose to participate in my study and those beyond the parameters of my study.

Institutional Review Board Process and Access to Participants

An honors thesis gives undergraduates an opportunity to be a researcher and explore their interests and passions. However, this experience, as I have found, is somewhat limited. Our undergraduate education in many ways gives us hands-on (and minds-on) experience, but perhaps falls short of teaching us how to navigate the realms of authentic research. Our undergraduate theses are supposed to challenge what we can do with what we have not yet learned, but wish to procure. This is a difficult endeavor, and one that I have often described to my friends and family as similar to stumbling around like a baby first learning how to walk. I was unsure of what I was doing, where I was going, and what I was going to do when I got there. All I had was the hope of a completed thesis.

Originally, I had wanted to interview women in breast cancer support groups. I assumed this would be a convenient place for me to recruit willing participants and a great way to view the potential group interactions and exchange about the topic. I wanted to do statistical research on variables and get quantifiable results about the reasons women accept or reject breast reconstruction after breast surgery due to breast cancer treatment. The support groups that I was aware of nearby were connected to Mount Nittany Medical Center. I knew I would have to go through the Institutional Review Board, but no one, it seemed, had done anything like what I wanted to do at an undergraduate level. I tried to go through a hospital to gain permission to talk to the women in their support group. After contacting all the wrong people, I finally got a meeting with someone who seemed as though she would help. At this meeting, I was treated as a professional researcher. I tried my best to present my proposal to them, but didn't know exactly what was required of me. The meeting did not go well at first, but eventually the hospital representative figured out I was clueless and gave me a ton of materials to fill out— ten page

consent forms, HIPAA waivers, signature documents, and the like. It took me a few weeks to fill them out correctly, and when I handed them back in, I was told that it was not professional enough. After I had spent many hours preparing the material, it was disheartening that I had not met the standards they held. I did not know if I was not living up to my expectations or theirs. All I knew was that I had already spent a couple months preparing to do research that was never going to happen.

Hospitals are very protective of their patients—and they should be! However, considering the regulations the hospital had concerning research, there was no one there who had any experience helping students navigate the hospital research world correctly. I was treated as a professional when I should have been recognized as a student. At this point I did not have the time required to follow through with my plans and had to abandon the hospital site altogether. Interviewing the hospital support group had been made impossible. This was a huge blow because I had spent my entire fall semester of senior year working on trying to go through the separate IRB proposal I would have had to complete. Mount Nittany Medical Center required its own IRB proposal, separate from the one that was required of me from The Pennsylvania State University. Medical humanities research in hospital settings is, from my experience, very rare, however urgently needed. I can only imagine the difficulties other students may have.

My recommendations to future students considering social science research in medical settings would be to start very early and to enlist the help of someone who has done something like it before. Present yourself professionally, and know what you will be getting into. I was intimidated when the representative I spoke with asked, “What would you do if the person you were talking to expressed that they wanted to commit suicide?” Of course I would be prepared with hotline numbers or contact information of someone who could more appropriately help though I felt that the point of asking the question was to point out her assumption that the situations I might experience were things that I could not handle because I was an undergraduate

student. However, just because I have not had as much experience with research as professionals does not mean that I will be incapable of learning how to correctly mitigate a situation. At some point in our lives we must make ourselves vulnerable to risks, and all professionals have to start somewhere (usually when they are students).

In hindsight it may have been better to have interviewed women who had some distance from their diagnosis; however, had a woman who was just diagnosed contacted me, I would have met with her. I also should not assume that a woman who has had some time to experience life again without treatments is not just as affected as a woman who was just diagnosed. I knew how I was going to do the interviews, but the problem rested more on how to get interviews with the women at the hospital. I met a lot of resistance, but eventually found my own way that was just as effective at finding and interviewing participants.

Students should be open to the fact that they need a lot of guidance through the hospital IRB process, and, if possible, look to other studies to see how the process has been conducted in the past. Being familiar with IRB regulations would be to one's advantage and asking questions about doing research instead of 'auditioning' to do research is a better approach to take.

With any research there will be time when the researcher has to take a step back to take a step forward. Keeping perspective about the significance of one's research can help determine how encompassing you can feasibly make your study. It helps to take risks to get what you want; however, sometimes the path may have to be modified to make the most of your investigation.

Appendix A
Recruitment Flyer

Participate in a Research Study

Do you have **breast cancer** or are a breast cancer survivor? Have you had or thought about **breast reconstructive surgery**? If you are willing to talk about your experience for a Penn State University undergraduate research study, please contact:

Devon Santoro
email: dcs5224@psu.edu
phone: (908)235-6094

Devon Santoro
dcs5224@psu.edu
908 235-6094

Appendix B

Consent Form

Summary Explanation of Research

The Pennsylvania State University

Title of Project: Reconstructing Perspectives: A Mosaic of Narratives from Women with Breast Cancer about Breast Reconstruction

Principal Investigator: Devon Santoro

Telephone Number: 908-235-6094

Advisor: Dr. Patricia Johnson

Advisor Telephone Number: 814-865-3129

Printed Name of Participant: _____

You are being invited to volunteer to participate in a research study. This summary explains information about this research.

- The purpose of this study is to understand more fully women's desires to accept or reject breast reconstruction after breast surgery related to treatment of breast cancer.
- Participants will pick a public location for an interview or request an interview by phone. The interview time will range from 45 minutes to an hour and focus on personal experiences with breast reconstruction and breast cancer. The participant has the option of whether or not they want the interview to be audio recorded, and whether or not the principle investigator is allowed to take notes during the interview if not recorded. First, participants will be assured confidentiality, and then will be asked to answer the questions as fully as possible and to the best of their ability; noting that the interview is

voluntary and they may stop the interview at any point if they wish. After the interview, I will transcribe the material (if applicable) and use it anonymously in my research. A copy of the paper will then be given to each participant after it is finished.

- Your research records that are reviewed, stored, and analyzed at The Pennsylvania State University will be kept in a secured area in a locked cabinet in Dr. Patricia Johnson's locked office at:

518 Carpenter Building

University Park, PA 16801

In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared.

If you have questions or concerns, you should contact Devon Santoro at 908-235-6094.

If you have questions regarding your rights as a research subject or concerns regarding your privacy, you may contact the Office for Research Protections at 814-865-1775.

Your participation is voluntary and you may decide to stop at any time. You do not have to answer any questions that you do not want to answer.

Tell the researcher your decision regarding whether or not to participate in the research. [*For verbal consent*] **OR** Your participation implies your voluntary consent to participate in the research. [*For implied consent*]

Your signature below means that you have received this information, have asked the questions you currently have about the research and those questions have been answered. You will receive a copy of the signed and dated form to keep for future reference.

Participant: By signing this consent form, you indicate that you are voluntarily choosing to take part in this research.

Signature of Participant Date Time Printed Name

Person Explaining the Research: Your signature below means that you have explained the research to the participant/participant representative and have answered any questions he/she has about the research

Signature of person who Date Time Printed Name
explained this research

Permission to be audio recorded OR to have notes taken by the Principle

Investigator

Participant: By signing below, you indicate that you are voluntarily giving your permission for the principle investigator to audio record interviews that you participate in.

Signature of Participant Date Time Printed Name

Person Explaining the Research: Your signature below means that you have made known to the participant/participant representative that they must give their permission to be audio recorded during interviews and have answered any questions he/she has about the audio recordings.

Signature of person who Date Time Printed Name
explained this research

Participant: By signing below, you indicate that you are voluntarily giving your permission for the principle investigator to take notes during interviews that you participate in.

Signature of Participant	Date	Time	Printed Name
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Person Explaining the Research: Your signature below means that you have made known to the participant/participant representative that they must give their permission to the principle investigator to take notes during interviews he/she takes part in, and have answered any questions he/she has about the note taking.

Signature of person who explained this research	Date	Time	Printed Name
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Appendix C
Unstructured Interview Questions

List of potential questions

> = only ask if participant has a partner

BREAST CANCER PATIENT (BEFORE RECONSTRUCTION):

1. Tell me about your experience with breast cancer.
2. What kind of reconstruction surgery are you eligible for?
3. Are you still deciding whether or not to receive breast reconstruction?
4. What factors are important for your decision about breast reconstruction?
5. If you opted for breast reconstruction, would you be able to afford it?
6. Can you think of any important qualities that you would gain from breast reconstruction?
7. Do you think breast reconstruction could improve the quality of your life if you opted for it?
- >8. Does your partner express any encouragement for or against breast reconstruction?
- >9. Do you think future partners will find you more so attractive if you opt for breast reconstruction?
10. How do you think others would respond to seeing you without breasts if you do not opt for the surgery? (Your partner, family, friends, acquaintances, strangers?)

11. Do you think you are expected to get breast reconstruction? (by your partner, family, friends, acquaintances, strangers?)
12. What are your doctors' opinions about breast reconstruction?
13. Do your doctors have conversations with you about your decision to receive breast reconstruction or is it presented as just an option?
14. Are you influenced or encouraged in any way by other breast cancer patients and survivors to opt for breast reconstruction?
15. How do you feel about the process of breast reconstruction?
16. How do you think of breast reconstruction compared to other treatments you have gone through for breast cancer?

SURVIVOR (post-reconstruction surgery):

1. Tell me about your experience with breast cancer.
2. What type of mastectomy have you had?
3. What kind of reconstruction surgery were you initially eligible for?
4. How did you come to the decision to get breast reconstruction?
5. What were the most important factors in your decision?
6. Were you able to afford the surgery?
7. Through your experience, what are the advantages and disadvantages of the reconstruction surgery and having reconstructed breasts?
8. Has the surgery improved your quality of life? Or has it at all?
- >9. Did your partner express encouragement or discouragement towards the surgery?
- >10. How do you think the surgery has affected your relationship with your partner/will affect future relationships?

11. How do you think others responded to seeing you without breasts? (Your partner, family, friends, acquaintances, strangers?) Do they see you differently now that you have reconstructed breasts?

12. Do you think you were expected to get breast reconstruction? (By your partner, family, friends, acquaintances, strangers?)

13. What were your doctors' opinions about breast reconstruction?

14. Did your doctors have conversations with you about your decision to receive breast reconstruction or was it presented as just an option?

15. Were you influenced or encouraged in any way by other breast cancer patients and survivors to opt for breast reconstruction?

16. How do you feel about the process of breast reconstruction?

17. How do you think of breast reconstruction compared to other treatments you have gone through?

SURVIVOR (decided against breast reconstruction):

1. Tell me about your experience with breast cancer.

2. What type of mastectomy have you had?

3. What kind of reconstruction surgery were you eligible for?

4. How did you come to the decision to not get breast reconstruction?

5. What were the most important factors in your decision?

6. Would you have been able to afford the surgery?

7. What did you perceive the advantages and disadvantages of having the reconstruction surgery to be?

8. Do you think breast reconstruction could have improved or worsened the quality of your life if you had opted for it? Do you think your quality of life would have been the same?

>9. Did your partner express encouragement or discouragement towards the surgery?

>10. How do you think NOT getting the surgery has affected your relationship with your partner/will affect future relationships?

11. How do you think others respond to seeing you without breasts? (Your partner, family, friends, acquaintances, strangers?) Has that changed from the time of the initial mastectomy?

12. Do you think you were expected to get breast reconstruction? (by your partner, family, friends, acquaintances, strangers?)

13. What were your doctors' opinions about breast reconstruction?

14. Did your doctors have conversations with you about your decision to receive breast reconstruction or was it presented as just an option?

15. Were you influenced or encouraged in any way by other breast cancer patients and survivors to opt for breast reconstruction?

16. What are your views on the process of breast reconstruction?

17. How do you think of breast reconstruction compared to other treatments you have gone through?

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ACADEMIC VITA

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EDUCATION:

- 2014 **The Pennsylvania State University, University Park, PA** Graduation: May 10,
The Schreyer Honors College
Bachelor of Arts in Anthropology and History
Minor in Sexuality and Gender Studies
Dean's List all semesters Paterno Fellow
- 2013) **Universiteit van Amsterdam, The Netherlands** (Spring
and Courses in Anthropology of East Asia, Sexuality and Gender in the Context of Amsterdam, Gender
and Ethnicity in Post-Colonial History, Dutch Language and Culture

RESEARCH:

Honors Thesis (In Progress): Narrative Mosaic of Breast Reconstruction

(April 2013-Present)

Student

- Wrote a proposal for my thesis which was approved by the Schreyer Honors College
- Gained Penn State Institutional Review Board approval for research study with human participants
- Interviewed women in person from State College, PA
- Reflected on these women's experiences in my thesis
- Analyzed how breast reconstruction affects femininity and assessing women's desire to get reconstruction

Paper: Breast Cancer and Sexuality in the Netherlands, Utrecht, Netherlands

(February 2013-June 2013)

Student

- Interviewed sexological researcher at Rutgers WPF, located in Utrecht
- Found that there is apparent ageism for women seeking sexological help, and there is little sexological help available in general for women in the Netherlands
- Wrote twenty-five page paper based on findings from interview and library research

Zooarchaeology Laboratory, Pond Lab, University Park, PA

(Fall 2011-Fall 2012)

Researcher

- Conducted faunal analysis on the length of pinniped femora and humeri from an archaeological site in the Channel Islands
- Assisted in building a comparative animal skeleton collection
- Sorted faunal material from an archaeological field site in El Gigante, Honduras

Penn State Archaeological Field School, Shirleysburg, PA

(Summer 2012)

Student

- Participated in a field school at a mid-18th century trading post and British Colonial fort
- Learned how to draw profile and plan view maps, take soil and flotation samples, and curate artifacts
- Wrote detailed excavation notes and created a journal of my experience
- Established and tested a hypothesis about the location of the east and west palisades

LEADERSHIP:

Penn State Anthropology Society

(Fall 2011-Spring 2012)

President

- Organized club events such as graduate panels, information sessions, activity area at Discovery Space Children's Science Museum and fundraising
- Conducted weekly meetings that promoted educational awareness of anthropology
- Organized and planned educational outing to Elk Creek Cafe on the history and culture of beer

HONORS/ AWARDS:

- IES Abroad Ambassador (June 2013-Present)
- Penn State Education Abroad Peer Adviser (Fall 2013-Present)
- Phi Alpha Theta National History Honor Society (Fall 2012-Present)
- Member of the National Society of Success and Leadership (Fall 2012-Present)
- Undergraduate Enrichment Award (Summer 2012) (Spring 2013), Hatch Memorial Enrichment Fund Award (Summer 2012) (Spring 2013), Schreyer Honors College Grant (Summer 2012) (Spring 2013), History Enrichment Award: Penn State Department of History (Spring 2013), Penn State Alumni Association Education Abroad Scholarship (Spring 2013)

COMMUNITY SERVICE

- Volunteered for Habitat for Humanity (Fall and Spring 2010)
- Volunteered for New Eyes for the Needy (2006-2011)
- NSLS THON (Fall 2012-present)
- NSLS Community Service Committee Lead (Fall 2013)

LANGUAGE SKILLS: Seven years of written and oral French, Elementary Dutch.

CERTIFICATIONS:

Tibetan Usui Reiki Ryoho II Practitioner

- Performs the Japanese practice of effective energy healing through the use of spiritually guided life force energy